NHS Shetland Annual Review 2018

Self assessment for 2017/18

SECTION 1: Progress on 2017 Annual Review action points

The Board must:	
1	Continue to review, update and maintain robust arrangements for controlling Healthcare Acquired Infection, with particular emphasis on C.Diff and SABs
	Please see Section 2 with regard to HAI LDP standards and HAI heading in Section 4: Healthcare is safe for every person, every time.
2	Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safetyos
	Please see Quality, Safety, Clinical Effectiveness heading in Section 4: Healthcare is safe for every person, every time.
3	Keep the Health and Social Care Directorates informed on progress towards sustainable achievement of access performance standards
	NHS Shetland is participating in the Scottish Access Collaborative programme and kept the Scottish Government informed of improvement work to achieve and sustain access performance standards through the executive waiting times group (disbanded in 2018), as well as midyear reviews and weekly monitoring reports. Our plan for achieving access performance standards was approved by the Board in June 2018 and sets out in detail the work that we are in the process of undertaking to deliver access targets, redesign services and ensure that we align the way in which we provide care pathways with Realistic Medicine principles. A link to the Operational Plan 2018-19 is shown below: https://www.shb.scot.nhs.uk/board/meetings/2018/0622/20180622-2018-19-21.pdf Performance against the LDP target for Psychological Therapies has dipped during the period of 17/18, and further work is ongoing to improve performance and access. Locally monitored access to primary and secondary care shows that despite the challenges around recruitment, access remains good.
4	As a minimum achieve the same elective waiting time performance at the 31st March 2018 as the Health Board delivered at the 31st March this year
	The waiting times for AHPs have continued to perform well, with the Physiotherapy self-referral programme bedding in. Pressure continues in our Public Dental Service; however there is an option for people to register with an independent practice who are offering NHS care and have capacity. **Access to 12 Week Outpatient Appointments** In 2017-18, 76.8% of patients waited less than 12 weeks from referral to a first

outpatient appointment, missing the 95% target.

This is due to the continued pressure and lack of capacity available to deliver key specialities which are part of shared clinical pathways with NHS Grampian (e.g. ENT, orthopaedics, ophthalmology, dermatology, and oral surgery) and this has resulted in a number of patients who waited longer than 12 weeks to their first appointment.

Despite fully embracing the Modernising Outpatient Programme, we expect that during 2018-19; we will not meet the 12 week Outpatient appointment standard in ENT, ophthalmology, oral surgery, rheumatology, orthopaedics, orthodontics and dermatology because the core capacity available from NHS Grampian does not meet the demand for these services. We have used access funding made available to NHS Shetland to put in place recovery plans in all these specialty areas as a short term measure, mainly through identification of additional capacity from the independent sector.

We expect the provision of additional funding made available through the Waiting Times Improvement Plan will be dispersed to tertiary centres in such a way that the forecast shortfall in provision to the Island Boards is included in recovery plans developed by Health Boards that are given extra funding.

The table below shows our performance at the end of 2017 and expected performance against a range of metrics.

Measure	*Latest Performance*	*Planned March 2019 Performance*	*Time Period - Month/Quarter*
62 day Cancer	50%	79%	Dec 17
31 day Cancer	100%	97%	Dec 17
12 weeks outpatient	265 (did not meet access standard)	1990 (will not meet access standard)	Jan 2018
6 weeks diagnostics	1 (ultrasound)	< 10 (ultrasound)	Dec 17
18 weeks CAMHS	100%	90-100%	Oct – Dec 17
12 weeks TTG	0 (did not meet access standard, although up to 85 patients will not meet TTG by end of Q4)	409 (will not meet access standard)	Dec 17
4 hour A&E	95.9%	96%	Oct – Dec 17

A more detailed account of the elective care service plan can be found in the NHS Shetland Operational Plan 2018-19:

https://www.shb.scot.nhs.uk/board/meetings/2018/0622/20180622-2018-19-21.pdf

5	Continue to keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme and plans in place to meet financial targets
	Regular updates are given. Please see item 8. below and Section 6: Best use is made of available resources.

6	Continue to work with planning partners on the critical health and social integration agenda and the key objective to significantly reduce delay in general and particularly patients experiencing delayed discharge
	Health and Social Care Integration continues to develop in Shetland, with performance on the Ministerial Strategic Group key indicators demonstrating the continued shift to care in community settings. This has impacted positively on delayed discharge performance.
7	Continue to make progress against the staff sickness absence standard
	Our sickness absence rate for 2017-18 was 3.92% and was the best amongst territorial Boards in Scotland. Please see Section 7: Staff feel supported and engaged
8	Keep the Health Directorates informed of progress with redesigning local services
	We have continued to engage with the Scottish Government Performance Team and Finance Directorate on our redesign programme. This has included highlighting specific service issues where appropriate and discussion with the Finance Directorate on the link between our redesign programme and our projected financial position. We have also hosted a number of visits to Shetland from Scottish Government teams including, for example with representatives of the Primary Care Directorate to discuss the new GP contract/Primary Care redesign.

SECTION 2: At a Glance LDP Standards Performance during 2017/18 (unless otherwise stated)

• Within **smoking cessation services** we helped **33 people** (in the 60% most deprived SIMD data zones) to successfully quit at 12 weeks. This missed our challenging local target of 43.	**R**
• 75% of **pregnant women in each SIMD quintile had booked for antenatal care** by the 12th week of gestation, narrowly missing the 80% target.	**A**
• During the years 2016 and 2017 combined, 28.8**%** of people were **diagnosed and treated in the first stage** of breast, colorectal and lung cancer, which is in line with our target of 29% and is the 2nd best rate in Scotland.	**G**
• 96.1**% 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%.	**B**
• 55.4**% of patients waited less than 18 weeks** from referral to treatment for **Psychological Therapies,** which missed the target of 90%.	**R**
• We had four **Staphylococcus aureus bacteraemia (including MRSA)** infections, which gave us a rate of 40.8 cases per 100,000 acute occupied bed days. This missed our target rate of 24. Every case had a root cause analysis carried out and no specific concerns were identified.	**A**
• We had one **C Diff infection**, which gave us a rate of 10.2 cases per 100,000 total occupied bed days. This met our target rate of 32.	**B**
• 96.5% of patients **waited less than 4 hours at A&E,** meeting the target of 95%.	**G**
• 96.8% clients **waited less than 3 weeks** from referral to **appropriate drug and alcohol treatment that supported their recovery**, meeting the target of 90%.	**G**
• 183 **Alcohol Brief Interventions** were delivered in the 3 priority settings (Primary Care, A&E, antenatal), missing our target of 261.	**R**
• We had a **Sickness Absence rate** of 3.92%, meeting the target of 4% and being the best rate among territorial Boards in Scotland.	**G**

• Patient experience survey indicated that 90% of patients rated as positive the **"last time you needed to see or speak to a doctor or nurse from your GP practice quite urgently, how long did you wait?"** meeting the target of 90%.	**G**
• Patient experience survey indicated that 61% of patients believed they were able to make an **advanced booking for an appropriate member of the GP Team within 3 days,** missing the target of 90%.	**R**
• 100% of **eligible patients had commenced IVF treatment within 12 months**, meeting the target of 90%.	**B**
• 84.1**%** of **planned/elective patients commenced treatment within 18 weeks of referral**, missing the 90% target.	**A**
• 76.8% of **patients waited less than 12 weeks from referral to a first outpatient appointment,** missing the 95% target.	**R**
• 19 **patients waited longer than 12 weeks from patient agreeing treatment with the hospital to treatment for inpatient or day case treatments,** missing the zero target.	**A**
• We **operated within our agreed revenue resource limit; our capital resource limit; and met our cash requirement.**	**G**
• During 2015-16, 56% **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. 81% of these people received **12 months of support**.	**A**
• 98.1% of **patients diagnosed with cancer** waited less than 31 days from d**ecision to treat to first treatment,** meeting the 95% target.	**G**
• 90.6% of **patients with urgent referrals with suspicion of cancer** were treated within 62 days, missing the 95% target.	**A**

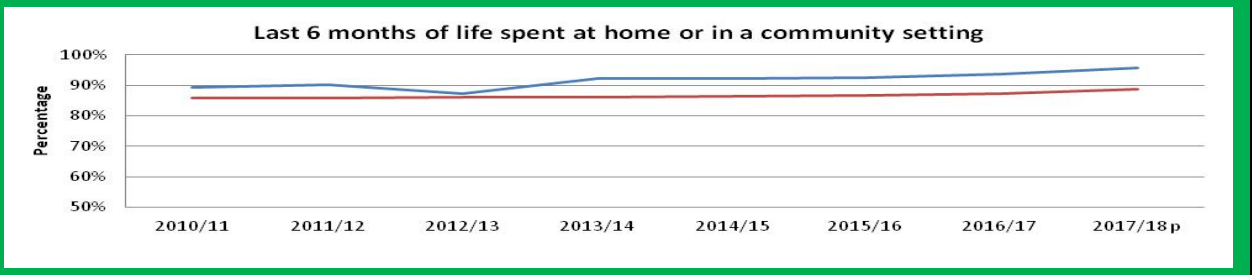
Key:

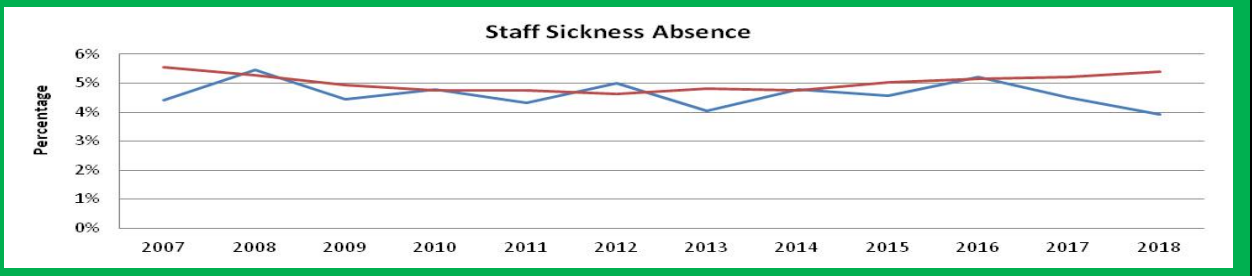
R	Not meeting and not within trajectory limit
A	Not meeting but within trajectory limit
G	Meeting or better than trajectory
B	Well ahead of trajectory or met early

