

SHETLAND NHS BOARD

ANNUAL REVIEW 21 & 22 AUGUST 2017

PROGRAMME

Monday 21st August 2017

- 0945 - 1010 Meet with the Chair and Chief Executive
- 1015 - 1045 Minister meets Medical Education Group (presentation on current training and medical workforce position)
Skerries Room, Montfield
- 1045 - 1100 Break (Fair Isle Room, Montfield)
- 1100 - 1200 Joint meeting with Area Partnership Forum and Area Clinical Forum
Bressay Room, Montfield
- 1200 - 1215 Break (Fair Isle Room, Montfield)
- 1215 - 1315 Meeting with Patients/Patients Representatives
Skerries Room, Montfield
- 1315 - 1400 Pre meeting for Minister and her team / lunch
Fair Isle Meeting Room, Montfield
- 1400 - 1500 Annual Review Public Meeting
Bressay Room, Montfield
- 1500 - 1530 Media Interviews
Skerries Room, Montfield
- 1530 - 1630 Annual Review Private Session with Full Board and IJB Chief Officer
Bressay Room, Montfield
- 1645 – 1715 Minister meets with ICT team

Tuesday 22nd August 2017

- 0930 - 1050 Health Improvement visit
- 1100 Leave for Sumburgh Airport

NHS Shetland Annual Review 2017
At a Glance LDP Standards Performance 2016/17

<ul style="list-style-type: none"> • Within smoking cessation services during 2016-17 we helped 46 people to successfully quit at 12 weeks. This met our increased and challenging target of 43. 	G
<ul style="list-style-type: none"> • During 2016-17, 75.9% of pregnant women had booked for antenatal care by the 12th week of gestation. <i>*note: we are working on data issues with mothers delivering outwith the islands, so have not reported the SIMD breakdown. Small numbers magnify these issues.</i> 	A
<ul style="list-style-type: none"> • During the years 2015 and 2016 combined, 27.6% of people were diagnosed and treated in the first stage of breast, colorectal and lung cancer, which narrowly missed our target of 29%, but is among the best rates in Scotland. 	A
<ul style="list-style-type: none"> • During the quarter from January to March 2017, 100% of patients waited less than 18 weeks from referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services, which met the target of 90%. 	G
<ul style="list-style-type: none"> • During the quarter from January to March 2017, 79.3% of patients waited less than 18 weeks from referral to treatment for Psychological Therapies, which missed the target of 90%. 	R
<ul style="list-style-type: none"> • During 2016-17, we had eight Staphylococcus aureus bacteraemia (including MRSA) infections, which gave us a rate of 0.73 cases per 1000 acute occupied bed days. This missed our target of 0.24. 	R
<ul style="list-style-type: none"> • During 2016-17, we had one C Diff infections, which gave us a rate of 0.08 cases per 1000 total occupied bed days. This exceeded our target of 0.32. 	B
<ul style="list-style-type: none"> • During 2016-17, 96.1% of patients waited less than 4 hours at A&E, meeting the target of 95%. 	G
<ul style="list-style-type: none"> • During 2016-17, 89.3% clients waited less than 3 weeks from referral to appropriate drug and alcohol treatment that supported their recovery, narrowly missing the target of 90%. 	A
<ul style="list-style-type: none"> • During 2016-17, 207 Alcohol Brief Interventions were delivered in the 3 priority settings (Primary Care, A&E, antenatal), missing our target of 261. 	R
<ul style="list-style-type: none"> • During 2016-17, we had a Sickness Absence rate of 4.51%, which missed the target of 4%, but was the best rate among territorial Boards in Scotland. 	A

<ul style="list-style-type: none"> During 2015-16, 95.2% of patients accessed an appropriate member of the GP Team within 48 hours, meeting the target of 90%. 	G
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> During 2016-17, 100% of eligible patients had commenced IVF treatment within 12 months, meeting the target of 90%. 	B
<ul style="list-style-type: none"> During 2016-17, 87.5% of planned/elective patients commenced treatment within 18 weeks of referral, narrowly missing the 90% target. 	A
<ul style="list-style-type: none"> During 2016-17, 82.5% of patients waited less than 12 weeks from referral to a first outpatient appointment, missing the 95% target. 	R
<ul style="list-style-type: none"> During 2016-17, 6 patients waited longer than 12 weeks from patient agreeing treatment with the hospital to treatment for inpatient or day case treatments, narrowly missing the zero target. 	A
<ul style="list-style-type: none"> During 2016-17 we operated within our agreed revenue resource limit; our capital resource limit; and met our cash requirement. 	G
<ul style="list-style-type: none"> During 2014-15, 70% of people newly diagnosed with dementia were referred for post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan. 72% of these people received 12 months of support. 	A

Key:

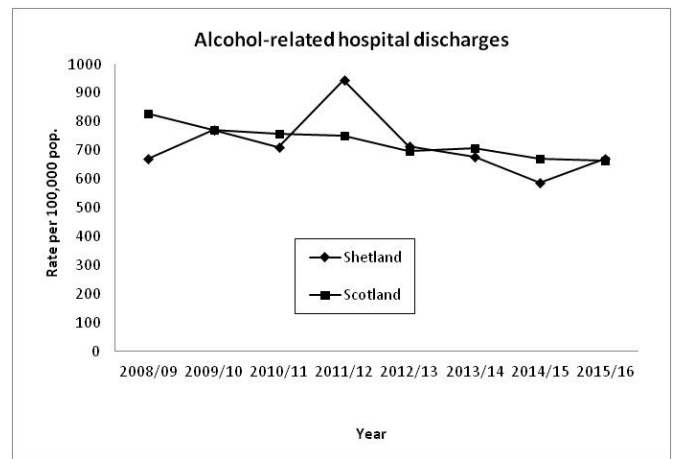
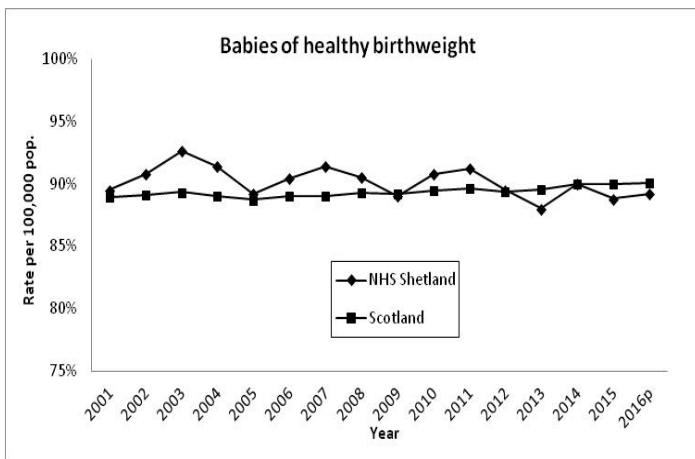
B	Well ahead of trajectory or met early
R	Not meeting and not within trajectory limit
A	Not meeting but within trajectory limit
G	Meeting or better than trajectory

