Shetland Islands Health and Social Care Partnership

Joint Strategic Commissioning Plan

2019- 2022

For comments and queries, please contact:

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Foreword

"We are the community, and they are us[1]"

Shetland, in keeping with other areas in the UK, is facing a period of unprecedented change in its public services. Investment in health and care services has been hugely successful, with people living longer and being able to live longer even though they may have more complicated health and care needs. Shetland has an excellent reputation for delivering high quality, safe and effective services. However, the pressures before us continue to grow and our financial challenges are significant, never mind dealing with increasing demand. We therefore need to set out clearly how we can deliver services into the future that meet need, and continue to be safe, effective and of quality. It goes without saying that individuals, families, unpaid carers, volunteers, staff and communities will be at the heart of the changes – after all that is why we are all in the business of public service. Our challenge is to genuinely change the way that we work to and make sure that services are integrated around the needs of individuals, their families and unpaid carers and are not built around the convenience of organisations.

It is a hugely exciting challenge to be at the forefront of modernising public sector service in Shetland and to help individuals enjoy a good quality of life. We want to grow a system where skilled staff and volunteers are trusted to do the best they can for the individuals that we serve within a safe and open learning environment and we look forward to working with the Shetland community to make that happen.

Marjorie Williamson
Chair of Shetland Islands Health and Social Care Partnership Integration Joint Board

Gary Robinson
Chair
Shetland Health Board

Steven Coutts
Leader
Shetland Islands Council

[1] Feedback from member of staff 2015

Contents

Executive Summary

In line with the Integration scheme this is a plan for the whole of the health and care system in Shetland which sets out the changing models of health and care services. The Plan is supported by more detailed plans and policies.

The partners are:

- Shetland Islands Health and Social Care Partnership, through the formal arrangements of the Integration Joint Board (IJB);
- NHS Shetland; and
- Shetland Islands Council.

There are competing issues around increasing demand and diminishing resources which makes it not possible to continue to deliver services in the same way we do at the moment into the future. Our population is growing older and there are more people living with lifelong conditions, including people with learning disability, complex needs and autistic people. With that comes increasing demand for services associated with older age and throughout life.

Alongside that, our working age population is expected to decrease and there will not be enough working age people to maintain the same services models into the future. We also face particular challenges around the recruitment and retention of staff.

Health and care services will continue to face a real term restriction in resources over the next three years.

We therefore need to find a way, collectively, to develop the mix of hospital, primary care, community care and health improvement services that best meet the needs of our population.

We consider that there are opportunities to change how we deliver our services which may provide the same – and sometimes better – services, but at a lower cost. That might seem counter-intuitive but we believe by working together collaboratively to reduce the boundaries between all the different parts of the health and care system, we can find a way to make sure that citizens are seen by the right person, at the right time and in the right place.

The change projects that we want to work on to do this includes:

- working with individuals to help them to look after their own health and care needs;
- primary care;
- repatriation of care back to Shetland where it is safe to do so;
- unscheduled, or emergency, care;

- managing long term conditions, such as diabetes, respiratory disease and stroke; and
- working with people to maintain or increase independence and quality of life.

This Plans sets out why we want to make those changes. More details on any of these issues are included in supporting plans and documents, all of which are referenced at the back of this Plan.

Why do we need to change?

Health and care services in Shetland are delivered to a consistently high standard, in most areas. However, there are many factors which make the current models of service delivery difficult to sustain.

Audit Scotland, in their report on 'Changing Models of Health and Social Care' stated that,

> *"the growing number of people with complex health and social care needs, particularly frail older people, together with continuing tight finances, means that current models of care are unsustainable. New models of care are needed."*

The 'National Clinical Strategy for the NHS in Scotland 2016', summarised the position as:

> "*Our population is growing older, and some older people will need increasing amounts of health and social care. More people are living with long-term conditions such as diabetes, high blood pressure, cancer and dementia, each of which requires ongoing treatment and care. And we still have a high level of health inequality – a person living in the most socially deprived community in Scotland can expect to live at least 10 years less than someone living in a well-off area. All of this means that demand for health and care services will increase over the next 15–20 years.* "

NHS Shetland recently facilitated a 'Scenario Planning' exercise to understand more fully the issues which we are facing and what we need to do about it. The participants identified the key variables that are likely to impact on health and care services in the future and the key themes and issues which emerged were:

- Demographics
- Workforce and Training
- Demand Management
- Whole System Approach
- Connectedness
- Communications
- Technology and Systems
- Prevention
- Money
- Self Care / Self Management
- Culture and Risk
- Decision Making
- Clinically Led Changes
- Stakeholder Involvement
- Politics

The key factors identified are explored in more detail below.

Demand

- The population is aging rapidly and it is therefore likely that demand for adult health and care services will increase.
- With advances in medical science, there is an increase in the number of people surviving birth issues and living with complex and lifelong conditions
- Longevity is improving for people with lifelong conditions, including people with learning disabilities, who now also experience age related issues, for example, learning disability and dementia.
- The Regional Discussion Paper estimates that the gap across the north of Scotland between demand and resources for outpatient referrals to be 9% per year and for inpatient and day case treatment to be 13% per year.

- Ageing can be an indicator for a potential associated rise in conditions such as sensory impairments, mental ill-health, hypertension, asthma, diabetes, dementia and multiple chronic disorders.
- There is a trend towards more people living nearer to centres of population, making sustaining services in the more rural areas challenging.
- There is evidence of more people living longer, with long term conditions.
- Determining actual levels of future need is difficult, as there are so many factors at play, especially with a relatively small population.

Prevention

- There is a need to continue to invest time in helping people to help themselves in order to tackle the causes of ill health.
- Continued investment in preventive services is paramount to managing growth in demand, alongside supporting existing need.
- Many preventative services will be outwith health and care so we need to work with individuals, communities and partners to get better at early intervention and preventative services.
- There is a specific need to work with our partners in sign posting people to more appropriate services outwith health and care.

Economics

- The wider economic and political environment has restricted the availability of investment in the health and care system. This has led to a challenging financial environment and an ongoing need to identify efficiencies and savings
- The financial efficiency savings that need to be addressed over the next 5 years is £7.6m for the NHS.
- The Council has set out its financial aims in the medium term financial plan but there is no specific detail - as yet - in how the £15.6m savings target will be applied to individual service areas but it is expected that social care will not be exempt from the need to find savings.
- Opportunities and ideas for the NHS to work more efficiently have been identified by the Government (using national metrics) in line with the annual efficiency targets expected to be achieved.
- There are significant diseconomies of scale associated with the current service model which is compensated for, to some extent, by the financial support from the Government.

Workforce

- The working age population is predicted to reduce.
- There is difficulty in recruiting to some jobs, in some areas.
- A number of our services have been categorised as ‘at risk’ where either recruitment to key posts is difficult, the service relies on a single person or there is an aging workforce.

	- It is likely that there will be insufficient staff to address future care needs, if the current models of service stay the same. In some areas, use of locum or agency staff is already required to meet current need. - Our staff are highly skilled, often with skills beyond the job that they actually do, so we need to find a way to build multi-disciplinary teams that work flexibly and makes the best use of everyone's skills so that people get seen by the 'right person' to meet their need.
Integration	- For any area, and especially for an area the size of Shetland, we need to find a way to progress a 'whole system approach'. - There is a need to stop considering secondary care, primary care, social care, health improvement and the third sector as separate services and find a way to seamlessly wrap services, advice and support around the needs of individuals and families. - Services often work in a 'fragmented' way so there is a need for staff to work more collaboratively – and avoid silo working. - Our services users see one health and care system; there is a need for us to respond to that.
Technology	- We need to get better at using technology for routine appointments and advice. - There is a need to accelerate the use of technology, to save people having to travel. - Our data systems do not easily talk to each other so there is a need to work towards a series of compatible systems that wrap around the patients', staff and citizens' needs. - We need to get better at using technology to support positive risk taking and risk enablement as a core part of placing people at the centre of their own care and support. - Developing technology will provide new opportunities to change and redesign the way and type of service we provide

What we are trying to Achieve

This section sets out the various legislative and policy statements, to describe what we are trying to achieve.

Scottish Government 2020 Vision

The Government's overall Vision is that,

> "By 2020, everyone is able to live longer, healthier lives, at home or in a homely setting".

The National Health and Care Delivery Plan states that the Government's aim,

> "... is a Scotland with high quality services, that have a focus on prevention, early intervention and supported self-management. Where people need hospital care, our aim is for day surgery to be the norm, and when stays must be longer, our aim is for people to be discharged as swiftly as it is safe to do so".
>
> Where there is in place "a health and social care system that:
>
> - is integrated;
> - focuses on prevention, anticipation and supported self-management;
> - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
> - focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
> - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission".

Shetland Partnership (Shetland's Community Planning Partnership)

The overall purpose of the Shetland Partnership's approach is to work together to improve the lives of everyone in Shetland. The key focus will be to reduce inequality of outcome by tackling issues that mean some people and groups have poorer quality of life than others.

The shared vision of the Shetland Partnership, as set out in Shetland's Partnership Plan 2018-28, is,

> "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."

Effective community planning focuses on where partner's collective efforts can add most value for their local communities, with particular emphasis on reducing inequalities. Shetland's Partnership Plan therefore focuses on a small number of local priorities where we will make the most difference for our most vulnerable individuals, families and communities and by moderating future demand for crisis services. The shared priorities are:

People	Individuals and families thrive and reach their full potential
Participation	People participate and influence decisions on services and use of resources
Place	Shetland is an attractive place to live, work, study and invest
Money	All households can afford to have a good standard of living

Whilst all areas need to continue to deliver effective services for the Plan to work as a cohesive whole, the focus of activity for health and care will be in the following areas.

For the 'People' dimension, the focus will be on:

- tackling alcohol misuse;
- healthy weight and physical activity;
- social isolation and loneliness; and
- reducing health and wellbeing inequalities

For the 'Participation' part of the plan, activity will be centred on:

- satisfaction with public services;
- community participation activity and impact; and
- people's ability to influence and be involved in decisions which affect them.

For the 'Place' priority, the focus will be on:

- service innovation;
- recruitment and underemployment; and
- balancing our working age population.

For the 'Money' priority, the focus will be on:

- households earning enough to have an acceptable standard of living.

Public Health Priorities

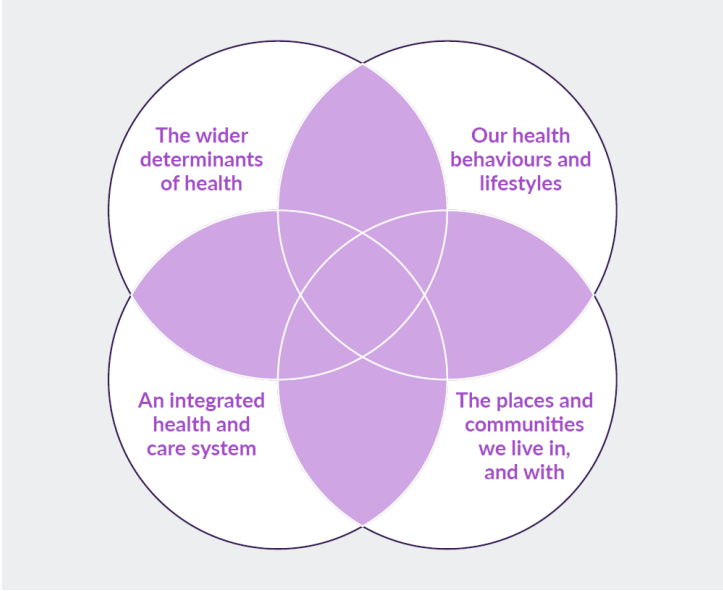
Substantial improvements in life expectancy over the past 100 years mean that people are living longer, healthier lives than ever before; however Scotland still has the lowest life expectancy in the UK. Within Scotland, Shetland has traditionally had a good life expectancy

and a level of health amongst the best in Scotland, reflecting the high quality of life in Shetland, as well as the quality of local services. Recently, the year on year improvements in life expectancy have slowed down across the UK, including Shetland. The reason for this slowdown is under investigation by universities and other academic institutions. For men the life expectancy at birth using the three year rolling average for 2013-15 was 77.6 years, down from 78 and for women was 81.9 years, down from 82.45.

Life expectancy (LE) is an estimate of how many years a person might be expected to live, whereas **healthy life expectancy (HLE)** is an estimate of how many years they might live in a 'healthy' state. HLE is a key summary measure of a population's health.