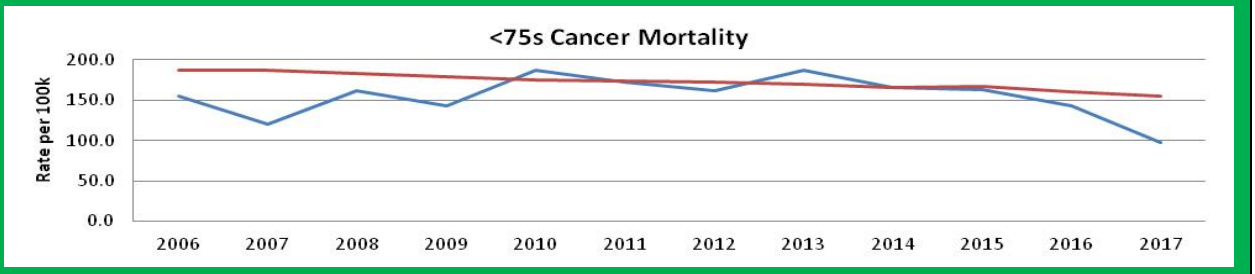
At a Glance Outcomes 2017/18

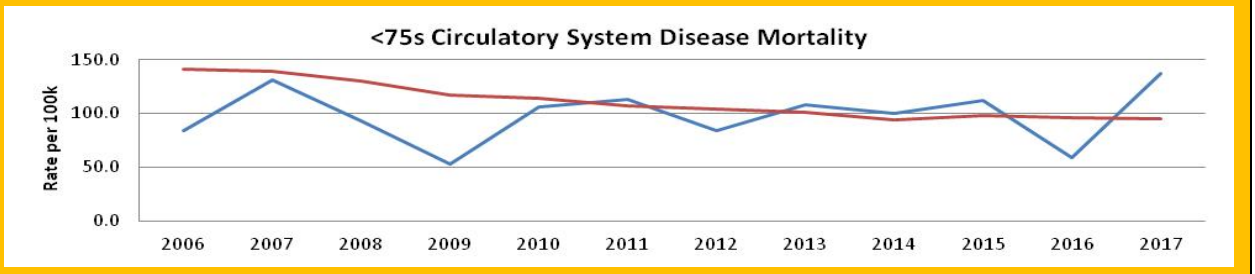
Shetland

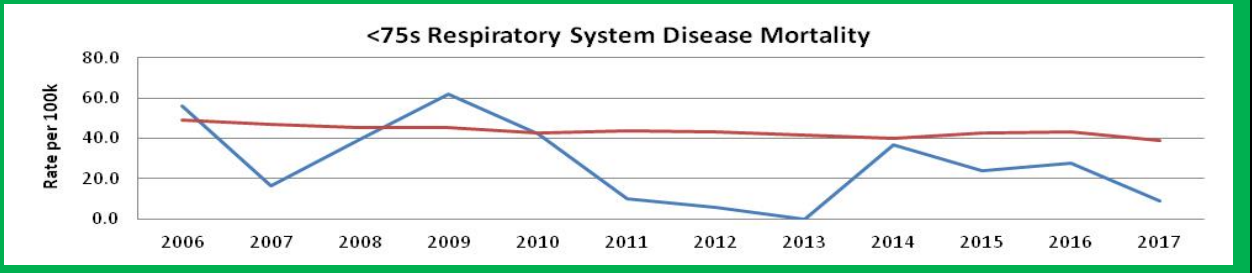
Scotland

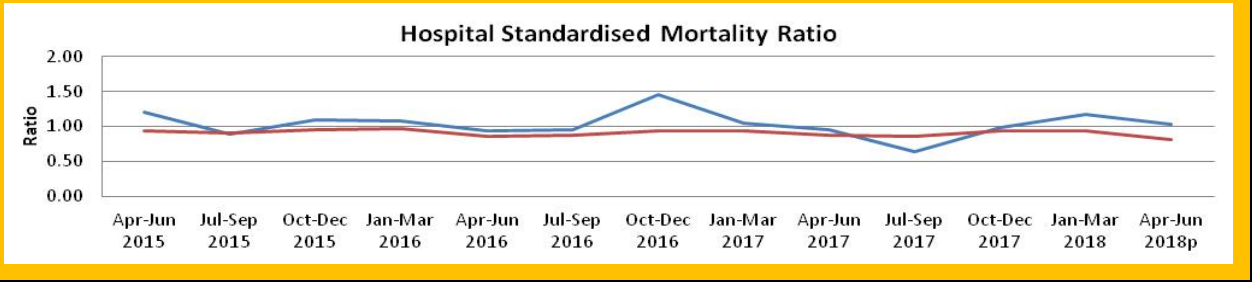




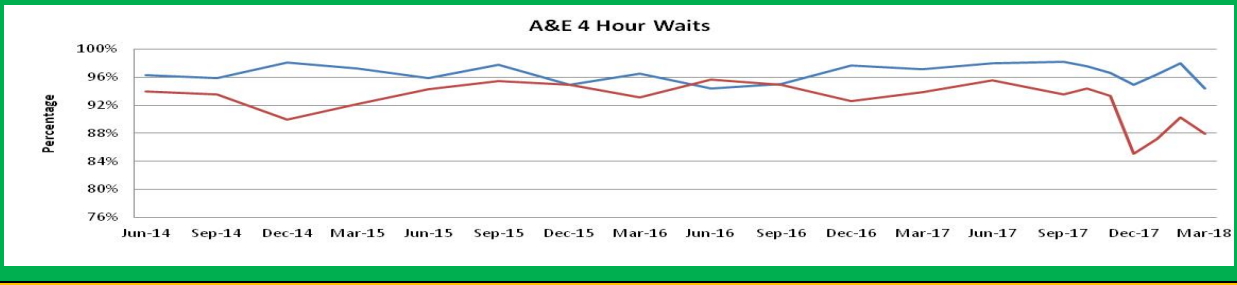


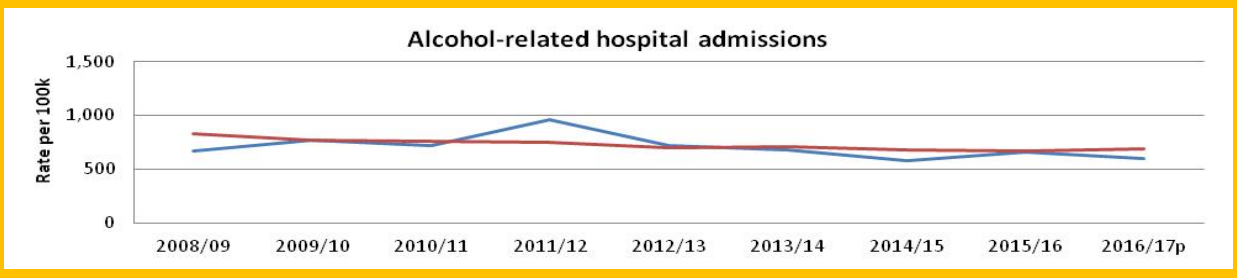


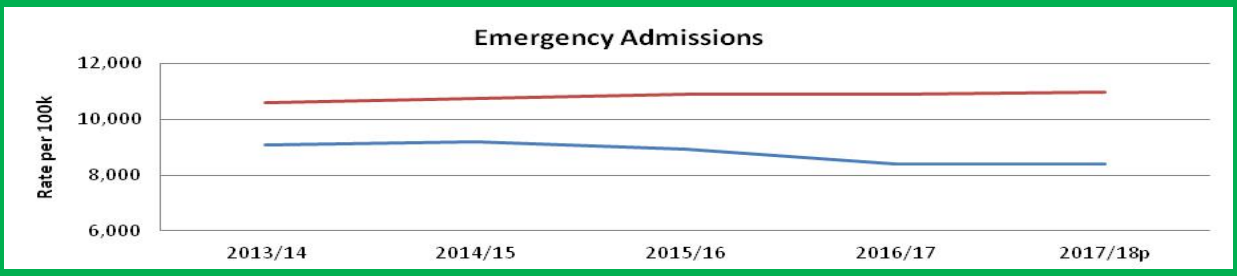


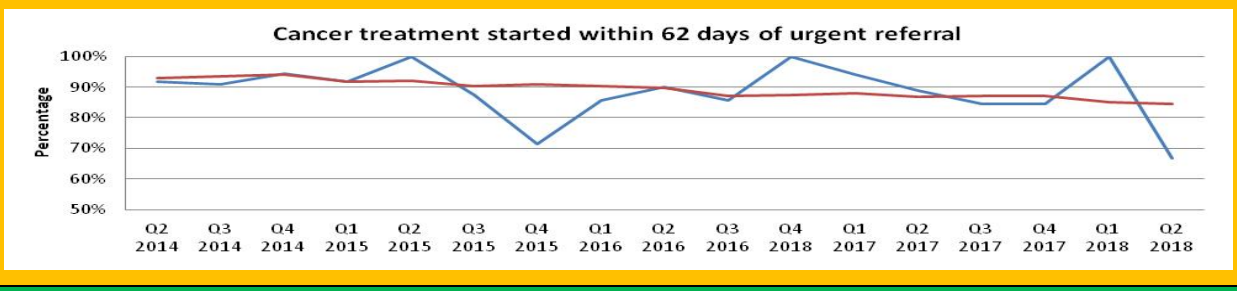


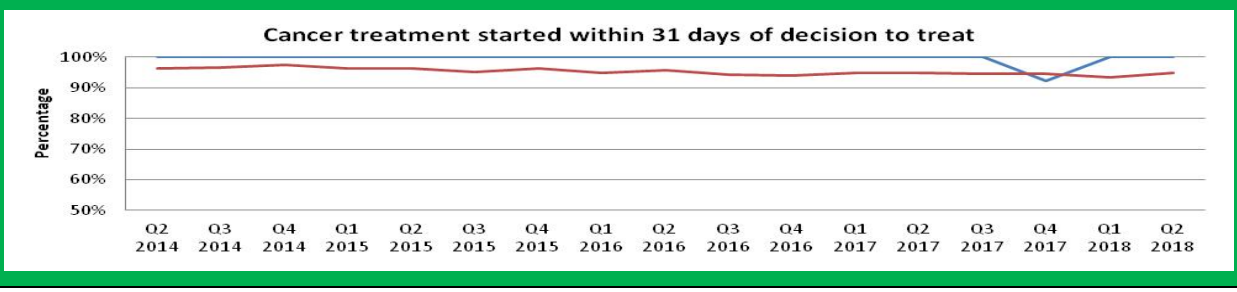
Shetland ——— Scotland ———











p = provisional data

Key:

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

SECTION 3: Performance in 2017-18 against LDP standards

Better Health

Smoking cessation

During 2017-18 we supported 50 people to stop smoking (based on 3 month follow up contact), with 33 of those coming from the 60% most deprived data zones in Shetland. This missed our challenging local target of 43 from the most deprived data zones.