NHS Shetland Annual Review 2017

Draft At a Glance Outcomes 2016/17

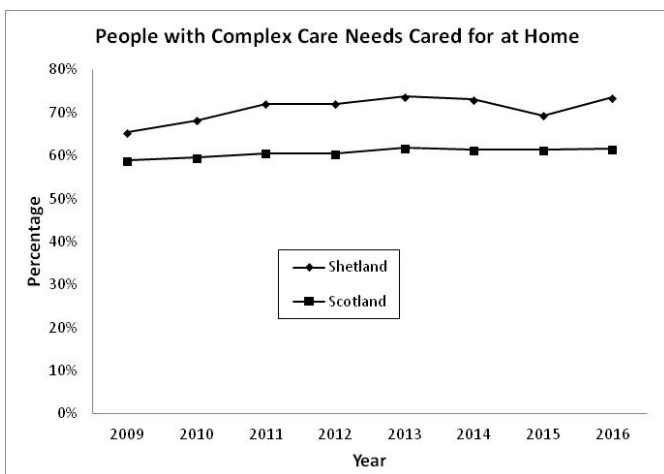
<div style="background-color: yellow; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: yellow; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: green; height: 20px; margin-bottom: 5px;"></div> <div style="text-align: center; color: black; font-weight: bold; font-size: 24px;">↑</div> <p>Cancer patients beginning treatment within 62 days of urgent referral ranged from 85.7% to 100% over the past year. 100% of patients began treatment within 31 days of decision to treat. (note: small number variation)</p>	<div style="background-color: red; height: 20px; margin-bottom: 5px;"></div> <div style="text-align: center; color: black; font-weight: bold; font-size: 24px;">↓</div> <div style="background-color: green; height: 20px; margin-bottom: 5px;"></div> <div style="text-align: center; color: black; font-weight: bold; font-size: 24px;">↑</div> <p>Twelve MRSA/MSSA infections and one C. Diff infection in the year – missing our SAB target and meeting our C Diff target.</p>	<div style="background-color: green; height: 20px; margin-bottom: 5px;"></div> <div style="text-align: center; color: black; font-weight: bold; font-size: 24px;">↑</div> <p>Overall Healthcare Experience – NHS Shetland scored 85.5 for the Inpatient Patient Experience Survey, which is well above the Scottish average.</p>
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<div style="background-color: yellow; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: yellow; height: 20px; margin-bottom: 5px;"></div> <p>No significant trend in percentage of babies born at healthy birthweight (appropriate for gestational age).</p>	<div style="background-color: green; height: 20px; margin-bottom: 5px;"></div> <div style="text-align: center; color: black; font-weight: bold; font-size: 24px;">↑</div> <p>Alcohol related hospital admissions have decreased in recent years, coming down to around the national average.</p>
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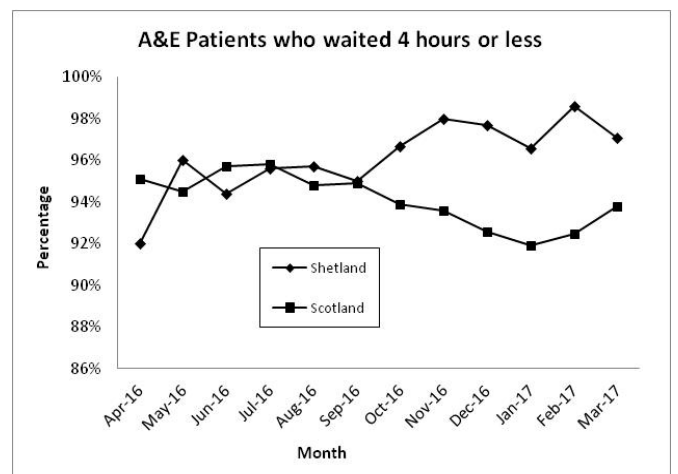
↑

73.5% of people with complex care needs are cared for at home. Improving trend and consistently amongst the highest levels in Scotland.

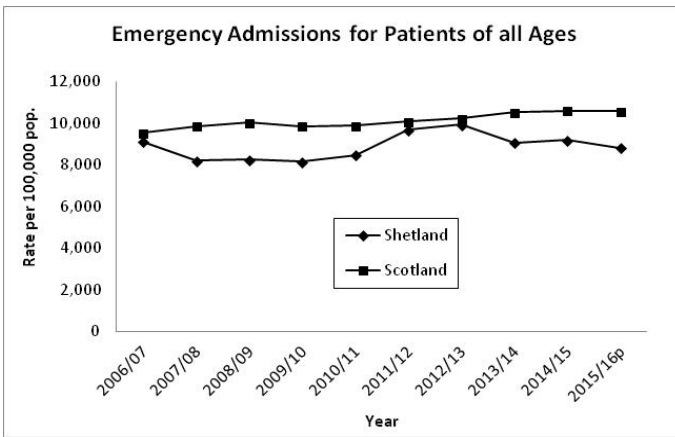


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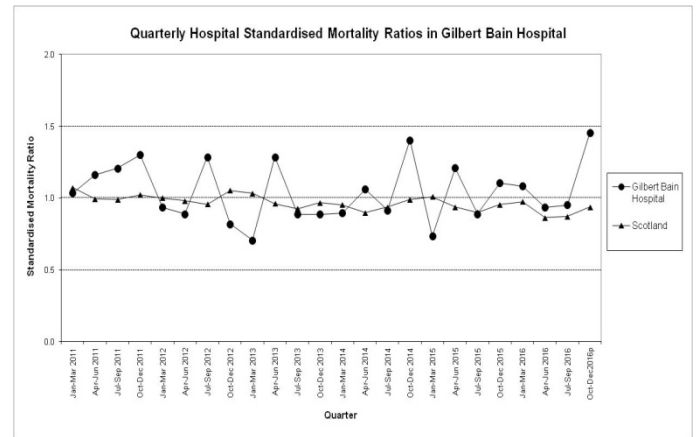
Consistently achieving over 95% of people being seen in A&E in 4 hours or less in past 9 months.



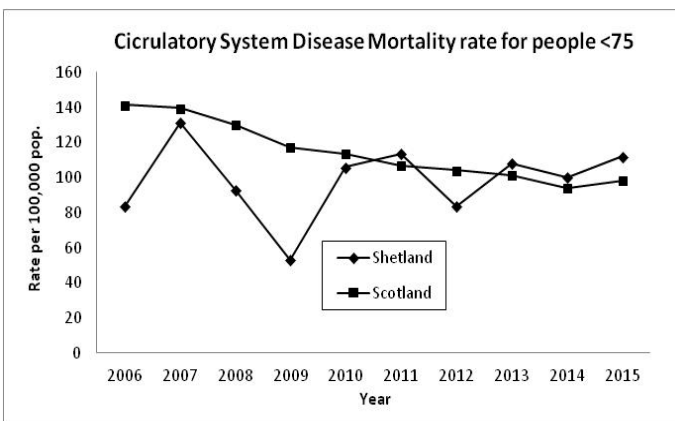
Emergency admission rate has remained steady and consistently lower than the national rate.