Men in Shetland have one of the shortest periods expected to be spent in 'not healthy' health (LE minus HLE); around 11-12 years. By contrast, the figure for Greater Glasgow and Clyde was 15.1 years. Women in Shetland can expect to spend the last 13.5 years of their lives in poor health compared to 17.8 in Greater Glasgow and Clyde and 11 in Orkney. (ScotPHO).

We recognise that NHS Shetland and the Shetland Health and Social Care Partnership cannot influence these outcomes alone. The King's Fund has developed a useful framework for planning actions to tackle population health (an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population).



- There is now a wealth of evidence that the **wider determinants of health** are the most important driver of health. In addition to income and wealth, these determinants include education, housing, transport and leisure.
- **Our health behaviours and lifestyles** are the second most important driver of health. They include smoking, alcohol consumption, diet and exercise. For example, while reductions in smoking have been a key factor in rising life expectancy since the

1950s, obesity rates have increased and now pose a significant threat to health outcomes.

- There is now increasing recognition of the key role that **places and communities** play in our health. For example, our local environment is an important influence on our health behaviours, while there is strong evidence of the impact of social relationships and community networks, including on mental health.
- Recent years have seen a strong focus on developing an **integrated health and care system**. This reflects the growing number of patients with multiple long-term conditions and the need to integrate health and care services around their needs rather than within organisational silos.

We are clear that work needs to be balanced across the four pillars and that work in one area alone will not be effective. A more balanced approach is required that distributes effort across all four pillars and, crucially, makes the connections between them.

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 agreed priorities reflect public health challenges that are important to focus on over the next decade to improve the public's health. Underpinning these priorities are health protection activities such as ensuring the safety and quality of food, water, air and the general environment and preventing the transmission of communicable diseases.

Regional Planning

The North of Scotland Health and Social Care Discussion Paper, Plans and Propositions for the future 2018-2023, sets out the strategic intent of the partners across the north of Scotland, the need for change, the model of care and the workstreams that will make the changes happen.

The partners in the North of Scotland Health and Care system are set out in the diagram below.

The key proposals for changing how we work – called 'propositions' - in the North of Scotland Health and Care Discussion Paper centre around:

- Changing Demand and Improving Efficiency – focusing on closing the demand and capacity gap for elective care
- Developing Effective Alliances – forging partnerships and focusing on improvement
- Transforming Care through Digital Technology – shrinking distances and improving access to services
- Developing World Class Health Intelligence - supporting change, quality improvement and efficiency
- Making the North the Best Place to Work – recruiting and developing the best staff

The proposed Model of Care for the North of Scotland is set out below.

- Create opportunities for the prevention of illness and promotion of health and wellbeing
- Support people to have the knowledge and skills to stay healthy
- Provide people with different ways of getting advice, treatment and care
- Provide as much support to allow people to live at home, or as close to home as possible, if ill, frail or living with long term health conditions
- Organise for diagnosis and treatment to be provided as locally as possible to minimise travel from home

- Ensure that the stay in, or visit to, hospital is as short as possible to give the best treatment outcome
- Ensure that the return home from hospital is organised and coordinated with community services
- Organise effective clinical networks of professional staff to provide support for those complex treatment and care needs
- Provide specialist services in the North of Scotland as far as possible
- Coordinate the treatment and care effectively if the condition or illness requires travel outside the North of Scotland

Working to improve people's wellbeing

Our work is to improve the wellbeing of service-users, as described in the nine national health and wellbeing outcomes[2] below:

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 who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
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.
9. Resources are used effectively and efficiently in the provision of health and social care

The strategic outcomes[3] relating to the vision, values and goals of the *Scottish Strategy for Autism and the Keys to Life: Scotland's learning disability strategy*, 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.* The strategic outcomes are:

[2] Public Bodies (Joint Working) National Health and Wellbeing Outcomes (Scotland) Regulations 2014

[3] https://www.gov.scot/publications/scottish-strategy-autism-outcomes-priorities-2018-2021/
https://keystolife.info/

- A Healthy Life
- Choice and Control
- Independence
- Active Citizenship

How we will work

The following integration planning principles[4] "will underpin how we shape our services and find innovative solutions to meet our communities' needs and improve the wellbeing of service-users so that our services:

- are integrated from the point of view of service-users
- take account of the particular needs of different service-users
- take account of the particular needs of service-users in different parts of Shetland
- take account of the particular characteristics and circumstances of different service-users
- respect the rights of service users, whilst ensuring they understand and respect their responsibilities
- take account of the dignity of service-users
- take account of the participation by service-users in the community in which service-users live
- protect and improve the safety of service-users
- improve the quality of the service
- are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- best anticipate needs and prevent them arising
- make the best use of the available facilities, people and other resources".

Delivering quality services

We will deliver services in line with the Healthcare Quality Strategy for Scotland:

> Safe - There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time
>
> Person-Centred - Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values

[4] Section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014

and which demonstrates compassion, continuity, clear communication and shared decision-making

Effective - The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated

We will deliver services in line with Scotland's Care Inspectorate standards as the national regulator for care services in Scotland. Care Inspectorate inspect the social work (and social care) services provided by local authorities and carry out joint inspections with partner organisations.

The Care Inspectorate[5] exists to:

- provide assurance and protection for people who use services, their families and carers and the wider public
- play a key part in improving services for adults and children across Scotland
- act as a catalyst for change and innovation
- promote good practice.

People have the right to expect the highest quality of care and their rights promoted and protected. It is the Care Inspectorate's job to drive up standards of care and social work services through regulation and inspection.

Shetland's Health and Care Vision

Our Vision is that by 2025 everyone is supported in their community to live longer, healthier lives and we will have reduced health inequalities.

[5] *http://www.careinspectorate.com/*

Developing the Future of Health and Care

NHS Shetland has facilitated a series of workshops to map out possible futures for health and care services in Shetland, using a management tool called Scenario Planning. This is one strand of our approach to making sure that the Strategic Plan is developed and owned by a range of stakeholders. There were representatives from:

- NHS Shetland Board
- Service user representatives
- NHS staff
- IJB Board
- Shetland Islands Councillors
- Council staff
- Third sector partners
- Community planning partners

Services being available at a local level is really important to people – and local can mean at home, in local communities or in Lerwick at the Gilbert Bain Hospital. The Scenario Planning exercise therefore placed 'local services' at the heart of the discussion on what the future should look like.

Two scenarios were explored in detail to determine what impact a change to <u>where</u> services might be delivered from, as follows:

- a lower level of local healthcare provision in 5-10 years than we have now on Shetland - a 'step down' from where we are now in terms of local service delivery.

- a higher level of local healthcare provision in 5-10 years than we have now on Shetland - a 'step up' from where we are now in terms of local service delivery.

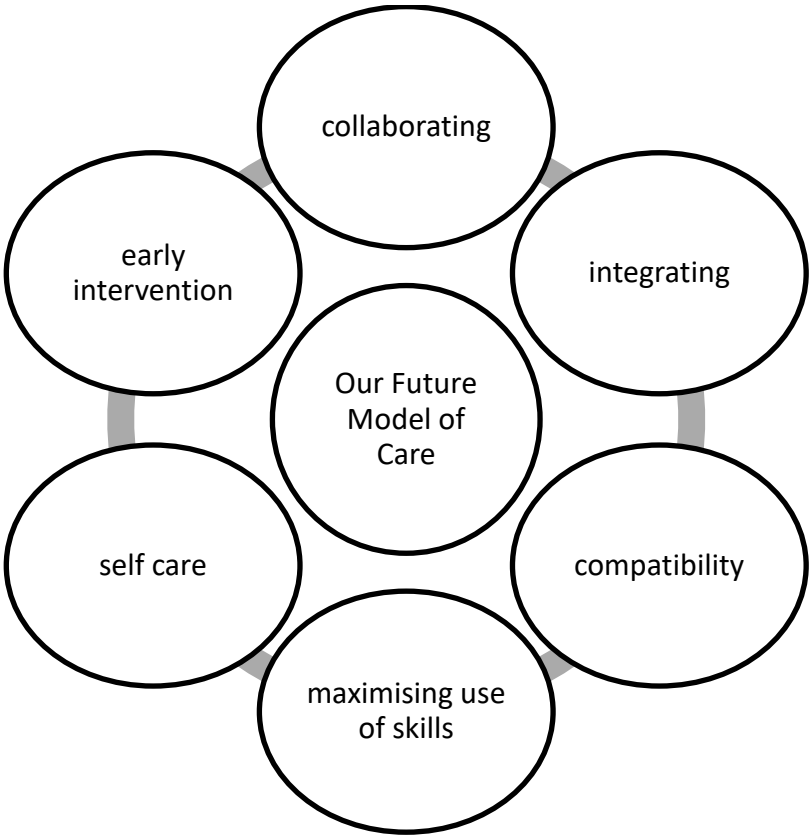
This was considered from the point of view of a continuum, from a more 'centralised' model, to a more 'locally based' model.

It was strongly felt that a 'step down' scenario of less local access (ie more care being provided on the Scottish mainland, with less local access across Shetland and a reduced emphasis on prevention and self care) was undesirable and likely to lead to poorer patient outcomes, reduced health in the population and less effective use of resources. It was recognised that if proactive steps are not taken, it would be perfectly possible for this scenario to become the reality.

However, there was a clear preference to work towards a future based on the 'step up' scenario where it would be possible to provide more services on mainland Shetland and reduce the need for patients to travel to the UK mainland. This scenario would reduce the need for care to be provided in hospital settings and there would be a significant increase in

focus on prevention and developing alternative approaches to support patients to control and improve their own health.

A description of that Model of Care is centred on a suite of enablers and principles:



The participants stated that what is important to them is an approach where we:

- put the person or service user at the centre of our decision making (person centred care);
- enable clinical leadership, based on evidence;
- maximise opportunities to support self care and self management;
- empower an early intervention and preventative agenda along with our service users and partner organisations;
- collaborate with each other to make sure that services are delivered by the right person, with the right skills;
- work to maximise how people can use their skills to best effect;
- integrate how we work to blur boundaries between organisations, buildings, systems and resources;
- create seamless systems – including ICT systems - for the purpose of data and decision making.

The Scenario Planning process helped to refocus thinking around the need for:

- clinical leadership;
- a whole system, or single system approach;
- communication and community engagement;
- seeing the wider impact of health and care from a community planning perspective;
- positive engagement of partners and the third sector; and
- opportunities through the Islands (Scotland) Act 2018.

What will our health and care services look like in future?

We will have in place seamless services, wrapped around the needs of individuals, their families and communities, which are not restricted by organisational or professional boundaries. Where possible we aim to deliver a 'one stop shop' approach to health and care.

Our underpinning principle will be to use an 'Asset Based' approach to working with individuals, families and communities. An asset based approach is one which builds on the assets that are found in the community and mobilises individuals, associations, and institutions to come together to realise and develop their strengths. The identified assets from an individual are matched with people or groups who have an interest in or need for those strengths by using what is already in place in each the community. This approach sees health and care solutions being developed with communities and often outwith the formal health and care settings.

We will support people to have the knowledge and skills to stay healthy. There is an increased emphasis on community-led health promotion and ill-health prevention, including at school. This is also supported by an increasing emphasis on self-care and self-management, alongside providing additional support to unpaid carers, including receiving training appropriate to the needs of those they care for.

All stakeholders use compatible Information Technology systems and share information and data easily and readily. This will be supported by robust but appropriate rules around how we use personal and health and care data. We will use technology to explore new ways of working, especially around: self care; advice and information; and virtual appointments to minimise travel and maximise access to services within Shetland and outwith Shetland for specialist treatment.

Services will share facilities and accommodation with less "names on doors". The concept of local "hubs" is developed that have a wider focus than just health. Service providers increasingly work out of shared buildings. Services will, where appropriate, share spaces, utilise shared reception and administrative staff, with teams co-located in some areas. Accommodation is being developed in the context of a wider public sector plan, with appropriate rationalisation and cost reduction but without any detriment on service delivery.

Training systems better reflect the needs of remote and rural practice, with at least some generalists available, supported by increased investment in rural training and local recruitment. Effective clinical and care networks of staff will be in place to provide support for treatment and care needs.

We will organise for diagnosis and treatment to be provided as locally as possible to minimise travel from home. There is faster and earlier intervention of the "right service" supported by effective" sign-posting - which includes social care and third sector services – so that people know where to go to access services. There is also a less obvious barrier between primary and acute care with staff coming together more where it is in the best interest of the patient or service user.

We will ensure that the stay in, or visit to, hospital is as short as possible to give the best treatment outcome. Out-patient, ambulatory and day care services will be the norm, and in-patient stays will be minimised.

