Shetland NHS Board

Annual Review – 4 October 2016

Bressay Room, Montfield

Programme

1.00pm	ACF/APF representatives meeting with Board Members
4.00pm	PPF representatives meet with the Board
(4.45pm	*informal time for PPF members to have refreshments and discuss themes/questions for Q&A session – Skerries Room)*
5.30pm	Presentation from Mr Ian Kinniburgh, Chair and Mr Ralph Roberts, Chief Executive on key achievements in 2015/16 and the challenges that lay ahead
5.50pm	Refreshments
6.00pm	Public question and answer session ***Live on BBC Radio Shetland from 6.10pm prompt*** Members of the public will be able to directly ask questions of the panel.

It is anticipated there will be some questions generated through the local media ahead of the event which will also be responded to in this session. The question and answer session will be broadcast live on BBC Radio Shetland from 6.10pm.

NHS Shetland Annual Review 2016
At a Glance LDP Standards Performance 2015/16

• Within **smoking cessation services**, at the end of March 2016 we had helped **51 people** to successfully quit at 12 weeks. This met our target of 33.	B
• At the end of March 2015, **75.6%** of **pregnant women in each SIMD quintile had booked for antenatal care** by the 12th week of gestation. This is just behind the target of 80%.	A
• In 2015, 16.9**%** of people were **diagnosed and treated in the first stage** of breast, colorectal and lung cancer, which missed our target of 29%.	R
• For the quarter from January to March 2016, 50**% of patients waited less than 18 weeks** from referral to treatment for specialist **Child and Adolescent Mental Health Services (CAMHS) services**, which missed the target of 90%.	R
• For the quarter from January to March 2016, 94.4**% of patients waited less than 18 weeks** from referral to treatment for **Psychological Therapies,** which met the target of 90%.	G
• During the period April 2015 to March 2016, we had twelve **Staphylococcus aureus bacteraemia (including MRSA)** infections, which gave us a rate of 0.95 cases per 1000 acute occupied bed days. This missed our target of 0.24.	R
• During the period April 2015 to March 2016, we had six **C Diff infections**, which gave us a rate of 0.42 cases per 1000 total occupied bed days. This missed our target of 0.32.	R
• At the end of March 2016, 96.5% of patients **waited less than 4 hours at A&E,** meeting the target of 95%.	G
• During 2015-16, 88.9% clients **waited less than 3 weeks** from referral to **appropriate drug treatment that supported their recovery**, narrowly missing the target of 90%.	A
• During 2015-16, 91.2% clients **waited less than 3 weeks** from referral to **appropriate alcohol treatment that supported their recovery**, meeting the target of 90%.	G
• During 2015-16, 360 **Alcohol Brief Interventions** were delivered in the 3 priority settings (Primary Care, A&E, antenatal), exceeding our target of 261.	B
• During 2015-16, we had a **Sickness Absence rate** of 5.2%, missing the target of 4%.	R

• During 2015/16, 93.6% of patients accessed an **appropriate member of the GP Team within 48 hours,** meeting the target of 90%.	G
• During 2015/16, 76.4% of patients were able to make an **advanced booking for an appropriate member of the GP Team within 3 days,** missing the target of 90%.	R
• At the end of March 2016, 100% of **eligible patients have commenced IVF treatment within 12 months**, meeting the target.	G
• At the end of March 2016, 83.1**%** of **planned/elective patients commenced treatment within 18 weeks of referral**, missing the 90% target.	R
• At the end of March 2016, 88.3% of **patients waited less than 12 weeks from referral to a first outpatient appointment,** missing the 95% target.	R
• At the end of March 2016, **no patients waited longer than 12 weeks from patient agreeing treatment with the hospital to treatment for inpatient or day case treatments,** meeting the zero target.	G
• During 2015-16 we **operated within our agreed revenue resource limit; our capital resource limit; and met our cash requirement.**	G
• To deliver expected rates of dementia diagnosis and **by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support** coordinated by a link worker, including the building of a person-centred support plan. Note: 1st release of national data due in October 2016.	

Key:

B	Well ahead of trajectory or met early
R	Not meeting and not within trajectory limit
A	Not meeting but within trajectory limit
G	Meeting or better than trajectory

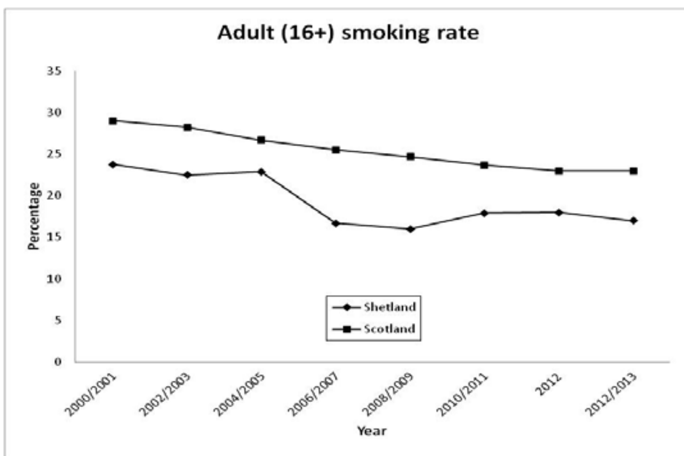
NHS Shetland Annual Review 2016
At a Glance Outcomes 2015/16

Cancer patients beginning treatment within 62 days of urgent referral ranging from 71.4% to 100% over the past year.
(note: small number variation)

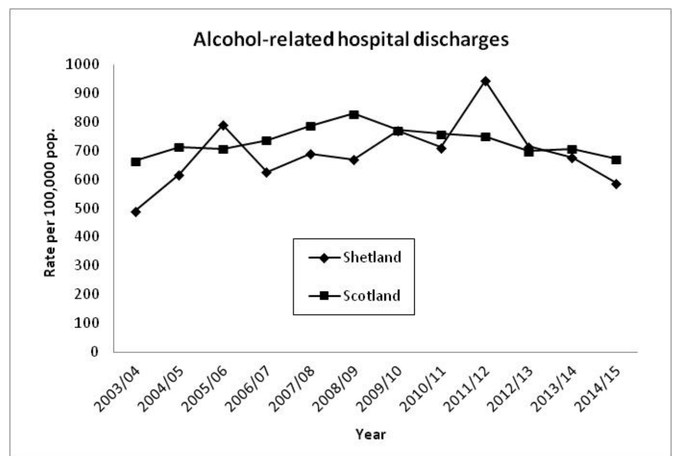
Twelve MRSA/MSSA infections and six C. Diff infections for year – missing our SAB and C Diff targets, though the bed day rates are not statistically significant.

Overall Healthcare Experience – NHS Shetland scored 82.0 for the Inpatient Patient Experience Survey, which is above the Scottish average.

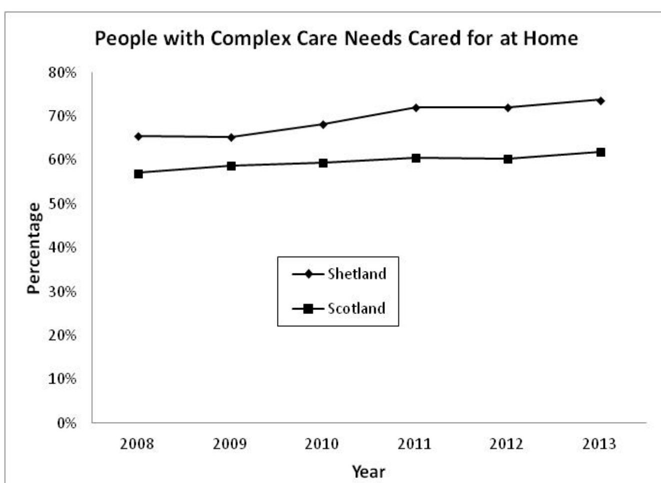
Smoking rate shows a decreasing trend and at 17.0% we have the lowest level in Scotland.