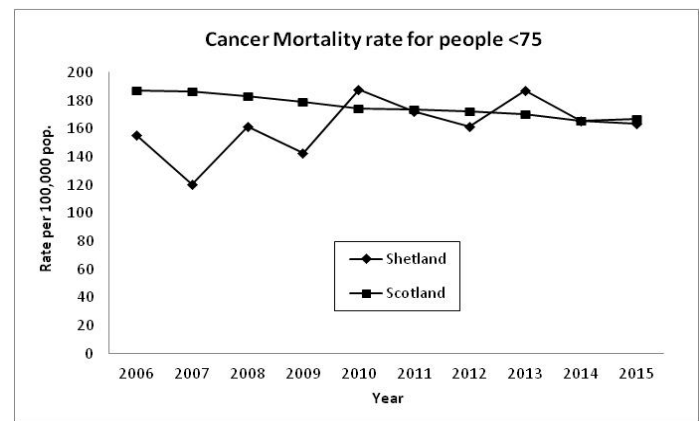
No significant trend in Quarterly Hospital Standardised Mortality Ratio. (note: small number variation)



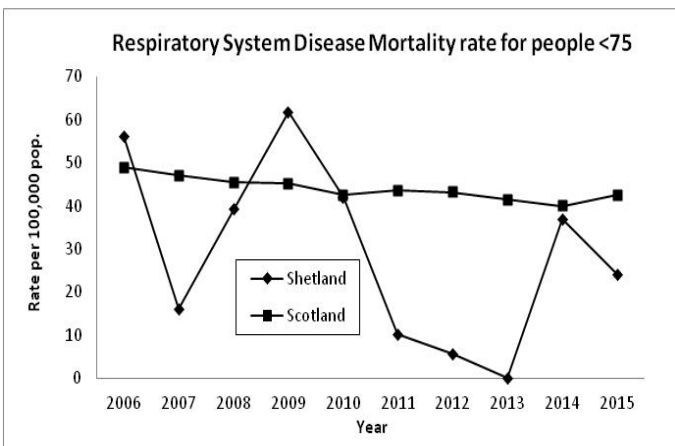
No significant trend in Circulatory Disease mortality in under 75s. (note: small number variation)



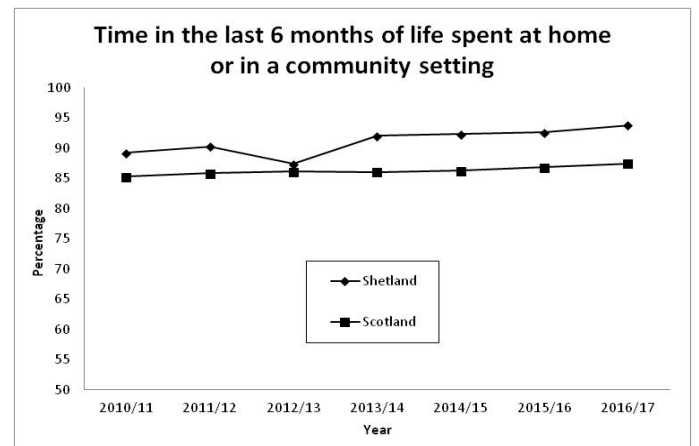
No significant trend in cancer mortality in under 75s in recent years. (note: small number variation)



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



↑ Slight increasing trend in end of life setting. Consistently the highest rate in Scotland.



Key:



Improving trend or performing well



No change/trend



Worsening trend or not performing well

ITEM 1

Update on progress against actions identified in 2015-16 Annual Review

The Board must:
Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection, with particular emphasis on C.Diff and SABs
See Item 3: Healthcare is safe for every person, every time
Keep the Health and Social Care Directorates informed on progress towards achieving all access targets and standards, in particular for Outpatient appointments and Psychological Therapies.
<p>The service has employed a Consultant Clinical Psychologist who is working on addressing the ongoing long waits for accessing psychological therapy. This is still likely to take a considerable time. Work is progressing on a stepped care approach including computerised CBT, telephone CBT, supported self help, Behavioural Activation and training for mental health professionals in Safety and Stabilisation. There is a plan to repeat this training and provide additional training for CPN's to run a Survive and Thrive group for individuals with complex trauma (who constitute the majority of the long waiters). The Talking Therapies service provides psychological interventions at the primary care level and the clinical psychologist provides Highly Specialist interventions, consultancy, training, group work and reflective practice in secondary care. These initiatives, combined with work on improving referral systems and an opt-in process are addressing the long waiting times. Of the 86 individuals who have been referred to clinical psychology 14 are currently being seen, 34 have been closed and 38 are awaiting input. In order to improve accuracy of waiting time data, all information is being input to TrakCare and for greater efficiency there has been a focus on improving collaboration between services, including the third sector.</p> <p>In the year 1st April 2016 to 30th March 2017 165 patients were treated, of those 128 patients (78%) were treated within 18 weeks. As of 31st March 2017 there were 104 people waiting for Psychological Therapy - 76 patients (73%) having waited less than 18 weeks. Waits above 26 weeks were due to a backlog of unmet need which is now being addressed following the recruitment of the Consultant Clinical Psychologist.</p> <p>The Talking Therapy Service is a 6 session model providing psychological interventions for mild to moderate presentations within primary care. As of July 2017 additional capacity will be available with the start of a new primary care Behavioural Activation service. The cCBT programme (Beating the Blues) continues to be offered following successful completion of the Mastermind pilot project.</p>
Continue to make progress against the staff sickness absence standard
See Item 6: Staff feel supported and engaged
Continue to achieve financial 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 is 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 2016/17

Shetland traditionally has a good life expectancy and a level of health that is amongst the best in Scotland. This reflects the high quality of life in Shetland, as well as the quality of local services. However the most recent life expectancies for men and women have fallen compared to the previous year. 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 it was 81.9 years, down from 82.45. Neither has yet reached the ambitious local targets of 79.2 and 86.2 years. While life expectancy is still better than many other parts of Scotland we recognise that there are health inequalities within Shetland that are often hidden and not reflected in available data.

Suicide: Suicide still remains a significant area of concern although the most recent available figures show a sustained reduction from 21.55 per 100,000 population in 2013 to 13.4 in 2016 (5 year rolling average 2012-2016). Although the rate was only 4.3 per 100,000 population in 2014, this wide fluctuation is due to the very small numbers involved. The local target is 20.7 per 100,000 population. A programme of prevention work continues, including tackling stigma on mental health issues, training and a local audit of all sudden deaths and suicides to help us understand local risk factors and target our preventative work.

Keep Well: The impact of reduced outcomes due to decreasing resources is seen with Keep Well checks. These are carried out mainly in workplaces by the Health Improvement Team. We set ourselves a local target of 250 during 2016-17, but had only achieved 193 by the end of March 2017, due mainly to reduced staffing levels. This is compared to the previous year total of 252 health checks.

Early years: The most recent available figures show that we met the target of 80% of pregnant women in each SIMD centile booking by 12 weeks, with 82.3% booking by 12 weeks in 2015-16. The most recent figures for breastfeeding at 6-8 weeks show that the rate for Shetland is 54.2% (quarterly rolling average at end 2016), above the national target of 50% but below our ambitious local target of 58%.

Smoking: To date (July 2017) there had been 46 successful quits at three months (with the quit date being between April 2016 and March 2017). This exceeded the Government set target by 3 (the target being 43 successful smoking cessation quits at 12 weeks, in the 60% most deprived areas of Shetland). Overall, we have supported 80 people across Shetland to have maintained their quit at 12 weeks. The target was increased by 30% last year, despite reduced resources within the Health Improvement Team (which delivers most of the smoking cessation interventions) and the fact that the people who are now smoking are those that find it the hardest to give up.

Alcohol: We have not met the target for delivering Alcohol Brief Interventions, despite doing well in previous years. In 2016-17 200 ABIs were undertaken against a target of 261. This again reflects a reduction in resources in the Health Improvement Team, who had been delivering the majority of the interventions with very few being done in Primary Care. On a positive note, the recording system in A&E, where around 15 ABIs per month are usually recorded is now up and running again, so we are confident that the target will be met in future years. Latest national data for alcohol-related admissions shows that the rate increased in Shetland during 2015-16. (671.3/100,000 against a rate of 580.3 / 100,000 last year and a local

target of 500 / 100,000). However it is anticipated that the considerable work carried out in 2016-17 to prevent harm relating to substance misuse, including work with the local Licensing Board and a redesign of drug and alcohol services to develop a substance misuse recovery service, will be reflected in future figures. Our local programme of culture change on alcohol use, known as “Drink Better”, is being reviewed again, and will be informed by the result of successful local engagement with the Shetland public, including focus groups.