We will support people with health and care needs to live and be cared for in their own home. Where people cannot be cared for in their own home, we will support them to live in a community setting that is not institutional.

Service delivery is characterised by improved collaboration with the "not my job" mentality largely gone.

This is further enhanced by policies that seek to remove barriers and a political dimension that increases the rural focus and voice in line with the principles of the Islands (Scotland) Act 2018.

Funding is increasingly spent on the core establishment – not supplementing it or filling gaps through expensive agency costs – with monies from all stakeholders increasingly seen as Shetland-wide resources rather than agency specific. The overall impact is to improve value for money and significantly reduce the recurring deficit.

Our Priorities for the next 3 years

The service models have changed over the years, as the population's needs have changed and new medicines and technology have evolved. This Plan represents a continuation of the approach to continually develop services to best meet our communities needs and make the best use of scarce resources.

Taking all the national, regional and local drivers for change, we intend to continue to evolve our service models to:

Develop a single health and care system - We will have in place seamless services, wrapped around the needs of individuals, their families and communities, which are not restricted by organisational or professional boundaries. Where possible we aim to deliver a 'one stop shop' approach to health and care.

Maximise population health and wellbeing – people will be supported to look after and improve their own health and well-being, helping them to prevent ill health and live in good health for longer

Develop a unified primary care service with multi-disciplinary teams working together to respond to the needs of local populations

Streamline the patient's journey in hospital – we will work to make sure that people get the right care in the right place at the right time by maximising outpatient, ambulatory, day care services and minimising in-patient stays

Achieve a sustainable financial position by 2023

Delivering the Best Start for Children and Families

Obstetric, Maternity and Neonatal Care in Shetland

The health, development, social, and economic consequences of childbirth and the early weeks of life are profound; and the impact, both positive and negative, is felt by individual families and communities as well as across the whole of society. Therefore, high quality maternity and neonatal care and services are vitally important to the health and wellbeing of Scotland's people. The importance of this is reflected in the Scottish Government 'Best Start: Five Year Forward Plan to improve maternity and neonatal care', which was published in January 2017.

The 'Best Start' plan focuses on developing models to support continuity of care, locally delivered services, person centredness and keeping families together. Thus, recognising the relationship between these factors and the impact on positive health and socio-economic outcomes for women, their babies and the wider family.

In 2017-18, 219 live births were registered in Shetland that year (National Records Scotland, 2018), 50% of women delivered their baby out with Shetland. The birth rate in Shetland is in line with the national average and has remained static over the last 10 years with 217 births registered in 2008.

The delivery of the plan is a key priority for local services over the next five years. NHS Shetland employs a team of Midwives who provide an integrated midwifery service (i.e. the same midwives work in the hospital and the community setting) offering support from pre-conception through to postnatal care.

NHS Shetland has used the funding made available so far to implement the Best Start plan to:

- Further extend the telemedicine options available so fewer women and their families need to travel to Aberdeen for ante-natal or post natal care;
- Continue to train senior Healthcare Support Workers (HCSWs) to provide ante-natal health improvement advice and signposting to other services and support including welfare advice e.g. Best Start Grants;
- Support Midwives to develop expert skills in a range of disciplines e.g. sexual health, obstetric sonography and public health so that more services can be offered locally;
- Support Midwives to develop enhanced skills to support neonatal care, working in a multi-disciplinary team which does not have a Neonatal Unit on site;

- Worked with NHS Grampian to ensure that families who are separated are able to stay in contact e.g. using technology to link in with the nursing team on the Neonatal Unit;

- Supporting volunteers to provide breast feeding support and advice to new mothers.

The Maternity Service is part of the wider obstetric care model in Shetland, which includes medical staff based in Shetland and Aberdeen, multidiscplinary Theatre and A&E teams as well as the Scottish Ambulance Retrieval services. The extant model for obstetric care in Shetland has been a 'GP with special interest' (GPwSI) approach. However, due to the changing landscape in medical training over last 15 years and the need to implement Keeping Childbirth Natural and Dynamic (KCND) published in 2009; there has been a greater emphasis placed on the role of the Midwife in leading maternity care for low risk women.

In 2010, we formally reviewed the obstetric model recognising the growing challenge for GPs to maintain obstetric skills and in line with our need to implement (KCND) which set out the pathway for normal maternal care.

The conclusion of the review was that the GPwSI model provided the best degree of fit for us as an Island Board. The rationale for this was the continued need to provide a safe model of care for low risk women; but also the recognition that our geographical distance from Aberdeen Maternity Hospital means that we also need to be equipped to manage obstetric emergencies and the needs of high risk women. Between 2010 and 2018, we have maintained a model including GPwSI, albeit that we have found it difficult to recruit and train new doctors as others have left during that time.

However, the other Island Boards have now shifted to a Consultant Obstetrician led model of care because of the difficulty in recruiting GPwSI and so now NHS Shetland is also transitioning to that model. We are looking at options for developing an intra-Board or regional model to help sustain access to Consultant Obstetricians in Shetland.

We have opted for this approach because developing a model that would shift services away from Shetland is counter to the local and national policy context of promoting choice, person centred care, delivering care close to home, tackling health inequalities and improving outcomes, providing the best possible start in life for our children. It is also inconsistent with the priorities Vision in Shetland's partnership plan that "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" or the priority agreed in this plan that "Shetland is an attractive place to live, work, study and invest".

Developing a model with Consultant Obstetricians is a key priority for NHS Shetland over the next 2-3 years in order to:

- Ensure we are able to provide safe and sustainable obstetric care in Shetland;
- Reduce the number of higher risk women who need to travel to Aberdeen for obstetric care and continue to provide surgical interventions such as c-sections safely in Shetland;
- Ensure that we continue to provide a sustainable model for neonatal care, recognising the change in roles and responsibilities in the team and the new skills that are needed to maintain safe practice.

Supporting Early Years

'Getting it right for every child' (GIRFEC) aims to improve outcomes for all children and young people. It is a multi-agency practise model that puts the wellbeing of children and young people at the centre. A common coordinated framework for holistic assessment, planning and action across all agencies is used to address needs, including the development of a Childs Plan. GIRFEC recognises that children, young people and their parents/carers have the right to be consulted about decisions that affect them.

It promotes a shared approach that:

- Builds solutions with and around children and families;
- Enables children to get the help they need when they need it;
- Supports a positive shift in culture, systems and practice;
- Involves working together to make things better;
- Getting it right for every child is the foundation for our work with all children and young people, including adult services where parents are involved

The Joint Strategic Plan for Children develop by partner organisations in Shetland utilises GIRFEC principles to improve outcomes for children and has commissioned projects to:

- Develop multi-agency approaches to support psychological wellbeing and resilience, especially around early intervention and prevention e.g. Incredible Years and ANCHOR projects;
- Further developing transitional pathways for young people with complex health needs transitioning into adult services including mental health;
- Continuing to develop local capacity and capability to support young people with complex needs e.g. working with local and specialist Learning Disabilities services;

- Providing training and support to generalist practitioners, particularly developing close working with Schools, GPs, and Child Health e.g. reducing Adverse Childhood Experiences (ACES).

In recognising that the Early Years have a profound impact on an individual's future experience of health and wellbeing; health professionals, particularly Health Visitors, have a vital role to play in supporting children and families in the first few years of a child's life and ensuring that GIRFEC principles are reflected in day to day practice . In order to provide a consistent approach to Health Visiting roles and services across Scotland, The Scottish Government published the Universal Health Visiting Pathway in Scotland: pre-birth to pre-school in 2015.

Fundamental to the changes in the pathway are: the utilisation of public health approaches in responding to all families; an emphasis on reducing inequalities by increasing access to appropriate interventions; responding to vulnerable groups and importantly, ensuring that the right number of Health Visitors are in post to support the delivery of the pathway across Scotland.

Since 2016-17, NHS Shetland has received incremental increases in funding to support the implementation of the Universal Health Visiting pathway. The funding has been used to increase the number of Health Visitors in post in Shetland and implement a programme of role development to ensure that we can support and train Health Visitors who have the specialist and generalist skills necessary to practise in a remote and rural setting.

Integral to the Health Visitors role is the requirement to:

- Build strong relationships with women (and families) from pregnancy;
- Promote, support and safeguard the wellbeing of children;
- Offer support during the early weeks and planning future contacts with families;
- Promote person-centeredness; and
- Focus on family strengths, while assessing and respectfully responding to their needs.

In 2017-18, the proportion of children receiving a Health Visitor led development review at 24-30 months was in line with the national and peer group averages of 88%. As a positive outcome, 6.3% of children had one or more developmental concerns identified (lower than) rates in our peer group (9%) and across Scotland (15.3%).

NHS Shetland priorities for Health Visiting services are to:

- Ensure that we prioritise workforce planning so that we continue to sustain our Health Visiting workforce and support our practitioners to grow and develop;

- Ensure that we sustain the requirements of the pathway and increased emphasis on home visits, in particular supporting pre-school checks and developing innovative ways to increase the uptake of these checks;

- Ensure that Health Visitors have the capacity to work across all agencies and contribute to the development of multi-disciplinary/agency models of care in Shetland e.g. through local services to strategic planning level.

School Nursing and Children's Nursing

Over the last four years considerable work, nationally and locally, has been undertaken to refocus and maximise the School Nursing contribution in response to current policy directives, population need and service requirements. This includes:

- Ensuring the focus is on prevention, early identification and intervention
- Consistently providing evidenced based assessments and interventions for 5-19 year olds and their families based on the GIRFEC practice model
- Reducing inequalities and increasing focus on vulnerable groups and populations.

There are 10 priority areas under these overall headings which ensure focus is on vulnerable children and young people, mental health and wellbeing and risk taking behaviour. They are:

- Emotional Health and Wellbeing
- Substance Misuse
- Child Protection
- Domestic Abuse
- Looked After Children
- Homelessness
- Youth Justice
- Young Carers
- Transitions
- Sexual health/pregnancy

These ten areas were initially identified based on public health need, research and evidence of what factors contribute to poor health and wellbeing outcomes in later life. It is anticipated that the establishment of a robust foundation of assessment, will significantly improve identification of children, young people and families who will benefit from additional support and resource.

The redesign of the school nurse role incorporates the health assessments of all Looked After Children, looked after at home or in kinship care children and young people, thus enabling

greater reach in assessment and routine screening for the most vulnerable children and young people.

The team remains very small with an increasing remit and there is significant support needed to ensure the team have the education and resilience to support this programme of work.

As part of the wider child health remit the school nursing team work with the practice nursing team in delivering the immunisation and vaccination programmes in schools. This programme has expanded and continues to expand with no additional resources to support the team. This is a risk both for the school nursing pathways and the immunisation programme.

The wider children's nursing team comprises of a community children's nurse and a hospital children's nurse who support children with long term and complex condition both in an acute and community setting. The hospital children's nurse supports children from emergency to routine surgical admissions to the hospital. The community children's nurse supports children with complex needs and takes on the Lead Professional role within the GIRFEC process to support children and their families manage their complex conditions.

Child and Adolescent Mental Health Services (CAMHS)

Child Health services include Child and Adolescent Mental Health Services (CAMHS) in Shetland which are also linked to specialist services provided in Dundee for children and young adults with complex care needs. Children referred to CAMHS may have depression, anxiety, eating disorders, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD) or self-harm.

Over the last three years the multi-disciplinary CAMHS team has implemented clearer pathways for access to tier 2, 3 and 4 services which include working with regional teams and clarifying the interface/transitional arrangements between adult and CAMHS services. Funding made available by Scottish Government in 2016-17 to improve access to CAMHS service has been used to increase the Consultant Psychologist and Consultant Psychiatrists clinical capacity in the team.

More recent funding has been used to increase the nursing establishment to support young people who need more intensive CAMHS input and children with Learning Disabilities.

NHS Shetland is one of only three Boards to have achieved the 18 week referral to treatment target for CAMHS access in 2018. The priority for the team is to continue to manage increasing demand for CAMHS service and maintaining access so that children with clinical need are assessed and supported in a timely way.

Child Health and Emergency Paediatric Care

Children make up approximately 18% of the total population of Shetland. NHS Shetland provides a range of emergency paediatric care (in the hospital and general practice) and planned Child Health services, including Child and Adolescent Mental Health Services (CAMHS). Due to the specialist nature of paediatric care, then we have close links with specialist services particularly in Aberdeen and Glasgow that provide both inpatient care and visiting services for Children in Shetland. There are also a number of regional networks for children's care and clinicians visit Shetland to provide highly specialised input e.g. Orthopaedic Consultants, Child Development Specialists and Consultants who specialise in Diabetes in Children.