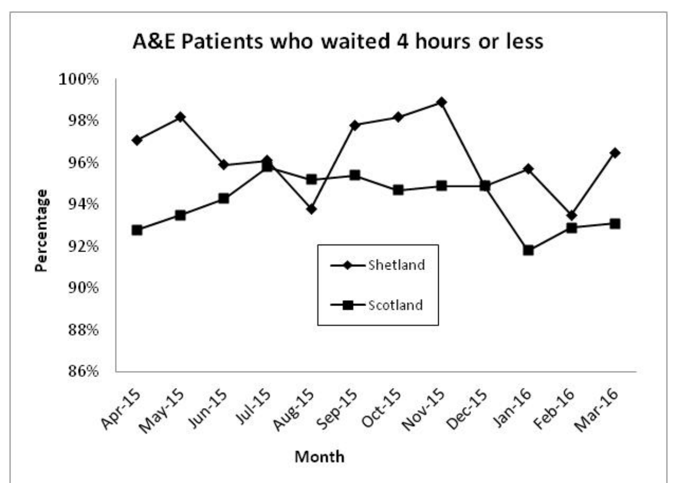
Increase in alcohol related hospital admissions since 2003-04, though showing signs of improvement in recent years.



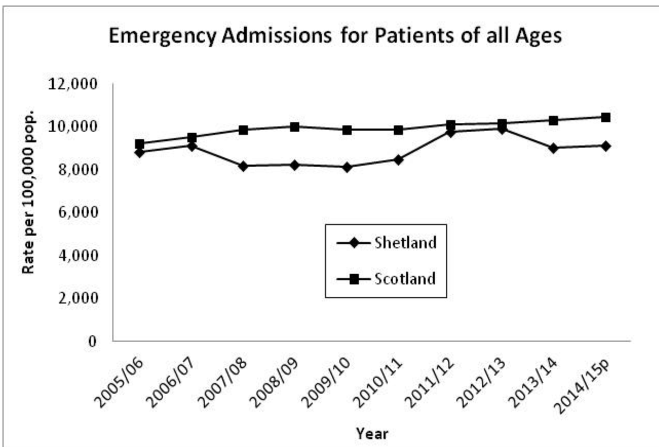
73.8% of people with complex care needs are cared for at home. Improving trend and consistently amongst the highest levels in Scotland.



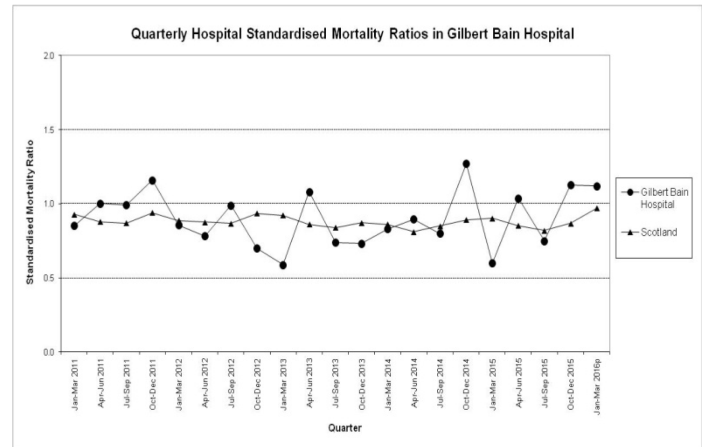
Mostly achieving over 95% of people being seen in A&E in 4 hours or less.



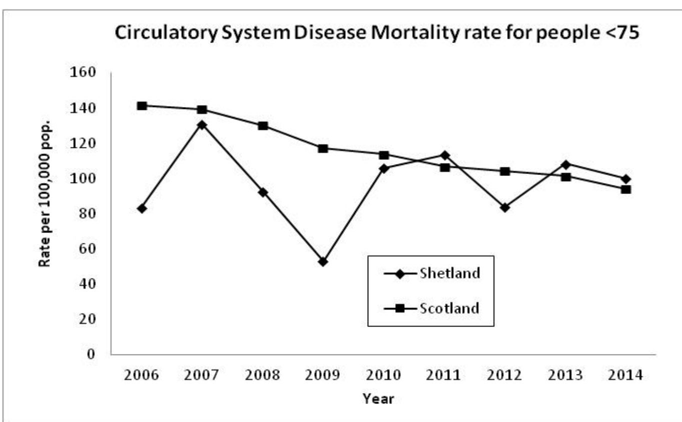
Emergency admission rate has remained steady and consistently lower than the national rate.



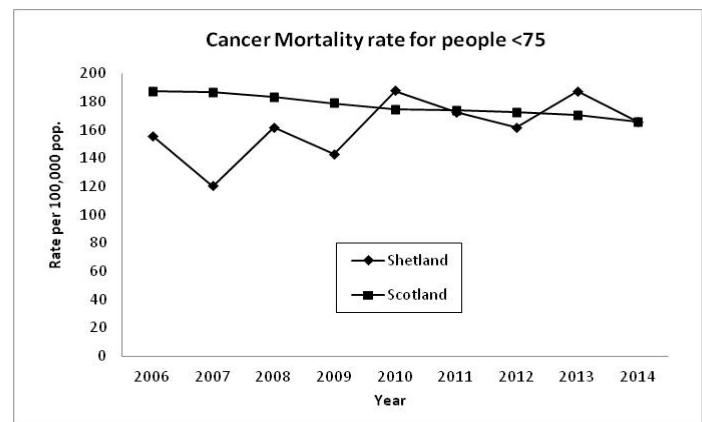
Quarterly Hospital Standardised Mortality Ratios has been stable over recent years.



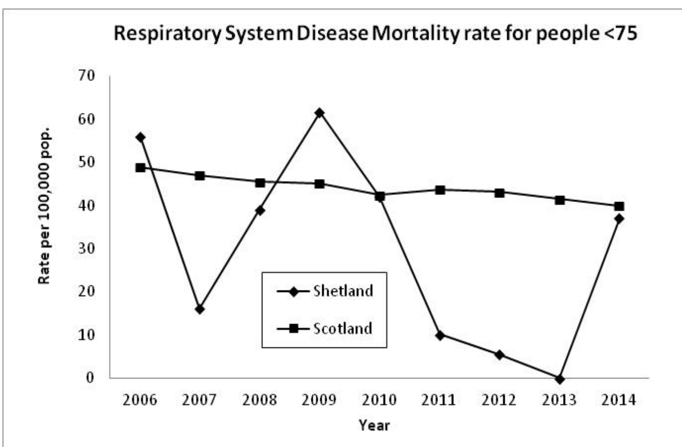
No significant trend in Circulatory Disease mortality in under 75s. (note: small number variation)



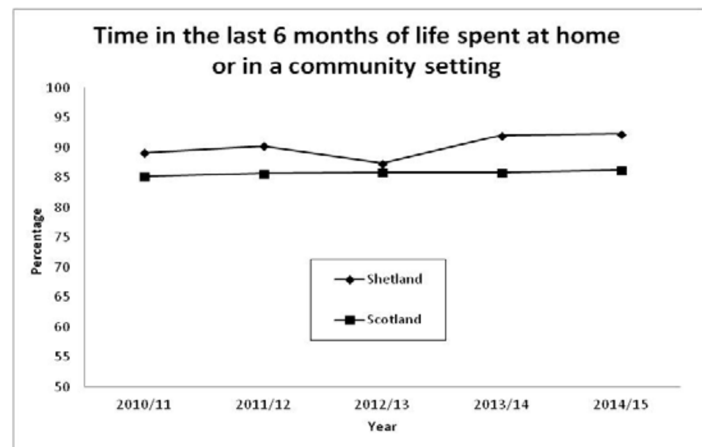
Slight increasing trend in cancer mortality in under 75s. (note: small number variation)

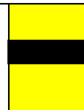


Slight decreasing trend in Respiratory System Disease mortality in under 75s. (note: small number variation)



No significant trend in end of life setting. Recently above the Scottish average and highest in Scotland.



