Shetland Islands Health and Social Care Partnership

Shetland NHS Board	**Shetland Islands Council**

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7 May 2019

Dear Member

You are invited to attend the following meeting:

Integration Joint Board
Tuesday 14 May 2019 at 10a.m.
Council Chamber, Town Hall, Lerwick

Please note the **venue** for this meeting and the change in **time**.

Apologies for absence should be notified to SIC Committee Services on 01595 744599.

Yours sincerely

Simon Bokor-Ingram
Chief Officer

Chair: Ms Natasha Cornick
Vice-Chair: Mr Allison Duncan

AGENDA

A Welcome and Apologies

B Declaration of interests - Members are asked to consider whether they have an interest to declare in relation to any item on the agenda for this meeting. Any member making a declaration of interest should indicate whether it is a financial or non-financial interest and include some information on the nature of the interest. Advice may be sought from Officers prior to the meeting taking place.

C Confirm minutes of meeting held on 13 March 2019 (enclosed).

ITEM

1 Appointments to the IJB
GL-05

2 Primary Care Improvement Plan
CC-19

3 Directions to Shetland Islands Council and NHS Shetland
CC-22

4 2019/20 Recovery Plan projects and Invest to Save Proposals
CC-20

5 Community Led Support Programme (Report to follow)
CC-21

6 Integration: Self Evaluation and Development Plan
CC-23

7 IJB Business Programme 2019 and IJB Action Tracker
CC-18

Agenda Item

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Shetland Islands Council

MINUTES – PUBLIC

Meeting	**Integration Joint Board (IJB)**
Date, Time and Place	**Wednesday 13 March 2019 at 2.30pm** **Bressay Room, NHS Shetland (NHSS) Headquarters, Montfield, Burgh Road, Lerwick, Shetland**
Present [Members]	**Voting Members** Natasha Cornick Allison Duncan Shona Manson Emma Macdonald Robbie McGregor Marjory Williamson **Non-voting Members** Simon Bokor-Ingram, Chief Officer/Director of Community Health and Social Care Maggie Gemmill, Patient/Service User Representative Jim Guyan, Carers Strategy Group Representative Catherine Hughson, Third Sector Representative Ian Sandilands, Staff Representative Edna Watson, Senior Clinician – Senior Nurse Karl Williamson, Chief Financial Officer
In attendance [Observers/Advisers]	Claire Derwin, Self Directed Support Sheila Duncan, Management Accountant Christine Ferguson, Director of Corporate Services, SIC Kristen Johnston, Solicitor, Governance and Law, SIC Jane Haswell, NHS Board representative Gary Robinson, Chairman of the NHS Board Hazel Sutherland, Head of Planning and Modernisation Bob Kerr, Communications Officer Leisel Malcolmson, Committee Officer, SIC *[note taker]*
Apologies	**Voting Members** None **Non-voting Members** Susanne Gens, Staff Representative, SIC

	Denise Morgan, CSWO Pauline Wilson, Senior Clinician: Local Acute Sector Edna Watson, Senior Clinician – Senior Nurse (for lateness) **Observers/Advisers** R Roberts, Chief Executive, NHS Board
Chairperson	Marjory Williamson, Chair of the Integration Joint Board, presided. Ms Williamson advised that this would be her last meeting of the IJB before she retires from her role as Non-Executive Director on the NHS Board and Chair of the IJB. She advised that the NHS Board had appointed Ms Natasha Cornick as the next Chair of the IJB and Ms Jane Haswell had been appointed as a voting member representative with Mr Gary Robinson becoming a substitute for the NHS Voting Members. The Chair thanked all Members and attendees for their scrutiny and contributions noting the support she received from a number of particular individuals including the Chief Officer and the Vice-Chair. The Chair explained that she had been on the IJB since it started and commented that there had been many ups and downs. She took time to reflect on the work of the IJB and the successful projects and initiatives that had been progressed. The Chair commented on the work ahead and the requirement to work in partnership with other agencies to achieve the strategic aim to look after people at home. The Chair reiterated her thanks to everyone for their time in achieving all that had been done so far and wished everyone well moving forward.
Declarations of Interest	None.
	The Vice-Chair again raised his frustration at the size of the pack of papers presented to Members and asked for consideration to be given to holding more meetings when the agenda becomes too big. During some discussion it was indicated that every effort is made to use background documents as much as possible however statutory requirements and deadlines meant that it is not possible to reduce the amount of information. Comment was made that covering reports bring forward the key issues for consideration providing Members with the choice to use the attachments for reference as opposed to reading attachments in their entirety. The Director of Corporate Services added that the officer's role is to provide the best possible advice and they have a duty to present the best information they have. She advised that the use

	of briefings would remove the noting reports but reports to committee is a judgement call and good dialogue is essential. The Director of Corporate Services said that Members must be satisfied that they have all possible information to make a good decision within the IJB's authority. It was agreed that the effectiveness of the board would be considered and a report brought in due course.
Minutes of Previous Meetings	The minutes of the meetings held on 23 January 2019 were confirmed on the motion of Mr Duncan, seconded by Ms Cornick.
06/19	**Financial Monitoring Report to 31 December 2018**
Report No. CC-13-19-F	The IJB considered a report by the Chief Financial Officer that provided information on the Management Accounts for the period to 31 December 2018. The Chief Financial Officer introduced the report and highlighted the main variances identified in section 4. During discussions there was some consideration given to the carer costs and the Chief Financial Officer was asked to find a way to provide detail on carers costs to show the true spend in this area and to circulate that to all Members. The Chief Financial Officer also responded to a question in regards to pharmacy and on whether the forecast in this area had included any provision for the possible impact of Brexit. He advised that current forecast was based on the best information available at the time and didn't include any adjustment for Brexit.. The IJB noted that Brexit was being considered by a working group and recognised that every Health Board was in a similar situation in terms of forecasting what will be required. Any significant cost impact may have to be covered by the Scottish Government as health Boards across Scotland do not have contingency budgets available. Reference was made to paragraph 4.13 "Unscheduled Care" and the costs incurred for use of locum doctors. It was acknowledged that these costs also included travel and accommodation which was unique to island and remote areas which offered a good business case that could be made to the Scottish Government for funding. A suggestion was made that Mr Robinson, Chair of the NHS Health Board raise this with Ministers. These comments were acknowledged but it was explained that the Scottish Government had provided funding to support initiatives to address the challenges. It was noted that funding had been provided for a bureau for GP recruitment in a number of health boards in Scotland and Shetland was running a bureau, with locally provided jobs to do that. (*Mr Sandilands left the meeting).*

	The IJB were advised that there had been considerable interest in the GP bureau and a weekend event would be held on Mainland Scotland by the Director of Human Resources and Support Services, NHS, and the Service Manager Primary Care with a view to recruit. It was suggested that once efforts to solve the problem at the root had been exhausted there would be discussions held. A final plea was made for all parties to work together to bring more money in for locum costs. In response to a question it was agreed that information would be circulated to Members providing more detail on the areas of overspend covered by GP locums highlighted in section 4 of the report.
Decision	The IJB NOTED the 2018/19 Management Accounts for the period to 31st December 2018.
07/19	**Shetland Islands Health and Social Care Partnership - Quarterly Performance Overview, Quarter 3: October - December 2018**
Report No. CC-12-19-F	The IJB considered a report, by the Director of Community Health and Social Care and Head of Planning and Modernisation, NHS Shetland that presented the strategic overview of all elements of progress towards delivering on the strategic plan. The Head of Planning and Modernisation introduced the report and advised that given earlier discussion she would consider what information could be circulated by web link and briefings to ensure focus is given to the right areas. During discussion it was agreed that the first item listed in Appendix 2 would be the first to be provided and that data is to start being recorded and presented in two performance reports time so as to gather sufficient data to report on. Reference was made to the third item of Appendix A "Community Care Resources" and in responding to a question the Chief Officer advised that the business cases were being formulated and would be tested on tangible outcomes and the business cases would be aimed at getting better outcomes providing support in day care or the community. He advised that the business cases would be brought to the IJB with more detail. There was some discussion around the targets in Appendix D indicators CCR009 "people waiting for placements" and CCR005 "occupancy of care homes" and clarification was provided on the differences between the data sets. Indicator NIPI06 "Balance of Care" was highlighted as one of many that the IJB should be proud of given that it was the best of

	Scotland and Officers and staff were commended for their hard work in all areas within the report.
Decision	The IJB NOTED the Shetland Islands Health and Social Care Partnership's Strategic Commissioning Plan 2017-2020.
08/19	**IJB Medium Term Financial Plan 2019/20 to 2023/24**
Report No. CC-16-19-F	The IJB considered a report by the Chief Financial Officer that provided information on the first medium term financial plan (MTFP) for the IJB for the period 2019/20 to 2023/24. The Chief Financial Officer introduced the main terms of the report set out in section 2 and advised that the MTFP would be revised annually and future decisions would be aligned to the plan. (*Ms Watson attended the meeting)* Comment was made that the IJB needs more money and that was highlighted given the level of savings set out in the plan. There followed discussion around how savings are identified and the use of formula and projections until changes are made. It was acknowledged that where it becomes clear that savings cannot be realised once initiated, it would be necessary to recalculate or consider something else. Further comment was made that in order to get more funding from the Scottish Government for a project it was important to have a good evidence base and as much information as possible. The Chief Financial Officer reassured that a good business case would have information, timescale and figures attached that was not just based on an algorithm. He added that this would be set against the long term financial plan and Members would be fully informed when making decisions. The IJB noted that there would be detailed plans for some areas presented in May. The IJB were informed that it was necessary to tackle the root cause of the problem and in terms of the difficulties around recruitment it was important to work on attracting GPs to Shetland. Mr Duncan moved that the IJB approve the recommendation contained in the report. Ms Cornick seconded.
Decision	The IJB APPROVED the IJB Medium Term Financial Plan 2019/20 to 2023/24.
09/19	**2019/20 Budget**
Report No. CC-15-19-F	The IJB considered a report by the Chief Financial Officer that set out the proposals for the 2019/20 payments to the IJB from Shetland Islands Council (SIC) and NHS Shetland (NHSS) and the associated budget of the Shetland IJB.

	The Chief Financial Officer introduced the report and advised of a change to the decision note presented at section 1. It was agreed that the published version would be updated accordingly. The Chief Officer suggested that the IJB consider both this and the next item together before considering the decisions to be made. Officers were asked why the NHS does not provide a fully balanced budget at the beginning of each year as opposed to providing top up payments at the end. It was noted that the NHS has significant savings targets of its own and therefore cannot pass on funding that it does not have. There are also additional funding allocations received throughout the year which are not known at the budget setting stage. During further discussion technical questions were asked in regard to how the IJB is funded and managed and it was acknowledged that the use of seminars and the Liaison Group is key to the process. In considering the recovery plan savings areas identified at paragraph 4.12 concern was expressed that the IJB were to approve the plan without a SMART business plan in place. The IJB were assured that business plans would be presented for the four service areas listed, in May 2019, and would include more detail and relevant dates. In terms of Pharmacy and Prescribing specific concern was expressed in regard to potential shortages and increased costs as a result of Brexit. The Chief Officer advised that staff were working with the information they have and the Director of Pharmacy was looking towards tangible savings. It was stated that should there be a situation where there are higher charges or supply costs there would be a need for either central government funding or there would be an increase in costs across a number of service areas. The Chief Officer said that things had to carry on but the risk was acknowledged. He said it was important to continue with savings not just within Health but with Social Care as well. In referring to the contingency set aside by the NHS in paragraph 4.35 and the proposed payment noted at 4.2 it was acknowledged that this was a fair proposal and likely to be the best offer. Ms Cornick moved that the IJB approve recommendation 1.1, seconded by Ms Manson. Ms Manson moved that the IJB approve recommendation 1.2, seconded by Ms Macdonald.
Decision	The IJB • APPROVED the proposed budget for the Shetland Integration Joint Board (IJB) based on the conditions stipulated in 4.30 –

	4.40. If the IJB is content with the Strategic Plan and the proposed budget for 2019/20, a report on updated Directions will be prepared for the next cycle of meetings; and • APPROVED the proposed application of the Scottish Government Additionality funding as detailed in Appendix 2.
10/19	**Shetland Islands Health and Social Care Partnership - Joint Strategic Commissioning Plan 2019-2022**
Report No. CC-14-19-F	The IJB considered a report by the Head of Planning and Modernisation, NHS Shetland that sought approval of the Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan (Strategic Plan), 2019-2022. The Head of Planning and Modernisation introduced the report and provided an overview of what was contained in the Strategic Plan and the new information included therein. She advised that she had worked with the Clinical, Care and Professional Governance Committee (CCPGC) where the Strategic Plan had been positively received. The Head of Planning and Modernisation added that the Chief Executive, NHSS had developed an action plan which was attached following on from the Scenario Planning exercise. Ms Haswell, Chair of the Clinical, Care and Professional Governance Committee advised that the group recognised what it was being asked to do is assurance of the process and come to the IJB with information. She said that the CCPGC had approved the Strategic Plan with development points. Comment was made that it would be useful to have the Strategic Plan reviewed at the end of the year in order to update finance and be able to populate a request for funding. The Head of Planning and Modernisation explained that it was hard for the document to align with funding in that way but the strategic plan describes the model to help the IJB make good decisions on what must be included. She advised that there is a decision point in the autumn when the IJB will be asked for approval again but an update could also be provided in June 2019. The Chief Officer advised that in June the IJB would look at what the process will be like with a Seminar in June or July so that there is something formal in place in August 2019. The Chief Financial Officer confirmed that there would be figures provided based on the Medium Term Finance Plan and that in June he would present the first monitoring report. It was noted that this would identify if any big variances were appearing. Ms Cornick moved that the IJB approve the recommendation contained in the report. Mr Duncan seconded.

Decision	The IJB APPROVED the Shetland Islands Health and Social Care Partnership: Joint Strategic Commissioning Plan, 2019-2022.
11/19	**Carers Eligibility Criteria and Directions**
Report No. CC-11-19-F	The IJB considered a report by the Self-directed Support (SDS) Implementation Officer/ Carers Lead that sought agreement on the local Carers Eligibility Criteria for determining the level of support offered to Carers. The Self-directed Support (SDS) Implementation Officer/ Carers Lead introduced the main terms of the report. During questions the third sector representative referred to paragraph 4.4 and advised that the VAS (Voluntary Action Shetland) and Shetland Care Attendant Scheme had attracted money for digital recording of data now being collected. The SDS Implementation Officer confirmed that she was aware of the funding and advised that recording had not been a duty before now and she had supported the funding for VAS. The third sector representative suggested that information could be shared for the additional work around carers support but the funding arrangements had not appeared within section 8 of Appendix 2. The SDS Implementation Officer advised that these figures were not included as they did not relate to the Direction sought. She said that this would be brought to the IJB under budget setting reports. She also confirmed that there are other areas of spend for Carers but this report was for additional funding under the Carer's Act. Some discussion was held around the true costs associated with young and adult unpaid carers and the IJB were advised that much of the support provided had been done so long before the Act was enforced, from within existing resources. It was noted that additional training was also covered under the "with you for you (WYFY)" processes and rather than create additional paperwork the recording of adult support plans would remain there. The SDS Implementation Officer clarified that anything not covered under Section 8 would be covered under different budget setting processes and not this allocation of funding and that the IJB were being asked to direct the additional funding for continued implementation of the Carers Act only. In response to a further question the Chief Officer said that it was clear that there were services contributing to supporting carers and this funding would never be able to cover that cost. He said that this additional funding allocations relates specifically to the work of the IJB. It was agreed that the Chief Financial Officer would carry out a piece of work, with the Council, to provide figures to demonstrate

	the true cost of support for carers, however he reported that this was not straight forward. Further comment by the Third sector representative was made that the support for unpaid carers is underfunded and locally commitment went above and beyond the content of the Carer's Act. It was also noted that five years ago the total money provided for unpaid carers was 94% local authority and this was now 35% with match funding and VAS was trying to match fund with external funding. In terms of eligibility criteria The SDS Implementation Officer confirmed that this had been developed across Scotland including rural areas to ensure that it was not based solely on city living and need. She said that it had been developed by those with carers at heart to ensure that staff have a shared and consistent approach and shared locally with the Carers Strategy group. The Financial Officer agreed to undertake some work in conjunction with the council to demonstrate the true spend for unpaid carers as it was considered that this is underfunded by government allocation. During further discussion two items within the report were highlighted for change: • Page 32 of the appendix 3 Paragraph 5 under Assessing needs – Change "Shetland" to "Scotland". • On the notes column of table 2 on page 33 insert the correct figure for the number of under 16s in Shetland of 5,000. Ms Cornick moved that the IJB approve the recommendations contained in the report. Ms Macdonald seconded.
Decision	The IJB: • AGREED the local Carers Eligibility Criteria for determining the level of support offered to Carers; and • DIRECTED the Community Health and Social Care Partnership to deliver the services contained in the Direction.
12/19	**IJB Business Programme 2019 and IJB Action Tracker**
Report No. CC-17-19-F	The IJB considered a report by the IJB Chief Officer that presented the planned business to be reported during the financial year 31 March 2020. The Chief Officer introduced the report and following some discussion the following items were agreed for inclusion on the Business Programme: • Recovery plan to be added to the agenda of each meeting.

	• Items to be added to the business programme or included under business to be planned: o Code of Corporate Governance o Right to advocacy o Development of workforce protocol o Effectiveness of the board o Service transformation o Primary care • 4 service areas listed in budget report to be brought to May meeting. • Ms Watson to provided written addendum to the primary care update on GP Practice Nursing. • Risk register – training sessions to be arranged following change in membership.
Decision	The IJB: • APPROVED its business planned for the financial year to 31 March 2020; and • REVIEWED the IJB Action Tracker.

The meeting concluded at 4.45pm.

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Chair

Shetland Islands Health and Social Care Partnership

Agenda Item

1

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	14 May 2019
Report Title:	Appointments to IJB	
Reference Number:	GL-05-19-F	
Author / Job Title:	Executive Manager - Governance and Law	

1.0 Decisions / Action required:

That the IJB:

1.1 NOTE that following the retirement of Marjorie Williamson, Chair of the IJB, the following NHS appointments have been made:

- Chair: Natasha Cornick
- Voting Member: Jane Haswell
- Substitute: Gary Robinson

1.2 APPOINT Josephine Robinson, Interim Joint Director of Community Health and Social Care, as Interim Chief Officer, jointly nominated by Chief Executives of the Shetland Islands Council and NHS Shetland.

2.0 High Level Summary:

2.1 The purpose of this report is to inform the IJB, in accordance with the Integration Scheme and the approved Scheme of Administration and Delegations, of recent NHS Chair and other appointments by the NHS and nomination by the SIC requiring approval by the IJB.

2.2 The IJB shall appoint the Chief Officer in accordance with Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 Act. Following the appointment of the current Chief Officer, Simon Bokor Ingram as Interim Chief Executive of NHS Shetland, the IJB is required to appoint an Interim Chief Officer for the IJB

2.3 The Shetland Islands Council, with the concurrence of NHS Shetland, has appointed Josephine Robinson as Interim Joint Director of Community Health and Social Care, with effect from 13 May 2019. Accordingly both parties nominate Ms Robinson for appointment to the position of Interim Chief Officer of the IJB.

3.0 Corporate Priorities and Joint Working:

3.1 Approval of the decisions required in this report will ensure that membership of the IJB and its committees is maintained, which supports the strategic aims of the Partnership to ensure joint strategic and operational planning, clear accountability for decision-making and spending decisions, and responses to community needs and aspirations.

4.0 Key Issues:

4.1 Following the retirement of Marjorie Williamson, from the NHS Board, and at its meeting on 19 February 2019 the Board filled the vacancy for IJB Chair by appointing Natasha Cornick to that role. Ms Cornick's term as IJB Chair will end on 1 March 2020 when the position will fall to a Shetland Islands Council appointed Voting Member.

4.2 Ms Cornick's appointment created a vacancy for a Voting Member on the IJB and the NHS Board appointed one of their IJB substitutes, Ms Jane Haswell to that vacancy.

4.3 To ensure sufficient cover is in place the substitute vacancy created by Ms Haswell's appointment as Voting Member, has been filled by the appointment of Gary Robinson to the substitute role.

4.4 The IJB must make sure that the Chief Officer and Chief Financial Officer of the IJB are duly appointed in accordance with the Integration Scheme. Following the appointment of the current Chief Officer, Simon Bokor Ingram as Interim Chief Executive of NHS Shetland, the IJB is required to appoint an Interim Chief Officer for the IJB.

5.0 Exempt and/or confidential information:

5.1 None

6.0 Implications:

6.1 Service Users, Patients and Communities:	The changes in membership detailed in this report will not impact on service users, patients or communities.
6.2 Human Resources and Organisational Development:	The changes in membership detailed in this report will not impact on employees and/or wider workforce management and development. There are no issues health, safety and well being which need to be addressed.
6.3 Equality, Diversity and Human Rights:	The changes in membership detailed in this report does not have any Equalities, Diversity or Human Rights and does not require an Equalities Impact Assessment to be undertaken.
6.4 Legal:	Appointment of the members of the IJB Audit Committee is in line with the Integration Scheme and the Public Bodies (Joint Working) (Scotland) Act 2014.
6.5 Finance:	Any expenses and costs associated with the IJB including backfill for the members will be met from within existing budgets

	of the Council and the Health Board. The costs will be recorded and monitored to inform future budget setting processes.
6.6 Assets and Property:	There are no implications for major assets and property arising from this report.
6.7 ICT and new technologies:	There are no implications for ICT and ICT systems arising from this report.
6.8 Environmental:	There are no environmental issues arising from this report.
6.9 Risk Management:	The main risk addressed by this report is failure to make all the appointments necessary to populate the IJB in line with legislation and the Integration Scheme.
6.10 Policy and Delegated Authority:	Section 2.9 of the IJB Scheme of Administration and Delegations relating to terms of office, states that "... individual IJB appointments will be made as required when a position becomes vacant for any reason."
6.11 Previously considered by:	This report has not been presented to any other meeting.

Contact Details:
Jan Riise, Executive Manager – Governance and Law jan.riise@shetland.gov.uk
7 May 2019

Appendices:
None

Background Documents:
Integration Scheme and IJB Scheme of Administration
http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/IJBSchemeofAdmin-V2.0-19January2016.pdf

Shetland Islands Health and Social Care Partnership

Agenda Item

2

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	7 May 2019
Report Title:	Primary Care Improvement Plan - Update	
Reference Number:	CC-19-19-F	
Author / Job Title:	Lisa Watt, Service Manager Primary Care	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board is asked to:

(i) AGREE the Primary Care Improvement Plan for 2019/20 attached at Appendix 1.

2.0 High Level Summary:

2.1 The purpose of the report is to present the updated Primary Care Improvement Plan, as per the requirements of the Scottish GP Contract (the contract), which came into effect on 1st April 2018.

3.0 Corporate Priorities and Joint Working:

3.1 The 2018 contract supports significant development in primary care. In Shetland we have one Integration Board, unlike some other areas in Scotland, and this means that there will be one co-ordinated Primary Care Improvement Plan, with a focus on local priorities and delivery where services are commissioned within the Health and Social Care Partnership (HSCP), based on population need. The plan will be updated yearly in 2019/20 and 2020/21.

4.0 Key Issues:

4.1 Existing work has shown the benefits from working with a wider multi-disciplinary team aligned to General Practice. The Memorandum of Understanding agreed by the IJB on 22nd February 2018 (Minute reference 04/18) noted that a Primary Care Improvement Plan must be in place by 1st July 2018, with an update of the plan having to be considered in 2019/20 and 2020/21. This paper presents the updated plan for 2019/20, as well as giving an update on the actions for 2018/19.

4.1 The initial plan was previously considered by the Integration Joint Board and was then formally submitted to Government on 31st July 2018. The refresh of the plan in 2019/20 has to be signed off by the Local Medical Committee and GP Sub Group;

formally ratified by the Integration Joint Board; and is then submitted to Government thereafter.

4.3 The submitted plan sets out the priorities for 2019/20, as well as noting work under way to review needs for 2020/21. It has been confirmed that funding for the next two years will see a year on year increase, although it should be noted that the increase in 2019/20 is only £30,000, with all Boards receiving a large increase in funding in 2020/21. This is to enable scoping work to be undertaken and to look to employ staff to be in post by 1st April 2020.

5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The benefits of the proposals in the new contract for patients are to help people access the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes.
6.2 Human Resources and Organisational Development:	The new contract will support the development of new roles within multi-disciplinary teams working in and alongside GP Practices. The contract also plans the transition of the GP role into an Expert Medical Generalist. These changes will require local and national workforce planning and development and there will be work undertaken locally to align to national data gathering tools.
6.3 Equality, Diversity and Human Rights:	There are no equality implications arising from the report.
6.4 Legal:	The central purpose of the 2018 GMS contract is to provide better service to patients by providing stability and sustainability to General practice. In so doing it also provides an environment that supports the wider policy aim of delivering care and support close to home when possible.
6.5 Finance:	The implementation of the 2018 General Medical Services contract for Scotland will see £250million per annum phased investment in support of General Practice. This is part of an overall commitment of £500million per annum investment in Primary and Community Health and Care services by the end of this parliament. Specific funding for the Primary Care Improvement Plan will be allocated to Boards on an NRAC basis. Funding will be provided up to and including 2021/22, in order to implement the

	plan.	
6.6 Assets and Property:	There are no implications for major assets and property.	
6.7 ICT and new technologies:	There are no ICT and new technology issues arising from this report at this moment, although it is acknowledged that a new GP IT system is expected in 2020/21. The Improvement Plan will be updated and developed as further information on ICT is known.	
6.8 Environmental:	There are no environmental issues arising from this report.	
6.9 Risk Management:	The new contract seeks to address GP primary care sustainability but it is recognised nationally that recruitment remains challenging across clinical groups. The IJB risk register will be updated to reflect the risks shown in the Primary Care Improvement Plan.	
6.10 Policy and Delegated Authority:	Consideration of this Primary Care Improvement Plan is a matter reserved to the IJB as set out in Section 6 of the IJB's Scheme of Administration.	
6.11 Previously considered by:	Local Medical Committee and GP Sub Group	1st May 2019

Contact Details:
Lisa Watt
Service Manager Primary Care
e.watt1@nhs.net
30th April 2019

Appendices:
Appendix 1: Updated Primary Care Improvement Plan 2019/20

Background Documents:
Primary Care Improvement Plan Report presented to IJB on 6 June 2018

http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=22586

PRIMARY CARE IMPROVEMENT PLAN
2019-21

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PRIMARY CARE IMPROVEMENT PLAN

Introduction

Following agreement in January 2018 to introduce a new General Medical Services (GMS) Contract in Scotland, an initial report was presented to the Integration Joint Board to advise of the context and content within the contract and associated Memorandum of Understanding (MoU). Boards were advised of the content within the contract, as well as the requirement for a three year Primary Care Improvement Plan to be developed by 1 July 2018

In Shetland we have one Integration Board, unlike some other areas in Scotland, and this means that there will be one co-ordinated Primary Care Improvement Plan, with a focus on local priorities and delivery where services are commissioned within the Health and Social Care Partnership (HSCP), based on population need.

Background

The first iteration of the Primary Care Improvement Plan covered the period 1st April 2018 to March 2019. The Shetland Plan has now been updated in April 2019, to both update on the work already undertaken and to reflect the work to be carried out in the period April 2019 to March 2020.

Primary Care Improvement Plan criteria

The criteria for the Plan remains as per the Memorandum of Understanding for the GP contract, which noted the following for the development of the Primary Care Improvement Plan:

- IJBs will set out a Primary Care Improvement Plan to identify how additional funds are implemented in line with the contract Framework;
- The Plan will outline how these services will be introduced before the end of the transition period at March 2021, establishing an effective multi-disciplinary team model at Practice and Cluster level;
- These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. Any specific contractual elements must be agreed with the Local Medical Committee. In Shetland, the plan will also go to the Patient Focused Public Involvement group and the Shetland Partnership Engagement Network, to enable consultation with members of the public.
- IJBs have a statutory duty and the infrastructure established to consult in relation to Strategic Planning and stakeholders should be engaged in the plan's development;
- Local and Regional Planning will recognise the statutory role of IJBs as commissioners. IJBs will give clear direction to the NHS Board on its function to secure these primary care services;
- In developing and implementing these plans, IJBs should consider population health needs and existing service delivery;
- Integration Joint Boards will be accountable for delivery and monitoring progress for the local Plan

The MoU outlined the key priorities to be covered over a three year period (April 2018-

March 2021) within the Primary Care Improvement Plan and these remain in place :

i. Vaccination services (staged for types of vaccinations but fully in place by April 2021)
ii. Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics)
iii. Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage;
iv. Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care;
v. Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services)
vi. Community Link Workers (please note, in Shetland, Health Improvement colleagues have been undertaking much of this role in recent years and this model will continue).

- New staff will be employed predominantly through the NHS Board and work in models and systems agreed between each HSCP and local GPs;
- New staff should, where appropriate, be aligned to GP practices or groups of practices (e.g. clusters).
- Where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Each of the six key priority areas will be detailed further below, together with funding stream requirements where these have been identified. It should also be noted that, where appropriate, areas of improvement will be undertaken jointly with Acute and Specialist Services e.g. in managing unscheduled and urgent care. This aspect will be expanded as the plan develops.

Risks to the Plan Implementation

Whilst consulting on the 2018/19 plan, several risks were highlighted, particularly in relation to funding. It was noted that owing to work already underway in Primary Care redesign, funding had been allocated in previous years to specific posts and these will need to continue. This risk continues in 2019/20. There is an additional £30,000 of funding in 2019/20, which does not allow much flexibility for new posts, although it is noted that the overall PCIP funding will double in 2020/21.

A risk was identified in 2018 in relation to physical space within the existing health centres. NHS Shetland has developed good working relationships with the local Citizens Advice Bureau, who provide a regular visiting services to health centres and there has also been a commencement of visiting services from the local CLAN team. As more services are delivered closer to the patient, this will undoubtedly have an impact on the physical space within health centres and discussions are already underway to consider whether there are other public buildings available to enable some of this outreach work to take place e.g. visiting physiotherapy services could potentially

use space in local leisure centres. Two health centres will have capital works undertaken in 2019/20 to expand the clinical space available, through utilisation of other space within the buildings.

It was also noted that there is a risk with regard to Information Technology, in particular with broadband speed and connectivity. Given that the new GP IT system will be cloud based and technologies such as Attend Anywhere are being trialled in Shetland, suitable broadband is considered a "must have" for the implementation of aspects of this plan.

Finally, while elements of the plan are intended to address some of the consequences of gaps in the workforce, a key risk to the plan will be our ability to continue to recruit and retain members of the Primary care multi-disciplinary team.

Consultation
This plan will be presented to the following groups for discussion:

NHS Shetland Executive Management Team
Shetland GP Cluster
Strategic Planning Group
Area Clinical Forum
Patient Focus Public Involvement Group
Shetland Patient Engagement Network

Comments received as part of this consultation process will be incorporated into the final plan and then the plan will need formal sign off by the Local Medical Committee and GP Sub Group; ratification by the Integration Joint Board; with submission to Scottish Government thereafter.

KEY PRIORITY AREAS

i. **Vaccination services (staged for types of vaccinations but fully in place by April 2021)**

The Vaccination Transformation Programme (VTP) is a three year national programme to modernise how vaccinations are delivered to our communities which commenced in April 2018. The aim is to '*empower Health Boards and their local partners to deliver vaccinations rather than the current practice of contracting national delivery through General Practice*'.

Immunisations, alongside clean water, are the two public health interventions that have had the greatest impact on the World's health. Immunisation is an excellent example of PREVENTION that is essential to protect the Shetland community against infectious diseases, such as meningitis, flu, mumps, measles, polio and whooping cough. It is therefore vital that our local vaccination services are properly resourced and supported to protect the health of the local population.

The Scottish Immunisation Programme's schedule involves several different vaccination programmes, each of which provides protection against infectious disease to individuals or populations at different stages in the life course, including:

- Routine infant and childhood vaccinations
- School-age vaccinations (including HPV and childhood flu)
- Adult vaccinations such as flu and shingles
- Vaccinations delivered to 'at risk' individuals on the basis of specific clinical need or identified risk factors (for example, people who are immunocompromised)

In addition there are travel vaccines, which should be administered in the context of a travel health assessment. These are not part of the national routine programme, and often given privately, but are a significant workload in Shetland.

The national transformation programme has been prompted by a number of developments including the significant expansion in the vaccination schedule, the increasing complexity of vaccinations and the modernisation of the roles of those involved in delivering vaccinations.

Locally, we are in a different position to most other Boards in that 80% of our practices (covering 85% of the population) are already Board run. So although most of the immunisation programmes are delivered in GP practices, for most of the population the service is technically Board run.

However, there are a number of reasons why we must take this opportunity to change the way in which we deliver immunisation services in Shetland:

- There is currently variation in the organisation and delivery of immunisation services between practices. And, given the size of many of our communities and practices, there are a number of staff delivering the programmes who only see a small number of patients which makes it very difficult to keep up to date with the continuing increase in size and complexity of the immunisation programme. The VTP is therefore an excellent opportunity to redesign how

our services are delivered to ensure that we have a high quality, safe and equitable immunisation services across Shetland, whilst maintaining the good uptake rates that exist for most vaccines.

- It also gives us the scope to change the way services are delivered in order to improve uptake of specific vaccines that we struggle with in Shetland: specifically MMR and the pre-school booster.
- Currently the school nursing team deliver some of the immunisation programmes in school, and in 2018 we moved delivery of the teenage booster from GP practices to schools. However immunisation delivery is no longer within the new school nursing pathway and therefore we need to have a different process for delivery in schools.
- Travel health is a priority in Shetland as most of the practices have stopped providing this service. It has been picked up by community nursing whilst developing plans for a sustainable service into the future. This includes a better understanding of demand (numbers have been increasing since community nursing took on the service); what the Board should be providing, and training. There are added demands in Shetland because private travel health services can only be accessed via services on the Scottish mainland.
- Occupational health vaccination services are not part of the routine national programme, but there are national recommendations regarding vaccination and it is a significant workload for the Board run Occupational Health service. The service has made huge improvements to the delivery of the seasonal flu vaccination of NHS staff, resulting in a big increase in uptake. However, there has never been a pro-active service for social care workers (who are recommended by the Government to get seasonal flu vaccine in the same way as healthcare staff). The VTP is therefore an opportunity to address this area of work.
- BCG vaccination for eligible individuals is a very small element of the overall vaccination programme, but the service is currently fragile as it requires specific training and opportunities to maintain skills given the small number of BCG vaccinations done. We need to be able to deliver the BCG to eligible babies and children, healthcare workers and for public health purposes in the event of a single case or outbreak. The VTP is an opportunity to review how this service is delivered and who by.

In addition, we have identified that service delivery and practice in a number of areas varies between the individual GP practices including for example training requirements and opportunities, call-recall, operational procedures, recording and monitoring, use of PGDs. None of the practices have traditionally run vaccination clinics other than for seasonal flu. Only two of the practices currently use SIRS for call recall. There are a number of governance related issues to address such as standardisation of procedures, training and CPD, reporting and managing incidents and errors etc. As previously reported, the lessons learnt from a vaccine storage incident in 2018/19 has also informed our plans..

All the health boards have appointed a Business Programme Manger (in Shetland this is the Immunisation Co-ordinator / CPHM) and started working on their VTP plans during 2017-18. In Shetland we have a steering group that has met regularly since May 2017 and includes representation from Public Health, Community and

Practice Nursing, School Nursing, Health Visiting, Primary Care, Pharmacy and Finance.

Since April 2019, the Immunisation Co-ordinator has been allocated one session a week for VTP work. Work on a sessional basis has also been undertaken by a community nurse team leader and other community nursing staff to primarily deliver travel health / vaccination services

During the first year we have:

- Identified the main Governance issues for immunisation services (informed by Incident Report).
- Developed a local training framework for staff, based on a training needs analysis that has been undertaken, and work has started in tailoring immunisation training sessions to different groups of staff based on need..
- Picked up all the travel health work for the eight board run practices whilst developing a model for a travel health clinic. This will be an interim solution until there is further national guidance and implementation of a national 'triage' system .
- Developed a model for a 'virtual' immunisation team for vaccination in schools (comprising school nurses, practice and community nurses) and continued to deliver primary school flu, teenage boosters and HPV for girls in schools.
- Developed a more proactive approach to promoting flu immunisation amongst care home and other social care staff.
- Developed a model for delivery of all antenatal immunisations in maternity which will be implemented from 1st May 2019.
- Reviewed the delivery of the local flu immunisation programme during 2018-19 to inform plans for improving or changing the current local models
- Started work on a sustainable model for delivering BCG vaccinations, including refresher training for the public health nurse.
- Made some progress on implementing SIRS call –recall for all practices, however this has been delayed by issues with the current implementation of this process in one of the practices that already uses SIRS.
- Implemented governance actions from the vaccine storage incident relating specifically to vaccine storage and monitoring of fridge temperatures, including a new local policy.

Actions for the second year (2019-20) include:

- Implementing SIRS call recall for all practices.
- Fully implementing a new local training programme within the context of our local training framework
- Implementing a clinic model for travel health, as interim solution whilst awaiting further national guidance and national triage system.
- Finalising a model for BCG vaccinations
- Reviewing the flu immunisation programme to improve or change the model for flu vaccinations currently delivered in primary care; and to improve the model for flu vaccination of social care staff.

- Developing and agreeing immunisation team model within primary care and the community, to include staffing and travel considerations - dependant on progress with other elements of PCIP, particularly nursing models.
- Working with the two independent practices to incorporate the vaccination requirements of their patients into the Board delivered service
- Inequalities impact assessment of all proposed changes.

ii. **Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics)**

Pharmacotherapy is generally understood as that function of multidisciplinary and direct patient healthcare associated with the safe, effective and economical ongoing use of medicines. The science underpinning pharmacotherapy is pharmacology. Pharmacists, supported by pharmacy technicians within modern healthcare lead in pharmacotherapy.

The transformation of primary care provides an opportunity to revisit the role of pharmacists and pharmacy technicians within general practice and develop the pharmacotherapy services to improve patient care within Multidisciplinary Teams.

What is emerging in Scotland is the need for a three tiered pharmacotherapy service, divided into core and additional activities, Level one activities are at a generalist level of pharmacy practice focused on a range of acute and repeat prescribing and medication management activities (technical and basic clinical). Level two (advanced) and level three (specialist) are additional services and describe a progressively input of clinical pharmacy practice and experience. Particular opportunities are associated with repeat prescribing and medication or polypharmacy reviews.

A key aim of the pharmacotherapy service is to release GP time to focus on their Expert Medical Generalist role by providing a first point of contact for prescription or medicine requests; delivering a range of activities and clinics related particularly to the management of a repeat prescribing related activities, this is now embedded in the new GP contract.

When established the GP practice-based pharmacist in Shetland will have a key role in supporting safe prescribing systems and processes including authorising repeat and serial prescribing. This includes dealing with discharge letters, authorising hospital outpatient requests, all acute and repeat requests, establishing serial prescriptions, medicines reconciliation and non-clinical medication review. These are core activities that should ultimately be provided to all GP practices, the level of which will initially be determined by the experience and training of the pharmacist however the practicalities of delivering this in Shetland will be challenging given the current spread of practices.

Pharmacotherapy services

	Pharmacists	Pharmacy technicians
Level one (core)	• Authorising/actioning[1] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests include: • Authorising/actioning hospital outpatient requests • Authorising/actioning non-medicine prescriptions • Authorising/actioning installment requests • Authorising/actioning serial prescriptions (STU) • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

[1] Pharmacist Independent Prescribers can action (instigate and sign) prescriptions, non-prescriber pharmacists can action prescriptions but they still require to be signed by a prescriber

The GP contract stipulates that practices across Scotland will, as a minimum, have access to a level one tier of core service by March 2021. Recruitment of pharmacists at any level is problematic in Shetland, and our best approach is to "grow our own pharmacists and technicians". At the moment both preregistration pharmacists and technicians are currently in training and there already is some level one support available to practices. In particular level one support has been available in Lerwick for two years and recently the appointment of a pharmacy technician mainly to support patients receiving care and their carers has facilitated the introduction of all levels of input by pharmacists

A GP practice-based pharmacist working at levels two and three increasingly provides medication and polypharmacy reviews/clinics for vulnerable patients and those with complex care needs and helps to resolve high risk medicine related problems. GP practice-based pharmacists who are independent prescribers are also be able to prescribe, monitor and adjust treatment as appropriate. This is already happening throughout Shetland and a regular hypertension clinic for example happens in Lerwick, and a chronic conditions clinic in Brae. Introduction of these activities is reached in agreement with the practices.

Evaluation of the practice pharmacist role nationally has demonstrated a significant saving on GP time, improvements in the quality and safety of services, a reduction in medication errors and better care of more complex cases of people with multi-morbidity. In Shetland we are already seeing a reduction in GP non face-to-face 'prescribing' workload since the summer of 2016. New guidance in areas such as Diabetes, Inhaler Guidance and standardisation of anticoagulation management is being implemented in Shetland with significant pharmacy input, with the aim improving patient safety.

A phased approach to recruitment of pharmacists for the service is underway. While there is likely to be an increase in funding each year for the next three years with potentially additional new posts being created

For consistency across the North of Scotland, the shape of the pharmacotherapy service will be led by the Directors of Pharmacy for the three year trajectory period until 2021. This will allow workforce planning to be supported regionally, and appropriate governance arrangements to be embedded. It is also important that successful initial momentum to be maintained. When the service reaches a level of maturity it is anticipated that funding arrangements will be directed towards the Integration Authority.

Meantime in Shetland provision of pharmacy support to care at home services and care homes could be enhanced by the appointment of a second primary care technician, to concentrate more on the systems and processes within GP practices. Further early careers training will be offered to ensure that the new posts are manageable and that we have a sustainable service, work with Scottish Government and NES while help establish a sustainable flexible and appropriately trained workforce.

Appointment of a further 2 GP practice pharmacists over the next two years will be key providing a substantive named pharmacist service to all practices, with some degree of separation of the prescribing advisor role. The aim is to provide a consolidated approach while as far as possible avoiding disaggregation of the pharmacotherapy service across Shetland. This will be dependent on appropriate funding, recognising the issues associated with economies of scale in Shetland.

iii. **Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage**

The new GMS contract highlighted the need for more nurses within the community setting to enhance the services available for the public as well as to support the delivery of right practitioner, right place and right time.

Over the last year, with the NHS Board responsible for the provision of Practice Nursing services at 8 out of the 10 practices across Shetland, we have had the opportunity to progress the development of skill mix teams at each of the Health Centres. Each Health Centre will have access to a team of practice nursing staff that includes Band 3 healthcare support workers, Band 5 Community Treatment Nurses and Band 6 General Practice Nurses. This team structure supports the delivery of right practitioner, right place and right time in line with the skill mix team structure identified in the GP contract and the nursing roles for Band 6 General Practice Nurse as outlined through the national Transforming Nursing Roles agenda.

The Band 3 Healthcare Support Workers will predominantly perform core tasks e.g. venepuncture, recording of Electrocardiographs (ECGs), recording of baseline observations. This has enabled us to ensure that we can meet the priority in stage 1 of the Implementation plan of ensuring that there is a phlebotomy service delivered at all practices by an appropriately skilled practitioner within this year.

The Band 5 Community Treatment Nurse will undertake a broad range of core Registered Nursing skills e.g. chronic disease monitoring, management of minor injuries, dressings, ear syringing, suture removal etc in line with the role and requirements of this service. This role is still in development at some of the Health centres, although the functions required are delivered at all Health Centres via the original staffing model.

The Band 6 General Practice Nurse will focus on the management of long-term conditions. The Band 6 role locally has been reviewed against the Band 6 General Practice Nurse core role descriptor developed via the Transforming Nursing roles General Practice Nursing work-stream. Skill mixing the practice nursing team as noted above will enable the Band 6 postholders to have the time and capacity to focus on supporting individuals with long-term conditions and undertaking the other clinical priorities as outlined in the descriptor.

Vacancies and other opportunities which arose in 2018/2019 have enabled us to move forward with the creation of skill mix teams in a timely manner across the service. Unfortunately it remains difficult to obtain accurate activity data from across the practice areas and therefore measures are being put in place to better understand demand and capacity at each of the Practices going forward. The ultimate size and shape of services throughout Shetland will be influenced by the

results of this data collection and any future proposed structural change within Primary Care.

There is an aspiration to develop a dedicated Community Treatment Room service in Lerwick with open access to residents from throughout Shetland. This facility would support individuals being able to have ready access for relatively routine procedures eg bloods, suture removal, simple dressings at a central location where the majority of the Shetland population work. This would minimise time off work for individuals whilst also support timely access to healthcare services. The development of a shared IT system, accessible Shetland wide would facilitate the organisation of this service and therefore the timescale for moving forward with this project is likely to be in 2020/2021/2022.

Depending on the timing of establishing this service additional staffing resource at Band 3 and Band 5 level may be necessary and a bid for funding will be made through the Primary Care Implementation Plan, alternatively service redesign within Primary Care may support a move to this new model of service provision at limited, if any, additional cost.

In terms of supporting the development of the practice nursing workforce, based upon the previous skills analysis staff have been able to continue to access various training opportunities funded via the NES General Practice Nursing Training and Development monies. Challenges are experienced in maximising benefit from the training on offer due to limited monies for backfill and the shortage of appropriately trained Bank staff to cover roles whilst substantive staff are away.

We were successful in obtaining 2 places on the NES General Practice Nurse training programme, one of which was to enable us to support a newly qualified nurse (NQN) into the General Practice Nursing workforce. This NES /Scottish Government supported initiative provides funding to meet the salary and training costs on a part-time 2 year basis to enable a newly qualified nurse to enter the practice nursing workforce at no direct employment cost to the NHS Board.

A further bid will be submitted in 2019/2020 to support the training and development of the postholders newly recruited into the service.

Funding from the local Transformational Change fund enabled the establishment of a single management and professional leadership structure for all of the Practice Nurses across the Health Centres by a qualified General Practice Nurse operating at Advanced Practice Level. The creation of this leadership position has supported the development of clinical practice and will, following securing additional resources, will be a substantive arrangement going forwards.

iv. **Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care**

The New GMS contract identifies the use of Advanced Practitioners to provide urgent care, both providing urgent unscheduled care within primary care settings as well as providing a first response for home visits.

In NHS Shetland development to date in relation to Advanced Practice has been in Nursing. Advanced Nurse Practitioners have been employed in General Practice since March 2015 with their focus being on addressing the need for an on the day appointment. The national ANP Service and Educational Needs Analysis conducted in 2017 identified a need for approx. 30 Advanced Nurse Practitioner posts across the acute sector and the Health and Social Care Partnership.

Across the Health and Social Care Partnership we have the following Advanced Nurse Practitioner posts currently in place - 1 ANP and 5 ANP Development positions in the largest practice at Lerwick, 1 development post based at Brae /Scalloway. Whilst the postholder working at Brae/Scalloway is an experienced practitioner we are utilising the term 'development' for all positions where the postholder is yet to fully satisfy the NHS Scotland criteria for definition of an Advanced Nurse Practitioner, namely having gained the clinical competencies necessary and achieved academic preparation at Masters Degree level in Advanced Clinical Practice.

In addition to the ANPs working in General Practice we have 1 working as a Clinical Team Leader and 1 post, which although vacant at this time is, attached to the Intermediate Care Team.

As advanced practice develops further in Shetland we will see some extensions to the roles that are in place currently which will align with the GMS contract position of 'these practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits'.

We have already been piloting unscheduled care clinic sessions at the weekend staffed by ANPs or GPs and an ANP on shift in the Accident and Emergency Dept is currently being trialled to support staff with unscheduled primary care presentations. In the rural areas, going forward Advanced Nurse Practitioners will have within their remit a responsibility for attending to the healthcare needs of individuals within the care homes within the locality as well as undertaking home visits as appropriate.

A review of the local out of hours unscheduled care services is being undertaken in 2019/2020. It is anticipated that this will lead to a more multi-professional response for both scheduled and unscheduled care presentations.

An Advanced Practice Strategic group has been established locally. This group will support the development of advanced practice across all of the professional disciplines as we move forward. This is Chaired by the ANP Practice Educator who is leading the educational development of our local 'ANP' workforce. We will be part of the Academy model for Advanced Practice in the north of Scotland region once this is established. This model will be core to supporting the development of more Advanced Nurse Practitioners locally.

A bid for funding to support the academic development of candidates locally with the potential to develop into Advanced Nurse Practitioners has already been made to NHS Education for Scotland.

v. **Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services)**

Mental Health Workers

Currently the Community Mental Health Team (CMHT) is based predominately in Lerwick in its own Mental Health base. The Talking Therapies Service provides Therapists across 5 of the Health Centres in Shetland; for a minimum of 1 day per week. The Community Psychiatric Team works across 6 of the Health Centres.

Action 15 plans are being implemented in Shetland; these include increasing core staff in order to be able to respond to people presenting in distress in the key areas identified in the Action 15 guidance. Shetland will increase its core staff by 3.92 WTE over the next 4 years.

Over the last 12 months the adult mental health service has been subject to an evidence based review. Key findings from the review have identified a number of actions that will be taken forward in an Improvement Plan; these include

- Reviewing the referral process; specifically from Primary Care colleagues and ensuring people access the right service at the right time.
- Working with Primary Care colleagues and Community Link Workers to implement a stepped care model.

Year 2 (2019) will see the development of the Mental Health Plan – taking into account the new Mental Health Workers, the redesign process/identified gaps etc. This will detail how we take the identified actions forward throughout year 3.

Occupational Therapy

There is an initial proposal with regard to the provision of Specialist Mental Health Occupational Therapy practitioner time to primary care settings. A scoping exercise will be necessary to identify the demand in line with the GP contract proposal that community clinical mental health professionals (e.g. nurses, occupational therapists), based in general practice, can work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression.

The role of occupational therapy in mental health includes (but is not restricted to):

- Interventions support the client in developing or maintaining a satisfying personal and social identity.
- Interventions move the client in the direction of fuller participation in society through the performance of occupations that are appropriate to her or his age, social and cultural background, interests and aspirations.
- Interventions are designed to overcome physical, psychological, social and environmental barriers to participation.

- Interventions assist the client to achieve greater autonomy of thought, will and action.

In terms of strategic direction, vocational rehabilitation (as a component of mental health Occupational Therapy) is a key priority of the Scottish Government's Active and Independent Living Plan (2016). Initial stages will require consultation with GP's to establish areas of potential need and demand, in line with availability of current support services within other services e.g., CMHT, CBT services, Post Diagnostic Support services etc. Suitably trained occupational therapists could undertake CBT sessions, family support activities, the facilitation of groups to address issues in a self-help method, or activity based sessions. Many of these activities could be designed and monitored by an Occupational Therapist, but with additional support from other social care workers, or third sector staff. Depending on need, clients could be seen individually, as families, or in time-limited group activities. Given the nature of the work, there are significant overlaps with the existing occupational therapists providing vocational rehabilitation in Shetland already. Bringing some alignment to these services should be considered to ensure a flexible and responsive service with some resilience and shared expertise, in line with the specialist/generalist nature of services in Shetland. A scoping exercise will need to be undertaken with a range of GP practices to determine levels of potential support required, and an initial service design implemented within a single practice, that could be scaled-up to include other areas. This would need additional resources to implement the scoping and initial phase, at a Band 7 level, although recruitment to this post may be challenging.

Physiotherapy

There is an initial proposal to enhance MSK services with a physiotherapist working in GP practices as a first contact practitioner taking on appointments which would previously have been seen by a GP. They would assess, diagnose and manage MSK problems. How much time is needed will depend upon demand e.g. how many MSK consultations already happen within GP practices.

A scoping exercise undertaken in 2018 has determined probable demand, which will in turn determine the level and location of service delivery. The MSK outpatient service is based at GBH covering all of Shetland and is provided by 5.2 WTE physiotherapists. An additional 0.2 WTE is allocated for supporting orthopaedic and rheumatology services.

Although the majority of referrals are self-referrals, anecdotally we are aware these aren't true self-referral but are at the recommendation of GP/other health professional. There is potential to reduce the demand for physiotherapy services by directing patients to self-management at initial consultation (rather than recommending/referring to physiotherapy).

It is expected that an additional Band 7 practitioner will be required to augment the existing Physiotherapy Team and it should also be noted that there will be training requirements. A job description for a dedicated primary care Physiotherapist to be based in one of our local health centres is in the process of being job matched but as already detailed in the section on risk, it may not be possible to implement this post in 2019 due to funding issues.

vi. **Community Link Workers**

The health improvement practitioners work in localities across Shetland. Each team member is assigned to a geographical area of Shetland and linked to a local health centre. The amount of time they spend at each health centre is related to need and demand, so there is facility for increasing and decreasing the amount of time that each health centre receives, depending on need. Although each practitioner retains an area of specialist knowledge/interest (leading, for example, on smoking, healthy eating or mental health), they are trained in all topic areas. Each practitioner can deliver the following:

Individual patient based:

- Keep Well Health Checks
- Mental Health self-help resource information
- Smoking cessation
- Counterweight (Adult weight management programme)
- Child healthy weight programme
- Physical activity brief advice
- Alcohol brief advice
- Brief Behavioural Activation (low level psychological therapy for mild-moderate depression)
- Practical support in accessing Beating the Blues, a computerised CBT programme.

Locality/group based:

- Healthy Working Lives advice to workplaces
- Safe talk training
- Self-harm training

As well as being based in health centres, staff have also negotiated work spaces in local community venues including schools and community enterprise companies. Community health needs are being assessed through a number of methods including health profiles, community surveys and through direct conversations with the public and health professionals. It has brought the practitioners closer to other professionals on the ground so that issues around health improvement both at a community and individual level can be picked up and dealt with quicker due to the direct lines of communication. It also allows staff to deliver the right services in the right place at the right time, and a survey of primary care staff during 2017 demonstrated an overwhelming desire for this model to continue.