In 2017-18, 60 children had paediatric surgery in Shetland and 964 had outpatient appointments. Children and families also travelled to the Royal Aberdeen Children's Hospital (RACH) for elective care, where 116 outpatient appointments, 33 inpatient episodes of care and 29 Day Case procedures were performed. Wherever possible, we are looking at opportunities to deliver care locally, reducing the requirement for patients to travel and using technology to bridge the gap between local services and specialist care on mainland Scotland.

Children who need emergency paediatric care are triaged at the Gilbert Bain Hospital where either treatment is provided and completed, or the child is transferred to a specialist children's hospital out with Shetland. In the majority of cases care is delivered locally by multi-disciplinary teams with support from Consultant Paediatricians based in Aberdeen. Between December 2017 and December 2018, 44 children were admitted to the Royal Aberdeen Children's Hospital for emergency care.

The table below shows the number of children aged 0-19 who attended A&E in 2018. It shows that we have a higher rate of A&E attendances compared with our peer group. The reasons for this are multi-factorial and include the fact that A&E is our formal hub Out of Hours for care in Shetland and we have a 24/7 Consultant led model of care; which means that more children can be treated locally (compared with other some of the Rural General Hospitals that transfer higher numbers of children to specialist centres).

A Table to show the A&E attendance rate for children and young people in Shetland (age 0-19 years), December 2017-December 2018

Age Range (years)	A&E Attendance (number of cases)	Population (number of children in age range	Shetland Rate per 1,000 population	Peer Group Rate per 1,000 population
0-4	665	1,279	519	273
5-9	360	1,349	267	154
10-14	411	1,558	303	207
15-19	545	1,279	426	259
Total	2,011	5,465		

Approximately 11% of children are admitted to hospital from A&E in Shetland (n=220) which is higher compared with peer groups and is again likely to be attributable to our geographical distance from specialist centres (i.e. local surveillance is provided instead) and the level of Consultant input that is available locally.

Sustaining safe and effective paediatric care is a priority for NHS Shetland and a local paediatric taskforce was established in 2018 to review the current pathways for emergency care, skill mix in our teams, supervision and models of support for decision making and training.

The taskforce has helped to put in place shared guidelines for paediatric care with NHS Grampian. Work has also been undertaken to provide enhanced induction to doctors and other health professionals who will be providing emergency paediatric care in the hospital setting.

Our strategic priorities for emergency paediatric care include:

- Working with NHS partner organisations to ensure that we continue to be part of the strategic planning and decision making for paediatric care across the region;
- Clarifying the clinical pathways for children so that as much care can be provided locally as is safe to do so and there are robust arrangements in place for the transfer and discharge of children from specialist care;
- Agreeing the skill mix in our local teams in order that we can sustain our emergency paediatric care requirements (supporting practitioners who are responsible for neonatal care and through to critical care/stabilisation);

- Ensuring that we support our multi-disciplinary teams to develop and sustain the necessary skills to provide emergency paediatric care, in collaboration with specialist, off island services;
- Ensuring that we develop approaches to reduce patient travel and increase access to services through the use of technology.

Our Approach to Mental Health Across All Ages

The Scottish Government's Mental Health Strategy[6], gave a commitment to,

> " prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems".

The Shetland Health and Care Partnership shares that commitment. This will mean working to improve:

- Prevention and early intervention;
- Access to treatment, and joined up accessible services;
- The physical wellbeing of people with mental health problems;
- Rights, information use, and planning.

Local priorities cover:

- Ensuring people can access information to maintain their own mental health
- Promoting resilience and mental health promotion to prevent mental illness
- and distress.
- Early recognition and treatment of mental illness and disorder
- Providing person centred care which can only be achieved through well integrated services focussing on an individual's needs including their carer(s) and families.
- Ensuring service users are at the centre of care and treatment
- Effective engagement of families and carers to support care and treatment
- Embedding recovery approaches within services

A review of our Mental Health Services is progressing which aims to:

- Ensure people who require services achieve better outcomes;
- Assess service users needs, outcomes and recovery plans;
- Ensure that services are integrated, flexible and responsive to people's assessed need;
- Assess the extent to which services are supporting people to live safely and independently through a focus on recovery and / or maintenance of long term conditions / preventable relapse;
- Ensure resources are used effectively and wisely.

The work is linked to the Primary Care Improvement Plan. The Mental Health Strategy will also be updated in line with the national Strategy and guidance.

[6] https://beta.gov.scot/publications/mental-health-strategy-2017-2027/

What will change about our services?

We have used the 'Scenario Planning' workshops to help us to shape the new models of care. While we have some work to do yet to design exactly what our services might look like in the future, we think it will be helpful to describe how we see the services developing.

Develop a single health and care system

Our overall ambition is to move away from seeing health and care services as single services organised across departmental managerial lines. We all recognise the intrinsic relationships between all aspects of health and care services, as people move through and between services. We want to continue our approach towards a single health and care system, which is seamless from the point of view of the service user ie it doesn't matter which service or organisation is delivering the service, the service is determined by the patient / service user's needs. This approach is the under-pinning philosophy of the work we already do through the auspices of the Integration Joint Board. We want to accelerate that philosophy to find a way to deliver a 'one system, one budget' approach for Shetland. This will involve changes, with a need to implement data systems which will support this way of working and to invest in staff to support them to respond and innovate in an ever changing environment. We want to do this through collaboration, building trusting relationships to give staff and partners permission to try to do things differently. Technology will help us to improve access to services – and equity of access – and where people live should not be a barrier to access.

This 'whole system' approach is shown diagrammatically below in the health and care system adopted by Canterbury in New Zealand. The system is built around the question of 'What Does it Mean for Agnes' (the lady in the red cardigan at the centre of the diagram).

The idea that the diagram conveys is based on the layers of input and interventions into health and care and that really it is the whole community working together that makes for an effective health and care system.

From the centre, it starts with the individual person; their own health and care needs and their motivation to look after their own wellbeing through lifestyle and other choices.

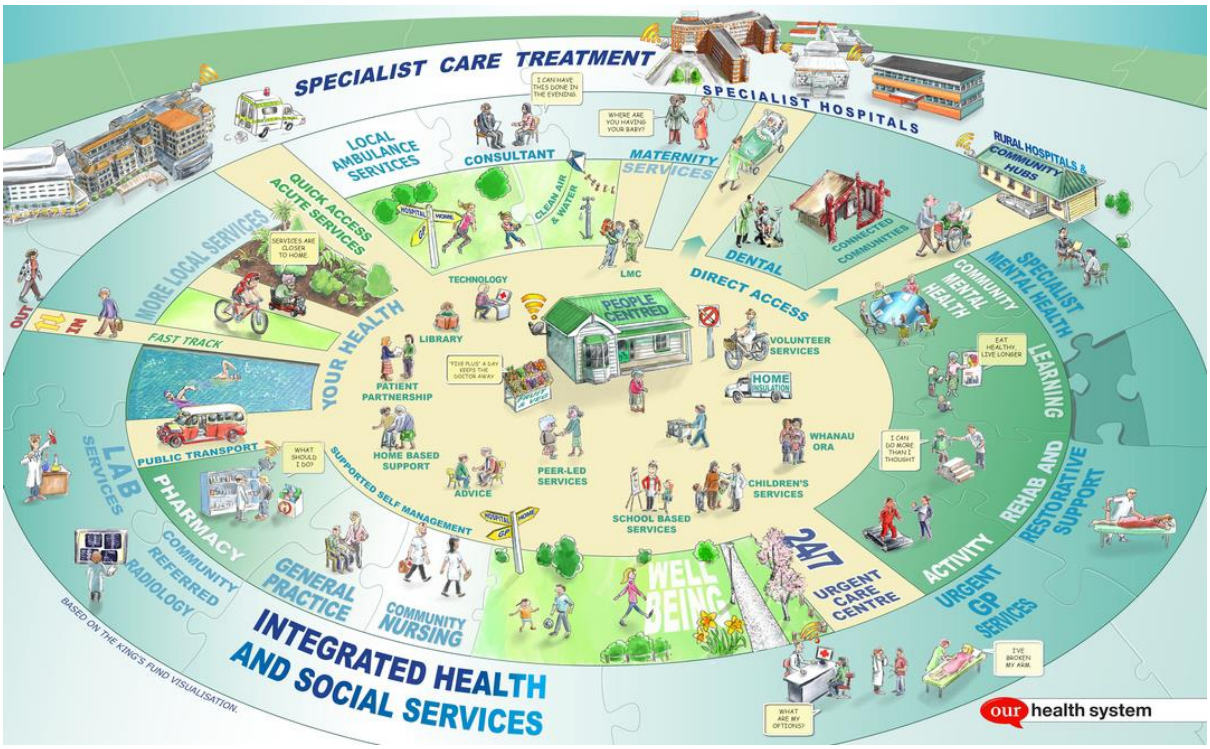
The next step is to think about friends and family and the contributions that others around us can make to our health and wellbeing, including the support of unpaid carers. We can also think about community services (those available to all of us) and how those services help us to live our lives.

The next stage is to think about how services help us with specific issues – for example going to the dentist for a check up, going to the pharmacy for medicines, seeking help from a GP or nurse for a specific illness on a one-off or ongoing basis.

The next layer is the specialist services which come into play when a particular intervention is required, for example calling an ambulance in an emergency, having an appointment to see a consultant for a specific illness or attending a specialist mental health service.

At the outer rim of the diagram are the specialist treatments centres where people will go if they are medically unwell and that will usually be a hospital setting.

People will move in, out and through these services on a changing basis as their health and care needs change. Our focus will be on making sure that all the services are aligned and co-ordinated around people's needs - and that is why we call it the 'whole system' approach.



We will deliver this through the following principles and projects:

- ✓ Clinical leadership
- ✓ workforce development and integrated teams, enabling people to work to the maximum of their skill set
- ✓ technology enabled, working to remove organisational and system boundaries around data

Maximise population health and wellbeing

We will continue to invest in a wide range of early intervention and preventative measures to minimise, and sometimes avoid, the need for health and care needs to occur. It is our ambition that a significant proportion of preventative services will be provided outwith the

statutory health and care framework, through voluntary, community and third sector provision and from people investing in and looking after their own health and wellbeing. Health improvement and ill health prevention is not just a function of Public Health; it is a fundamental role of all health and care professionals to support people to take control of their own lives and their health.

Services will consider how best to respond to help families who are struggling to thrive and work with local communities and voluntary services to ensure that no one is lonely or stigmatised. It has been identified that approximately 5% of people in Shetland, at any life stage, are not able to have the same positive experiences and opportunities as the majority of people living in Shetland. Over the last 15 or so years, it has become more common to see these poor experiences being passed down the generations. Shifting money and staff to better target support, and at an earlier stage, is known to help these families and also save money. There are many local examples of the impact of stigma, isolation and loneliness on people and families and there is an increasing body of research showing the negative impacts on physical and mental health. Services will be encouraged to target resources to break negative cycles for individuals and within families.

The recent Annual Report from the Chief Medical Officer, entitled Realistic Medicine, challenged current health care by stating that,

> *"Doctors generally choose less treatment for themselves than they provide for their patients. In striving to provide relief from disability, illness and death, modern medicine may have overreached itself and is now causing hidden harm – or at best providing some care that is of lesser value.... Waste in healthcare should be assessed not in terms of what might be thrown away, but in interventions that don't add value for patients....We need to change the outdated 'doctor knows best' culture to one where both parties can combine their expertise and be more comfortable in sharing the power and responsibility of decision-making. It requires system and organisational change to promote the required attitudes, roles and skills".*

This will be an underpinning philosophy in all the service redesign models.

A key recommendation from the Commission for the Future Delivery of Public Services was that we need to work closely "with individuals and communities to understand their needs, maximise talents and resources, support self reliance, and build resilience". We do this by moving away from a paternalistic approach of doing things to people, to working out ways to work with people to help them to look after their own health and wellbeing.

We will deliver this through the following principles and projects:

- ✓ we will update and implement a Welfare Reform Outcomes Focused plan to ensure that our NHS Board continues to support the working-age population to move into, remain in and progress in good quality employment, and access the social security supports that they are entitled to
- ✓ we will work in partnership with the local authority to deliver a Child Poverty Action Plan which makes a difference to the outcomes and life chances of children and young people in Shetland
- ✓ We will implement the Diabetes Prevention Plan
- ✓ Further develop opportunities to increase physical activity for people who are least active through the implementation, with our partners, of the Active Shetland Strategy
- ✓ Continue to develop and deliver the smoking cessation service
- ✓ Increase the capacity of our weight management services
- ✓ Continue work to increase wellbeing and mental health

Developing a unified primary care service

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, therapists, third sector support, etc.