Key: Improving trend or performing well  No change/trend Worsening trend or not performing well

Update on progress against actions identified in 2014-15 Annual Review

The Board must:
Work to maintain its strong performance in relation to health improvement and public health activities
See item 2: Everyone has the best start in life and is able to live longer healthier lives.
Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection, with particular emphasis on SABs
See item 3: Healthcare is safe for every person, every time.
Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety, including robust monitoring of actions arising from inspections and implementation of the recommendations of the Vale of Leven Inquiry
See item 3: Healthcare is safe for every person, every time.
Maintain emphasis on the delivery of all access targets and standards, in particular the 12 week outpatient standard and the 62 day cancer access standard
Overall satisfactory progress has been maintained in the delivery of the Outpatient, cancer access and Treatment time guarantee targets. Individual services have had specific issues during the year and close attention is paid to addressing these as issues have arisen. Delivery of these targets is closely linked to the support provided by visiting services (from NHS Grampian) and the provision of cancer treatment services in Aberdeen. See also Item 4: Everyone has a positive experience of healthcare.
Maintain focus on improving progress towards the 18 week target for access to Psychological Therapies
The waiting times for psychological therapies have continued to show that some people are waiting for a significant time. Shetland is part of the “Mastermind” initiative that promotes the use of computerised cognitive behavioural therapy for mild/moderate anxiety and depression, and this has been rolled out across Shetland. A Consultant Clinical Psychologist has been recruited, who will start in post later this year, and this post will form a significant part of our resource to reduce the waiting times for psychological therapies. NHS Education Scotland will support the recruitment of a trainee Clinical Psychologist for Shetland to work under the supervision of the Consultant Clinical Psychologist. See also Item 7: People are able to live well at home or in the community.

Update on progress against actions identified in 2014-15 Annual Review

Continue to make sustainable progress against the staff sickness absence standard
See Item 6: Staff feel supported and engaged.
Continue to work on the achievement of in-year and recurring financial balance, and keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme
See Item 5: Best use made of available resources.

ITEM 2

Everyone has the best start in life and is able to live longer healthier lives

Performance against public health targets for delivery in 2015/16

Progress against public health targets continues to be generally good. Achievement against targets for child healthy weight, smoking cessation, pregnancy booking, breastfeeding, detect cancer early and screening, and drug and alcohol waiting times are described in the sections below.

Progress against other specific actions and objectives in LDP:

Increasing physical activity: There has been further expansion of localities based activities such as health walks, aiming in particular to support the least active and roll out of the Laterlife chair-based exercise programme. Physical activity brief advice and referral / participation pathways are in primary care and being introduced into secondary care.

Reducing harm caused by alcohol: Alcohol Brief Interventions continue to be delivered within the key settings of primary care, Accident & Emergency, Sexual Health Clinic and Maternity, again exceeding the nationally set target for 2015-16. However, during the first half of 16-17, the numbers of ABIs in primary care have fallen showing that this is not yet embedded in primary care practice. In addition there has been difficulty in collecting data from maternity and A&E which are moving / have moved to new electronic patient record systems. Keep Well checks are used to identify people who may be more disadvantaged or vulnerable, and need an ABI.

Reducing mental health problems and suicides: Our rate of suicide or deaths of undetermined intent (measured over five years because of the small numbers involved) continues to fall, although the rate of male suicide is still above the national average. We use rates because this allows us to compare ourselves more easily to other areas, but in real terms this was 23 people over the last five years. We continue to work with partners such as Mind Your Head and Samaritans to increase community awareness and confidence in talking about mental health, and deliver training in workplaces to increase knowledge of mental health issues and help people develop skills in supporting people with mental health issues. We have also continued to audit every sudden death that may be due to suicide or drugs, identify common themes and trends and take appropriate action if possible.

Reducing obesity: We promote access to Counterweight for the most disadvantaged groups through locality working, with more intensive targeted response to more disadvantaged groups. We are continuing to work with partners (e.g. Shetland Recreational Trust, Active Schools) to improve access to support and activities to help manage weight. Reducing childhood obesity continues to be a challenge (see below).

Reducing smoking: in addition to continuing prevention activities with children and young people in particular, we have continued to help people stop smoking – see below.

Immunisation - a local challenge

Immunisation uptake for MMR at age two years continues to be a challenge locally, though by the age of school entry we meet the target, and uptake is still on a slow upward trend overall. Work is done at individual GP and family level to influence the decisions of parents on this and another local campaign is planned for the end of the summer 2016. The overall uptake for 2015-16 was low at 88.8% (28 children who reached the age of two during the year had not

been vaccinated) which was due to particularly low uptake in the middle two quarters. During January to March 2016, 95.6% of the children who reached age of two had been vaccinated, and three children had not. We are also monitoring the impact of the introduction of the new Men B vaccine in 2015 to see if it has any impact on the uptake of MMR and the other vaccines given at the 12-13 month visit.

Progress in reducing health inequalities and early years outcomes

Early years outcomes

In the first six months of 2015-16, 41.2% of pregnant women in each SIMD quintile had booked for antenatal care by the 12th week of gestation. However, local audit from maternity records puts the compliance with early booking at a significantly higher figure and the discrepancy in data is being reviewed.

For 2014-15 breastfeeding rates at 6-8 weeks were significantly above the national target of 50% at 59.4%.

The objective of the Early Years Collaborative nationally is to accelerate the conversion of the high level principles set out in GIRFEC and the Early Years Framework into practical action. The Early Years Collaborative has introduced a structure in which partners can easily learn from each other and from recognised experts in areas where they want to make improvements, and improvement methodologies are applied to bridge the gap between what we know works and what we do.

Reducing health inequalities

On reducing health inequalities, our year-end target for Keep Well health checks was exceeded, and our local programme continues despite even larger reductions in national funding. We continue to play an active part through partnership work on achieving the healthier and fairer priorities in the Local Outcome Improvement Plan and we were actively involved in providing evidence to Shetland's Commission on Tackling Inequalities.

In Shetland we do not have some of the harder to reach groups such as prisoners and travellers. We do have relatively small numbers of people who are homeless, and these are generally accommodated in temporary accommodation rather than being on the street or in hostels. We have small immigrant populations and few non-English speakers. However, rurality and access is a major issue for us. In terms of socio-economic and remote and rural disadvantage, our Keep Well (previously Well North) programme targets and engages with those living in the most disadvantaged areas of Shetland and has been rolled out across all practices including those in the most remote and rural areas. The programme includes a health check (including uptake of screening) healthy lifestyle advice and referral for alcohol problems, smoking cessation and weight management. Evaluation shows that we are reaching people who often struggle to be engaged with services. Our success in helping people to stop smoking and lose weight is very much tied into this outreach approach.

We continue to implement our Outcomes Focussed Action Plan to mitigate against effects of Welfare Reform. This has included awareness raising for staff on welfare reform to enable staff to identify issues and signpost / refer patients (and themselves / colleagues) to services such as CAB where appropriate. CAB has continued to provide an outreach service to GP practices, including those in remote and rural areas. In health settings, we are also promoting grant schemes to reduce fuel poverty.

Procurement & HR contributions to health inequalities:

Local suppliers continue to be included in the list of national contracts to allow access to local business and resultant benefits for the local economy. We have contributed to the Single Outcome Agreement objective on maintaining financial sustainability in the local economy. We have targeted support for staff in recruitment and professional development e.g. for those who may have difficulty accessing web-based recruitment methods or IT based learning opportunities, and a good record of employment for people with disabilities or additional support needs.