Alcohol & drug treatment

The national standard is that 90% of clients referred for drug or alcohol treatment should be seen within 3 weeks of the date of referral. We achieved 100% for drug treatment and 96.4% for alcohol treatment (local reporting).

Primary Care (48 hour access)

The standard is 90% positive responses to a question in the National Health and Care Experience Survey, which is conducted every two years. The survey published in May 2018 showed us at 90%. All practices are sustaining same day access for urgent need.

Primary Care (advance booking)

The standard is to achieve 90% positive responses to a question in the National Health and Care Experience Survey, conducted every 2 years. The survey published in May 2018 (with a 29% response rate for Shetland), showed Shetland at 61%. All Shetland practices advise that they provide same day access for urgent need and patients can book an appointment or phone call with a clinician more than 3 days ahead. However, it is recognised that a number of practices have had vacancies with locum cover in place and feedback from patients (including Community Councils) would indicate that patients prefer to wait to see someone they are familiar with.

Antenatal booking

75% of pregnant women in each SIMD quintile had booked for antenatal care by the 12th week of gestation, falling slightly short of the 80% target.

Alcohol Brief Interventions

We have not met the target for delivering Alcohol Brief Interventions (ABI), despite doing well in previous years. In 2017-18 183 ABIs were undertaken against a target of 261. This 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, and a significant recording issue in Accident & Emergency, which means that numbers are not able to be recorded by the patient management system. This position has improved and we are on target in 2018-19.

IVF

100% of eligible patients commented IVF treatment within 12 months, which meets the target of 90%.

Early Detection of Cancer

The most recently available figures (Jan 2016 - Dec 2017) show that the percentage of patients diagnosed with cancer at Stage 1 has increased to 28.8%, second highest in Scotland, compared to a baseline of 19.3% in 2010-11. (It should be noted that the percentage diagnosed at Stage 1 varies year on year as the breast screening programme only runs every three years and figures that include a breast screening year

will always have a higher percentage of early diagnoses. Both the baseline and the most recent figures include a breast screening year.)

Better Value

Financial Balance
We operated within our agreed revenue resource limit, our capital resource limit, and met our cash requirement in 2017-18.

Efficiency Savings
We delivered recurring Efficient Government savings of £2,375k in year, £2,710k full year effect.

Sickness absence (annualised)
The national target is to achieve 4% or less. At March 2018, NHS Shetland met this target with a sickness rate of 3.92% (the lowest rate of the territorial health boards).

Better Care

Child & Adolescent Mental Health Services
The national standard is that 90% of referrals should start treatment within 18 weeks. Throughout 2017-18, 96.1% of patients met this target. We have been working on an improvement plan to address the identified gaps in service. 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. This has seen us maintain better access throughout 2017-18.

Psychological Therapies
The national standard is that 90% of referrals should start treatment within 18 weeks. As at March 2018, Shetland was achieving 55.4% (local reporting). The performance against the LDP target for Psychological Therapies dipped during 17/18 for a number of reasons:

- Increase in referrals: this is due to ongoing work within the community to reduce the stigma of ‘asking for help’; a higher number of locum GPs/Primary Care staff who are often unaware of other services available for mild to moderate conditions i.e. within the 3rd sector and/or Health Improvement.
- A gap in provision for individuals with moderate to severe conditions - our current service model works with mild to moderate and severe to extreme - until alternative service models are in place for this cohort of patients they are effectively on the waiting list for the single handed Consultant Clinical Psychologist who is clinically prioritising patients with severe to extreme need.

We are working towards addressing these issues by:

- Establishing an agreed step care model within Primary Care and ensuring appropriate signposting/referral occurs.
- Developing sustainable MDTs in localities that will support Primary Care colleagues, as well as deliver a service for individuals as close to home as possible.
- Developing group programmes that support the moderate to severe conditions whilst both reallocating resources and securing new ones.

A&E
The national standard is that 95% of patients should be seen in less than 4 hours. 96.5% of patients waited less than 4 hours during 2017-18.

Achieving the target has been more challenging at times during 2017-18, because we have seen an increase in the clinical complexity and frailty of patients presenting at A&E and this has had a wider impact on patients across the hospital system. We have also seen a significant increase in the use of locums to supplement the consultant workforce with 45% of posts currently vacant. This has also had an impact on thresholds for admission and transfer to specialist services, but access to A&E and overall emergency demand has remained good.

As part of our winter planning, we have made good progress in the development of community mental health services over the last three years and we now offer improved access to mental health services as an alternative to A&E or an emergency care setting (reducing the number of patient presentations to A&E, particularly out of hours). We have also seen a positive impact from the development of community based services, which has reduced A&E attendances and inpatient admissions by increasing the range and availability of anticipatory care in localities.

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

Cancer waits
In 2017-18, 90.6% of patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral and this reflects the national challenge across urological services. In 2017-18, 98.1% 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. Patients who do not meet the target are in the main, treated at tertiary centres. We estimate that our performance (based on the profile of patients treated for cancer over the last 18 months) will be 79%. The dip in performance is associated with access to diagnostics or recruitment issues in specific specialities.

18 Week Referral to Treatment
The national standard is that 90% of patients waiting for planned/elective care should be seen and treated within 18 weeks of referral. At March 2018, Shetland was achieving 84.1%.

12 Week Treatment Time Guarantee (TTG)
The treatment time guarantee places a legal requirement on health boards that once planned inpatient and day case treatment has been agreed with the patient then the patient must receive that treatment within 12 weeks. The standard is for 100% of patients to be seen within 12 weeks of agreeing inpatient/day case treatment.

For the first three quarters of 2017-18, we reported that 100% of patients commenced inpatient/day case treatment within 12 weeks. However, in the last quarter, due to

reduced capacity in gynaecology and ophthalmology service provision during 2017-18, a number of patients (19) waited longer than the 12 week TTG and we have put in place a recovery plan to ensure as many of these procedures are undertaken as soon as possible. Overall performance in 2017-18 was 97.9%.

In order to reduce the risk of not meeting the TTG, we have prioritised clinical capacity to ensure that interventions can be delivered within 12 weeks. This has been achieved by using additional capacity to maintain waiting lists and meet demand for a number of visiting specialities.

12 Weeks Outpatients - the national standard is that 95% of patients will be seen for first outpatient appointment within 12 weeks. In 2017-18 76.8% of our patients waited less than 12 weeks, missing the 95% target.

Staphylococcus Aureus Bacteraemia (including MRSA)
The target rate of SAB infections per 100,000 acute occupied bed days is 24. We had four SAB infections which gave us a rate of 40.8 cases per 100,000 acute occupied bed days, missing the target. Every case had a root cause analysis carried out and no specific concerns were identified.

C diff
The target rate for C diff infection per 100,000 total occupied bed days is 32. We had one C Diff infection which gave us a rate of 10.2 cases per 1000,000 total occupied bed days, therefore meeting the target.

SECTION 4: Health Improvement and Reducing Inequalities

Performance against public health targets for delivery in 2017-18

Key local achievements

Shetland's smoking rate (based on local GP data) has decreased from 15.8% to 14.6%. We continue to make attempts to improve the accuracy and completeness of data recorded on EMIS (the GP data collection system).

Latest national data for alcohol-related admissions shows that the rate reduced during 2016-17. It was 603.4/100,000 against a rate of 671.3/100,000 last year and a local target of 500/100,000. Work continues to prevent harm relating to substance misuse, including work with the local Licensing Board and the starting of a strategic needs assessment of drug and alcohol needs in Shetland. Our local programme of culture change on alcohol use, known as "Drink Better", has been informed by the result of successful local engagement with the Shetland public, including focus groups.

Our rate of mothers smoking during pregnancy has fallen dramatically to 6.3% from 14.1% last year.

The most recent figures for breastfeeding at 6-8 weeks show that the rate for Shetland is 65.1% (quarterly rolling average at end of 2016), above the national target of 50% and our ambitious local target of 58%, and the third best performing Board in Scotland.

Key challenges

Shetland has traditionally had a good life expectancy and a level of health amongst the best in Scotland. For men the life expectancy at birth using the three year rolling average for 2014-16 remained at 77.6 years; however for women it was 82.0 years, down from 82.45. Life expectancy and healthy life expectancy is still better than many other parts of Scotland but there are health inequalities within Shetland that are often hidden and not reflected in available data.

Despite sustained effort and resource going into our smoking cessation services we have seen a reduction in people accessing services, making it increasingly difficult to meet targets set by government. During 2017-18 we supported 50 people to stop smoking (based on three month follow up contact), and are now able to receive electronic referrals from other services such as Dental, who are very keen to engage in health improvement. This should hopefully improve referral and eventually outcome rates. However, as identified above overall smoking outcomes are improving.