We will be supporting more people – and more frailer people - to remain living at home for as long as possible. People with care needs living in the community will have even higher levels of support needs than at present.

The 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 chances of them having to be 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 and move around 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 Primary Care Improvement Plan provides us with the opportunity to do this.

An exercise has been carried out to start to describe in detail what our future service models might look like. We have explored 'what will success look like for our patients / service users' and how will we evidence that. An extract of this work is included below, as an indication of what services are working towards.

Service name/project	What will success look like	Outcomes what evidence of success
Primary care	Single point of access for queries Better access to the right person Parity of service Full utilisation of all staff No locums	Reduced demand Healthier population More self-service One system Non premises led service
Virtual Services	No door is the wrong door Easier and more immediate access to services Reduced need at higher levels People are responsible for directing their own care	Reduction in frequent attendees Reduction in frustration in getting appointments Increased self care Reduction in emergency care
Adults with Learning Disabilities and Autistic Spectrum Disorder	Support people to live independently Support people to stay at home Right support at right time whatever age (child, young person, adult, lifelong) Asset based approach to assessment of need Support for transitions Reducing barriers Community support Focus on equality	Communities are empowered Access is equal Opportunity is equal
Pharmacy and prescribing / effective prescribing	Patient / Service User is safer and more in control of their health Better use of resources Medicines needed on time	People know why they are taking medicine Reduce variation in prescribing Morbidity and Mortality Rates
Mental health	Support people to live at home Individuals with mental health conditions are able to live as independently as possible Be active and have a purpose To be accepted and participate Step up and step down care	Focus on Recovery Services are responsive
Community nursing	Access to right professional, right time, right place Autonomous Practitioners Working at advance levels	Nursing care and support provided in timely appropriate way Sustainable workforce
Allied Health Professionals	Support people to live independently Appropriate use of skills Self care Self directed treatment	Maximise use of Independent Living Centre (increased access and services on offer)

	First point of contact	

We will deliver this through the following change projects:

- ✓ Management of Long Term Conditions
- ✓ Primary Care Improvement Plan

Changing Models of Care:

If you are a patient who is remote from your health care professionals, and have a condition they are supporting you with, you can use 'Attend Anywhere' from any smartphone, tablet, laptop or computer which is connected to the internet to connect with them. Whenever you have an appointment with a health care professional, Attend Anywhere has the potential to allow you to have it at a time to suit your: work commitments; mobility; remoteness from health centres and hospitals; so you can receive care where you are. There's no need to log in, you just go to the NHS Shetland website and click the link to enter the "Waiting Room" on the device you have, or follow the link on an email. When you're in the waiting room, the health care professional supporting you will "call you in" to start the appointment. You'll both be able to see each other face to face, and provide updates and get advice on your condition. The connection is secure and private, from you to the professional. An appointment, which used to take you a day to travel to/from the Gilbert Bain Hospital to physically see someone for a brief appointment could maybe be carried out remotely from your own home. There are a number of different scenarios where this can be beneficial for those involved, ranging from seeing your specialist, to seeing your local practice nurse – at a distance and in a way convenient for all.

Social Care

The overall objective is to work with people to enable them to live independently in their own home, or in a homely setting within their community and to be centred on helping people maintain or improve quality of life. There is in place a range of care services including nutritional support, care at home, respite care, short breaks, supported vocational activity and residential care.

A recent review of the social care service concluded that an enhanced care at home service was the preferred option. In order to fulfil that ambition, many other services and support need to be in place, as described below.

The elements of services that need to be in place for an enhanced care at home service to be delivered 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.

Some areas for improvement have been identified to help to continue to support people to live at home around:

- access and participation;
- anticipate needs and prevent needs arising;
- service users being in control of the decisions affecting how they live, have flexible and responsive services and choice;
- making best use of all resources; and
- the model of health and care is able to be adequately staffed.

The specific improvement plan will include consideration of:

- Support for unpaid carers through the implementation of the Carers Act (Scotland) 2016, specifically to extend day services to provide extended respite opportunities.
- Carry out a needs assessment of Levels 1 and 2 care needs in one locality, 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).
- Explore further geographically dispersed models for supporting care at home in one locality, 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.

These projects are currently being worked up as Spend to Save Projects within the Shetland Islands Council as additional funding will be required from outwith proposed joint delegated budgets to provide initial investment for these tests of change

Alongside this, Housing services will continue to invest in all housing stock, to increase overall supply and support a range of housing choices. Working with housing colleagues to enable people with care needs to remain living at home will remain a priority. There is a presumption against having to move house in order to receive a care package, where it is practicable and feasible to do so. Technology enabled will continue to be a key component of that ambition. More detailed is included in the Housing Contribution Statement, which supports this Plan, at Appendix 3.

Criminal Justice Service

The Strategy for Justice in Scotland sets out the Government's approach to make the Scottish justice system fit for the 21st century. The second phase of the Reducing Reoffending Programme which began in 2012 is focused on making sure that the right

services and support are provided so that prolific offenders can address their reoffending and its causes.

The Community Justice (Scotland) Act 2016 sees the responsibility for community justice transferred to 'community justice partners', with oversight and assurance to Ministers being given by a new national body, Community Justice Scotland. In Shetland, a local Community Justice Partnership has been established and reports to the Shetland Partnership. The Partnership will be responsible for producing a strategic plan that will address local and national priorities. Criminal justice social work services are statutory partners in ensuring effective community justice in local communities.

Shetland Islands Council has had a statutory duty to provide criminal justice social work services for individuals awaiting sentencing; subject to community based disposals or custodial sentences. The Service ensures that all people who are referred to the service are appropriately assessed, supervised and risk managed. 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. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences. The service also offers support and advice to family members.

Right Place Right Time – Providing Hospital Based Care and Specialist Services

Over the last 10 years we have increased investment in community based services and developed new ways of delivering care that means less people need to go into hospital and if they do require care in hospital, their length of stay will be shorter. Between 2014 and 2018, we saw a 39% reduction in the number of occupied medical bed days.

This 'shifting the balance of care' has been possible due to a number of factors which includes enhancing the skills of our local teams, using technology to support people at home and enable remote monitoring and advancements in medical practice.

For example, 30 years ago the average length of stay in hospital to recover from an uncomplicated myocardial infarction (heart attack) was 9 days and by 2017 the average length of stay had reduced to between 2-3 days. This has been driven by enhancements in interventional treatments, medications, cardiac rehabilitation and active changes that people have made to their lifestyles e.g. reduction in smoking. Work is being driven at both a national and a regional level to develop clinical pathways that are streamlined and mean that patients are able to leave hospital as soon as it is safe to do so. This driven by a number of factors, some are relate to ensuring that we effectively design services which can cope

with increasing demand and others are more focussed on ensuring that we redesign services so that we can support patients to have the best possible clinical outcomes.

There is good evidence available, which shows that older people who have an admission to hospital which is 10 days or longer will experience muscle ageing and functional decline and people who are medically fit for discharge but are delayed in hospital, are at greatest risk of this with over 40% of people developing loss or decline in their potential to regain independence and leave hospital (NHS Improvement, 2018).

Over the last five years we have been working closely as an integrated health and social care service to ensure that we effectively discharge plan together (and with patients and their families). This includes ensuring that we offer early supported discharge whenever possible; through the combined efforts of hospital based staff, carers, community and social care teams. In that timeframe, we have invested in multi-disciplinary teams to provide community based rehabilitation, falls prevention care, enhanced dementia services, prescribing advice and community based pharmacy teams as well as technology to assist people to live at home safely.

This has led to an increase in the range of care that can be delivered in the community and an increasing focus on prevention and rehabilitation. We have seen over that time a decrease in the length of time that people wait in hospital for community care input.

The recently published Draft Discussion Paper entitled 'Delivering Health and Social Care to the North of Scotland 2018-21', includes some important commitments to treatment being carried out as close to people's homes as is possible. The commitment is to decentralise access to treatment and care as much as possible with the aim of providing local access.

In response to this plan and implementing improvement approaches set out in the Modernising Outpatients programme; we have redesigned planned care services, which means that a greater range of services are now provided at the Gilbert Bain Hospital rather than specialist off island services. These changes have included investment in training and equipment for local staff, developing new roles and using technology to bridge the gap between Lerwick and Aberdeen services. For example, patients requiring biologic medications can now access treatments in Shetland, previously having to travel to Aberdeen on a regular basis.

Since 2014, we have reduced outpatient activity by 18% and we have increased Day Surgical activity by 27%. In the last three years we have increased the number of tele-health consultations from 600 in 2016 to over 2,000 in 2018, significantly increasing the number of patients who can access care locally and reducing unnecessary travel.

These changes have all helped to contribute to a position where we have been able to ensure that hospital services in Shetland have been able to adjust to increasingly complex

patient care and frailty and also offer more services locally (previously only available on the mainland).

Therefore our focus over the last 10 years which is carried through into this strategic plan is to:

- Utilise the principles of realistic medicine to ensure that we challenges historical norms and episodic care and instead offer more individualised approaches;
- Continue to identify ways in which we can bring together teams to streamline the patient journey and offer safe alternatives to hospital care;
- Continue to invest in role development to ensure that we can maintain and grow specialist care in our Rural General Hospital setting;
- Continue to invest in technology to support improved access to specialist care, particularly to bridge the gap with services previously only available in mainland hospitals;
- Continue to grow the number of services which can be offered 'in outpatients' or as 'day care' to aid speedy recovery and reduce likelihood of complications;
- Continue to invest in equipment and the Hospital infrastructure to ensure that it is fit for purpose and able to deliver the clinical strategy set out in this Strategic Plan. This includes medium and longer term planning for the provision of the Gilbert Bain Hospital over the next 10 years and beyond

Changing Models of Care...

You have been in hospital due to a minor heart attack; the Specialist Cardiac Nurse sees you in hospital and gives you support and advice about recovery. The Nurse invites you to attend the cardiac rehabilitation class that she organises. At the class you are able to meet other people with heart conditions and share experiences, make friends. You are also able to access advice about changing your lifestyle, you had been thinking about it anyway after the shock of being in hospital. At the class you are able to get advice about making healthy meals, find out about ways to stop smoking and look at ways to get fitter. The class is at the Leisure Centre so you are able to try out different sports and activities.

In this model of care, the approach is person centred and everyone is working together to minimise the number of different places people need to go to get advice and support to change their lifestyle as well as making key clinical advice available to support recovery from a heart attack.

Changing Models of Care...

Your GP has referred you for sleep studies. Instead of travelling to the Sleep Clinics in Aberdeen or Edinburgh, you are asked to attend a clinic at the Gilbert Bain Hospital.

You are fitted with monitoring equipment and you return the data to the hospital and it is sent electronically to a Specialist Nurse, who is based on the mainland. The Nurse analyses the results of the sleep studies remotely and agrees a treatment plan with the Consultant.

You return to the Outpatient clinic at the Gilbert Bain Hospital to discuss the results which may mean lifestyle changes, a dental appliance or airway pressure device is recommended.

Travel is minimised and the pathway has less steps.

Our overall approach is shows diagrammatically below.

Enablers

Alongside day to day service delivery and the change programmes, there needs to be in place a range of 'enabling' activity. These are the support services, systems, skills and knowledge that we need to have in place to help keep delivering high quality services and implement any changes. Often, the support services arrangements can be aligned to the Regional Planning approach, as we work towards an environment of sharing resources and skills across the North of Scotland, and the 'Once for Shetland' approach where partners in Shetland work hard to find ways to streamline how we work together. We recognise the inherent tension between working out how best to do things for Shetland's Health and Care Partnership at a local level whilst also responding to the challenges for the NHS of working better at a regional and national level.

Staff are at the heart of all the service delivery models. It is therefore intended, as part of all our projects, to put in place the right staffing numbers, ratios and skills mix for each service area. Within this we will respect professional boundaries while also supporting multi-disciplinary team working. There is a need to support staff to be the best they can be through positive leadership and creating a culture of openness and trust which allows staff to grow, learn and develop in a safe environment in a rapidly changing service. We expect our staff to be the champions of the transformational change that this plan advocates. There will therefore be specific support arrangements to build organisational capacity and resilience to focus on staff health and well-being, including aspects of leadership, values and behaviours and clear communication.

Alongside the support to staff, there will be a programme to redesign business and organisational systems, integrated insofar as they possibly can be, so that our staff can focus on tasks which support front line service delivery and are not wasteful. This might also involve working locally with partners in Shetland to make the best use of systems and resources, where it might be possible to develop a common approach, or working across the North of Scotland region, or working at a national level on a 'Once for Scotland' approach.