Performance against child healthy weight interventions, smoking cessation and drug and alcohol waiting times targets

At the end of 2014/15 Shetland had the lowest percentage of Primary 1 children “at risk of overweight and obesity combined” in Scotland. However there was a significant jump upwards in the numbers for 15/16. This may be because of the small numbers involved, or because there are underlying conditions which affect weight, and we are undertaking some further interrogation of the data to identify patterns and opportunities for earlier intervention. Although there is a comprehensive programme of family and child weight management support available, we struggle to get families engaged at an early enough stage for there to be an impact by the time they are weighed and measured at Primary 1. It is anticipated that the new health visiting pathway will have a positive impact on identifying and encouraging parents to take up support earlier.

We recognise, however, that trying to tackle behaviour in isolation is difficult; we continue to work with community planning partners to tackle physical inactivity and promote healthy environments, but it would be incredibly helpful to have political backing for reducing the availability and attractiveness of sugar laden soft drinks and promotions of high calorie/low nutrition foodstuffs.

Smoking cessation services again exceeded their targets (51 people quit at 3 months against a target of 33) which we see as a significant achievement for all the staff involved locally in helping people to stop smoking. Since our smoking rates are now low compared to the rest of Scotland (less than 16% from GP systems data, 17% from Scottish Household Survey data), the people they are helping now are generally those who find it the hardest to quit. This includes the percentage of mothers smoking in pregnancy: midwives are now fully trained in delivering smoking cessation support and a range of programmes aimed at reducing the numbers smoking at booking are in place.

We met our targets on drug and alcohol waiting times, through a period of time when the local services have undergone major redesign to make them more resilient and sustainable with a renewed focus on recovery.

Performance against the waiting times standard and early diagnosis and treatment targets under the Detect Cancer Early campaign

The percentage of breast, bowel and lung cancers that were diagnosed as Stage 1 in the two year period January 2014- December 2015 was low at 16.9% (15 patients); compared to 25.1% for the whole of Scotland. This figure has not varied much over the four years of the DCE campaign, ranging from 15.6% to 19.3%. Our target has been 29% (a 25% increase in the baseline, which equates to six more people being diagnosed at Stage 1 rather than a later stage).

The factors that influence this figure include completeness and accuracy of the data; screening rates; presentation at the GP; GP referral rates and waiting times for secondary care

appointments and diagnostics.

We are reliant on Grampian for much of our data capture, and are working with the teams there to ensure the accuracy and completeness. We have made use of some of the non recurrent allocations to support our cancer tracker to carry out audit work.

The uptake rates for the breast and bowel screening programmes in Shetland are high: uptake of breast screening is usually one of the highest in Scotland and uptake of the bowel screening programme has consistently been the highest in Scotland. The most recently published figures show uptakes of 84.4% and 66.3% respectively. However, as breast screening is only carried out every three years, then the opportunity for picking up very early non-symptomatic cancers is restricted to one year in three. During the two year period 2014-15 there was no breast cancer screening in Shetland.

There is no screening programme for lung cancer and the current advice for people to visit their GP after three weeks of a cough is difficult to manage given the prevalence of non-specific viral infections, especially in the winter.

The national DCE campaigns do not seem to have made much difference to the figures by encouraging people to present earlier with symptoms, although with the very small numbers involved it can be difficult to interpret. However we will continue to promote national awareness raising campaigns for breast, bowel and lung cancer. Publicity materials are widely distributed across Shetland with the aim of reaching all communities, especially the most remote and rural, and ensuring that the materials are available in a variety of settings including local rural shops and post offices, leisure centres and public halls. Other national campaigns to promote early detection of cancer are promoted locally; for example oral cancer week is promoted annually, including free checks at dental surgeries.

There has also been work with community pharmacists and other community based practitioners to identify people with potential cancer trigger symptoms who are using these services e.g. following medications reviews.

Once patients present to their GP, our GP referral rates are amongst the highest in Scotland, so low GP referrals does not seem to be a specific issue.

There are no significant delays for cancer diagnostics and even if there were, one or two weeks is unlikely to make any difference to the stage of the cancer, particularly if the patient has waited two years before going to their GP. At the beginning of the programme we reviewed our capacity for any increase in clinical workload, and used some of the non recurrent allocations for diagnostic equipment.

Looking at the breakdown of cancers detected at Stage 1 in the two year period 2014-2015:

- 26.9% of breast cancers were stage 1. This is much lower than other areas (40.5% across Scotland) but can be explained by no breast screening during this period.
- 11.8% of bowel cancers (4 people) were Stage 1. This is lower than Scotland (15.4%) but slightly higher than our neighbouring Boards, Grampian and Orkney.
- 13.8 % of lung cancers (4 people) were Stage 1. This is lower than Scotland (17.9%) , but again slightly higher than Grampian (12.1%).

The number of cancers where the staging is not known can make a significant difference to the figures, especially where the numbers are so small. For Shetland, the staging was recorded for all lung cancers, and for all but one bowel cancer (compared to 4.8% and 9.8% for Scotland). However for breast cancer, with Shetland residents the staging was not known for 15.4% of

cancers (four patients) compared with 3.0% for Scotland.

In order to identify if there is any more than can be done to encourage patients in Shetland to present earlier with symptoms potentially consistent with cancer, we are conducting a retrospective audit of late presenting cancers.

ITEM 3

Healthcare is safe for every person, every time

To demonstrate systems are robust in terms of clinical governance, clinical effectiveness, adverse events and risk management

In terms of Board assurance, there are regular standing items at the Board setting out local work and progress in relation to quality, safety and clinical effectiveness. The Board receives a quality strategy implementation progress report, Healthcare Associated Infection (HAI) report and performance report at each meeting. These reports include the care quality indicators (CQI) metrics as well as national HEAT target performance, Scottish Patient Safety Programme (SPSP) measures and where appropriate indicators from the Local Outcome Improvement plan delivered in partnership through Community Planning.

More detailed reporting and discussions about service delivery, patient outcomes and clinical effectiveness take place in the standing committees – and in particular, the Clinical, Care and Professional Governance Committee (CCPGC) and the Strategy and Redesign Committee. The committees have a remit for ensuring that there is appropriate scrutiny of performance measures and patient outcomes and local policy development. This also includes the review of service provision, delivery and quality where we have shared services with other providers e.g. Scottish Ambulance Service, NHS 24 and NHS Grampian. The standing committees receive reports on specific topics such as risk management, corporate risks, complaints, adverse events and investigations and clinical effectiveness which includes our locally developed service improvement grid. This sets out the quality improvement work which is being taken forward across the organisation which is mapped to specific headings such as patient experience, safe, effective etc. The committee has a work plan detailing planned in-depth review of areas of activity that span across all aspects of health and social care looking at the demographics, current service provision and outcomes and benchmarking that against other similar areas.

Work is currently underway, including engagement with clinical staff to update the Adverse Event Policy in light of the revised national guidance.

Category 1 adverse events are reviewed by the Clinical Risk Assessment Team (CRAT) within one working day. This comprises the Medical Director, the Director of Nursing and Acute Care and the Director of Community Health and Social Care who is the Chief Officer of the Integration Joint Board and the Chief Social Work Officer (when appropriate) to assess the seriousness of the event and decide how it will be investigated and what actions need to be taken immediately. Once completed the report is then submitted to the Risk Management Group which consists of the Chief Executive, the Director of Human Resources (Chair), the Director of Finance, the Medical Director, the Director of Nursing and Acute Care, the Director of Public Health and the Director of Community Health and Social Care with the Clinical Governance and Risk Lead and other members of the Clinical Governance and Risk Team. Suitably anonymised summaries based on the Health Improvement Scotland national learning summary template are circulated within the Board and also nationally as appropriate.

The Clinical, Care and Professional Governance Committee (which is a sub-committee of the NHS Board, IJB and the local council) receives reports on Quality & safety at each meeting and has the remit to provide quality and safety assurance both to the NHS Board and services within the remit of the Integration Joint Board. The development of this new committee has been a key task in the past year and work is continuing on the way this committee will support the quality and safety agenda across the whole Health & care system.

The Medical Director, Director of Nursing and the Chief Social Work Officer act in partnership to provide professional leadership for governance. They have been working on a joint framework for clinical care and professional governance which was approved by the CCPGC in August 2016.