Although the NHS Shetland Health Improvement team locality model was developed prior to the establishment elsewhere in Scotland of Community Links Practitioners, it has become clear that what the local team can offer is an enhanced version of the Community Links model. Staff work with individuals from the practice list populations on a one-to-one basis to help identify and address issues that negatively impact their health, and central to the approach is identifying and supporting individuals to access suitable resources within the community that can benefit their health and increase health competence. They also network with these local community resources to

support the development of their own capacity and identify any gaps in local service provision.

Currently there are 2 Full time equivalent staff covering the primary care role within Health Improvement (although in practice the service is delivered by a number of different staff).

Information Technology

There are several strands of work within the e-health portfolio which will continue and develop over the course of the Primary Care Improvement Plan, namely the development of a North of Scotland Regional Portal and the replacement for the existing GP IT system across Scotland. There is an Attend Anywhere project underway, which is being expanded to take on additional services, and this has meant that some patients in the trial areas have not had to travel to the local hospital but have instead had a VC appointment in their local health centre. The project will be monitored and evaluated and has so far had good outcomes for those involved.

We are also taking forward a piece of work moving towards a single system of working across the Shetland salaried practices, which aims to reduce professional isolation and reduction of duplication of effort. This is a two year project, commencing in April 2019, and will require ongoing IT support, which will include the roll out of an on line appointment booking facility.

FUNDING REQUIREMENTS IDENTIFIED

Proposed funding requirements for 2019/20 are shown below, albeit that it is acknowledged that there is a risk to the PCIP through the funding available. Nonetheless, these figures are included to show what will be required in order to implement the actions outlined in this paper. These figures will be amended and updated for 2020/21 as the plan develops.

The Integration Joint Board and NHS Shetland are planning to fund up to the value of the Scottish Government allocation.

Expenditure Commitment Reconciliation

	17/18	18/19	18/19	19/20	19/20	19/20 revised	19/20 revised
Overall Funding:	**300,992**		**248,707**		**269,500**		**269,500**
Current Expenditure Commitments:							
Primary Care Transformation Fund							
Nursing ANP in Brae Band 7		57,084		58,797		61,346	
GP Out of Hours (OOH) Fund							
Nursing ANP LK - Band 6 developmental role **currently vacant** but intention to fill				43,393		47,193	
Health Care support workers							
BVC 1516 3 X 0.4 TWE (15HR) Band 3 Practice Nurses (Part Year 18/19)							
(30 hrs, 22.5 Brae & 7.5 Bixter)		14,165		21,885		23,473	
15 hours Yell/Unst		7,381		10,409		11,430	
Primary Care Transformation Vaccinations							
Consultant Public Health 1 additional session		13,639		13,775		13,500	
Band 7 Project Manager 1 day p/wk		9,876		10,172		12,269	

Nursing Input for BVG and flu vacs	5,084	6,053	0
Non Pay	1,401	0	4,231
Primary Care Mental Health Fund			
1.6 wte Community Link Workers band 5 (Part year 18/19)	27,130	55,887	
1wte			37,043
0.6wte			20,569
Primary Care Fund - Pharmacy			
Pharmacists	108,536	112,000	117,300
Pharmacy First	4,250	4,250	4,250
Associated Employment Costs			
Relocation, travel, training, IT equipment, Furnishings etc	Unknown at this time	Unknown at this time	Unknown at this time
	248,546	**336,621**	**352,604**
New Funding Available if Current Commitments Honoured	**161**	**-67,121**	**-83,104**

ACTION PLAN

Key Priority Area	Year 1 - 2018	Year 2 -2019	Year 3
Vaccination Transformation Programme	• Identify the main Governance issues for immunisation services (informed by Incident Report). - **Completed** • Implement SIRS call recall for all practices / treatment centres (currently only 20% use it) – **c/f to 2019** • Develop a training framework for staff, based on a training needs analysis that has been undertaken. **Completed** • Develop a local model for delivering travel health services (in light of national work that is ongoing). **Completed** • Develop a model for a 'virtual' immunisation team for vaccination in schools (comprising school nurses, practice and community nurses) **Completed** • Begin to develop a	• Implement SIRS call recall for all practices / treatment centres (currently only 20% use it) • Fully implementing a new local training programme within the context of our local training framework • Implementing a clinic model for travel health, as interim solution, whilst awaiting further national guidance and national triage system • Fully develop and agree immunisation team model within primary care and the community, to include staffing and travel considerations - dependant on progress with other elements of PCIP. • Work with the two independent practices to incorporate the	• Implement immunisation team model within primary care and the community; • Audit SIRS call recall system following implementation • Audit travel health service delivery model

	model for immunisation teams within primary care and the community -**in progress** • Audit BCG immunisations to inform planning for a sustainable model – **in progress** • Develop a plan for seasonal flu immunisation for social care staff (informed by a recent Care Centre flu outbreak). **Completed**	vaccination requirements of their patients into the Board delivered service • Finalise and implement a BCG immunisation model; • Review the flu immunisation programme to improve or change the model for flu vaccinations currently delivered in primary care; and to improve the model for flu vaccination of social care staff. • Inequalities impact assessment of all proposed changes.	
Pharmacotherapy Services	Directors of Pharmacy to develop consistent approach across North of Scotland	The intention for 19-20 was to recruit an additional 2 Practice Pharmacists to be employed. There is however insufficient funding to progress this.	Pharmacist time in practices embedded
Community treatment and care services	Implement Skill Mix Practice Nursing team at all 8 of the Board provided Health Centres by August 2018. (**Completed**) Implement Phlebotomy service	Bid for further NES funding to support development of general practice nursing workforce by August 2018 (**In progress**) Implement leadership	Skill mix General Practice Nursing team in place providing a safe and sustainable service delivery model, appropriate to local service design. Community Treatment Room

	at each Health Centre/ Practice area by August 2018 (**Completed**) Conduct workload analysis across the service by October 2018 (**In progress**) Develop general practice nursing workforce in alignment with future service model by March 2019 (**Completed**) Host training for nursing workforce as per outcome of NES funding bid by June 2018 (**Completed**) Review leadership/ management of general practice nursing by 31 March 2019 (**Structure in place led by GPN Qualified Team Leader**)	structure for general practice nursing from 1 April 2019 (**In place**) Scope staffing requirements for Community Treatment Room facility Consider further refinement of service provision across Shetland to ensure capacity meets demand with appropriately skilled practitioners available to deliver to service model by 31 March 2020	Facility available in largest population centre, with appropriate workforce
Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care	Review current unscheduled care weekend clinics to determine future service model by August 2018 – **current model continuing**. The Strategic nurse group will agree how to take forward a	Work plan to be developed and agreed Future OOH model to be developed via Professional Alliance process during 2019/20.	In collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design.

	programme of work to support primary care advanced practice role development and liase with AHP Leads to ensure the work programme also reflects role development for these professions.		
Multi disciplinary team: Mental Health Workers	Redesign of services currently underway to implement an integrated service	Development of Mental Health Plan	Implementation of agreed actions from Mental Health Plan
Multi disciplinary team: Occupational Therapy	Exploration of mental health occupational therapy input including vocational rehabilitation within General Practice	Implementation of Mental Health Occupational Therapy service	
Multi disciplinary team: Physiotherapy	Scoping exercise for roll out of Physiotherapy provision to General Practice **Completed**	Implementation of additional Physiotherapy support to General Practice	
Community Link Workers	Continue existing Health Improvement input to GP Practices	Audit of workload, demand and potential requirements for expansion of service	

Appendix 1

	Service Area	**Project Sponsor**
1.	Vaccination Transformation Programme (VTP)	Susan Laidlaw/Susan Webb
2.	Pharmacy	Chris Nicolson
3.	Community Treatment & Care Services	Edna Mary Watson
4.	Urgent Care	Edna Mary Watson Lisa Watt Dylan Murphy
5.	Additional Professional Roles	
a.	MSK Physiotherapy	Jo Robinson
b.	Community Mental Health Services	Karen Smith
6.	Community Links Worker (CLW)	Elizabeth Robinson
7.	I.T & Data/Information Collection	Craig Chapman

Shetland Islands Health and Social Care Partnership

Agenda Item

3

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB)	14 May 2019
Report Title:	Directions to Shetland Islands Council and NHS Shetland	
Reference Number:	CC-22-19-F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board approves the Directions to Shetland Islands Council and NHS Shetland set out in Appendices 1.1 – 1.12.

2.0 High Level Summary:

2.1 On 23June 2017 (Min. Ref. 29/17), the IJB approved a report by the Executive Manager – Governance and Law (SIC) in respect of the legislative requirements for Directions. This set the mechanism and template to be used for the IJB to direct the operational bodies – NHS Shetland and Shetland Islands Council – to deliver the services as required. The template covers, amongst other things, the functions or services, a description of what it is the IJB is directing the parties to do, the resources required, the outcomes expected and the performance monitoring arrangements.

2.2 The IJB has approved the Joint Strategic Commissioning Plan for 2019-2022, on 13 March 2019 (Min. Ref. 10/19). The NHS Board did not require the IJB to rewrite the Strategic Plan, when it met on 16 April 2019. Shetland Islands Council will formally consider the Draft Plan at their Policy and Resources Committee on 13 May 2019 and the Full Council on 15 May 2019. This Report is therefore subject to confirmation from Shetland Islands Council that it is in agreement with the Joint Strategic Plan and does not require the IJB to re-write some or part of the Draft Plan.

2.3 Recently, through a self evaluation exercise on Integration, an improvement action has been highlighted to include more detail on the Directions – to ensure that the IJB has a consistent approach to understanding the services which they are commissioning and the likely outcomes. There was also a requirement to focus the Directions on outcomes and improvements, rather than a description of existing

delivery mechanisms. Members will be aware that the operational detail on how Directions are implemented is the responsibility of the partner organisations.

2.4 The templates for Directions were trialled in January and March 2019, for the Mental Health service, delivery of the Domestic Abuse and Sexual Violence Strategy and implementation of services to unpaid carers. Those Directions were approved by the IJB, so the templates have been retained to provide consistency in approach.

3.0 Corporate Priorities and Joint Working:

3.1 The IJB Joint Strategic Commissioning Plan (The Strategic Plan) describes how health and care services can be delivered, jointly, across the services described in the Shetland Islands Health and Social Care Partnership's Integration Scheme.

3.2 The IJB is required by law to issue Directions in writing to the Council and NHS Shetland to deliver services in accordance with the Joint Strategic Plan. Directions will impose obligations on Shetland Islands Council and NHS Shetland in respect of matters delegated by the Integration Scheme. Each delegated function and the associated net budget required to deliver the services is detailed in the written Directions.

4.0 Key Issues:

4.1 The Directions set out a clear description of what is it the IJB is commissioning from the delivery partners, NHS Shetland and Shetland Islands Council. There is then an expectation that NHS Shetland and Shetland Islands Council will deliver those services, within the resources allocated and achieve the performance targets and outcomes as determined. The Directions now also include more detail of the improvement actions and development plans which each services intends to implements from 2019-20 onwards. This will be monitored by the IJB throughout the year, through various performance reports and management accounts.

4.2 The IJB needs a mechanism to action their Strategic Plans and the legally binding Direction is that mechanism. The Directions meets all legislative requirements and are in line with Scottish Government guidelines.

4.3 The Table below shows the alignment of services, budgets and directions. There is still a mismatch between the cost of the current service delivery mechanism and available funding so a separate report on the Recovery Plan is presented to the IJB today and should be read in conjunction with this Report. Where appropriate, savings and efficiency targets are recorded in the Directions in Appendix 1.

Ref	Service	Approved Budget 2019-20 £	Latest Direction	Status
	Mental Health	2,031,247	January 2019	Already Approved
1.1	Substance Misuse	581,863	December 2017	For approval
1.2	Oral Health	3,124,523	December 2017	For approval
1.3	Pharmacy & Prescribing	6,645,510	December 2017	For approval
1.4	Primary Care	4,430,563	December 2017	For approval
1.5	Community Nursing	2,721,212	December 2017	One combined Direction, for approval
	Intermediate Care Team	452,182	December 2017	
1.6	Adult Services	5,521,982	December 2017	For approval
1.7	Adult Social Work	2,992,639	July 2017	For approval
1.8	Community Care Resources	11,542,901	July 2017	For approval
1.9	Criminal Justice	38,842	July 2017	For approval
1.10	Speech & Language Therapy	89,116	December 2017	Included in one overall Allied Health Professionals Direction, for approval
	Dietetics	116,280	December 2017	
	Podiatry	235,962	December 2017	
	Orthotics	138,329	December 2017	
	Physiotherapy	593,382	December 2017	
	Occupational Therapy	1,621,469	December 2017	
1.11	Health Improvement	224,174	December 2017	For approval
1.12	Sexual Health	44,813	December 2017	Included with Unscheduled Care, for approval
	Unscheduled Care	2,864,454	December 2017	
	Renal	201,524	December 2017	
	Unpaid Carers		March 2019	Already Approved, budget in other service headings
	Domestic Abuse and Sexual Violence		January 2019	Already Approved, budget in other service headings
	Reserve	645,895	No Direction	
	SG Additionality	166,000	No Direction	
	IJB Running Costs	26,762	No Direction	
	Directorate	1,050,072	No Direction	
	Pensioners	79,845	No Direction	
	Efficiency Target	(2,532,980)	No Direction, see Recovery Plan Report	
	Grand Total	**45,648,561**		

5.0 Exempt and/or confidential information:

5.1 None.

6.0 Implications :

6.1 Service Users, Patients and	The Joint Strategic Plan sets out the way in which services will respond to the needs of service users, patients and

Communities:	communities. The Directions set out more detail of the service delivery arrangements, expected outcomes and performance measures for certain categories of service users.	
6.2 Human Resources and Organisational Development:	There are no impact on Human Resources and Organisational Development arising from this Report.	
6.3 Equality, Diversity and Human Rights:	There are no specific issues to consider.	
6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to issue Directions in writing. The Directions must set out how each function is to be exercised and the budget associated with that function.	
6.5 Finance:	The IJB have a statutory responsibility for the delivery of services within the budget allocations. A separate report on today's agenda deals with the Recovery Plan.	
6.6 Assets and Property:	There are no specific issues to consider.	
6.7 ICT and new technologies:	There are no specific issues to consider.	
6.8 Environmental:	There are no specific issues to consider.	
6.9 Risk Management:	Having in place formal written Directions between the IJB and the delivery partners will assist with clarity of expectation and therefore minimise any potential for misunderstanding in terms of service delivery and performance. It provides the Chief Officer and Chief Financial Officer with clear instructions on what each partner organisation needs to deliver on behalf of the IJB.	
6.10 Policy and Delegated Authority:	The IJB was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration and Financial Regulations. The IJB is responsible for the functions delegated to it by the Council and NHS Shetland. These delegated functions are detailed in the Integration Scheme and the IJB is required to issue Directions to the parties to ensure services are delivered within the allocated budgets.	
6.11 Previously considered by:	None	

Contact Details:
Name: Hazel Sutherland
Title: Head of Planning and Modernisation, NHS Shetland
E'mail: hazelsutherland1@nhs.net

23 April 2019

Appendix 1, Formal Direction for Approval by IJB to NHS Shetland and Shetland Islands Council

Appendices

CC-22-19	1.1	Substance Misuse
CC-22-19	1.2	Oral Health
CC-22-19	1.3	Pharmacy & Prescribing
CC-22-19	1.4	Primary Care
CC-22-19	1.5	Community Nursing including the Intermediate Care Team
CC-22-19	1.6	Adult Services
CC-22-19	1.7	Adult Social Work
CC-22-19	1.8	Community Care Resources
CC-22-19	1.9	Criminal Justice
CC-22-19	1.10	Combined Allied Health Professionals
CC-22-19	1.11	Health Improvement
CC-22-19	1.12	Hospital Based Services (comprising Unscheduled Care, Sexual Health and Renal)

Direction from the Integration Joint Board

Substance Misuse

		Direction Approved July 2017	Proposed Direction 2019
1.	**Reference Number**	CC-61-17	CC-22-19 1.1
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council & NHS Shetland	Shetland Islands Council & NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	Information and advice, screening and referrals, treatment, residential treatment (outwith Shetland) and aftercare	Information and advice, screening and referrals, treatment, residential treatment (outwith Shetland) and aftercare
7.	**Full text of Direction**	• Provide specialist treatment and support for 18+ adults with substance use issues • Provide early intervention and easy access into treatment via drop-in facilities • Provide community based medicated detox for both alcohol and drugs • Facilitate in-patient detox for both alcohol and drugs	• Provide specialist treatment and support for 18+ adults with substance use issues • Provide early intervention and easy access into treatment via drop-in facilities • Provide community based medicated detox for both alcohol and drugs • Facilitate in-patient detox for both alcohol and drugs • Provide a dual

		• Provide a dual diagnosis service for both alcohol and drugs • Provide facilitated aftercare through the provision of Mutual Aid Partnership groups • Provide opportunities for employment via the Employability Pathway • Provide support to Families Affected By (FAB).	diagnosis service for both alcohol and drugs • Provide facilitated aftercare through the provision of Mutual Aid Partnership groups • Provide opportunities for employment via the Employability Pathway • Provide support to Families Affected By (FAB).
8.	**Budget allocated by IJB to carry out Direction.**	NHSS £496,000 SIC £180,000 **Total Budget £676,000**	NHSS £402,269 SIC £179,594 **Total Budget £581,863**
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes Reduce prevalence of problem alcohol and drug use in adults by 5% by 2020, through prevention, early intervention and detection Reduce alcohol and drug related harm to children and young people Improve recovery outcomes for Service Users	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes Reduce prevalence of problem alcohol and drug use in adults by 5% by 2020, through prevention, early intervention and detection Reduce alcohol and drug related harm to children and young people Improve recovery outcomes for Service Users Reduce drug related deaths and/or deaths from alcohol or

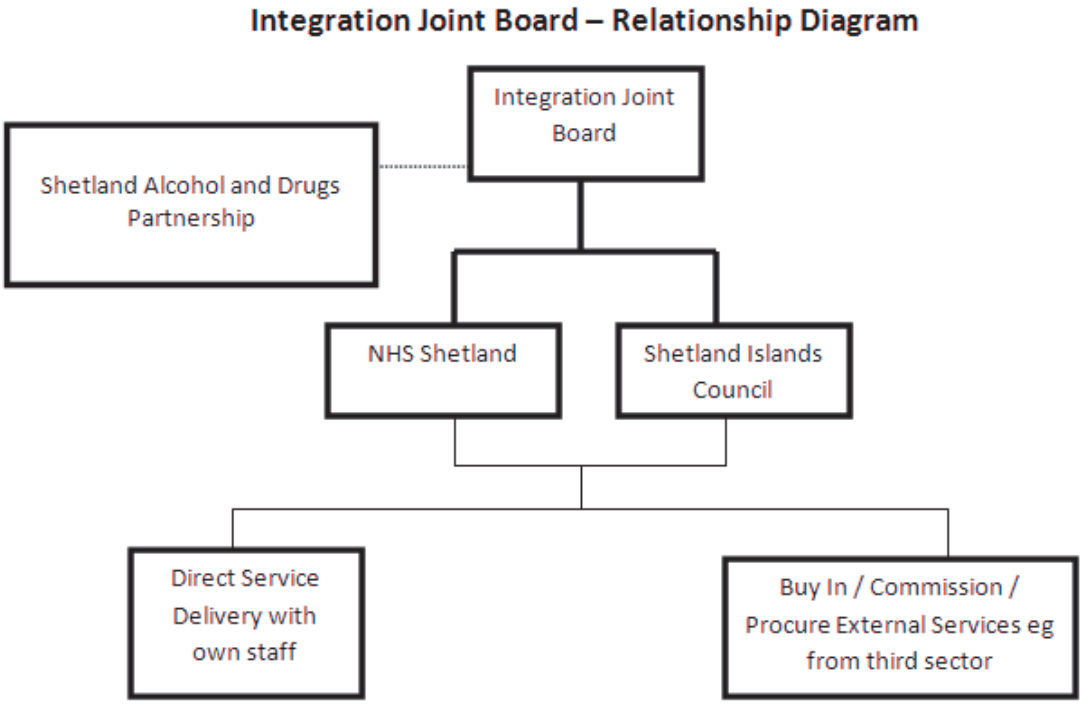
		Reduce drug related deaths and/or deaths from alcohol or suicide to 2 or fewer a year by 2020.	suicide to 2 or fewer a year by 2020.
10.	**Performance monitoring**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2018

Shetland Islands Health and Social Care Partnership
Direction for Substance Misuse Services

Governance
Service Model
Outcomes Framework
Resources
Improvement Plans

Governance

Substance Misuse Services are commissioned through the IJB with support from the Shetland Alcohol and Drug Partnership. This is shown diagrammatically below.



The Shetland Alcohol and Drugs Partnership supports the IJB by considering the Needs, Service Models, Resources and Funding and making recommendations to the IJB in respect of effective service models for Alcohol and Drug Education, Prevention, Detection and Treatment Services.

The Scottish Government, in a letter dated 11 August 2017, stated that,

> *"The Scottish Government is committed to tackling alcohol and drug related harm; ADPs have a wealth of expertise in providing and commissioning these services and we are keen to ensure that ADPs and IJBs develop effective joint-working relationships, adapted to suit local needs. To facilitate this, it is proposed that the same broad Ministerial Priorities are maintained for 2017-18, in order to ensure that appropriate focus is given to the continuity of existing services and outcomes. Ministerial Priorities have been copied to Chief Officers of IJBs and it is expected that the IJB and ADP will work together in the delivery of agreed service levels.*
>
> *Future funding is conditional upon ADPs and IJBs collectively demonstrating progress against both national and locally relevant alcohol and drug outcomes, and also in respect of the Ministerial Priorities outlined below. Ministerial Priorities will continue to be reviewed and set annually, as ADPs and IJBs undertake to embed the structural and governance changes brought*

about by the Public Bodies (Joint Working) (Scotland) Act 2014. ADPs and Integration Authorities will need to develop effective joint-working relationships to ensure the effective discharge of these functions, in line with current strategic priorities.

Additionally, we will review the existing ADP reporting infrastructure, for future years, in line with the public outcomes reporting that will be provided annually by IJBs".

The ADP in Shetland is made up from the following partners:

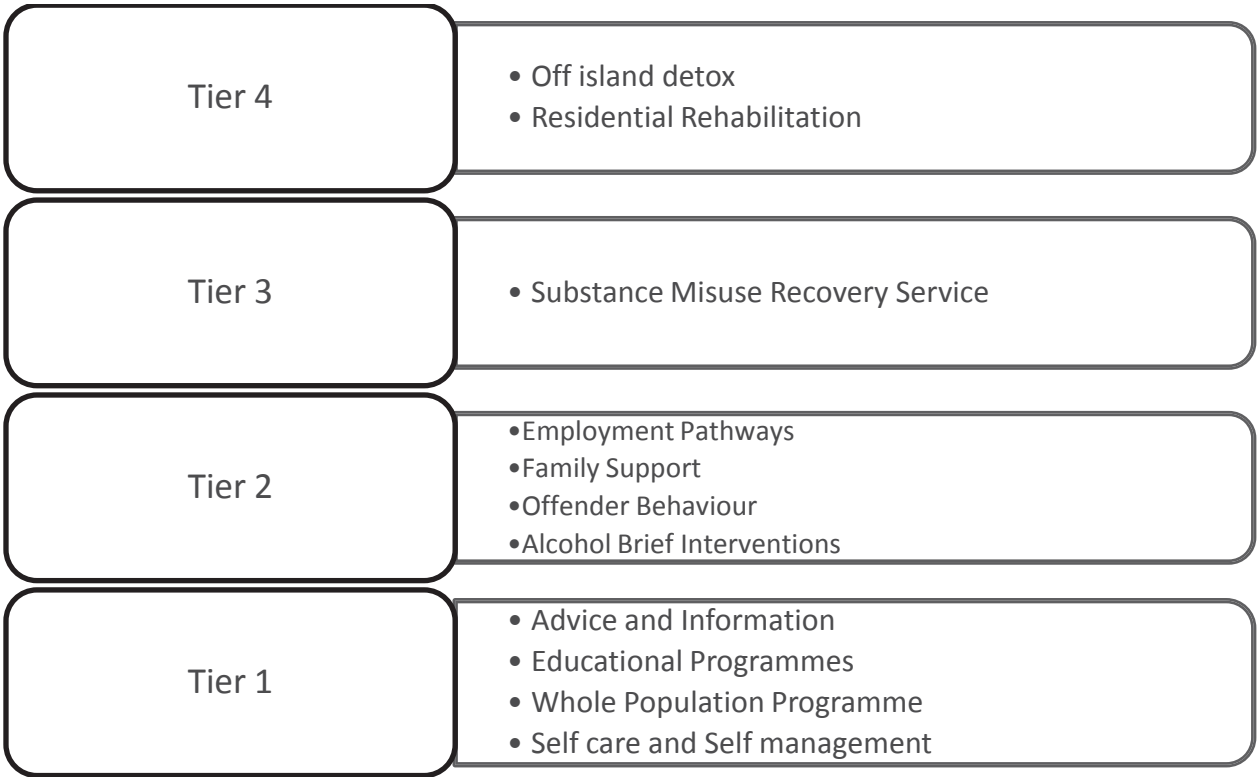
Police Scotland
NHS Shetland
Shetland Islands Council
Scottish Fire and Rescue Service
Procurator Fiscal (Observer)

SADP is currently chaired by Chief Inspector Lindsay Tulloch.

It should be noted that SADP business covers children and young people as well as adults, and services outwith the responsibility of IJBs.

Service Model

The service model is based on a Tiered Service Model approach, summarised below.



This is the service model that the IJB is commissioning from Shetland Islands Council and from NHS Shetland, and through them from some third sector providers. This commissioning is on the basis of recommendations received from the Shetland Alcohol and Drugs Partnership.

Current Service Model

The service model is based on the Strategic Outcomes set out by the Scottish Government:

1. Fewer people develop problem drug and alcohol behaviours
2. People access and benefit from effective, integrated, person centre support to achieve their recovery.
3. Children and families affected by alcohol and drug use will be safe, healthy, included and supported
4. Vulnerable people are diverted from the justice system wherever possible and those within justice settings are fully supported.
5. A Scotland where less harm is caused by alcohol and drugs.

Tier 1: Tier 1 interventions include provision of alcohol and/or drug-related information and advice, screening and referral to specialized treatment.

Interventions include; alcohol and/or drug treatment screening and assessment, referral to specialised alcohol and/or drug treatment, alcohol and/or drug advice and information, partnership or 'shared care' working with specialised treatment interventions for alcohol and/or drug users within the context of their generic services. Specific treatment liaison schemes may be specifically designed for alcohol and/or drug users i.e. housing projects for those leaving rehabilitation.

Provider	**Activity**	**Funding/resource**
NHS Shetland School Nursing service	Provide drug and alcohol education to young people in schools and drop-in services, as part of the revised School Nursing Pathway.	NHS Shetland funded
OPEN Peer Project	Peer led education programme for S1 – S6 • 400+ pupils per year • Alcohol and drug sessions • Sexual health • Mental Health	£13,000 ADP funding + external funding
Dogs Against Drugs	Drugs and the law education programme for P1 – P7 • 800+ pupils per year • 62 teachers per year Awareness raising sessions to the	£27,000 ADP funding + external funding

Provider	Activity	Funding/resource
	general public, youth groups etc showing how detection dogs operate • 140+ adults per year Provide the deployment of detection service at main points of entry into Shetland as and when appropriate • 28 positive incidents in 15/16	
Health Improvement	Alcohol brief intervention (ABI) training delivered minimum of 3 times a year ABIs delivered 150+ annually Alcohol screening undertaken at all counterweight and smoking cessation appointments Drink Better lead Alcohol and drug profiling projects Information and signposting	£27,000 ADP funding + NHS Shetland funding
NHS Shetland	ABIs undertaken in: • Maternity • A&E • Primary Care • Sexual Health Clinic	NHS funded
Voluntary Action Shetland	Providing support for Families Affected By drug and alcohol use.	VAS funded

Tier 2: Tier 2 interventions include provision of alcohol/drug related information and advice, triage assessment, referral to structured treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.

Interventions include; triage assessments and referral for structured drug treatment, Drug intervention which **attracts** and **motivates** drug users into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users, Interventions to reduce harm and risk due to Blood Borne Viruses (BBVs) and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges, Interventions to minimise the risk of overdose and diversion of prescribed drugs, Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment), Brief interventions for specific target groups including high-risk and other priority groups, Drug-related support for clients seeking abstinence, Drug-related aftercare support for those who have left care-planned structured treatment, Liaison

and support for generic providers of Tier 1 interventions, Outreach services to engage clients into treatment and re-engage people who have dropped out of treatment, A range of the above interventions for drug-using offenders

Provider	Activity	Funding/resource
Shetland Community Bike Project	Employability Pipeline Project • 12x alcohol and drug placements per annum (2 x 6 places) • Monday – Saturday work placements, learning work-related skills • All participants earn a wage • 6 x mental health placements per annum	£39,500 ADP funding for 12 placements (£3,300 per client) + external funding
Substance Misuse Recovery Service (SMRS)	Interventions to engage people into treatment • ABIs • Assertive Outreach • Liaison with Primary/Secondary Care • Liaison with Police Scotland Recovery Groups – Mutual Aid Partnerships	£359,665 ADP funding (this is for both Tier 2 & Tier 3 services)
Adult Social Work	Advice to SMRS Assessment of 'suitability' for detox/rehabilitation programmes.	SIC Funded
Criminal Justice	Overall responsibility for the delivery for community based sentences in Shetland. Alcohol and drug work undertaken as part of an offending programme. Drug Treatment Testing Orders (DTTOs) are treatment focused rather than focusing on offending behaviour and is delivered in partnership with SMRS.	SIC Criminal Justice funded IJB Funded
Community Pharmacy	Needle Exchange Observed substitute prescribing	NHS funded £30,000 ADP funding

Tier 3: Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison.

Interventions include; Comprehensive Substance misuse assessment, Care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions as standard practice, harm reduction activities as integral to care-planned treatment, a range of prescribing interventions in the context of a package of care, a range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviours, structured day programme and care-planned day care, liaison services for acute medical and psychiatric health services (i.e. pregnancy, mental health and hepatitis service), liaison service for social care services (i.e. child protection and community care teams, housing, homelessness), a range of the above interventions for drug-using offenders.

Provider	**Activity**	**Funding/resource**
Substance Misuse Recovery Service	Comprehensive Assessments Recovery planning – recovery indicators set Prescribing specialist doctor Dual Diagnosis GP- GPwSI Dual Diagnosis CPN	£359,665 ADP funding (this is for both Tier 2 & Tier 3 services)

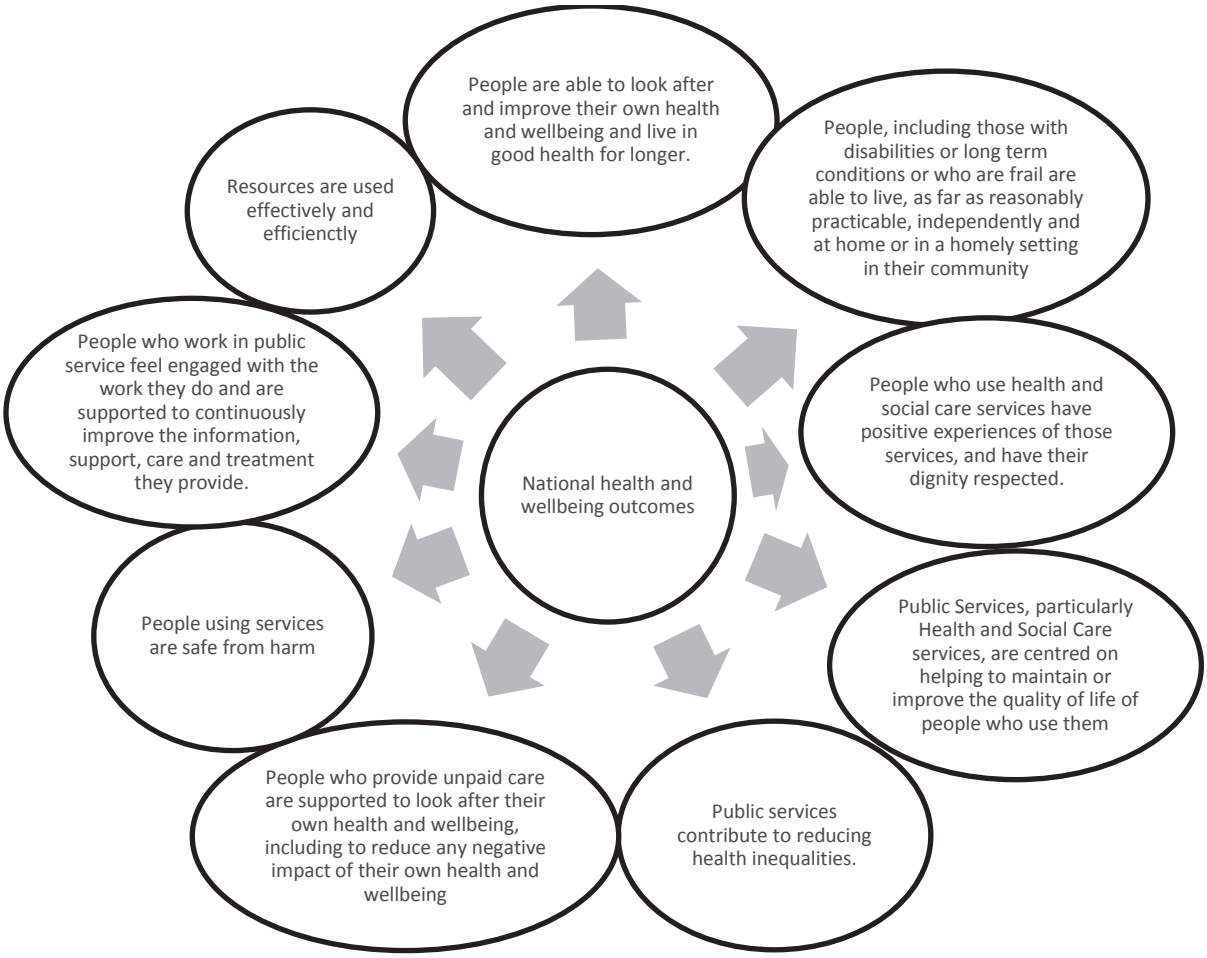
Tier 4: Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.

Interventions include; Inpatient specialist alcohol and drug assessment, stabilisation and detoxification/assisted withdrawal services; a range of alcohol and drug residential rehabilitation units to suit the needs of different service users; a range of halfway houses or supportive accommodation for substance misusers; residential alcohol and drug crisis intervention units (in larger urban areas); inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals, provision for special groups for which a need is identified (i.e. pregnant women, substance users with liver problems, substance users with severe and enduring mental illness). These interventions may require joint initiatives between specialised substance use services and other specialist inpatient units; a range of the above interventions for substance misusing offenders.

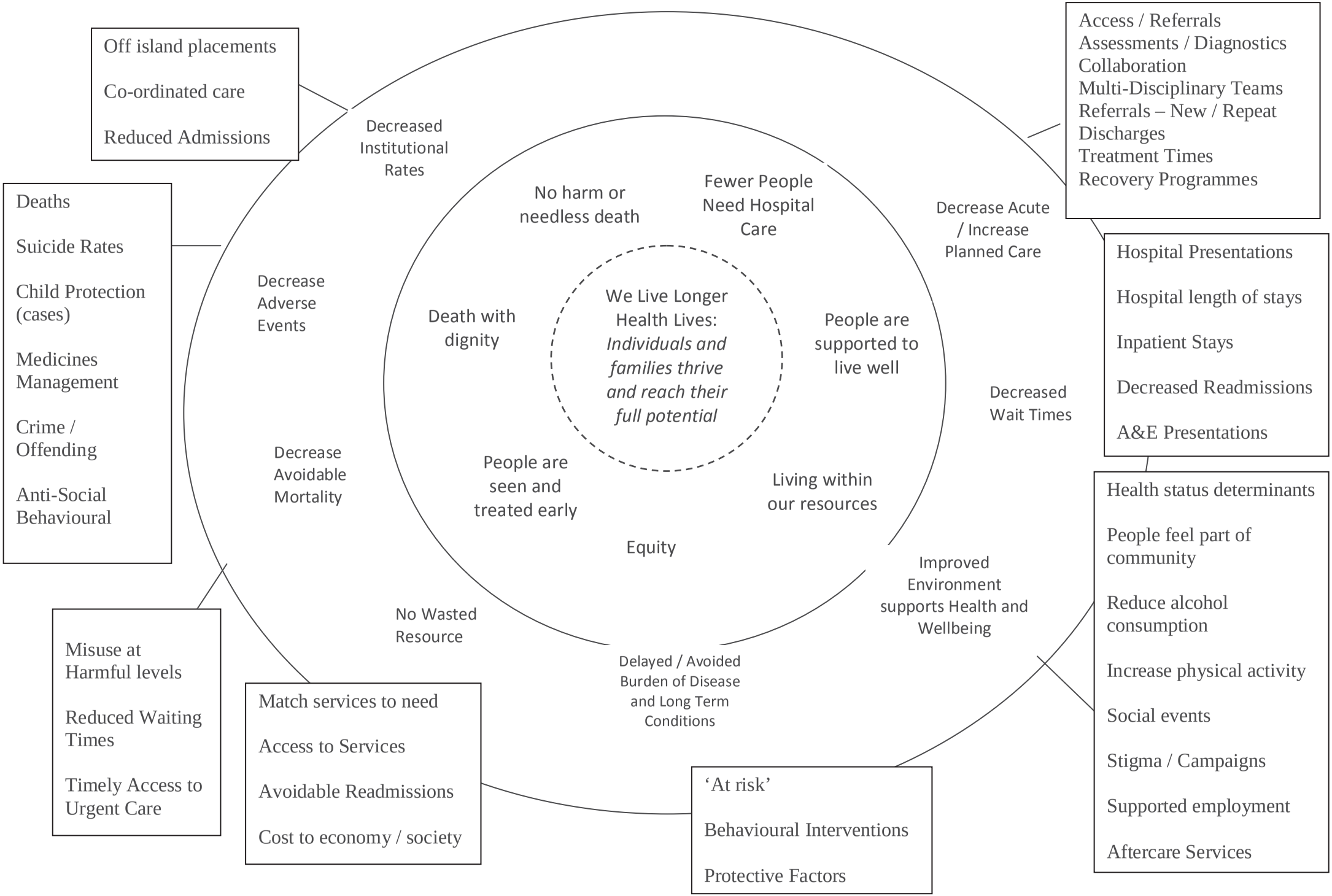
Provider	**Activity**	**Funding/resource**
NHS SIC	On/off island detox Off island rehab	NHS/SIC funded

Outcomes Framework

The IJB Commissions Substance Misuse Services in line with the general Health and Wellbeing Outcomes and the specific Alcohol and Drugs priorities.

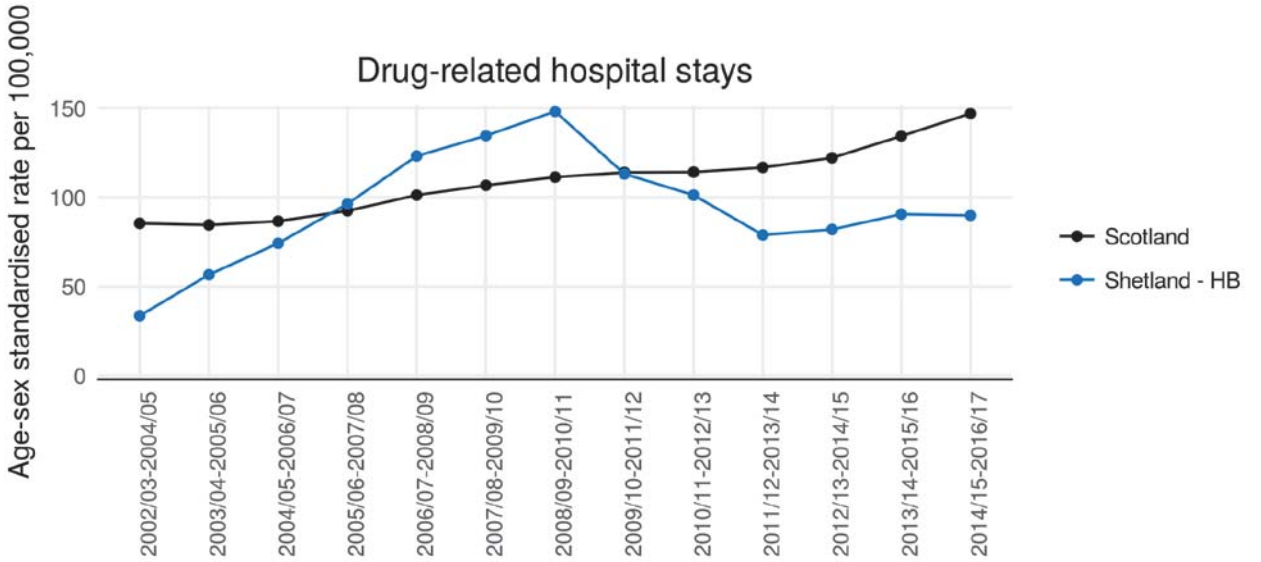


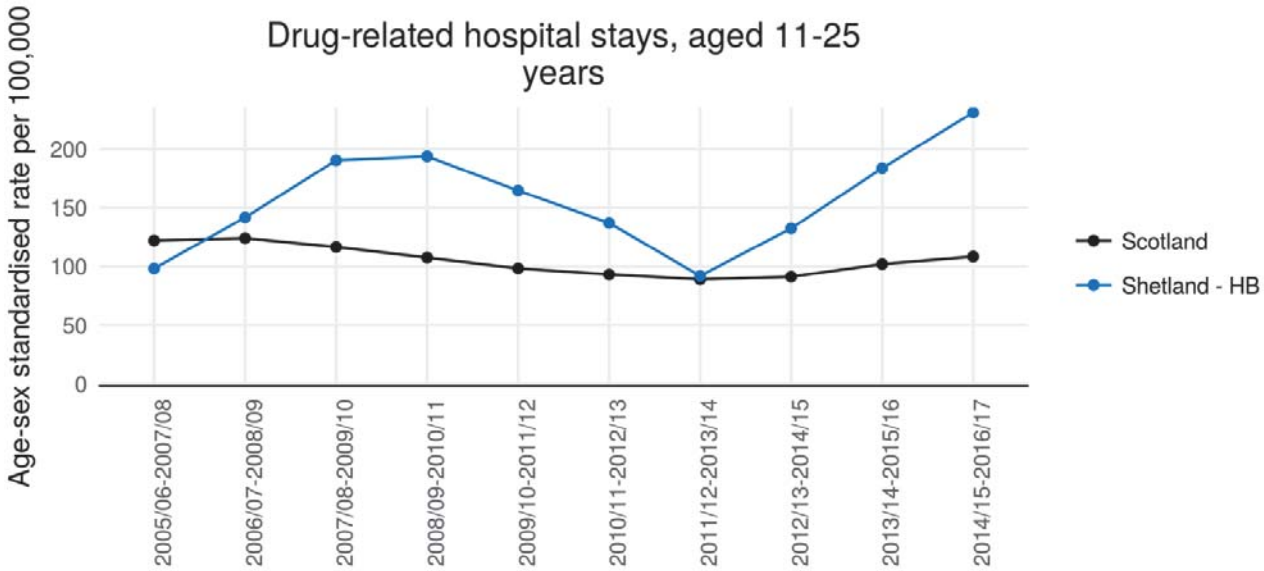
This diagram has been developed from the Canterbury, New Zealand Health System Outcomes Framework (http://ccn.health.nz/Resources/OutcomesFramework.aspx) shown below, with examples of indicators.

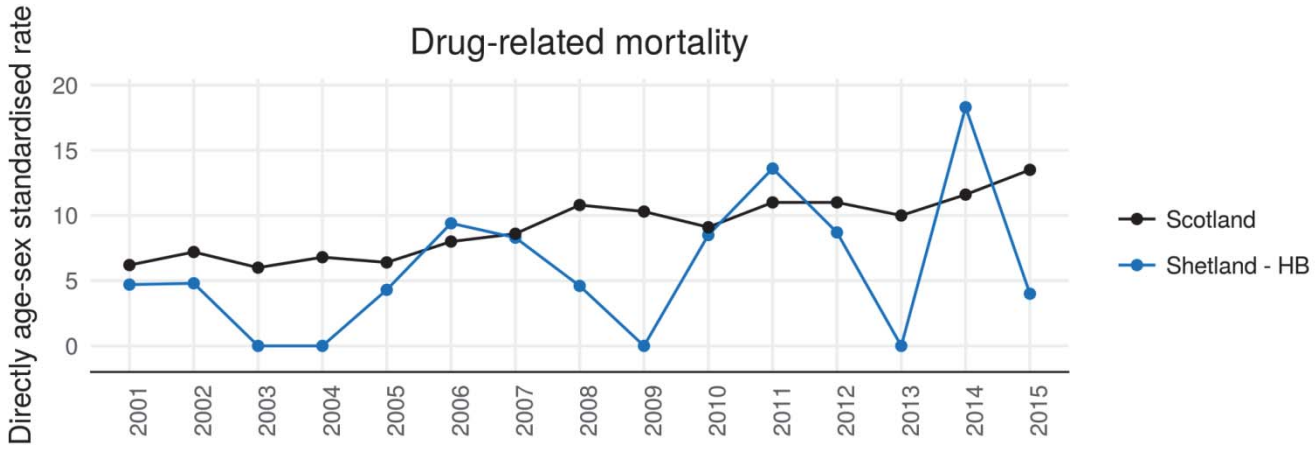

Off island placements
Co-ordinated care
Reduced Admissions
Deaths
Suicide Rates
Child Protection (cases)
Medicines Management
Crime / Offending
Anti-Social Behavioural
Misuse at Harmful levels
Reduced Waiting Times
Timely Access to Urgent Care
Match services to need
Access to Services
Avoidable Readmissions
Cost to economy / society
'At risk'
Behavioural Interventions
Protective Factors
Health status determinants
People feel part of community
Reduce alcohol consumption
Increase physical activity
Social events
Stigma / Campaigns
Supported employment
Aftercare Services
Hospital Presentations
Hospital length of stays
Inpatient Stays
Decreased Readmissions
A&E Presentations
Access / Referrals
Assessments / Diagnostics
Collaboration
Multi-Disciplinary Teams
Referrals – New / Repeat
Discharges
Treatment Times
Recovery Programmes
Decreased Institutional Rates
Decrease Adverse Events
Decrease Avoidable Mortality
No Wasted Resource
Delayed / Avoided Burden of Disease and Long Term Conditions
Improved Environment supports Health and Wellbeing
Decreased Wait Times
Decrease Acute / Increase Planned Care
No harm or needless death
Fewer People Need Hospital Care
Death with dignity
People are supported to live well
People are seen and treated early
Living within our resources
Equity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential

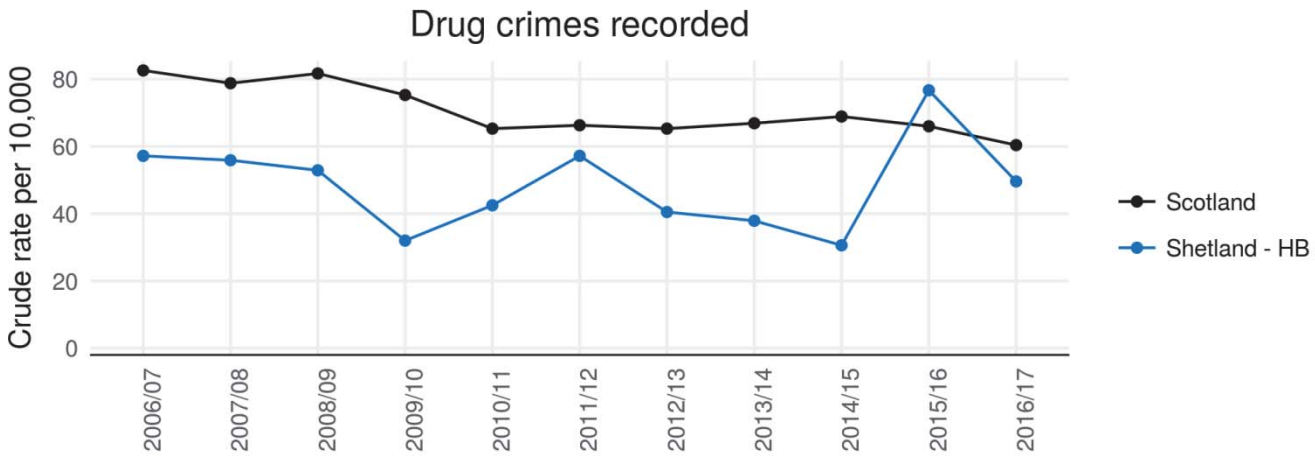
Substance Misuse Performance Data

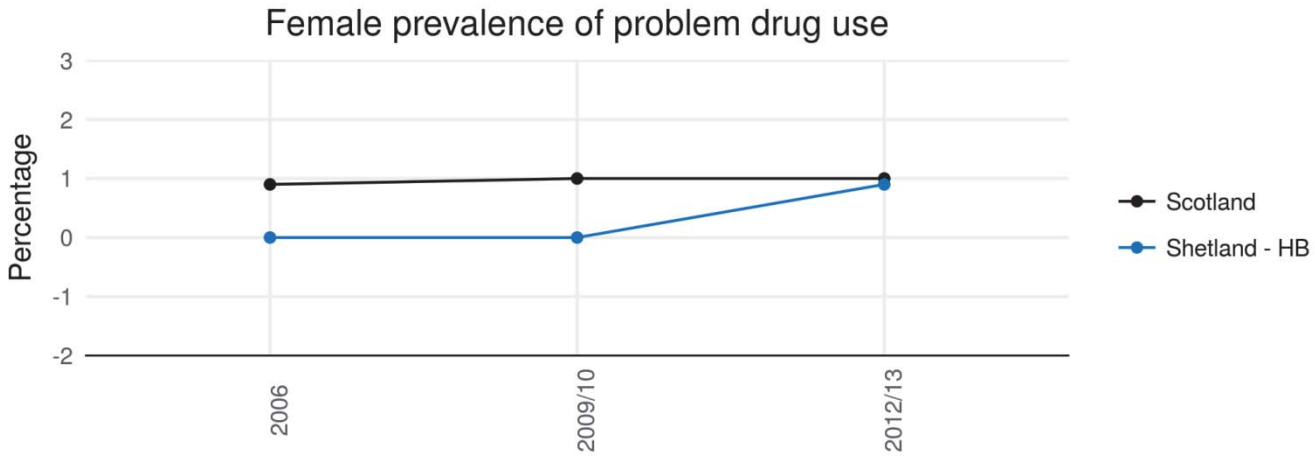
Problem Drug Use, national and local

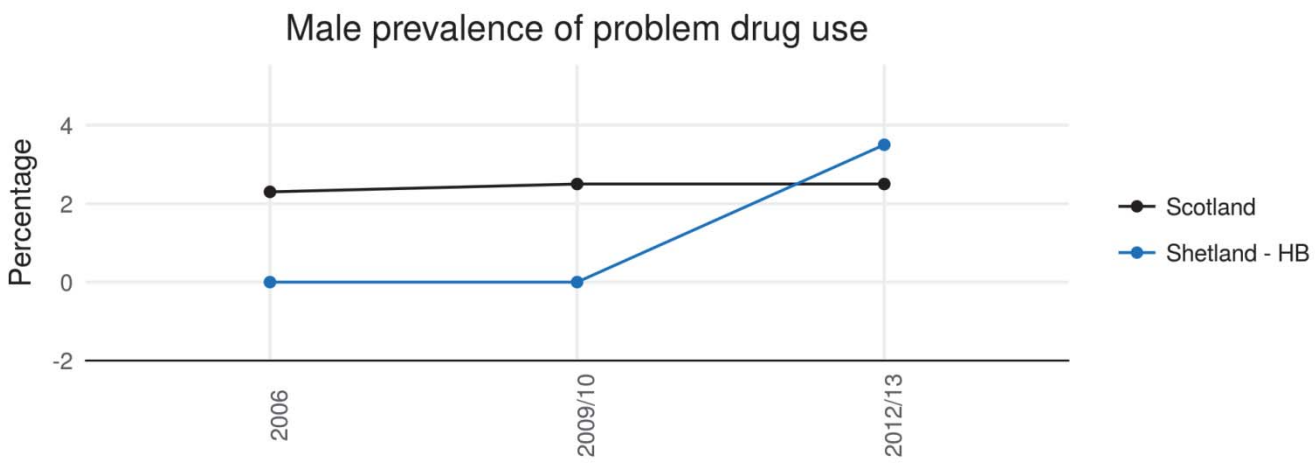


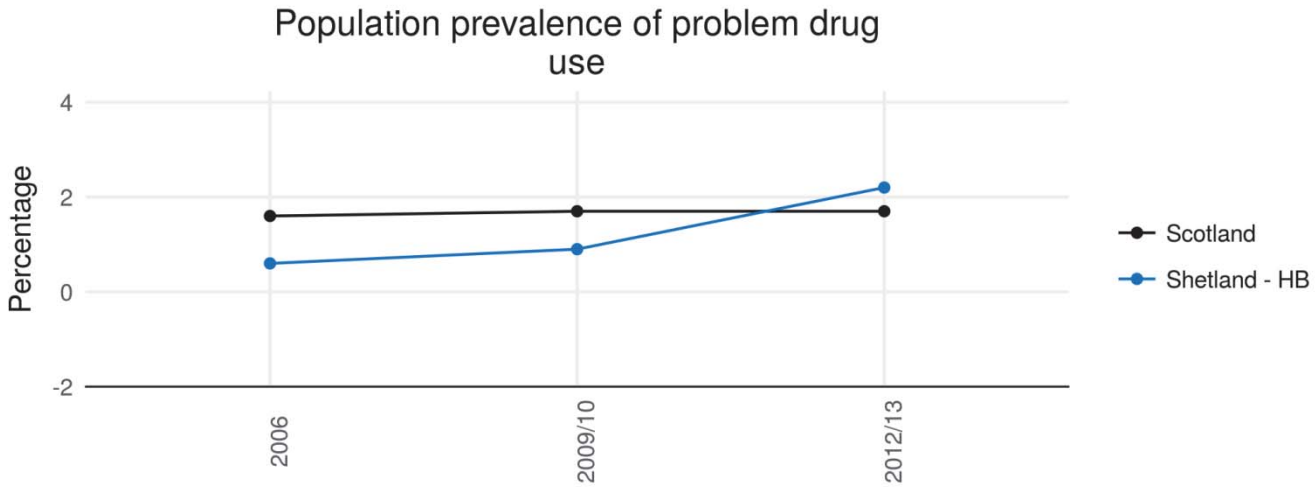



Drug-related mortality
Directly age-sex standardised rate
20
15
10
5
0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Scotland
Shetland - HB

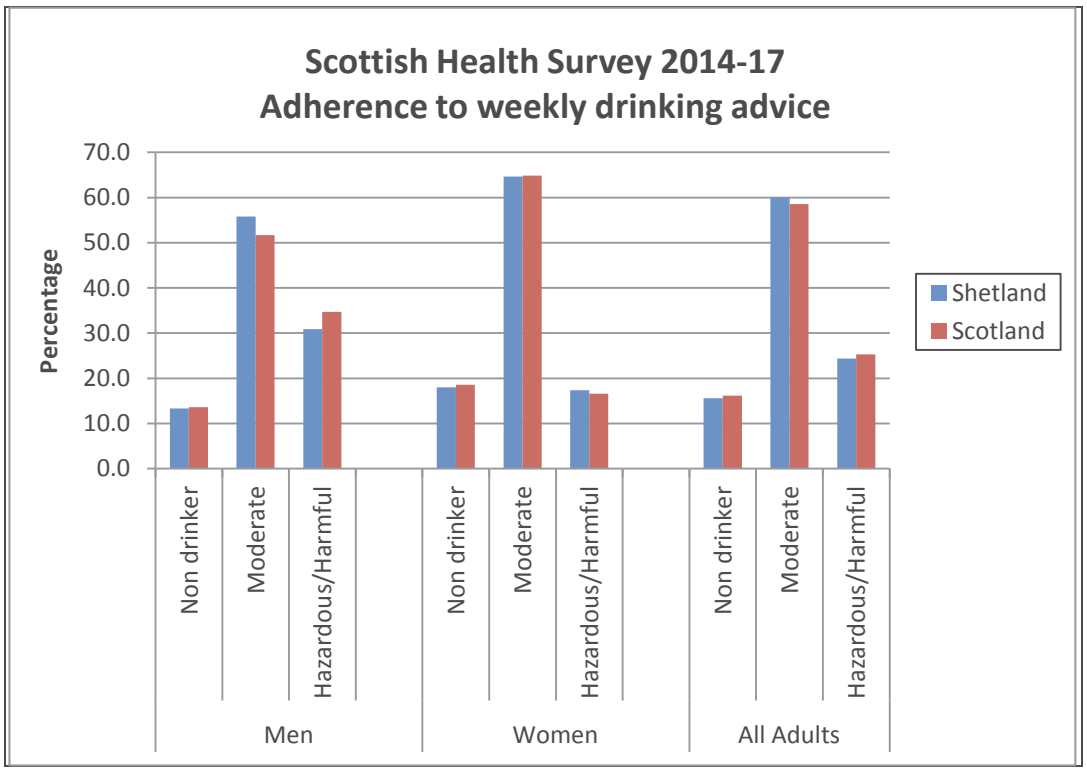

Drug crimes recorded
Crude rate per 10,000
80
60
40
20
0
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Scotland
Shetland - HB


Female prevalence of problem drug use
Percentage
3
2
1
0
-1
-2
2006
2009/10
2012/13
Scotland
Shetland - HB





Adherence to weekly drinking advice in comparison to Scotland.