We will deliver this through the following established programmes of work

- ✓ Delivery of the Joint Organisational Development and Workforce Protocol which includes:
  - Developing new and efficient ways of working
  - Implementing organisational capacity and resilience building initiatives
  - Establishing locality working arrangements
  - Developing participative approaches that involve communities / the public in service re-design
  - Creating a shared culture based upon shared values and expectations

- Developing collaborative and authentic leadership as the norm

✓ Supporting staff to:
  - continue to develop their skills and knowledge and work to maximum of their skill set
  - Develop opportunities to work in more generic roles
  - Continue to develop opportunities for specific remote and rural training and practice

✓ Participating in the Delivery Arrangements for the North of Scotland Health and Care Discussion Paper

✓ Delivering the NHS Board and North of Scotland Region and local E'Health Plans, including:
  - Working towards shared data systems (a portal approach)
  - A Joint approach to Records Management
  - Supporting technology enabled appointments
  - Providing evidence in support of investment in infrastructure

✓ Developing our Asset Investment Plan to put in place the assets and infrastructure to deliver the strategic objectives set out in this plan.

✓ Participating in developing the 'island proofing' issues for health and care in line with the Islands (Scotland) Act 2018.

Working with Others

The Commission On The Future Delivery Of Public Services (2011)[7], stated that,

> "A first key objective of reform should be to ensure that our public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience. Research evidence and our submissions suggest strongly that our public services can become more efficient and effective in working collaboratively to achieve outcomes. To do this, they must focus clearly on: the actual needs of people; energising and empowering communities and public service workers to find innovative solutions; and building personal and community capacity, resilience and autonomy".

We will do this is three specific ways:

- Working with our patients and service users
- Working with our staff
- Working with our partner organisations
- Working with communities

Self Care is the actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness. We will support people to look after their own health and well-being, through advice, support and interventions.

We will put the person receiving health and social care at the centre of decisions made about their care. We will encourage shared decision making between the person receiving care and the member of staff providing care.

NHS Shetland and Shetland Islands Council are the two key employers for health and care service, as well as a range of third sector providers and unpaid carers. We are committed to working with staff in an open, honest and transparent manner to reach the decisions on how best to meet the health and care needs of the community.

The third sector, which includes charities, social enterprises and voluntary groups, delivers essential services, helps to improve people's wellbeing and contributes to economic growth. It plays a vital role in supporting communities at a local level. Their contribution is

[7] https://beta.gov.scot/binaries/content/documents/govscot/publications/publication/2011/06/commission-future-delivery-public-services/documents/0118638-pdf/0118638-pdf/govscot:document/

recognised in our strategic approach – at an individual care pathway level and at the broader community level.

Community Planning is the name given to how public, private and third sector organisations work together to improve the overall wellbeing of people living in Shetland. An effective health and care systems relies on many other services and support being in place to help people to thrive and reach their full potential. Examples will be: housing; education; employment; transport and leisure. Working in partnership with other organisations and professions will become the norm.

With our Shetland Partnership partners, we want to help people in communities actively participate with public service providers to improve the lives of people in Shetland. We will do this by changing the way we work. We want to find ways to help people to be more closely involved in shaping the future of their communities. This will include supporting people and communities to develop their skills and knowledge in order to participate fully in community life and meet health and care needs.

Financial Position

NHS Shetland

The amount of funding which NHS Shetland is expected to receive to pay for services is set out in the Table below. The key assumption made is that Board's baseline funding will increase by 2.5%.

Table : Shetland Health Board Funding 2019-2024					
	2019-20	2020-21	2021-22	2022-23	2023-24
Opening Core Balance	49,611	50,851	52,122	53,425	54,761
Inflation Funding	1,240	1,271	1,303	1,336	1,369
Closing Balance	50,851	52,122	53,425	54,761	56,130
Percentage Increase	2.5%	2.5%	2.5%	2.5%	2.5%

The funding will not meet the projected growth in costs (as a result of inflation and the impact of demographics and innovation).

To address this gap NHS Shetland will need to deliver around £7.6m in savings to re-invest in these increased costs.

The Scottish Government's has a 3% efficiency target for the public sector. The funds released from the achievement of the target are re-invested in services to meet cost pressures and to offset the gap between funding and health inflation. Without the delivery of at least this level of efficiency there are no funds to address cost pressures and to ensure the Board's Income and Expenditure is balanced. The board's financial plans assume the continuation of this policy over the next five year planning cycle.

The implication of these new efficiency targets, over the five year period is outlined in the Table below, totalling £7.6m.

Table : Shetland Health Board New Savings Targets 2019-20 to 2023-24						
	2019-20	2020-21	2021-22	2022-23	2023-24	Total
Funding	48,167	49,407	50,678	51,981	53,317	
New Savings Target	-1,445	-1,482	-1,520	-1,559	-1,600	-7,606
Target as a Percentage	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%

Shetland Islands Council

The amount of funding which Shetland Islands Council is budgeting to contribute to community health and social care services in 2019-20 is £22m.

Longer term, the Council has in place a medium term financial plan. There is an expectation that the Social Care service will need to find a fair proportion of the overall savings target but there is no specific monetary value placed on it at this stage.

IJB

The Shetland Islands Integration Join Board (IJB) is facing significant financial challenges.

Taking into account costs, demands, estimated changes to funding and, assuming nothing else changes, the funding shortfall over the next five years is estimated to be £7.7m in total, as shown in the Table below.

	2019/20	2020/21	2021/22	2022/23	2023/24
	£	£	£	£	£
Cost of Services	48,181,541	50,108,803	52,113,155	54,197,681	56,365,588
IJB Funding					
SIC	22,019,069	22,093,249	22,215,729	22,395,022	22,628,955
NHSS	23,629,492	24,220,229	24,825,735	25,446,378	26,082,538
Total Funding	45,648,561	46,313,479	47,041,464	47,841,400	48,711,493
Cumulative Funding Shortfall	**-2,532,980**	**-3,795,080**	**-5,071,080**	**-6,355,280**	**-7,652,680**

Reliance on one-off initiatives to balance the books becomes increasingly difficult as opportunities have already been taken over the years.

The change programme will therefore need to be of a scale to address the underlying financial challenge to make sure that the cost of the service models can be accommodated within the overall funding made available.

While the programme is progressed, short term decisions will also be required so that NHS Shetland and Shetland Island Council continue to meet their immediate financial obligations and service issues. As far as possible any immediate decisions should be consistent with the aspirations set out in the Strategic Plan.

Longer term planning must be accelerated to enable safe, effective and sustainable services to be delivered within the funding available, through the change programmes set out in the next section.

Ultimately, the Financial Plan and the Strategic Plan should be aligned so that there is a link between the financial resources allocated by each funding partner and the desired outcomes of the Strategic Plan.

The IJB budget for 2019-20 is set out below. This is part of the NHS Budget, and all of the Council's Social Care budget and totals £46m.

2019-20 Budgets	**NHS Delegated**	**SIC Delegated**	**NHS Set Aside**	**Total**
Service Area	**£**	**£**	**£**	**£**
Mental Health	1,438,364	592,883	0	2,031,247
Substance Misuse	402,269	179,594	0	581,863
Oral Health	3,124,523	0	0	3,124,523
Pharmacy & Prescribing	6,073,749	0	571,761	6,645,510
Primary Care	4,430,563	0	0	4,430,563
Community Nursing	2,721,212	0	0	2,721,212
Directorate	92,990	957,082	0	1,050,072
Pensioners	0	79,845	0	79,845
Sexual Health	0	0	44,813	44,813
Adult Services	57,406	5,464,576	0	5,521,982
Adult Social Work	0	2,992,639	0	2,992,639
Community Care Resources	0	11,542,901	0	11,542,901
Criminal Justice	0	38,842	0	38,842
Speech & Language Therapy	89,116	0	0	89,116
Dietetics	116,280	0	0	116,280
Podiatry	235,962	0	0	235,962
Orthotics	138,329	0	0	138,329
Physiotherapy	593,382	0	0	593,382
Occupational Therapy	187,762	1,433,707	0	1,621,469
Health Improvement	0	0	224,174	224,174
Unscheduled Care	0	0	2,864,454	2,864,454
Renal	0	0	201,524	201,524
Intermediate Care Team	452,182	0	0	452,182
Reserve	440,674	0	182,021	622,695
SG Additionality	1,444,000	-1,278,000	0	166,000
IJB Running Costs	11,762	15,000	0	26,762
Total	**22,050,525**	**22,019,069**	**4,088,747**	**48,158,341**
Efficiency Target	-2,275,289	0	-257,691	-2,532,980
Grand Total	**19,775,236**	**22,019,069**	**3,831,056**	**45,625,361**

Change Programme and Projects

We will take a whole organisation approach to achieving the Plan. Looking after our day to day business is as important as focusing on any service changes. How all the elements will come together is show in the diagram below.

How the Whole Organisation Works

<table>
<tr><td colspan="7">Governance and Decision Making</td><td rowspan="8">Supported by:

Realistic Medicine</td></tr>
<tr><td colspan="6">Main Purpose: Delivering Services Day to Day to Patients and Service Users</td><td rowspan="4">Assured and Monitored through:

Performance Data,

Clinical Governance

Risk Management</td></tr>
<tr><td colspan="6">Leading and Managing Change: Changing and Developing Services to meet changing need</td></tr>
<tr><td colspan="6"><u>Supported by: Enablers - Services and Activities which support front line services</u></td></tr>
<tr><td>Workforce Recruitment and Retention</td><td>Workforce Training and Development</td><td>Budgets and Finance</td><td>Systems and Technology</td><td>Assets and Equipment</td><td>Data and Information</td></tr>
<tr><td colspan="7">Underpinned by communication and engagement with all stakeholders</td></tr>
<tr><td colspan="7">Reinforced through positive leadership, culture and behaviours</td></tr>
</table>

The elements of the programme of work to implement the Plan are outlined below and included in more detail at Appendix 1:

Vision and Strategic Context
Preventative Services
Sustainable Services
Enabling Services
Communication and Engagement

Many of the change projects for the IJB sit within the auspices of the Primary Care Improvement Plan, approved by the IJB on 6 June 2018. The overall timeline is included at Appendix 2.

Delivering ongoing day to day services is an equally important part of delivering the objectives of this Strategic Plan. Having a stable base and good performance provides a platform upon which the change projects can be built. The detail of service delivery, and service improvements, is outlined in the Board's Annual Operational Plan 2018-19[8].

How will this impact on the Board's Performance?

We already have a comprehensive approach to performance management and that will continue.

We will focus on specific strategic and high level performance indicators to help us to keep track of progress and to make sure that, in the medium to long term, we achieve what we set out to do. The high level indicators are:

- Number of people actively and successfully managing their own condition
- Unplanned admissions
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
- Community Participation activity and impact (also a Shetland Partnership Plan indicator)
- People engaging in physical activity (also a Shetland Partnership Plan indicator)
- People drinking at harmful levels (also a Shetland Partnership Plan indicator)

The current performance and the target we aim to achieve are set out in the table below.