Child Healthy Weight: Figures for children out with the healthy BMI in Primary 1 reduced during 2016. This had previously gone up markedly from 17.9% in 2014 to 27.1% in 2015 but has now reduced to 22% in 2016. Initial analysis shows that the increase from 2014 has been in children who are obese with the percentage of overweight children remaining stable. It remains a challenge to engage families at an early stage in programmes of support, and some of this appears to be about the confidence of health and other professionals in ‘raising the issue’ of child healthy weight. Further work is underway to tackle the issue in the pre-school years, as well as work to encourage and create more health promoting environments.

Immunisation: The most recent immunisation rates show uptake for the year April 2016 to March 2017 was slightly below the national target of 95% for primary immunisations of children by the age of one year (except Meningitis C) but had reached 97% for children aged two. However, the rates for MMR, and Hib/Meningitis C were slightly below 90% in this age group. Uptake of the first dose of MMR by age five years was 96.5%, exceeding the target of 95%, but uptake for the full course that should have been received by then was only 86.1%, although this is higher than last year. This is leaving 15% of children entering school potentially unprotected against measles, mumps and rubella. Published figures for the uptake of seasonal flu vaccine are not yet available, but the unpublished figures suggest that for adults, most of the rates are lower than last year (as was the case across Scotland). Shetland has slightly higher flu vaccination rates than the Scottish average for adults in risk groups and carers. The rates in Shetland for children were higher than last year, and higher than the Scottish average. The uptake amongst health care staff increased in the 2016-17 season.

These targets only represent a proportion of the Board’s public health and health improvement work. Work on increasing physical activity, especially amongst the most inactive, and healthy diet is continuing but outcomes are difficult to measure on a short term (annual) basis. Health protection and emergency planning (resilience) work has also continued including both strategic planning and reactive work dealing with day to day incidents. For the Public Health Directorate, there has also been a significant focus on tackling health inequalities and supporting the most vulnerable in our community: including for example partnership working on poverty and exclusion; domestic abuse and sexual violence; early years; black and minority ethnic group needs assessment; mental health issues and community justice.

Performance against the waiting times standard and early diagnosis and treatment targets under the detect cancer early campaign

Cancer screening programme: uptake remains good with all our uptake rates amongst the highest in Scotland. The most recent published figures show uptakes of:

- 66.5% for bowel cancer screening (May 14-Apr 16) above the target of 60%;
- 77.1% for cervical screening (2014-15) slightly below the target of 80% but highest in Scotland;
- 84.4% for breast screening (3 yr rolling average 2013-16) above the target of 80%.

Detect Cancer Early: The most recently available figures (Jan 2014- Dec 2015) show that the percentage of patients diagnosed in the early stages of cancer has fallen to 16.9% against a trajectory of 29%. This percentage represents 15 patients, out of a total of 89 in the period. It

should be noted that there was no breast screening during this period as it only happens every three years; it is anticipated that the figures for 2016 will show an increase in early cancer detection due to the breast screening programme. These figures have not yet been released. The low early detection rates are despite high uptake rates for cancer screening and appear to be due to late presentation of symptomatic cancers. There is ongoing audit work to understand this further.

Cancer Waiting Times: In the quarter ending December 2016, 100% of patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral. In the quarter ending December 2016, 100% of patients diagnosed with cancer started treatment within 31 days of their decision to treat.

Working in conjunction with NHS Grampian, we seek to maintain this good position in delivering cancer care promptly in 2017-18 and will prioritise the use of resources to provide appointments and diagnostic tests that facilitate cancer diagnosis and treatment.

ITEM 3

Healthcare is safe for every person, every time

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

In 2016-17, NHS Shetland's MSSA/MRSA rolling average infection rate for the year end was 0.73 per 1000 bed days which is above the target of 0.24. All of the 8 cases identified in that 12 month period were investigated using root cause analysis techniques and no linking factors were identified.

In 2016-17, we have also successfully implemented work to shift the balance of care into community focussed services which has reduced our acute occupied bed days and this has impacted on our infection rates (because we have a low rate of hospital bed occupancy) compared with other hospitals during the same period.

In 2016-17, we met the target for C. Diff infections (with a rate of 0.085 per 1000 bed days), with 1 case identified over the 12 month period. Again, no linking factors were identified following root cause analysis.

For the year ending December 2016 there have been 2 surgical site infections (SSI) in the 38 procedures undertaken giving a SSI incidence of 5.3%. Root cause analysis identified no further actions were required. The rate for E Coli Bacteraemia for the quarter ending December 2016 was 0.00 per 1000 bed days in the hospital setting. Overall, 14 cases have been identified during 2016-17 most of which originated in the community setting.

It is important to note that these numbers should be seen in the context of small number variation and the figures can change significantly from quarter to quarter with just one event.

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 2016-17 and we did not have any norovirus outbreaks during this period.

We also ensured that staff are prepared to manage patients presenting with more complex infectious diseases (e.g. CPE and haemorrhagic fevers) with training sessions and planning exercises and testing staff to ensure that FFP3 masks are available and ready for use.

The Gilbert Bain Hospital has had three unannounced, external inspections in the last 12 months and the findings from the inspections confirmed that we have robust systems in place and good compliance with infection control procedures across the hospital. Actions plans were quickly implemented and we are working through the capital projects identified in the most recent inspection at the beginning of April 2017.

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

- The appointment system at Lerwick Health Centre (our largest practice with just over 9,000 registered patients) was reviewed 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. Several vacancies through the year have caused difficulties with access but with the appointment of key personnel, it is expected that access will improve. All practices are sustaining same day access for urgent need despite a number of GP vacancies across practices.
- We introduced a Primary Care access clinic on both Saturday and Sunday, primarily staffed by ANPs. Access to the clinic is through NHS24 and feedback from patients and staff has been positive. We will continue to review this service through our unscheduled care work.
- We continued to expand self referral into services, and Allied Health Profession services have maintained this over the last year. The levels of demand have continued to increase for physiotherapy musculoskeletal services. The service continues to actively manage waiting times.
- Performance against acute and specialist 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.

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

Community Services waiting times

- Access to GP/Primary Care Clinician for on the day appointments was a particular issue at our largest health centre in Lerwick. The introduction of a GP/Advanced Nurse Practitioner model has drastically improved access.
- Psychological Therapies waiting times are beginning to improve. In the year 1st April 2016 to 30th March 2017 165 patients were treated and of those 128 patients (78%) were treated within 18 weeks. As of 31st March 2017 there were 104 people waiting for Psychological Therapy and 76 patients (73%) had waited less than 18 weeks. Waits above 26 weeks were due to a backlog of unmet need which is now being addressed following the recruitment of a Consultant Clinical Psychologist.
- Waiting times for AHP services vary according to discipline, but fall within 18 weeks referral to treatment parameters. Physiotherapy MSK waiting times do fluctuate according to demand, and we are seeing an increase in self referrals.

Acute and Specialist services

We have narrowly missed delivery of the 18 Week Referral to Treatment Standard overall for the last 12 months, with an aggregate of 87.5% as we have experienced pressures in a number specialities including: ENT, audiology, rheumatology, dermatology and gynaecology during 2016-17.