Alcohol related crime and disorder (ScotPHO)

		Shetland			Scotland
	Period	Number	Rate		Rate
Common assault	2016/17 financial year	133	57.3	rate / 10,000 pop	107.1
Attempted murder & serious assault	2016/17 financial year	9	3.9	Crude rate per 10,000 population	7.7
Breach of the Peace	2016/17 financial year	97	41.8	rate / 10,000 pop	107.7
Vandalism	2016/17 financial year	84	36.2	rate / 10,000 pop	92
% people perceiving rowdy behaviour very/fairly common in their neighbourhood	2016 calendar year	NA	4	Percentage	11.2

Hospital Stays

Alcohol Conditions (All) over the past 3 years.

- 2015/16 - 152 stays in relation to 105 patients, 63 of whom were new patients.
- 2016/17-140 stays in relation to 108 patients, 62 of whom were new patients.
- 2017/18 - 151 stays in relation to 101 patients, 62 of whom were new patients. 52 of these stays and 47 patients were in relation to acute intoxication.

"New patients are defined as patients who have not been previously admitted to hospital with an alcohol diagnosis within the last 10 years. If a patient has several alcohol-related stays over a number of years, this patient will be counted only in the year of the first alcohol-related hospital stay."

Cost to healthcare

In a 1-year period (2016-2017) there were 140 alcohol related hospital discharges in Shetland, with a yearly average of 149 (http://statistics.gov.scot/)

Assuming each patient receives minimum level of acute care (A&E attendance, mental health assessment and alcohol assessment), annual cost to NHS Shetland: £83,887 (excludes ongoing care costs)

- Average cost of stepping inside A&E: £148
- Initial mental health assessment: £301
- Drugs and alcohol assessment: £114
- Source: https://improvement.nhs.uk/resources/reference-costs/

> Nationally, in 2016-2017, 92% of alcohol related admissions to hospital were emergencies (NHS ISD)

Resources

The Scottish Government provides specific (but not ring fenced) funding to the NHS to the value of £402,269.

The Scottish Government letter to NHS Chief Executives, Local Authority Chief Executives, Chief Officer of the ADP and ADP Chair dated 31 May 2018 states that,

> "Ministers are clear that the full funding allocation should be expended on the provision of ADP services and service supports. Further, these resources should be invested transparently, informed by a robust evidence base and appropriate needs assessment."

Shetland Islands Council provides funding of £179,594.

The Scottish Government letter to NHS Chief Executives, Local Authority Chief Executives, Chief Officer of the ADP and ADP Chair dated 31 May 2018 states that,

> "The allocations described in this letter represent the minimum amounts that should be expended on alcohol and drug treatment and prevention services in 2018-19. We fully expect that additional resources, including funding, will continue to be contributed by ADP partners with an emphasis on investment in innovation and prevention."

The 2019-20 funding letter has not yet been received.

The estimated cost of the Substance Misuse services in 2019-20 is therefore £581,863.

Improvement Plans

In 2019-20, the Shetland Alcohol and Drugs Partnership intend to undertake the following improvement activity:

- Encourage changes in attitudes and culture towards alcohol and drug use; with the aim that harmful use of drugs and alcohol is seen as a health issue, and that public sector understand the roles they can play in reducing access to harmful substances
- Increase access to needle exchange services, supported by good quality outreach and harm reduction
- Increase capacity of Tier 2 service, with accessible, client centred recovery focused support
- Engage with businesses and workplaces in Shetland to enable them to intervene early to identify and support staff with drug and alcohol problems.

Direction from the Integration Joint Board

Oral Health

		Direction Approved December 2017	Proposed Direction
1.	**Reference Number**	CC-61-17	CC-22-19 1.2
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	NHS Shetland	NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	Provision of Public Dental Service (PDS) to provide:- – Routine dental care for persons who are registered with the PDS – Emergency clinical primary dental care for people registered with the PDS – Secondary care oral health for the whole population – for orthodontics and oral and maxilla-facial surgery in particular – Dental Public Health for the whole population though Childsmile, the National Dental Inspection Programme, Oral Health Education and Promotion and Caring for smiles – Primary Dental Care will be provided predominantly	Provision of Public Dental Service (PDS) to provide:- – Routine and general dental service (GDS) care for persons who are registered with the PDS – Routine core PDS oral health provision for patients with additional care needs, including special care patients, vulnerable patients and children – Emergency clinical primary dental care for people registered with the PDS – Secondary care oral health for the whole population – for orthodontics and oral and maxilla-facial surgery in particular – Dental Public Health Promotion and Prevention

		through independent NHS practices. Public Dental Service will cover: special needs; remote and rural; public health; oral health promotion; specialist services.	for the whole population though Childsmile, the National Dental Inspection Programme, Oral Health Education and Promotion and Caring for smiles – Develop patient access within the local independent NHS dental sector – Primary Dental Care will be provided predominantly through independent NHS practices. Public Dental Service will cover: special needs; remote and rural; public health; oral health promotion; specialist services.
7.	**Full text of Direction**	Encourage/facilitate at least one new independent NHS dental practice to open in Shetland. Develop an NHS Shetland PDS Oral Health Promotion Framework (2016 -2020) Publish a Use of Fluoride Protocol for all NHS Practices in Shetland Scope the risks/benefits of undertaking fissure sealant programme for children in Shetland To scope a project for direct engagement with schools to promote oral health promotion and healthy eating To publish a synopsis of the current NICE guidelines for the recall of children with caries and align PDS to this guidance To implement a child dental risk register To engage with local	Encourage / facilitate at least one other new independent NHS dental practice to open in Shetland. Scope the risks/benefits of undertaking fissure sealant programme for children in Shetland To sustain our direct engagement with schools to promote oral health promotion via child smile and healthy eating To align PDS practices to the current SIGN guidelines for the examination, treatment and recall of children with caries To maintain a child dental risk register To sustain engagement with local independent practices to ensure children at high caries risk are participating adequately To implement annual training for all care home staff and older persons carers in alignment

		independent practices to ensure children at high caries risk are participating adequately To implement annual training for all care home staff and older persons carers in alignment with the Caring for Smiles Programme To monitor PDS and independent registrations and 'pinch point' areas for access to GDS care to accurately inform the SDAI process To produce a Remote Island Examination Protocol to facilitate on island examination in remote areas and prioritise mainland appointments for those requiring further oral healthcare To ensure all PDS practices are complaint with CPI practice inspection regulations To review the emergency dental service and assess its fitness for purpose To use the clinical governance framework to undertake patient quality assessment of the service and to encourage independent practices to do the same To formulate a robust clinical audit policy and process for all GDS practitioners To undertake an annual appraisal of all PDS dentists To produce a review and options paper of current provision of Oral and Maxillofacial Surgery, special care dentistry, paediatric	with the Caring for Smiles Programme and to develop Caring for Smiles 'Champions' in the care community. To monitor PDS and independent registrations and 'pinch point' areas for access to GDS care to accurately inform the SDAI process To deliver a Remote Island Examination Protocol to facilitate on island examination in remote areas and prioritise mainland appointments for those requiring further oral healthcare, to ensure equity of access To ensure all PDS practices are complaint with CPI practice inspection regulations To continually review the emergency dental service and assess its fitness for purpose To use the clinical governance framework to undertake patient quality assessment of the service and to encourage independent practices to do the same To oversee the national clinical audit policy and process for all GDS practitioners To undertake an annual appraisal and job plan for all PDS dentists To oversee the provision of of Oral and Maxillofacial Surgery, special care dentistry, orthodontics and restorative dentistry, within established care pathways and clinical networks. To oversee the delivery plan for

		dentistry and restorative dentistry To produce a review and options paper for the provision of an Orthodontic Service for Shetland (in conjunction with Consultant) To produce a scoping paper for the establishment of dental laboratory work within NHS Shetland To review the role and staff mix and upskill within the dental team to enhance oral health promotion and clinical effectiveness within the dental team.	the long term provision of an Orthodontic Service for Shetland (in conjunction with Consultant and NES). To produce a scoping paper for the establishment of dental laboratory work within NHS Shetland To continually ensure an effective skill mix within the dental team. To link with national oral health promotion project aimed at adults with additional needs.
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £3,123,000	Total Budget £3,124,523
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes Performance Indicators: The ratio of the WTE of primary care dentists providing NHS oral health care to the total resident population of Shetland at the end of the year The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through: the Shetland Partnership Plan; Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan; and the National Health and Wellbeing Outcomes Ensure provision of quality dental services, both within PDS and GDS provision, via the Dental Services Clinical Governance Framework. Performance Indicators: The ratio of the WTE of primary care dentists providing NHS oral health care to the total

		Level of unmet capacity: Numbers of people on waiting lists to register for NHS dentistry Percentage of Shetland population registered with Independent NHS Practices. The percentage of newborn children in Shetland enrolled into the Childsmile Programme The percentage of P1 children who have consented to participation in the Fluoride Varnish Application programme The percentage of P1 validated and consented children receiving at least one Fluoride Varnish Application per annum. The percentage of schools in Shetland having access to the National Dental Inspection Programme for P1 and P7 pupils. Percentage of P1 Children in Shetland with no obvious decay Percentage of P7 Children in Shetland with no obvious decay 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. Decay experience of children in P7 The mean dmft (decayed, missing or filled teeth per child) of children aged 10-11 years in P7 attending SIC primary schools.	resident population of Shetland at the end of the year The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care Level of unmet capacity: Numbers of people on waiting lists to register for NHS dentistry Percentage of Shetland population registered with Independent NHS Practices. The percentage of newborn children in Shetland enrolled into the Childsmile Programme The percentage of P1 children who have consented to participation in the Fluoride Varnish Application programme The percentage of P1 validated and consented children receiving at least one Fluoride Varnish Application per annum. The percentage of schools in Shetland providing access to the National Dental Inspection Programme for P1 and P7 pupils. Percentage of P1 Children in Shetland with no obvious decay Percentage of P7 Children in Shetland with no obvious decay 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. Decay experience of children in P7

		Those children deemed to be at higher risk as assessed by being on the Dental Risk Register are recalled in accordance with current SDCEP Guidance. The percentage number of days when out of hours dental cover is available to the Shetland population. The percentage of emergency patients dealt with in accordance with SCEP timeline guidance Percentage of care homes who have at least one individual who has completed foundation training with the Caring for Smiles Team Percentage of care homes with a Caring for Smiles/Oral Health Champion Percentage of care homes who have had a dentist visit	The mean dmft (decayed, missing or filled teeth per child) of children aged 10-11 years in P7 attending SIC primary schools. Those children deemed to be at higher risk as assessed by being on the PDS Dental Risk Register are recalled in accordance with current SDCEP Guidance. The percentage number of days when out of hours dental cover is not available to the Shetland population. The percentage of emergency patients not dealt with in accordance with SDCEP timeline guidance Percentage of care homes who have at least one individual who has completed foundation training with the Caring for Smiles Team Percentage of care homes with a Caring for Smiles / Oral Health Champion Percentage of care homes who have had a dentist visit Percentage of designated non-Dentist islands having had a dental visit.
10.	**Performance monitoring arrangements**	Quarterly Reporting SMART Targeting	Quarterly Reporting SMART Targeting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Oral Health Services

Service Model
Outcomes Framework
Resources
Improvement Plans

Service Model

NHS Shetland has the responsibility to ensure that appropriate oral health care and advice is available for the entire population of Shetland, irrespective of whether they are registered for routine dental care at one of the six sites run by the PDS and one independent NHS practice in Lerwick. There is also responsibility for meeting the urgent/ emergency care needs of visitors and temporary residents.

On 31 March 2019 16,500 people were registered with the PDS for ongoing routine dental care and 6,500 are listed with the Independent practice in Lerwick.
It is hoped that during 2019-2020 both these figures should show further signs of rebalance with a subsequent increase in the numbers of patients registered in the independent sector and a decrease in those registered with the PDS for their routine dental needs.

The Emergency Dental Service operates during core working hours to accommodate people needing urgent dental care. There is an out-of-hours emergency service which incorporates NHS 24 and an on-call dentist to provide advice and access to emergency care. The out of hours emergency service is aligned with SDCEP guidelines to ensure that those who require access to the service can do so in a timely manner. The following are examples of cases which would be able to access the out of hours emergency service.

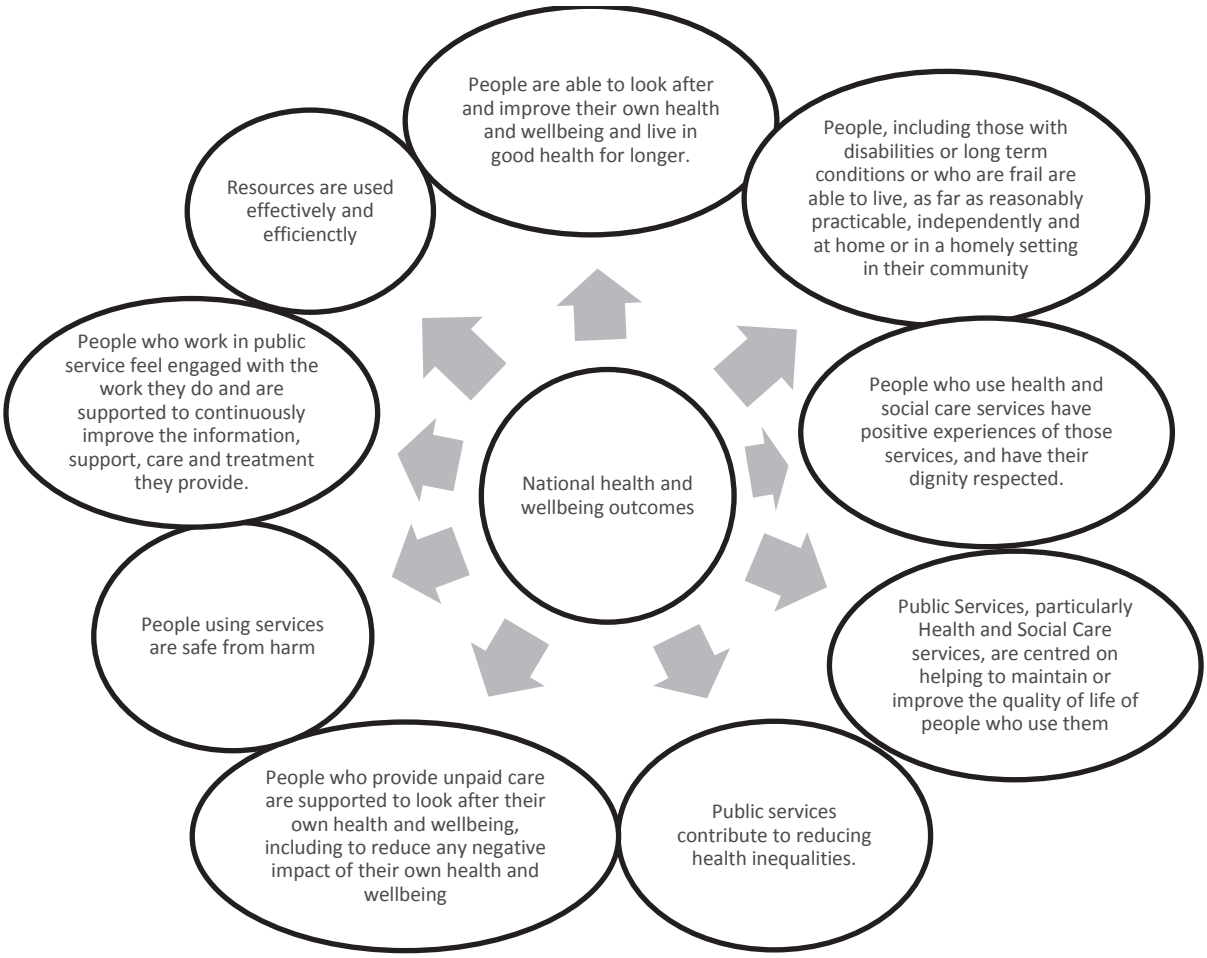
- People with trauma including facial/oral laceration and/or dento-alveolar bone injuries
- Oro-facial swelling that is significant and worsening
- Post-extraction bleeding that the patient is not able to control with local measures

- Dental infections that have resulted in acute systemic illness and raised temperature

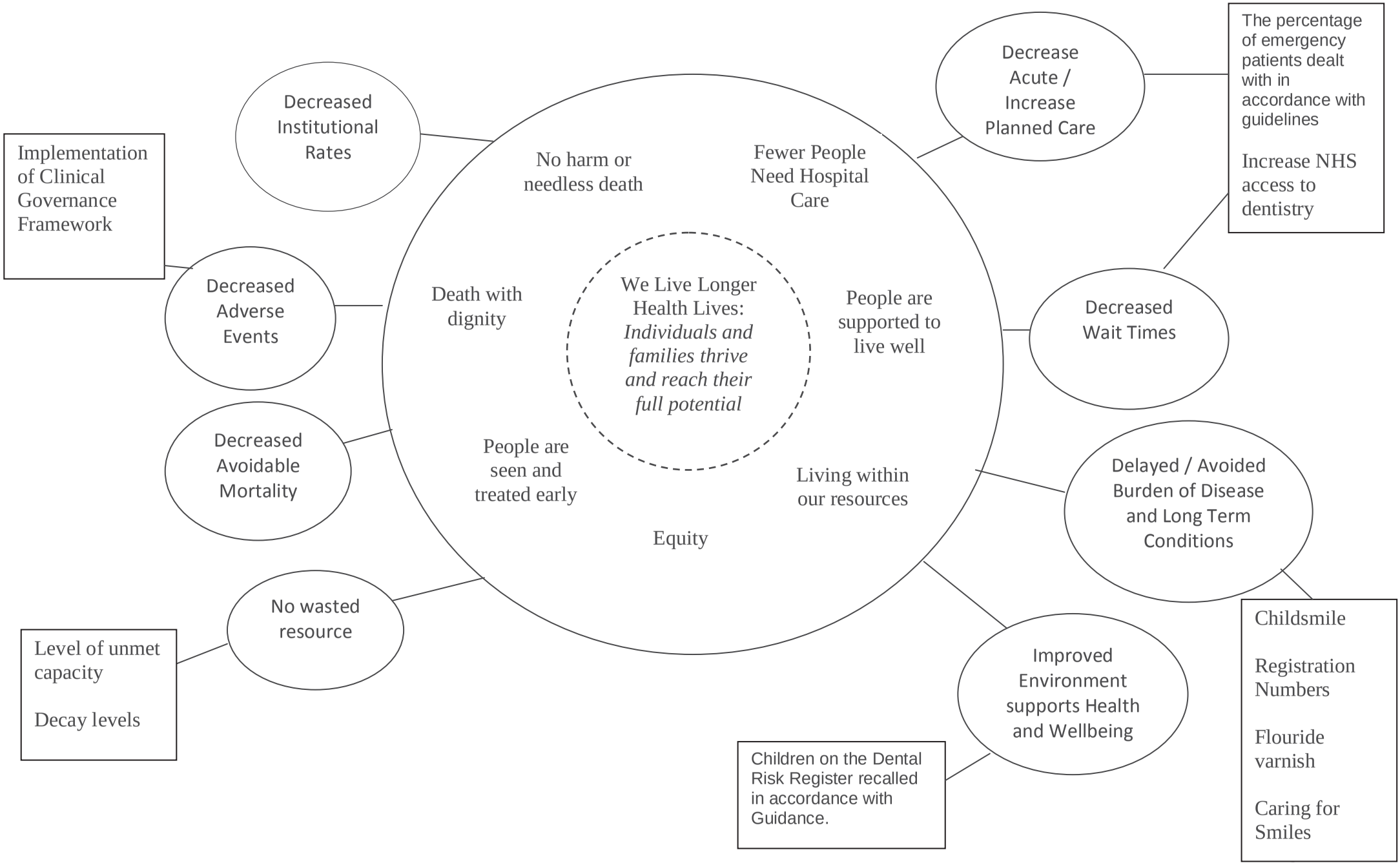
Oral Health Promotion activities such as the Childsmile programme and Caring for Smiles are undertaken by a dedicated NHS Shetland resourced oral health promotion team.

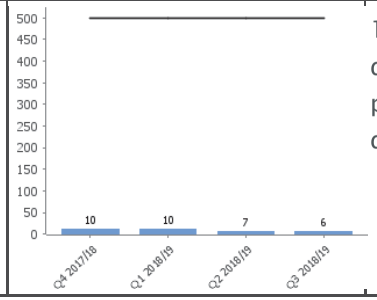
Outcomes Framework

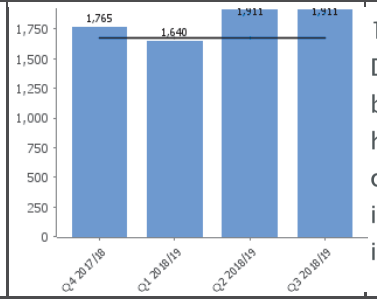
The IJB Commissions Oral Health Services in line with the general Health and Wellbeing Outcomes.

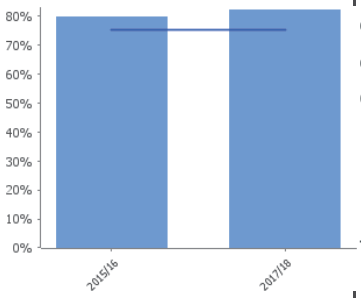
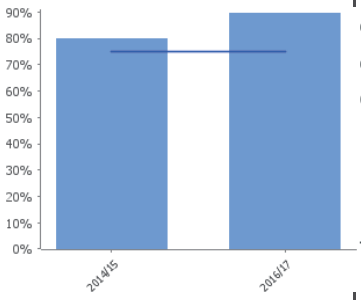


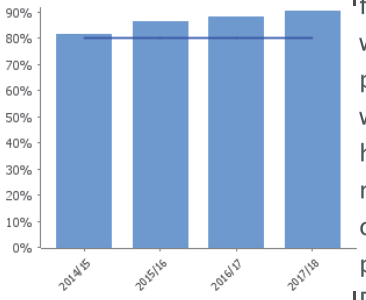
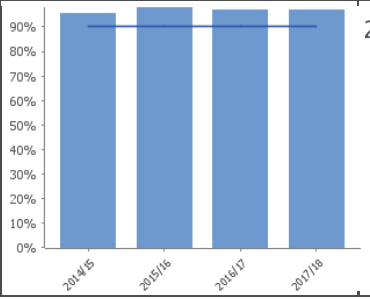
In order to capture the whole population / whole system approach, the outcomes are based on the Canterbury, New Zealand Health System Outcomes Framework. (http://ccn.health.nz/Resources/OutcomesFramework.aspx)


Decreased Institutional Rates
Implementation of Clinical Governance Framework
Decreased Adverse Events
Decreased Avoidable Mortality
No wasted resource
Level of unmet capacity
Decay levels
No harm or needless death
Fewer People Need Hospital Care
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
People are seen and treated early
Living within our resources
Equity
Decrease Acute / Increase Planned Care
The percentage of emergency patients dealt with in accordance with guidelines
Increase NHS access to dentistry
Decreased Wait Times
Delayed / Avoided Burden of Disease and Long Term Conditions
Childsmile
Registration Numbers
Flouride varnish
Caring for Smiles
Improved Environment supports Health and Wellbeing
Children on the Dental Risk Register recalled in accordance with Guidance.

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
DS004 Number of people who are waiting to register with Public Dental Service (PDS) for ongoing Care	572	500	10	500	10	7	6	500			14-Feb-2019 Source: Local data. Despite waiting, all these people are able to access NHS dental care elsewhere.

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q1 2018/19	Q2 2018/19	Q3 2018/19	Q3 2018/19	Q3 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
DS002 The ratio of WTE primary care dentists providing NHS oral health care to the total resident population of Shetland	2,083	1,670	1,765	1,670	1,640	1,911	1,911	1,670			14-Feb-2019 New Senior Dental Officer started at the beginning of February and have agreement on another clinical recruitment which will improve the ratio further later in the year.

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

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

Direction from the Integration Joint Board

Pharmacy and Prescribing

		Direction Approved December 2017	Proposed Direction February 2019
1.	**Reference Number**	CC-61-17	CC-22-19 1.3
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council & NHS Shetland	NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	To provide pharmaceutical services within the hospital including procurement storage supply and dispensing of medicines. To support and apply governance around prescribing both in the hospital and primary care, considering cost, effectiveness, training, safety and clinical input. To ensure safe and appropriate contractual arrangements are in place for the delivery of community pharmacy. To ensure dispensing arrangements are in place where it is not possible to dispense from a community pharmacy	To provide pharmaceutical services within the hospital including procurement storage supply and dispensing of medicines. To support and apply governance around prescribing both in the hospital and primary care, considering cost, effectiveness, training, safety and clinical input. To ensure safe and appropriate contractual arrangements are in place for the delivery of community pharmacy. To ensure dispensing arrangements are in place where it is not possible to dispense from a community pharmacy

		To provide strategic support, operational leadership and direction in the management of prescribing costs and budgets across Shetland. To ensure support training and governance in medicine use and administration in community care and care at home settings. To support a multidisciplinary approach within GP Practices providing pharmaceutical expertise and a pharmacotherapy service.	To provide strategic support, operational leadership and direction in the management of prescribing costs and budgets across Shetland. To ensure support training and governance in medicine use and administration in community care and care at home settings. To support a multidisciplinary approach within GP Practices providing pharmaceutical expertise and a pharmacotherapy service.
7.	**Full text of Direction**	The pharmacy service will work as a single team across traditional boundaries of Regional, Primary Secondary and Community Care to support the seamless and safe transfer of patients and their medicines between settings. The pharmacy workforce will develop in line with the commitments contained in This will involve specialist prescribing, by pharmacists in areas such as respiratory medicine diabetes and de-prescribing in polypharmacy. Pharmacists will be trained in Pharmacotherapy, and a modern technical service will support this. In carrying out the direction the pharmacy service is required to provide safety and clinical checks on medicines prescribed within the hospital environment and	The pharmacy service will work as a single team across traditional boundaries of Regional, Primary Secondary and Community Care to support the seamless and safe transfer of patients and their medicines between settings. Building on “Achieving Excellence in Pharmaceutical Care” develop a workforce plan to describe how a modern pharmacy service can be developed which incorporates the clinical specialisms and technical services and meets the increasing need for pharmacotherapy services. In carrying out the direction the pharmacy service is required to provide safety and clinical checks on medicines

		will provide clinical as well as technical support to GP practices in Shetland. Developing technical support will see the role of pharmacy technician in medicine management changing. The service will support people to manage their own medicines in community settings and provide services within care homes to ensure residents are receiving medicines safely and that waste is avoided. Development of Hospital Electronic Medicines Prescribing and Administration technology will require the full involvement of pharmacy staff. The Service will provide information and support to patients and prescribers around medicine use as required. The Implementation of the Direction will see better systems for the management of repeat prescribing and pharmacotherapy within GP practices. Pharmacotherapy development will necessitate the development of systems and leadership in managing medicine reconciliation and provision of support to General Practitioners so that safe and effective prescribing can be demonstrated. The service will lead on	prescribed within the hospital environment and will provide clinical as well as technical support to GP practices in Shetland. Expand the work of technicians to increasingly provide support people to manage their own medicines in community settings and provide services within care homes to ensure residents are receiving medicines safely and that waste is avoided. Fully participate in HEPMA roll out which will aid discharge arrangements and provide safer procedures for medicine prescribing and administration. The Service will provide information and support to patients and prescribers around medicine use as required. The Implementation of the Direction will see better systems for the management of repeat prescribing and pharmacotherapy within GP practices. Pharmacotherapy development will necessitate the development of systems and leadership in managing medicine reconciliation and provision of support to General Practitioners so that safe and effective prescribing can be demonstrated.

		governance for medicines prescribed by all clinicians in Shetland including those provided directly to patients by “Homecare” companies. The service will be accountable for the safe management of controlled drugs and lead on the delivery of controlled drug monitoring. In carrying out the direction, systems and processes need to fit for purpose there is a requirement to reduce waste improve efficiency and demonstrate value for money. Savings will be anticipated by delivering the priority cost savings projects: Biologicals/Biosimilars; Diabetes prescribing; respiratory prescribing waste reduction and polypharmacy reviews. Carrying out the Direction will involve working with North of Scotland Health Boards to maximise the effect of the above, avoiding duplication of effort and conflicting strategies.	The service will lead on governance for medicines prescribed by all clinicians in Shetland including those provided directly to patients by “Homecare” companies. The service will be accountable for the safe management of controlled drugs and lead on the delivery of controlled drug monitoring. In carrying out the direction, systems and processes need to fit for purpose there is a requirement to reduce waste improve efficiency and demonstrate value for money. Savings will be anticipated by delivering the priority cost savings projects: Biologicals/Biosimilars; Diabetes prescribing; respiratory prescribing waste reduction and polypharmacy reviews. Carrying out the Direction will involve working with North of Scotland Health Boards to maximise the effect of the above, avoiding duplication of effort and conflicting strategies.
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £6.5M which includes the cost of medicines.	Total Budget £6,645,510 which includes the cost of medicines
9.	**Outcomes**	The overarching outcome is to contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain	The overarching outcome is to contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and

		independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes. The service will Demonstrate an increase multidisciplinary working particularly in GP practices and care settings as outlined in "Delivering Excellence". The provision of pharmacy input into each GP practice and Care Home. Further development of specialist pharmacists roles, particularly in primary care The service will deliver on the Regional Pharmacy action plans. Develop a programme of recruitment activities and demonstrate investment in approaches to retaining pharmacy staff. Demonstrate that an effective medicines governance approach is in place in Shetland, which links to the regional approach and introduction of the Scottish National Formulary. The service will be able to describe a stronger focus on services delivered for patients wherever they live in Shetland. Services that make improvements to their experience and demonstrate	allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes. The service will Demonstrate an increase multidisciplinary working particularly in GP practices and care settings as outlined in "Delivering Excellence". The provision of pharmacy input into each GP practice and Care Home. Further development of specialist pharmacists roles, particularly in primary care Continue to participate in joint regional work. Incorporate the activities to aid recruitment into a pharmacy workforce plan. Work closely with NHS Grampian to ensure that a regional approach is applied to medicine governance an policy (Scottish Formulary is not currently being pursued nationally) The service will be able to describe a stronger focus on services delivered for patients wherever they live in Shetland. Services that make improvements to their experience and demonstrate

		realistic benefits from their prescribed medicine. Deliver on the prescribing savings plan is expected.	realistic benefits from their prescribed medicine. Update Prescribing strategy and produce a prescribing savings plan .to be updated
10.	**Performance monitoring arrangements**	Quarterly Reporting Development across the region of accessible prescribing reports Highlight reports on savings plans Director of Pharmacy updates and reports as required to the IJB and associated committees.	In addition to reporting on prescribing savings plans the Director of Pharmacy will produce an annual report
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Pharmacy and Prescribing Services

Service Model
Outcomes Framework
Resources
Improvement Plans

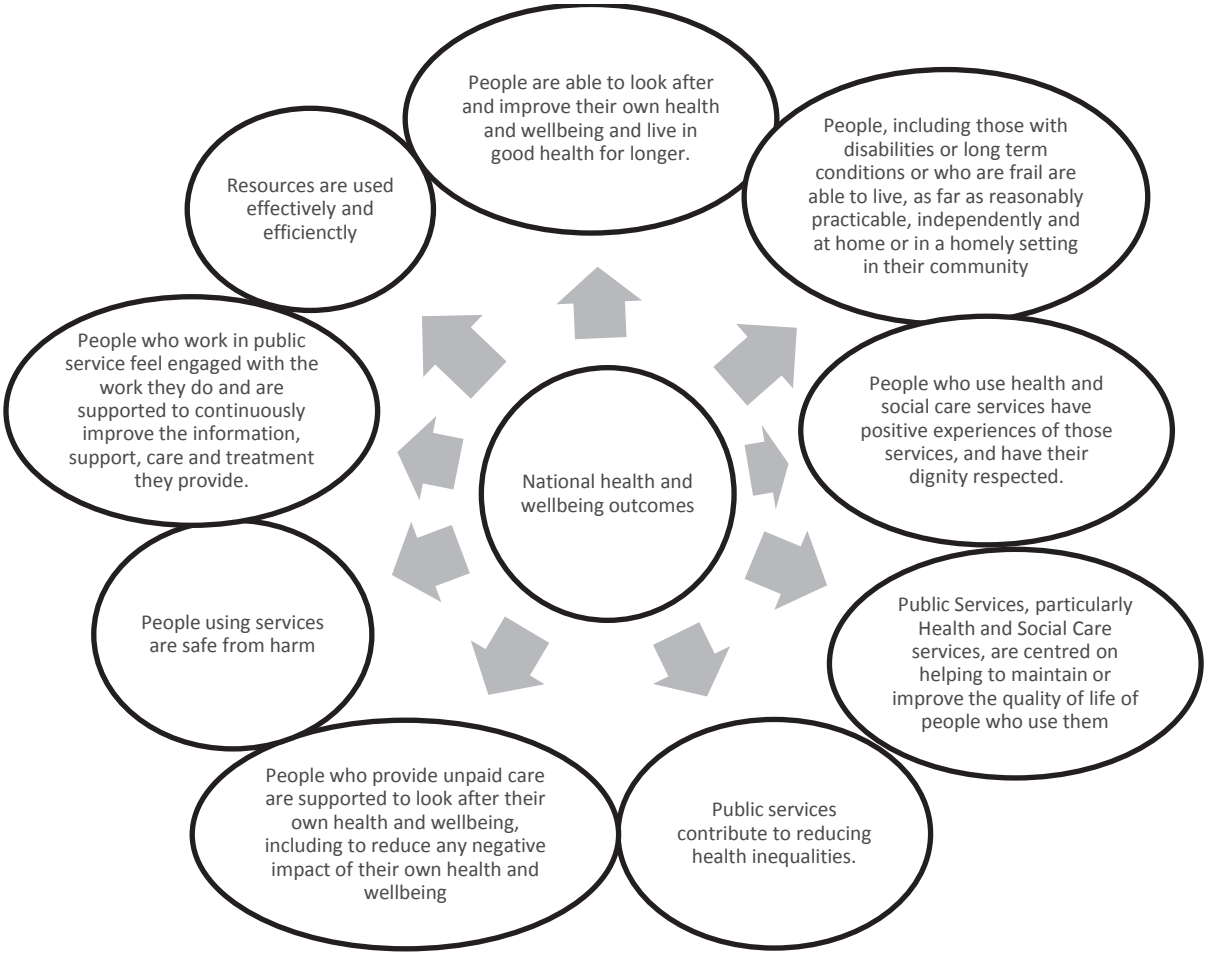
Service Model

The service model and indicative activity levels are shown below. This is the service model that the IJB is commissioning directly from NHS Shetland.

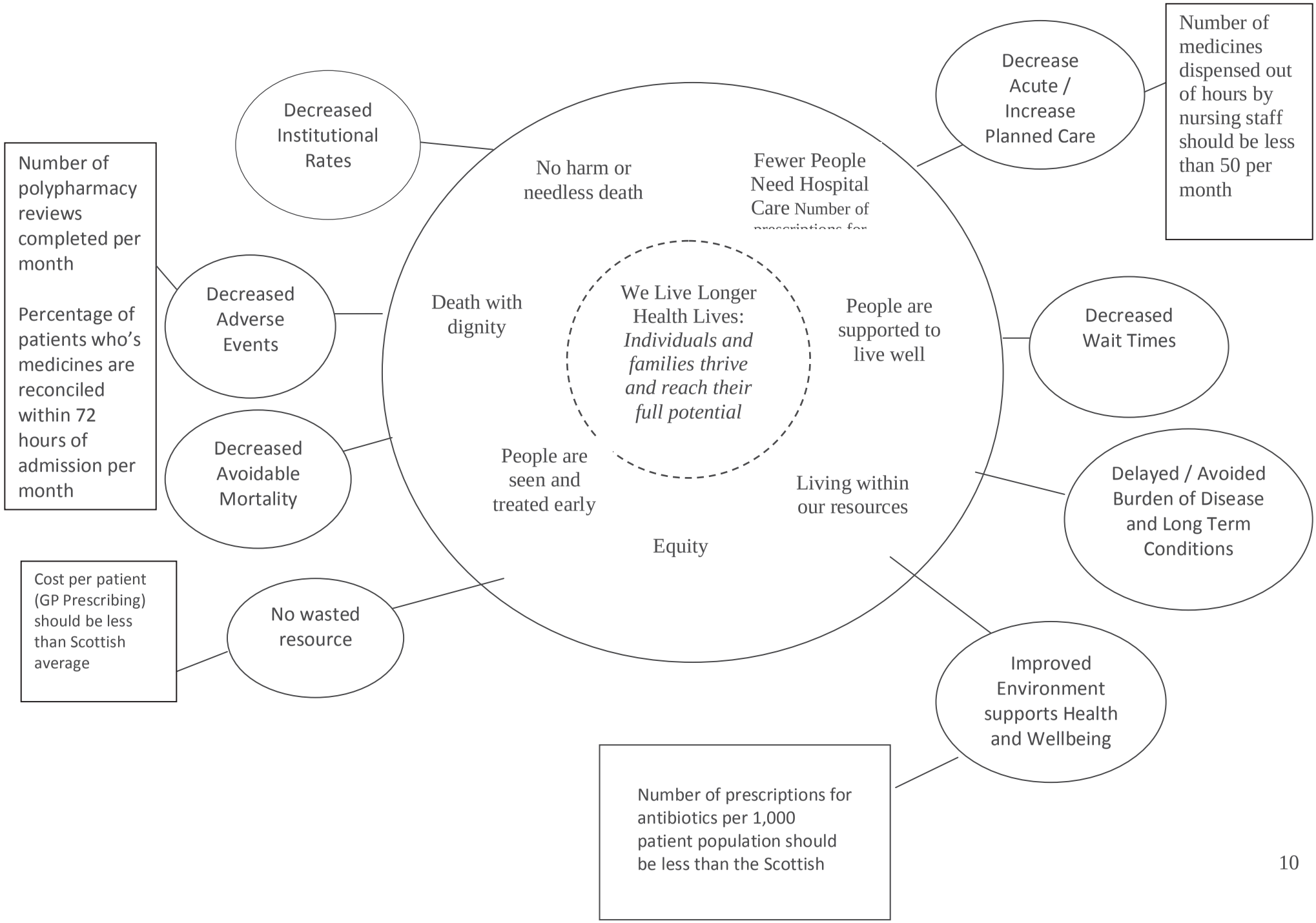
Current Activity	Numbers Patients / Service Users
Comprehensive Pharmacy service- advice, support, governance, dispensing, clinical pharmacy, procurement, which covers both the hospital and Health and Social care.	Shetland population
Support for GP practices - Pharmacotherapy	Nine practices

Outcomes Framework

The IJB Commissions Pharmacy and Prescribing Services in line with the general Health and Wellbeing Outcomes.



In order to capture the whole population / whole system approach, the outcomes are based on the Canterbury, New Zealand Health System Outcomes Framework. (http://ccn.health.nz/Resources/OutcomesFramework.aspx)


Decreased Institutional Rates
Number of polypharmacy reviews completed per month
Percentage of patients who's medicines are reconciled within 72 hours of admission per month
Decreased Adverse Events
Decreased Avoidable Mortality
Cost per patient (GP Prescribing) should be less than Scottish average
No wasted resource
No harm or needless death
Fewer People Need Hospital Care Number of
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
People are seen and treated early
Living within our resources
Equity
Decrease Acute / Increase Planned Care
Number of medicines dispensed out of hours by nursing staff should be less than 50 per month
Decreased Wait Times
Delayed / Avoided Burden of Disease and Long Term Conditions
Improved Environment supports Health and Wellbeing
Number of prescriptions for antibiotics per 1,000 patient population should be less than the Scottish

Performance Data

Category	Indicator	Evidence	Target	Current Performance	Improvement Actions /Notes
Cost of Medicines	Cost Per patient Less than scotland	From Prescribing Data	Should be less than 100%	96.5% and falling	Prescribing savings plan will be followed
Use of antibiotics	Less than Scottish average	From prescribing data	Less than 100%	100.76%	Prescribing of antibiotics in Shetland, on audit seems appropriate. More work needed.
Patient safety reducing harm and waste	Number of polypharmacy reviews conducted each month	From in house data collection	More than 20 per month (1% of population)	21	Difficult to increase with current staffing levels
Patient safety- Anticipatory discharge and planning	Number of discharges prepared by nurses out of hours	From ward data	Less than 20 per month	24	With shorter times in hospital it is increasingly difficult to predict discharge times.- various mitigations in place to improve safety.

Resources

NHS Shetland services are estimated to cost 6,645,510 in 2019-20.

The savings / efficiency target has been set at £150,000 for 2019-20.

Improvement Plans

Plans for change

The new General Medical Services contract in Scotland has identified that multi-disciplinary team working is crucial to reducing GP workload. As part of the agreed contract, every practice will receive pharmacy and prescribing support in the form of a pharmacotherapy service.

The aspiration of Scottish Government is for a pharmacotherapy service to evolve over a three year period from 2018 – 21 with pharmacists and pharmacy technicians becoming embedded members of the core practice clinical teams to establish a sustainable service.

Over the period, pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines, medication review, compliance review, medicines management

b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics

There will also be a local requirement to invest further in pharmacists and technicians. The Technicians in particular will help to realise savings, and there are significant savings opportunities for Shetland if investment can be identified. In response to this a pharmacy workforce plan will be developed in 2019

A 5 Year Strategic Prescribing Program has been established.

The program will achieve the following service outcomes:

- To ensure there is an effective medicines management approach in place across pharmacy in Shetland, which mindful and efficient prescribing is part of.

- To ensure that our systems and processes are fit for purpose and as lean as possible in order to reduce waste

- To increase multidisciplinary working

The change outcomes will be:

- A focus on services delivered for customers that make improvements to the customer's experience of services
- Adherence to evidence based care pathways.
- Evolution, building on what has been achieved so far
- Improved efficiency and value for money; providing efficiency savings for the public sector in Shetland

Savings will be sought, not by a cost driven approach but by a strategic approach to quality safety and effective medicines management.

Within the action plan the current priority projects are:

- Safe transfer of medicines on admission and discharge
- Pharmacists led interventions through pharmacotherapy.
- Development of the pharmacy technician role
- Diabetes prescribing
- Respiratory Prescribing
- Cardiovascular Prescribing
- Polypharmacy and reduction in waste.