Figures for children out with the healthy BMI in Primary 1 vary from year to year, due to small numbers; the figures were 17.9% in 2014, 27.1% in 2015, decreasing again to 22.3 in 2016 and then a further increase to 26.1% in 2017. We recognise that significant impact on these figures will only come from strengthening of partnership working in Shetland, and this is informing a significant area of our work in 2018-19, and is a strand of the Shetland Local Outcome Improvement Plan.

We missed the Alcohol Brief Intervention target in 2017-18 due to a new electronic recording system in A&E which does not capture ABIs, and a reduction in staffing in Health Improvement. However, the team is now fully staffed and the ABI target is on trajectory. Online training in ABIs is being developed, which should help to build capacity.

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

- 66.3% for bowel cancer screening (Nov 15 - Oct 17) above the target of 60%
- 78.9% for cervical screening (2017-18) slightly below the target of 80%
- 84.4% for breast screening (3 yr rolling average 2013 -16) above the target of 80% (no more recent figures available).

Section 5: Healthcare is safe for every person, every time

Quality, safety and clinical effectiveness

The Board's high level assurance includes 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 and the LOIP, delivered in partnership with the local authority.

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), Risk Management Group (RMG) and the Integration Joint Board (IJB). These 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/Boards receive reports on specific topics such as risk management and incident reporting, corporate risks, complaints, adverse events and investigations as well as our locally developed quality score card. This sets out the quality improvement work being taken forward across the organisation which is mapped to specific headings such as patient experience, safe, effective etc.

Pathway development is managed through clinical networks, the Acute Services Management Team, the Health and Social Care Partnership (H&SCP) Management Team and specific groups such as the Discharge Planning Group, Repatriation Group, Joint Governance Group etc which contribute to the decision making process and service improvement, implementing clinical guidelines etc. Representation on all of these groups is multi-professional and multi-agency. Approval and decision making (e.g. strategy and policy development) is undertaken jointly and reports into the CCPGC or the IJB depending on the topic. For example, service developments which are aligned to the Unscheduled Care Improvement Programme will include projects/services which are being delivered by a number of partner organisations e.g. NHS Shetland, third Sector and Council. The IJB includes professional advisers from community, social work and hospital services to ensure that it has appropriate advice available when considering key policy and performance details.

In 2017-18, a Medical Education and Governance Group (MEGG) was established to ensure that we have a structured approach in the delivery of medical education and role development.

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, NEWS 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 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.

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 in 2017-18. As part of the governance structure, a group to support the implementation of the realistic medicine agenda has been established.

Healthcare Acquired Infection (HAI)
HAI is a standing item at Board meetings and forms part of our Quality Improvement Agenda. Lay representatives are involved in reviewing cleanliness standards and patient feedback materials as well as the work of the Infection Control Committee.

In 2017-18, we continued to shift the balance of care into community focussed services by establishing a community based rehabilitation service and reducing our inpatient bed base. This has reduced our acute occupied bed days and impacted on our infection rates (because we have a low rate of hospital bed occupation) compared with other hospitals during the same period. Over the last three years we have reduced bed occupancy by 12%.

In Shetland the rate for E Coli Bacteraemia per 100,000 bed days in 2017-18 was 14.9, lower than the national average of 16.7 cases.

It is important to note that HAI 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.

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 2017-18 and we did not have any norovirus outbreaks affecting hospital services during this period. We did have increased outbreaks in the community/care home setting and additional measures have been put in place by the Public Health team to support services provided by the H&SCP.

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 via the Link Nurse Forum and planning exercises and testing staff to ensure that FFP3 masks are available and ready for use.

The Gilbert Bain Hospital had two inspections during 2016-17 and one in early April 2017 as were reported on and discussed at our 2016-17 Annual Review. We have continued to work on and complete actions associated with those review processes.

SECTION 6: Everyone has a positive experience of healthcare

Improving access to services

Access to primary care medical services is monitored on a monthly basis and reported to the Integration Joint Board on a quarterly basis. People are able to access a primary care professional at all our health centres, and in Lerwick, the introduction of Advanced Nurse Practitioners has continued to sustain good access. Patients also have the option of an appointment with a pharmacist, which has released GP time and improved access to medicines expertise. Feedback from patients indicates a high level of satisfaction with this service.

One element of our service transformation is an improvement programme focussing on improving access to services which includes:

- continuing to review pathways to increase efficiency and reduce waste e.g. ensuring that pathways conform to best evidence and clinical standards; optimising available capacity by setting clear parameters for referral into specialist services and renewing approach for managing DNA rates within sub specialities.
- continuing to maximise the potential for technology enabled decision making e.g. electronic vetting, pre-referral advice and optimising systems for sharing clinical information effectively such as SCI Store and PMS Trak. We have also established a Patient Focussed Booking Plus service to support patients who are seeking an alternative to travelling to mainland Scotland for routine follow up appointments.
- putting in place the technology and infrastructure to support telemedicine in outpatient and primary care settings in Shetland. In 2017, 1400 patients accessed healthcare using technology (an increase from 600 the previous year).
- identifying opportunities for repatriating planned care services (e.g. shared delivery with local clinicians). In 2017-18, we put in place an EVLT pathway and shared care for patients with inflammatory bowel disease, non inflammatory joint disease and rheumatology (local biologics treatment).
- identifying opportunities to change the skill mix to create more sustainable pathways across local, regional and national services e.g. increasing the number of GPwSI and Specialist Nurse led clinics and pathways.
- progressing a business case to enhance the day surgery and ambulatory care facilities at the Gilbert Bain Hospital. An Interim Unit has been established and an Initial Agreement has been prepared for review by the Capital Investment Group (CIG) in November 2018.

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 single Medical Ward is where all patients with stroke are cared for as it provides all the services that a dedicated Stroke Unit would offer. Our performance against this target is therefore 100%. In 2017-18, 35 patients had a stroke and received care in line with the Scottish Stroke Care Standards. Areas where we have found it more difficult to meet the standards includes: TIA imaging and access to specialist neuro-psychology services.

In 2017 we put in place a community based recovery model for slow stream rehabilitation and reablement. We have fully established these pathways and recruited additional practitioners to enable the Intermediate Care Team to offer intensive, non acute rehabilitation which will include supporting people following stroke illness. We have also reviewed our stroke integrated care plan and stroke thrombolysis management protocols.

The link below includes the most recent national stroke audit data for 2018.

https://www.strokeaudit.scot.nhs.uk/Publications/docs/2018-07-10-SSCA-Report.pdf

Approach to person-centred care and patient experience

Our local arrangements for Patient Focus Public Involvement (PFPI) include an active Shetland Patient Experience Network (SPEN) which meets every six weeks to discuss health and wellbeing related topics and provide advice/feedback on proposed service change and/or development. The SPEN has an established lay representative Chair who is also a lay representative on the IJB.

We have worked with SPEN 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, sustaining communities and services in the very remote parts of Shetland, primary care, palliative care and mental health services to formulate strategies.

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 in place bringing various strands of work together (e.g. utilising feedback from complaints, Patient Opinion, local and national surveys, person centred health and care collaborative). We are building on this work to consider the Our Voice framework and strategies to engage young people in policy development and decision making. This includes work undertaken this year to empower young people to get involved in designing a range of activities as part of the 'Big Take Over' which was hosted in Shetland as part of the Year of the Young Person.

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.

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 developed a professional framework model to support practitioners to deliver effective care in all settings. This has been jointly commissioned by the Medical Director, Nurse Director and Chief Social Worker. A professional assurance model for nursing and midwifery has been in place since 2014-15 and the professional leads are working on putting in place clear professional assurance arrangements for the other professions.

We have 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, reviewing service provision in very remote parts of Shetland, focusing on prevention e.g. roll out of the Otago exercise programme etc). 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.

SECTION 7: Best use is made of available resources

Financial balance and efficiency savings

Main Achievements in 2017-18

- Revenue under spend £88k, equivalent to 0.1% under spend against total funding.
- Capital expenditure £574k, resulting in an under spend of £5k (0.9%) on CRL.
- Delivered recurring Efficient Government savings of £2,375k in year, £2,710k full year effect.
- Delivered non recurring Efficient Government savings of £2,232k

Work on best value characteristics included: updating our Best Value framework to assure ourselves that we are delivering the Best Value characteristics. Committee chairs have '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:

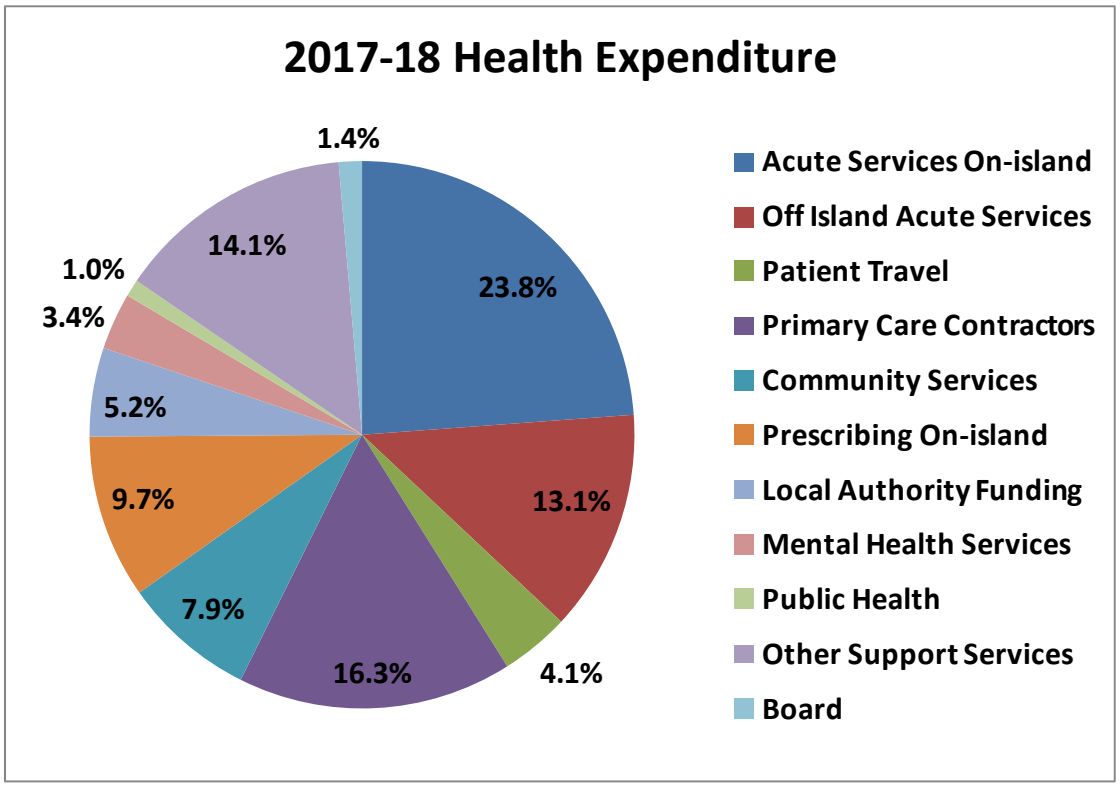
Characteristic (Sub-Characteristic)	
Sound Governance (Performance)	Continued improvement in the performance reporting to the Board.
Accountability	Patient focus public involvement, seeking feedback and using local newspapers and radio to engage with local community.
Sound Management of Resources (Risk Mgt/Assets/Procurement)	Significant work on procurement to deliver value for money maximised from national and local procurement hubs. Local contract renegotiation with Loganair produced savings of £395k. Worked with NSS on Procurement Strategy leadership as a shared services model and PECOS move to national system.
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. This includes patient centred repatriation of out-patient clinics from Aberdeen to reduce unnecessary patient travel and costs.
Contribution to Sustainable Development	Scenario planning workshops with local stakeholders and staff to create an agreed basis for sustainable redesign of local NHS Various measures to reduce energy consumption.
Joint Working (Planning)	Partnership working through the change fund initiative, developing the local integration joint board and other projects with Shetland Island Council.

Utilisation of Funds and Shifting the Balance of Care

NHS Shetland continues to work to shift the balance of care locally as illustrated by the relative shift in share of resources that has increased expenditure in the Community by 3.10% over the last three years.

	Acute	Community	Support Services
2014-15	43.66%	40.36%	15.98%
2017-18	41.05%	43.46%	15.50%
Movement	-2.61%	3.10%	-0.48%

Further analysis of how these funds were used in 2017-18 are outlined:



Direct expenditure on General Medical Services at 10.0% accounts for the majority of the 16.3% spent locally on services that are traditionally delivered via Primary Care Contractors. However in Shetland, for both General Medical Services and General Dental Services we have a mixed economy of providers with the majority delivered through directly managed salaried services.

As an Island board Patient Travel costs represents a larger share of expenditure than most mainland territorial boards. However work is on going to reduce Patient Travel as part of the Patient Centered agenda to reduce off island out-patient appointments. In Shetland, Patient Travel, share of overall expenditure has fallen from 5.4% in 2014-15 to 4.1% in 2017-18.

Main Challenges in 2017-18

Financial Planning

- Challenging savings target in 2017-18 – while there was slippage against the £4.3M recurring savings target, this was covered by identifying non recurring schemes and the use of the Board's contingency reserve. There is a requirement, in addition of the "efficient Government savings target (3%), to reduce the underlying deficit (currently £1.6m) over the course of the next three years with a plan to bring the Board back into recurrent balance in a phased way by 2020-21.
- Maintaining progress on the delivery of recurring savings to address the underlying deficit. The shortfall in 2017-18 resulted in the need to revise 2018-19 financial plans which currently have a recurrent savings target of £3.5m. For 2018-19 there are currently £1.5m in recurrent savings identified leaving a requirement of at least £2.0M of non recurrent savings if the Board is to break even in 2018-19.
- Over the next five years an estimated £9.3 million in recurrent efficiency savings will be required to achieve long term financial sustainability. To deliver this it is essential that the Board's redesign programme builds on the output from the scenario planning process, is incorporated into the updated Joint Strategic Plan, identifies sufficient opportunities to redesign services and also has local buy in to proposals that are brought forward.

Indicative Savings Target Requiring to be Delivered over the period 2018-19 to 2022-23						
	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	Total £000's
Brought Forward balance from 2017/18	1,596.3	0.0	0.0	0.0	0.0	
New Target 3% Target	1,402.1	1,426.0	1,448.0	1,470.0	1,493.0	7,239.1
New Target Additional 1% Target for 2018-19	456.6	0.0	0.0	0.0	0.0	456.6
Sub-total In Year Savings target	3,455.0	1,426.0	1,448.0	1,470.0	1,493.0	9,292.0

- NHS Shetland delivered a high level of efficiency targets in the last six years:

NHS Shetland Historic Efficiency Savings Performance			
Year	**Recurrent savings delivered (£Ms)**	**Non Recurrent Savings delivered (£Ms)**	**Total savings delivered (£Ms)**
2012-13	1.90	0.78	2.68
2013-14	2.07	1.38	2.65
2014-15	1.55	0.96	2.51
2015-16	0.71	1.46	2.17
2016-17	1.90	2.27	4.17
2017-18	2.38	2.32	4.70
Net Total	**9.71**	**9.17**	**18.88**

- Transformational Change Board has been created with oversight for all the redesign work required to deliver the significant number of redesign projects required to deliver the level of change required.
- Prescribing expenditure continues to grow at a much higher rate than the underlying funding. This is particularly true for the new SMC approvals approach for orphan, ultra-orphan and end of life drugs where locally expenditure grew by 46% during 2017-18. To date in 2018-19 locally expenditure has increased by a further 23% on last year.

Sustainable staffing models – recruitment and retention

Primary Care

NHS Shetland is now fully responsible for the delivery of GP Primary Care services in 8 out of our 10 GP practices/health centres, including the three smaller island practices. Recruitment to GP Practices, especially for the single handed practices that have to provide a 24/7 service in our remote areas remains challenging. Removing the reliance on locum staff in providing primary care services is a key priority to support the provision of quality services, including continuity of care, as well as reducing the significant costs associated with the current model.

NHS Shetland Salary GP Practices Locum Costs versus Funding				
Practice / Year	2017-18	2016-17	2015-16	2014-15
Whalsay	297,625	196,349	190,771	247,528
Lerwick	826,274	307,607	249,326	269,716
Yell	352,951	193,717	151,780	45,910
Unst	313,701	203,781		
Brae	221,824			
Scalloway	305,799			
Bixter	220,117			
Walls	120,221			
Total Expenditure	2,305,561	901,454	591,887	563,154
Available Local Funding	1,570,341	639,099	434,055	399,033
Cost Pressure	**-735,220**	**-262,355**	**-157,822**	**-164,121**

The current national funding model does not reflect the true cost of this requirement. Recruitment difficulties in salaried practices directly managed by the Board have meant high unavoidable locum costs over a number of years to maintain essential services. In 2018-19 the likely cost pressure will be around £1.0m.

In addition to the cost of locums, NHS Shetland funded from our core allocation an additional £44.88 per person on top of the Primary Care allocations the Board received in 2016-17 (compared to the NHS Scotland average of £8.33 – based on 2016-17 published data). This would suggest NHS Shetland invests £843k more from core funds than the Scottish average and brings NHS Shetland's total expenditure per head on primary care broadly in line with spending in NHS Western Isles and NHS Orkney (the total figures per head spent are equivalent at £215, £231 and £222 respectively even though our primary care allocation is lower).

Mental Health

The Board made a decision in June 2014 to invest in the Mental Health Psychiatric workforce and increase this to 2.0 wte. This is in line with the national priority around mental health services. The initial recruitment in 2015 provided additional staff, however during 2017-18 a vacancy occurred that has been filled by locums causing a cost pressure of £313k. While NHS Grampian had historically provided a virtual on-call out of hours advice service to Shetland, due to a combination of staffing issues in NHS Grampian and the fragility in the on island physician rota (who provide the initial hospital Consultant input), it has been judged necessary to provide on island Psychiatric OOH input which has increased locum costs.

Gilbert Bain Hospital

The Acute Consultant model at the Gilbert Bain Hospital had been relatively stable at 3.0wte Consultant General Surgeons (with additional annual leave and weekend cover), 4.0wte Consultant Physicians and 4.0wte Consultant Anaesthetists. However due to retirements and career moves, the Board ended 2017-18 with 2.0wte vacant Consultant Physicians and 3.0wte vacant Consultant Anaesthetists. Progress has been made with replacing these with 2.0wte Consultant Anaesthetists appointed substantively. Recruitment for the other posts, but more specifically the Consultant Physicians posts that are "Generalist", remains extremely challenging.

To continue to provide the essential on island emergency service at the Gilbert Bain Hospital, locums are being used and this will need to continue until sustainable staffing is in place. Locum consultant cost in 2017-18 caused a cost pressure of £467k. In 2018-19 these costs are likely to be around £1.1m.

Partnership working with other NHS Boards

Extensive work is underway to manage our 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. We continue to work with NHS Grampian via the obligate network to maximise on island provision and avoid the centralisation of services on the mainland where this is not clinically required. 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 footprint of patient journeys.

We are continuing to manage potential issues with the Highlands and Islands Travel Scheme but incurring some inflationary cost pressures out with the Board's control. We are 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. We are continuing to roll out "Attend 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. In efforts to manage the cost of patient travel off island we have renegotiated travel booking system and fare schedules to reduce costs by £390k as part of local efficiency savings.

We are also working with the Golden Jubilee National Hospital in respect of orthopaedic pathways to minimise patient travel through the use of video conference out-patients supported on island by our Physiotherapy team.