18 Week RTT Performance figures

NHS board of treatment	Shetland	Scotland
Apr- 16	92.3%	87.2%
May- 16	90.6%	87.0%
Jun- 16	84.2%	86.6%
Jul- 16	86.6%	86.0%
Aug- 16	89.5%	84.7%
Sep- 16	83.6%	84.2%
Oct- 16	87.6%	83.8%
Nov- 16	91.8%	83.8%
Dec- 16	87.5%	83.2%
Jan- 17	87.3%	83.0%
Feb- 17	84.2%	83.2%
Mar- 17	92.3%	87.2%

Outpatient performance has also been challenging throughout the year. This is due to an overall increase in outpatient referrals and reduction in capacity in a number of the specialties. The greatest effect has been on our visiting services (e.g. ENT, dermatology and gynaecology) and the local rheumatology clinics.

We implemented recovery plans in 2016-17 to work down the backlog of patients waiting greater than 12 weeks for their initial appointment, but there has continued to be a mismatch between the capacity available and demand from referrals. This has been for a variety of reasons including an increase in the referral rates for all specialties along with challenges in recruiting key clinicians.

This means that a number of our shared services with NHS Grampian are not performing consistently within the national waiting times targets and we are developing a recovery plan to ensure that we address short term (non recurrent) access issues as well as using the 'Getting Ahead' methodology to understand the opportunities to redesign pathways taking a whole systems approach. During 2016-17, we received very limited gynaecology and dermatology services and we expect that to continue into 2017-18 whilst we look for mutual aid from other Health Boards.

We have also seen the impact of the shift towards increasing clinical sub specialisation on service sustainability where the historical model was that clinicians with 'generalist' skills supported remote and rural services - this is no longer possible and so we are starting to explore alternative models such as increasing access through telemedicine and telecare approaches. In 2016-17, we delivered over 600 appointments using technology enabled approaches (ranging from emails and phone calls, to complex multi-site video conferencing).

We have been working with NHS Grampian and National Waiting Times Hospital (Golden Jubilee National Hospital) to look at how we can maximise the potential for technology enabled orthopaedic pathways. We intend to build on this work to look at the potential for embedding telemedicine into pathways (particularly for routine patient follow up).

We have a major focus on this work in 2017-18 to look at further pathways which can be streamlined and/or delivered more efficiently.

12 Weeks (outpatients)

Date / NHS board of treatment	Shetland (number of pts who waited > 12 wks for an OP appt - Shetland)	Number of pts who waited > 12 wks for an OP appt - Scotland
31-Mar- 16	96	29,609
30-Jun- 16	160	42,480
30-Sep- 16	255	64,283
31-Dec- 16	322	73,491
31-Mar- 17	392	59,029

Treatment Time Guarantee

For the first three quarters of 2016-17, we reported that 100% of patient commenced inpatient/day case treatment within 12 weeks. However, due to the lack of gynaecology service provision during 2016-17, a number of patients (5) waited longer than the 12 week TTG and we put in place a recovery plan to ensure that these procedures were completed by the end of March 2017.

In order to reduce the risk of not meeting the TTG, we have prioritised clinical capacity to ensure that where interventions are indicated; we can deliver them within 12 weeks of the decision to treat. This has been achieved by using additional capacity to maintain waiting lists and meet demand for a number of visiting specialities. However, this is not a financially sustainable option in 2017-18 and we are working with NHS Grampian to develop a joint post so that we have a more sustainable approach for delivering shared gynaecology services.

Date	Completed waits for patients seen (waited > 12 weeks)
Mar- 16	0
Jun- 16	1
Sep- 16	0
Dec- 16	0
Mar- 17	5

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 an average compliance of 96.1% throughout 2016-17. We review each case where patients had waited more than 4 hours in A&E as part of our ongoing improvement work and delivery of the six essential actions to support effective unscheduled care.

Although the number of patients attending A&E has fallen slightly, we have a higher conversion rate of patients requiring hospital admission (than the rest of our peer group). Whilst it is not

reflected in our A&E performance, there is pressure on the overall hospital system, and contributory factors for this include delays in the availability of beds in (mainland) specialist units for inter-hospital transfers, patients presenting with complex needs including frailty and crisis management to support acute psychiatric/mental health needs.

Date	Shetland	Scotland
Apr- 16	92.0%	95.1%
May- 16	96.0%	94.5%
Jun- 16	94.4%	95.7%
Jul- 16	95.6%	95.8%
Aug-16	95.7%	94.8%
Sep- 16	95.0%	94.9%
Oct- 16	96.7%	93.9%
Nov- 16	98.0%	93.6%
Dec- 16	97.7%	92.6%
Jan- 16	96.6%	91.9%
Feb- 16	98.6%	92.5%
Mar- 16	97.1%	93.8%

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. In 2016-17, 40 patients had a stroke and received care in line with the Scottish Stroke Care Standards.

In 2017, we put in place a community based recovery model for slow stream rehabilitation and reablement. We are in the process of fully establishing these pathways and recruiting additional practitioners to enable the Intermediate Care Team to offer intensive, non acute rehabilitation which will include supporting people following stroke illness.

Approach to person centred care and patient experience

Following the resignation of the Public Participation Forum (PPF) lay chair in December we have been reviewing our local arrangements for Patient Focus Public Involvement (PFPI). The PPF had previously met every six weeks to discuss health and wellbeing related topics and provided advice/feedback on proposed service change and/or development. Unfortunately as there was no immediate successor to lead the PPF, we have discussed through our PFPI Steering Group how we can utilise the lay members on the Steering Group to help re-engage with the public to establish a "PPF" type subgroup structure in order to progress matters of concern for the public as well as provide a structure for open discussion on initiatives. The previous subgroup structure of the PPF had worked well in terms of members working with the Board to help to progress service developments e.g. Implementation of a Consultant Clinical Psychologist post.

The PPF Chair had also held the user rep position on the IJB and thus a separate open recruitment process is underway to fill this position. The PPF Chair provided helpful feedback on the challenges of that position and we are mindful as to how we address these issues as we move forward with a new appointment.

During 2016 we have appointed a new Non Executive Director to be the Chair of our PFPI Steering Group. This individual is also the Chair of the IJB and thus through her Chairmanship we can ensure that the voice of the patient/client is brought both to the attention of the NHS Board and IJB to ensure that the voice of the patient is truly at the heart of decision making.

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 in place which brings various strands of work together (e.g. utilising feedback from complaints, Care Opinion, local and national surveys, person centred health and care collaborative).

The NHS Board had been an early implementer of the Patient Opinion feedback mechanism and we are currently progressing the roll out of Care Opinion across all parts of the Health and Social Care Partnership.

Work has also 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 gained revalidation with the Investors in Volunteering award and 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).

The local results from the national 2016 Health and Care experience surveys have been reviewed by the individual GP Practices and action plans put in place to address areas of concern raised by the public. Most practices received very positive results, however the challenge of accessing a GP appointment at some of the practices was noted and this is in line with the recruitment challenges the Board faces. The results and associated action plans have been shared at the PFPI Steering Group and discussed at both the IJB and NHS Board meetings to ensure that the feedback from the public is brought to the attention of the key decision makers.

Work has been undertaken to implement the new national Complaints Procedure across Health and Social Care. The implementation of the 2 stage approach to complaints resolution is already proving to be useful with individuals having an area of concern dealt with by frontline staff in a timely manner and thus we hope that once there is an increased awareness of the actions that are taken when someone does have an issue of concern that patients, carers, staff or public will feel more confident in raising issues going forward and thus help to enhance the patient experience for all future patients/clients.

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.

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 in place since 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 was undertaken as part of the work to create an integrated health and care governance framework for the Board and the IJB.