The Joint Governance Group (JGG) is an integrated group which reports to the CCPGC. Work has taken place to review the meetings and align them with the CCPGC meetings. This group acts as the officer / manager group that supports the CCPGC and co-ordinates the governance work across the system.

Pathway development is managed through clinical networks, the Acute Services Management Team, the CHSC Management Team and other specific groups such as the waiting times group and a joint management group that brings together managers from both the acute and community services. Representation on these groups is multi-professional and multi-agency as appropriate. Approval and decision making (e.g. strategy and policy development) is undertaken jointly and reports into the CCPGC and/or the IJB depending on the topic. For example, service developments which are aligned to Integrated services and may include projects/services which are being delivered by a number of partner organisations e.g. Mental Health are now reported to the Integration Joint Board.

At an operational level, results of audits (e.g. falls, pressure care, food/fluid and nutrition), patient feedback surveys and patient safety interventions such as SSKIN, HAI and nutritional audits are discussed at regular meetings with Senior Charge Nurses, Heads of Departments and team leaders and are also reviewed through the clinical and care governance structure. Specific topics, which may include audit findings, are reviewed at the departmental Clinical Governance meetings and the wider Clinical Governance afternoons which are held throughout the year, co-ordinated by the clinical teams.

Our annual record keeping audit has been completed and areas for improvement noted and actioned. This audit covers all clinical and clinical support teams.

We also have active professional committees which take a lead quality assurance role as part of our clinical governance arrangements, in particular the Area Clinical Forum has 'quality' as a standing item and has commented extensively on local clinical matters.

We have continued to meet with the Scottish Ambulance service through our Ambulance Liaison Group. This is a multidisciplinary and multi-agency group that has resolved local governance and operational issues, including review of all adverse events reported by either organisation relating to our partnership working.

Scottish Patient Safety programme, HEI/ HAI and any matters arising from external scrutiny visits and reports

In 2015-16, NHS Shetland's MSSA/MRSA rolling average infection rate (0.95 per 1000 bed days) was above the target of 0.24. All of the 12 cases identified in that 12 month period were investigated using root cause analysis techniques and no linking factors were identified.

We were close to the target for C. Diff. infections (at 0.37 per 1000 bed days), with six cases identified over the 12 month period. Again, no linking factors were identified following root cause analysis.

It is important to note that these numbers need to be seen in the context of small number

variation and the figures can change significantly from quarter to quarter with just one event, for instance the rate of C. Diff in the last quarter of 2015-16 had a rate of 0.00 per 1000 bed days, but overall performance was just outside the target for the 12 month period.

We continue to review and refresh our HAI arrangements and we have robust HAI procedures in place. This includes a rolling programme of training for staff at all levels of the organisation and regular audits to show compliance with standard operating procedures. Each case (where a patient develops an infection) is reviewed by the clinical team to understand how the infection was acquired and to identify any lessons for improvement. We did not find any linked cases in 2015-16 and we did not have any norovirus outbreaks during this period, but we did undertake tabletop exercises to ensure that refresher training was in place.

We also ensured that staff were prepared to manage patients presenting with viral haemorrhagic fevers through training sessions and planning exercises and testing staff to ensure that FFP3 masks are available and ready for use.

In line with the new HAI standards, we have revised our infection control manual, moving to the national resources and updated our HAI self assessment (the last inspection for NHS Shetland was November 2013).

HAI is a standing item at Board meetings and forms part of our Quality Improvement Agenda. HAI compliance also forms part of our leadership and safety walk around arrangements – lay representatives are involved in safety walk rounds, cleanliness standards review and the control of infection committee.

ITEM 4:

Everyone has a positive experience of healthcare

Improving access to services

- Performance against access targets has been challenging. We are continuing to work with local and visiting teams to deliver Stage of Treatment and Treatment Time Guarantee performance.
- The appointment system at Lerwick Health Centre (our largest practice with just over 9,000 registered patients) has not been popular. Work has been carried out to increase capacity through a significant expansion of the Advanced Nurse Practitioner service, and there has been a decrease of attendances at A&E of primary care patients over a period of time. All practices are sustaining same day access for urgent need.
- We continue to expand self referral into services, and Allied Health Profession services have focused on this over the last year. The levels of demand have increased for Physiotherapy musculoskeletal services, and along with some sporadic gaps in staffing the waiting times have not reduced over the year.

Performance in relation to waiting time targets and the legal treatment time guarantee

We have achieved delivery of the 18 Week Referral to Treatment Standard overall for the last twelve months, with an aggregate of 90.48%, with the exception of May 2015 and December 2015 – March 2016 when we were experiencing pressures in the Audiology service due to a significant increase in referrals. We have put a number of measures in place to effectively manage demand across this service and ENT as a whole and increased the capacity in the Audiology team through the addition of an Assistant Practitioner.

18 Week RTT Performance figures

NHS board of treatment	Shetland	**Scotland**
Apr- 15	91.8%	**87.8%**
May- 15	84.6%	**87.6%**
Jun- 15	96.2%	**88.5%**
Jul- 15	94.8%	**88.3%**
Aug- 15	93.5%	**88.0%**
Sep- 15	95.7%	**87.9%**
Oct- 15	91.9%	**87.2%**
Nov- 15	94.0%	**86.5%**
Dec- 15	89.6%	**86.3%**
Jan- 16	88.3%	**87.1%**
Feb- 16	85.5%	**86.7%**
Mar- 16	87.7%	**86.2%**

Outpatient performance has also been challenging throughout the year, but particularly in Q4 of 2015-16. This is due to an overall increase in outpatient referrals and demand. This has had the greatest effect on the visiting services (e.g. ENT, ophthalmology, gynaecology etc) and the local rheumatology clinics.

We implemented recovery plans, with additional clinics in March and April 2016 and we had worked down the majority of the backlog going into 2016-17. This will continue to be a challenge in 2016-17 as we look at ways in which we can ensure that we have evidence based pathways in place and technology e.g. e-triage and tele-health are maximised to support efficient utilisation of the clinicians time/expertise in primary, secondary and specialist services.

12 Weeks (outpatients)

Date / NHS board of treatment	Shetland (number of pts who waited > 12 wks for an OP appt - Shetland)	Shetland (number of pts who waited > 12 wks for an OP appt - Scotland)
31-Mar- 15	74	**19,854**
30-Jun- 15	15	**28,310**
30-Sep- 15	101	**39,325**
31-Dec- 15	144	**33,527**
31-Mar- 16	114	**32,961**

Treatment Time Guarantee

We have maintained good performance around this guarantee across all specialties in 2015-16. There was one patient who was not seen within the waiting time guarantee, this was in connection with the ENT visiting service from Aberdeen and was due to pressures in the service. ENT continues to be an area for concern, and we are currently reviewing referral pathways and treatment options to address this.

Since September 2014, NHS Grampian has been utilising support from Golden Jubilee National Hospital (GJNH) to provide additional capacity that has been used to put in place an outreach clinic in Shetland. This has reduced waiting times for patients that meet the criteria for the GJNH pathway and we have not had any further TTG compliance issues since the pathway was put in place.

Date	Completed waits for patients seen (waited > 12 weeks)
Mar- 15	0
Jun- 15	1
Sep- 15	0
Dec- 15	0
Mar- 16	0

Unavailability

We regularly review the trends in recorded unavailability and have not identified any areas of concern but continue to work with staff to ensure that recording and use is in line with the national guidance.

Performance against the 4 hour A&E waiting time standard

We have achieved 95-%+ compliance throughout 2015-16, with the exception of September 2015 and January and March 2016 when we were experiencing additional seasonal / winter pressures. We review each case where patients had waited more than four hours in A&E as

part of our ongoing improvement work and delivery of the unscheduled care plan.