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

Main Achievements

- Delivered agreed Capital Plan of £0.57m including –
  - £0.32m on new medical equipment (Anaesthetic Monitors £153k, Defibrillator £82k, Theatre Operating Tables £48k, Anaesthetic Pendants £23k, Video laryngoscope £16k).
  - £0.13m on the Boiler replacement at the Gilbert Bain Hospital
  - £0.12m on IT projects for network resilience and Primary Care
- Maintaining investment in sustainable development including further work to improve energy efficient lighting and heating systems.
- Outlining the 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 2018) (£'000s)

	Year (all values £k)									
Project	*18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28
Ambulatory Care	0	0	0	0	0	0	0	0	0	0
Additional Clinical Space Scalloway Health Centre	0	50	0	0	0	0	0	0	0	0
Washer Disinfectors	200	0	0	0	0	0	0	0	0	0
Ronas alterations	50	0	0	0	0	0	0	0	0	0
Replacement Pharmacy Drawer Unit	25	0	0	0	0	0	0	0	0	0
Replacement Pharmacy Fridge	6	0	0	0	0	0	0	0	0	0
Resus reconfiguration	20	0	0	0	0	0	0	0	0	0
Lerwick Health Centre Reconfiguration	50	0	0	0	0	0	0	0	0	0
Renal additional space	50	0	0	0	0	0	0	0	0	0
Labs Clinisys Server replacement	20	0	0	0	0	0	0	0	0	0
Phone system	25	100	0	0	0	0	0	0	0	0
Application Blocking Solution	10	0	0	0	0	0	0	0	0	0
Replacement wireless access infrastructure Phase I	40	0	0	0	0	0	0	0	0	0
Replace Firewalls	20	0	0	0	0	0	0	0	0	0
Storage capacity to support PRSA and GDPR	10	0	0	0	0	0	0	0	0	0
Server capacity to support eHealth applications	20	0	0	0	0	0	0	0	0	0
LIMS Demand Management	17	0	0	0	0	0	0	0	0	0
IT Rolling Replacement	0	100	100	100	100	100	100	100	100	100
Phototherapy	0	25	0	0	0	0	0	0	0	0
Endoscopes	40	40	40	40	40	0	0	0	0	0
Renal Dialysis	0	20	20	20	20	0	0	0	0	0
Ultrasound Scanners	0	0	100	100	100	100	100	0	0	0
Defibrillators (community and GBH)	24	0	0	0	0	0	0	0	0	0
Image Intensifier	0	0	0	0	0	100	0	0	0	0
Ward 3 Monitors	0	0	0	100	0	0	0	0	0	0
Video Endoscope Stack	0	0	0	0	150	0	0	0	0	0

Project	*18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28
Harmonic Scalpel	0	0	0	0	25	0	0	0	0	0
Phacoemulsifier	0	0	0	0	0	0	100	0	0	0
A&E Monitors	0	0	0	0	0	0	0	100	0	0
X-Ray Room 1	0	0	0	0	0	0	0	275	0	0
OCT Scanner	0	0	50	0	0	0	0	0	0	0
Med Equip Rolling Replacement	0	120	120	120	120	120	120	120	120	120
Capital Projects (non-specific)(unallocated)	8	60	50	50	50	50	50	50	50	50
Estates Backlog Maintenance	432	482	517	467	392	527	527	352	727	727
Allocation	1067	997	997	997	997	997	997	997	997	997

Unallocated; Funding required										
Ambulatory Care (allocated in principle)		126	826	412						
X-Ray Room 2 Fluoroscopy				800						
GBH Feasibility							50	50		
CT Scanner (CG Funded £1.2m)						500				
Early Warning - Drugs fridges replacement	5									
Early Warning - OCT Machine	66									
Unallocated Yearly Totals:	71	126	826	1212	0	500	50	50	0	0

SECTION 8: Staff feel supported and engaged

iMatter

During 2017-2018 the implementation plan included all Health and Social Care teams. The organisation achieved 30% of teams with an agreed an action plan.

- 2017 response rate 61%
- 2017 EEI 75
- 2017 dignity at work response rate 33%

Challenges

There have been a number of challenges engaging with staff and teams. 2018-19 will focus on improving organisational leadership and at the Board Development session a number of actions were agreed (as below) and will be monitored via the Staff Governance Action Plan.

We had some concerns on the validity of the Dignity at Work results as staff in multiple roles were sent multiple questionnaires and could not differentiate which role the questionnaire was for. This may also have impacted on the response rate.

Moving forward, our Staff Governance Self Assessment return defined

The aim for 2018-19 is to improve iMatter action planning with 40% completed in the 12 week period after team reports become available. A driver diagram has been agreed with a clear set of actions and these will be progressed through our Staff Governance Action Plan. This includes the Board undertaking its own iMatters process and agreeing to publish and share its action plan.

Key Achievements

- As a result of the action plan put in place the current achievement in action planning is at 54%.
- Excellent engagement with Estates and Facilities. The poster below was shared with the iMatter National Working Group as a showcase of good practice.

Challenges

- Balance between iMatter as a team development tool and a shift to using this as a performance tool.
- 55% of the organisation's staff completed the questionnaire, which can be seen as an achievement. This is below the 60% threshold to activate the organisation's report, although at an organisational level there are no risks around confidentiality issues.
- Issues with access to the system.
- Encouraging all senior teams to share action plans and ensure this is an increasingly transparent process/culture.
- We have not yet had clinical teams who have agreed to share their stories.
- Conversion of the iMatter conversation into action planning.
- Engagement in clinical services/with clinical staff.

Healthy Organisational Culture

Key Achievements

- To support the creation of a Healthy Organisational Culture we have established a Workforce and Wellbeing Group. This includes a mix of APF members and appropriate staff to support the actions of the group.
  The main priorities include:
  1. Communication: work in partnership with EMT members leading on Shaping the Future to enable effective communication using a range of medias.
  2. Development of Management Bundles for managers and developing those identified with potential via succession planning.
- Sickness absence for the year at 3.92%.
- Staff side has agreed to carry out exit interviews with members to gain their views on the process followed following investigations.
- The Estates and Facilities Team was granted NES funding to support Educational Pathways and a sustainable model for development. The project has been running for two years (phase 1 complete and phase 2 underway). This project has had a dramatic cultural effect on the whole team.
- The Estates and Facilities team's willingness to contribute to several work streams associated with the Staff Governance agenda is huge. There is an improvement that has been created around learning, development, communication and staff value has been spread and sustained.

Challenges

- Supporting staff to challenge inappropriate behaviour in real time.
- Ensuring consistent feedback to individuals whose behaviour has been a challenge for others.
- Negative perception from staff of the robustness of managers in dealing with 'poor' behaviour/performance, which cannot always be shared because of confidentiality issues.
- Addressing staff concern about challenging senior clinical colleagues.
- Building momentum in having courageous conversations, particularly at leadership levels.

Sustainable workforce

Key achievements

- North of Scotland Workforce plan produced.
- North of Scotland HR teams progressing on a Regional Shared Services engagement process in partnership with staff side.
- A series of facilitated workshops were held to support Scenario Planning and shape the future for the Board.
- Management Bundles have been rolled out to support existing managers and succession planning. Initial evaluations are positive.
- Staff Development Awards have been successful in supporting the following:

Masters (Year 2) Paediatric Emergency Medicine	£4600
Advanced diploma in counselling children and young people using creative arts	£6050
Masters in Public Health and Health Promotion	£2860
Food as medicine – fertility and pregnancy and introduction to paediatric nutrition units	£842
Level 5 Certificate in Learning and Development (CIPD)	£2996
SVQ Level 3 in Business & Administration	£1462
Level 3 Human Resource Practice (CIPD)	£2465

Challenges

- Ensuring consistent use of service planning templates which makes the development of workforce and training planning less challenging.
- Ensuring that the outcomes from the Scenario planning workshops support future workforce plans.
- Having the necessary clinical and management capacity to support service redesign and workforce planning in a small health and care system.
- Ensuring effective communication of the redesign agenda with staff and the public.
- Needing to improve the way in which we influence key stakeholders (e.g. Scottish Government, external scrutiny and training bodies, politicians) on the issues such as standards, training curriculum and funding that all impact on our ability to provide sustainable services.

Capable workforce

Key Achievements

NHS Education for Scotland (NES) has developed the Turas Appraisal application – Turas means 'journey' in Gaelic – which replaces eKSF as the national electronic application for recording summaries of annual personal development planning and review (PDPR) discussions. Turas Appraisal was launched on Monday 2 April 2018 and is available for all NHSScotland staff and can also support appraisal processes for staff across health and social care and in the wider public sector. Turas Appraisal is available on a range of devices. NHS Education for Scotland has also developed Turas Learn, a learning management system and a platform for learning and support resources. It was Launched in Oct 2018 and currently provides health staff the opportunity to book on and access local learning and learning and support resources produced by NHS Education for Scotland. Teams have been supported locally with digital literacy through a NES programme Digital Matters to improve

skill and will to access and use digital systems.

Turas Learn will also be able to be used by the Shetland Islands Council Staff to allow them access integrated training.

Challenges

- Ensuring effective links between service planning and workforce and training plans to support service redesign.
- Embedding succession planning in ongoing service planning.

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

Integrated workforce

Key achievements

- Joint HR practitioner forum to discuss and support practical on the ground developments.
- Supporting managers who are leading joint teams and reviewing matrix working.

Challenges

- Defining an integrated workforce model.
- Clarity for policy approval.
- Complexity for managers managing staff under different sets of terms and conditions and policy directions.

Effective leadership and management

Focused on developing the skills of key individuals.

Key achievements

- Full complement of Non-Executive Board members (from mid July 2017).
- New Board Chairman appointed (in post from August 2018).