Direction from the Integration Joint Board

Primary Care

		Direction Approved December 2017	Proposed Direction February 2019
1.	**Reference Number**	CC-61-17	CC-22-19 1.4
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	NHS Shetland	NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes – CC-61-17
6.	**Functions covered by the Direction**	There are currently 10 Health Centres in Shetland providing GP services together with 5 non-doctor islands which are staffed by community nurses and receive GP services from a local health centre. Of the 10 GP practices 8 are currently salaried to NHS Shetland (all staff are employed by NHS Shetland). The other two are independent practices which means they contract with NHS Shetland to provide core GP services funded through a national contract. In addition, Primary care provides Ophthalmic Services with three providers of ophthalmic services based in Lerwick. GP Services and Ophthalmic Services (Pharmacy and	There are currently 10 Health Centres in Shetland providing GP services together with 5 non-doctor islands which are staffed by community nurses and receive GP services from a local health centre. Of the 10 GP practices 8 are currently salaried to NHS Shetland (all staff are employed by NHS Shetland). The other two are independent practices which means they contract with NHS Shetland to provide core GP services funded through a national contract. In addition, Primary care provides Ophthalmic Services with three providers of ophthalmic services based in Lerwick. GP Services and Ophthalmic Services (Pharmacy and Dental included elsewhere)

		Dental included elsewhere) To ensure support training and governance in medicine use and administration in community care settings. To support a multidisciplinary approach within GP Practices providing pharmaceutical input.	To ensure support training and governance in medicine use and administration in community care settings. To support a multidisciplinary approach within GP Practices providing pharmaceutical input.
7.	**Full text of Direction**	Implement 2017/18 GP contract and QOF amendments • Plan and negotiate for implementation of new GP contract for 2018/19 once the detail has been agreed and notified to Boards • Develop capacity to do prevention, early intervention, supported self management and anticipatory care planning effectively • Develop a comprehensive website with links to self care advice for common conditions • Recognise the value and invest in good quality administration, management and clinical leadership in Primary Care • Improve the recruitment and retention of GP's in Shetland • Influence partner organisations such as Scottish Ambulance Service, Shetland Islands Council with regard to transport issues and Scottish Government on national policy that will affect local services • Actively pursue Schemes such as Remote and Rural Fellows Scheme • Increase the number of training practices in Shetland • Development of local primary care team to include	Plan, develop and implement Year 2 of the Primary Care Improvement Plan. This is an overarching plan which covers six key areas, as outlined in the 2018 Scottish GP Contract. The plan is attached. • Improve the recruitment and retention of GP's in Shetland through leading on the "Discover the Joy" recruitment campaign, for which Shetland is the recruitment hub. • Influence partner organisations such as Scottish Ambulance Service, Shetland Islands Council with regard to transport issues and Scottish Government on national policy that will affect local services • Actively pursue Schemes such as Remote and Rural Fellows Scheme • Increase the number of training practices in Shetland • Development of local primary care team to include GP roles as envisaged in the new GP contract, pharmacy and other health improvement practitioner time working with community nursing, social care and other professionals such as OT to develop a more integrated model of health and social care – this ties in with the Primary Care

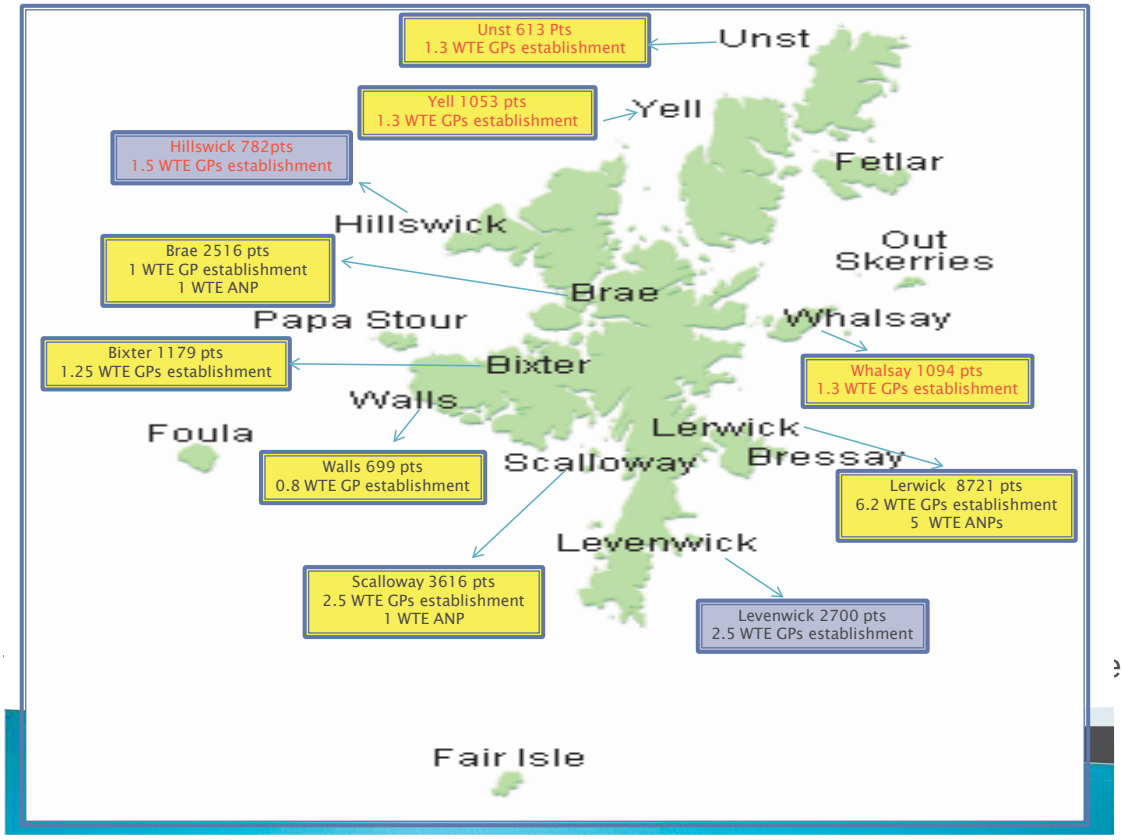
		GP roles as envisaged in the new GP contract, pharmacy and other health improvement practitioner time working with community nursing, social care and other professionals such as OT to develop a more integrated model of health and social care • Provide skills development and training • Understand how existing communications structures and pathways can be used more effectively or reform them to meet the needs of Shetland • Implement the national Out of Hours review locally in a way that will improve primary care delivery in Shetland, particularly in terms of access to services for unscheduled care and GP recruitment and retention • Develop service models for Shetland to suit the local context.	Improvement Plan, which holds more information. • Develop service models for Shetland to suit the local context, to include different staffing models, within the funding received.
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £4,571,000	NHS Shetland £4,430,563
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way.	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way.
10.	**Performance monitoring arrangements**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

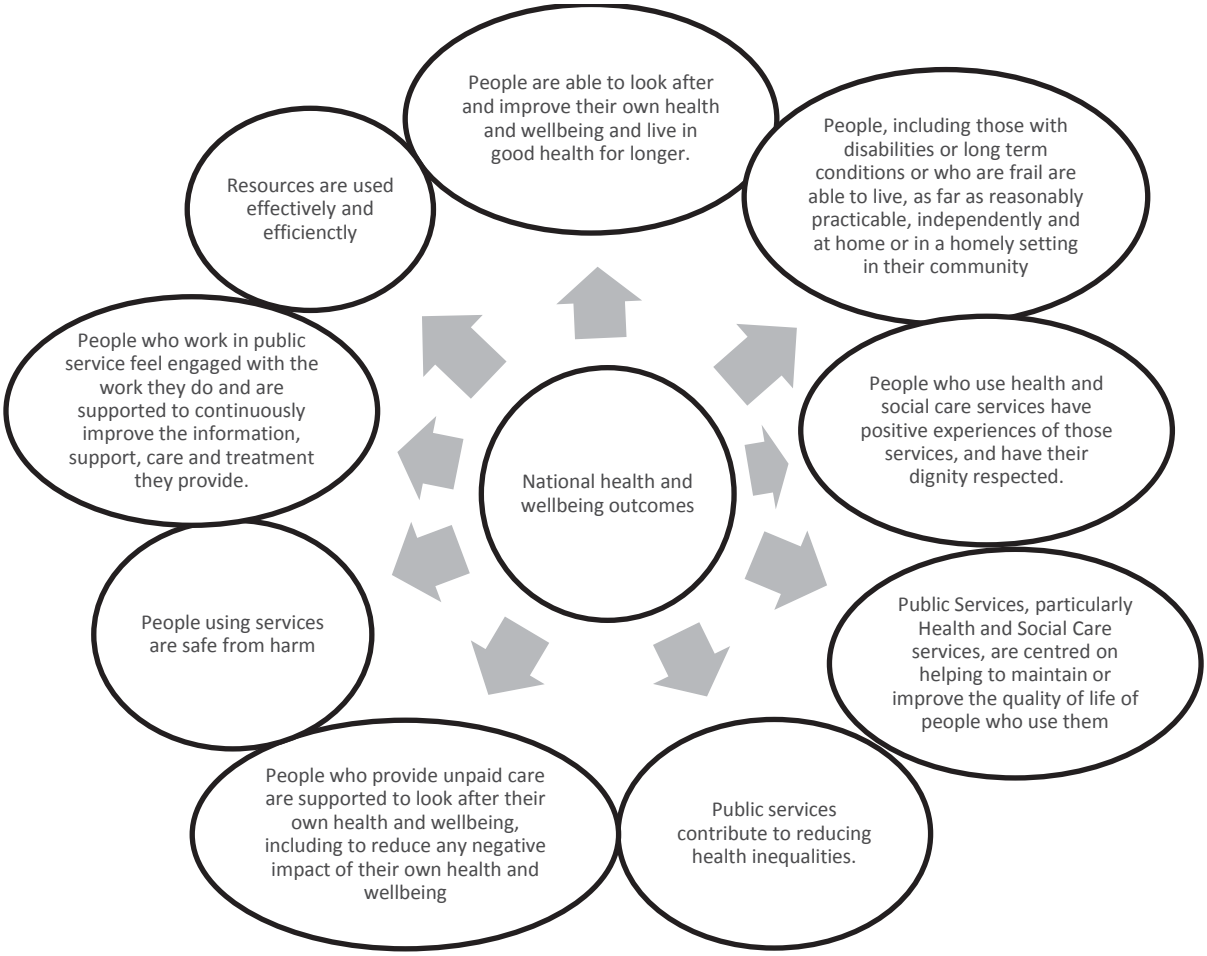
Shetland Islands Health and Social Care Partnership
Direction for Primary Care Services

Service Model
Outcomes Framework
Resources
Improvement Plans

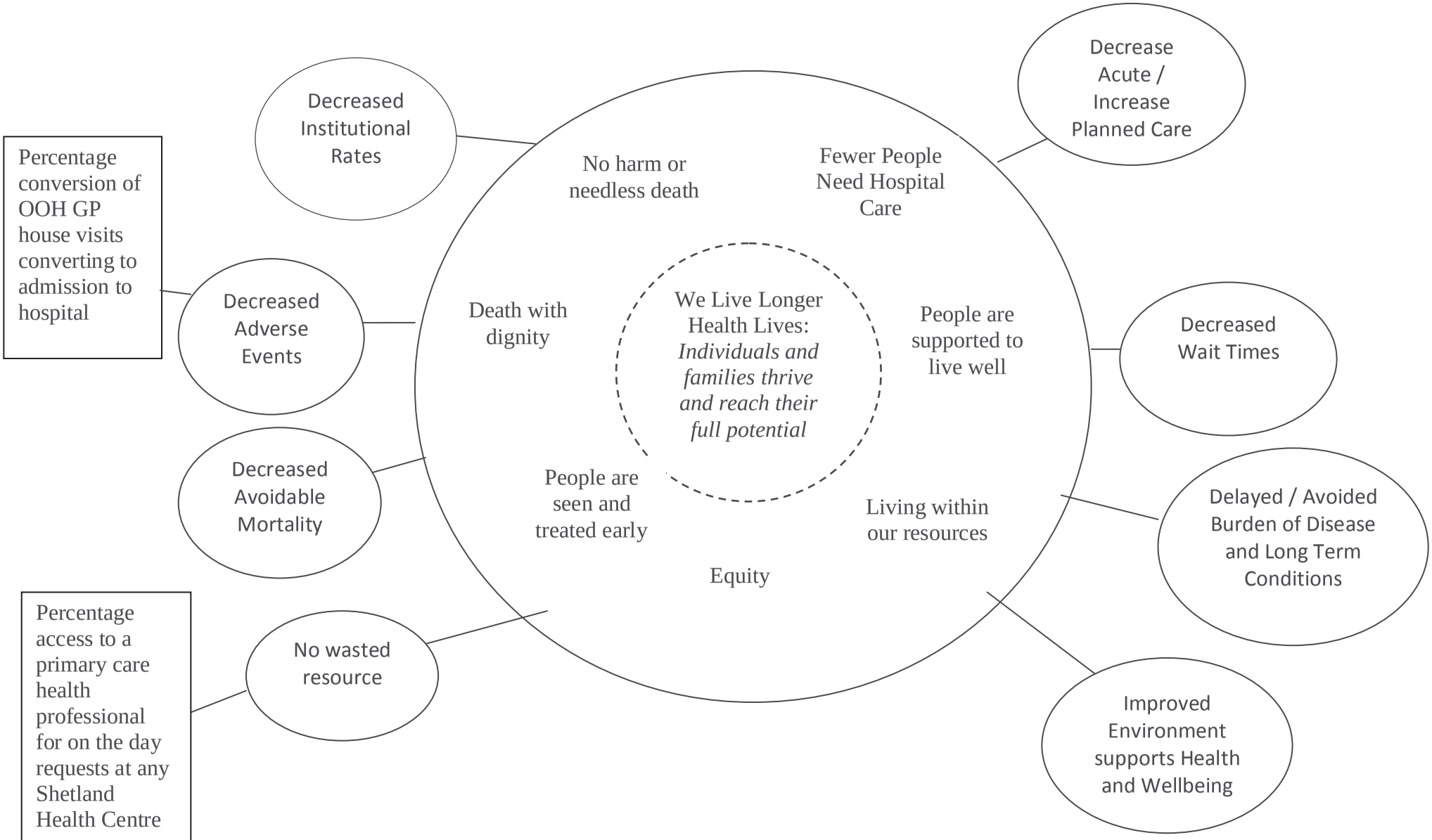
Service Model

Primary Care Services are universal services available to all residents in Shetland. The Service Model is described in the diagram below.





In order to capture the whole population / whole system approach, the outcomes are based on the Canterbury, New Zealand Health System Outcomes Framework. (http://ccn.health.nz/Resources/OutcomesFramework.aspx)


Decrease Acute / Increase Planned Care
Decreased Institutional Rates
Percentage conversion of OOH GP house visits converting to admission to hospital
No harm or needless death
Fewer People Need Hospital Care
Decreased Adverse Events
Death with dignity
We Live Longer Health Lives: *Individuals and families thrive and reach their full potential*
People are supported to live well
Decreased Wait Times
Decreased Avoidable Mortality
People are seen and treated early
Living within our resources
Delayed / Avoided Burden of Disease and Long Term Conditions
Equity
Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre
No wasted resource
Improved Environment supports Health and Wellbeing

Resources

NHS Shetland services are estimated to cost £4,430,563 In 2019-20.

The savings / efficiency target has been set at £100,000 in 2019-20.

The Primary Care Project is a two year plan, commencing in April 2019.

Improvement Plans

Primary Care Improvement Plan Action Plan

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

		Pharmacists to be employed	

Key Priority Area	Year 1	Year 2	Year 3
Community treatment and care services	Implement Skill Mix Practice Nursing team at all 8 of the Board provided Health Centres by August 2018. Implement Phlebotomy service at each Health Centre/ Practice area by August 2018 Conduct workload analysis across the service by October 2018 Develop general practice nursing workforce in alignment with future service model by March 2019 Host training for nursing workforce as per outcome of NES funding bid by June 2018 Review leadership /management of general practice nursing by 31 March 2019	Bid for further NES funding to support development of general practice nursing workforce by August 2018 Implement leadership structure for general practice nursing from 1 April 2019 Consider further refinement of service provision across Shetland to ensure capacity meets demand with appropriately skilled practitioners available to deliver to service model by 31 March 2020	Skill mix General Practice Nursing team in place providing a safe and sustainable service delivery model, appropriate to local service design.
Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care	Recruit Practice Educator for Advanced Nursing Practice by July 2018 Participate in the development of the regional Advanced Practice Academy (as per regional timescale) Review current unscheduled care weekend clinics to determine future	Continue to support ANP (development) posts – ongoing Bid for further NES funding to support development of Advanced Practice workforce	In collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design.

Key Priority Area	Year 1	Year 2	Year 3
Multi-disciplinary team: Mental Health Workers	Redesign of services currently underway to implement an integrated service	Development of Mental Health Plan	Implementation of agreed actions from Mental Health Plan
Multi disciplinary team: Occupational Therapy	Exploration of vocational rehabilitation within General Practice	Implementation of vocational rehabilitation	Multi disciplinary team: Occupational Therapy
Multi disciplinary team:	Scoping exercise for roll out of Physiotherapy provision to General Practice	Implementation of additional Physiotherapy support to General Practice	Multi disciplinary team:
Community Link Workers	Continue existing Health Improvement input to GP Practices	Audit of workload, demand and potential requirements for expansion of service	

Direction from the Integration Joint Board

Community Nursing Services including the Intermediate Care Team

		Direction Approved December 2017	Proposed Direction February 2019
1.	**Reference Number**	CC-61-17	CC-22-19 1.5
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	NHS Shetland	NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	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, which 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.	The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting. These services include: **District Nursing** - community based 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. **Practice Nursing** – at all 8 Board provided general practices; **Advanced Nurse Practitioners** – Advanced Nurse Practitioner posts based in Primary Care;

		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 NHS Board provided general practices, namely Lerwick, Unst, Yell, Brae 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. 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. Whilst the Community Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16years and are housebound, the services will endeavour to meet the needs of any individual across the lifespan from birth to death,	**Specialist Nurse - Continence Nurse Advisor** – Shetland wide service to support patients, care and nursing staff; **Non-Doctor Island Nursing** – nurses resident on the small outer islands of Fair Isle, Foula, Fetlar, and Skerries; and **Intermediate Care Team** – multi-disciplinary, partnership team focussed on provision of re-ablement programmes, additional support to increase independence on discharge home from hospital and provision of additional support at home to prevent unnecessary admission to hospital or care home. Whilst the District Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16years and are housebound, all of the Community Nursing 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. Community Nursing staff also provide support and teaching to informal or family carers to enable them to care effectively for their relative, whilst also addressing any care and support needs the individual carer might have themselves.

		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. The purpose of Intermediate Care is to provide time-limited interventions at points in a person's life where this will restore or avoid a loss of independence and confidence, or reduce the risk of hospital admission (or a longer stay in hospital).	All of the component services within the Community Nursing service work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.
7.	**Full text of Direction**	Implement sustainable extended Care Team with integral overnight nursing/care services Source EmisWeb 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 service Continue to progress review of local District nursing service in line with national "Transforming Nurses roles" project	Explore / Test potential electronic solutions to record keeping for Community Nursing whilst awaiting new GP IT systems with longer term aim of being able to interface to GP, social and secondary care records Further embed model of case management within Community Nursing Services, including addressing frailty Continue to support implementation of eKIS Anticipatory Care Planning across the services Continue to progress review of local District nursing service in line with national Transforming Nurses roles" project, reviewing DN role against national Band 6 DN role

		Review of skill set across Nursing and Care Staff Develop Advanced Nurse Practice Structure/Capacity and Capability Develop Governance and professional leadership structure for all Practice Nurses Shetland Wide Review Model of service provision in remote areas	position paper and skill mix of the team Progress development of a 24hour nursing and care at home service, as a test of change, thus facilitating early supported discharge from hospital as well as avoiding unnecessary admissions Review model of service provision in remote areas, with respective communities, to ensure sustainable, safe, effective, person-centred services are in place Work with partner agencies, SAS (under Strategic Options Framework) and SFRS, regarding establishing First Responder services on Non-Doctor Islands Implement 'Attend Anywhere' capability on all Non-Doctor Islands to both support clinical consultations and enhance access to peer/ professional support for staff Progress development of General Practice Nursing in line with the national Transforming Nursing Roles Band 6 GPN position paper. Establishment of Skill mix teams. Continue to develop governance and professional leadership structure for all Practice Nurses Shetland wide

			enhancing quality and safety of services Lead Nursing contribution to areas of service redesign within GP Contract, via Primary Care Improvement Plan (further detail in the PCIP) Vaccine Transformation Programme - ensure comprehensive approach to immunisation delivery to all people across Shetland; -Establish formal “VTP” team, for immunisation delivery across Shetland; -Discuss delivery, by VTP team, of Vaccine services for Independent Practices to be added to delivery model – by 2021 Community Treatment & Care Services - Skill mix Practice Nursing team to support delivery of Community Treatment Room services; - Scope feasibility of centralised service to provide “open access” to care and treatment in Lerwick (support access to healthcare for working age population). Urgent Care (Advanced Practitioners) Continue to increase number of ANPs locally. 1 Qualified, 5 in development (LK), 1

			development (Sc / Brae). Recruitment to additional posts as funded through Primary Care Improvement Plan. Set strategic direction for nursing in community settings by developing Nursing in Community Strategy Implement Excellence in Care Community measures as a consistent and robust system for measuring, assuring and reporting on the quality of nursing practice in place in the Community. The system will inform quality of care reviews at national and local level and drive continuous improvements in the quality of nursing care. Continue to progress opportunities for development within and by the Intermediate care team eg increased rate of falls assessment and advice provided by linking in with Bone Density Scanning service;
8.	**Budget allocated by IJB to carry out Direction.**	Community Nursing Total Budget £2,330,000	Community Nursing £2,721,212 Intermediate Care Team £452,182 Total £3,173,394
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way

		society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes	through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes Increase in number of individuals who spend last 6 months of life at home/ in a community setting Increase in number of individuals with an Anticipatory Care plan in place A review of the District Nursing outcome measures will be undertaken in 2019/2020 Excellence in care measures (awaiting final confirmation) but known categories are: -Numbers of individuals with preferred place of care documented in their record -Number of individuals supported to die in preferred place of care -Number of individuals with a caseload acquired pressure ulcer -Number of individuals developing a catheter acquired urinary tract infection Outcome measures for General Practice Nursing will be developed in 2019/2020 Number of individuals who have seen an ANP as first point of access to healthcare Intermediate care outcome measures

			Number of early supported discharges with no re-admission in 30 days Number of individuals supported at home to prevent inappropriate hospital admission
10.	**Performance monitoring arrangements**	Quarterly Reporting	Quarterly reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership

Direction for Community Nursing Services including the Intermediate Care Team

Service Model
Outcomes Framework
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Service Model

The Community Nursing Service comprises a range of services which provides a frontline clinical service to individuals with a nursing and / or healthcare need within a community setting.

The District Nursing service is the largest part of Community Nursing services, which 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.

District Nursing services are practice based at each of the Health Centres throughout Shetland with the exception of Bixter/Walls and Hillswick/Brae where the District Nursing team is based at Bixter and Brae respectively.

The District Nursing service model for **Mainland Shetland** comprises:

0830hrs-1700hrs – normal day service provided by Community Nursing staff based at each Health Centre.

1700hrs-2130hrs – there is a Community Nurse available on shift.

2115hrs-0815hrs – an oncall service is provided to respond to urgent or emergency nursing issues overnight.

For the **remote outer islands** (Yell, Unst and Whalsay) and the **non-doctor islands** (Fair Isle, Foula, Fetlar, Bressay and Skerries) - District Nurses are available between 0830hrs-1700hrs daily and then provide an on call service overnight for individuals who need emergency assistance in the out of hours period.

On the Non-Doctor Islands, the District Nurse presence is the only resident healthcare provider on the island and therefore the postholder has a role and remit wider than that held by the District Nurses on mainland Shetland.

NHS24 is used to triage all calls to the District Nursing Service on Mainland Shetland.

District nurses also promote healthy lifestyle choices; promoting independence and supporting selfcare, wherever possible. Physical, psychological and social support and encouragement is provided for people with disabilities and long-term conditions to enable them to live as an independent life as possible.

District Nurses also support patients with terminal illness to die in their preferred place of care, which may be at home.

The Queen's Nursing Institute of Scotland (QNIS) identifies the role of the District Nurse as

- Expert in the Care of the Older Adult;
- Caring for individuals with an Increasing number of co-morbidities;
- Caring for individuals with an Increasing number of Longterm conditions;
- Caring for individuals with Polypharmacy;
- Supporting complex social care needs with an emphasis on the importance of case management and utilising the specialised clinical skills possessed by District Nurses; and
- Proactively managing care by promoting health, anticipating health needs, enabling and supporting self care, and providing support and supervision to the well older adult.

Continence Service

The Continence Nurse Advisor provides a range of services to adults and children with continence problems on a Shetland wide basis. The postholder is supported by a multi-professional team which addresses continence related issues locally, offering assessment, advice, liaison, support, health promotion and awareness raising within primary and secondary care settings. The service provides: holistic general health assessment, bladder residual scan, pelvic floor exercises, bladder retraining, intermittent self catheterization, product advice and fitting, and catheter management advice.

The Continence Service is provided by a 15 hour a week, 0.4 Whole Time Equivalent (2 days per week) Band 6 Nurse.

At April 2019, there were 39 registered patients on the Continence database. On average, the caseload at any one time varies between 40 and 50 people.

Positive changes in clinical practice eg reduced catheterisation has resulted in an increase in the caseload of the Continence Nurse. Self referrals have also increased due to enhanced publicity meaning that the public are well informed as to who to go to for advice and support and there is now less stigma / embarrassment attached to the condition.

Education and Training is provided for individual patients, carers and health and social care professionals.

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 NHS Board provided general practices;
- Advanced Nurse Practitioners – the Advanced Nurse Practitioner posts based within Primary Care;
- Specialist Nurses, eg Continence Nurse Advisor;
- Non-Doctor Island Nursing – there are resident nurses on the non-doctor islands of Fair Isle, Foula, Fetlar, and Skerries. 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 16years 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.

Community Nursing staff also provide support and teaching to informal and /or family carers to enable them to care effectively for their relative, whilst also addressing any care and support needs the individual carer might have themselves.

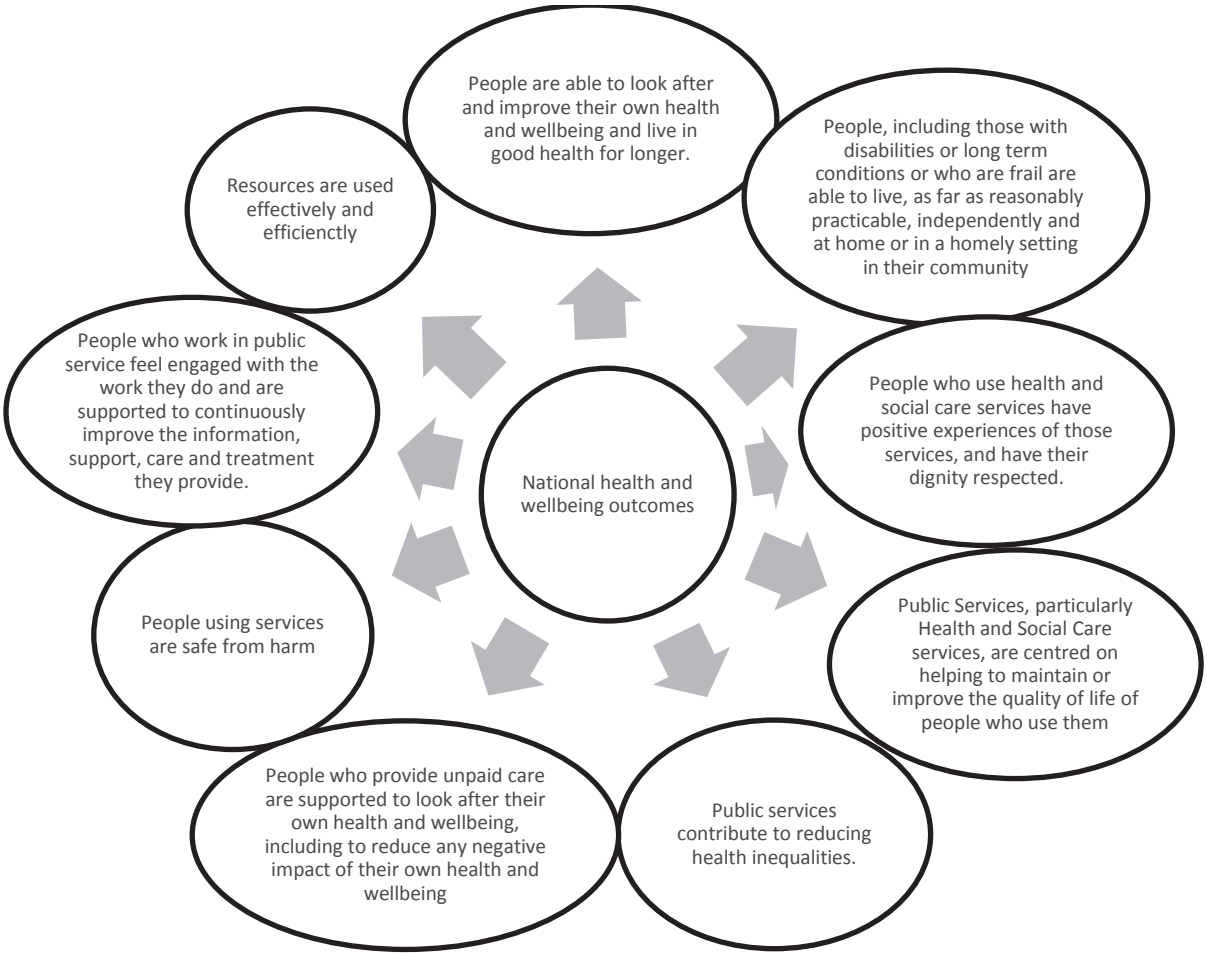
All of the component services within Community Nursing services work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.

The Chief Nursing Officer (CNO) Transforming Nursing Roles workstream aims to ensure that the nursing workforce has the capacity and skills necessary to meet the requirements of the GP contract and to support the development of integrated teams as outlined in the Public

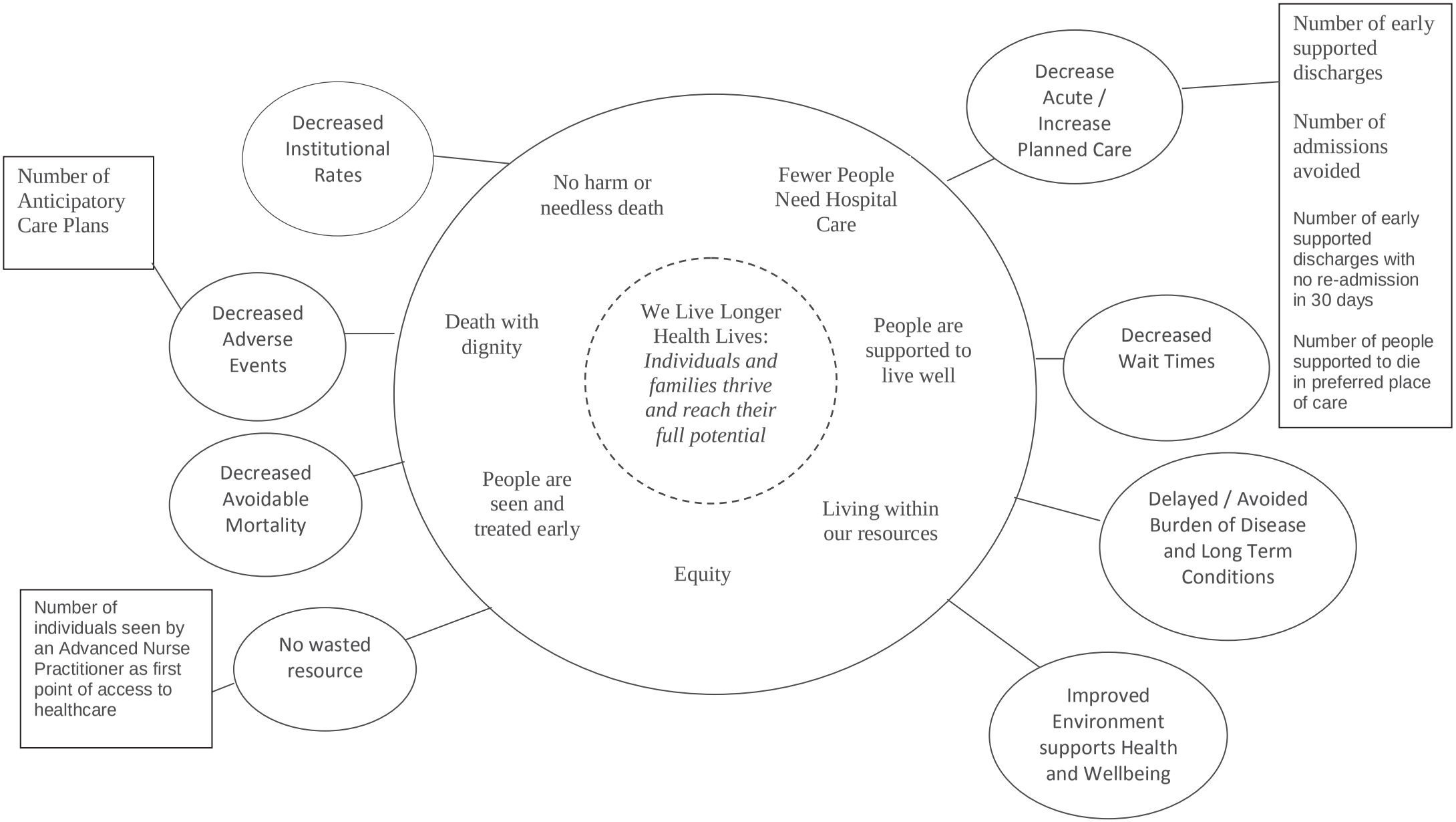
Bodies (Joint Working) (Scotland) Act 2014 in order to deliver on the Health and Wellbeing Outcomes for the local population in the future.

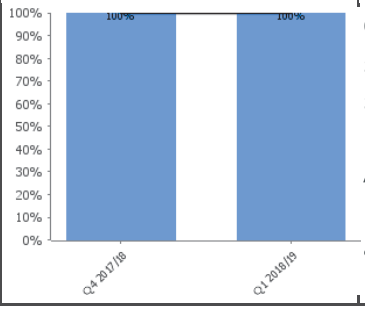
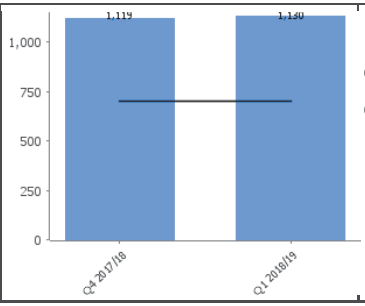
Outcomes Framework

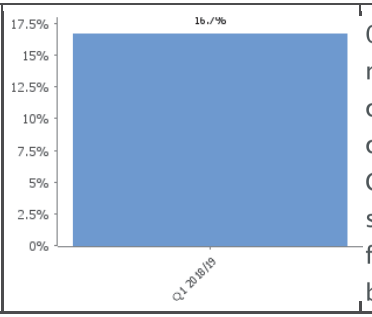
The IJB Commissions Community Nursing in line with the general Health and Wellbeing Outcomes.



In order to capture the whole population / whole system approach, the outcomes are based on the Canterbury, New Zealand Health System Outcomes Framework. (http://ccn.health.nz/Resources/OutcomesFramework.aspx)


Number of Anticipatory Care Plans
Decreased Institutional Rates
Decrease Acute / Increase Planned Care
Number of early supported discharges
Number of admissions avoided
Number of early supported discharges with no re-admission in 30 days
Number of people supported to die in preferred place of care
Decreased Adverse Events
Decreased Avoidable Mortality
Decreased Wait Times
Delayed / Avoided Burden of Disease and Long Term Conditions
Number of individuals seen by an Advanced Nurse Practitioner as first point of access to healthcare
No wasted resource
Improved Environment supports Health and Wellbeing
No harm or needless death
Fewer People Need Hospital Care
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
People are seen and treated early
Living within our resources
Equity

Indicator	Years				Quarters			Current Target	RAG Status	Graphs	Note
	2016/17		2017/18		Q4 2017/18	Q1 2018/19	Q2 2018/19	Q2 2018/19	Q2 2018/19		
	Value	Target	Value	Target	Value	Value	Value	Target	Status		
CN002 Percentage of early supported discharges with no readmission in 30 days by Intermediate Care Team	90%	100%	100%	100%	100%	100%					03-Sep-2018 15 patients supported by ICT - 10 Early supported Discharge from Hospital, 3 Prevention of Admission, 1 Early Supported Discharge from Care Home and 1 Falls Assessment only. 1 Death and 0 re-admissions.
CN001 Number of Anticipatory Care Plans in Place	1,061	700	1,119	700	1,119	1,130					25-Jul-2018 Continued month on month increase in number of Anticipatory Care Plans in place

CN003 Percentage of Catheter Associated Infections in individuals with an indwelling urinary catheter	0%	0%				16.7%					04-Sep-2018 2 infections reported within 10 days of catheter insertion. No common issues identified. Continence Nurse Advisor has staff update sessions arranged for September. Repeat audit to be done in next quarter.

Improvement Plans

All Improvement plan activity is outlined in the Primary Care Implementation Plan (see Primary Care Direction) and in the text of this Direction.

Direction from the Integration Joint Board

Adult Services (Learning Disability and Autism)

		Direction Approved July 2017	Proposed Direction 2019
1.	**Reference Number**	CC-61-17	CC-22-19 1.6
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council & NHS Shetland	Shetland Islands Council & NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	The care and support of adults with learning disabilities and Autism Spectrum Disorder • Supported Living Service • Supported Vocational Activity Service • Supported Employment • Short Break and Respite Services • Day care for older people with learning disabilities and Autism Spectrum Disorder • Learning Disability Nurse (Learning Disability and Autism)/Visiting Specialist Consultancy services (Adult LD Psychology and Adult LD Psychiatry) • Support for Carers of adults with learning disabilities and Autism Spectrum Disorder.	The care and support of adults with learning disabilities and autism spectrum disorder • Supported Living and Outreach Service • Supported Vocational Activity Service • Supported Employment and Training • Short Break and Respite Services • Day care for older people with learning disabilities and autism spectrum disorder • Community Learning Disability Nurse (Learning Disability and Autism)/ Specialist Consultancy services (Adult LD Psychology and Adult LD Psychiatry) ** NB Community Learning Disability Nurse role provides clinical advice and direction to children and adults with specialist or complex health needs relating to learning disability and/or autism*. • Support for unpaid carers of adults with learning disabilities and autism spectrum disorder.

7.	**Full text of Direction**	Progression of replacement Supported Vocational Activities Build • Delivery of findings from the Adult Services Audit • Delivery of Shetland Autism Spectrum Disorder Strategy • Remodelling of commissioned clinical services for adults with learning disabilities • Monitor progress of review of LD and Autism within the Mental Health (Care and Treatment)(Scotland) Act 2003 • Identification of unmet need/drivers for change	
8.	**Budget allocated by IJB to carry out Direction.**	NHSS £66,000 SIC £4,944,000 **Total Budget £5,010,000**	NHSS £57,406 SIC £5,464,576 **Total Budget £5,521,982**
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes • Progression of the Replacement Vocational Activities Build (EGRC) • Delivery of findings from the Adult Services Audit. • Delivery of Shetland Autism Spectrum Disorder Strategy • Remodelling of commissioned clinical services for adults with learning disabilities.	
10.	**Performance monitoring arrangements**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Adult Services (Learning Disability and Autism)

Service Model
Outcomes Framework
Resources
Improvement Plans

Service Model

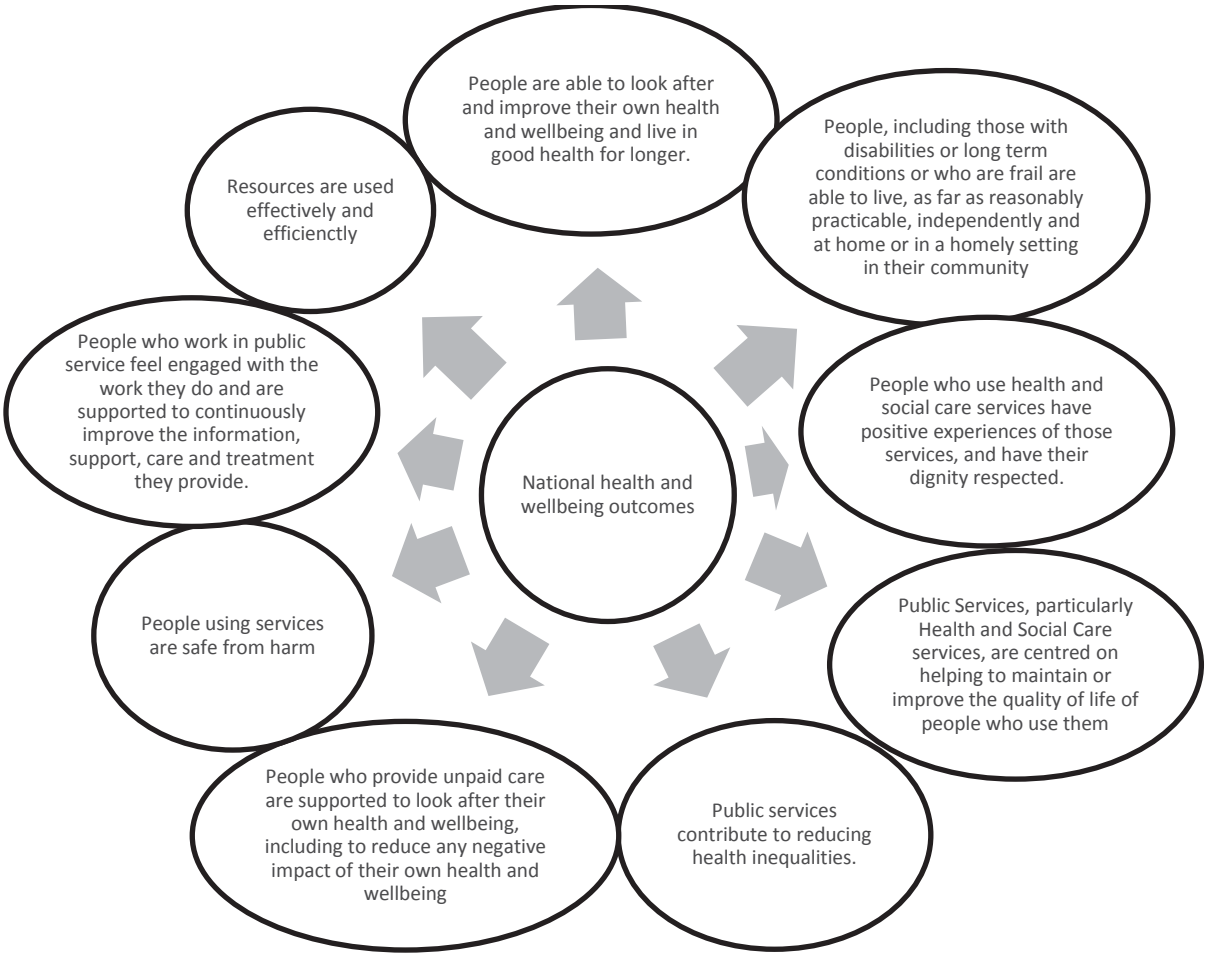
The service model and indicative activity levels (where available) for services to adults with learning disability and/or autism spectrum disorder are shown below. This is the service model that the IJB is commissioning directly from NHS Shetland and Shetland Islands Council and through them from other NHS Boards and the voluntary sector.

Adult Services (LD & ASD) Current Activity	**Numbers Service Users**
Number of People known to the local authority	152
Number of People in Service	136
Number of Carers of adults with learning disabilities and Autism Spectrum Disorder	82
Number of People Accessing the Supported Living and Outreach Service	42
Number of People Accessing the Supported Vocational Activity Service	62
Number of People Accessing Supported Employment and Training Opportunity	20 (COPE)
Number of People Enrolled in Project SEARCH (academic year 2018/19)	4
Number of People Accessing Short Break and Respite Services (in-house at Newcraigielea)	30
Number of People Accessing LD Day Care	2
Number of People Accessing GOLD Group (Growing Older with Learning Disability) Day Care for older people with learning disabilities and autism spectrum disorder	8
Number of Adults registered with the Learning Disability Nurse (Learning Disability and Autism	29 (14 critical; 5 substantial; 10 moderate to low) Plus 5 adult referrals undergoing/awaiting allocation.
Number of People registered with the Learning Disability Visiting Specialist Consultancy services (Adult LD Psychology and Adult LD Psychiatry)	Under review, however a number of on island adults are receiving specialist LD input.
Commissioned (contracted) services:	• COPE • Disability Shetland

	- Adult Sports Group - Autism Drop-In Group • Advocacy Shetland
Self-Directed Support (SDS) Options: • Option 1 • Option 2 • Option 3 • Option 4	

Outcomes Framework

The IJB Commissions Adult Services (Learning Disability and Autism) in line with the general Health and Wellbeing Outcomes.



Legislative and strategic drivers that shape best practice in Adult Services (Learning Disability and Autism) include;

Self-Directed Support. Social Care (Self-directed Support) (Scotland) Act 2013 was implemented on 1st April 2014. The strategy and legislation were designed to encourage significant changes to how services are provided. It requires public bodies to give people eligible for support more say in decisions about local services and more involvement in designing and delivering them.
Four fundamental principles of Self-directed Support are built into the legislation: participation and dignity, involvement, informed choice and collaboration. Social care should be provided in a way that gives people choice and control over their own lives and which respects and promotes human rights.
There are four Self-Directed Support options under the legislation:

- Option 1: The individual or carer chooses and arranges the support and manages the budget as a direct payment.
- Option 2: The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
- Option 3: The authority chooses and arranges the support.
- Option 4: A mixture of options 1, 2 and 3.

A Fairer Scotland for Disabled People is Scottish Government's delivery plan to 2021 for the United Nations Convention on the Rights of Persons with Disabilities. The Plan is built around five key ambitions:

1 Support services that promote independent living, meet needs and work together to enable a life of choices, opportunities and participation. Health and social care support services are designed to meet - and do meet - the individual needs and outcomes of disabled people.
2 Decent incomes and fairer working lives. Making sure disabled people can enjoy full participation with an adequate income to participate in learning, in education, voluntary work or paid employment and retirement.
3 Places that are accessible to everyone. Housing and transport and the wider environment are fully accessible to enable disabled people to participate as full and equal citizens.
4 Protected rights. The rights of disabled people are fully protected and they receive fair treatment from justice systems at all times.
5 Active participation. Disabled people can participate as active citizens in all aspects of daily and public life in Scotland.
https://www.gov.scot/publications/fairer-scotland-disabled-people-delivery-plan-2021-united-nations-convention/pages/1/

'*The Keys to Life*' Scotland's Learning Disability Strategy
https://keystolife.info/
Scottish Strategy for Autism
https://www.gov.scot/publications/scottish-strategy-autism-outcomes-priorities-2018-2021/
Both plans set out the strategic vision, values and goals for people with learning disability and autistic people. They contribute to all of the National Health and Wellbeing Outcomes and resonate strongly with the ambitions set out in *A Fairer Scotland for Disabled People*.

Keys to Life. 4 Strategic Outcomes:

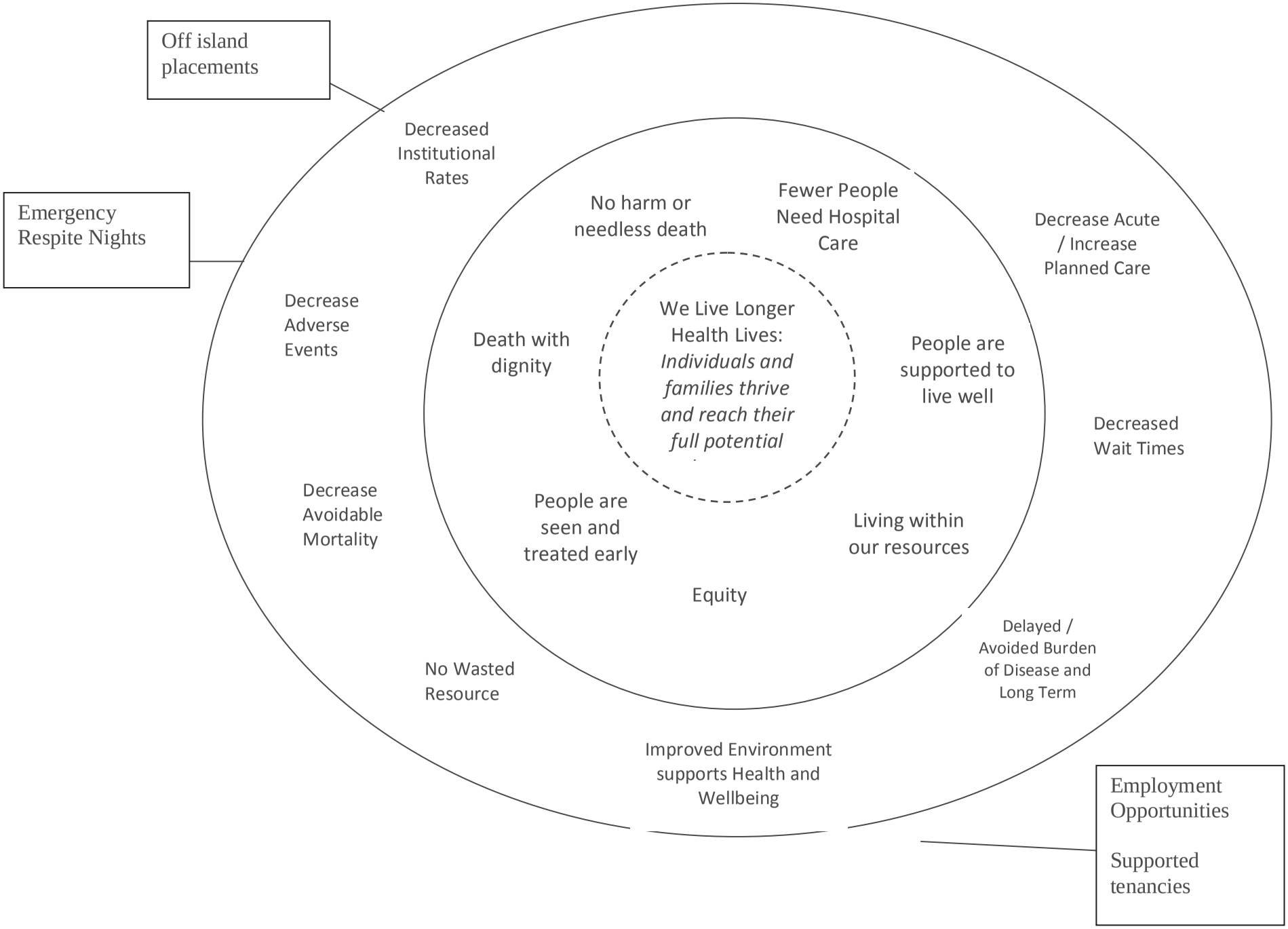
1. A Healthy Life - People with learning disabilities enjoy the highest attainable standard of living, health and family life.

2. Choice and Control - People with learning disabilities are treated with dignity and respect, and are protected from neglect, exploitation and abuse.
3. Independence - People with learning disabilities are able to live independently in the community with equal access to all aspects of society.
4. Active Citizenship - People with learning disabilities are able to participate in all aspects of community and society.

Scottish Strategy for Autism 4 Strategic Outcomes:

1. A Healthy Life - Autistic people enjoy the highest attainable standard of living, health and family life and have timely access to diagnostic assessment and integrated support services.
2. Choice and Control - Autistic people are treated with dignity and respect and services are able to identify their needs and are responsive to meet those needs.
3. Independence - Autistic people are able to live independently in the community with equal access to all aspects of society. Services have the capacity and awareness to ensure that people are met with recognition and understanding.
4. Active Citizenship - Autistic people are able to participate in all aspects of community and society by successfully transitioning from school into meaningful educational or employment opportunities.

The Carers (Scotland) Act 2016. Passed in the Scottish Parliament on February 4 2016, this came in to effect on 1 April 2018. The Act aims to ensure better and more consistent support for carers and young carers so that they can continue to care, if they so wish, in better health and to have a life alongside caring. https://careinfoscotland.scot/topics/your-rights/legislation-protecting-people-in-care/carers-scotland-act-2016/


Off island placements
Emergency Respite Nights
Employment Opportunities
Supported tenancies
Decreased Institutional Rates
No harm or needless death
Fewer People Need Hospital Care
Decrease Acute / Increase Planned Care
Decrease Adverse Events
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
Decreased Wait Times
Decrease Avoidable Mortality
People are seen and treated early
Living within our resources
Equity
Delayed / Avoided Burden of Disease and Long Term
No Wasted Resource
Improved Environment supports Health and Wellbeing

Category	Indicator	Target	Current Performance	Improvement Actions /Notes
AS002	Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills	30	32	People are able to look after and improve their own health and well-being and live in good health for longer Public services are centred on helping to maintain or improve quality of life of people who use them Public services contribute to reducing health inequalities People are safe from harm
AS003	Number of incidents of emergency respite provided for adults with Learning Disability/Autistic Spectrum Disorder	0	2018/19 Q1:1 Q2: 0 Q3: 0 Q4: 0	Continue to work with unpaid carers and people who use the service (cared for people and officers) to have and emergency plan in place to help prevent and emergency becoming a crisis requiring unplanned emergency respite
SP-EA-004	Number of LD/ASD short breaks provided (Hrs)			

Resources

Adult Services (LD & ASD) Budget 2019-20 (£)	Original £
NHS	57,406
SIC	5,464,576
Total	5,521,982

Improvement Plans

In 2019-20, Adult Services (LD & ASD) has ongoing review of funded service for adults with learning disability, autism and complex needs, and includes support and services to unpaid carers.

The purpose of this work is:

- to ensure fair and equitable access to resource and service where eligible need has been assessed;
- to ensure sustainable resource and service delivery in an area of demographic rise;
- to consider support for adults with complex assessed need;
- support people to maintain and improve their own health and wellbeing and quality of life;
- to meet base value objectives.

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

Progress position:
Adult Services (LD & ASD) will strive to achieve improved local outcomes for adults with learning disability, autistic people and unpaid carers through its activity in line with the national priorities for people with learning disability and autistic people:
A Healthy Life, Choice and Control, Independence, Active Citizenship
and Shetland's Partnership Plan 2018 - 28. Working well together to improve the lives of everyone in Shetland. *"Shetland is a place where everyone is able to thrive; living well in strong, resilient communities; and where people and communities are able to help plan and deliver solutions to future challenges".*

Outcomes for adults with learning disability, autism and complex needs and unpaid carers will be met through a range of ongoing service delivery, reviewed service activity and development of new sustainable models where required.

Short Break and Respite. An area of service where work has started (January 2019) is short breaks and respite. Families, users of the service and staff have engaged with a facilitator over pre-arranged sessions. 6 key outcomes have been identified from which an action plan has been created. A Project Board has been established with a range of members round the table including officers at operational and strategic level, family carers, co-opted members and the facilitator. The Board meets regularly to maintain pace and facilitator is delivering in service training to support and embed change.

Supported Vocational Activity sessions moved to the replacement build, Eric Gray@Seafield, in mid-January 2019. Sessions there continue to be reviewed and developed to meet personal and group outcomes of those who use the service. The new build provides many benefits including a range of light, modern flexible and dedicated spaces; fully accessible and 'changing place' toilets; wide corridors; safe external garden and work spaces; good staff and office accommodation.

Employment. Everyone should have the right to work if they want to. Fair work is good for the economy and for individual health and wellbeing – in addition to providing a source of income, it can also foster social interaction, contribute to a sense of happiness and self-esteem, and support our independence. Those who are denied equal access to employment, including many disabled people, are all too familiar with the negative consequences; risk of feeling isolated; poverty; being denied the right to fulfil their potential. At a societal level, we also lose out, failing to realise the benefits of a talent pool and diversity of experience. Scottish Government's priority is to significantly reduce the disability employment gap. Recognising the need to provide appropriate support and

training for people with learning disabilities and autistic people who want to work, Adult Services (LD & ASD) are working in conjunction with SIC Human Resources, SIC Education, Shetland College and NHS S and in September 2018 commenced a 3 year pilot project using the Project SEARCH model. This is an intensive, one year employer led transition programme in order for young adults with disability to acquire necessary skills leading to competitive employment. Scottish Government recognise the success already achieved by Project SEARCH as a model enabling young people with learning disabilities and autism to secure sustainable employment.
https://www.gov.scot/publications/fairer-scotland-disabled-people-delivery-plan-2021-united-nations-convention/

Supported Living and Outreach continues to review the model of care at home and housing support it offers to meet the needs and outcomes of learning disabled and autistic people living in supported accommodation and community housing. Ongoing review of overnight support will continue to ensure that people's needs are appropriately and safely met. Overnight support is provided in a variety of ways including sleep-in staff, waken night staff, night responders and use of technology.

The Community Learning Disabilities and Autism Nurse (CLDAN) provides high quality specialist nursing care to adults and children with a learning disability and autism, to enhance health quality of life in the community and to provide care and support to their families and carers. As a single handed post, appropriate management of demand on the CLDAN is crucial. We will continue to explore opportunity to embed a step up - step down approach, ensuring that health needs are met by the most appropriate service.
NHS Shetland and NHS Orkney have successfully secured external funding from Scottish Government of £51,758.00 (50/50 split) for a 2 year (2019 - 21) Health Inequalities & Screening Project (LD & ASD) project. The aim of the project is to improve uptake and improving the experience of bowel, cervical screening and HPV immunisation by people with learning disability and/or autism within Shetland and Orkney. Incorporating and building on the success of the NHS S Health Inequalities and Learning Disability (LD) Fund Communication Project 2014/15, the project aims to reduce barriers to attendance and improve knowledge and understanding of the benefits of screening and immunisation programmes and of the screening and results process. Work is now underway to recruit a Health Inequalities & Screening Project Coordinator (Learning Disabilities & Autism) to take forward the work. The fixed term post will sit within the Adult Services (LD & ASD) team.

Young people in transition into adulthood cuts across a number of national policies and local arrangements for example GIRFEC, Additional Support for Learning and Autism, With You For You, eligibility criteria, etc. Adult Services will continue to work with partner colleagues (SIC Children Services (Education and Resources), NHS S Child and Family Health, Community Care Social Work) to enable continual improvement of support and achievement of positive outcomes for young people with additional needs who are making the transition to young adult life.

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25th April 2019

Appendix 1.7

Direction from the Integration Joint Board

Adult Social Work

		Direction Approved July 2017	Proposed Direction May 2019
1.	**Reference Number**		CC-22-19 1.7
2.	**Date Direction issued by IJB**	13 July 2017	14 May 2019
3.	**Date from which Direction takes effect**	1 August 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	No
6.	**Functions covered by the Direction**	Screening of Referral to establish whether or not a social work response is required Assessment of social need and care management Mental Health assessment, support and intervention Adult Support and Protection	• Screening of Referral to establish whether or not a social work response is required • Assessment of social need and care management • Mental Health assessment, support and intervention • Adult Support and Protection • Out of Hours Social Work Service
7.	**Full text of Direction**	People are able to look after and improve their own health and wellbeing and live in good health for longer People are able to live, as far as is reasonably	• People are seen by the right person, at the right time and in the right place • People are able to look after and improve their own health and wellbeing

		practicable, independently at home or in a homely setting People who use services have a positive experience of those services and have their dignity respected Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users Contribute to reducing health inequalities Unpaid carers are supported to reduce any negative impact of their caring role Service Users are safe from harm Staff are supported to continuously improve the information, support and care they provide Resources are used effectively and efficiently in the provision of services	and live in good health for longer • People are able to live, as far as is reasonably practicable, independently at home or in a homely setting • People who use services are supported to be in control of the decisions affecting how they live, have flexible and responsive services and choice • People who use services have a positive experience of those services and have their dignity respected • Health and Social Care Services are centred on helping to maintain or improve the quality of life of supported people • Contribute to reducing health inequalities • Unpaid carers are supported to reduce any negative impact of their caring role • Supported people are safe from harm • Staff are supported to continuously improve the information, guidance, support and care they provide • Resources are used effectively and efficiently in the provision of services
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £2,385,625 SIC	Total Budget £2,992,639 SIC

9.	**Outcomes**	To enable older people to remain at home To maintain or increase levels of independence To reduce unplanned, emergency and inappropriate admission to hospital To facilitate discharge from hospital appropriately To protect adults from abuse Linked to Our Plan 2016-2020 Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes	• To enable older people and those with disabilities or long term conditions to remain at home or in a homely setting in their community • To maintain or increase levels of independence and inclusion • To reduce unplanned, emergency and inappropriate admission to hospital • To facilitate discharge from hospital appropriately • To protect adults from abuse • Linked to Our Plan 2016-2020 Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes
10.	**Performance monitoring arrangements**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Adult Social Work

Service Model
Governance
Outcomes Framework
Resources
Improvement Plans

Service Model

The service model and indicative activity levels (where available) for services to adults are shown below. This is the service model that the IJB is commissioning directly from Shetland Islands Council and through them from the voluntary sector.