Although the number of patients attending A&E has fallen slightly, we have a higher conversion rate of patients requiring hospital admission and higher inpatient bed utilisation. Whilst it is not reflected in our A&E performance, there is greater pressure on the overall hospital system, and contributory factors for this include delays in the availability of beds in specialist units for inter-hospital transfers and providing services which support the presence of the oil and gas industry in Shetland.

Date	Shetland	Scotland
Apr- 15	97.2%	**92.2%**
May- 15	97.1%	**92.8%**
Jun- 15	98.2%	**93.5%**
Jul- 15	95.9%	**94.3%**
Aug-15	96.1%	**95.8%**
Sep- 15	93.8%	**95.2%**
Oct- 15	97.8%	**95.4%**
Nov- 15	98.2%	**94.7%**
Dec- 15	98.9%	**94.9%**
Jan- 16	94.9%	**94.9%**
Feb- 16	95.7%	**91.8%**
Mar- 16	93.5%	**92.9%**

Progress in improving access to stroke unit care

It has been agreed with the National Stroke Audit team that whilst we do not have a dedicated stroke unit, our Medical Ward is where all patients with stroke are cared for as it provides all the services that a dedicated Stroke Unit would offer, including the level of expertise through training that staff have attained. Traditionally all patients with a diagnosis of stroke have been admitted to the Medical Ward resulting in our 100% rate of admission to a stroke unit against the current performance target. We have also put in place a six bedded unit, based in the Gilbert Bain Hospital which provides time limited, multi-disciplinary rehabilitation and the most common reason for admission is to support people following a stroke. We are currently developing a model to support rehabilitation in the community which will support people with stroke in the future.

We performed well in the national stroke standards audit undertaken in 2015.

Approach to person centred care and patient experience

In respect of our local arrangements for Patient Focus Public Involvement (PFPI), we have an active Public Participation Forum (PPF) which meets every six weeks to discuss health and wellbeing related topics and provide advice/feedback on proposed service change and/or development. The PPF has an established lay representative Chair (where it was previously co-ordinated by NHS staff) who has led a major project to review service user opinions regarding access to primary care services in the Lerwick area. A second sub group has been established to support the implementation of the mental health strategy, particularly in relation to developing crisis response models and an enhanced 'place of safety'. This has led to plans for an emergency psychiatric assessment group in A&E and the support of a case for change to recruit additional clinical psychology input for Adult Services.

We have also worked with the PPF and local Community Councils to engage the local community in discussions about health and social care services, including topics such as

integration, older people's care and dementia care to formulate strategies. The conversations in localities with a range of stakeholders helped shape the Strategic Plan that was developed by the Integration Joint Board for 2015/16. Our PFPI Steering Group is chaired by a Non Executive Director and reports to the Board. The development of strategies to gather patient experience and patient satisfaction feedback has been discussed at Board level as well as with clinical teams and ACF and a local framework is under development to bring various strands of work together (e.g. utilising feedback from complaints, Patient Opinion, local and national surveys, person centred health and care collaborative). The Director of Nursing and Acute services, Director of Community Health and Social Care and the Medical Director review all formal complaints received to take an overview of learning for the organisation. This approach has been commended by the Scottish Health Council when reported in our feedback and complaints report.

Work has continued across the NHS Board and Health and Social Care Partnership to publicise and implement the Our Voice Framework.

Volunteers are involved in a wide range of activities including supporting patients in clinical settings (mainly the hospital), signposting and participating in specific activities such as auditing managed meal times compliance, tasting food, being part of leadership walk rounds and cleaning standards audits. We have successfully completed the Investors in Volunteering award (revalidation) and we are continuing to roll out our local improvement plans.

As part of our person centred approach, we have developed a local framework describing how we use patient feedback to drive quality improvements. This includes implementing systems which improve the quality of patient care and care experiences (e.g. safety bundles, comfort rounds, Must Do With Me information gathering, patient stories etc).

We have also developed a professional framework model to support practitioners to deliver effective care in all settings, which is a jointly commissioned project between the Medical Director, Nurse Director and Chief Social Worker. A professional assurance model for nursing and midwifery has been approved by the professional advisory group and the Clinical Governance Committee in 2014-15. In 2015-16, we developed an overarching clinical, care and professional governance framework to support the professional assurance arrangements across all professions which has been part of the work to create an integrated health and care governance framework for the Board and the IJB.

We have also taken forward a number of joint projects across health and social care services to ensure that we have a person centred approach to service delivery (e.g. developing intermediate care services, integrated approach to medicines management etc). Work on delayed discharges has yielded positive results, with significant reductions in the number of people experiencing a delay when ready for discharge from hospital.

The Intermediate Care Team has successfully supported individuals back to their own homes with only three individuals out of 107 requiring readmission within 30 days. Two of these were due to deterioration in health conditions/surgery as opposed to a failed discharge.

The development of the various partnership approaches has been undertaken with input from a wide range of stakeholders including service users, lay representatives and staff. We are keen to see expansion of the Third Sector, and the Integrated Care Fund developed includes the procurement of a Third Sector service to work with acute and community services so people can be supported better in their own homes e.g. through resources for carers and 'take home' services.

ITEM 5:

Best use is made of available resources

Financial balance and efficiency savings

Main Achievements in 2015-16

- Revenue under spend £396k, equivalent to 0.7% under spend against the CRRL.
- Capital expenditure £687k, resulting in an under spend of £76k on CRL
- Delivered recurring Efficient Government savings of £711k
- Delivered non recurring Efficient Government savings of £1,458k

Work on best value characteristics included: updating refining our more formal Best Value framework in order to assure ourselves that we were demonstrating the required characteristics. Committee chairs were given 'ownership' of characteristics relating to their Committees and were required to produce a formal statement at the end of the financial year.

A few examples are given below:

Characteristic (Sub-Characteristic)	
Sound Governance (Performance)	Continued improvement in the performance reporting to the Board
Accountability	Patient focus public involvement, seeking feedback and using both local newspapers and radio to engage with local community. Worked with Scottish Health Council to develop on-line patient feedback
Sound Management of Resources (Risk Mgt/Assets/Procurement)	Significant work on procurement to deliver value for money maximised from national and local procurement hubs. Commenced work with NSS on Procurement Strategy leadership as a shared services model.
Use and Review of Options Appraisal	Establishment of projects groups under the Efficiency and Redesign Project which includes a review of the acute hospital to predict and reflect in planning the changing circumstances.
Contribution to Sustainable Development	Various measures to reduce energy consumption
Equal Opportunities Working	Equality Annual Report approved by Board
Joint Working (Planning)	Partnership working through the change fund initiative, developing the local integration joint board and other projects

Main Challenges

- Challenging savings target for 2015/16 – while there was slippage on initial recurring savings schemes these were covered by non recurring schemes and the contingency reserve the Board holds to manage non recurrent pressures
- Requirement, in addition to "efficient Government savings target (3%), to reduce underlying deficit (currently £1,462k) over the course of the next three years with a plan to bring the Board back into recurrent balance in phased way by 2018/19
- Maintaining progress and momentum on delivery of recurring savings to address underlying deficit and achieve national annual 3% target (currently assumed to continue year on year) plus an additional local 1% savings target in 2016-17 and 2017-18. Over the next five years £9.5 million in efficiency savings will be required to achieve long term financial sustainability.