Another important part of our approach to enhancing patient experience has been through increasing the knowledge and awareness of the public regarding particular health topics and services available to support individuals. A programme broadcast on our local Radio Shetland evening programmes, "Shetland's Heartbeat" has tackled many health issues over the last two years and a third season is in the planning. One of the subject areas tackled during this last year has been Mental Health and Personality Disorder. Following this broadcast the radio station received many positive calls from individuals thanking the presenters for the level of information provided, the sensitive manner that this was done in and the positive message given for those living with a mental health issue thus helping to tackle stigma within the local community.

These radio programmes have been led by a lay member of our PFPI Steering Group who through their dedication and commitment to this series has enabled a number of areas of health and wellbeing to have been discussed in an open way helping to enhance public knowledge.

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 119 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 has included 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 the RVS 'take home' services.

ITEM 5:

Best use is made of available resources

Financial balance and efficiency savings

Main Achievements in 2016-17

- Revenue under spend £312k, equivalent to 0.5% under spend against total funding.
- Capital expenditure £736k, resulting in an under spend of £50k on CRL
- Delivered recurring Efficient Government savings of £1,897k
- Delivered non recurring Efficient Government savings of £2,271k

Work on best value characteristics included: updating our 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 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. Progressed work with NSS on Procurement Strategy leadership as a shared services model
Use and Review of Options Appraisal	Establishment of projects under the Transformational Change Board which includes a review of primary and secondary care services for the future.
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 2016/17 – while there was slippage against the recurring savings schemes target of £2.7m, this was covered by identifying other non recurring schemes and the use of the Board's contingency reserve. Requirement, in addition to "efficient Government savings target (3%), to reduce underlying deficit (currently £1.8m) over the course of the next three years with a

plan to bring the Board back into recurrent balance in phased way by 2019/20.

- Maintaining progress and momentum on delivery of recurring savings to address the underlying deficit revised 2017-18 plan which currently has recurrent savings target of £3.0m and a non recurrent target of £1.3m if the Board is to break even in 2017-18.
- Over the next five years £12.2 million in efficiency savings will be required to achieve long term financial sustainability.

Table: Indicative Savings Target Requiring to be Delivered over the period 2017-18 to 2021-22

	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	Total £000's
Brought Forward balance	1,804.9	1,315.9				
New Target 3% Target	1,308.0	1,337.9	1,365.2	1,508.0	1,562.0	7,081.1
New Target to meet 2017-18 funded developments	330.0	0.0	0.0	0.0	0.0	330.0
New Target Additional 1% Target for 2017-18 and 2018-19	443.0	451.0	0.0	0.0	0.0	894.0
Assumption: Social Care Fund within Inflation uplift not additional	420.0	420.0	420.0	420.0	420.0	2,100.0
Sub-total In Year Savings target	4,305.9	3,524.8	1,785.2	1,928.0	1,982.0	12,210.1
Plan for actual achieved in-year recurrently	-2,990.0	TBC	TBC	TBC	TBC	
Balance Carried Forward:	1,315.9					

- Transformational Change Board has been created with oversight for all patient-focused pathway redesign and support services re-organisations to deliver the significant number of redesign projects required to deliver the level of efficiencies.

Cost pressure issues to address

- Removing reliance on locum staff for primary care medical services whilst still supporting remote and rural practices and especially for 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 over a number of years to maintain essential services.

NHS Shetland Salaried GP Practices Locum Cost versus Funding			
Practice / Year	2016-17	2015-16	2014-15
Yell	193,717	151,780	45,910
Whalsay	196,349	190,771	247,528
Unst	203,781		
Lerwick	307,607	249,326	269,716
Total Expenditure	901,454	591,877	563,154
Available Funding	639,099	434,055	399,033
Cost Pressure	-262,355	-157,822	-164,121

- 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 CO2 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. Working to implement “See Anywhere” out-patient e-technology with NHS Grampian and other North of Scotland partners to make efficient use of e-technology to reduce patient travel as part of redesign projects.

- Prescribing expenditure continues to grow at a much higher rate than the underlying funding. This is particularly true for Hepatitis C and with the new SMC approvals approach for orphan, ultra-orphan and end of life drugs.

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

Main Achievements

- Delivered agreed Capital Plan of £0.73m including –
 - £0.45m on new medical equipment
 - £0.12m upgrading infrastructure at the Gilbert Bain Hospital and Health Centres
 - £0.16m on IT projects for network resilience and Primary Care
- Maintain investment in sustainable development including further work to improve energy efficient lighting and heating systems.
- Outline 10 year Capital Plan presented to the Board to aid strategic direction, however not all schemes can be funded from within the specific Board allocation.

10 Year Capital Programme - (May 2017)

Project	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	27/28
Emergency Psychiatric Assessment Room	70									
Mortuary Trolley	6									
Washer Disinfectors	200									
Anaesthetic Pendants	20									
Electrotherapy	15									
Video Laryngoscope	13									
Additional clinical space Scalloway Heath Centre	15									
Clinical Portal	100									
Phone Systems	0	200								
Server and Storage Capacity	30									
Hospital Pager System	20									
IT Rolling Replacement	0	100	100	100	100	100	100	100	100	100
Endoscopes	0	40	40	40	40	40				
Anaesthetic Monitors		80								
Mobile X-Ray		80								
Renal Dialysis		20	20	20	20	20				
Phototherapy			25							
Ultrasound Scanners			100	100	100	100	100	100		
OCT Scanner				50						
Image Intensifier				100						
Ward 3 Monitors					100					
Video Endoscope Stack						150				
Harmonic Scalpel						25				
Phacoemulsifier								100		
A&E Monitors									100	
X-Ray Room 1									275	
Warming Unit	12									
Gastroscope	60									
Infant Warmer	11									
Med Equip Rolling Replacement	0	120	120	120	120	120	120	120	120	120
Capital Projects (non-specific)(unallocated)	0	45	110	50	50	50	50	50	50	50
Estates Backlog Maintenance	425	312	482	417	467	392	627	527	352	727
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			800					
Acute ward Redesign		300	2850	2850						
GBH Feasibility								50	50	
CT Scanner (CG Funded £1.2m)				1200			500			
Unallocated Yearly Totals:	126	1926	3262	4050	800		500	50	50	

ITEM 6:

Staff feel supported and engaged

Progress made in staff engagement and development

Key Achievements

- iMatter:
 - The role out of iMatter across the Health and Social Care Directorate has now been delivered.
 - The Board Development Day included a facilitated discussion to allow Board members to formulate their own action plan.
 - iMatter EEL score is currently 77%: this includes the Health and Social Care Directorate.
 - Staff involved in service change (TUPE of GP Practices/Ronas Ward etc)
- This year the Board had four posters approved for the NHS Scotland event. Three were short listed and one of those won its category section. All were based on improvement projects which allowed staff to showcase their work nationally.
- To enable staff to share ideas prior to Staff Governance Committees there is an informal meeting where staff come and speak about their ideas. Posters have also been disseminated via Team Brief (internal staff newsletter) encouraging staff to share their improvement ideas.
- Team Brief continues to be well received by staff.

Challenges

- Challenges with regard to clarity for joint policy approval. Still issues around duplication and triplication of work for the Board/Council and IJB – governance arrangements challenge delivery.

Healthy Organisational Culture

Agreement of the content for the performance score card which enables the Board to oversee the impact changes have on staff. This will include: incident reporting, joint development review completion, complaints, sickness absence rates with breakdown and iMatter engagement.