The Adult Social Work Team provides a generic social work service to any adult who requests or requires an assessment for care. Our supported people include adults with dementia, mental health difficulties, brain injuries, lifelong conditions, autism, learning disabilities, physical disabilities, older and frail people, unpaid carers and those at risk of abuse. In addition, Adult Social Work supports young people with additional support needs in transition, alongside colleagues in Integrated Children's Services, NHS Shetland, Adult Services and the third sector.

Those who have a social worker as a care manger have complex and changing needs. As well as themselves, their family and community support, they usually have several services or agencies supporting them.

The number of people supported on a short term basis, either through screening or assessment will be higher than this and can fluctuate.

The number of people supported by this service has increased significantly in recent years. In 2012/13 a total of 367 people were supported by the service, this increased to 393 in 2013/2014 and to 428 in 2015/16. Current figures show that **431** people were supported by the service.

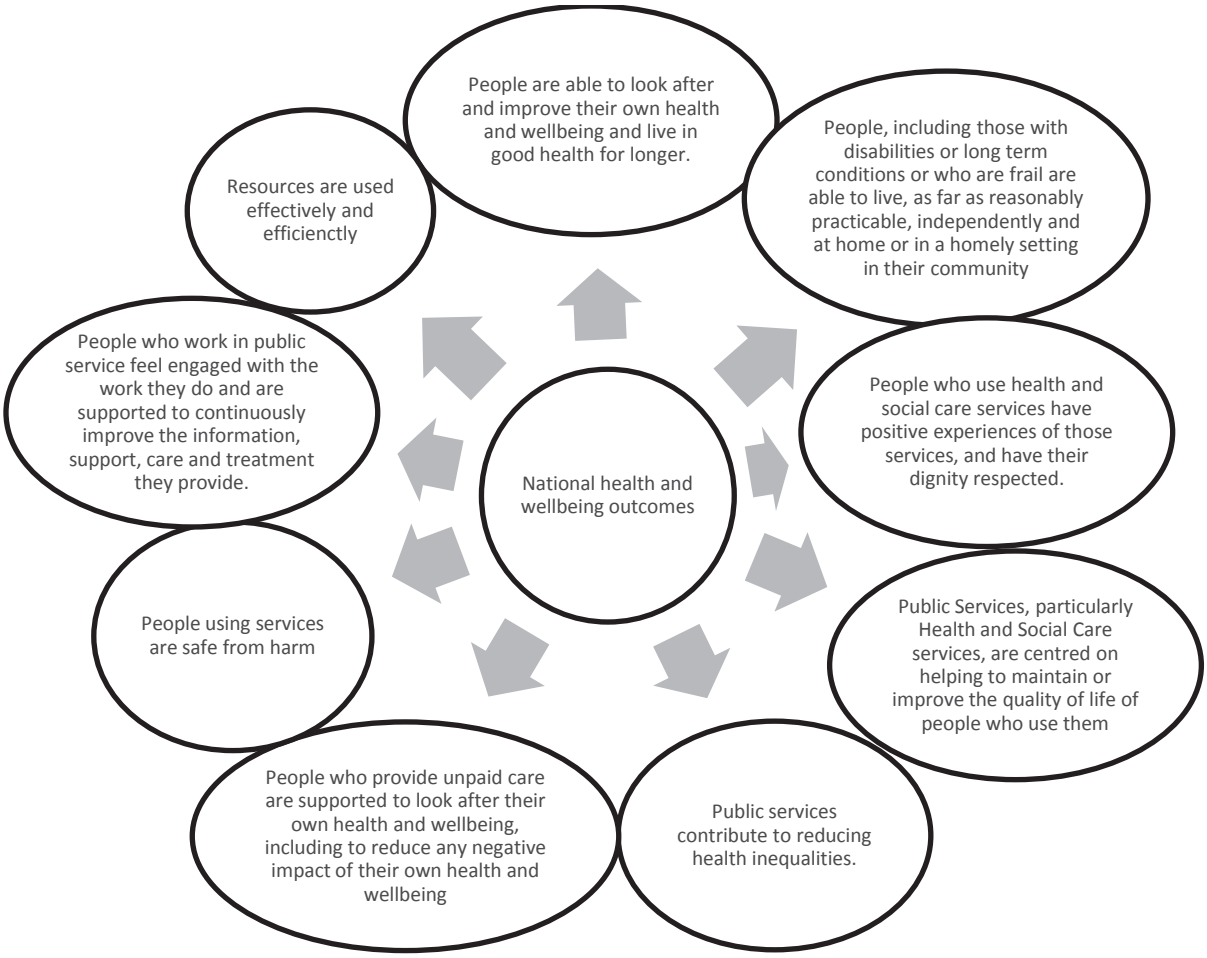
Current Activity	**Numbers Service Users**
Current team caseload	431
Incoming contacts	210 per month
Assessments completed	22 per month
With You For You Reviews	30 per month

Social Care Client Group (all allocations across services)

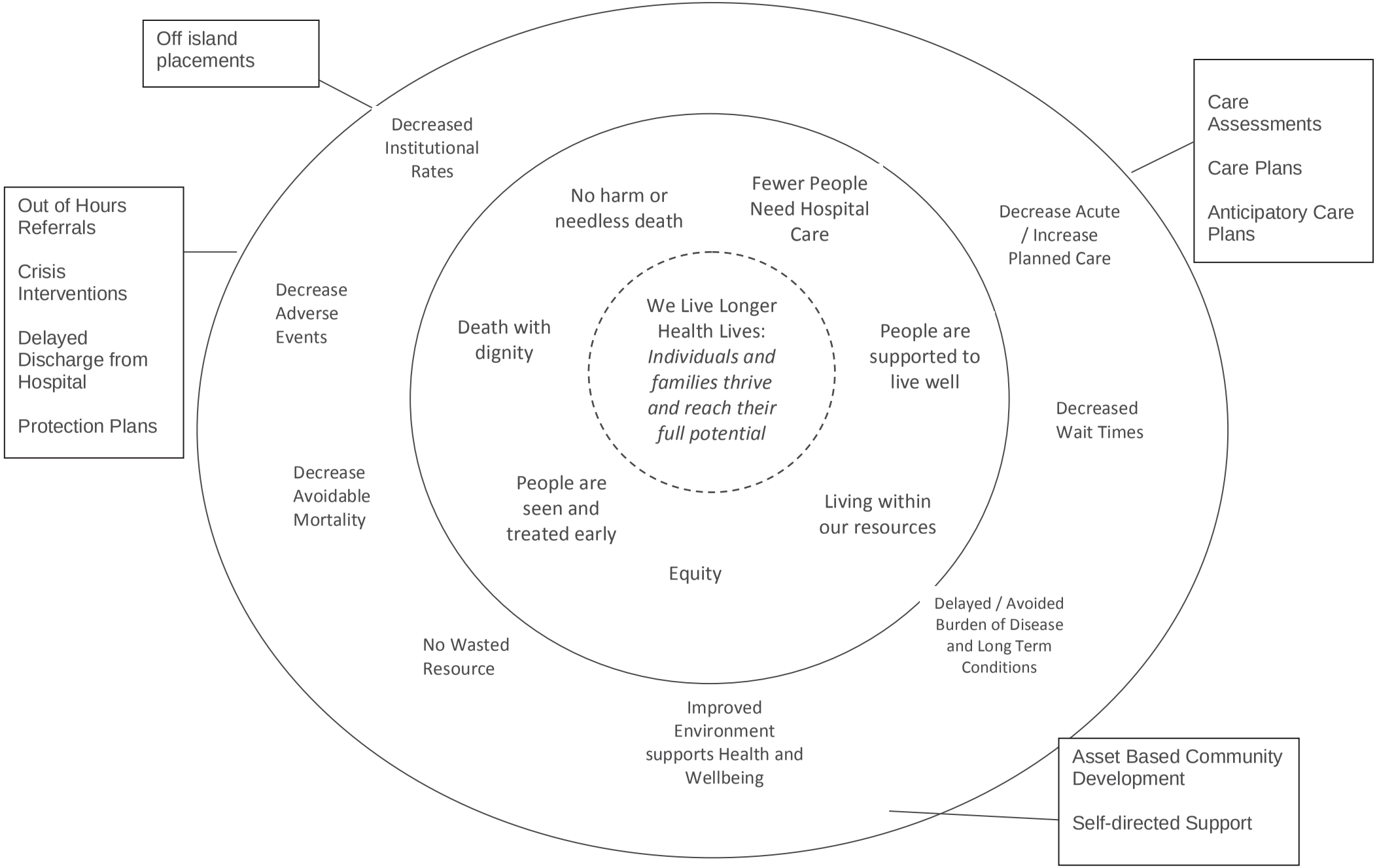
	Dementia	**Mental Health**	**Learning Disability**	**Physical Disability**	**Older people**	**Addiction**	**Palliative Care**	**Carer's**	**Other**	**Not Known**	**Total**
Total	47	66	88	458	257	12	4	73	19	88	1,112

Outcomes Framework

The IJB Commissions Adult Social Work in line with the general Health and Wellbeing Outcomes.



There are no specific outcomes in place for Adult Social Work; the work of the team provides the assessment and support for achieving all of the Health and Wellbeing Outcomes. This diagram has been developed from the Canterbury, New Zealand Health System Outcomes Framework (http://ccn.health.nz/Resources/OutcomesFramework.aspx) shown below, with examples of indicators.


Off island placements
Out of Hours Referrals
Crisis Interventions
Delayed Discharge from Hospital
Protection Plans
Care Assessments
Care Plans
Anticipatory Care Plans
Asset Based Community Development
Self-directed Support
Decreased Institutional Rates
Decrease Adverse Events
Decrease Avoidable Mortality
No harm or needless death
Fewer People Need Hospital Care
Decrease Acute / Increase Planned Care
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
Decreased Wait Times
People are seen and treated early
Living within our resources
Equity
Delayed / Avoided Burden of Disease and Long Term Conditions
No Wasted Resource
Improved Environment supports Health and Wellbeing

Adult Services Performance Data

Category	Indicator	Target	Current Performance	Improvement Actions /Notes
Outcome 1 People are able to look after and improve their own health and wellbeing and live in good health for longer	ASW003 Percentage of outcomes for individuals are met		93%	New indicator which is under development, and relates to the % of people who have achieved, or mostly achieved, their agreed outcomes after assessment. Further work will include looking at QA processes, that ensure consistency of approach, whilst support staff development.
Outcome 3 People who use health and social care services have positive experiences of those services, and have their dignity respected	ASW001 Percentage of assessments completed on time	100%	56.3%	Assessment data is now extracted from our recording system and completion rates should rise when recording issues are resolved. Figures are currently low and will be monitored closely via internal QA processes. Completion target is currently 3 weeks. This needs to be reviewed, and benchmarked.
Outcome 3	ASW002 Percentage of reviews completed on time	90%	86.3%	Percentage of all reviews completed within 7 days of due date. Reviews often miss target dates due to a number of factors such as availability of client or family member or a change of circumstances. Completion target reset to more realistic 90%.

Resources

Shetland Islands Council services are estimated to cost £2,992,639 in 2019-20.

Improvement Plans

Adult Social Work may be seen as the thread that runs through Community Health & Social Care, given the daily interactions across all service areas. As with Community Care Resources, and alongside our CHSC teams, in 2019-20 Adult Social Work the elements of services that need to be continued include:

- Taking an ‘asset based’ approach to needs assessment, whereby the assessment of need starts from the premise of what a person is able to do for themselves, then works outwards to statutory provision;

- Provide information on the 4 Options within Self-directed Support, which allows people to choose how their support is provided, and gives them as much control as they want of their individual budget;
- Support for unpaid carers through the implementation of the Carers Act (Scotland) 2016;
- Extended approach to falls prevention (this service is included in the Health Improvement Direction);
- Supporting the further development of integrated local teams, building resilience and cover especially around single handed practitioners and out of hours arrangements;
- Maximising the use of Anticipatory Care Plans;
- Supporting staff to be mobile, flexible, and working to their maximum skill set and where staff with a general skill set are able to work across services;
- Positively promote a range of ill health prevention and good health promotion initiatives and messages (around activity, diet, lifestyle, etc);
- Stepping up post diagnostic support for people recently diagnosed with dementia (this service is included in the Allied Health Professionals Direction);
- Maintaining the strong partnership arrangements around winter planning specifically and business continuity planning in general to manage unusual peaks in demand;
- Continue to explore how best to focus support on improving people's quality of life, with an emphasis on early intervention and preventative services and tackling inequality;
- Apply, where appropriate, emerging technological solutions to support people to live independently at home;
- Support for financial wellbeing, fuel poverty and social isolation / loneliness.
- Working with partners to explore community transport arrangements to support people being able to be connected within and between communities

Adult Social Work is taking forward a Business Case for the Community Led Support programme, which supports Health and Social Care Partnerships in Scotland to put their work right at the heart of communities, thus providing a framework to progress the service elements highlighted above. Community Led Support:

- seeks to change the culture and practice of community health and social work delivery so that it becomes more clearly values-driven, community focused in achieving outcomes, empowering of staff and a true partnership with local people;

- assists organisations to work collaboratively with their communities and their staff teams to redesign a service that works for everyone, that evolves and is continually refined, based on learning;

- is an 18 month change programme, delivered in partnership with the participating Health & Social Care Partnerships and local authorities, which seeks to put the front door of both Health and Social Care back into the community.

Coordinated support for young people with additional support needs in transition into adulthood cuts across a number of national policies and local arrangements, for example Getting It Right For Every Child, Additional Support for Learning and Autism, With You For You, eligibility criteria, etc. Adult Social Work will continue to work with partner colleagues across Integrated Children's Services, NHS Shetland, and Adult Services to enable continual improvement of support and achievement of positive outcomes for young people with additional support needs who are making the transition to young adult life.

The Community Care Resources Direction identified specific workstreams that are recommended for progressing to the Outline Business Case stage in support of an Enhanced Care at Home model:

- Support for unpaid carers through the implementation of the Carers Act (Scotland) 2016, specifically to extend day services in Lerwick to provide a 'drop-in' service to provide extended respite opportunities.

- Explore further geographically dispersed models for supporting care at home in the South Mainland, for example hubs within localities, including respite at home where appropriate and exploring different contractual staffing models to best suit client's needs.

- Investigate a 24/7 responsive service to further support care at home and out of hours arrangements. This will involve exploring partnership arrangements with other statutory and third sector partners.

This suite of activity has the potential to deliver enhanced levels of support to enable supported people to "live, as far as reasonably practicable, independently and at home or in a homely setting in their community". This also has the potential cost benefit of reducing reliance on the provision of 'sleep-ins' within a range of packages of support, enabling us to create efficiencies, whilst maintaining individuals safely within their place of choice in their community.

Following the Thematic Review of Self-directed Support by the Care Inspectorate during September and October 2018, an action plan will be developed during the first quarter of 2019/20 that addresses key recommendation, that we improve the shared understanding of Self-directed Support across all staff groups and, in particular, health care staff so that supported people can use support creatively and promptly without hindrance.

Direction from the Integration Joint Board

Community Care Resources

		Direction Approved July 2017	Proposed Direction 2019
1.	**Reference Number**		CC-22-19 1.8
2.	**Date Direction issued by IJB**	13 July 2017	14 May 2019
3.	**Date from which Direction takes effect**	1 August 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, July 2017
6.	**Functions covered by the Direction**	Residential Care for long term care and short breaks (respite) Day Services Care at Home Domestic Meals on wheels	Residential Care for long term care and short breaks (respite) Day Services Care at Home Domestic Meals on wheels
7.	**Full text of Direction**	Review current models of care in Shetland to ensure sustainability of service Thematic Self Evaluation in the area of Day Care Services Develop a Performance Management Framework	• Provide support to unpaid carers through extended, 'drop in' day care services in Lerwick • Carry out level 1 and 2 needs assessment across the over 75's in Whalsay trialling simplified assessment tools. Map existing resources and develop arrangements to

			best meet those needs including preventative services outwith the Partnership • Explore geographically dispersed models for care at home in the South Mainland including enhanced and overnight provision • Develop a 24/7 response service in Lerwick to provide nursing and social care support • Develop Outline Business Case for capital and revenue investment in telehealth and telecare resources • Co- Production. Working with the Community in Yell to explore ideas and develop services that are safe and effective; able to be staffed by permanent staff without relying on agency or locum arrangements and affordable
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £10,031,999 SIC	SIC £11,542,901
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the

		Commissioning Plan and the National Health and Wellbeing Outcomes	National Health and Wellbeing Outcomes
10.	**Performance monitoring**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Community Care Resources

Service Model

The service model and indicative activity levels (where available) for services to adults are shown below. This is the service model that the IJB is commissioning directly from Shetland Islands Council and through them from the voluntary sector.

Current Service Model

The current model is a dispersed locality model of service, with care centres being the 'hub' for arranging service delivery in each of the seven localities.

The seven localities in Shetland are:

- North Isles
- North Mainland
- West Mainland
- Whalsay and Skerries
- Central Mainland
- Lerwick and Bressay
- South Mainland

Each area currently has a set of services delivered within the locality:

- primary care;
- community nursing;
- care at home; and
- care home resources

alongside a broad range of voluntary activity to support individual and community wellbeing.

There is in place a range of voluntary and community provision in each area to support well being. Examples of this will include: support for individuals with dementia; befriending; lunch clubs; craft circles; leisure and learning opportunities. These deliver invaluable social benefits to those attending and form an intrinsic part of the network of provision to support individual health and wellbeing and community resilience.

Social Care services addresses people's specific care needs, where people have a specific condition or disability. The services can include:

- permanent residential placement
- short break or respite in a residential setting
- help with your personal hygiene, such as bathing and washing
- help with going to the toilet
- help with getting up and going to bed
- reminding you to take your medication
- help with preparing meals and eating
- help with general domestic tasks including cleaning, cooking and shopping.

Age group	Dementia	Mental Health	Learning	Physical Disabilit	Older people	Addiction	Palliative Care	Carer's	Other	Not Known	Total
Under 65	1	50	86	102	0	7	0	39	108	62	455
65 and over	93	22	13	506	200	1	0	24	1	54	914
Unknown	1		1	18	2			11	2	11	46
Total	**95**	**72**	**100**	**626**	**202**	**8**	**0**	**74**	**111**	**127**	**1,415**

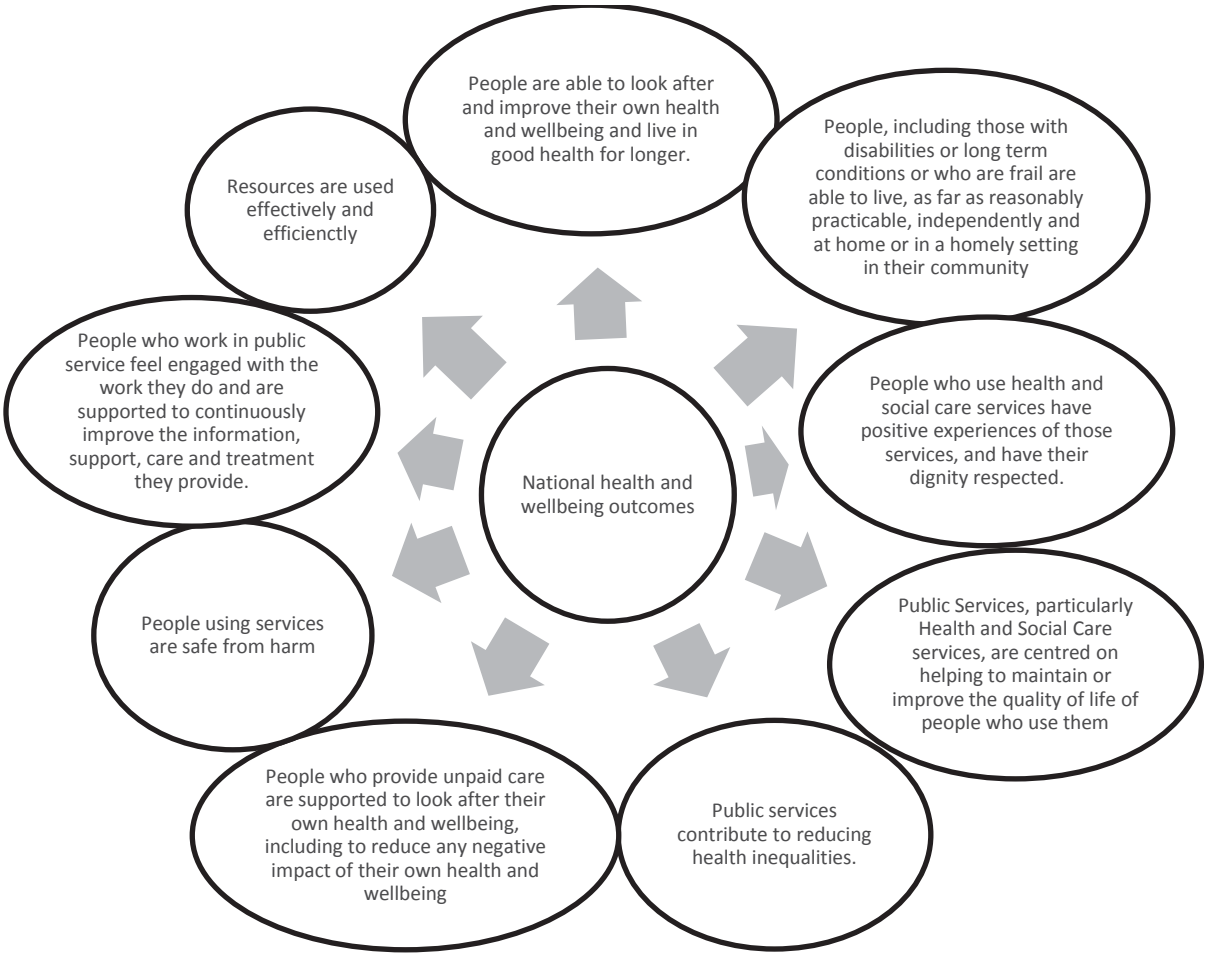
The service supports about 1,112 people, as shown by category of need below.

Social Care Client Group (Main)

Age group	Dementia	Mental Health	Learning Disability	Physical Disability	Older people	Addiction	Palliative Care	Carer's	Other	Not Known	Total
Total	**47**	**66**	**88**	**458**	**257**	**12**	**4**	**73**	**19**	**88**	**1,112**

Outcomes Framework

The IJB Commissions Community Care Resources in line with the general Health and Wellbeing Outcomes.

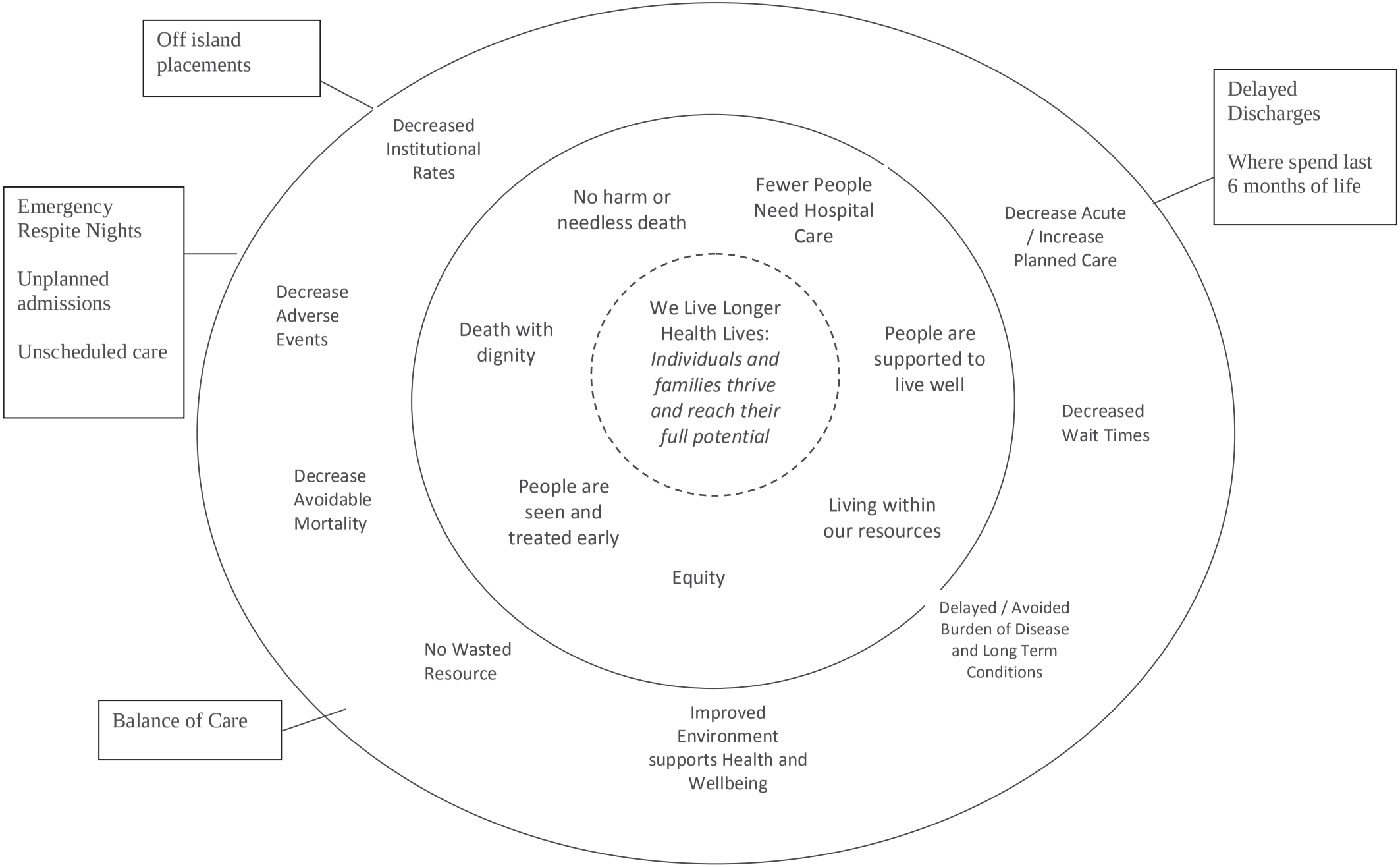


The Scottish Government has asked that Shetland Islands Health and Social Care Partnership, along with all other partnerships, pay particular attention to the following indicators:

- Unplanned admissions
- Occupied bed days for unscheduled care
- A&E performance
- Delayed discharges
- End of life care and
- The balance of spend across institutional and community services.

Current Performance	Place in Scotland
Unplanned admissions 2017-18 unplanned admission rates 75+ all specialities	Second
Occupied bed days for unscheduled care 2017-18 unplanned bed day rates 75+ all specialities	First
Proportion of the last six months of life spent at home or in a community setting for people who died in 2017-18	First

In order to capture the whole population / whole system approach, the outcomes are based on the Canterbury, New Zealand Health System Outcomes Framework. (http://ccn.health.nz/Resources/OutcomesFramework.aspx)


Off island placements
Emergency Respite Nights
Unplanned admissions
Unscheduled care
Balance of Care
Delayed Discharges
Where spend last 6 months of life
Decreased Institutional Rates
No harm or needless death
Fewer People Need Hospital Care
Decrease Acute / Increase Planned Care
Decrease Adverse Events
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
Decreased Wait Times
Decrease Avoidable Mortality
People are seen and treated early
Living within our resources
Equity
Delayed / Avoided Burden of Disease and Long Term Conditions
No Wasted Resource
Improved Environment supports Health and Wellbeing

Community Care Resources Performance Data

Category	Indicator	Target	Current Performance	Improvement Actions /Notes
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 the community	CCR007 Number of 65 and over receiving personal care at home	200	207	Personal care is offered to those that need it. Assessments are thorough and the Council policy of reablement, which includes a six week period of free support, has helped us to achieve good performance over a number of years.
Outcome 2	CCR009 Number of people waiting for permanent residential placement	10	5	Target is to have less than 10 people waiting for permanent residential placement. Currently within target.
Outcome 9 Resources are used effectively in the provision of health and social care services, without waste	CCR005 Occupancy of Care Homes	90%	75%	Increased use of permanent beds for re-ablement and respite care means occupancy rates decrease. Effectiveness of care provided at home results in less demand for residential beds.

Resources

Shetland Islands Council services are estimated to cost £11,542,901 in 2019-20.

Improvement Plans

The elements of services that need to be continued include:

- the ‘asset based’ approach to needs assessment, whereby the assessment of need starts from the premise of what a person is able to do for themselves, then works outwards to statutory provision;
- encourage ‘Self Directed Support’ which allows people to choose how their support is provided, and gives them as much control as they want of their individual budget;
- support for unpaid carers through the implementation of the Carers Act (Scotland) 2016;
- extended approach to falls prevention;
- Supporting the further development of integrated local teams, building resilience and cover especially around single handed practitioners and out of hours arrangements;
- Maximising the use of Anticipatory Care Plans;

- Supporting staff to be mobile, flexible, and working to their maximum skill set and where staff with a general skill set are able to work across services;
- Supporting the Effective Prescribing project, where it focuses on care homes and community settings;
- Accelerated campaign to support home owners to make investments now to plan for future care needs (accessible ramps, showers, etc, etc);
- Positively promote a range of ill health prevention and good health promotion initiatives and messages (around activity, diet, lifestyle, etc);
- Stepping up post diagnostic support for people recently diagnosed with dementia;
- Maintaining the strong partnership arrangements around winter planning specifically and business continuity planning in general to manage unusual peaks in demand;
- Continue to explore with Shetland Charitable Trust how best to focus support on improving people's quality of life, with an emphasis on early intervention and preventative services and tackling inequality;
- Apply, where appropriate, emerging technological solutions to support people to live independently at home;
- Support for financial wellbeing, fuel poverty and social isolation / loneliness
- working with partners to explore community transport arrangements to support people being able to be connected within and between communities

The specific workstreams recommended for progressing to the Outline Business Case stage in support of an Enhanced Care at Home model are:

Support for unpaid carers through the implementation of the Carers Act (Scotland) 2016, specifically to extend day services in Lerwick to provide a 'drop-in' service to provide extended respite opportunities.

Carry out a needs assessment of Levels 1 and 2 care needs in Whalsay, map those to existing resources and services, identify gaps and develop arrangements to best meet those needs (including preventative services outwith the formal health and care sector including voluntary, community, third sector and housing services and support). Trial simplified assessment tools for this care group, to assess if the mandatory reporting requirements can be captured in a more cost effective way (eg the Better Futures system).

Explore further geographically dispersed models for supporting care at home in the South Mainland, for example hubs within localities, including respite at home where appropriate and exploring different contractual staffing models to best suit client's needs.

Investigate a 24-7 responsive service to further support care at home and out of hours arrangements. This will involve exploring partnership arrangements with other statutory and third sector partners.

Direction from the Integration Joint Board

Criminal Justice

		Direction Approved July 2017	Proposed Direction 2019
1.	**Reference Number**		CC-22-19 1.9
2.	**Date Direction issued by IJB**	13 July 2017	14 May 2019
3.	**Date from which Direction takes effect**	1 August 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council	Shetland Islands Council
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes
6.	**Functions covered by the Directions**	Provision of criminal justice social work services for individuals awaiting sentencing; subject to community based sentences; custodial sentences and reintegration into the community. Including; • Diversion from prosecution services. • Bail information and supervision. • Criminal Justice Social Work Reports. • Supervision and management of individuals subject to Community Payback Orders. • Unpaid Work Scheme. • Prison Throughcare • Statutory and Voluntary	Provision of criminal justice social work services for individuals awaiting sentencing; subject to community based sentences; custodial sentences and reintegration into the community. Including; • Diversion from prosecution services. • Bail information and supervision. • Criminal Justice Social Work Reports. • Supervision and management of individuals subject to Community Payback Orders. • Unpaid Work Scheme. • Prison Throughcare • Statutory and Voluntary

		Throughcare. • Public Protection - MAPPA	Throughcare. • Public Protection – MAPPA • Out of Hours Social Work Service
7.	**Full text of Direction**	Undertake statutory duties and core social work functions. Work with the Shetland Community Justice Partnership in delivering the strategic plan for 2017-20: • Review internal processes and intervention to ensure they remain fit for purpose. • Work with partners to plan and deliver services. Focus on recreation and employment opportunities. • Raise awareness of criminal justice services within the local community.	Undertake statutory duties and core social work functions. Work with partners in relation to public protection matters. Work with the Shetland Community Justice Partnership in delivering the strategic plan for 2017-20: • Develop Whole System Approach arrangements for young people up to the age of 21 and 26 for care experienced adults. • Support focus group to review Community Reintegration on Leaving Custody. • Work with partners to plan and deliver recreational and employment opportunities • Raise awareness of community payback scheme within the local community. • Explore better information management processes to increase feedback from service users, staff and partners
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £18,209 SIC	Total Budget £38,842
9.	**Outcomes**	Working with justice partners and stakeholders in Shetland to design, develop and deliver services that will improve outcomes for people involved in community justice and offending behaviour.	Working with justice partners and stakeholders in Shetland to design, develop and deliver services that will improve outcomes for people involved in community justice and offending

		Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan, CJSW National Outcomes and Objectives the National Health and Wellbeing Outcomes.	behaviour. Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan, CJSW National Outcomes and Objectives the National Health and Wellbeing Outcomes.
10.	**Performance monitoring arrangements**	Quarterly Reporting to IJB Community Payback Order Annual Report to Scottish Government.	Quarterly Reporting to IJB. Six monthly reporting to SCJP Annual Reporting to Northern CJSWS partners to benchmark services. CPO Annual Report to Scottish Government.
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Criminal Justice Services

Service Model
Governance
Outcomes Framework
Resources
Improvement Plans

Service Model

The Criminal Justice Social Work Service ensures that all people who are referred to the service are appropriately assessed, supervised and risk managed in line with Criminal Justice National Outcomes and Standards and MAPPA – Multi agency public protection arrangements. The service works predominantly with individuals over the age of 16 years and is responsible for the delivery and development of all criminal justice social work services throughout Shetland.

The service consists of a small team of qualified social workers and para professionals. Staff work across the different functions ensuring continuity of case management and risk management. It works collaboratively with statutory and third sector partners to ensure that individuals receive the assistance and support their need to improve their life chance.

The Shetland Islands Council has a statutory duty to provide criminal justice social work services for individuals who have committed a criminal offence. Services range from those awaiting sentencing to returning to Shetland from a custodial sentence. The main functions of the service is the provision of information to the Courts; supervising those individuals subject to community based sentences, primarily a Community Payback Order and throughcare services.

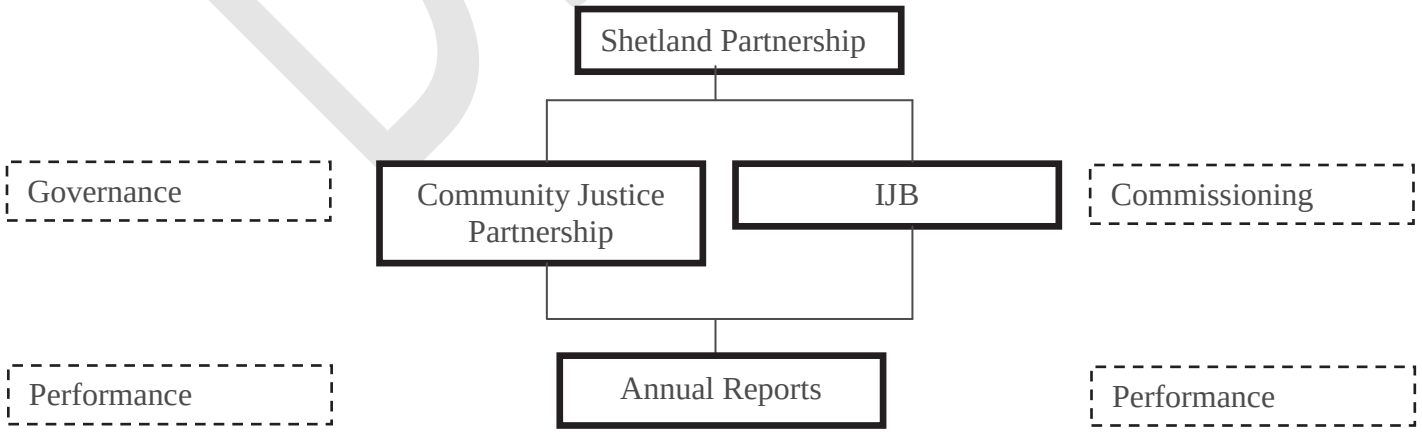
Activities include the production of court reports and risk assessments to aid the Court with sentencing decisions; reducing reoffending and assisting individuals to make positive changes to their lives through individual need and risk assessments and case management plans. Supporting individuals to payback to the community

for their crimes through the undertaking of unpaid work; and working with partners to promote public protection through supervision and management of individuals who pose a high risk of harm. The service also offers support and advice to family members.

Current Activity	Numbers
Social Work Court Reports and Reviews	73
Community Payback Orders	45
Supervision Requirement	31
Unpaid Work Requirement	35
Drug Treatment and Testing Orders	0
Diversion From Prosecution	17
Bail Information and Supervision Scheme	10
Fiscal Work Orders	0
Throughcare Statutory and Voluntary	25
Home Circumstances Reports	5
Home Detention Curfew Assessments	6

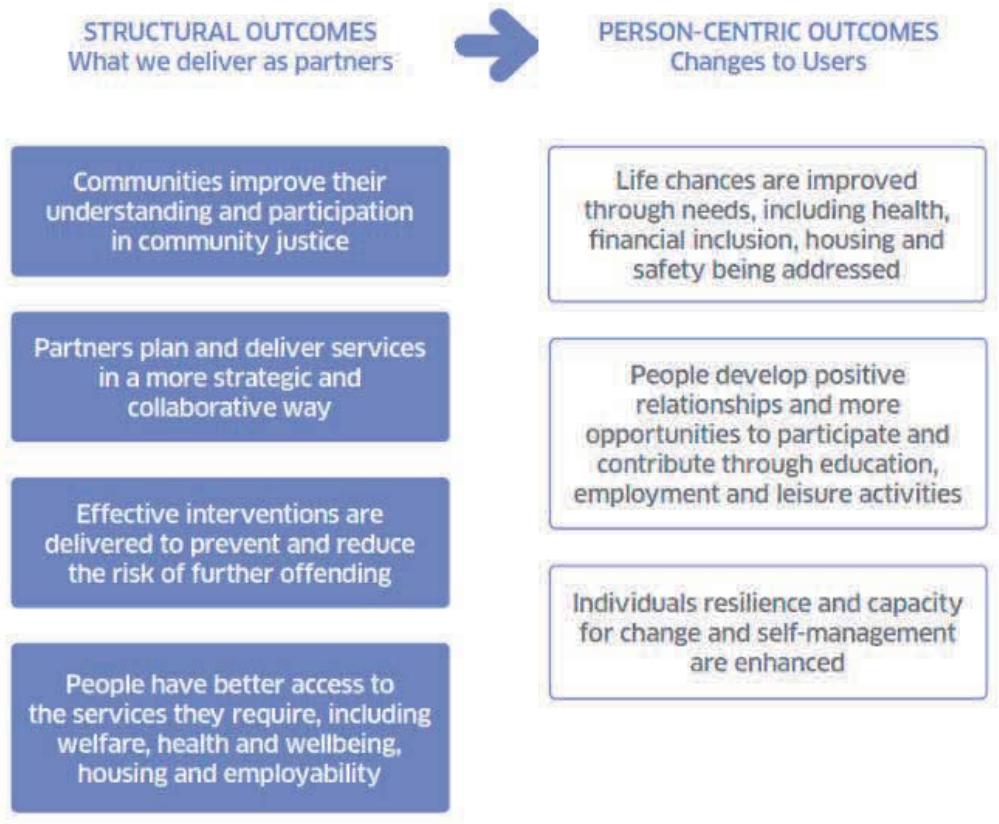
Governance

The work of the Criminal Justice Service is commissioned through the IJB and governed though the Social Work Governance Group, IJB joint governance arrangements and the Community Justice Partnership. This is shown diagrammatically below.



Outcomes Framework

The IJB Commissions Criminal Justice Social Work Services in line with the Scottish Governments vision for community justice and to deliver on community justice outcomes. “Scotland is a safer, fairer and more inclusive nation where we: prevent and reduce further offending by addressing its underlying causes; safely and effectively manage and support those who have committed offences to help them reintegrate into the community and realise their potential for the benefit for all citizens.”



Category	Key Service Indicator	Target	Current Performance	Improvement Actions /Notes
Structural Outcomes				
Communities improve their understanding and participation in Community Justice	Engagement with communities in relation to unpaid work projects. This is reported through the CPO Annual Report.	Annually	Targeted communication with community groups. CPO report reflects structural and personal outcomes.	Develop an unpaid work flyer advertising completed projects.
Participation in community justice, such as co-production and joint delivery of services.	Views of individuals subject to community based disposals is gathered via reviews and exit questionnaires. Representation of criminal justice staff at partnerships to encourage joint delivery of services. Feedback from unpaid work beneficiaries.	100%	Regular reviews capture progress of work and how the individual experienced the service. Partnership meetings are well attended. Very positive feedback from beneficiaries.	Develop more robust systems to gather feedback to ensure consistency across the service.
Person Centred Outcomes (Changes to Users)	Direct individual feedback on person centred outcomes is provided through reviews and exit questionnaires.	100%	Exit questionnaires capture individual outcomes but return is poor – 35% return	Increase exit questionnaire return.
Initiatives which will ensure that people who have offended get the support they need, when they need it, to encourage desistance.	Court Reports submitted on time.	100%	100%	
	Commencement of supervision within 7 working days.	100%	82%	Small percentage out with service control due to individuals not attending as instructed.
	Unpaid work	100%	71%	Ensure

	commenced within timeframes.			placement availability.
	% of offenders subject to CPO who feel they were treated with respect	100%	100%	
Reducing reoffending	Risk and needs identified within 20 days.	100%	TBC before meeting	
Changes in offending behaviour	Reduction in the level of assessed risk and need.	100%	TBC	
	Individuals completing sentences with no other criminal convictions.	75%	TBC	
Individual progress against personal outcomes	Education and Employment	75%	50%	Continue to work with colleagues in other agencies to develop opportunities.
	Housing	100%	75%	
	Substance misuse	75%	75%	
	Personal Relationships	75%	100%	
	Mental Health and Esteem	90%	85%	
	Problem Solving and Coping Skills	80%	100%	
	Financial	50%	75%	

Reporting on performance on Criminal Justice services will be through the Annual Reports on:

- Community Justice Strategic Partnership
- MAPPA (Multi-Agency Public Protection Partnership Arrangements)
- Community Payback Annual Report
- Chief Social Work Officer Report

Improvement Plans

In 2019-20, the Criminal Justice Service intends to undertake the following improvement activity:

Work with the Shetland Community Justice Partnership in delivering the strategic plan for 2017-20:

- Develop Whole System Approach arrangements for young people up to the age of 21 and 26 for care experienced adults.
- Support focus group to review Community Reintegration on Leaving Custody.
- Work with partners to plan and deliver services with a focus on recreational and employment opportunities
- Raise awareness of community payback scheme within the local community.
- Explore better information management processes to increase feedback from service users, staff and partners.

Direction from the Integration Joint Board

Allied Health Professionals

		Direction Approved July 2017	Proposed Direction 2019
1.	**Reference Number**		CC-22-19 1.10
2.	**Date Direction issued by IJB**	13 July 2017	14 May 2019
3.	**Date from which Direction takes effect**	1 August 2017	14 May 2019
4.	**Direction to:**	Shetland Islands Council	Shetland Islands Council NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, Amend July 2017
6.	**Functions covered by the Direction**	Various	Various
7.	**Full text of Direction**	Various	Various
8.	**Budget allocated by IJB to carry out Direction.**	Various	NHS Shetland £1,360,831 Shetland Islands Council £1,433,707 in 2019-20 Overall Total £2,794,538.
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning

		Plan and the National Health and Wellbeing Outcomes	Plan and the National Health and Wellbeing Outcomes
10.	**Performance monitoring arrangements**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Allied Health Professionals

Service Model
Outcomes Framework
Resources
Improvement Plans

Service Model

The service model and indicative activity levels (where available) for services to adults are shown below. This is the service model that the IJB is commissioning directly from NHS Shetland and Shetland Islands Council and through them from the voluntary sector.

Current Service Model

Team	Role
Dietetics	Dieticians assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. They use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. Dieticians treat complex clinical conditions such as diabetes, food allergy and intolerance, IBS syndrome, eating disorders, chronic fatigue, malnutrition, kidney failure and bowel disorders. They provide advice to caterers to ensure the nutritional care of all clients in NHS and other care settings such as care homes, they also plan and implement public health programmes to promote health and prevent nutrition related diseases. A key role of a dietician is to train and educate other health and social care workers. Dieticians also advise on diet to avoid the side effects and interactions between medications.
Occupational Therapy	Occupational therapy takes a whole-person approach to both mental and physical health and wellbeing, enabling individuals to achieve their maximum. It provides practical support to enable people to facilitate recovery and to overcome any barriers that prevent them from doing the activities (occupations) that matter to them. Occupational therapists work with adults and children of all ages

	with a wide range of conditions; most commonly those who have difficulties due to a mental health illness, physical (including frailty), or learning disabilities. In Shetland, the Occupational Therapy Team provides Occupational Therapy assessments in people's homes, in the Gilbert Bain Hospital (on the wards, or as outpatient appointments), rehabilitation and reablement services at home or in care homes, and within community settings for employment support. The overall service provides advice, assessment and provision of Equipment and Adaptations; a Sensory Impairment Service, Telecare and Telehealth provision and advice, Wheelchair Assessments and Blue Badge Assessments. The service also reviews and monitors equipment such as GPS devices, medication dispensers and home-based monitoring services (Just Checking), and coordinates the safety and inspection services for over 250 pieces of 'lifting' equipment across Shetland twice a year e.g., hoists, bath lifts and stairlifts. Each of the Shetland care homes has a named Occupational Therapist who runs an advice and information clinic each month.
Orthotics	Orthotists provide gait analysis and engineering solutions to patients with problems of the neuro, muscular and skeletal systems. They carry out differential diagnosis of musculoskeletal (MSK) conditions, design and provide orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They treat patients with a wide range of conditions including Diabetes, Arthritis, Cerebral Palsy, Stroke, MSK, sports injuries and trauma. As part of the multi-disciplinary team, patient focused solutions are achieved. Shetland Orthotic service holds clinics in the Balfour Hospital in Orkney on a monthly basis.
Physiotherapy	Physiotherapists help people affected by injury, illness or disability through movement and exercise, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible. The service is based at the Gilbert Bain Hospital and covers inpatient, outpatient, and domiciliary including schools. A wide range of specialities is covered including MSK, respiratory, paediatrics, neurology/falls/elderly/long-term conditions, ante- and postnatal. Also includes support for orthopaedic and rheumatology pathways.
Podiatry	Podiatrists triage, assess, diagnose and treat the full range of podiatric conditions of the foot and lower limb. We provide treatment for nail management, wound management, vascular and neurological assessment, advise on foot health and footwear, provide advice and practical solutions for personal footcare, work with the multidisciplinary "high risk limb" team. Musculoskeletal clinics, manufacture and prescription of orthoses, nail surgery,

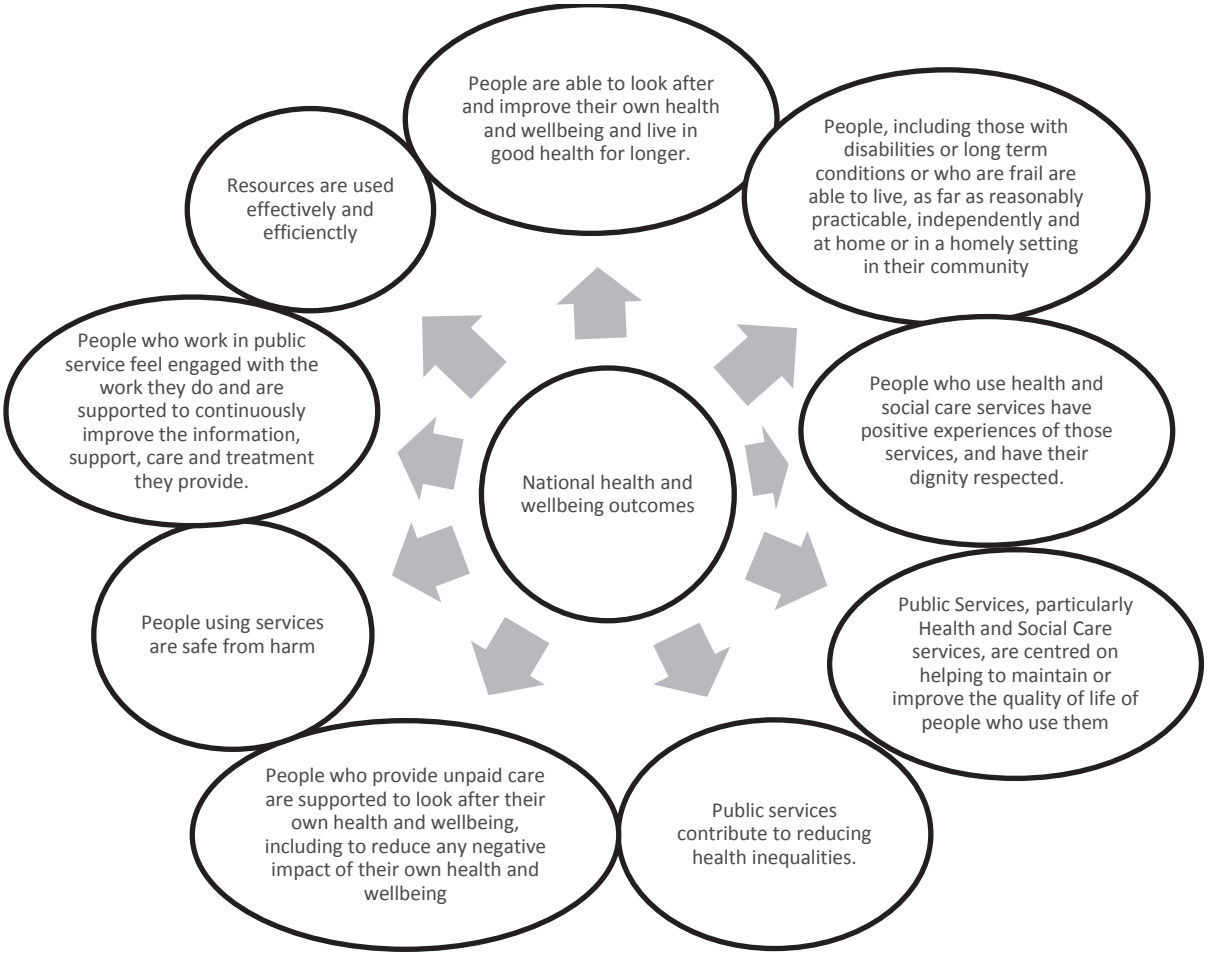
	undertake diabetic foot screening and assessment, assist patients in preventing trips and falls. Work towards prevention of foot problems therefore reducing non-planned hospital admissions, provide treatment for patients with long term conditions (LTC). Work in collaboration with other health care professionals, provide training to care workers, hold joint assessments with Physiotherapy and work closely with the Shetland Voluntary Nail Cutting Service (SVNCS). Provision of the High Risk Foot Clinic. Provide expertise for the Falls MCN and provide practical training and education for the Otago programme. Services are provided throughout Shetland with more specialist Podiatric services provide centrally in Lerwick. Services are provided to persons of all ages (including children and young people) and to those living with LTC eg dementia and persons with learning difficulties.
Speech and Language Therapy	Speech and language therapists (SLTs) provide life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking or swallowing. SLTs assess and treat speech, language and communication problems in people of all ages to help them communicate better. They also assess, treat and develop plans to support people who have eating and swallowing problems. Using specialist skills, SLTs work directly with clients and their carers and provide them with tailored support. They work closely with colleagues in education including teachers and health professionals such as nurses, doctors and other AHPs and psychologists.