  Target Savings Profile 2016-2021

Indicative Savings Target Requiring to be Delivered over the period 2016-17 to 2020-21						
	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	Total £000's
Brought Forward balance	1,461.9	1,401.1	0.0	0.0	0.0	
New Target 3% Target	1,194.0	1,204.0	1,224.0	1,245.0	1,266.0	
New Target to meet 2016-17 funded developments	1,056.5					
New Target Additional 1% Target for 2017-18 and 2018-19	0.0	408.0	418.9	0.0	0.0	
Plan for actual achieved in-year recurrently	-2,311.2	-3,013.1	-1,642.9	-1,245.0	-1,266.0	**-9,478.2**
Balance Carried Forward:	1,401.1	0.0	0.0	0.0	0.0	

- Removing reliance on non-recurrent additional allocation for primary care medical services whilst still supporting remote and rural single handed practices that have to provide 24/7 service throughout the year. The current national funding model is unable to reflect the true underlying cost of this requirement. Recruitment difficulties in salaried practices directly managed by the Board had high unavoidable locum costs to maintain essential services (£554k in 2014-15).
- Managing relationship and patient pathways with NHS Grampian for "off island" activity including the transfer of resources back to Shetland for the repatriation of services where this is clinically safe to do so. Work with NHS Grampian via the obligate network to discourage moving services off island back to Grampian as a solution to addressing waiting lists. This also assists in the reduction in off island travel with funding diverted to provide resources for sustainable on island service. Although not included as part of the Board's formal CO_2 target this will also reduce the carbon foot print of patient journeys.
- Managing potential issues with the Highlands and Islands Travel Scheme. Incurring some inflationary cost pressures out with the Board's control. Working with all NHS Scotland partners on patient centred care models for clinical pathways that reduce the need to travel off island for out-patient attendances and developing patient enabled care models.

Development of capital programmes including the Board's progress in maintaining estate

Main Achievements

- Investing £0.1m in revenue for essential medical equipment replacement programme
- Delivered agreed Capital Plan of £0.69m including –

- £0.18m on new Medical Equipment
- £0.40m to upgrade Infrastructure at the Gilbert Bain Hospital (i.e. Endoscopic washer, Pharmacy, Renal and Critical Care);
- £0.11m on IT projects for network resilience

- Maintain investment in sustainable development including further work to improve energy efficient lighting.
- Completion of the joint project with Shetland Island Council to relocate Scalloway GP Practice and community services within the Scalloway school campus in August 2015.
- Outline 10 year Capital Plan presented to the Board to aid strategic direction

	Year (all values £k)									
Project	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
A&E Trolleys	0	35								
Resus Storage	5									
RO Plant	12									
Mental Health Staff Accommodation	40									
Psychiatric Emergency Room	100									
Mortuary Trolley	0	6								
Ronas Therapy Kitchen	4									
Lerwick Health Centre Security	10									
Servery	0		25							
Washer Disinfectors	0		200							
GBH Boilers	0			60						
Phone Systems	0	350								
Medrex Scanner	40									
IT Rolling Replacement	100		100	100	100	100	100	100	100	100
Anaesthetic Machines	180									
Colposcopy Microscope	40									
Endoscopes	0	40	40	40	40	40	40			
Anaesthetic Monitors	0		80							
Mobile X-Ray	0		80							
Renal Dialysis	0		20	20	20	20	20			
Phototherapy	0			25						
Ultrasound Scanners	0			100	100	100	100	100	100	
OCT Scanner	0				50					
Image Intensifier	0				100					
Ward 3 Monitors Vital Signs	0					100				
Video Endoscope Stack	0						150			
Harmonic Scalpel	0						25			
Phacoemulsifier	0								100	
A&E Monitors	0									100
X-Ray Room 1	0									275
Med Equip Rolling Replacement	120	120	120	120	120	120	120	120	120	120
Capital Projects (non-specific / emergency contingenc	0	20	20	50	50	50	50	50	50	50
Estates Backlog Maintenance	346	426	312	482	417	467	392	627	527	352
Allocation	997	997	997	997	997	997	997	997	997	997
Unallocated										
Ambulatory Care (allocated in principle)	126	826	412							
X-Ray Room 2 Fluoroscopy			800							
Acute ward Redesign			300	2,850	2,850					
GBH Feasability									50	50
CT Scanner (CG Funded £1.2m)					1,200					
Unallocated Yearly Totals:	126	826	1,512	2,850	4,050				50	50

ITEM 6:

Staff feel supported and engaged

Progress made in staff engagement and development

Key Achievements

- Improved staff survey return percentage in 2015
- Staff Governance and the role of Area Partnership Forum is part of the Corporate Induction training programme so that all new staff in the organisation understand both the organisational responsibilities and their own role in supporting the Staff Governance Standards. At this session staff are made aware of the 2020 Workforce Vision "Everyone Matters" and our actions and progress against this. Staff are actively encouraged to participate in all consultation and engagement mechanisms. The sessions are delivered jointly by the Employee Director and the Director of Human Resources and Support Services.
- Since the inception of the IJB in 2015 the multi agency forum – the Joint Staff Forum has revised its Terms of Reference to ensure staff engagement and communication is seen as a vital component
- iMatters Phase 1 had its first annual review cycle – phase 2 – Acute Sector 65% response rate – Phase 3 and Phase 4 (Health and Social Care) business cases signed off
- Staff Governance Committee well sighted on action plan and progress along with workforce KPIs and outcomes
- Short life working group action plan combined into Staff Governance Action Plan
- Progressed the Work Life Balance PINs that were outstanding – Phased Retirement and Parental Leave

Challenges

- Ensuring and supporting consistent clinical engagement in service delivery planning
- Maintaining consistent and effective Leadership across and at all levels

Healthy Organisational Culture has had a focus on embedding the shared values that we agree as a Board in everything that we do.

Achievements

- Further work on the Healthy Working Lives agenda (Board a Gold member)
- Short life working group progressing the action plan around appropriate behaviours

Challenges

- In the moment challenges on inappropriate behaviour
- Non consistent feedback to individuals whose behaviour has been a challenge for others
- Negative perception from staff of robustness of managers in dealing with 'poor' behaviour
- Building momentum in having courageous conversations particularly at leadership levels

Sustainable workforce has been focused on strengthening our workforce planning process and capability of managers.

Achievements

- Delivered a number of sessions to Heads of Departments/Managers on how to workforce plan
- Created a template for service planning and how to develop workforce plans from service plans
- Reinforced the various workforce projection models and the 6 Step Methodologies
- Engaged with multi-disciplinary and integrated teams to produce their plans in a cohesive way

Challenges

- Numbers of suitable applicants across Scotland for some clinical roles – a disproportionate impact on Shetland
- Numbers of redesigns and capacity to deliver is difficult with small teams and managing the day job
- Some areas of support services now at de minimis level in response to changes required to achieve financial targets
- Service planning with key partners - this includes Shetland Islands Council, NHS Grampian, SAS etc
- Enabling managers to think of what roles are needed and how to do this differently and to look at emerging service delivery models and how to create career structures and sustainability
- Shared services agenda and the progress of EeSS.

Capable workforce – the focus has been on recruiting the right staff, having meaningful appraisals, increasing access to learning and development for support staff and building capacity.

Achievements

- Progress on training plan and delivery – including joint training plan
- Working with NES on an Education and Career pathway for administrators and clerical staff – NES visit and supportive of the pathfinder for Shetland – Administration Network working at SVQs established and working well

Challenges

- % completion rates recorded on eKSF – (23%)

Integrated workforce has and continues to have a focus on developing arrangements for health and social care integration.

Achievements

- Delivery of Joint HR action plan for IJB
- Health and Social Care staff co-habit the one office building (Montfield Board HQ)

- Working at locality level and looking at proposal for area management structure

Challenges

- Defining a model that will work locally for workforce planning, succession planning, career mapping, redeployment and secondments – when NHS clearly defined policy structure and Council more flexibility
- Structures that differ between NHS and Council – that creates duplication and triplication of paperwork for managers following processes

Effective leadership and management has focused on developing people skills

Achievements

- How management sessions are delivered
- Integrated leadership training delivered – using the Knowledge Network to progress

Challenges

- How to sustain investment in creative training plans whilst maintaining services
- Releasing the right managers to participate in leadership programmes

Local staff governance

The outgoing 2015/16 action plan was signed off by the Area Partnership Forum and the Staff Governance Committee: action plans are linked to Everyone Matters.

The PIN Compliance template is attached. The Board implemented the remainder of the outstanding Worklife Balance Policies in April 2016. The Board is aware of the additional service and cost implications of these and a review report will be received by SGC one year on to understand this further.