Achievements

- Staff sickness absence for the year was 4.35%, down from 5.18% the previous year. Only four non territorial Boards are performing better.
- Managers being actively supported to have difficult conversations around poor performance and behaviours.
- Improving behaviours in meetings: video clips and the etiquette guide have been completed and circulated. The etiquette guidance from the BMA was shared via our intranet.
- The etiquette tool for meetings has been adapted to allow qualitative feedback. This tool is currently being piloted by the Staff Governance Committee with a view that it will be rolled out.

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.
- Staff still feeding back that more could be done around challenging senior clinical colleagues.
- Building momentum in having courageous conversations, particularly at leadership levels.

Sustainable workforce

Led by the Director of Human Resources and Support Services, the Human Resources manager, the Head of Modernisation and Planning and the Staff and Organisational Development Manager have been developing an infrastructure to support managers and staff with workforce planning.

Achievements

- Service planning documentation has been agreed.
- Links with the training and workforce plan.
- Decision making agreed via the Transformational Change Board.
- The successes of some of the local programmes were showcased at the NHS Scotland Event.
- Production of a number of 'my story' videos to support recruitment.
- Engaging with senior school pupils considering a career in health. The Board sent representatives to the local careers event which included students on placement. The stall was well attended and this was followed up with a placement offer in which students could undertake simulated activities such as resuscitation, moving and handling and the opportunity to speak to staff about working in the NHS (20 attended). We received two access to nursing applications from students attending the placement. The Board plans to build on this next year by offering a placement to those interested in a career in Health and Social Care support work.

Challenges

- Numbers of suitable applicants across Scotland for some clinical roles – a disproportionate impact on Shetland.
- Nationally there needs to be more focus on increasing the numbers going into education for clinical roles as currently there are not enough qualified staff coming out to be recruited.
- Impact of Brexit and the potential for a more Independent Scotland? Having an impact on recruitment.
- IR35
- Succession planning in an environment of limited recruitment.
- Redesigning the clinical / staffing model to ensure service sustainability and ensuring this includes appropriate use of multi-disciplinary teams and advanced practice.
- Living within the overall budget and resources attracted to living and working in Shetland means having to make decisions around which services to invest in and which to disinvest in. The capacity and local political will to support change remains a challenge.

- Within a small organisation retaining the physical (staff) and organisational capacity to deliver the level of change / redesign required to sustain local services. Some support services now at a diminimus level.
- Complex service planning arrangements with our key partners - this includes Shetland Islands Council, NHS Grampian, SAS etc (particularly for a relatively small health & care system)
- Introduction of and working with 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

- An Integrated Support and Supervision Policy has been approved. This aims to enable staff to access the right individuals and models to support meaningful learning.
- There has been marked improvement with regard to appraisals being undertaken in Estates and Facilities (67% of staff now have an appraisal underway) following the development of a new paper-based tool.
- The training plan is now guided by service planning to ensure that resource is targeted at the right areas.
- The integrated training plan has been agreed and is progressing as part of the corporate training plan.

Challenges

- 24% completion rate recorded on eKSF. Moving forward the Board would like to explore alternatives to enable this process to link more closely with revalidation and registration. There has clearly been a disengagement with this for staff and managers despite a range of initiatives such as training and how to do guides being offered (see reference above to Estates & Facilities staff appraisals)
- A delay in service planning has slowed the progress of integrating our workforce and training plans with projected service redesign.
- Embedding succession planning in ongoing service planning.

Integrated workforce

This has and continues to be a focus on our developing arrangements for health and social care integration.

Achievements

- Delivery of the first integrated policy.
- Pilot Board for iMatter within Community Health & Social care which was a successful process. NHS Shetland was the first Board to achieve an EEI score of 60%.
- Joint posts are now filled for moving and handling training working across both Health and Social Care.
- Health Board nominations have been accepted for the Joint Staff Forum.

Challenges

- Defining an integrated workforce model.
- Clarity for policy approval.

Effective leadership and management

Focused on developing the skills of key individuals.

Achievements

- The Director of Dental, a Pharmacist and the Head of Modernisation and Planning have been nominated and are currently undertaking senior leadership programmes.
- Full complement of Non-Executive Board members (from mid July 2017).
- Human Resources drop in sessions for hot topics which were open to all staff.

Challenges

- Delays in the development of service planning have impacted on the identification of further staff that would benefit from leadership development.

Local staff governance

The outgoing 2016/17 action plan was signed off by the Area Partnership Forum and the Staff Governance Committee and the 2017/2018 plan approved: action plans are linked to Everyone Matters.

- We have representation from APF on the Joint Staff Forum to support the local integration agenda.
- Links with the Health and Safety Committee.
- Reviewing the Organisational Respect Charter to embed positive behaviours – wellbeing task force enhanced with members of the Health and Safety Committee.
- All PINs adopted.
- Staff side members of Health and Safety Committee an issue and looking to address this.
- The TUPE in of staff from what were independent GP practices and induction programmes going well with some minor challenges.
- Workforce planning still reactive with managers struggling to define/scope their future workforce models.

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 was completed in 2016. 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. The action plan for the strategy has been largely implemented but there have been a high number of practices asking to become salaried during 16/17 and this will require a further review to ensure that services can remain sustainable, particularly given the number of GP vacancies currently being experienced.
- Conversations were led in each of the seven planning localities in Shetland by the Head of Planning and Modernisation along with staff from Public Health, 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.
- A specialist clinical pharmacist has dedicated time with each practice helping to ensure that patients receive safe and effective pharmaceutical care and to optimise the efficient use of medicine in line with the national effective prescribing programme.
- Each locality now holds a regular multi-disciplinary meeting to plan care for complex cases and to foster better joint working between GPs, Community Nurses, Social Work and Social Care, and AHPs. The success of this locality focus is demonstrated in the good performance evidenced by low rates of delayed discharges; lower levels of admission to hospital for over 75s; and palliative care rates in the community.

Challenges

- Practices across Shetland continue 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. A pharmacist is now established in the practice, this is also helping to reduce GP workload.
- 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 very small number of GPs to staff it.
- We now have seven salaried practices (out of 10), with a further practice to become salaried on 1st September. Across these practices we are currently carrying a number of GP vacancies, and recruitment continues to be challenging. Our GP vacancy rate currently stands at 30%.

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. Pharmacists and technicians also support patients directly in these settings ensuring that medicine use is appropriate and that waste is minimised.
- 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 alternatives to admission and continue to achieve the target for delayed discharges as the population ages.
- To promote re-ablement across the community and embed the philosophy in all areas, garnering public support.
- To re-invigorate the Managed Clinical Network (MCN) approach to leading and developing long term conditions management across Shetland.
- 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 has been selected as one of three pilot sites in Scotland to trial the provision of Post Diagnostic Support based as part of the Primary Health Care Team. This pilot will run until April 2019 and the findings will influence the future of this provision across Scotland.
- 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.
- We are in the process of extending our intermediate care service, building on the success from an early pilot to extend the programme across all areas of Shetland. There is a real enthusiasm from our social care staff to support reablement programmes both in residential care and in the home setting, and through this over the last year we have been able to redesignate more care beds from 'permanent' to 'respite' status, thus enabling us to increase the number of individuals supported in their own home for longer whilst also providing respite support for any family carers.

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

Adult Psychological Therapies Waiting Times

- There are a number of people waiting for a service, who are waiting in excess of 18 weeks. Both Talking Therapies and Psychology are working down the waiting times, and this is being monitored closely.
- 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 is now in post within the Community Mental Health Team. We are also in discussion with NES as we want to recruit a trainee Psychologist, which will add capacity to the team. The Consultant Clinical Psychologist is leading on a training programme for the wider mental health team to enhance skills.