Current Activity	**Numbers Service Users**
Dietetics	
Average of 17 patients per month who opt in for an outpatients clinic appointment with a dietitian	There are currently 260 active service users
Average 22 outpatient appointments per week plus telephone appointments, home visits and inpatients – numbers vary according to demand	
Occupational Therapy	
Community Occupational Therapy	727 new clients referred and assessed in last year
Inpatient Occupational Therapy	Average 30 patients seen per month
Children's Occupational Therapy	69 children, including 11 who meet Complex and Exceptional health needs criteria, 17 baby follow up cases, 43 children seen for targeted group activities
Occupational Therapy provision to the Employability Pathway	60 clients seen over last year, 4 groups running regularly with 32 attendees, 30 people attending training events run by service
Telecare provision	714 community alarms and other telecare

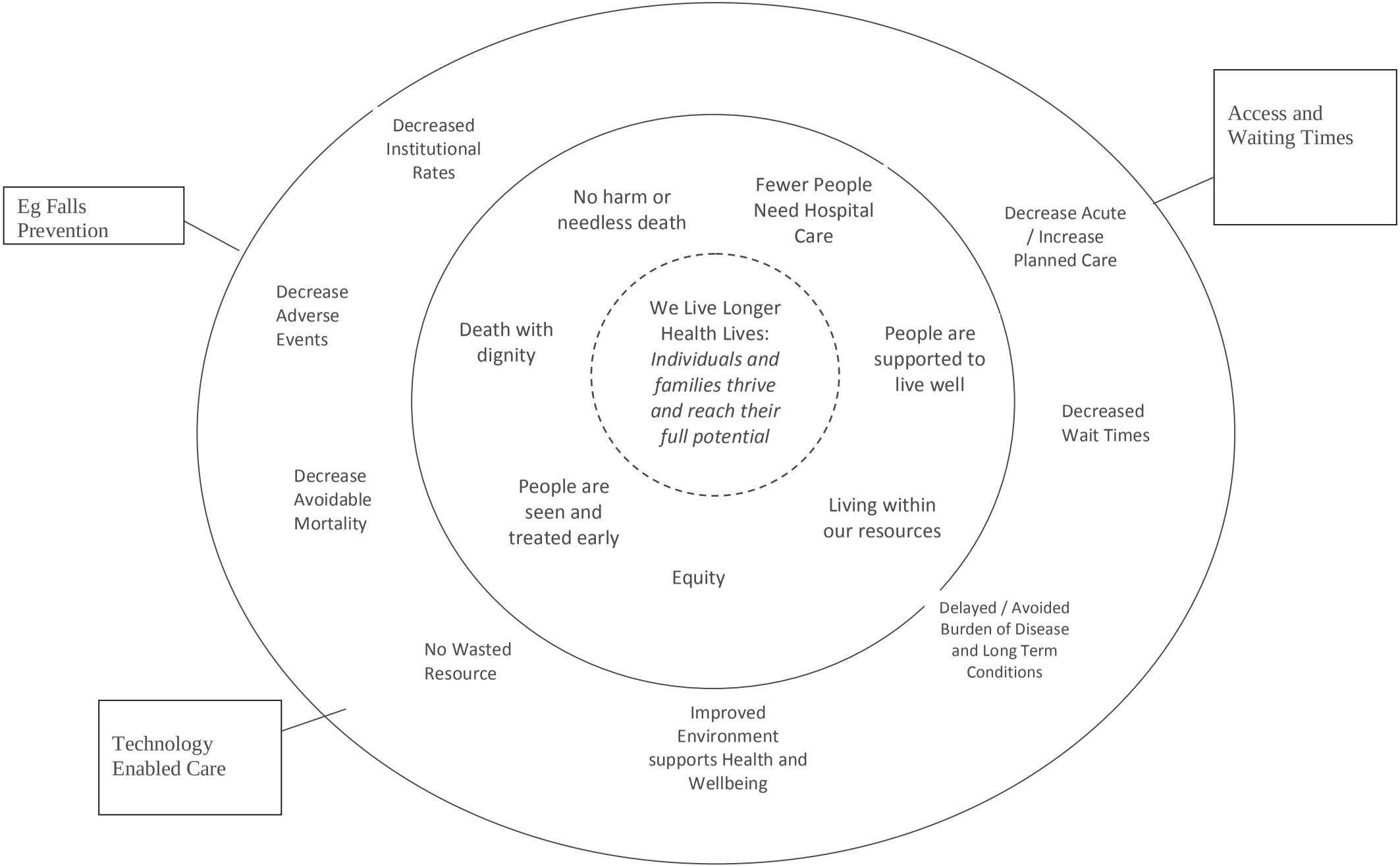
	equipment in situ
Monthly Occupational Therapy clinics in care homes	Eight Care homes across Shetland
Post diagnostic support for people with dementia including Home Based Memory rehabilitation	60 people already assessed and supported, 4 undergoing Home Based Memory Rehabilitation pilot (new project)
Scheduled care preoperative assessments	10-15 per month
Low vision support service	Varies on demand
Blue Badge assessments	Varies on demand
Items of equipment provided	859 new items/ year
No of adaptations provided	242 minor adaptations and 77 major adaptations
Orthotics	
Orthotic appointments Shetland 18/19	1049
Orthotic appointments Orkney 18/19	458
1064 orthoses supplied in Shetland 436 orthoses supplied in Orkney.	
Physiotherapy	
7,640 appointments in 2018	2667 outpatient referrals in 2018
Podiatry	
Nail Surgery	60+ annually
Musculoskeletal	300+ annually
Wound Care	Demand led
High Risk Foot	Demand led
Diabetes	1300+ persons with diabetes
Personal Foot care Training and Advice	Available to all Care Staff, patients, carers, family and friends.
Core Podiatric Intervention	600+
Falls Prevention / Awareness	Potentially all relevant “at risk of falls” patients, plus Otago programme.
Provision of “in-shoe” devices	Demand led
Speech and Language therapy	
Adult patients including voice and neurological conditions	46
Adults with learning disability	21
Children under school age	103
School age children	202
Total new referrals in 2018	191

Outcomes Framework

The IJB Commissions Allied Health Professionals in line with the general Health and Wellbeing Outcomes.



In order to capture the whole population / whole system approach, the outcomes are based on the Canterbury, New Zealand Health System Outcomes Framework. (http://ccn.health.nz/Resources/OutcomesFramework.aspx)


Access and Waiting Times
Eg Falls Prevention
Technology Enabled Care
Decreased Institutional Rates
No harm or needless death
Fewer People Need Hospital Care
Decrease Acute / Increase Planned Care
Decrease Adverse Events
Death with dignity
We Live Longer Health Lives: Individuals and families thrive and reach their full potential
People are supported to live well
Decreased Wait Times
Decrease Avoidable Mortality
People are seen and treated early
Living within our resources
Equity
Delayed / Avoided Burden of Disease and Long Term Conditions
No Wasted Resource
Improved Environment supports Health and Wellbeing

Allied Health Professionals Performance Data

Note: Project to implement an electronic record keeping system is underway; this will permit performance to be measured against the Allied Health Professional National Dataset
https://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/Allied-Health-Professionals-National-Dataset/_docs/AHP-Operational-Measures-Dataset-v1.pdf

Category	Indicator	Target	Current Performance	Improvement Actions /Notes
Dietetics				
Waiting times	18 week Referral to treatment	90% seen within 18 weeks	84% seen within the target time	Continue to streamline service provision
Occupational therapy				
Waiting times	Critical – 2 week referral to assessment	90% within 2 weeks	Waiting for information from SWIFT team	Improvement activity underway across all waiting times for assessment 90% within time limit
	Substantial – 6 week referral to assessment	90% within 6 weeks	As above	As above
	Moderate – 12 weeks referral to assessment	90% within 12 weeks	As Above	As above
Orthotics				
Waiting times	4 week Referral to treatment	90% seen in 4 weeks	73%	Difficult to attain 90% in a single handed post around Annual Leave and cover for Orkney
Decreased waiting times	DNA rate Shetland	5%	6%	Work towards reduction through use of Patient Focussed booking
Service effectiveness	Pain	50%	Data	Awaiting

	scores	reduction in pain scores at 6 week review.	collection under review	electronic record keeping system to allow regular audit.
Physiotherapy				
Waiting times	MSK: 4 week referral to first contact	90% seen in 4 weeks	March 2019 97%	
	Non-MSK: 18 week referral to first contact	90% seen in 18 weeks	March 2019 100%	
Podiatry				
New Outpatients	18 weeks referral to treatment	90%	98%	Continued vigilance of and caseload/workload management. Flexibility in clinical priorities. Requires continual development of team members.
New MSK patients	4 weeks referral to treatment	90%	79%	As above.
Speech and Language therapy				
Waiting times	Referral to treatment	18 weeks	166 patients in total 65% within 6 weeks 92% within 12 weeks 99.4% within 18 weeks	SLT staff on maternity leave for periods of time in 2018 resulted in reduced capacity – see improvement plan for alternative ways of working

Resources

NHS Shetland services are estimated to cost £1,360,831 in 2019-20.
Shetland Islands Council services are estimated to cost £1,433,707 in 2019-20
This gives an overall budget for Allied Health Professionals of £2,794,538.

Improvement Plans

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Collaborate with colleagues in education on Emerging Literacy programme	Clare Burke	April 2019, ongoing	Prevention and Early Intervention; Ready to Act; Scottish Attainment Challenge.
Developing the Universal and Targeted levels of the SLT service through joint working with other services.	Clare Burke	ongoing	Prevention and Early Intervention
Explore alternative service delivery options including "Attend Anywhere" and intensive SLT for short periods versus less frequent input for longer periods.	Clare Burke	October 2019	NHWO 9 More efficient use of resources.
Implement actions relating to Augmentative and Alternative Communication	Clare Burke	Ongoing	Health (Tobacco, Nicotine and Care)(Scotland) Act 2016
Contribute to developments with autism spectrum disorder (ASD) and neurodevelopmental (ND)pathways	Clare Burke	April 2019 - 2020	Prevention and early intervention
Installation of 3D scanning to reduce the number of visits required by patients.	Laurence Hughes	October 2019	NHWO 9 More efficient use of resources.
Reduce DNA rate to 5% by implementing Patient Focus Booking	Laurence Hughes	August 2019	NHWO 9 Reduce DNA rate making the clinic more efficient
Ensure Brief Interventions are embedded in practice	Laurence Hughes	April 2019 ongoing	NHWO 1 – improve health and wellbeing
Undertake a service review and implement any resulting recommendations.	Laurence Hughes	April 2020	NHWO 3,9 – positive experiences and efficient use of resources
Maximise support to people with dementia and their families, partners and carers to live positive, fulfilling and independent lives. Develop and maintain the Post-Diagnostic Support Service for people with Dementia, and their carers, and scale up the implementation of	Lorna Willis	April 2019 ongoing	NHWO 1, 2, 4 & 6. Improve health and well-being, enable people to live at home, improve quality of life and support for unpaid carers

Home Based Memory Rehabilitation			
Develop a mental health OT service underpinned by the Scottish Government's priorities and commitments to improve mental health services and to promote mental wellbeing and prevent mental illness. To focus initially on intervention via Primary Care.	Lorna Willis	April 2019 ongoing, subject to identified funding	NHWO 1, 4, 5 & 6. Improve health and well being, quality of life, reduce health inequalities, and support for unpaid carers
Develop and improve vocational rehabilitation provision via the Employability Pathway, now funded by SIC under the IJB. Develop new and evidence based interventions for eligible client groups, working in partnership with CMHT, and NHS colleagues in the community.	Lorna Willis	January 2019 ongoing	NHWO 1, 4, 5 & 9. Improve health and well being, quality of life, reduce health inequalities and ensure effective and efficient practice
Implement and develop an advice and information service, with a display area of equipment for trial and demonstration, based at the ILC	Lorna Willis	Following release of funding for building alterations, this will be ongoing throughout 2019/2020	NHWO 1, 2, 3, 4 & 9 improve their own health and wellbeing, independent living, quality of life, positive experience, effective use of resources.
Develop the use of the Independent Living Centre, including an equipment display area, to allow for more accessible and flexible clinic space and provide improved options for delivery of services out with the hospital setting.	Jo Robinson, Lorna Willis, Laurence Hughes	Following release of funding for building alterations, this will be ongoing throughout 2019/2020	NHWO 1, 3, 4, 8, & 9 Improve health and wellbeing, positive experience of services, improved quality of life, engagement with work, support to continuously improve information. Resources used effectively and efficiently.
Implement recommendations from Podiatry 5 year training plan	Chris Hamer	Dec 2018 complete by 2023	NHWO 8
Build on and develop Specialist Podiatric services	Chris Hamer	Jan 2019 ongoing	NHWO 1-9
Develop the orthopaedic triage VC clinic	Chris Hamer	Oct 2018 Ongoing	NHWO1,3,4,5,9
Continue to monitor and instigate effective and efficient	Chris Hamer	Nov 2018 ongoing	NHWO 1-9

models of practice delivery			
Devise and implement Tier 3 weight management pathways	Stefanie Jarzemski	Complete by March 2020	NHWO 1 & 2 Improve their health and well being, enable living at home
Complete review of NHS Shetland/ SIC Nutrition Policy	Stefanie Jarzemski	Complete by March 2020	NHWO 1, 2 & 7 Improve their health and well being, enable living at home, safe from harm
Implement an Oral Nutritional Supplement Pathway	Stefanie Jarzemski	Complete by March 2020	NHWO 1 & 2 Improve their health and well being, enable living at home
Explore reasons for high DNA rate in MSK service	Fiona Smith	Currently under review (May 2019)	All (1-9)
Establish physiotherapy support for rheumatology clinics and injection therapy, including consideration of options for service continuity and succession planning			
Explore options for ensuring continuity of strong links with APP in orthopaedics in NHS Grampian, particularly with regard to clinical support and supervision			
Complete review of community physiotherapy service, including community rehabilitation and input to Intermediate Care Team			
Explore options for improving self-management and patient education			
Review line management structure for physiotherapy team			
Consider options for recruitment, and how to manage risk, if there are ongoing difficulties and gaps between supply and demand.			
Explore options for Upper Limb rehabilitation			
Explore options for MSK Advanced Practice Physiotherapist in primary care, in conjunction with national group			
Develop succession plans for retirements and consider future options for paediatric service.			

Exploration of reasons for high referral rates and appropriateness of referrals. Investigation of re-referral rates and reasons for these.			
Continue service improvement work as identified within MSK and long-term conditions teams.			
Development and training as per physiotherapy training plan	Fiona Smith	March 2020	All (1-9)

Direction from the Integration Joint Board

Health Improvement

		Direction Approved December 2017	Proposed Direction May 2019
1.	**Reference Number**	CC-61-17	CC-22-19 1.11
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	NHS Shetland	NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	**Determining health promotion priorities,** including health needs assessment, health impact assessments and meeting health improvement targets **Co-ordination of health improvement**, including building alliances for health, campaigns and projects **Consultation and advice** in the development of strategies, policies and the planning, implementation and evaluation of health improvement programmes **Professional development and training**, including specialist led courses and advice and input into training programmes **Provision of information and resources:** provision of and sign-posting to health improvement resources and information. **Research and evaluation:** in	**Determining health promotion priorities,** including health needs assessment, health impact assessments and meeting health improvement targets **Co-ordination of health improvement**, including building alliances for health, campaigns and projects **Consultation and advice** in the development of strategies, policies and the planning, implementation and evaluation of health improvement programmes **Professional development and training**, including specialist led courses and advice and input into training programmes **Provision of information and resources:** provision of and sign-posting to health improvement resources and information. **Research and evaluation:** in

		addition to researching and evaluating its own work, Health Improvement can also advise and support other individuals and agencies in Shetland. **Delivery of and capacity building of others to deliver evidence based health improvement interventions and programmes,** including work place health through the healthy working lives programme, and one to one and group programmes such as Counterweight Healthy Weight programme.	addition to researching and evaluating its own work, Health Improvement can also advise and support other individuals and agencies in Shetland. **Delivery of and capacity building of others to deliver evidence based health improvement interventions and programmes,** including work place health through the healthy working lives programme, and one to one and group programmes such as Counterweight Healthy Weight programme.
7.	**Full text of Direction**	The Health Improvement Department has the specialist role within NHS Shetland, and Shetland as a whole, in overseeing and developing health improvement. A major part of its role is developing new approaches to tackling health issues and inequalities in Shetland and developing the skills of other professionals, volunteers, agencies and organisations in promoting health. The work of the department includes: Information and advice, awareness raising, education and capacity building to tackle wider issues impacting on health using range of tools and across a range of settings i.e. schools, work places, care centres, with a proportion of settings being within health and care, and a substantial amount external to health and social care.. Delivery of range of training programmes: • Mental health first aid (adults and children versions), • Mentally Healthy	The Health Improvement Department has the specialist role within NHS Shetland, and Shetland as a whole, in overseeing and developing health improvement. A major part of its role is developing new approaches to tackling health issues and inequalities in Shetland and developing the skills of other professionals, volunteers, agencies and organisations in promoting health. The work of the department includes: Information and advice, awareness raising, education and capacity building to tackle wider issues impacting on health using range of tools and across a range of settings i.e. schools, work places, care centres, with a proportion of settings being within health and care, and a substantial amount external to health and social care. Delivery of range of training programmes: • Mental health first aid (adults and children versions), • Mentally Healthy

		Workplaces • Self-harm awareness, • Raising the issue, • Health Behaviour Change. Management, co-ordination and direct delivery of health improvement/prevention/ inequalities programmes /projects; i.e. Inequalities targeted lifestyle checks, Falls prevention programme, Health Walks, Type II Diabetes Prevention programme Direct delivery of evidence based health improvement interventions in primary care: smoking cessation, adult and child weight management programmes, Get Active (for the least active), Behavioural Activation (low level mental health support programme) and support with online Cognitive Behavioural Therapy programme. Conduct Health Needs Assessment, Health Impact Assessments and Evaluation to encourage decision makers to take decisions which increase and do not damage health, to create positive healthy environments, and reduce inequalities in health. Strategic Planning to support and influence cross-sector organisations to incorporate health improvement and public health into wider public policy. Undertake healthy public policy and strategy development (translating latest national policy into locally relevant policy), implementation and monitoring with a focus on wider determinants of health, reducing health inequalities, capacity building and individual	Workplaces • Self-harm awareness, • Raising the issue, • Health Behaviour Change. Management, co-ordination and direct delivery of health improvement/prevention/ inequalities programmes /projects; i.e. Inequalities targeted lifestyle checks, Health Walks. Direct delivery of evidence based health improvement interventions in primary care: smoking cessation, adult and child weight management programmes, Get Active (for the least active), Behavioural Activation (low level mental health support programme) and support with online Cognitive Behavioural Therapy programme. Conduct Health Needs Assessment, Health Impact Assessments and Evaluation to encourage decision makers to take decisions which increase and do not damage health, to create positive healthy environments, and reduce inequalities in health. Lead and/or actively participate in a range of local strategic and operational partnership groups representing health improvement/public health i.e. Integrated Children and Young People Forum, Active Shetland Strategic group and sub groups, Mental Health Partnership and Forum. Represent Shetland at a national level through active involvement in national forums and groups i.e. National Child and Adult Healthy Weight Leads group, National Child

		/community empowerment (topic areas: smoking; inequalities; obesity; alcohol and drugs, mental health, sexual health, healthy eating, healthy weight, physical activity). Lead and/or actively participate in a range of local strategic and operational partnership groups representing health improvement/public health i.e. Integrated Children and Young People Forum and Strategy Group, Active Shetland Strategic group and sub groups, Mental Health Partnership and Forum. Represent Shetland at a national level through active involvement in national forums and groups i.e. National Child and Adult Healthy Weight Leads group, National Child Poverty group	Poverty group *The Health Improvement Team deliver a number of other programmes/services which are funded through different routes/external funding. For example:* *Falls prevention programme*: *IJB Reserves* *Type II Diabetes Prevention programme: Scottish Government* *Healthy Workplaces: Scottish Centre for Healthy Working Lives* *Because staff work generically it is hard to separate out the funding and staffing that supports each area.*
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget £310,000 (NHS). (However, it should be recognised that the role of the department is much wider than community health and social care business and IJB direction; it covers children and families, workplaces and community-wide health improvement.)	Total Budget £224,174 (NHS). (However, it should be recognised that the role of the department is much wider than community health and social care business and IJB direction; it covers children and families, workplaces and community-wide health improvement.)
9.	**Outcomes**	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through the Shetland Community Plan, Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes.	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through the Shetland Community Plan, Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes.

		Work with partners to reduce the overall smoking rate in Shetland from 14.6% in 2019 to 5% by 2022 Work with pharmacy and other colleagues to achieve the target for the number of successful quits for people residing in the 60% most-deprived data zones in Shetland (43 quits) The smoking targets above contribute to the outcome to reduce the incidence of smoking related disease in Shetland, such as COPD, and improve healthy life expectancy. Support Primary Care, A&E and Maternity to achieve the annual target for Alcohol Brief Interventions (261), in order to reduce the burden of alcohol related disease and socio-economic costs of alcohol. Support Community Planning Partners to take action to tackle the obesogenic environment; the outcome is a reduction in numbers of adults who are overweight or obese, which will in turn contribute to reductions in Type II Diabetes, Cardiovascular Disease and some cancers. Reduce the proportion of children with their Body Mass Index outwith a healthy range (>=85th centile) (to 15% of Primary 1 children) Support partners in working towards achievement of 50% of adults meeting moderate/vigorous physical activity (MVPA) guidelines These shorter-term outcomes will contribute to an increase in Healthy Life Expectancy and wellbeing in Shetland.	Work with partners to reduce the overall smoking rate in Shetland from 14.6% in 2019 to 5% by 2022 Work with pharmacy and other colleagues to achieve the target for the number of successful quits for people residing in the 60% most-deprived data zones in Shetland (43 quits) but still waiting confirmation of target for 2019/20. The smoking targets above contribute to the outcome to reduce the incidence of smoking related disease in Shetland, such as COPD, and improve healthy life expectancy. Support Primary Care, A&E and Maternity to achieve the annual target for Alcohol Brief Interventions (261), in order to reduce the burden of alcohol related disease and socio-economic costs of alcohol. Support Community Planning Partners to take action to tackle the obesogenic environment; the outcome is a reduction in numbers of adults who are overweight or obese, which will in turn contribute to reductions in Type II Diabetes, Cardiovascular Disease and some cancers. Reduce the proportion of children with their Body Mass Index outwith a healthy range (>=85th centile) (to 15% of Primary 1 children) Support partners in working towards achievement of 50% of adults meeting moderate/vigorous physical activity (MVPA) guidelines These shorter-term outcomes will contribute to an increase in

			Healthy Life Expectancy and wellbeing in Shetland.
10.	**Performance monitoring arrangements**	Quarterly Reporting in accordance with the Health Improvement and Public Health Performance Framework	Quarterly Reporting in accordance with the Health Improvement and Public Health Performance Framework Annual Public Health Report on focused topic.
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Health Improvement

Service Model

The service model and indicative activity levels (where available) for services to adults are shown below. This is the service model that the IJB is commissioning directly from NHS Shetland.

The Health Improvement Team provides one-to-one support in health centres for smoking cessation, weight management, increasing physical activity, treatment for mild to moderate depression. The staffing and funding described in this direction covers the whole population of Shetland, including all children, and every setting including hospital, workplace, schools, community and not just community health and social care settings.

The Health Improvement Team have an office base in the Grantfield Office, Lerwick. Band 5 Health Improvement Practitioners spend regular hours in each Health Centre in Shetland in order to support patients with health behaviour change, and to support primary care services to work towards a more preventative agenda. The aim is to work towards health centres providing health improvement interventions themselves through their current staff (creating capacity within the health improvement team to work with communities, workplaces, businesses, vulnerable groups and decision makers).

The number of people supported by this service has increased significantly in recent years; this is mainly because the remits of the health improvement practitioners have developed; for example, taking on delivery of Behavioural Activation, facilitation of Beating the Blues, and development of physical activity brief interventions, all aimed at preventing future ill health and potentially reducing the level of demand for GP services.

Future forecasts.....

It is likely that the work on weight management and increasing physical activity will increase over the next few years. Current GP data identifies 4559 adults over the age of 18 in Shetland who are at risk of Type II Diabetes, according to BMIs recorded in the past 3 years.

The smoking rate for Shetland is 14.6, but in order to meet the challenging locally set target, the numbers being referred in smoking cessation services will have to increase.

Low level mental health issues show no sign of reducing.

The following table presents a picture of service activity from April 2018 to March 2019, but cannot capture all the work that is undertaken by the team.

Current Activity	**Numbers Service Users**
Smoking cessation service	157 clients, up to 12 sessions per client
Counterweight Weight Management Programme	130 clients with at least 9 sessions per client
Physical Activity Brief Advice	3 sessions per client
Physical Activity Assessments	300
Beating the Blues	145 clients supported
Behavioural Activation	
Alcohol Brief Interventions	130
Training	
Walk Leader Training	17 community members trained
Mentally Healthy Workplace Training	68 participants
Mental Health First Aid/ Self Harm awareness	98 participants
Sexual Health and Relationships Education	14 participants
Counterweight	3 staff members trained
Malnutrition Universal Screening Tool (MUST)	12 Care home staff trained
Brook Traffic Light Training	14 participants
Projects and Programmes	
Health Walks Programme	
Workplace Wellbeing/Healthy Working Lives Programme	
Smoking cessation service – continual improvement/updating of protocol and procedures	
Development of Type II Diabetes Programme	
Support for Scalloway over 60s project	
Leading of Exemplar Physical Activity Employer Award Programme	
Support for Shetland Mental Health Forum	
Supporting the role out of Nature Prescriptions.	

Outcomes Framework

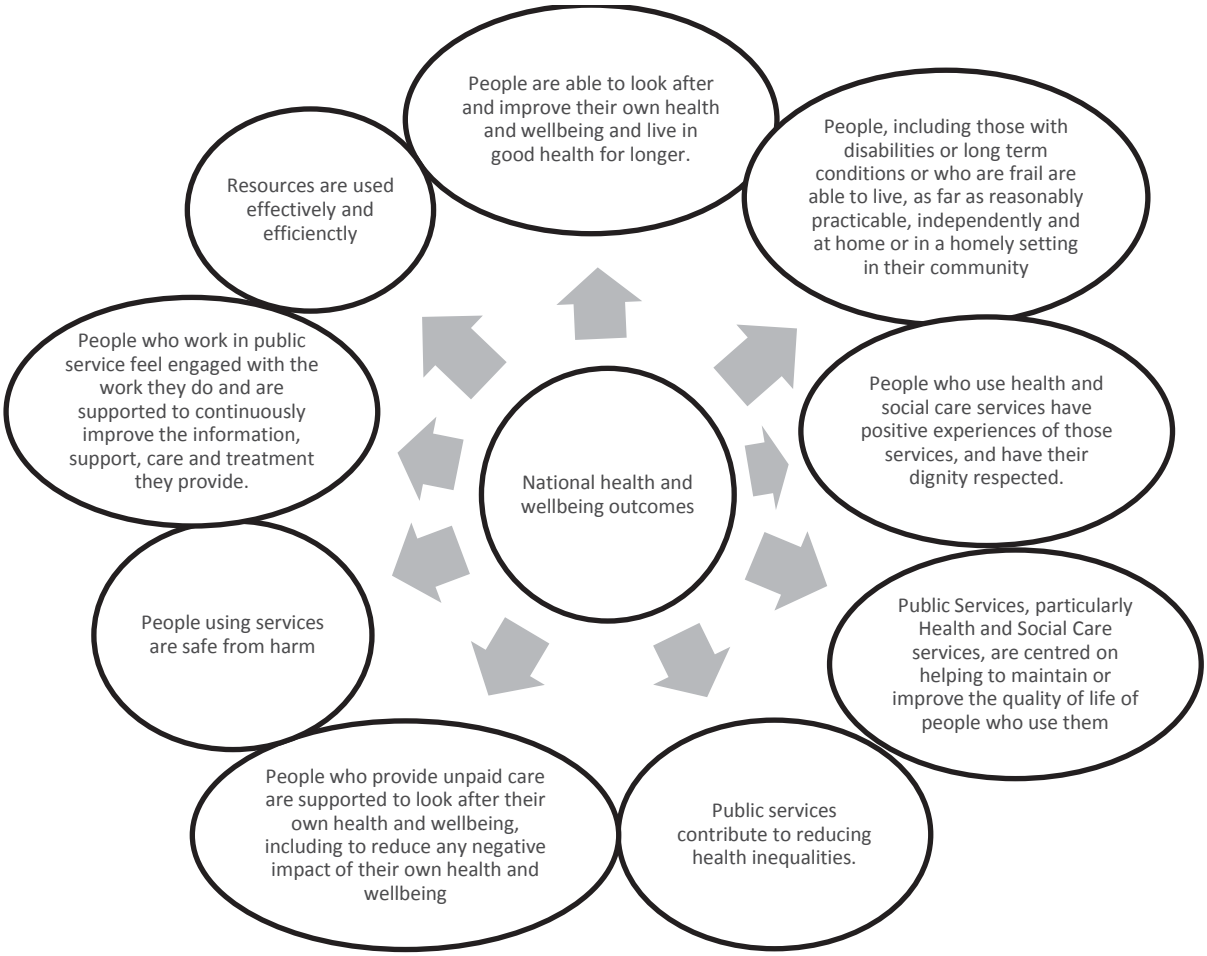
The IJB Commissions Health Improvement Services in line with the six priorities for Public Health and the general Health and Wellbeing Outcomes.

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

- A Scotland where we live in vibrant, healthy and safe places and communities.
- A Scotland where we flourish in our early years.
- A Scotland where we have good mental wellbeing.
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.

- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
- A Scotland where we eat well, have a healthy weight and are physically active.

The Health and Wellbeing Outcomes are:



Resources

NHS Shetland Health Improvement services are estimated to cost £224,174 in 2019-20.

Improvement Plans

In 2019-20, the Health Improvement Team intends to undertake the following improvement activity:

- Building capacity across NHS and IJB for prevention by:
- Increasing prevention agenda input into staff induction and CPD for other professional staff e.g. AHPs, social care, primary care staff
- Reviewing skill mix of staff to potentially create a tiered model of staff who are qualified to deliver health behaviour change
- Continue to implement programme of succession planning within team; this includes recognition of need for ongoing maternity covers given staff demographics.

Direction from the Integration Joint Board

Hospital Based Services

		Direction Approved December 2017	Proposed Direction
1.	**Reference Number**	CC-61-17	CC-22-19 1.12
2.	**Date Direction issued by IJB**	19 December 2017	14 May 2019
3.	**Date from which Direction takes effect**	19 December 2017	14 May 2019
4.	**Direction to:**	NHS Shetland	NHS Shetland
5.	**Does the Direction supersede, amend or cancel a previous Direction – if yes include IJB reference number**	No	Yes, CC-61-17
6.	**Functions covered by the Direction**	<u>Renal Services</u> Renal Services are part of the Set Aside services. Renal Services will have an element of planned care and an element of unscheduled care. • Haemodialysis • Holiday Dialysis • Peritoneal Dialysis • Pre Dialysis Education • Transplantation <u>Sexual Health</u> The Sexual Health Services are part of the Set Aside services. Sexual Health Services will have an element of planned care and an element of unscheduled care. • Sexual Health and Wellbeing (SHWB) Clinic • Primary Care • Health Visiting and School Nursing • Secondary Care / Hospital services • Health Improvement / Public Health • Services for Children and Young People (up to age 25)	<u>Renal Services</u> Renal services include a planned outreach renal clinic from NHS Grampian and a local Dialysis unit, which is a satellite of the NHS Grampian service. The Dialysis Unit provides: • Haemodialysis • Holiday Dialysis • Peritoneal Dialysis • Pre Dialysis Education The only unscheduled aspect of the service is the delivery of holiday dialysis to patients visiting from other parts of the UK. There has been a considerable increase in the need for dialysis in Shetland and investment in the unit to increase the number of dialysis stations was completed at the end of 2018-19. Further investment in the workforce to support dialysis is required from 2019-20 onwards, which is not currently

		• Drug and alcohol services <u>Unscheduled Care</u> Unscheduled care takes place across community, hospital and specialist settings. This Direction is in respect of Unscheduled Care in the hospital setting, part of the 'Set Aside' services. The majority of healthcare functions within the wider healthcare system have an unscheduled care response or pathway, but the main ones covered by this Direction are defined as: • Accident and Emergency Services • Acute Inpatient Medical Services • Acute Inpatient Surgical Services • Critical Care Services • Theatre Services • Obstetric Services • Emergency Service provision at NHS Grampian for patients requiring specialist interventions • 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. Out of Hospital services such as Community Nursing and Primary Care services also provide an Out of Hours Service.	in the established funding for the service. <u>Sexual Health</u> The Sexual Health Service includes: • A Sexual Health and Wellbeing Clinic (delivered in the hospital setting) • Family Planning Service (delivered in the hospital setting) • Contraceptives (provided in Primary Care) • Health Screening following Rape or Sexual Assault (delivered in the hospital setting) • Health Improvement and Education provided by a wide range of professionals including: GPs, Midwives and School Nurses The sexual health strategy sits in the Public Health portfolio <u>Unscheduled Care</u> Unscheduled care takes place across community, hospital and specialist settings. This Direction is in respect of Unscheduled Care in the hospital setting. The majority of healthcare functions within the wider healthcare system have an unscheduled care response or pathway, but the main ones covered by this Direction are defined as: • Accident and Emergency Services (Including Mental Health and Paediatrics) • Acute Inpatient Medical Services
7.	**Full text of Direction**	Patients who present to unscheduled care services	Patients who present to unscheduled care services

		have undifferentiated health needs, ranging from self limiting conditions such as minor ailments through to serious and life threatening illness and injury. There is also an increasing trend in the number of people presenting to emergency services with psychosocial issues and secondary problems such as substance misuse. Unscheduled care services are largely open access e.g. A&E, NHS 24 liaison with primary care services etc. Criteria are applied to prioritise patients in line with the likely severity of their clinical conditions. For instance A&E staff use a triage system to determine patient urgency (the Manchester Triage Tool is used in Shetland) and the Therapeutic Intervention Scoring System (TISS) is used by medical and critical care teams to determine if a patient has high dependency care requirements. In order to ensure that we can deliver safe emergency care service provision across the whole system, we have developed the LUCAP (Local Unscheduled Care Action Plan) to look at ways in which we can manage patients in the 'right place, at the right time, with the right practitioner'. This action plan along with the Older People's Strategy, Primary Care Strategy and Dementia Strategy will help to set the direction for the shape of services, including appropriateness and eligibility for different care settings. Particularly, promoting the development of community based services to support people who do not need to access acute hospital or	have undifferentiated health needs, ranging from self limiting conditions such as minor ailments through to serious and life threatening illness and injury (i.e. trauma). Unscheduled care services are largely open access e.g. A&E, NHS 24 liaison with primary care services etc. In order to ensure that we can deliver safe emergency care service provision across the whole system, we have developed the Unscheduled Care Action Plan to look at ways in which we can manage patients in the 'right place, at the right time, with the right practitioner'. This action plan along with the Older People's Strategy, Primary Care Strategy and Dementia Strategy will help to set the direction for the shape of services, including appropriateness and eligibility for different care settings. Particularly, promoting the development of community based services to support people who do not need to access acute hospital or specialist services.

		specialist services.	
8.	**Budget allocated by IJB to carry out Direction.**	Total Budget Unscheduled Care £3,190,000 Renal £145,000 Sexual Health £38,000	Total Budget Unscheduled Care £ 2,864,454 Renal £201,524 Sexual Health £44,813
9.	**Outcomes**	There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems Delayed Discharges Total Delayed Discharges No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs A&E 4 Hour waits 48 hour Access – GP Practice Team Advance booking – GP Practice Team Level of Older People with Complex Care Needs Receiving Care at Home Rate of attendance at A&E Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes	There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems Delayed Discharges Total Delayed Discharges A&E 4 Hour waits Rate of attendance at A&E Rate of emergency patients admitted to hospital Number of presentations 'Out of Hours' (OOHs) Number of children admitted to hospital (and length of stay) Average length of stay in hospital Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way through Our Plan 2016-2020, Shetland's Corporate Plan; the Joint Strategic Commissioning Plan and the National Health and Wellbeing Outcomes
10.	**Performance monitoring arrangements**	Quarterly Reporting	Quarterly Reporting
11.	**Date of review of Direction**	By March 2018	By March 2020

Shetland Islands Health and Social Care Partnership
Direction for Hospital Based Services (Unscheduled Care, Renal Services and Sexual Health)

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.

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
- Developing Alternatives to Hospital Care (e.g. enhancing community based service provision)

Current Services Provided

The majority of healthcare services have an unscheduled care pathway, but the main ones can be defined[1] as:

[1] 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.

- **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
- 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.

Other services which are subject to joint commissioning arrangements include: **Sexual Health, Renal, Medical Outpatient Services.**

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. the Scottish Access Collaborative
- Strategic plans to support palliative and end of life care

Plans for Change

In 2018, NHS Shetland consistently met the target for 4 hour maximum wait in A&E with an average performance of 96.4% However, achieving the target has been more challenging at times during 2018-19, because we have seen an increase in the clinical complexity and frailty of patients presenting at A&E and this has had a wider impact on patients across the hospital system. We have also seen a significant increase in the use of locums to supplement the Consultant workforce, where we peaked at 45% of Consultant posts vacant during 2018. This has also had an impact on thresholds for admission and transfer to specialist services, but access to A&E and overall emergency demand has remained good.

As part of the winter planning review process and actions to support unscheduled care services, we have seen the positive impact of the development of community based services, which has reduced A&E attendances and inpatient admissions by increasing the range and availability of anticipatory care in localities.

We continue to align our unscheduled care plans with work streams focussing on safety and prevention e.g. community based falls assessment and physiotherapy led education programmes, hip fracture management and early supported discharge.

Plans for 2019-20 include

- Using the Integration Fund to ensure that there are robust and responsive community services and hospital admissions only happen where appropriate. Focus on reducing lengths of stay in hospital, better liaison between community and hospital services and looking at early intervention available in A&E.
- Clear pathways for further/specialist assessment of conditions of old age in the community setting e.g. dementia through Community Mental Health/Dementia Liaison Services.
- Further develop the advanced practitioner model to support primary care settings (including remoter localities in Shetland) and the emergency practitioner role in the Hospital.
- Undertake an options appraisal to determine how best to deliver healthcare services OOHs and overnight – with greater integration of hospital and primary care teams and identification of ‘whole system’ solutions.
- Further developing locality based services (multi-agency) where 24/7 care is delivered, including support if a person has escalating care needs.

- Using the pilots for locality working to redefine the care at home services, using integration as the driver for improving capacity and responsiveness.
- Further developing intermediate care pathways to enhance the availability of community based rehabilitation.
- Further developing early supported discharge from hospital (e.g. in conjunction with the intermediate care team in the community) and co-ordination of the discharge planning process to reduce patient flow pressures.
- Further developing the model for anticipatory care planning to support locality based decision making and consistent delivery of care plans already agreed.
- Putting a local emphasis on developing shared information systems, records and assessments to reduce duplication and support decision making.
- Continuing to work with the Scottish Ambulance Service to put into place the actions agreed in the Strategic Options Framework.

Risks/Challenges

- Our workforce is made up of many small teams and that means some services remain fragile – we will need to reconsider some of the models that we have in place e.g. where we have single handed practitioners to ensure that we can continue to deliver safe services. This is an issue across health and social care, but is a particular challenge when considering services in the community including those supporting very remote communities.
- Affordability of the current models is a key challenge because of the diseconomies of scale across services. For example, there is a reliance on locums to cover key GP and hospital doctor posts that are critical for the provision of safe services; however this is not a financially sustainable option.
- We will need to determine at a strategic level what the balance of locality based services and centralised services we need to deliver services safely and affordably – our overnight care services (social care, community and primary care) are largely based on models using ‘on call’ staffing. Developing hub and spoke models to increase and enhance overnight care will need to be considered in order to deliver sustainable services for the future along with a change in the skill mix.
- We will need to develop a clear e-health strategy which focuses on technology enabled care – to support decision making and create opportunities for connecting locality based services with secondary and specialist care services.
- We will need to develop a clear approach and strategic plan to support self directed care and self management. The ANP model has helped to support increased capacity and access to primary care services; we have completed a service needs analysis to describe how we can develop the model across Shetland over the next 4 years.
- There is more work to do in developing our signposting, redirection and health education/awareness services to ensure that the public know what services are available, when they are available and how to access them appropriately.

Targets/Outcomes

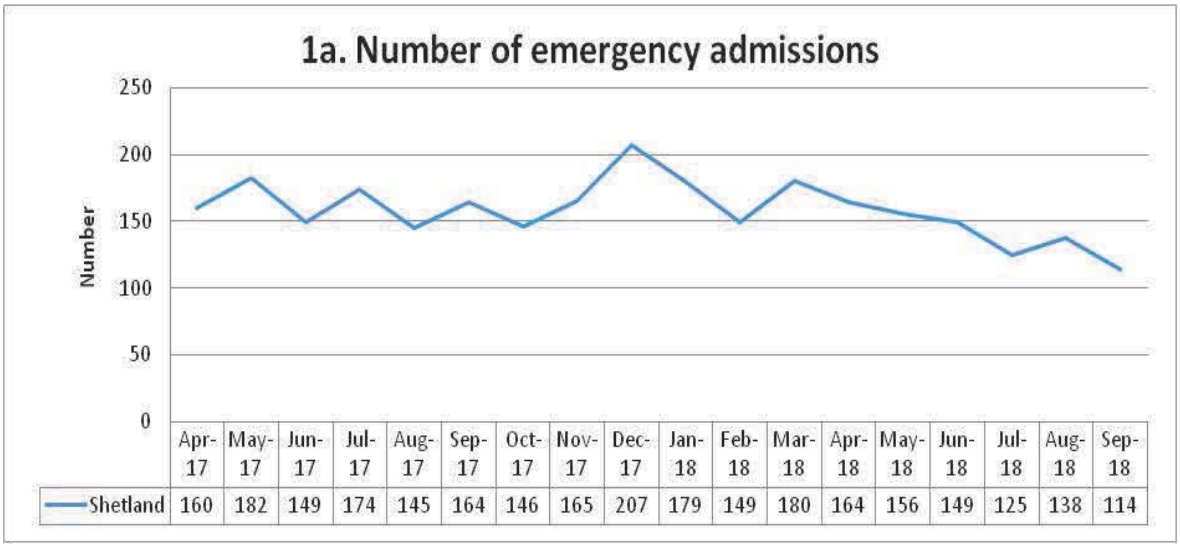
The Scottish Government supports a focus on key service areas through the use of performance indicators covering:

- Number of emergency admissions
- Admissions from Accident and Emergency
- Number of unscheduled hospital bed days; acute specialties
- Number of unscheduled hospital bed days; long stay specialties
- Accident and Emergency Attendances
- Percentage of attendances at Accident and Emergency seen within 4 hours
- Delayed discharge bed days

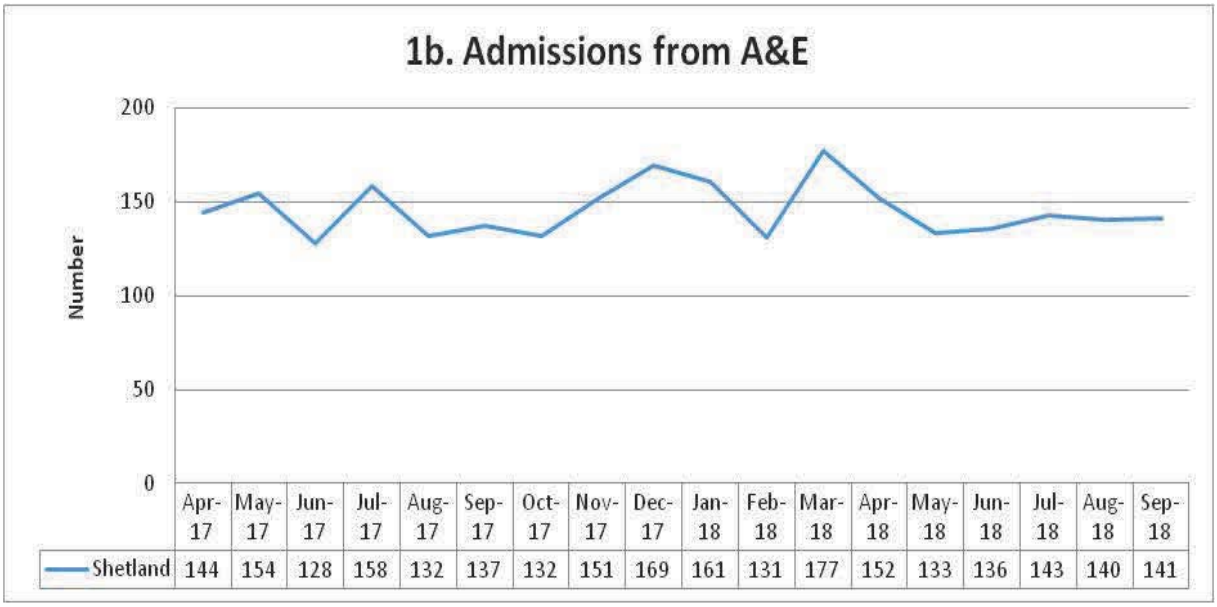
Shetland performs well across these indicators.

The section below shows the trends on each of the indicators in turn, together with an explanation of the IJB's target performance (which was approved in January 2019).

Unplanned Admissions, Performance Target - Maintain current position within Peer Group.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Shetland	160	182	149	174	145	164	146	165	207	179	149	180	164	156	149	125	138	114



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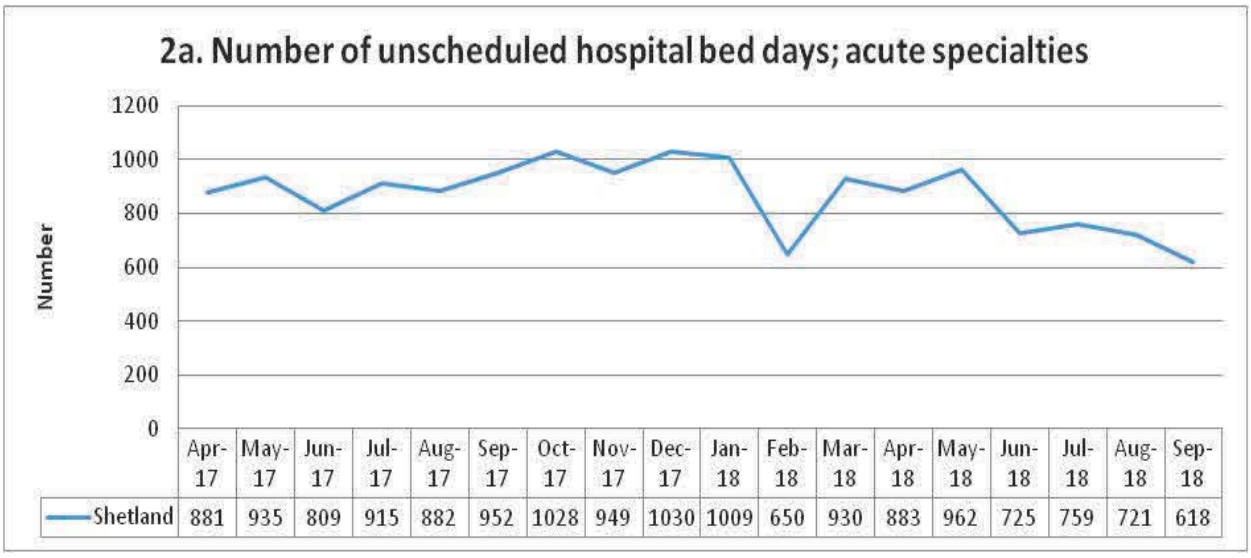
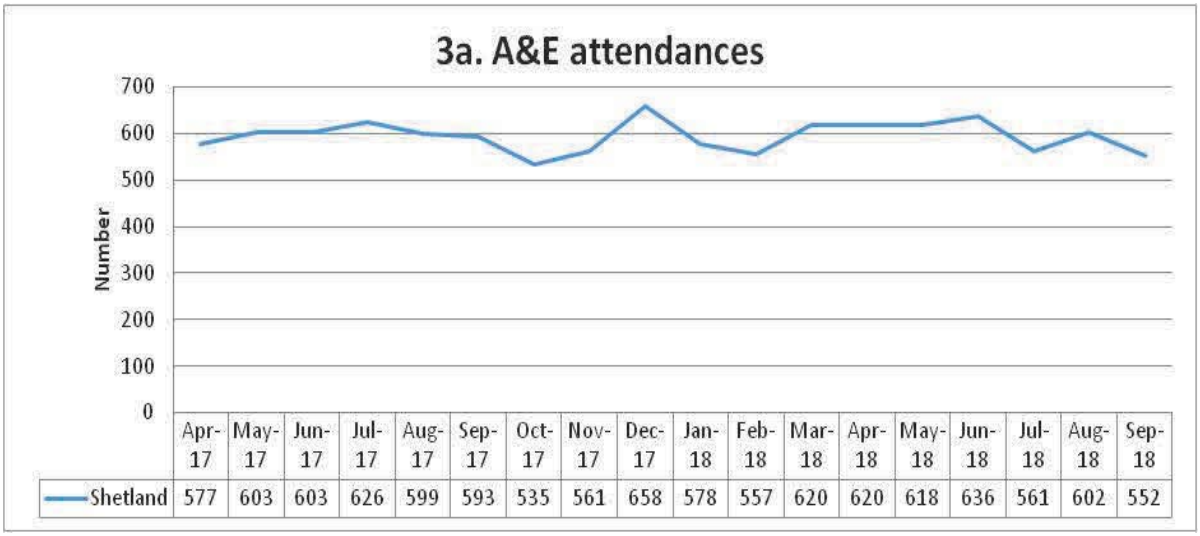
Shetland	144	154	128	158	132	137	132	151	169	161	131	177	152	133	136	143	140	141

Unplanned bed days, Performance Target - Maintain current position within Peer Group

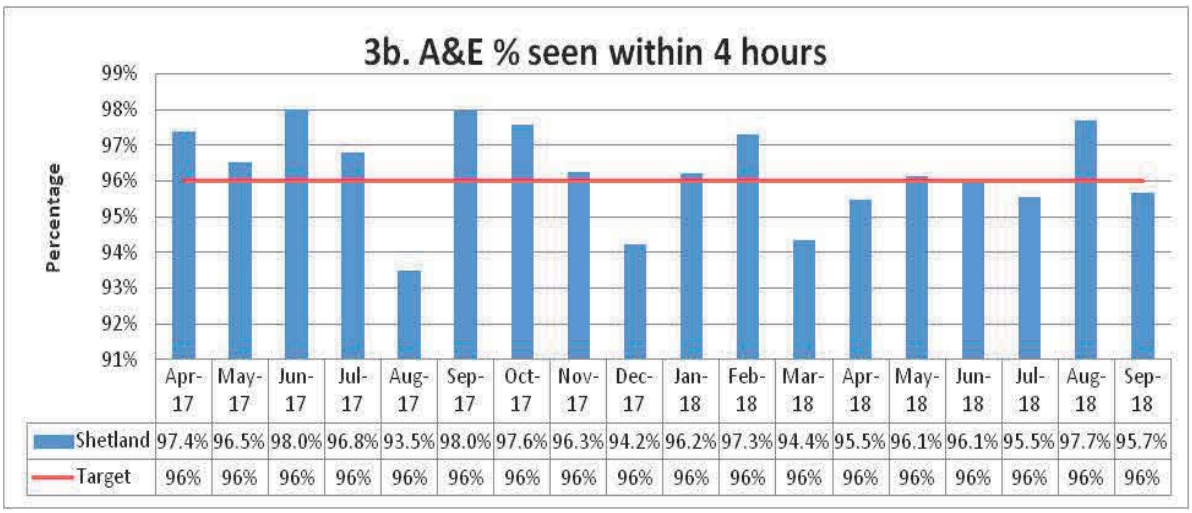


	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Shetland	881	935	809	915	882	952	1028	949	1030	1009	650	930	883	962	725	759	721	618

A&E Attendances, Performance Target - To maintain current position and achieve the 96% target by March 2019

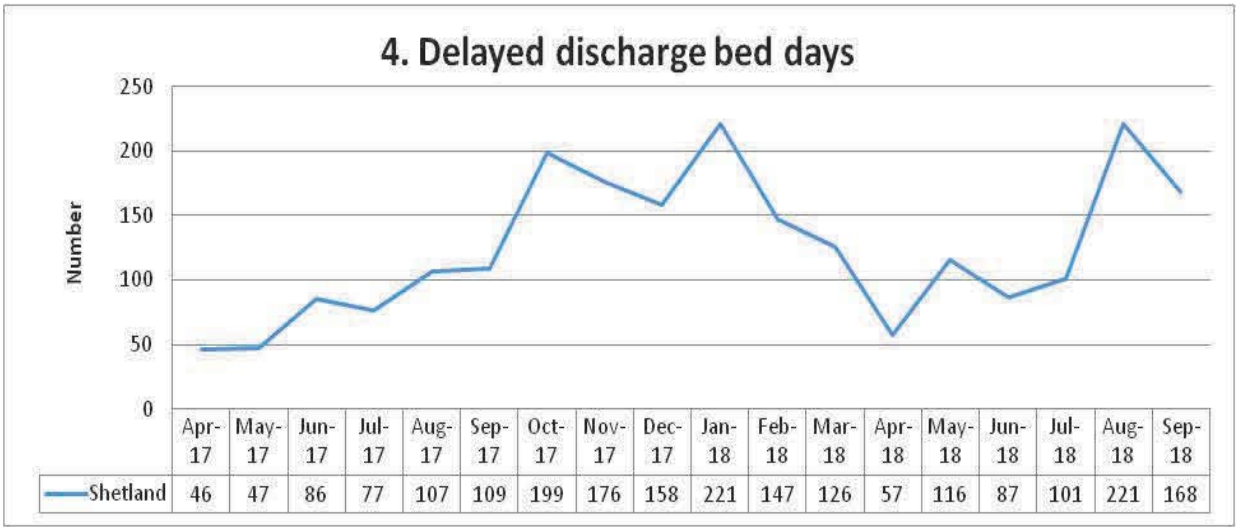


	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Shetland	577	603	603	626	599	593	535	561	658	578	557	620	620	618	636	561	602	552



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Shetland	97.4%	96.5%	98.0%	96.8%	93.5%	98.0%	97.6%	96.3%	94.2%	96.2%	97.3%	94.4%	95.5%	96.1%	96.1%	95.5%	97.7%	95.7%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Delayed Discharge, Performance Target - Maintain current performance
Note: Whilst our target is zero, 3 in number is the point at which managerial action is taken.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Shetland	46	47	86	77	107	109	199	176	158	221	147	126	57	116	87	101	221	168

Shetland Islands Health and Social Care Partnership

Agenda Item

4

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	14 May 2019
Report Title:	2019/20 Recovery Plan projects and Invest to Save Proposals	
Reference Number:	CC-20-19-F	
Author / Job Title:	Simon Bokor-Ingram/Director Community Health and Social Care	

1.0 Decisions / Action required:

That the IJB:

1.1 NOTE the detail in the plans to deliver efficiencies in 2019/20; and
1.2 APPROVE the proposals to be funded from the IJB reserve.