Challenges

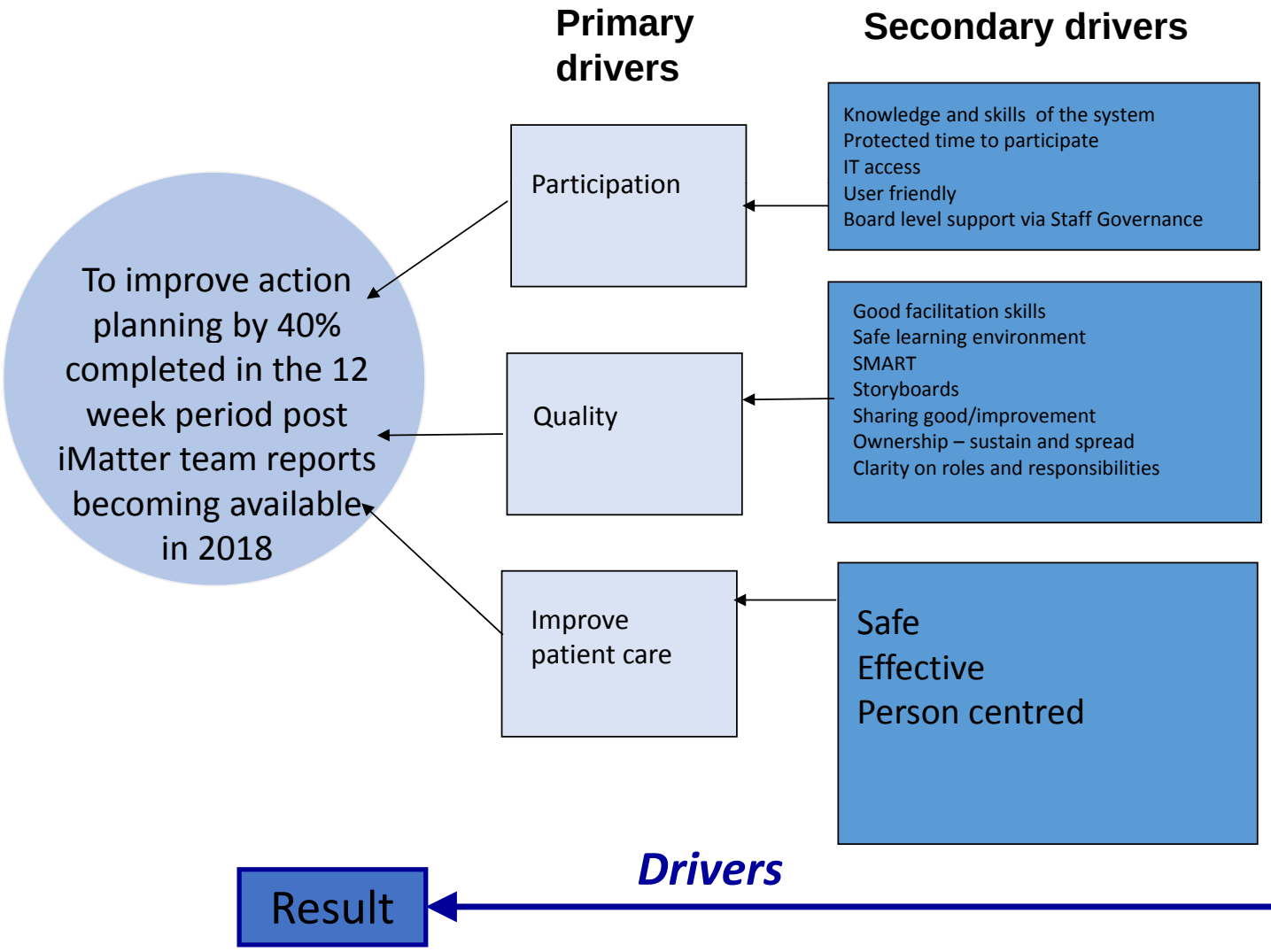
Delays in the development of service planning have impacted on the identification of further staff that would benefit from leadership development.

Local staff governance

The outgoing 2017/18 action plan was signed off by the Area Partnership Forum and the Staff Governance Committee.

- APF, Health and Safety and Staff Governance Terms of Reference reviewed and updated.
- All PINs adopted.
- Audit support on Whistleblowing.
- New Non Exec Whistleblowing champion identified.

IMatter action planning



Change ideas

IT
Invite IT to the huddle
Request single sign on
Move log in icon to the front of the intranet
Ensure all PCs are compliant and system runs smoothly

Leadership
Request the Board discuss iMatter and share their story
Request the Board share their action plan
Request the Board nominate a iMatter champion

Operational
Ensure re reporting happens at every SGC (dashboard)
Include iMatter support sessions in the managers training bundles
Hold an iMatter celebration event
Report on the biweekly huddle

Communication
Include a story in Team Brief every quarter
Advertise the timeline on the intranet banner
Global email outlining YOUR roles and responsibly
Request the COE to send out a communication
Hold a iMatter celebration event at the end of 2018

Other
Formally Engage with E&F team in developing digital literary skills
Formally Engage with E&F team with supporting confidence with Facilitating team meeting and action planning

SECTION 9: People are able to live well at home or in the community

Health and social care integration

The strategic planning function of the IJB has active input from a wide range of stakeholders. The importance of supporting people to remain as independent as possible has been a key focus in 2017-18. There are robust arrangements and escalation plans in place to minimise delays to discharge from hospital, with dedicated social work time allocated to the hospital. As important has been the work to support people to remain independent and at home, avoiding hospital admission. The IJB has developed a strong interest in the contribution of good medicine management, in avoiding unnecessary admission and has been quick to engage in the whole prescribing agenda. There is further work planned with the Scottish Ambulance Service to reduce conveyance to hospital where alternative support can be provided.

The outcomes from shift in resources from the closure of acute hospital beds alongside the creation of an intermediate care team have continued to prove the sustainability of the new service model. The intermediate care team has been a significant part of the plan to respond more quickly and improve outcomes for individuals who otherwise may not have remained at home, or been discharged home after a hospital episode. In 2017-18 the intermediate care team had 98 referrals. Of these 98, 74 (76%) were admitted to the caseload for an intermediate care intervention, 9 (9%) were declined, 8 (8%) were for Falls Assessment, and 7 (7%) had additional support from the intermediate care staffing to enhance an existing care package for a period of time.

Of the 74 individuals who received an intervention:

- 29 of these were to support discharge home from a care home
- 24 of these were early supported discharge from hospital
- 20 of these were as an alternative to admission. Only 2 individuals (2%) were readmitted within 28 days and both of these were as a result of the individuals being medically unwell

To date intermediate placements have been used to support early re-enablement prior to assessing an individual's ability to return home, however, we are looking to invest in 24/7 community based support which will allow more support and assessment to take place in people's homes. To continue to shift the balance of care from hospital to community settings, with a focus on service delivery at home, a number of tests of change have been identified. Local data sets will be developed to capture the extent to which these new and enhanced services will further reduce the demand for avoidable care home and hospital admission. It is recognised that fewer staff are required to sustain higher levels of care at home or alternative day care support, which reflects both the national priorities and also recognition of the challenge of recruiting to the social care workforce.

Specialist clinical pharmacists spend time in each of our health centres helping to ensure that patients receive safe and effective pharmaceutical care and to optimise the efficient use of medicines. A pharmacy technician is also active in providing practical support and training for people and their carers living in their own homes and in community care settings. Regular pharmacy input can be particularly challenging in remote areas. In achieving this, the innovative approach introduced by the pharmacy team has attracted interest from outside Shetland.

Third sector commissioning and partnering arrangements have been strengthened, and a number of third sector organisations are supporting the self care/management agenda. One

example is in conjunction with the Citizens Advice Bureau - we have visiting services from CAB going into every Shetland health centre to enable individuals to get assistance with issues such as debt, relationship and work matters. This enables Primary Care clinicians to signpost patients to third sector services who can help with issues impacting on health.

Following the 2017 vote on the new Scottish GP contract, a Shetland Primary Care Improvement Plan has been developed and is in the process of being implemented. There are challenges in relation to size and scale of service provision in Shetland but the plan gives an opportunity to develop services in line with resources, to support the ongoing work within Primary Care. One particular challenge is the recruitment of pharmacists into new pharmacotherapy services, particularly in remote practices, some of which are dispensing. The added value of pharmacy involvement is being considered alongside the plan.

In 2017-18, three of our practices became salaried, which means we now have 80% of our practices operating as 2c Practices. Recruitment of GPs has been particularly difficult, and although we have had some success, a number of vacancies remain, some of over one year in duration. The long term use of locum GPs is not desirable or affordable. Recruitment has been most successful to our largest practice in Lerwick, which is also a training practice. We have a full complement of trainees currently in place and have two further local GPs undertaking the work required to become a GP trainer – this will enable a second training practice in Shetland. Several of the trainees who have recently completed training have taken up substantive posts in Shetland.

Shetland was selected in 2017-18 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 at least April 2019 and the findings will influence the future of this provision across Scotland. The project is progressing well, and we have developed new referral pathways, to simplify the existing process. This in turn has led to an increased caseload, so additional support worker time is being put in place to the end of March 2019 to ensure patients are seen in a timely manner. This will be reviewed towards the end of the project to ascertain what is required for the future.

Shetland has the best performance in Scotland for the proportion of the last 6 months of life spent at home or in a community setting. There is more that we can do to support further improvement, and we are in the process of refreshing our local palliative care strategy with more of a focus on the contributions that social care and the third sector make to this agenda.

Working with communities

Recognising the need to plan and deliver services which are safe, effective and person-centred, the health and social care partnership has commenced projects with local communities to co-produce services for the future that are sustainable, affordable and professionally acceptable.

Bressay has to date been considered to be a non-doctor island where the only regular access to health care on island has been via a resident nurse. Limited social care support is available for islanders. The Bressay Community Council has jointly sponsored a project with the Partnership to explore how to address the health and care needs of their community for the future. Various engagement methods have been used with the community to explore their needs and it is anticipated that this project will be making recommendations for a new service model by the end of the financial year.