Child and Adolescent Mental Health Services

Throughout 2016-17, we have been working on an improvement plan to address the identified gaps. Specifically in response to the actions to review the skill mix and improve access to psychological therapies, we have developed a new model to increase the clinical capacity available for psychiatric and psychology input which is where the CAMHS service had the greatest deficit.

The changes to the skill mix have been funded from the £45,278 that is available to CAMHS from the Transforming Mental Health (2016) allocation to develop CAMHS capacity, as well as through a redistribution of core resources.

We have been working closely with NHS Grampian to develop clear, joint pathways between NHS Shetland and the specialist services in Aberdeen where a child may have complex needs and a learning disability so that an appropriate and coherent plan can be put in place quickly. A transitional pathway/model for young people transitioning into adult services has also been developed and is in draft.

A plan to support practitioners in new roles has also been developed in conjunction with NHS

Education Scotland (NES). Staff have made links with specialist services (e.g. tier 4) in Dundee to fully understand the clinical pathways, governance arrangements and role that local services need to play in supporting children in the Island context. Clear clinical supervision and management arrangements are also in place for the whole, multi-disciplinary team.

Priority has also been given to support the development of the capability and capacity of generalist practitioners working across health, social care and schools to provide appropriate support and advice to young people, who would otherwise have been referred to CAMHS (i.e. tier 1).

The service has recently moved into new premises, which will enable closer working with inter-agency partners and includes space that can be used for group work facilitated by the CAMHS team or partner organisations (e.g. youth groups, schools and the voluntary sector).

As a result in changes in our skill mix and the introduction of new pre-assessment clinics, facilitated group sessions and new pathways, we have improved access to the service considerably in the last six months.

In April 2016, 22% of patients waited less than 18 weeks from referral to treatment for specialist Child and Adolescent Mental Health Services. By October 2016, 100% of the children referred to the service were seen within the access target and this has been sustained for the rest of 2016-17. As a result of this work, the waiting list has reduced considerably with better triage arrangements.

Progress and performance of CAMHS is reported to the Integrated Children & Young Peoples Strategic Group as well as through NHS Shetland governance and management structures.

Dementia services performance

- The number of people with a dementia diagnosis continues to fluctuate marginally, 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.
- A new Dementia Strategy for Scotland was launched in July 2017 and the existing local Action Plan will be updated to reflect this.
- Funding from the Integrated Care Fund is supporting the pump priming of extending post diagnostic support activities to all localities in Shetland.

Shetland Area Clinical Forum Report (July 2017)

During 2016-17, the ACF has continued to implement the actions from CEL 16 (2010) with the aim of maximising the contribution of the ACF to both the work of the NHS Board and the Integration Joint Board (IJB). Whilst we had a period of stability in 2014-2015, over the last two years there have been a number of changes in membership in the individual Professional Advisory Committees (PACs) which has impacted on continuity and attendance at ACF meetings this year. However, despite this, a dedicated small core group has enabled us to hold eight quorate meetings during the year.

The main areas of work for the ACF have been to continue to provide input to the various service developments occurring across both acute and community based services. Specific areas of discussion and input by the ACF in the past year have included multi-professional input to the development of a sustainable out of hours unscheduled care model, development of rehabilitation in the hospital and community setting with an extension of the community based Intermediate Care Team and work to support the development of new medical criteria for patient escorts when patients have to travel to mainland Scotland for an appointment/admission.

The ACF has also been kept apprised of service developments and issues in relation to clinical services which have faced particular challenges e.g. Child and Adolescent Mental Health as well as mental health services in general and Primary Care. Where services have faced challenges, these have mainly related to access or service delivery issues which have followed from the difficulty in recruiting staff to some key positions. Workforce issues in remote and rural practice are becoming an increasing concern for all staff across acute and community services. A Transformational Change Programme has been established and it is hoped that the work undertaken through this change programme will help to address the workforce issues and create overall sustainability and viability of service provision.

During the year the ACF has discussed the following national and regional areas of work: National Clinical Strategy, Regional Clinical Strategy and Realising Realistic Medicine, giving due consideration to the relevant implementation and impact of these locally to ensure the greatest benefit for local people whilst also making sure that we deliver services in line with the overall clinical policy direction.

The local work to take forward the integration of health and social care services continues and the ACF has played a key role in looking at governance issues for integration e.g. supporting the development of a Clinical, Care and Professional Governance Framework, reviewing the Learning from Adverse Events Policy as well as contributing to the overall development of a Support and Supervision Policy for professionals across health and social care.

Work continues to attempt to increase the profile of the individual Professional Advisory Committees as well as the ACF itself. We have liaised with ACF colleagues in NHS Grampian and have revised our Terms of Reference to be reflective of those of NHS Grampian. We are currently progressing the review of the Constitutions of each individual PAC to ensure that they remain in line with the overarching ACF Constitution. Whilst undertaking this process the Dental team hopes to be able to reconstitute the local Area Dental Committee after a period of time with no formal recognised professional advisory structure being in place.

As ACF Chair, I have been invited to join the Executive Management Team on the Transformational Change Programme Board. The Board has been established to take forward the programme of change for the organisation. The programme focuses on the following three areas of work:

- Sustainable Service Models
- Organisational Issues
- Whole population

All of these areas of work are core to the ongoing provision of high quality, safe, effective and sustainable services locally. In my role as ACF Chair I will be able to ensure that there has been appropriate involvement and engagement of clinical staff in the development and agreement of the plans for the future.

ACF also continues to champion the local implementation of the national Quality Strategy through taking a 'quality assurance role'. This is a standing item on the agenda and the ACF receives regular reports on progress.

The work of the ACF during 2017-18 will continue to focus in particular on governance issues related to health and social care integration and the ongoing work of the Transformational Change Programme. We will continue to work with the Integrated Joint Board members on establishing a formal process for them to be able to access professional information and advice via the ACF.

EM Watson
ACF Chair
July 2017

Shetland Area Partnership Forum Report (July 2017)

Areas for APF included: HEAT targets (relevant to staff, organisational change, organisational culture, workforce, employment practices, culture, finance and life-long learning).

Achievements and challenges through the year

- Sub group of APF developed for workforce culture, with focus on sharing ways of working to support behavioural changes:
 - supported team working in teams where there were personality/behavioural issues with psychometric testing;
 - set behavioural team charters; and
 - development of etiquette guides.
- Focus on promoting attendance: supporting staff and managers in following the Promoting Attendance Policy and having robust/compassionate conversations (24 cases on capability and both formal and informal improvement plans during 2016-17 – some cases ongoing).
- Pro-active conversations around the financial position which resulted in a very pragmatic plain English narrative cascade to staff. Feedback has been positive.
- Productive conversations and engagement around service change – particularly around the move to the development of more enhanced Intermediate Care Team (and the staffing changes in terms of Ronas Ward).
- Robust conversation regarding the training plan and the need for senior clinical training to be seen.
- Challenges around the implementation of Phased Retirement and Parental leave PINS – cost vs sustaining small, sometimes single-handed services.
- Issues around supporting staff side engagement in sub groups (health and safety representation weak, staff side facilities time collection remains fragmented).
- APF and ACF agreed to review their meeting timings to host more than one meeting a year together: jointly discussed finance and the National Clinical Strategy.
- Director of Human Resources and Support Services along with the Employee Director co-host staff induction on working in partnership.

More information can be found in Section 6: Staff feel supported and engaged.

L Hall

Director of Human Resources and Support Services

I Sandilands

Employee Director

July 2017