2.0 High Level Summary:

2.1 This report sets out the detail of plans to deliver efficiencies in 2019/20, described at a high level in the 2019/20 Budget Report brought to the IJB on 13 March 2019 (Min. Ref. 09/19), along with proposals to be funded from the IJB reserve.

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

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

2.5 A significant gap between the payment made to the IJB and the cost of delegated budgets continues into 2019/20.

2.6 The IJB approved its 2019/20 budget at a meeting on the 13 March, and sought more detail on the plans to deliver the agreed level of savings.

3.0 Corporate Priorities and Joint Working:

3.1 The proposals support the IJB's vision, aims and strategic objectives as set out in the Integration Scheme and the Joint Strategic Commissioning Plan 2019-22.

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

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

4.0 Key Issues:

4.1 Recovery Plan

The IJB approved its budget for 2019/20 in March 2019. The budget contained an efficiency target of £2.533m.

Management identified several areas where savings can be achieved in 2019/20, and the table below was presented to the IJB in the 2019/20 Budget Report at the 13 March 2019 meeting.

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

It was anticipated that the remaining gap of £0.544m would be closed by additional non-recurrent actions.

NHS Shetland have now further refined their 2019/20 budget, taking account of efficiency savings achieved in 2018/19. This has reduced the overall funding gap to £2.331m

Identified savings proposals for 2019/20 have been revised and as per the detail at 4.6 have reduced to £1.806m, leaving a further £0.525m unidentified savings to be made from additional non-recurrent actions.

The revised IJB financial position summary is shown below (£m):

Recovery Plan	£m	Recurrent (R) / Non-Recurrent (NR)
Pharmacy & Prescribing	0.227	R
Primary Care Review	0.100	R
Community Nursing	0.179	R
Vacancy Factor	0.100	NR
Assumption of SG Additional Funding (Island Harmonisation)	1.200	To be confirmed

Total		**1.806**	
	SIC (£m)	NHSS (£m)	Total (£m)
Proposed payment	22.019	23.629	45.648
Current cost of services	22.019	25.960	47.979
Funding shortfall	0	(2.331)	(2.331)

	£m
Opening Funding Shortfall	2.331
Savings Proposals	1.806
Gap Remaining	**0.525**

Favourable movement of £0.029m

4.1 **Pharmacy & Prescribing**

4 Pharmacy has a good track record of delivering savings through specific strands of work that includes tackling polypharmacy; the use of generic medicines; and supporting clinicians with prescribing decisions. A new project to reduce the costs attached to nutritional supplements has a good potential to yield savings. See appendix 1 for the detailed plan.

4.2 **Primary Care Review**

There is opportunity to streamline back office functions and make improvements to the public facing administrative functions, whilst delivering efficiencies. I.T are supporting this project, which will create better access to records across primary care to facilitate these improvements. See appendix 2 for the detailed plan.

4.3 **Community Nursing**

The service has been working to create sustainability and resilience through a redesign project over the last couple of years. During that time additional health centres came into the health board managed portfolio, and considerable time and effort has been focused on incorporating practice nursing into the community nursing service. The output of this work will culminate in efficiencies being identified for the start of the 2019/20 financial year. See appendix 3 for the detailed plan.

4.4 **Mental Health SLA**

Recurrent savings of £100k were made against the Mental Health SLA in 2018/19. In the refinement of NHS Shetland savings proposals for 2019/20 it is felt no further savings can be made in this area at this time.

4.5 **Vacancy Factor**

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

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

With the receipt of £1.2 million as a non recurrent sum in 2018/19, we are

assuming at least a further non-recurrent allocation in 2019/20. We will also be seeking agreement on a recurrent sum for future years to fully recognise the cost of primary care. Discussions with the Scottish Government Primary Care Directorate are ongoing.

4.7 **Proposed use of IJB reserve**

The proposals to utilise the IJB reserve are contained at appendices 4, 5, 6 and 7**.** The proposals support the drive for better outcomes that will also make the way of working more efficient. These tests of change are vital for transforming how we deliver services to our population with the challenges we have around workforce and available financial resources. These tests of change aim to drive up quality and safety, whilst being more efficient, and support the redesign projects outlined earlier in this paper. The proposals can be summarised as follows:

Project	**Objective**	**Link to outcomes**	**Cost**
Stress Control (Appendix 4)	Greater community resilience	People are able to look after and improve their own health and wellbeing	£25,000 (delivered over 3 years)
Alternative to residential care accommodation (Appendix 5)	Greater choice and control for individuals	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonable practicable, independently at home or in a homely setting in their community	£12,172 (delivered over 3 years)
MSK Physiotherapy (Appendix 6)	Faster access to the most appropriate professional	Resources are used effectively and efficiently	£51,000 (2019/20 only)
Community Nursing Continence Service (Appendix 7)	Better quality and more efficient service	Public services, particularly Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use them	£8,750 (2019/20 only)

As at 31 March 2018 the IJB had a Reserve balance of £364,000 with £51,000 already committed. The total of the proposals made in this report amount to £107,322. Two of the four initiatives would be funded for 3 years. It should be noted that a further proposal for use of £26,460 from the IJB Reserve is presented in a separate report on today's agenda.

5.0 Exempt and/or confidential information:

None

6.0

6.1	**Service Users,**	Changes to budgets will occur as efficiency schemes are

Patients and Communities:	developed to address the current funding gap. Service change will require a separate process for public and user engagement in line with NHSS, SIC and IJB policies.
6.2 Human Resources and Organisational Development:	Any service development proposals or changes affecting staff will be subject to full staff engagement and consultation with staff and their representatives through the Joint Staff Forum and other consultation committees in line with the relevant agencies policies and procedures.
6.3 Equality, Diversity and Human Rights:	None arising directly from this report. Any equalities impacts will be assessed and considered as part of any proposals for change and schemes for efficiency savings.
6.4 Legal:	The proposals in this report are consistent with the Public Bodies (Joint Working) (Scotland) 2014 Act and the Integration Scheme for Shetland's IJB.
6.5 Finance:	The IJB approved its 2019/20 Budget in March 2019. The budget contained an efficiency target of £2.533m and IJB Members requested further detail of how those savings would be made in year to be presented at a future meeting. The IJB is required to have a Recovery Plan to address any identified forecast budget overspend. The proposed funding allocations from the Parties have been revised since the budget was approved and the funding shortfall has been reduced to £2.331m. Proposals have been made which are hoped to address £1.806m of the shortfall, with the remaining £0.525m expected to be met from further non-recurrent saving actions. Detail of the identified proposals is presented in this report. As at 31 March 2018, the IJB has a Reserve balance of £364,000, of which £51,000 has been committed. Proposals are made in this report to commit a further £107,322 from the Reserve. A separate report on today's agenda requests the use of £26,460 from the IJB Reserve.
6.6 Assets and Property:	None arising directly from this report as the IJB doesn't own any assets or property. Both partner organisations have policies and procedures in place which govern their assets and property.
6.7 ICT and new technologies:	None arising directly from this report.
6.8 Environmental:	None arising directly from this report.
6.9 Risk Management:	Should there be year-end overspends on IJB budgets and the Parties do not agree to provide additional funding there could be a financial risk to the IJB. Considering the fact that the SIC arm of the budget is fully funded and that NHSS has agreed to provide additional funding the risk is considered low, however the risk is predicated on the IJB achieving the level of efficiency described in this report.
6.10 Policy and Delegated Authority:	The IJB has authority from SIC and NHSS for the services delegated to it as per the Integration Scheme. The IJB must direct service delivery, within its funding allocation, to deliver the outcomes of the Strategic Commissioning Plan.
6.11 Previously	The proposals in this report were presented at a strategic level

considered by:	to the IJB on 13 March 2019.

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Appendices:

Appendix 1 Prescribing savings plan
Appendix 2 Primary Care Project Savings
Appendix 3 Community Nursing Re-design
Appendix 4 Stress Control bid
Appendix 5 Alternative to residential care accommodation bid
Appendix 6 MSK Physiotherapy bid
Appendix 7 Community Nursing Continence Service bid

PRESCRIBING SAVINGS PLAN

DATE – 25.04 2018

INTRODUCTION

The prescribing savings plan for 2019-20 is part of a long term savings programme, the paper describes the approach to making savings. Using the SMART acronym the challenges of making specific savings, which can be measured and attained in a way that is relevant to the directions of the IJB within the constraints of a timeframe are explored in the paper.

SERVICE DESCRIPTION

Staffing resource

The pharmacy staff work in an integrated way across Primary Care ad he hospital, with some of the staff the staff designated to Primary Care also providing cover within the hospital. Of the pharmacy budget (6.6M) around 6M is spent on medicines, and 0.5M on staff. When not providing cover elsewhere in the service, 3WTE pharmacists and 1WTE technician are occupied within Primary Care. Two of the pharmacist posts are funded by SG as part of the pharmacotherapy service. Half the technician post is funded by SIC to train Care staff and to help individuals with medicine management. There is only limited scope therefore to release pharmacy staff to undertake savings work. There is no dedicated data analysis, in order to measure savings.

Financial resource

Medicine budgets are set by the Shetland Health Board each year and uplift on the previous year's spend is based on the growth in prescribing. This has proved an effective methodology for budget setting over the years, and while other boards have tried to anticipate spend based on horizon scanning of new drugs and new uses for medicine, this methodology has not proved to be accurate except in the largest Boards. With so many variables using horizon scanning methodology for prediction of medicine spend in Shetland is not accurate.

The problem however with the Shetland methodology of budget is in designating the savings made each year as recurring. This assumption requires more hours each successive year to maintain the historic savings already made. So for example if a patient on many medicines is reviewed, the patient may well end up with fewer medicines. A year later some of the medicines stopped, together with some new medicines may well have been added back in, so only some of the savings are recurrent.

Making savings

Only the simplest of savings, for example switching a medicine from a more expensive product to a cheaper one can be made in year, more complex savings such as an agreed approach in prescribing inhalers will only result in savings after two years or so. There is a long term prescribing savings strategy in place which recognises the importance of concentrating on realistic medicine and patient safety. It is accepted across the UK that the best way to make long term savings safely is to prioritise approaches which tackle safety as much as savings, this is co-production: allowing pharmacists to concentrate on their

key skills of maximising benefits from treatment, while keeping patients safe from the harm caused by medicine and at the same time releasing savings.

The new savings target for 2019-20 is £150,000, the savings achieved last year according to finance calculations were £196,000, the target being an ambitious £272,594. This means that the unachieved savings added to the 19/20 target now requires savings of £226,594.

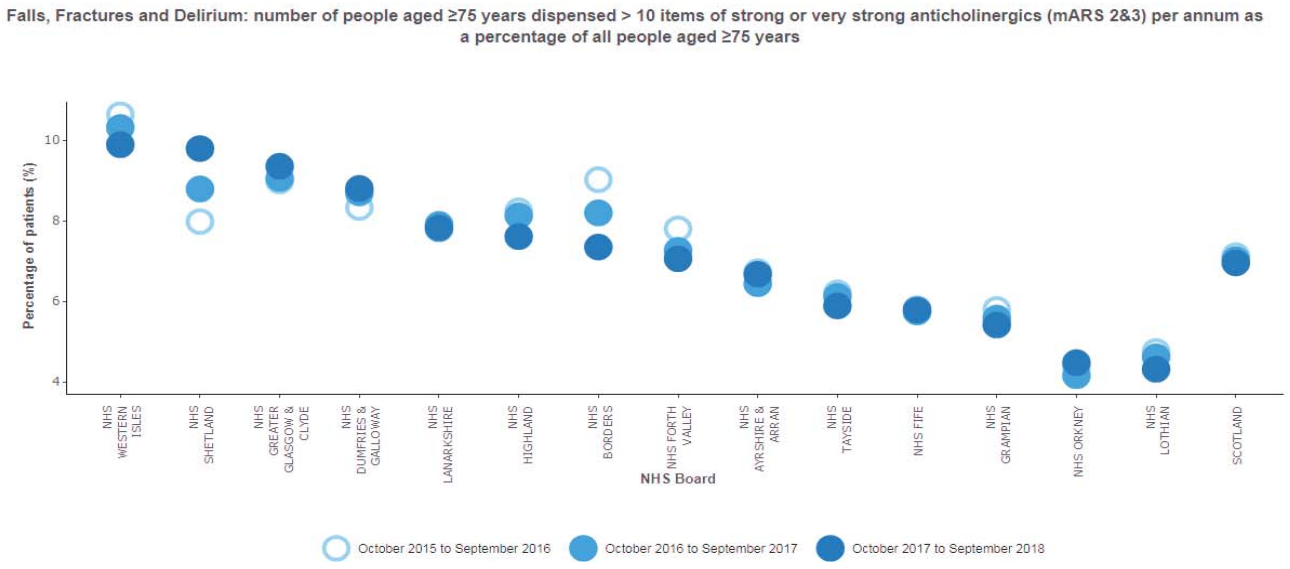
SPECIFIC

Each year within the priority workstreams specific projects are agreed within the pharmacy team. A mixture of quick wins and safety driven projects are considered. Studying prescribing data helps to prioritise effort. A few of these workstreams are now described.

Polypharmacy

For example, at the recent realistic medicine symposium one of the primary care pharmacists presenting encouraged prescribers to work with pharmacy to safely reduce the number of medicines with anti cholinergic side effects (this side effect causes falls among other things) so the saving is much more than just on the medicine. In Shetland our prescribing of these potentially harmful medicines in the over 75 year olds has increased over the last three years. (see figure 1) Often more than one medicine with anticholinergic side effects is taken – a polypharmacy effect. Reduction in prescribing in these areas will potentially improve outcomes for patients and save a small amount on the medicine budget . So this is a priority, although from a purely medicine savings effort it might not seem a good use of pharmacy hours.

Figure 1



Polypharmacy is the concurrent use of multiple medications by one individual, an increasingly common phenomenon that demands attention, there is a growth of an ageing population and the rising prevalence of multi-morbidity. Recently a more pragmatic approach to reduce the burden of medicines is being introduced and the terms 'appropriate' and 'problematic' polypharmacy help define when polypharmacy can be beneficial. For many people, appropriate polypharmacy will extend life expectancy and improve quality of life. Here medicines are being optimised and continue to be prescribed according to best

evidence. In problematic polypharmacy there can be an increased risk of drug interactions and adverse drug reactions, together with impaired adherence to medication and quality of life for patients. Evidence shows many dispensed medicines remain unused or are wasted patients may struggle with complex drug regimens; their perspective on medicine-taking as described in realistic medicine requires a greater involvement of pharmacists and technicians. There is a reliance on co-production as there are still a limited number of pharmacy staff available to undertake this direct engagement with patients.

Respiratory There are significant clinical benefits if patients use the correct and cost effective inhaler in the right way. Avoiding wastage will save money. A key priority in this area is the reduction in the use of high strength inhaled corticosteroids; this has significant safety and clinical benefits for benefits for patients. This work is time consuming and to move this workstream on a little we plan to use a community pharmacist in the Lerwick health centre later in the year with a prescribing qualification to help with this activity. Most of the savings from this work will begin to be realised in 20-21

Diabetes Diabetes is a large multidisciplinary project which has been adopted and scrutinised within the realistic medicine programme. Large savings are being made with this work mainly through rationalisation of test strips. The new technologies such as Feestyle libre are revolutionising the lives of Type 1 diabetics. Overall the costs of managing diabetes will rise in Shetland, but clearly savings will need to be made.

Pharmacotherapy This work in GP practices is largely funded through specific Scottish Government, this work is not intended primarily to produce savings, it is about bringing the specific and unique skills of pharmacists and pharmacy technicians into the Primary Care Team, increasing benefits for patients and reducing workload for GPs. However it does produce savings in the medicine budget, reducing waste and avoidable costs. The utilisation of pharmacists will produce efficiencies in Primary Care particularly as we move towards a single system of working.

C**urrent Savings projects**

Area of savings	**Priority Projects 19-20**	**Anticipated annual (not neccessarily 19-20) savings**
Simple savings	Switches:	£20,000 (see annex 1)
	Oral Nutritional supplements	£10,000
	Vitamin D guidance and preferred choice	£12,000
	Tadalafil review and drug tariff update	£9,000 (Largely achieved)
	Pregabalin twice daily and drug tariff update	£50,000- (mostly already achieved in 18-19)
Cardiovascular	DOAC preference	£40,000
	Felodipine-shortage response	£5,000 (18/19 saving mainly)
Respiratory	High dose inhaled corticosteroids	£45,000 (around half this saving already realised)
Diabetes	Rationalisation of test strips – reviewing eligibility criteria	£8,000
	Switch to preferred DDP4i (Gliptin)	£10,000 (see Annex 2)
Pharmacotherapy	Repeat prescribing rationalisation	Difficult to estimate.
Polypharmacy	Anticholinergic reduction	£2,000

	Reviewing patients in own homes medicine management or polypharmacy reviews	£35,000
Procurement	Savings on cost of hospital medicines	7,000
	Recovered overcharging from NHS Grampian	30,000
	Ensuring Medicine rebates are realised	10,000
	Ensuring Biosimilars are taken up	£50,000 (probably now mostly achieved)

MEASURABLE

It is difficult to measure savings, simply measuring the overall spend against the budget does not give any data on the actual savings made, it cannot account for unpredictable growth in use and in price fluctuations. To demonstrate actual savings in any particular therapeutic area or activity more sensitive data analysis is required. We have developed tools to predict and monitor such savings, see Annex 2, it should be noted that the full effect of savings initiatives seldom happens in a year.
Where savings can be made in the reduction of costs in one area, the knock on cost pressure in another area can be difficult to describe. So for example, it is fairly easy to measure the savings made by the reduction in the use of a particular medicine, for example a reduction in the use of anti-inflammatory gels, which have limited evidence of effectiveness. However it is difficult to measure whether the reduction in prescribing of these agents might be responsible for a rise in oral analgesics and anti-inflammatory drugs, perhaps with inclusion of medicines for gastric protection.

Ultimately the balance has to be struck between using valuable pharmacy resource to design and produce reports such as the report in Annex 2 to enable more accurate calculation of savings, or just using the small number of staff to improve patient safety while making these concurrent savings which are not easily measured.

ATTAINABLE

A dashboard has been developed to alert pharmacy to unexplained changes in prescribing behaviours and costs. (Annex 3 page 1)
This helps to inform where some attention may need to be given. Savings are frequently being achieved, and the year 2019-2020 is just one year in the rolling programme of savings. Activities start at various points in the year and may weeks, months or even years to complete the activity. Some work such as polypharmacy reviews and pharmacotherapy are ongoing. It will always be required.

There are always risks to making savings, for example the introduction of new expensive medicines, an increase in the number of patients with a particular long term condition. It should also be noted that the

growth in a condition can lead to other co-morbidities. For example the increases in type 2 diabetes we are seeing just now will increase the costs in cardiovascular treatments and the costs of dressings in the years to come.

The IJB should be aware of three specific risks around the programme of savings that are particularly pertinent over the next three years.

1. It can be seen from Annex 3 page 2, that there is considerable variation between the practices. Reducing variation between practices has been achieved through the years, but the next steps will be to introduce specific treatment protocol across Shetland to reduce variation, this is being developed in diabetes and asthma treatment in particular. There is a move to develop a single system of working across the practices in Shetland, this will be an outcome from the Primary Care project. If the Primary Care wok is delayed, less savings will be made.
2. We have a small pharmacy staffing resource, one of the smallest per head of population in Scotland. We have not received the anticipated pharmacotherapy resource from Scottish Government to put sufficient numbers of technicians and pharmacists in practices. This will have a knock on effect on the ability to make savings, particularly if there are ongoing recruitment or retention difficulties.
3. The costs of medicines continue to fluctuate, generic medicines can increase rapidly in price when there are shortages, sometimes by many hundreds of percent. Should the anticipated exit from the EU impact further on shortages and prices then it's unlikely that many savings could be made.

RELEVANT

The prescribing savings plans link easily to the National health and wellbeing outcomes, particularly:
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People using health and social care services are safe from harm
4. Resources are used effectively and efficiently in the provision of health and social care services.

The savings plans are part of the Pharmacy and Prescribing Services action plan, and is developed from the 5 year prescribing strategy required by IJB Directions.

TIME BASED

Savings are ongoing and long term as part of a five year strategy. Progress in achieving savings will be monitored in year, the effect on the budgeted allocation becoming apparent in 2020. Switching from one medicine to another is a process assisted by software (Scriptswitch) on the GP system. These savings are ongoing and assumed each year. Some switches described in Annex 1 are quick wins, but often only of short term benefit and do not necessarily improve patient outcomes or safety.

SELECTED NHS SHETLAND SAVINGS POTENTIAL FROM THERAPEUTIC SWITCHES 2018-19

Note: switches may require discussion with specialists within and out with NHS Shetland for agreement and support.

REF	Therapy	Brief Description of Type of Recommendation	Potential Annual * Saving (£)	Comment	Process to Facilitate Change **	Success Likelihood
28	Direct Oral Anticoagulants	Change preferred DOAC used in NVAF to Edoxaban	30000	A national procurement framework has been agreed and will be in place until 2021, for the product Edoxaban tosilate. This framework improves the cost-effectiveness of Edoxaban, now the most cost-effective DOAC. Territorial boards across Scotland are also pursuing this change, including two other NoS boards. Rivaroxaban and Apixaban are NHS Shetland's two most commonly used DAOCs (>95% of volume).	Update NVAF treatment pathway and include therapeutic choices > Start new patients on the new therapy > Consider switch project for existing patients > Review of patient notes notes > Face to face consultation	Med/High
19	DDP-4 inhibitors	Switch preferred Gliptin from Sitagliptin to Allogliptin	9000	Alogliptin is the most cost effective DDP-4 inhibitor. NICE recommends that the most cost effective agent should be used. DDP-4 inhibitors are not the most cost effective agents, even when used as second or third line. Review of efficacy is important, to confirm adequate reduction of HbA1c has taken place.	Letter to patients > Telephone consultation	High
29	Topical Rectal Steroids	Use alternatives to Prednisolone rectal foam	15000	Prednisolone is at least 3 times the cost of other alternatives – Hydrocortisone and Budesonide. GBH no longer stocks Prednisolone foam enema.	Agree preference with surgeons > Circulate advice to GPs & Community Pharmacies	High
30	Oral Nutritional Supplements	Review of long term ONS use	7000	Review patients prescribed long term ONS, reduce inappropriate use of specialist products. Encourage use of cost effective powder sachets – Complan.	Review with dieticians as audit project > feedback to GP practices > produce guidance document	High
24	Alimemazine	Switch to alternative antihistamines. Stop prescribing Alimemazine in NHS Shetland.	14000	Alimemazine's price has been been inflated due to market changes (sole supplier).	Review of notes > Telephone consultation	High
6-9	Diprobase, Doublebase, E45, Epaderm, Aveeno etc.	Switch to Zero range equivalent	4000	Simple switch	Letter to patients	High
5	Dicycloverine & Mebeverine	Switch to most cost effective formulation.	6500	Patients may have already tried Mebeverine unsuccessfully in the past.	Face to face consultation	Med/High
17	Tadalafil	Generic prescribing review following patent expiry	14000	Tadalafil's patent has expired and is now available as generic preparations.	Review of notes > Telephone consultation	High
31	Vitamin D Preference	Switch preferred vitamin D formulation	12000	NHS Shetland has successfully changed the majority to monthly (85%). New PCRS available for 25,000IU oral tablet. More cost effective than current therapeutic choices.	Letter to patients	High

*Estimated by assuming close to 100% switch effectiveness

** Each > represents a move to a next step in the process, not an either or. The process for each switch will need further discussion with Clinical Pharmacists, GPs, Physicians, Surgeons and Nursing staff.

PERIOD REVIEWED UP TO	APR-JUN 2018/19 Q1	**ISSUE NUMBER**	1
FREQUENCY OF REPORTING	6 MONTHLY	**NEXT DUE**	MARCH 2019

PRESCRIBING INITIATIVE MONITORING

DDP4 INHIBITORS (GLIPTINS)

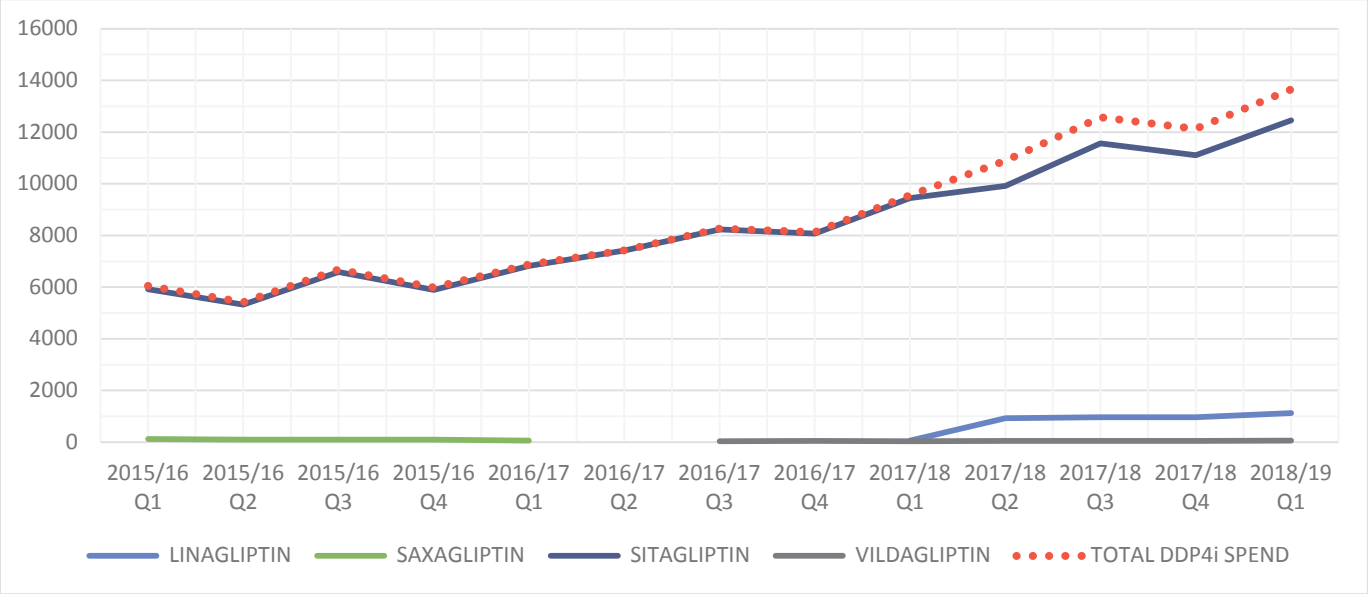
INITIATIVE SUMMARY

To switch preferred DDP4 inhibitors from Sitagliptin to Alogliptin. Alogliptin is 20% more cost effective than Sitagliptin.

Initiative Start Date	October 2019		
Expected Completion	6 months		
Expected Success	>80% of patients switched		
Previous 12 month Spend	£45143		
Year vs Year comparison	47% (increase of £14455)		
Growth Expectations	Increasing volume and cost, up to additional £2000/quarter in Q1 2019/20		
Expected annual saving (based on previous 12 months)	100% achieved	75% achieved	50% achieved
	£9859.85	£7394.89	£4929.93

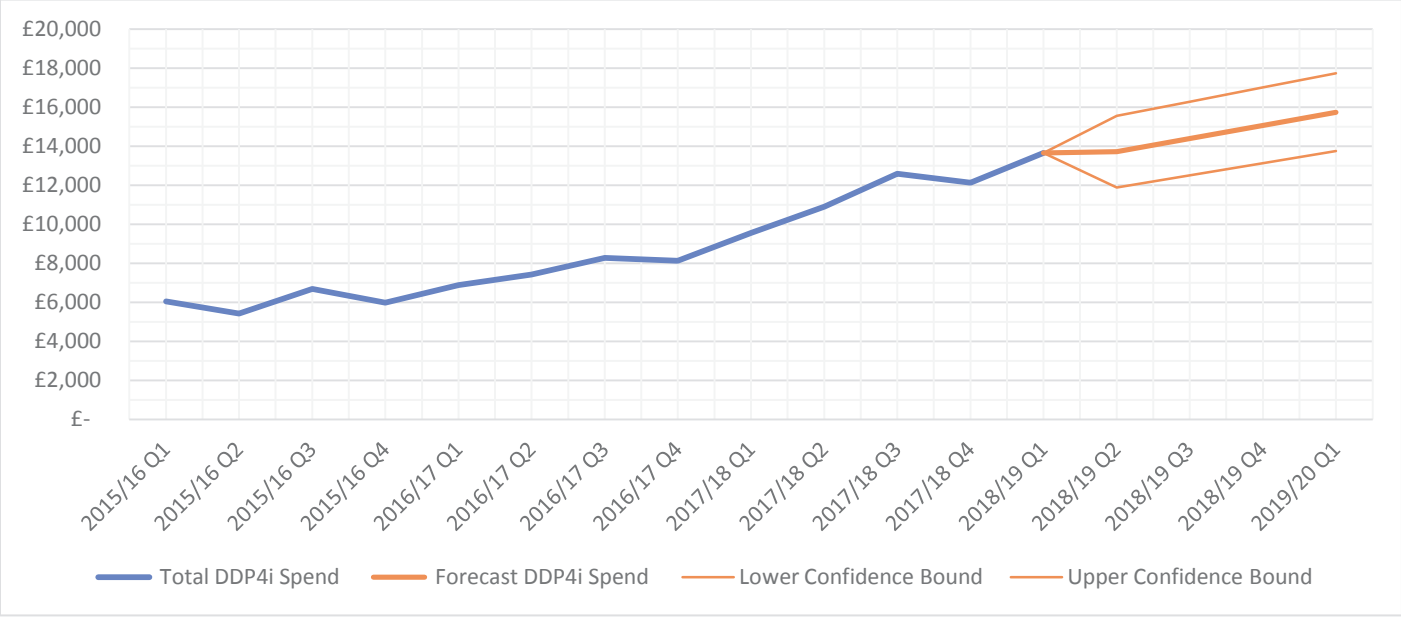
HISTORICAL USE

Figure 1 NHS Shetland DDP4i Spend - Q1 2015/16 to Q1 2018/19

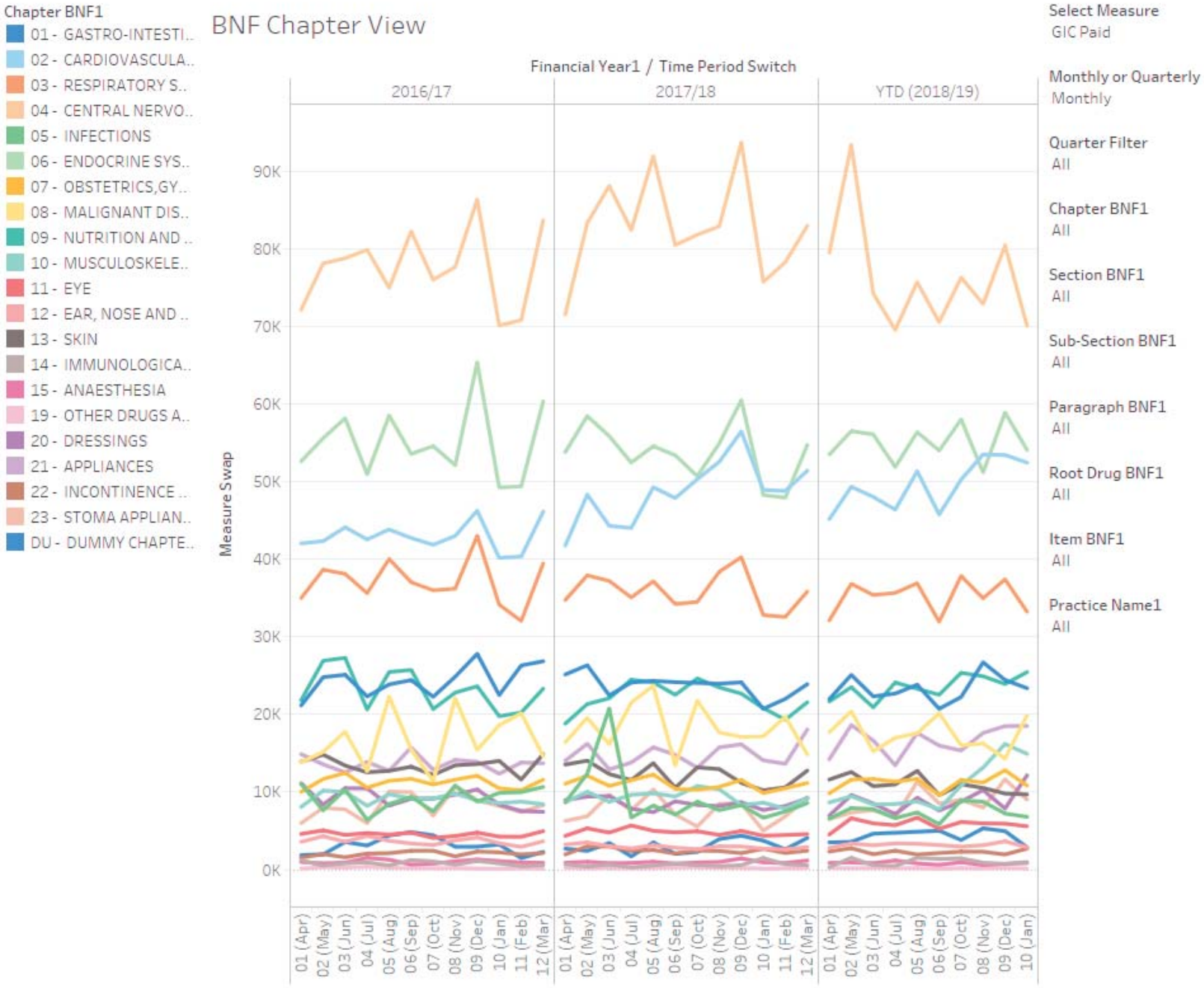


PROJECTED USE

Figure 2 - Projected Spend DDP4i



Annex 3 Dashboard Prescribing trends in Shetland – Note that prescribing data is only available three months after prescription is issued.



Annex 3 Dashboard Practice variation in Shetland – Note that prescribing data is only available three months after prescription is issued.

BNF Chapter

	39015	39020	39034	39049	39053	39068	39072	39087	39091	39161	Min:	Max:	Avg:
01	3.13	3.50	3.27	4.84	4.43	4.05	4.56	4.80	4.77	3.43	**3.13**	**4.84**	**4.24**
02	8.25	10.20	9.19	7.84	9.06	8.59	8.65	8.16	9.40	9.78	**7.84**	**10.20**	**8.85**
03	15.61	9.14	14.00	9.14	7.64	8.72	8.68	10.76	11.87	8.53	**7.64**	**15.61**	**9.14**
04	8.21	8.70	8.86	9.39	15.28	6.84	12.64	11.87	15.02	12.84	**6.84**	**15.28**	**10.63**
05	1.29	1.36	1.82	1.65	1.50	1.17	2.30	1.51	2.30	2.19	**1.17**	**2.30**	**1.58**
06	12.28	11.24	18.79	12.62	12.15	14.74	16.14	16.43	17.21	23.72	**11.24**	**23.72**	**15.44**
10	2.76	3.31	2.71	4.48	3.82	2.80	2.86	5.70	4.23	2.74	**2.71**	**5.70**	**3.08**
11	4.36	4.50	4.45	4.73	5.34	5.17	4.88	4.79	7.61	4.21	**4.21**	**7.61**	**4.76**
12	2.83	2.12	1.99	1.62	1.11	1.74	1.87	1.98	2.27	1.33	**1.11**	**2.83**	**1.92**
13	4.36	3.17	2.52	2.66	3.49	3.10	2.34	3.12	4.00	2.54	**2.34**	**4.36**	**3.11**
20	10.73	7.39	28.36	21.08	40.32	33.33	17.97	17.67	14.98	19.13	**7.39**	**40.32**	**18.55**
21	6.00	7.21	7.75	4.91	4.22	3.84	4.70	7.08	5.51	6.03	**3.84**	**7.75**	**5.76**
22	9.04	11.70	12.78	20.50	7.54	14.19	17.17	24.49	19.81	26.98	**7.54**	**26.98**	**15.68**
23	99.21	115.55	132.94	58.92	50.66	62.91	111.81	63.52	66.06		**50.66**	**132.94**	**66.06**

PI BNF Chapter Code	PI BNF Chapter Description
01	GASTRO-INTESTINAL SYSTEM
02	CARDIOVASCULAR SYSTEM
03	RESPIRATORY SYSTEM
04	CENTRAL NERVOUS SYSTEM
05	INFECTIONS
06	ENDOCRINE SYSTEM
10	MUSCULOSKELETAL & JOINT DISEASES
11	EYE
12	EAR, NOSE AND OROPHARYNX
13	SKIN
20	DRESSINGS
21	APPLIANCES
22	INCONTINENCE APPLIANCES
23	STOMA APPLIANCES

Primary Care Project – Current Position April 2019

Background

Shetland has 10 GP practices, 8 of which are now salaried. There are ongoing recruitment issues and difficulties in sustaining current services and in addition, there is a requirement for Primary Care to achieve efficiency savings in line with the rest of NHS Shetland. There is a new Scottish GP contract, implemented on 1st April 2018, which requires that a Primary Care Improvement Plan be developed and delivered over a 3 year period and in addition, the scenario planning meetings indicated that a review of Primary Care services was now required.

During 2016/17 and 2017/18, 5 Shetland practices became salaried, taking the salaried total to 8; this was for a variety of reasons, including viability and difficulties in recruiting new GPs. The resulting locum costs have fallen on NHS Shetland. However it has been more expensive to take these practices on as salaried, owing to the need to harmonise terms and conditions and pay scales.

Following national agreement in January 2018 to introduce a new General Medical Services (GMS) Contract in Scotland, an initial report was presented to the Integration Joint Board to advise of the context and content within the contract and associated Memorandum of Understanding (MoU). This report also outlined the requirement for Integration Authorities to develop a three year Primary Care Improvement Plan by 1 July 2018, which was developed and submitted by the required date.

There are several reasons for change, including but not limited to:

- Recruitment & retention – national shortage, local impact with difficulties in recruiting new staff, particularly to single handed posts, service model appears unpopular;
- The “first five” GPs – GPs in their first five years following qualification tend to work in more multi-disciplinary teams and do not want to work in a single handed position;
- Governance and safety
- Reducing isolation
- The need for equitable access to clinicians by patients
- Easier sharing of staff, e.g. pharmacists/physios/link workers

Assessment

The existing 2014 Primary Care Strategy, agreed by the NHS Board, is no longer fit for purpose in terms of transformational change. It does not provide a framework to enable such change to happen.

The Primary Care Improvement Plan 2018 provided information on the following areas:

i. Vaccination services (staged for types of vaccinations but fully in place by April 2021)
ii. Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics)
iii. Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage;
iv. Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care;
v. Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services)
vi. Community Link Workers (please note, in Shetland, Health Improvement colleagues have been undertaking much of this role in recent years and we would be looking for this to continue).

In terms of recruitment, we are beginning to see some interest in our vacancies, mostly through personal contact with interested individuals, the work being undertaken through the “Discover the Joy” project for which Shetland is acting as recruitment hub, and the ongoing successful training programme for GPs at Lerwick Health Centre. The vacancies at Lerwick and Bixter are filled but recruitment to single handed practices remains an issue. A new Associate Medical Director for Primary Care was appointed in March 2018 to support the service, and an administration review has been undertaken looking at the existing admin processes across the salaried practices.

The AMD for Primary Care has had discussions with GP colleagues and their views collected as to a future model of care across the salaried practices in Shetland. The preferred model is to create a single system of working across the salaried practices, which will have more efficient processes e.g. reducing duplication and a potentially wider range of services. Opportunities will include, for example:

- Management functions can be centralised to allow for more specialist functions such as data management, quality and human resources.
- New services can be delivered

- Other purported advantages are improving recruitment and retention through addressing work-life balance issues and providing more varied career paths.

This option would enable a "working to scale" model to be introduced, ensure that clinical staff work in a multi-disciplinary team rather than single handed and enable a single IT system across the salaried practices. This will facilitate shared working across booking appointments, typing letters (using digital dictation) and allow for cover arrangements to be put in place for periods of annual leave. This process is in line with the vision for a unified Primary Care service, outlined in the Joint Strategic Commissioning Plan for Health and Care, which reads:

> "Investment in community based services and strengthening primary care are two key elements of making the 'whole system' approach work by keeping activity out of the acute and hospital sector. We recognise that this shift in emphasis may put pressure on community resources, including GPs. There is a need to make sure that we make the best possible use of GP time and resources and get better at further developing a team approach to meet people's needs. These teams will be multi-disciplinary and can include any health care professionals appropriate to meet health and needs, such as social care staff, nursing staff, allied health professionals, pharmacists, health improvement practitioners, counsellors, third sector support, etc.
>
> Their main aim is to support people with health and social care problems to stay in their own communities, help them to learn to manage their conditions and, whenever possible, reduce the likelihood of being admitted to hospital. This will mean that some services traditionally supplied in hospitals will be provided in community settings.
>
> The teams can by physically located in one place and work out of any of the health and care buildings, in people's own homes, or be 'virtual' in nature and supported by technology to take place through Video Conferencing, telephone or other technology enabled solutions.
>
> It might mean that people do not necessarily need to see a GP first to arrange health and care needs; people might see, for example, a nurse or a pharmacist or a physiotherapist. This might mean that staff have to travel throughout Shetland a bit more. It might mean that service users have to wait a little while longer, so that there are enough people to see to make it an efficient use of staff time. It might mean that we have to share scare resources throughout Shetland, to make better use of all our staff resources and skills. Much of this is in place at the moment, through permanently located and visiting services, but we want to formalise the arrangements; the (proposed) new GP contract provides us with the opportunity to do this".

A project team has been initiated and funding has been made available from the Transformational Change Board to support the employment of an IT project officer for the duration of the two year project, to take forward the required changes to the IT infrastructure.

SMART Objectives for the Project

The Primary Care project has the following SMART objectives:

Specific – the project will create a single system of working across the salaried practices.

Measureable – the project will be measured through audits of patient satisfaction, uptake of online booking systems, uptake of Attend Anywhere (where this option is suitable) and reduction in cost of locums across practices.

Achievable – the project is achievable in the two year timescale, although it is acknowledged that the merging of databases is reliant on the GP IT system provider.

Relevant – the project aligns with the vision outlined in the Joint Strategic Commissioning Plan for Health and Care.

Time-bound - the project work will be undertaken over a two period, from 1st April 2019 to 31st March 2021.

The Primary Care Project has an efficiency target in 2019/20 of £100,000; initial savings have already been identified as shown below and further savings will be identified during the latter half of the year:

	Recurring	**Non recurring**	**Total**
Efficiencies	£36,087	£13,537	£49,624

Appendix 3

Community Nursing Redesign

Introduction

The Community Nursing redesign project focuses on the following areas:

- District Nursing;
- Interface between District and Practice Nursing at a locality level;
- Non-Doctor Island Nursing.

The redesign project is being carried out to support local services to transform by ensuring that a developed nursing workforce is in place, in line with the recommendations set out in the series of briefing papers from the Chief Nursing Officer (CNO) Directorate, Scottish Government.

Briefing papers outlining the future role of District Nurses, General Practice Nurses, and the position of Advanced Practice in Integrated community teams are available from the following weblink: https://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/careers-and-recruitment/transforming-nmahp-roles.aspx

The development of nursing teams is core to the delivery of the establishment of integrated multidisciplinary teams as outlined in the Joint Public Bodies (Scotland) Act Integration of Health and Social Care, as well as to the delivery of the new GMS (GP) contract.

Savings Proposals

The Chief Financial Officer set out in IJB Paper CC-15-19 the Recovery Plan to enable the IJB to return to financial balance. Within this plan the identified remaining savings target for Community Nursing services for the financial year 19/20 was detailed as £0.179 million (£179,000).

Presented below is an outline plan of savings to be achieved, detailing amounts and timescales when these will be realised throughout this financial year

Savings	May 2019	June	July	August	Sept	Oct	Nov	Dec	January 2020	Feb	March
Consumables – products/ dressings etc	£1,800										
Car Lease / Insurance		£7,000									
PFPI budget – reduction in advertising costs			£500								
Service redesign – alternative model in place				£48,872							
Continued review of service establishment and skill mix in line with Primary Care redesign								£35,900			
Creation of more efficient out of hours service model using Professional Alliance											£75,000
Continence products – see Bid for 'spend to save' from IJB reserves											£10,000
Cumulative Total £	1,800	8,800	9,300	58,172				94,072			**179,072**

Overall Savings Target - £179,000
Proposed Savings - £179,461

It should be noted that relatively small amounts of savings will be made early in the financial year through more efficient working practices. Larger efficiency savings will become possible through changes in service models later in the year.

Contact Details:

NAME: EM Watson
POSITION: Chief Nurse (Community)
DATE: 25 April 2019
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Appendix 4

Improving Community Mental Health Resilience- bid to IJB reserve

Background

Shetland compared to the other island Boards has the highest rate of referrals into its NHS Psychological Therapy Service.

Evidence shows that delivering the Stress Control Programme for whole populations enables individuals to learn tools for self help that reduces the need for individual therapeutic interventions

The Stress Control Programme is a six session, 90 minute evidence based class for common mental health problems; anxiety, depression, panicky feelings, insomnia and poor well being. It will be delivered by NHS staff already working within the therapy field.

The programme has been successfully running in NHS Orkney for 2 years; is well attended and has reduced the referral rate into the CMHT.

Funding is required to purchase the training (and associated costs), licence for 3 years and delivery of the programme.

Waiting times for Psychological Therapies in Shetland continue to be beyond the 18 weeks target. The demands on the service, particularly Talking Therapies that deal with the mild to moderate conditions i.e. anxiety, low level depression etc, continues to be high.

Stress Control has been running in Orkney for the last 2 years with a high success rate, over 40 people attending each session; men making up just under half of the attendees.

Stress control focuses on a population level reducing the stigma of thinking about mental health. This is a community based mental health treatment rather than a confidential/hidden treatment and can be promoted as such.

Stress Control is a non-interactive class where you don't have to share; it covers multiple areas of psychological wellbeing (not just anxiety) and is non-stigmatising – 'everybody gets stressed'.

It is evidence based and has shown well to work in rural communities where stigma can be higher in relation to mental health, leading to a more stoical attitude that can prevent accessing help

There is no referral required for this programme. GPs will be encouraged to signpost this to people allowing quicker access to educational materials and support. It will be widely advertised and initially run in health centres/ community halls

Although this may have little impact on the current waiting list as people are waiting for a service, longer term the numbers requiring individual interventions will reduce.

What is Stress Control?

Stress Control is a six session, 90 minute, didactic CBT/wellbeing transdiagnostic 'class' (never 'group') approach for the common mental health problems: anxiety, depression, panicky feelings, insomnia and poor wellbeing.

It was developed over 30 years ago by Dr Jim White for use in a low-intensity clinical psychology NHS service in Glasgow. Now used across the world, well over 100,000 people have attended a Stress Control class. It is extensively used in the NHS, HSE (ROI), occupational health settings and voluntary care settings.

There is no discussion of personal problems thus there is no limit on the numbers who can attend. Typical NHS classes run with 20-100 participants, making Stress Control a highly cost-effective intervention.

Stress Control aims to teach individuals to 'become your own therapist'. This aim is supported by 'Stress Control in nine words': Face your Fears, Be more Active, Boost your Wellbeing.

'Trainers' are supported by Power Points, audio and video. The class avoids jargon and the eleven booklets (plus supplements) which accompany the class are 'easy' to understand.

Stress Control aims to help people with any level of anxiety or depression ('stress') – mild, moderate or severe – and, for those with common *and enduring* common mental health problems, to help keep 'heads above water'. It can also be used as a relapse-prevention approach or as early intervention/prevention.

Stress Control is among the best-evidenced psycho-educational approaches for common mental health problems in the world. Independent IAPT studies show that 'recovery' and 'reliable and clinically significant improvement' data are equivalent to IAPT individual therapy.

https://stresscontrol.org/home

Costs

The cost of delivery over the 3 years totals **£25,000.**

The components consist of:

Licence for 3 years – £10,800 (inc VAT)
Training - £2,400 (inc VAT)
Travel and accommodation for trainers – £2,500
Delivery of Programme over 3 years - £9,300

Contact Details:
NAME: Karen Smith
TITLE: Head of Service, Mental Health
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DATE: 25/04/2019

Appendix 5

Application to access IJB reserves from Community Care Resources to develop alternative respite, re-enablement and palliative care facilities for the Yell Community.

Background

In June 2018 recruitment and retention issues within Isleshavn care centre reached a crisis point which resulted in a reduction in the number of residents. The demographics of increasing demand for community care services against a backdrop of decreasing numbers of people available to provide care is the main driver for national and local policy. The aim is to shift the balance of care from hospital to community and more specifically to people's own homes. We know that older people do not want to end their lives in institutional care and the staffing crisis at Yell provided an opportunity to refocus on service redesign and development, including telehealth and telecare investment.

The staff team, despite the stresses, developed an action plan which included communicating their aims with the multi-disciplinary team and the wider community. The plan recognised that care at home services were underdeveloped on Yell which increased the risk of unnecessary hospital and care home admission as well as contributing to further depopulation of the Isles. Care at homes services were developed as a result of the willingness of the staff team to work flexibly and creatively to create a sustainable community care service for Yell with outreach capability for Fetlar. Staff participated in piloting vehicles for care at home staff which provided data to support the business case for fleet vehicles across the service, made maximum use of telehealth/telecare solutions currently available, senior staff undertook resilience and QI training to enable them to upskill and support the staff team with change processes and key staff commenced advanced training to support service users with mild/moderate dementia to maintain their cognitive and communication functioning.

The action plan also reflected a recognition that key strengths within the professional services offered at Isleshavn included respite, re-enablement and palliative care. At the same time it was recognised that a residential setting was not always appropriate venue for the optimal delivery of these services and the staff team decided to investigate alternative venues for providing care for those requiring care.

Property in Yell

A single housing unit in Yell is likely to become available in near proximity to the existing care centre which could offer high standard accommodation while enabling a variety of needs to be met. Community Care Resources are seeking funding of £7,672 representing £ 49.18 per week for 3 years rental plus £2,500 towards furniture and equipment etc

The intention is to provide services to the resident of Yell (and the wider Shetland Community in the event that the facility is not required for Yell residents on a full time

basis). More people can be supported by fewer members of staff outside of institutional setting and while we anticipate that care at home will increase it is also likely that from time to time individuals may require alternative accommodation to enable them to avoid unnecessary admission to residential care or hospital. The Care Inspectorate have confirmed that should overnight support be required then this could be provided by the 'sleep in' member of staff at Islehavn which is situated in close proximity to the housing unit.

Policy Background.

It is noteworthy that the business case for the replacement of the care centre facilities by Islehavn in Mid Yell was presented and approved by SIC's Capital Programme Management Team in October 2006. By November 2009 (SC-19-09-F) the Council's Services Committee had considered the Feasibility Study for the Islehavn Redesign Project following extensive consultation which ruled out refurbishment of the existing building. What was proposed at that time was the redevelopment of the Mid Yell School site to include a new care centre as well as extra care housing which was costed at £6,290,000 (excluding VAT). It is noteworthy that had the residential care home facility been built (for 16-18 resident) it would have been underutilised and therefore would not represent best value. In addition, it could not currently be staffed for more than 7 residents.

The 6-8 person extra care housing complex proposed in 2009 was not developed and it is therefore crucial that we explore alternative accommodation options to ensure we can deliver the highest quality care in the future. It should be noted that the feasibility study identified that previous studies had concluded that there were no realistic options to upgrade the current building to an acceptable standard and that the current building could not be changed sufficiently to allow care to be delivered in good living conditions for clients or good working conditions for staff.

The 'Review of Sheltered Housing In Scotland' (Scottish Government 2008) stated 'there is a strong national policy drive to reduce the use of residential and nursing homes where possible'. Shetland Islands Council subsequently carried out an extensive review of sheltered housing in Shetland and in addition to investment in extra care housing it was recognised that low demand properties in low demand areas could easily (and cost effectively) be remodelled to provide accessible living accommodation to those with care and support needs. The property in Yell has been remodelled as part of that capital project.

The proposal to rent the refurbished property from existing housing stock makes use of previous change fund investment to provide high quality multi-purpose accommodation which can accommodate changing needs. While the initial proposal is for short term use by individuals it is possible that this option could provide an alternative to institutional care for older people and those with long term conditions in accordance with the needs and wishes of older people to be cared for in an environment that is **not** institutional care. It may be the case that in the future other similar properties could be rented by CCR's to meet longer term needs avoiding institutional care while enabling people to remain within their own communities. It

requires no additional staffing and care needs will be met from the established care at home team with overnight cover provided by the Care Centre.

Funding Request

Rental £49.18 X 52 = £2557.36 per annum	**£7,672**
Furniture and equipment	**£2,500**
Rates and utilities	**£2,000**
Total funding request	**£12,172**

Contact Details:

NAME: Jaine Best
POSITION: Executive Manager Community Care Resources
DATE: 25 April 2019
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NHS Shetland

Development of Primary Care Physiotherapy Service

Section 1

Background

The 2018 General Medical Services Contract in Scotland[1] identified that musculoskeletal (MSK) problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. Under the new contract, Health and Social Care Partnerships (HSCPs) are required to embed an acute MSK physiotherapy service within practice teams by 2021.