The Staff Governance Committee is the lead committee not only for the Staff Governance Action Plan but also the Health and Safety and the Equality agendas. The Committee, in its annual cycle, receives a Health and Safety annual and four quarterly reports and also minutes of the Health and Safety Committee.

ITEM 7:

People are able to live well at home or in the community

How we are developing primary care services through health and social care integration

- A Primary Care Strategy has been completed. The strategy aims to create sustainability, ensure quality and improve access in primary care, whilst dealing with the challenges of issues such as GP recruitment. The key principles of the strategy will be to have safe, effective and efficient patient centred care within the resources allocated for Primary Care in Shetland, whilst acknowledging the demographic and unique geographic challenges we experience. An implementation group has been established and will take forward the action plan.
- Conversations were led in each of the seven planning localities in Shetland by the Director of Public Health and Planning, as part of the development of a Strategic Plan for 16/17. The IJB held staff meetings in each of the seven planning localities to better understand the challenges and opportunities for integrated service delivery.
- Health Improvement colleagues have been assigned to each Health Centre to work collaboratively with Primary Care staff to focus on local issues and that community's particular needs. Counselling is in the process of de-centralising and returning to being based more in primary care.
- Each locality now holds a regular multi-disciplinary meeting to plan care for complex cases and to foster better joint working.

Challenges

- Lerwick continues to have GP vacancies which are proving hard to fill. We have recruited more Advanced Nurse Practitioners to improve choice and access in the Lerwick Health Centre, who along with GPs offer same day appointments, particularly for urgent need, but a minimum number of GPs are still required and availability of GP time is lower than required.
- The reduction in the number of available GPs has also had an impact on the Out of Hours rota, although to date it has remained manageable and shifts are covered. The rota remains dependent on a small number of GPs to staff it.

Implementation of long term condition plans

We have had a number of work streams that have been ongoing for some time to address the challenges for patients with long term conditions. These include:

- Hospital and care centres - more proactive planning for earlier discharge from hospital, with focused reablement packages to support people to return home
- Preventative and anticipatory care - accelerating the rate of Anticipatory Care Plans being developed to support people living at home and in care facilities
- Effectiveness of interventions - Pharmacy input to support care staff in care centres and care at home for medicines administration
- Supportive enablers - increasing the stock of adapted housing to support people to live in the community
- Mental health in old age - developed older people's mental health and psychiatric pathways to enable and support people to remain living in their community
- Ensuring dementia care services are fit for purpose and meeting need
- Carers - continue to develop and support existing carers and carers groups throughout

the islands, and develop the Carers Strategy
- Community capacity building - support communities and Third Sector to develop a range of services to assist in the delivery of health and wellbeing to older people

Increasing the use of technology enabled care is key, and Shetland is part of the RemoAge alliance, taking an active part in testing new equipment and systems.

Challenges

- To continue with a whole systems approach to support early hospital discharge; appropriate admission avoidance; and achieve the target for delayed discharges as the population ages
- To promote re-ablement across the community and embed the philosophy in all areas
- To build on the integrated and joint management arrangements that are already in place to create multi-professional teams that span health and care
- To ensure an appropriate skill mix across all our services that makes the most effective use of resources

In the context of Health and Social Care Integration, progress in providing more services in primary and community care settings

- There has been an increase in the number of residents, particularly for those with dementia, who are being supported in their communities, and able to live at home with support from health and social care staff with the use of technology enabled care. There are a number of local activities linked to post diagnostic support. Each person with a new diagnosis of dementia is offered access to a Post Diagnosis Support Worker for a year. The Third sector (specifically Alzheimer Scotland) runs a range of community and social activities for people with dementia, which can form part of a post diagnostic support for individuals and families.
- Shetland was selected (as part of a three year Europe wide project called Mastermind) to trial a GP based cCBT (computerised Cognitive Behavioural Therapy) service. The service is now live and rolled out across Shetland. We are also working in partnership with Health Improvement Practitioners to deliver guided self help/mental health support in health centres.
- Integrating pharmaceutical care into care homes and care at home has been a substantive benefit and has resulted in the introduction of a new person centred medicine management system. Developing and introducing pharmacy skill sets has resulted in the new system of medicine management which is transferrable, safer and more efficient.

Challenges

- There is pressure on both Acute Services and Community budgets, and this makes shifting resources highly challenging.

Mental Health Services – inc faster access to child adolescent mental health services; psychological therapies and dementia

Psychological Therapies Waiting Times

- There are a number of people waiting for a service, who are waiting in excess of 18

weeks.

- The challenge of providing an appropriate range of on island interventions continues. We recognised the gap we have in psychology, and have now, with the support of NHS Education Scotland, recruited a Consultant Clinical Psychologist who will take up post later this summer within the Community Mental Health Team. We have also agreed to recruit a trainee Psychologist which will add capacity to the team.

CAMHS Waiting Times

- As of July 2016, seven patients were waiting for CAMHS – three of which had waited 18 weeks or more. The longest wait is 31 weeks. This is a marked improvement on performance during 2015-16 where compliance with the access target slipped from 70% to 50%. This was due to a number of factors including an increase in referrals, significant changes within the CAMHS team including sickness at the end of December 2015 which temporarily reduced the capacity in the team. By the end of 2015-16, 35 patients were waiting to be seen, so we put in place a recovery plan to ensure that there was the necessary capacity in the team to provide improved access to the service. This included increasing the sessional time available from the Consultant Psychiatrist and the Clinical Psychologists and we have recruited an additional CPN and Assistant Practitioner to the team. Since April 2016, we have improved access to CAMHS and the number of patients now waiting to be seen has reduced from 35 to 7. The team has been reviewing clinical pathways and working closely with local and specialist services, particularly where more complex assessments and treatments are required as we have identified that this can increase the waiting time for patients e.g. we have reviewed the pathway for children who need access to LD and CAMHS services.

Dementia services performance

- The number of people with a dementia diagnosis continues to fluctuate, however the service remains focused on identifying those with dementia and encouraging the community to see the benefits of getting an early diagnosis.
- Community nurses continue to use cognitive screening as part of their assessment process for older people if memory issues are suspected. In addition, our Occupational Therapists are incorporating an assessment as part of their Falls Strategy assessments. The action plan resulting from our Shetland Dementia Strategy continues to be implemented through the multi-agency Shetland Dementia Services Partnership. Funding from the Integrated Care Fund will support the extension of post diagnostic support activities to all localities in Shetland.

Joint Older People's Inspection Report Recommendations

- **Take action to reduce the number of Code 9 delayed discharges from hospital.** This has been addressed by committing additional community resource in the hospital to help assess people as early as possible. This has resulted in a reduction in the number of people being delayed and the amount of time they are delayed.
- **Develop a strategic approach to community capacity building.** An Engagement and Participation Strategy has been approved by the IJB. Work on strategic and community planning and management continues.
- **Review arrangements for strategic planning**. Key posts were recruited to and some interim posts were recruited to on a permanent basis. The Head of Planning post has been recruited to and further work continues in relation to locality planning and management.

- **Strategy for older people should be completed**. This was approved by the Health Board and Shetland Islands Council in October 2015.
- **Take decisive action to address the problems which are adversely impacting on effective multi-agency discharge planning for older people in hospital.** As in the first bullet point above.
- **Take action to review partnership working arrangements. This should include both external and internal partners and in particular the Third Sector.** The Strategic Commissioning Plan for 2016 – 2019 will include all partners and will create a clear set of objectives for the Shetland Partnership that includes the Third Sector.
- **Develop an overarching plan which identifies its priorities for self-evaluation and improvement activity for the next 3 years.** Some specific action has been taken in relation to learning from previous improvement activity. An annual interagency file reading exercise will be conducted with support from the Adult Protection Committee. This will be based on the Care Inspectorates file reading tool and will help us evaluate our whole system practice which will highlight good practice and areas for improvement.