In the North Isles of Yell, Unst and Fetlar a project has been established to look at how we can

best meet the health and care needs of these three island communities where there is an ever increasing ageing population, a decreasing working age population impacting upon local recruitment and a significant challenge to recruit professional staff to live and work in this area. A different service model will be necessary in order to create a sustainable service for the future Work will continue in 2019-20 to progress this project.

Mental Health Services

Improving Adult Mental Health Services

Shetland's Mental Health Strategy (2014-2024) and the National Mental Health Strategy (2017-27) are driving the transformation of adult mental health services in Shetland. After a period of instability in staffing, we now have a permanent Head of Service, Clinical Nurse Manager, and Lead Consultant Psychiatrist.

With a reliance on locums for additional Consultant Psychiatrist capacity, and to cover the out of hours period, the NHS Board has agreed to create a third consultant/medical post, which we are currently trying to recruit to. This will strengthen the team, sustain cover over the 24 hour period, support succession planning and minimise the risk of locum costs. 24/7 cover will minimise the potential of off island transfers (to Cornhill Hospital in Aberdeen) which leads to better outcomes for individuals and their families. We have introduced a new stepped care model in Primary Care. A menu of local and national services is available for referrers to signpost patients to the most appropriate, based on their need. The level of demand for Psychological Therapies continues to rise however. The new model of delivery alongside group work therapy and additional resources is planned for 2018–20.

There is a challenge in providing an appropriate range of on island interventions with the significant diseconomies of scale we experience. We have recognised our gap in psychology and have recruited a Consultant Clinical Psychologist to work with the most complex patients. Our Talking Therapies service works with mild to moderate presentations and this has left an ongoing gap in supporting patients with moderate to complex needs. To address this we have earmarked additional resources from Action 15 of the National Mental Health Strategy to fund new Therapist posts. In addition the Consultant Clinical Psychologist is leading on a training programme for the wider mental health team to enhance skills so that a more interventional approach can be rolled out.

There is a Service Level Agreement in place with NHS Grampian for specialist mental health services, and we are reliant on the Obligate Network model that is crucial when specialist interventions are required, particularly as Shetland does not have an in-patient unit for mental health. There was also a gap identified in providing specialist clinical pharmacy support to the complex medicine regimes for mental health patients on island. These new medicines help to reduce hospital admission. We have now recruited a Specialist Pharmacist in mental health to the Shetland based team.

Mental Health Services for adults in Shetland are supported by a range of partnerships. There is a Mental Health Partnership and a Mental Health Forum. There are connections to a range of related services and initiatives that cover: unpaid carers; domestic abuse; adults with disabilities; the Criminal Justice Service; and substance misuse/addictions.

A formal needs assessment has been undertaken by NHS Shetland's Public Health Department to support the development of these services and this is nearing completion. The additional Scottish Government funding in support of adult Mental Health Services is welcome. There are specific demands and gaps in service which we will be able to address through the additional investment. Due to small numbers and fluctuations in demand it is not

possible in Shetland to have the dedicated array of services to cover both day time and out of hours, especially for crisis support. Our aim is therefore to establish a multi-disciplinary team in each locality, supported by the Mental Health Team based in Lerwick and accessing specialist support through regional service delivery arrangements (predominantly with NHS Grampian through the Obligate Network).

The following gaps in core service have been identified and this is what forms the core of the Action 15 Plan for Shetland:

- Cognitive Behavioural Therapy (CBT)
- Occupational Therapy
- Skill mix that utilises recovery pathways
- Community links

Improving Child and Adolescent Mental Health Services (CAMHS)

Over the last 2-3 years, the CAMHS team worked on developing clearer pathways for access to tier 2, 3 and 4 services which include working with regional teams and clarifying the interface/transitional arrangements between adult and CAMHS services.

Key findings from the evaluative work so far are that there are some specific gaps in:

- Interfaces between specialist services – regional network and specialism's such as Learning Disabilities
- Capacity to provide an acceptable level of access to CAMHS services, particularly psychological therapies
- Skills and skill mix of the team – we are reviewing training requirements across the multi-disciplinary team
- Supporting the provision/awareness of universal services e.g. multi-agency approach providing general advice and support to promote resilience and wellbeing

Throughout 2017-18, 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. This has seen us maintain access at near 100% throughout 2017-18.

Annex 1: Shetland Area Clinical Forum Report (October 2018)

During 2018-19, the Area Clinical Forum (ACF) has continued to work with the aim of maximising the contribution of the ACF to both the work of the NHS Board and the Integration Joint Board (IJB). Over the last year a number of challenges on individuals' time have impacted on attendance at meetings of both the individual Professional Advisory Committees (PACs) as well as on attendance at ACF meetings. However, despite this we are pleased to report that the ACF has held six quorate meetings and two joint sessions with Area Partnership Forum (APF) colleagues over the course of the last year. We are also pleased to report that the Area Dental Committee has become reconstituted during the year and the ACF Chair has also been re-appointed for a further period of two years.

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, e.g. out of hours service and the pharmacy service for the Gilbert Bain Hospital in the out of hours period.

The ACF has also been kept appraised of service developments and issues in relation to clinical services which have faced particular challenges e.g. paediatric services as well as issues within 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.

The joint sessions held with our APF colleagues were in relation to the Regional Delivery Plan and to Shifting the Balance of Care to be more Health Promoting.

Deb Jones, NHS Highland and regional representative and Hazel Sutherland, NHS Shetland Head of Modernisation and Planning, facilitated the Regional Delivery session and members were able to express their concern over the apparent exclusion of social care within the report, bearing in mind the significant change force which is the integration of health and social care. The importance of good communications and the use of technology to support this was also highlighted in terms of staff being able to support the delivery of patient care through a regional pathway.

Following a session held for NHS Board members, ACF and APF members participated in a session on Shifting the Balance to Prevention. This session, led by colleagues from Public Health and Health Improvement, provided an opportunity for clinical staff and those representing staff side to consider our local services and actions taken to date in relation to shifting the balance to prevention, utilising the Health Promoting Health Services framework to consider where we currently are and where we could have a more targeted approach that would support a greater reduction in health inequalities within our communities.

Specific areas of discussion and input by the ACF in the past year have included participation in the review of the development of the Joint Strategic Commissioning Plan, review of the NHS Operational Plan and consideration of a change in a service

delivery model within primary care as a result of recruitment issues leading to an unsustainable service model. Due to changes in key personnel locally, the ACF has not had the opportunity to consider in depth the implementation of Realising Realistic Medicine, however, the new organisational lead for this area of work is a member of the ACF. It is therefore anticipated that we will have a stronger role in supporting the roll out of this ethos amongst professionals across the organisation, ensuring the greatest benefit for local people is agreed, 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 considering the local implementation of the new GP contract and in signing off the Primary Care Implementation Plan prior to submission to the Scottish Government.

Work commenced to revise the ACF Constitution and to review the coverage of Professional Advisory Committees locally and will conclude in this year. It is hoped that this will assist with raising the profile of the Advisory Committees and thus increase the participation in PACS, supporting succession planning for the ACF for the future.

As ACF Chair, I am part of the Transformational Change Programme Board which was established to take forward the programme of change for the organisation. The programme has overseen the hosting of a series of workshops utilising a scenario planning approach, to engage the clinical workforce, key stakeholders and lay reps to help shape the future of local services. It is hoped that the work undertaken through this change programme will help to address some of the workforce issues and create overall sustainability and viability of service provision. The ACF and PACs have volunteered to take forward individual projects to support the delivery of the changes for the organisation.

The work of the ACF for the next 12 months will continue to focus in particular on health and social care integration and the ongoing work of the Transformational Change Programme. We will continue to work with the IJB members on establishing a formal process for them to be able to access professional information and advice via the ACF.

EM Watson
ACF Chair
October 2018

Annex 2: Shetland Area Partnership Forum Report (October 2018)

Staff side supported staff in a number of areas throughout 2017-18:

Communication
We continue to look at ways to improve communication with staff. Unison produces a bulletin update and has agreed to share this on the staff side page. The Employee Director sends a one page email with highlights from meetings.

Integration
The Joint Staff Forum is operational and has a meeting schedule in place.

There is still no joint approval process to support decision making. This has been ongoing for over two years.

Workplace Wellbeing Group
This has been established as a sub group of Area Partnership Forum (APF) and Staff Governance. The main focus is to:

- Improve communication across the Board with regard to changes that impact on staff such as Scenario Planning and Shaping the Future
- Develop management bundles to support managers and staff aspiring to deliver change

Key Achievements

- **Banding:** supporting staff in the Band 1 to Band 2 change.
- **Pay:** moving staff from monthly to weekly pay.
- **NHS 70th:** staff side were involved in helping organise a family day at the Gilbertson Park and disco and both events were well attended.
- **Workforce and Wellbeing Group:** as already highlighted.

Challenges

- **Service Planning:** Our approach to service planning was discussed and agreed at APF and Staff Governance Committee. This was intended to improve the link between service, workforce and financial planning. This approach has not been embedded and this has made it more challenging to progress workforce and training plans and ultimately limited the ability to communicate change and the impact of this to our members.
- **PAIAW:** Payment as at work continues to be an issue for the Terms & Conditions group but the prospective payments started in November 17 and a new formula is currently being worked out for the retrospective payments. Representation has increased this year with a number of reps reporting increased work around supporting staff.

- **Finance:**
  - Staff are concerned that due to the location of Shetland there are high locum costs. It is the associated costs that concern staff side.
  - This includes travel and accommodation which staff side feel is not appropriately funded in any formula including for locums but also for substantive staff who need to travel for meetings and Continuous Professional Development.
  - Safer staffing in a remote area means that you do not have other wards or departments from which to source staff.
  - Many posts are single handed posts. Individuals leaving can be a high risk for the Board.
  - Government funding for new initiatives often does not create a sustainable post for Island Boards (e.g. it is difficult to recruit to 0.4 wte).
  - Lack of affordable housing for incoming staff.

Ian Sandilands
Employee Director
October 2018