[8] https://www.shb.scot.nhs.uk/board/documents/OperationalPlan-20182019.pdf

Strategic Indicator	Current Position Baseline	2021 Target	2028 Target
Percentage of adults able to look after their health very well or quite well.	95% [Peer Group average 95%] 2015-16	Maintain position	Maintain position
Unplanned admissions	2016-17 9,566 / 100,000 2016-17 First in Scotland	Maintain position	Maintain position
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	84% (2015-16) Peer Group average is 87%	87%	90%
People who feel they can influence decisions affecting their local area	27% of people feel they can influence decisions affecting their local area	At least 35% of people feel they can influence decisions affecting their local area	At least 50% of people feel they can influence decisions affecting their local area.
People engaging in physical activity	77% of people engage in some form of sport and physical activity (2018)	At least 80% of people engage is some form of sport and physical activity	At least 90% of people engage in some form of sport and physical activity
People drinking at harmful levels	20% of people drink at harmful levels (2018)	No more than 18% of people drink at harmful levels	No more than 15% of people drink at harmful levels (or in line with the National Average, whichever is lower)

Appendix 1 : Action Plan

Area	Item	Comment
Vision & Strategic Context	**Update Shetland Health & Care Vision & Objectives**	Progress as part of Joint Strategic Plan refresh ; Involve stakeholders and Strategic Planning group
	Develop detail on "step up / Step down" scenarios	Progress as part of Joint Strategic Plan refresh ; Involve stakeholders and Strategic Planning group
Preventative	**Long term conditions**	
	Prevention /Self care	Build on 10 year PH Plan
	Realistic Medicine	Work beginning to be developed by Realistic Medicine group
	Effective Prescribing	Build on current work; Requires clinical leadership
Sustainable Services	**Unscheduled Care**	Project team to be developed;
	Primary, Community & Social care Services	Building on current work (including work on sustainable Social care services and North isles project); project team developing
	Hospital Services & workforce sustainability	Need to link to previous 2 work streams.
	Elective Model (repatriation)	Build on current work; supports reduction in cost of service provision
Enablers	**Information (analytics)**	Link to National / Regional work
	eHealth	
	Workforce development	Build on Workforce plan
	Recruitment and Retention	Develop current approaches to sustaining recruitment / existing staffing
	Financial Framework	
Communication & Engagement	**Key Community leaders**	Include SIC, Community planning / NHS Board members / IJB
	Clinical / professional leaders	Ensure continued clinical / professional involvement. Use Professional advisory committee structure alongside management meetings
	Unpaid Carers	Link to formal and informal unpaid carers
	Staff / service providers	Progress at work stream / project level
	Communities / Service users	Progress at work stream / project level

Appendix 2 : 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

Key Priority Area	Year 1	Year 2	Year 3
Pharmacotherapy Services	Directors of Pharmacy to develop consistent approach across North of Scotland	Funding permitting, additional 2 Practice Pharmacists to be employed	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. 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.

Key Priority Area	Year 1	Year 2	Year 3
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.
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	

Housing Contribution Statement

March 2019

Introduction

The Housing Contribution Statement (HCS) is a statutory requirement, as set out in the Government's Housing Advice Note, 'Statutory Guidance to Integration Authorities, Health Boards and Local Authorities on their responsibilities to involve housing service in the Integration of Health and Social Care, to support the achievement of the National Health and Wellbeing Outcomes'.

The HCS sets out the contribution of housing and related services in Shetland towards helping achieve priority outcomes for health and social care. It serves as a key link between the Strategic Commissioning Plan and the Local Housing Strategy and supports improvements in aligned strategic planning and the shift to prevention.

As a local housing authority, the Council has a statutory duty and a strategic responsibility for promoting effective housing systems covering all tenures and meeting a range of needs and demands.

The Council's strategic housing plan is articulated in the Local Housing Strategy[9] which is underpinned by the robust and credible evidence from the Housing Need and Demand Assessment (HNDA)[10]. Both these key documents are in the process of being revised and the Housing Contribution Statement will be updated in line with published versions.

Health & Social Care Partnership

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care to ensure joined-up, seamless services. In 2015 the Integrated Joint Board (IJB) was established as a separate legal entity.

The Executive Manager – Housing is represented on the Strategic Planning Group to actively promote the housing sector's role in health and care integration. The Chief Executive of Hjaltland Housing Association is also a member of the Strategic Planning Group.

National Outcomes

The national health and wellbeing outcomes to be delivered through integration set out 9 specific outcomes. Outcome 2 is of particular relevance to setting out the housing contribution.

[9] http://www.shetland.gov.uk/housing/policies_housing_strategy.asp

[10] http://www.shetland.gov.uk/housing/policies_housing_need.asp

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

Locality Planning

Locality planning has been established and unified in Shetland at a Community Planning level. This means that strategic documents such as the LHS reflect the same 7 localities. This will allow for integration of services operationally as the local implementation plans develop.

Delegated Function

The Act sets out a range of health and social care functions, including functions under housing legislation which 'must' or 'may' be delegated to the IJB. These are contained in the Health and Social Care Integration Scheme approved in June 2015.

The housing functions that are delegated to the IJB are:

- Housing Adaptations (General Fund and Housing Revenue Account) – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. The General Fund adaptations are carried out by Hjaltland Housing Association through their One-Stop-Shop and are for owner occupiers and tenants of private landlords. The Housing Revenue Account is where any adaptations for tenants of Council houses are funded.

Other housing functions which have a close alignment with health and social care outcomes but are not part of any delegated functions are:

- Housing support services and homelessness
- Other broader strategic functions to address future housing supply, specialist housing provision and measures to address fuel poverty.

Local Housing Strategy

The Local Housing Strategy (2011-2016) sets out the vision for Housing in Shetland:

"to work in partnership to enable everyone in Shetland to have access to: A choice of affordable housing options across all tenures that are warm and safe, energy efficient and in keeping with the Shetland environment, of good quality and in good repair, able to meet demand and the particular needs of households in inclusive and vibrant communities."

The Local Housing Strategy sets out 5 key themes/priorities:

- Future Housing Supply
- Fuel Poverty

- Housing Support/Housing for an Ageing Population
- Homelessness
- Private Sector Housing

All of the key themes of the LHS are relevant to the HCS.

Key Issues for Shetland

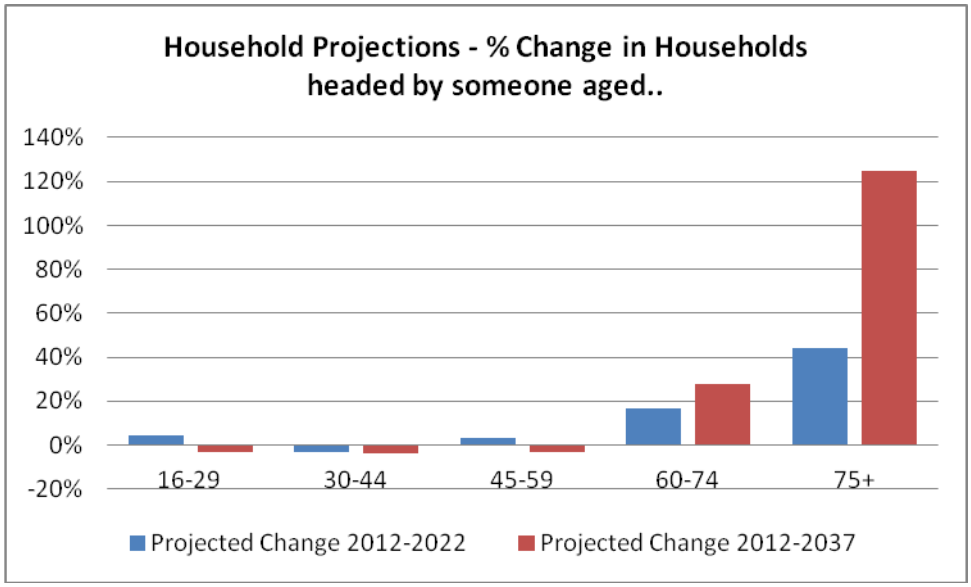
Housing Profile

Population	• 23,230[11] • 3,946 (17%) aged over 60 years
Households	• 10,201 • 9.8% increase 2004-2014 • Average household size 2.26 • 3.8% decrease 2004-2014
Household Composition	• 33% single adult households[12] • 58% small family households • 8% large family households
Dwellings	• 10,950 • 8.2% increase 2004-2014
Completions	• Annual average 94 (2010-2015) • 47% Affordable housing • 53% Private housing
Tenure	• 65% Owner occupied • 24% Social rented • 9% Private rented • 2% other
Specific needs	• 83% of the population do not consider that they are limited by a disability[13]
Specific Housing Provision	• 273 sheltered houses (social rented) • 25 extra care units (social rented) • 15 Homes for Life units (social rented in pipeline)
Adaptations	• 223 adaptations to private sector properties through Scheme of Assistance since 2011 • 70% to provide level access shower • 15% to provide ramped access • 8% both shower and ramp provision • 3% to provide WC upstairs/downstairs • 3% extension/conversion • 1% driveway/external access • Adaptations to Council properties in graph below

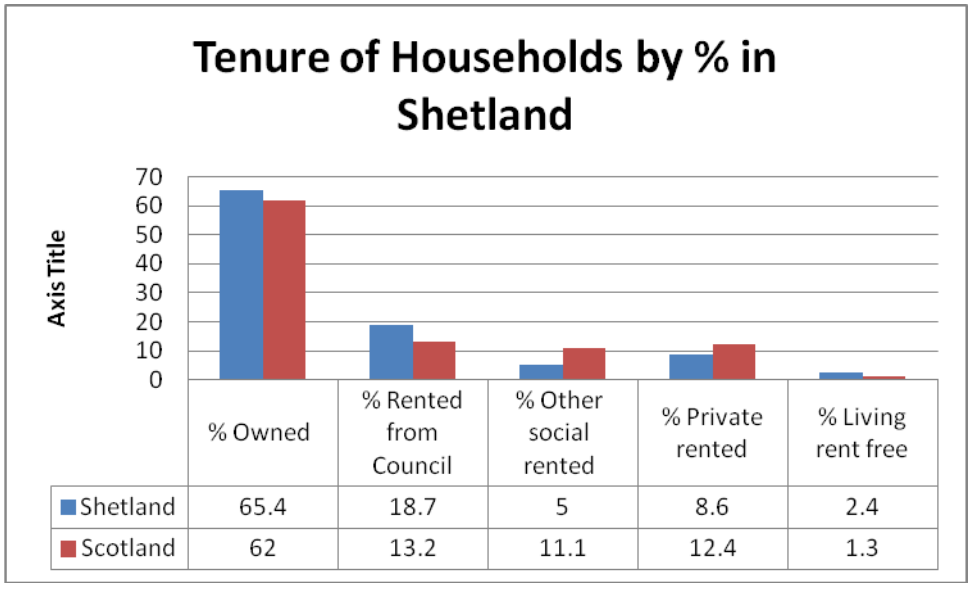
[11] GRO Scotland mid-2014

[12] National Records of Scotland 2012

[13] Census 2011



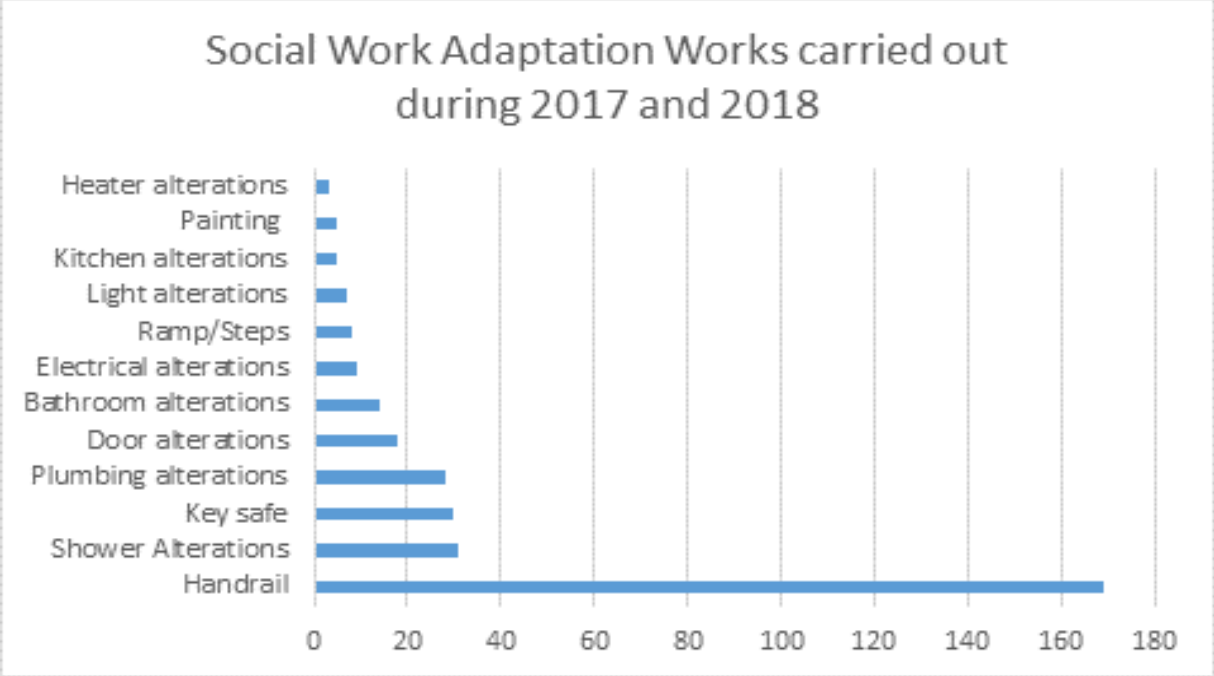
Source National Records Scotland



Source: Census 2011

Age group	Total no.	Day to day activities limited a lot	Day to day activities limited a little	Day to day activities not limited
65-74	2143	266 (12%)	505 (24%)	1372 (64%)
75-84	1178	337 (29%)	398 (34%)	443 (38%)
85 and older	456	265 (58%)	123 (27%)	68 (15%)

Source 2011 Census



Housing Contributions to Integration

- Encourage future housing supply that is the right size and in the right location across all tenures; built to modern standards and future-proofed design, mainstreaming of barrier-free, dementia friendly design and promoting provision for the use of assistive technologies.