It has been estimated that MSK conditions alone account for around 20% of GP appointments[2], however estimates for the prevalence of patients with MSK complaints within a GP's workload range from 18-33%[3,4].

Where first contact physiotherapy posts have been established there are additional benefits[2] to the quick access to expert MSK assessment, diagnosis, treatment and advice. These include reduced number of MSK referrals into secondary care (therefore reduced demand and waiting times for orthopaedics, pain services, rheumatology, physiotherapy), improved use of imaging, release of GP time and reduced prescription costs. There is potential to reduce the demand for physiotherapy services by directing patients to self-management at initial consultation (rather than recommending/referring to physiotherapy).

The MSK physiotherapy team is based at the Gilbert Bain Hospital and covers all of Shetland, with a caseload which includes age 14+. The establishment for this service is 5.09 physiotherapists with administrative support. An additional 0.4 WTE is allocated for supporting orthopaedic and rheumatology services.

The physiotherapy service is under increasing strain with high referral rates and increasing patient complexity. The redesign of MSK and primary care services will impact positively on both GP appointments and waiting times, and secondary care-based physiotherapy demand and waiting times.

NHS Shetland introduced self-referral to physiotherapy in 2012, and it is the most common means of referral – at 55% of all MSK referrals in 2018. It is apparent that not all self-referrals to MSK physiotherapy are true self-referral, a significant number are at the recommendation of GP, or other health professional. This has therefore not significantly reduced the workload of GPs with regard to MSK problems.

Referrals to MSK physiotherapy in 2018 totalled 2090 (an increase of 19% since 2017). This equates to 91 per 1000 population. The referral rate in 2017 was 80 per 1000 population, which was one of the highest rates in Scotland. Referral source for MSK physiotherapy is 55% self, 23% GP and 22 % other healthcare professionals. In 2018 the GP referral rate to MSK physiotherapy in Shetland rose by 27%.

Service Model Change
Given the growth in the number of referrals into the Physiotherapy service in Shetland and the increasing demand on GP appointments, it is proposed to introduce an earlier change of model concept in 2019/20. The change of model will be derived through offering patients with a MSK problem seeking a GP appointment an appointment with the most appropriate professional. The 2018 Primary Care Improvement Plan noted that a scoping exercise would be undertaken in 2018/19, which is now complete, and that it was anticipated to have a postholder in place from 1st May 2020, in line with Primary Care Improvement Plan funding. However, the scoping exercise has evidenced that there is existing demand in Lerwick Health Centre alone for a full time physiotherapist and it is proposed to commence the placement of a physiotherapist in order to test the concept, prior to any mainstreaming of this initiative. The physiotherapist would work in primary care as a first contact practitioner taking on appointments which would previously have been seen by a GP. They would assess, diagnose and manage MSK problems. The physiotherapist would provide an alternative to the GP/ANP for MSK problems. Please note that funding is required for one year only, as the post could be fully funded in 2020/21 through the Primary Care Improvement Plan monies if this pilot is successful.

Physiotherapists working in general practice are able to address the needs of a large proportion of the patient population. They have the clinical expertise and autonomy to assess, diagnose and treat patients with a range of conditions. The role of the physiotherapist in primary care is to assess patients with soft tissue, muscle and joint pain and to decide on the most appropriate management pathway. The physiotherapist will advise on self-management, initiate further investigations and referrals, and have specialist skills in health promotion and early intervention[2].

Project Objectives
1. To identify the scope for the role of MSK physiotherapist in a GP practice
2. To agree the governance structure
3. To propose a model of service provision
4. To identify potential development needs of post-holders
5. To provide an alternative to GP/ANP appointments for acute MSK problems.
6. To comply with Guidance on the Principles for Planning and Delivering Integrated Health and Social Care[6], taking account of the needs of service users and improving quality of service.

All objectives will be completed within 1 year of commencement of the project with a review after 6 months of service provision (once the post is funded through the PCIP monies).

Project Scope
The initial project will include all aspects of Lerwick Health Centre MSK consultations. Indirectly it will impact on NHS Shetland MSK physiotherapy services, particularly with regard to referral pathways.

Subject to the outcomes of the initial project, the workload and working patterns of the secondary care physiotherapy service will be reviewed and there is potential for the project to be expanded to include Shetland-wide MSK services.

Exclusions from Scope

- Acutely unwell patients
- Children under 16
- Medical management of rheumatoid conditions
- Women's health, antenatal and postnatal problems
- Medication reviews
- Headaches
- Acute mental health crises
- Patients who do not want to see a physiotherapist.

Deliverables

National Health and Wellbeing Outcomes[7]

The project will contribute to meeting all nine National Health and Wellbeing Outcomes, but will specifically target the following five:

- Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.
- Outcome 3: People who use health and care services have positive experiences of those services, and have their dignity respected.
- Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Outcome 9: Resources are used effectively and efficiently in the provision of health and care services.

Core Suite of Integration Indicators[8]

The project will contribute towards several of the Core Suite of Integration Indicators for NHS Shetland. Outcome indicators 5: *Percentage of adults receiving any care or support who rate it as excellent or good* and 6: *Percentage of people with positive experience of care at their GP practice* will be measured through a CARE audit[9,10].

Health Promoting Health Service

The project with be in line with the health promoting health service concept[11] that every healthcare contact is a health improvement opportunity. It promotes patient participation and empowerment. Promotion of supported self-management is a key part of this philosophy.

Clinical Outcomes

There is evidence[2,12] to suggest that potential outcomes include reduced number of MSK referrals into secondary care, this includes reduced demand and waiting times for orthopaedics, pain services, rheumatology and physiotherapy. Reduced use of imaging and medication are also recognised as outcomes.

Constraints

- There are potentially conflicting priorities for funding.
- Potential demand exceeds availability of resources.
- Recruitment to specialist posts is challenging.
- There may be delay due to the job evaluation process

Assumptions

- That injection therapy and prescribing skills are not essential. These are more appropriate to an orthopaedic/rheumatology secondary care role.
- Ability to refer for imaging is essential to the post.
- That recurring funding for 1 WTE Band 7 is available.
- That recruitment to the vacancy, and retention of staff recruited, is successful.

Risk Analysis

Risk Identification

- Failure to recruit to the post (nationally there are large numbers of similar MSK posts being recruited currently).
- If recruitment is from the existing physiotherapy team there may potentially be an impact on recruitment/retention for the MSK physiotherapy secondary care service.
- That the project is not completed within the proposed timescale. Potential delays include the job evaluation process and confirmation of Funding/permission to recruit.
- That the service delivery options identified require additional resources.
- That the job evaluation process delivers a different result to that anticipated.

Risk Prevention

- A detailed project plan, including timescales, will be developed prior to commencement of the project

Risk Management

- The project will not proceed in this format if funding is unavailable or recruitment fails.
- If recruitment is unsuccessful alternative options will be identified.
- If there is slippage regarding timescale this will be reported to the project sponsor.
- If the job evaluation outcome requires a different resource to that identified it will be reported to the project sponsor.

Risk Monitoring
Risks will be monitored and reviewed monthly by Fiona Smith (project manager and lead).

Section 3
Roles and Responsibilities

Project Overview
Simon Bokor-Ingram, Director of Community Health and Social Care
Lisa Watt, Primary Care Service Manager

- Will receive reports on progress towards meeting objectives
- Will maintain an overview of the project

Project Sponsors
Lisa Watt, Primary Care Service Manager

Project Manager
Fiona Smith, Head of Physiotherapy

- Responsible for the agreed outcomes of the project

Project Lead
Fiona Smith, Head of Physiotherapy

- Responsible for detailed project planning, including producing Gantt chart/schedule, day-to-day running of the project, assigning work

Project Team
Fiona Smith
Dylan Murphy

Section 4

Initial Project Plan
Year 1 2018-19: Scoping
Scoping exercise for roll out of Physiotherapy provision to General Practice
Status: complete

Year 2 2019-20: Implementation
Implementation of Physiotherapy role in General Practice

Year 3 2020-21: Review
Review and further planning

Assignments
1. Scoping of job include job description and skills required
2. Agreement of governance structure, including line management
3. Agreeing model of service provision
4. Recruitment and Implementation
5. Service Review

Will be undertaken by project lead, with support from project team and project sponsors.

Schedule
Detail will be confirmed by project lead.

Project Control
Monitoring mechanisms
The project will be monitored and reviewed by the project team who will update the project sponsor.

Quality Control
Audits will be undertaken with regard to all the objectives. The project lead will facilitate these. Themes will include clinical outcome and patient satisfaction. Evaluation will include a review of referrals to secondary care (including physiotherapy) and outcomes regarding availability of GP and ANP appointments.

Appendix 1

Annual availability of 1 WTE physiotherapist

Annual WTE hours = 1950 hours		
	Minus	***Balance***
AL/PH (307.5 hours) sickness absence (allow 4%= 78 hours) study leave (45 hours)[13] mandatory training (10 hours)	440.5 hours	1509.5 hours

Allocation of clinical resource is detailed below

1509.5 hours available per year
70% direct patient contact = 1056.5 hours/year
30% indirect patient contact (triaging, report writing, liaising with other professionals, clinical supervision, etc) = 453 hours / year
26 hours per week available for direct patient contact.
Allowing 20 minutes per appointment, the practitioner would see 15-16 patients per day (3170 patients per year). This is in line with the predicted activity of 14-16 appointments per day[12]

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Appendix 7

Application from Community Nursing services/ Community Care Resources to access IJB reserves to support client dignity and quality of care by enhancement of the Continence service

Background

Continence is an important component in a person's health and well-being at any stage of life but especially in adulthood. It is also an important factor in the use of health resources for the following reasons:

- Adult incontinence produces marked loss of self-esteem, depression, loss of independence, and can affect relationships and employment prospects.
- In older people, incontinence and associated bladder and bowel disorders may be associated with physical problems such as skin breakdown, falls, urine infection and catheter associated urinary tract infection which in turn often causes confusion. Confusion can result in falls, head injury or femur fractures requiring an acute hospital admission.
- Incontinence or dependence on a urinary catheter significantly increases the level of dependency in frail older people. This may delay discharge from hospital or initiate a move into a residential or nursing care setting.

NHS England (2018) have produced a resource for commissioners and leaders in health and social care, "Excellence in Continence Care", which notes that to help ensure people receive excellent continence care, consideration should be given to:

- Early assessment by an appropriately trained professional which then allows a patient centred and cost effective care pathway to be followed. After assessment the use of containment products, medication and the level of intervention can be triaged and escalated.
- Effectively resourcing the continence team and its management structure as part of an integrated service.
- How local people may need more specialist assessment which should be provided based on population needs.
- Containment with the use of pads or catheters may be the only realistic option for some people, but this management should be recognised as having associated problems.

  Actively support the individual to participate in the management and treatment of their continence care.
- Simple approaches to care delivery, including electronic and telecommunications, can help people lead healthy lives as well as providing advice and support to implement best practice or services in organisations.

The Scottish Government's Primary Care vision puts general practice and primary care at the centre of a community based health service, improving outcomes for local individuals and communities. Working within the context of Health and Social Care integration, Health and Social Care Partnerships are responsible for the commissioning, planning and delivery of all community and primary care services in

their localities. Within this context, the Continence Service has an integral role to play in achieving the delivery of the 9 Health and Wellbeing outcomes.

Incontinence is a symptom, not a disease or diagnosis, and has many possible causes as well as being only one of a range of other bladder or bowel symptoms. The Association of Continence Care (ACA) advise that continence care requires a higher priority than it currently receives, as improving provision through better integration can improve outcomes and provide a better quality of life for individuals and their families; and increased independence through finding solutions appropriate to individual needs.

Service Model

The Continence Nurse Advisor provides a range of services to adults and children with continence problems on a Shetland wide basis. The postholder is supported by a multi-professional team which addresses continence related issues locally, offering assessment, advice, liaison, support, health promotion and awareness raising within primary and secondary care settings.

Clinical input involves: holistic general health assessment, bladder residual scan, pelvic floor exercises, bladder retraining, intermittent self catheterization, product advice and fitting, and catheter management advice.

The Continence Service is provided by a 15 hour a week, 0.4 Whole Time Equivalent (2 days per week) Band 6 Nurse.

At April 2019, there are 39 registered patients on the Continence database. On average, the caseload at any one time varies between 40 and 50 people. Positive changes in clinical practice eg reduced catheterisation has resulted in an increase in the caseload of the Continence Nurse.

Self-care, as a result of publicity, people are now not so embarrassed about the condition and are well informed as to who to go to for advice; this has resulted in more self referrals.

As people get older, age related conditions can affect the bladder and the bowel; this can increase the number of people being seen. However the positive focus on treatment as opposed to simply providing containment products has resulted in a significant decrease in expenditure on continence products in the last 5 years despite the increasingly ageing population, see below

Year	Budget / Expenditure
2012/2013	£80,900
2016	£87,990
2017	£75,991
2018	£72,991
2019	£68,023

Thus the shift in focus from containment to treatment has saved the NHS Board almost £20,000 (£19, 967) in the last 3 years. From these figures there is a possible budget reduction for 2020 of £4,968 and it is anticipated that following the implementation of this initiative that it will be possible to make further savings through the implementation of better practice which will make for more efficient use of containment products and therefore a total reduction of £10,000 has been estimated as a possible saving against this budget in the year 2019/2020.

Education and Training is provided for individual patients, carers and professionals. Representatives of the product providers undertake yearly training for care staff, in relation to the individual products, fitting and appropriate use of specific products, supported by the Continence Nurse Advisor. However, training at this level is insufficient to maintain good care throughout the year.

Proposal

This proposal seeks funding to employ the Continence Nurse Advisor an additional one day (0.2wte) per week from 20 May 2019 to 31 March 2020 to specifically support clinical practice within the care home sector, supporting staff in both residential care and care at home services.

The Continence Nurse Advisor will

- Set up some initial 'drop in' sessions in each of the Care Centres in order to further strengthen relationships with care staff and to identify if there are specific issues in that particular centre to be addressed through staff training;
- Provide advice and support on the promotion of continence for all residents;
- Undertake assessment/reassessment of all individuals who have incontinence issues and develop appropriate treatment or management plans, supporting the staff to implement these in practice;
- Identify individuals who are interested and willing to undertake some additional training in order to be able to act as a "continence champion" going forward. The "continence champion" would act as a local source of additional information for peers and link directly with the Continence Nurse Advisor for advice and support on the management of individuals with specific complex issues.

Outcomes

The following positive outcomes are expected from this project:

- All Individual care home residents will have their current continence needs reviewed by our local Specialist Nurse with the opportunity to ensure that all have the most appropriate current plan of care in place for them whether that is with a treatment or containment focus;
- Staff knowledge will be enhanced and therefore they will be better able to identify continence issues early and seek appropriate support for the individual and for themselves as care providers;

- Distributed network of Continence Champions established who help support the work of the Continence Nurse Advisor and thus we will have enhanced workforce capacity for dealing with this fundamental aspect of care;
- Containment products will be used appropriately and only on an assessed needs basis.

Evaluation of this initiative will be undertaken in the following ways:

- Staff survey to check for enhanced knowledge of the principles of continence management, as well as improved knowledge and use of containment products (where necessary);
- Patient experience survey to check for their perspective on any changes to their continence management;
- At least one Continence Champion identified in each care centre;
- Aim to have developed some Continence Champions within "support at home" teams but the focus will be on the care centre staff first;
- Each Continence Champion will have completed the identified training modules;
- Reduction in cost of containment products and thus an efficiency saving to the Community Nursing budget through the more appropriate use of containment products;
- Project report will be drafted to report back on implementation of the project and to demonstrate positive progress in relation to the requirements of the SGHD/CMO (2018)08 Letter Improving Services for People with Continence Issues.

Funding Request

Funding is requested to employ the Continence Nurse Advisor for an additional 1 day per week from 20 May 2019 to 31 March 2020

Total funding request for this period £8,750

Contact Details:

Joint Application from Community Nursing and Community Care Resources

NAME: Edna Mary Watson / Jaine Best
POSITION: Chief Nurse (Community) / Executive Manager Community Care Resources
DATE: 30 April 2019
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References

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SGHD/CMO (2018)08 Letter - Improving Services for People with Continence Issues Accessed at https://www.sehd.scot.nhs.uk/cmo/CMO (2018)08.pdf

Shetland Islands Health and Social Care Partnership

Agenda Item

6

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board (IJB)	14 May 2019
Report Title:	Integration: Self Evaluation and Development Plan	
Reference Number:	CC-23-19-F	
Author / Job Title:	Hazel Sutherland, Head of Planning and Modernisation, NHS Shetland	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board COMMENT, ADVISE on and AGREE the Draft Integration Self Evaluation and Development Plan, set out at Appendix 1, for submission to the Scottish Government Ministerial Strategic Group.

2.0 High Level Summary:

2.1 On 6 March 2019, The Director General Health And Social Care Directorates, Scottish Government, and the Chief Executive, COSLA wrote to Integration Authority Chief Officers, NHS Board Chief Executives and Local Authority Chief Executives seeking feedback on progress towards health and care integration. The work is in response to the recently published Audit Scotland Report "Health and Social Care Integration- Update on progress" (November 2018).

2.2 On 13 March 2019, the IJB Audit Committee considered the Audit Scotland Report and agreed a local response (Min. Ref. 2/19).

2.3 IJB Members and advisers were invited to submit individual self assessments on their own personal views of integration against the 22 dimensions relevant to the role of the IJB. Seven responses were received and collated and shared at a seminar on 18 April 2019, where 16 members and advisers were in attendance. At that meeting, the self evaluation scores were considered and a broad consensus reached on the assessment. At times, members felt that an additional category of 'mostly achieved' would have been useful. Where this occurred, the score is recorded as 'partially achieved', rather than 'established'. The Development Plan has specific ideas and activities which can realistically be achieved in the short term, over a period of one year. This will form the basis of the submission to the Scottish Government; the deadline for submission is 15 May 2019.

2.4 The Table below shows the scoring for each dimension, at a summary level.

Not Yet Established	Partially Established	Established	Exemplary	Total
0	16	6	0	22

2.5 At the Seminar, Members and advisers put forward ideas and suggestions for a Development Plan to help frame the improvement programme for the year ahead. This has been aligned with the programme of work already agreed at the IJB Audit Committee in March 2019 into a combined Draft Development Plan (Appendix 1). There is a considerable degree of overlap between the ideas for improvement as the activities will contribute to many dimensions; it is not a linear relationship so the improvement ideas will appear in more than one section. Members are invited to consider and comment on the Draft Development Plan prior to submission to the Scottish Government's Ministerial Strategic Group.

2.6 Each of the three partners - the IJB, Shetland Islands Council and NHS Shetland - are required to submit separate responses. It is, however, acknowledged that there will be strength in having one aligned Development Plan for Shetland, as the fundamental issues will be similar for each of the parties. Indeed, the Scottish Government / COSLA letter supports this approach, where they state, "we would greatly appreciate your support in ensuring completion of this self-evaluation tool and would emphasise the importance of partnership and collective ownership across local partners of the actions required at a local level". Those issues will cover: governance and accountability; roles and responsibilities; strategic priorities; resource allocation; and participation and engagement.

3.0 Corporate Priorities and Joint Working:

3.3 Achieving the full potential of integration, through the Public Bodies (Joint Working) (Scotland) Act relies on partnership working between Shetland Islands Council, NHS Shetland, Shetland Charitable Trust, other regional and national organisations (such as the Scottish Ambulance Service, NHS Grampian and other specialist Health Boards), third sector providers and community assets. Shetland has a long tradition of positive partnership work and collaboration on health and care services, through the Shetland Health and Social Care Partnership.

4.0 Key Issues:

4.1 The self-evaluation template covers the 22 proposals contained in the review report, pertinent to the IJB. The template is intended to, "assist local partners in developing collective insights from across local systems to deliver integration". The intention is that the information from self-evaluations will support discussion at a local level and the sharing of good practice between and across local systems. The Scottish Government and COSLA also wish to gain an insight into progress on delivery of the recommendations from the Audit Scotland Report at local level.

4.2 Integration in Shetland is supported by a Liaison Group, with senior representatives from each of the partners. In the spirit of shared learning, each of the self evaluation templates will be shared at the next Liaison Group in May 2019, with a view to aligning the Development Plans across the three partner organisations. The Development Plan for Shetland will be developed to meet SMART criteria (Specific, Measured, Achievable, Realistic and Time-specific).

4.3 Shetland has a long history of successful partnership working, borne out by good performance, an expectation of working in partnership and established relationships between the partners. The Self Evaluation has been considered from a position of an open exchange of views and continuous learning, with an aspiration that the partners continue to work together through the complexities of the health and care integration

agenda to deliver the best possible outcomes for the community.

4.4 Appendix 1 contains a Draft Self Evaluation and Development Plan. There is an expectation that this will be used as a baseline to monitor progress and it is the intention of the Scottish Government to formally seek a progress update in a year's time. The Development Plan can also help to inform the topics which the IJB might consider at its programme of development sessions and seminars.

5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The underlying philosophy of the integration agenda is to help people to live longer, healthier lives and have the best possible experience of health and care services by taking an integrated and person centred approach.
6.2 Human Resources and Organisational Development:	There are no direct implications for staff. However, the issues identified in the Development Plan can be supported by focused Organisational Development support, especially around collaborate leadership and team building.
6.3 Equality, Diversity and Human Rights:	There are no specific issues to address with regard to equality, diversity and human rights.
6.4 Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014 established the legislative framework for the integration of health and social care services. Progress towards achieving the duties in the act are monitored regularly at a national and local level.
6.5 Finance:	There are no specific financial implications associated with this Report. If specific training and skills development needs are identified, this will need to be accommodated within each partners training plans.
6.6 Assets and Property:	There are no implications for assets and property.
6.7 ICT and new technologies:	Digital tools and techniques may assist the IJB with communication between members, with partners and with the wider community.
6.8 Environmental:	There are no specific environmental implications to highlight.
6.9 Risk Management:	The risks of not proceeding with a Development Plan will be: - That the IJB does not fully maximise the potential for improvement to services made possible through the Public Bodies (Joint Working) (Scotland) Act 2014; and - That effective decision making is not supported; There is in place a Risk Register for the work of the IJB, which covers a range of topics including governance, finance, partnership working and

	accountability. A control framework has been established to help to mitigate the risks identified. This self evaluation builds on the established framework.	
6.10 Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) was formally constituted on 27 June 2015 and operates in accordance with the approved Integration Scheme, Scheme of Administration, and the Financial Regulations. This Report, and the associated Development Plan, is in support of the effective implementation of this core governance framework.	
6.11 Previously considered by:	IJB Seminar Strategic Planning Group	18 April 2019 1 May 2019

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6 May 2019

Appendices:

Appendix 1: DRAFT Integration Self Evaluation and Development Plan

References

IJB Audit Committee, February 2019, Health and social care integration - Update on progress
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=23730

Health and Social Care Integration- Update on progress (November 2018).
http://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress

Ministerial Strategic Group for Health and Community Care

Integration Review Leadership Group

Self-evaluation

For the Review of Progress with Integration of Health and Social Care

Name of Partnership	Shetland Health and Social Care Partnership - Integration Joint Board
Contact name and email address	Hazel Sutherland, Head of Planning and Modernisation NHS Shetland
Date of completion	2 May 2019

Key Feature 1 **Collaborative leadership and building relationships**				
Proposal 1.1 **All leadership development will be focused on shared and collaborative practice.**				
Rating Descriptor	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of clear leadership and support for integration.	Leadership is developing to support integration.	Leadership in place has had the ability to drive change with collaboration evident in a number of key areas. Some shared learning and collaborative practice in place.	Clear collaborative leadership is in place, supported by a range of services including HR, finance, legal advice, improvement and strategic commissioning. All opportunities for shared learning across partners in and across local systems are fully taken up resulting in a clear culture of collaborative practice.
Our Rating		√		

Proposal 1.2 **Relationships and collaborative working between partners must improve**				
Rating	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of trust and understanding of each other's working practices and business pressures between partners.	Statutory partners are developing trust and understanding of each other's working practices and business pressures.	Statutory partners and other partners have a clear understanding of each other's working practices and business pressures – and are working more collaboratively together.	Partners have a clear understanding of each other's working practices and business pressures and can identify and manage differences and tensions. Partners work collaboratively towards achieving shared outcomes. There is a positive and trusting relationship between statutory partners clearly manifested in all that they do.
Our Rating		√		

Proposal 1.3 **Relationships and partnership working with the third and independent sectors must improve**				
Rating	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of engagement with third and independent sectors.	Some engagement with the third and independent sectors.	Third and independent sectors routinely engaged in a range of activity and recognised as key partners.	Third and independent sectors fully involved as partners in all strategic planning and commissioning activity focused on achieving best outcomes for people. Their contribution is actively sought and is highly valued by the IJB. They are well represented on a range of groups and involved in all activities of the IJB.
Our Rating		√		

Key Feature 1 **Collaborative leadership and building relationships**	
Evidence / Notes	Opportunity for local liaison meetings between IJB, SIC and NHS representatives. Opportunity to attend national IJB Chairs and Vice Chairs meetings. Integration works well at a service delivery level. Financial accountability remains with the partner organisations. Committed representation from the third sector. The Joint Staff Forum is well established in Shetland, meets regularly is a key enabler in helping to build relationships across the partnership
Proposed improvement actions	Develop understanding of roles and responsibilities, especially with regard to accountability and decision-making, across all partners. Better communication, on a formal and informal basis, between all partners, and with the wider community to explain the role of the IJB. Opportunities to develop an Organisational Development Plan to include eg Collaborative Leadership and Team building. Established diary of events, training, development sessions, etc as well as formal meetings. Developing the IJB as a single entity, rather than a bringing together of partners. Developing the approach to locality management. Developing the IJB's implementation of the Market Facilitation Strategy, through an open and transparent approach, equity of consideration for solving issues, full cost recovery principles; perhaps through pilot projects. Evaluation of IJB's effectiveness (as a Board).

Key Feature 2 **Integrated finances and financial planning**				
Proposal 2.1 **Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of consolidated advice on the financial position of statutory partners' shared interests under integration.	Working towards providing consolidated advice on the financial position of statutory partners' shared interests under integration.	Consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions.	Fully consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions. Improved longer term financial planning on a whole system basis is in place.
Our Rating			√	

Proposal 2.2 **Delegated budgets for IJBs must be agreed timeously**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of clear financial planning and ability to agree budgets by end of March each year.	Medium term financial planning is in place and working towards delegated budgets being agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium term financial and scenario planning in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium to long term financial and scenario planning is fully in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB as part of aligned budget setting processes. Relevant information is shared across partners throughout the year to inform key budget discussions and budget setting processes. There is transparency in budget setting and reporting across the IJB, Health Board and Local Authority.
Our Rating		√		

Proposal 2.3 **Delegated hospital budgets and set aside budget requirements must be fully implemented**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Currently have no plan to allow partners to fully implement the delegated hospital budget and set aside budget requirements.	Working towards developing plans to allow all partners to fully implement the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance, to enable budget planning for 2019/20.	Set aside arrangements are in place with all partners implementing the delegated hospital budget and set aside budget requirements. The six steps for establishing hospital budgets, as set out in statutory guidance, are fully implemented.	Fully implemented and effective arrangements for the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance. The set aside budget is being fully taken into account in whole system planning and best use of resources.
Our Rating		√		

Proposal 2.4 **Each IJB must develop a transparent and prudent reserves policy**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is no reserves policy in place for the IJB and partners are unable to identify reserves easily. Reserves are allowed to build up unnecessarily.	A reserves policy is under development to identify reserves and hold them against planned spend. Timescales for the use of reserves to be agreed.	A reserves policy is in place to identify reserves and hold them against planned spend. Clear timescales for the use of reserves are agreed, and adhered too.	A clear reserves policy for the IJB is in place to identify reserves and hold them against planned spend and contingencies. Timescales for the use of reserves are agreed. Reserves are not allowed to build up unnecessarily. Reserves are used prudently and to best effect to support full implementation the IJB's strategic commissioning plan.
Our Rating			√	

Proposal 2.5 **Statutory partners must ensure appropriate support is provided to IJB S95 Officers.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	IJB S95 Officer currently unable to provide high quality advice to the IJB due to a lack of support from staff and resources from the Health Board and Local Authority.	Developments underway to better enable IJB S95 Officer to provide good quality advice to the IJB, with support from staff and resources from the Health Board and Local Authority ensuring conflicts of interest are avoided.	IJB S95 Officer provides high quality advice to the IJB, fully supported by staff and resources from the Health Board and Local Authority and conflicts of interest are avoided. Strategic and operational finance functions are undertaken by the IJB S95 Officer. A regular year-in-year reporting and forecasting process is in place.	IJB S95 Officer provides excellent advice to the IJB and Chief Officer. This is fully supported by staff and resources from the Health Board and Local Authority who report directly to the IJB S95 Officer on financial matters. All strategic and operational finance functions are integrated under the IJB S95 Officer. All conflicts of interest are avoided.
Our Rating			√	

Proposal 2.6 **IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Total delegated resources are not defined for use by the IJB. Decisions about resources may be taken elsewhere and ratified by the IJB.	Total delegated resources have been brought together in an aligned budget but are routinely treated and used as separate health and social care budgets. The totality of the budget is not recognised nor effectively deployed.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority. The IJB's strategic commissioning plan and directions reflect its commitment to ensuring that the original identity of funds loses its identity to best meet the needs of its population. Whole system planning takes account of opportunities to invest in sustainable community services.
Our Rating		√		

Key Feature 2 Integrated finances and financial planning	
Evidence / Notes	Established Local Partnership Finance Team. Mid Term Financial Plan in place. Approved budget for 2019-20. Established budget monitoring and forecasting Strategic Plan and Service delivery models cost more than funding available; ongoing need for Recovery Plans. Clear, easy to understand reporting and advice. NHS Funding agreed after the start of the financial year; conflict with IJB financial framework built on agreeing budgets prior to start of financial year. Examples of implementation of 'Shifting the Balance of Care' structural changes at a local level Reserves Policy in place.
Proposed improvement actions	Budgeting processes in both partner organisations have primacy; further exploring mechanisms for the IJB to participate effectively. Aligning the Strategic Plan and service delivery models with the Financial Plan, from an outcome focused perspective and further structural / stepped change to service models. Opportunities to further understand the respective financial context of the funding partners. Continue training to develop understanding of IJB financial position, and how best to apply resources to outcomes (include 'Set Aside' arrangements, the application of the Reserves Policy, etc). Opportunity to explore the IJB's place in developing local solutions to Unscheduled Care. Aligning Sustainable Service Models with the Recovery Plan, forecasting within year, the Reserves Policy to make best use of all available resources. Aiming for an approach where the funding is seen as 'IJB funding to deliver the best possible outcomes'. Re-established reporting mechanisms for overseeing transformational change and service redesign at IJB level.

Key Feature 3 **Effective strategic planning for improvement**				
Proposal 3.1 **Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of recognition of and support for the Chief Officer's role in providing leadership.	The Chief Officer is not fully recognised as pivotal in providing leadership. Health Board and Local Authority partners could do more to provide necessary staff and resources to support Chief Officers and their senior team.	The Chief Officer is recognised as pivotal in providing leadership and is recruited, valued and accorded due status by statutory partners. Health Board and Local Authority partners provide necessary resources to support the Chief Officer and their senior team fulfil the range of responsibilities	The Chief Officer is entirely empowered to act and is recognised as pivotal in providing leadership at a senior level. The Chief Officer is a highly valued leader and accorded due status by statutory partners, the IJB, and all other key partners. There is a clear and shared understanding of the capacity and capability of the Chief Officer and their senior team, which is well resourced and high functioning.
Our Rating			√	

Proposal 3.4 **Improved strategic planning and commissioning arrangements must be put in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Integration Authority does not analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. There is a lack of support from statutory partners.	Integration Authority developing plans to analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide some support for strategic planning and commissioning.	Integration Authority has undertaken an analysis and evaluated the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide good support for strategic planning and commissioning, including staffing and resources which are managed by the Chief Officer.	Integration Authority regularly critically analyses and evaluates the effectiveness of strategic planning and commissioning arrangements. There are high quality, fully costed strategic plans in place for the full range of delegated services, which are being implemented. As a consequence, sustainable and high quality services and supports are in place that better meet local needs. The Local Authority and Health Board provide full support for strategic planning and commissioning, including staffing and resources for the partnership, and recognise this as a key responsibility of the IJB.
Our Rating		√		

Proposal 3.5 **Improved capacity for strategic commissioning of delegated hospital services must be in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No plans are in place or practical action taken to ensure delegated hospital budget and set aside arrangements form part of strategic commissioning.	Work is ongoing to ensure delegated hospital budgets and set aside arrangements are in place according to the requirements of the statutory guidance.	Delegated hospital budget and set aside arrangements are fully in place and form part of routine strategic commissioning and financial planning arrangements. Plans are developed from existing capacity and service plans, with a focus on planning delegated hospital capacity requirements with close working with acute sector and other partnership areas using the same hospitals.	Delegated hospital budget and set aside arrangements are fully integrated into routine strategic commissioning and financial planning arrangements. There is full alignment of budgets. There is effective whole system planning in place with a high awareness across of pressure, challenges and opportunities.
Our Rating		√		

Key Feature 3 Effective strategic planning for improvement	
Evidence / Notes	The underlying accountability of the partner organisations can cause complexity in effective decision making. Strategic Plan is in place and refreshed regularly. Directions are in place for all services.
Proposed improvement actions	Opportunity to develop the IJB as a separate entity. Support for the Chief Officer with routine inquiry and administrative requests - from the Chair and other Members of the IJB. Developing the IJB's approach to commissioning for outcomes (rather than to established Service Models). Emerging developments on Performance Framework and reporting arrangements (with a focus on outcomes and away from operational matters). Opportunity to explore the IJB's place in developing local solutions to Unscheduled Care.

Key Feature 4 **Governance and accountability arrangements**				
Proposal 4.1 **The understanding of accountabilities and responsibilities between statutory partners must improve.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No clear governance structure in place, lack of clarity around who is responsible for service performance, and quality of care.	Partners are working together to better understand the governance arrangements under integration to better understand the accountability and responsibilities of all partners.	Clear understanding of accountability and responsibility arrangements across statutory partners. Decisions about the planning and strategic commissioning of delegated health and social care functions sit with the IJB.	Clear understanding of accountability and responsibility arrangements and arrangements are in place to ensure these are reflected in local structures. Decisions about the planning and strategic commissioning of delegated functions sit wholly with the IJB and it is making positive and sustainable decisions about changing the shape of care in its localities. The IJB takes full responsibility for all delegated functions and statutory partners are clear about their own accountabilities.
Our Rating		√		

Indicator 4.2 **Accountability processes across statutory partners will be streamlined.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Accountability processes unclear, with different rules being applied across the system.	Accountability processes being scoped and opportunities identified for better alignment.	Accountability processes are scoped for better alignment, with a focus on fully supporting integration and transparent public reporting.	Fully transparent and aligned public reporting is in place across the IJB, Health Board and Local Authority.
Our Rating		√		

Proposal 4.3 **IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	IJB lacks support and unable to make effective decisions.	IJB is supported to make effective decisions but more support is needed for the Chair.	The IJB Chair is well supported, and has an open and inclusive approach to decision making, in line with statutory requirements and is seeking to maximise input of key partners.	The IJB Chair and all members are fully supported in their roles, and have an open and inclusive approach to decision making, going beyond statutory requirements. There are regular development sessions for the IJB on variety of topics and a good quality induction programme is in place for new members. The IJB has a clear understanding of its authority, decision making powers and responsibilities.
Our Rating		√		

Proposal 4.4 **Clear directions must be provided by IJB to Health Boards and Local Authorities.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No directions have been issued by the IJB.	Work is ongoing to improve the direction issuing process and some are issued at the time of budget making but these are high level, do not direct change and lack detail.	Directions are issued at the end of a decision making process involving statutory partners. Clear directions are issued for all decisions made by the IJB, are focused on change, and take full account of financial implications.	Directions are issued regularly and at the end of a decision making process, involving all partners. There is clarity about what is expected from Health Boards and Local Authorities in their delivery capacity, and they provide information to the IJB on performance, including any issues. Accountability and responsibilities are fully transparent and respected. Directions made to the Health Board in a multi-partnership area are planned on an integrated basis to ensure coherence and take account of the whole system.
Our Rating		√		

Proposal 4.5 **Effective, coherent and joined up clinical and care governance arrangements must be in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is a lack of understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making is not well understood. Necessary clinical and care governance arrangements are not well established.	There is partial understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making. Arrangements for clinical and care governance are not clear	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. There are fully integrated arrangements in place for clinical and care governance.	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. Arrangements for clinical and care governance are well established and providing excellent support to the IJB. Strategic commissioning is well connected to clinical and care governance and there is a robust process for sharing information about, for example, inspection reports findings and adverse events information, and continuous learning is built into the system.
Our Rating		√		

Key Feature 4 Governance and accountability arrangements	
Evidence / Our Notes	Established governance structure in place. Well supported through the Council's Corporate Services Department. Established Liaison Group, with senior representatives from all partners. Uncertainty around actual decision making responsibilities due to enduring accountability by each partner organisation. Balance of debate between understanding operational delivery and commissioning for outcomes. Directions are in place for all services, in line with guidance. Development sessions and seminars on wide ranging topics; well attended. There is one CCPGC but that it has been difficult to get that fully established with all aspects being reported to the committee.
Proposed improvement actions	Developing understanding of clinical care governance between partners, and particularly for Children's Services (outwith the IJB) Explore opportunities to streamline the governance arrangements in the spirit of Integration and 'Once for Shetland'. Continue to explore mechanisms to help with the consistent reporting of complaints to the IJB. Further develop the concept of quality improvement from the perspective of the patient / service users' outcomes. Develop a more comprehensive and consistent approach to community engagement, using examples of local best practice and with a focus on under-represented groups. Review Internal Audit function and the Audit Committee of the IJB, including the preparation of an audit universe over a 3 year period with a remit beyond the traditional financial role. Further develop the approach to Member induction and ongoing skills / training needs assessments (for example, collaborative leadership, partners in policy making, a rights based approach, health inequalities, quality improvement, etc) Ensure that Reports are well written and constructed to focus debate and engage Members in effective decision making. Established funding mechanism to enable the Chair to attend national events. There is an imbalance between the Directions issued and the actual funding available; the Recovery Plan needs clarity on impact on delivery and performance. Directions tend to describe the status quo, rather than focusing on commissioning for outcomes and continuous improvement.

Key Feature 5 **Ability and willingness to share information**				
Proposal 5.1 **IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on by July 2019.	Work is ongoing to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019. Some benchmarking is underway and assisting consistency and presentation of annual reports.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, to ensure public accessibility, and to support public understanding of integration and demonstrate its impact. The annual report well exceeds statutory required information is reported on. Reports are consistently well presented and provide information in an informative, accessible and readable format for the public.
Our Rating			√	

Proposal 5.2 **Identifying and implementing good practice will be systematically undertaken by all partnerships.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve the Integration Authority annual report to identify, share and use examples of good practice and lessons learned from things that have not worked.	Work is about to commence on development of the annual report to enable other partnerships to identify and use examples of good practice. Better use could be made of inspection findings to identify and share good practice.	The Integration Authority annual report is presented in a way that readily enables other partnerships to identify, share and use examples of good practice and lessons learned from things that have not worked. Inspection findings are routinely used to identify and share good practice.	Annual reports are used by the Integration Authority to identify and implement good practice and lessons are learned from things that have not worked. The IJB's annual report is well developed to ensure other partnerships can easily identify and good practice. Inspection findings and reports from strategic inspections and service inspections are always used to identify and share good practice. All opportunities are taken to collaborate and learn from others on a systematic basis and good practice is routinely adapted and implemented.
Our Rating			√	

Key Feature 5	Ability and willingness to share information
Evidence / Notes	Annual performance report in place, developed in line with the guidance.
Proposed improvement actions	More locality based examples of best practice to be included. Develop approach to benchmarking with peers, in line with national guidance. Continue to work with national data collection and analysis teams to use evidence to drive local outcomes and improvements. Seek out good practice from other areas of Scotland to maintain momentum on innovation and redesign. Continue to explore tools and techniques to communicate performance with a wider audience.

Key Feature 6 **Meaningful and sustained engagement**				
Proposal 6.1 **Effective approaches for community engagement and participation must be put in place for integration.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is a lack of engagement with local communities around integration.	Engagement is usually carried out when a service change is proposed.	Engagement is always carried out when a service change, redesign or development is proposed.	Meaningful engagement is an ongoing process, not just undertaken when service change is proposed. Local communities have the opportunity to contribute meaningfully to locality plans and are engaged in the process of determining local priorities.
Our Rating		√		

Proposal 6.2 **Improved understanding of effective working relationships with carers, people using services and local communities is required.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve effective working relationships with service users, carers and communities.	Work is ongoing to improve effective working relationships with service users, carers and communities. There is some focus on improving and learning from best practice to improve engagement.	Meaningful and sustained engagement with service users, carers and communities is in place. There is a good focus on improving and learning from best practice to maximise engagement and build effective working relationships.	Meaningful and sustained engagement with service users, carers and communities is in place. This is given high priority by the IJB. There is a relentless focus on improving and implementing best practice to maximise engagement. There are well established and recognised effective working relationships that ensure excellent working relationships.
Our Rating		√		

Proposal 6.3 **We will support carers and representatives of people using services better to enable their full involvement in integration.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve involvement of carers and representatives using services.	Work is ongoing to improve involvement of carers and representatives using services.	Carers and representatives on the IJB are supported by the partnership, enabling engagement. Information is shared to allow engagement with other carers and service users in responding to issues raised.	Carers and representatives of people using services on the IJB, strategic planning group and locality groups are fully supported by the partnership, enabling full participation in IJB and other meetings and activities. Information and papers are shared well in advance to allow engagement with other carers and service users in responding to issues raised. Carers and representatives of people using services input and involvement is fully optimised.
Our Rating		√		

Key Feature 6 Meaningful and sustained engagement	
Evidence / Notes	Examples of good practice of early engagement in place (eg Bressay Project) but work required to ensure more effective engagement at all stages of the commissioning cycle. Shetland Public Engagement Network committed to assist with engagement and communication. Committed representation from Carer's representatives. Recognition of need for engagement to be on a 'Once for Shetland' basis, ie all partners aligned to strategic vision and objectives. Established links to Shetland Partnership (Shetland's community planning partnership). Established Joint Staff Forum and feedback mechanisms.
Proposed improvement actions	Formalise the IJB's commitment to engagement through a refresh of the Participation and Engagement Strategy, with a focus on an implementation plan for timely, consistent and effective engagement on a Shetland-wide and locality basis. Explore tools and techniques for communicating well on a formal and informal basis with all stakeholders. Develop the ambassadorial role of all members of the IJB. Complete the exercise to publicise the profiles of the members of the IJB, and their interests. Continue to support the Carer's Representative with the approaches to establishing networks.

Shetland Islands Health and Social Care Partnership

Agenda Item

7

Shetland NHS Board	Shetland Islands Council

Meeting(s):	Integration Joint Board	7 May 2019
Report Title:	IJB Business Programme 2019 and IJB Action Tracker	
Reference Number:	CC-18-19-F	
Author / Job Title:	Simon Bokor-Ingram, IJB Chief Officer	

1.0 Decisions / Action required:

1.1 That the Integration Joint Board RESOLVES to consider and approve its business planned for the financial year to 31 March 2020 (Appendix 1).

1.2 To REVIEW the IJB Action Tracker (Appendix 2).

2.0 High Level Summary:

2.1 The purpose of this report is to allow the IJB to consider the planned business to be presented to the Board during the financial year to 31 March 2020, and discuss with Officers any changes or additions required to that programme.

3.0 Corporate Priorities and Joint Working:

3.1 The IJB Joint Strategic Commissioning Plan describes how health and care services can be delivered, jointly, across the services described in the Shetland Islands Health and Social Care Partnership's Integration Scheme.

3.2 In order to fulfil the statutory duties with regard to the functions delegated to the IJB by the Shetland Islands Council (the Council) and Shetland NHS Board (the Health Board), and in order to meet public governance principles, the IJB must make sure its Business Programme supports its role in the planning and direction of services to meet the needs of some of the most vulnerable people in our community, and to set its business in accordance with local and national reporting frameworks.

4.0 Key Issues:

4.1 The IJB's governance documents contain the legislative requirements and matters of best practice and standards, and the Business Programme enhances these by publicising the plans for decision making and other public reporting requirements, in keeping with the principles of good governance.

4.2 There is a strong link between strategic planning and financial planning, to provide the best possible environment to ensure that the strategic direction, service models and resources to deliver services are aligned.	
5.0 Exempt and/or confidential information:	
5.1 None.	
6.0 Implications :	
6.1 Service Users, Patients and Communities:	The Business Programme provides the community and other stakeholders with important information, along with the Strategic Commission Plans, as to the planned business for the coming year.
6.2 Human Resources and Organisational Development:	There are no direct impacts on staffing or organisational development matters with regard to approval of the Business Programme. However approval of the Business Programme will give direction and assurances to staff with regard to the timing and requirements for decisions and public reporting that the IJB has agreed. Changes that have the potential to impact on the workforce will be reported to the Joint Staff Forum for consultation with staff representatives.
6.3 Equality, Diversity and Human Rights:	There are no direct impacts on equality, diversity or human rights with regard to approval of the Business Programme, although individual items will have to have regard to those in terms of any outcomes and associated risks. The recommendation in this report does not require an Equalities Impact Assessment.
6.4 Legal:	The IJB is advised to establish a Business Programme, but there are no legal requirements to do so. There are no direct legal impacts with regard to approval of the Business Programme, although individual reports will have to have regard to current and impending legislation and the impact on the IJB, and the services which the NHS and SIC deliver, in terms of outcomes and legal risks.
6.5 Finance:	The there are no direct financial implications by approving the Business Programme, but indirect costs may be avoided by optimising time spent by officers and members of the IJB at scheduled meetings. Regular financial and performance reporting will ensure that the IJB fulfils the terms of the Integration Scheme.

	Any costs associated with the development and maintenance of the IJB Business Programme will be met from within existing budgets of the Council and the Health Board.
6.6 Assets and Property:	There are no implications for major assets and property. It is proposed that all meetings of the IJB will be held in either the premises of the Council or the Health Board and that the costs will be covered accordingly by the Council and the Health Board.
6.7 ICT and new technologies:	There are no ICT and new technology issues arising from this report.
6.8 Environmental:	There are no environmental issues arising from this report.
6.9 Risk Management:	The risks associated with setting the Business Programme are around the challenges for officers meeting the timescales required, and any part of the Business Programme slipping and causing reputational damage to the IJB, the Council or the NHS. Equally, not applying the Business Programme would result in decision making being unplanned and haphazard and aligning the IJB's Business Programme with the objectives and actions contained in its Strategic Plans could mitigate against those risks.
6.10 Policy and Delegated Authority:	As a separate legal entity the IJB has full autonomy and capacity to act on its own behalf. Having in place a structured approach to considering key planning, policy and performance documents at the right time is a key element of good governance. Regular Business Planning reports are already prepared for each IJB meeting.
6.11 Previously considered by:	NA

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Appendices:
Appendix 1 Business Programme 2019-20
Appendix 2 IJB Action Tracker

Shetland NHS Board

Shetland Islands Council

Shetland Health and Social Care Partnership

Integration Joint Board

Meeting Dates and Business Programme 2018/19

as at Monday, 06 May 2019

Integration Joint Board 2019/20		
	Date of Meeting	**Business**
Quarter 1 - 1 April 2019 to 30 June 2019	Tuesday 14 May 2019 10 a.m.	• 2019/20 Primary Care Improvement Plan • 2019/20 Service Plans and Directions • 2019/20 Recovery Plan Update • Community Led Support • IJB Self-Assessment on Integration • Appointments to IJB • IJB Meeting Dates, Business Programme 2019/20
	Thursday 27 June 2019 *Special Meeting A/Cs only* 3 p.m.	• Draft 2018/19 Accounts • Financial Monitoring Report to 31 March 2019 • Deloitte (Wider Scope) Audit Report • Shetland Islands Health and Social Care Partnership Quarterly Performance Overview : Quarter 4 – January - March 2019 • Annual Performance Report for 2018-19 • Palliative and End of Life Care Strategy • IJB Meeting Dates, Business Programme 2019/20
Quarter 2 – 1 July 2019 to 30 September 2019	Thursday 29 August 2019 3 p.m.	• Review of Self Directed Support and action plan • IJB Meeting Dates, Business Programme 2019/20
	Thursday 26 September 2019 *Special Meeting A/Cs only* 3 p.m.	• Final 2018/19 Accounts • Annual Audit Report 2018/19 • IJB Meeting Dates, Business Programme 2019/20
Quarter 3 - 1 October 2019 to 31 December 2019	Thursday 28 November 2019 3 p.m.	• 2020/21 IJB Budget progress report • CSWO annual report • IJB Meeting Dates, Business Programme 2019/20
Quarter 4 - 1 January 2020 to 31 March 2020	Tuesday 25 February 2020 11 a.m.	• Final 2020/21 IJB Budget • Medium Term Financial Plan Update • IJB Meeting Dates, Business Programme 2019/20

Shetland NHS Board

Shetland Islands Council

Shetland Health and Social Care Partnership

Integration Joint Board

Meeting Dates and Business Programme 2018/19

as at Monday, 06 May 2019

Planned business still to be scheduled - as at Monday, 06 May 2019

- Code of Corporate Governance
- Right to Advocacy
- Joint Organisation and Workforce Development Protocol
- Effectiveness of the board

END OF BUSINESS PROGRAMME as at Monday, 06 May 2019

	ACTIONS - IJB						
No	**Agenda Item**	**Responsible Post Holder**	**IJB Meeting Date**	**Target Date**	**Action**	**Update**	**R/A/G Status C (Completed)**
1	Intermediate Care Team Update	Chief Nurse (Community)	11.11.18		Once resolved provide briefing by email about car insurance issue around the use of the NHS owned vehicle for SIC use/delivery Intermediate care team updates to be provided in quarterly performance reporting.	Ongoing issue which has been raised at a national level. Exception reporting only.	A
2	Carers Information Strategy Update	Self-directed Support Officer / Carers Lead	11.11.18		Future report to include census data and information on types of care, age and demographic.	Update presented to IJB on 13th March 2019	Complete
3	Primary Care Improvement Plan Update	Service Manager Primary Care/Community Nursing Manager	11.11.18		Training Budget issues for GPs and other professionals to be raised as an issue for future budgeting Briefing to be provided on general practice nursing	Future reporting through performance reporting.	G

					More detail on how far along towards completion of actions to be included in Appendix 2		
4	Shetland Islands Health and Social Care Partnership Quarterly Performance Overview, Quarter 2: July - September 2018	Director of Community Health and Social Care/ IJB Chief Officer and Head of Planning and Modernisation	23.01.19		For future reporting on the Risk Register more clarity in the wording used to be considered. Indicator E15 data to be provide differently on ongoing basis. Appendix 1A will be refreshed and updated for 2019/20 following the approval of the Joint Strategic Commissioning Plan.	IJB seminar being arranged to focus on the development of the risk register	G
5	Mental Health Service Review: Findings and Directions	Director of Community Health and Social Care/K Smith, Mental Health Service	23.01.19		Provide an email to IJB members an update on progress in regard to multipurpose accommodation for use by the Mental Health Team.		A
6	IJB Meeting Dates, Business Programme 2018/19 and 2019/20,and IJB Action Tracker	Director of Community Health and Social Care	23.01.19		• Self assessment for IJB – consider how best that can be done. • Carer Eligibility Criteria – consider if this can be reported to the next meeting. Number of action tracker	IJB self assessment on agenda of IJB meeting 14th May 2019	Complete

					points to be removed or updated		
7	Financial Monitoring Report to 31 December 2018	Chief Financial Officer	13.03.19		Find a way to provide detail on carers costs to show the true spend in this area and circulate to Jim Guyan and Natasha Cornick. Circulate to Members more detail on the areas of overspend covered by GP locums highlighted in section 4.		
8	Shetland Islands Health and Social Care Partnership - Quarterly Performance Overview, Quarter 3: October - December 2018	Director of Community Health and Social Care and Head of Planning and Modernisation	13.03.19		Appendix 2 first indicated - data to start being recorded and presented in two performance reports time to allow time for the data to be gathered. Targets to be checked on page 39 People waiting for placements and page 47 occupancy of care homes and provide future data showing respite separately.		G
9	2019/20 Budget	Chief Financial Officer	13.03.19	May 2019	4 service areas listed 4.12 in budget report to be brought to May meeting with more detail.	Recovery plan update on IJB meeting agenda 14th May 2019	Complete

10	Carers Eligibility Criteria and Directions	Self-directed Support (SDS) Implementation Officer/ Carers Lead	13.03.19		Page 32 of the appendix 3 Paragraph 5 under Assessing needs – Change “Shetland” to “Scotland”. On the notes column of table 2 on page 33 insert the correct figure for under 16 in Shetland.	Paper updated.	Complete
11	IJB Business Programme 2019 and IJB Action Tracker	IJB Chief Officer	13.03.19		Recovery plan to be added to the agenda of each meeting. Items to be added to the business programme or included under business to be planned: • Code of Corporate Governance • Right to advocacy • development workforce protocol • effectiveness of the board • Service transformation • Primary care 4 service areas listed in budget report to be brought to May meeting. Ms Watson to provided written addendum to the primary care update on GP Practice Nursing		G

					Risk register – training session to be arranged following change in membership.		