- Moving away from ‘sheltered housing’ and ‘very sheltered housing’ labels to provide more flexible solutions through accessible housing, homes with support and homes for life.

- Developing better shared assessment processes with health and care teams in localities to link with housing support plans and housing allocation process.

- Reviewing the housing allocations policy to ensure that it continues to match people with housing that is suitable for their needs.

- Developing a housing options approach which would assist with longer term planning and anticipating future needs by fostering a prevention/early intervention approach to housing need. This will include developing a range of information and advice access points in partnership with a range of agencies in all localities.

- Providing a flexible and adaptable housing support service in all localities.

- Anticipate an increase in the number of adaptations required. The range and flexibility of adaptations should be reviewed to enable choices and to allow for future planning to happen as early as practicable. Timescales and priorities for adaptations to be kept under review.

- Increase the number of accessible houses in the Council's housing stock. There is a template for this from the North Isles pilot project.

- Integrating telecare and telehealth technology with provision of adaptations

- Review and develop the Handyman service for all tenures

- Recording and analysing a range of data and indicators on housing need, demand and provision to provide a robust baseline of future and anticipated needs.

Challenges

Demographic – projected rapidly ageing population will present a universal challenge in terms of delivering services to meet projected increased demands.

Financial – continued financial pressure on public sector budgets will present a number of challenges going forward. Changes to welfare benefits will continue to impact on the housing sector.

Knowledge – there is a real need to develop better, shared baseline information about the housing and support needs of people with long term, multiple health conditions and complex needs.

Support needs – demographic change suggests that there will be a small but significant number of people who will require intensive levels of support and care. This will bring challenges in a small, mainly rural local authority where availability of specialist services may not always be locality based. There is also likely to be an increase in the demand for lower level housing support to enable people to sustain their own tenures and allow them to continue to be supported at home as far as is practicable.

Housing Stock – Shetland has an imbalance in its housing stock with a prevalence of larger sized properties whereas demand is currently for smaller properties. There are also more 'sheltered' properties in landward areas and a lack of such provision in the town. Work has been done on a pilot project to demonstrate that accessible conversions can be carried out to stock in a cost effective way.

Resources

Housing Adaptations General Fund	£355k
Housing Adaptations HRA	£104k
Total	£459k

There are no plans for any staff with responsibility for housing functions to be transferred to the health and care partnership. Close partnership working will be essential, both strategically and operationally to ensure that housing's contribution can be achieved.

The General Fund adaptations are delivered through an agreement with Hjaltland Housing Association through a 'one-stop-shop'. This model has successfully provided a range of adaptations. With projected increased demand for adaptations to enable people to stay in their own homes, resources for aids and adaptations are likely to require close monitoring and review.

Programmes of maintenance and investment in housing stock has ensured that tenants in social rented sector have homes that meet the Scottish Housing Quality Standard. Continued planned investment will focus on energy efficiency which makes a significant contribution to health inequalities.

The Council and Hjaltland Housing Association (HHA) work in partnership to deliver the Strategic Housing Investment Plan which is the development of a new build programme to meet the needs and priorities identified through the LHS. The current new build plan contains provision for the proposed Homes for Life development at King Harald Street, Lerwick. HHA have completed a master-planning exercise on thesite at Staneyhill, Lerwick and there may be opportunities to include specialist provision in the planned development as that takes shape.

Monitoring and Review

This statement forms the link between the LHS and the SCP. Actions will be reviewed jointly through monitoring arrangements for both documents.

Anita M Jamieson

Executive Manager – Housing March 2019

Appendix 4, Schedule of Services and Directions

The pooled budget envelope for each theme in the Strategic Plan will be prioritised and detailed budget allocation will be made for the services to be delivered by the Parties under the direction of the IJB in line with the agreed priorities set out in the Strategic Plan and any associated strategic planning documents. The existing Directions will be updated to reflect the priorities and expected outcomes of this Strategic Plan.

Service	Direction	Reference
Mental Health	January 2019	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=23531
Substance Misuse	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Oral Health	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Pharmacy & Prescribing	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Primary Care	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Community Nursing	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Sexual Health	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Adult Services	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Adult Social Work	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Community Care Resources	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Criminal Justice	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Speech & Language Therapy	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Dietetics	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833

Podiatry	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Orthotics	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Physiotherapy	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Occupational Therapy	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Health Improvement	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Unscheduled Care	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Renal	December 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21833
Unpaid Carers	July 2017	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=21151
Domestic Abuse and Sexual Violence	January 2019	http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=23530

Appendix 5, Impact Assessment

Part 1 – Background Information

Name of Responsible Authority	**Shetland Integration Joint Board, NHS Shetland and Shetland Islands Council**
Title of Plan, Programme or Strategy (PPS)	Joint Strategic Commissioning Plan 2019-2021
Contact Name, Job Title, Address, Telephone Number and email	Simon Bokor-Ingram Director of Community Health and Social Care NHS Shetland Board Headquarters Burgh Road Lerwick, Shetland ZE1 0LA Telephone: 01595 743087 Email: simon.bokor-ingram@nhs.net
Signature	
Date of Opinion	February 2019
Purpose of PPS. Please give a brief description of the policy, procedure, strategy, practice or service being assessed.	The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.
Why PPS was written What is the intended outcome of this policy, procedure, strategy, practice or service?	Joint Strategic planning document for Integrated Joint Board (IJB) business. Statutory requirement for IJB when planning services.
Period covered by PPS	3 financial years from 2019 to 2022.
Frequency of Updates	Annual
Area covered by PPS (geographically and/or population)	Shetland
The degree to which the PPS sets a framework for projects and other activities, either with regard to the location, nature, size and operating conditions or by allocating resources.	The Plan will set a framework for all service activities including planning change and delivery within localities and decisions on resource deployment.
The degree to which the PPS influences other PPS including those in a hierarchy.	Overarching strategic planning document for integrated health and care services, and for NHS Service Planning. The overall objective of the Plan is to set out how to best deliver safe, high quality and effective services to meet the needs of the local community.
Summary of Content	It is a strategic commissioning plan which is structured around the client groups / services that are included within the delegated authority of the IJB. In addition, it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

Part 1 – Background Information (continued)

Objectives of PPS	To improve national health and wellbeing outcomes for people in Shetland through the joint commissioning of services that are included within the delegated authority of the IJB, and as a single system approach to health and care service planning through NHS Shetland. The overall objective of the Plan is to set out how to best deliver safe, high quality and effective services to meet the needs of the local community.
What are you trying to achieve?	Service delivery and redesign to improve health and wellbeing outcomes.
Is this a new or an existing policy, procedure, strategy, practice or service being assessed?	Existing strategic plan updated.
Please list any existing documents which have been used to inform this Integrated Impact Assessment.	Draft Ethnic Minorities Health Needs Assessment for Shetland 2017 The needs assessment and consultative elements of Older People's Strategy and Primary Care Strategy.
Has any consultation, involvement or research with people impacted upon by this change, in particular those from protected characteristics, informed this assessment? If yes, please give details.	Yes in relation to specific client groups. For example, a health needs assessment for Minority Ethnic People in Shetland is underway. Initial findings show an increase in numbers of people from ethnic minority backgrounds in Shetland. Health Improvement: ongoing consultation / dialogue with people with learning disabilities, lower paid men in mainly manual type work, people of ethnic minorities, people with mental health issues. Adult Services for Learning Disability and Autism – Progression of the Day Services New Build (Eric Gray Resource Centre) Stakeholder engagement has taken place in the form of regular meetings and consultation with the Eric Gray Users Group; the new Eric Gray Resource Centre Working Group which includes nominated family, carers and users. Occupational Therapy Informal feedback from clients and stakeholders has helped us to define areas for improvement. Primary Care Issues of importance to local communities have been identified through the round of locality planning meetings. Additional service specific information has been held by engagement with various groups eg patient satisfaction survey for Advance Nurse Practitioner service at Lerwick Health Centre. General satisfaction survey across all of District Nursing and Continence Service. Discussions with community councils on health issues. Podiatry Services produce annual patient satisfaction surveys for a% of caseload. Feedback from survey enables service to produce and implement action plans.

Is there a need to collect further evidence or to involve or consult people, including those from protected characteristics, on the impact of the proposed policy? (example: if the impact on a group is not known what will you do to gather the information needed and when will you do this?)	Ongoing process of needs assessment in Health Improvement. It is clear from the Ethnic Minority Health Needs Assessment that statutory services in Shetland do not routinely collect enough data on protected characteristics, such as ethnicity, to be able to judge the accessibility and appropriateness of current services, let alone proposed changes to services. The EMHNA will recommend further work to fill this gap in future. The audit of Adult Service Learning Disability and Autism service included engagement with people with learning disability, autism spectrum disorder, families and carers through meetings and gathered feedback. The implementation of the findings includes service user input and family representation on the project team. Further engagement work will be undertaken with island communities to explore / discuss sustainable service models for the future. The PPF will be used to discuss changes in nursing services based on the outcome of the national review of District Nursing services. Podiatry service will continue to use both formal and informal feedback from service users to redesign and develop service provision.

Part 2 – People and Communities

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Economic	No impact / positive. In Health Improvement all our programmes are adapted to suit individual circumstances as far as possible. For Primary Care; not known at this stage – potential negative impact if reduction of employment in small communities through changes in service provision / increased use of technology.	Discussions with partner agencies / other stakeholders as part of service review. We will use the recommendations contained in 'On Da Level' (the report of the Shetland Inequalities Commission, 2016) in assessing the impact of proposed service changes.
Cultural	Primary Care – potentially negative; communities may perceive changes in service provision as having negative impact on their culture. It is possible that significant changes in service provision may encourage community activism and an increase in communities taking ownership of and responsibility for health and social care.	Discussions with stakeholders as part of service reviews and engagement with communities in any major service change. Support for community initiatives and 'capacity building' in conjunction with Community Development and Learning and the Third Sector.
Environmental	There may be an increase in travel required if services are delivered further away from local communities. However the programme to return services to Shetland from Grampian and elsewhere may counterbalance this, alongside the increasing use of technology for routine appointments and checks.	We will ensure that all changes in service provision are considered with regard to impact on environment.

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Poverty	No impact / positive. Primary Care – not known, may have negative impact if changes in access to services rely on car ownership or availability of public transport.	We will use the recommendations contained in 'On Da Level' (the report of the Shetland Inequalities Commission, 2016) in assessing the impact of proposed service changes. We recognise that services may need to be adapted to individual circumstances to ensure that fewer people in Shetland live in poverty. Engagement with communities in any major service change.
Health	No impact / positive. As services are more targeted in their approach to the provision of services to those in greatest need.	
Stakeholders	No impact / positive. Primary Care	Discussion with partner agencies / other stakeholders as part of service review.

Equalities

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Ethnic Minority Communities (consider different ethnic groups, nationalities, language barriers)	We are not aware of any impact – positive or negative – at present.	Completion of EMHNA may allow an assessment of impact. It is likely that more complete data recording and engagement with people from ethnic minorities will be required to properly assess the impact of changes to services
Gender	No impact / positive	
Gender reassignment (consider transgender and transsexual people. This can include issues such as privacy or data and harassment).	No impact / positive	
Religion or Belief (consider people with different religions, beliefs or no belief)	No impact / positive	
People with a disability (consider attitudinal, physical and social barriers)	No impact / positive	
Age (consider across age ranges. This can include safeguarding, consent and child welfare)	No impact / positive	
Lesbian, Gay and Bisexual	No impact / positive	
Pregnancy and Maternity (consider working arrangements, part-time working, infant caring responsibilities)	No impact / positive	
Other (please state)	No impact / positive	

Part 3 – Resources

	Impact **Positive, Negative, No impact or Not Known**	**Next Steps**
Staff	Positive / Negative. Staff in some services will have to spread themselves more thinly with few resources	
Finance	Positive / No impact. We will continue to deliver within current or available resources. Some services identify that savings still need to be identified.	Investigating alternative methods of service delivery
Legal	Positive / No impact.	
Assets and Property	Not known currently but potentially opportunities for sharing assets and property through integration, especially at locality levels.	Consider as part of all developments being progressed.

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