Programme

5.15pm  Presentation from Mr Ian Kinniburgh, Chair and Mr Ralph Roberts, Chief Executive on key achievements in 2013/14 and the challenges that lay ahead

5.30pm  Refreshments and informal discussions/feedback

6.00pm  Public question and answer session

*Live on BBC Radio Shetland from 6.10pm prompt*

Members of the public will be able to directly ask questions of the panel which will comprise:

- Ian Kinniburgh, Chair
- Ralph Roberts, Chief Executive
- Simon Bokor-Ingram, Director of Clinical Services / Interim Director of Community Care
- Dr Sarah Taylor, Director of Public Health
- Mrs Kathleen Carolan, Director of Nursing and Acute Services

It is anticipated there will be some questions generated through the local media ahead of the event which will also be responded to in this session. The question and answer session will be broadcast live on BBC Radio Shetland from 6.10pm.
Summary of Progress against key actions from 2013 Annual Review

Following NHS Shetland’s “non-ministerial” Annual Review in 2013 the Cabinet Secretary’s letter captured the key points from the discussion and self-assessment. This included the recognition that NHS Shetland had performed impressively and was making significant progress. It also noted that we were not complacent and there were a number of areas that we recognised we were working to further improve.

The Cabinet Secretary identified the following key actions and we have set out below progress against these.

<table>
<thead>
<tr>
<th>1. Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection</th>
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<tbody>
<tr>
<td>In 2013/14 NHS Shetland (0.33 per 1000 bed days) was close to the national average (0.31) for MSSA/MRSA infection rates Although this was above the target of 0.24. We were below both the national average and target for C. Diff. Infections (at 0.24 per 1000 bed days). However these numbers need to be seen in the context of small number variation and the figures can change significantly from quarter to quarter with just 1 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 2013-14 and two norovirus outbreaks were well managed resulting in no transmission of infections to staff or other patients. The unannounced inspection in November 2013 demonstrated that we were compliant with most procedures and patients all stated that the environment was clean and staff followed key procedures e.g. hand hygiene. We completed the actions in our improvement plan within 16 weeks of the inspection. The results of the inspection were widely reported across the organisation and through standing committees and the Board. 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 infection control committee.</td>
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<tr>
<th>2. Continue to deliver key responsibilities in terms of clinical governance, risk management, quality of care and patient safety</th>
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<td>We have reviewed our arrangements for clinical governance in order to ensure that the operational and quality assurance arrangements are working effectively and reflect the inter-professional working between health and social care teams.</td>
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</table>
A draft, integrated clinical governance framework has been developed along with a professional framework to support safe, effective practice in all care settings. In order to ensure that there is visibility of our performance and compliance with quality measures and care standards, we have developed a quality dashboard. This includes patient safety indicators, local improvement measures and metrics from national improvement programmes (e.g. Early Years Collaborative). The reports are available at all levels of the organisation (from ward to Board) and are used for quality improvement and quality assurance.

In 2014, an announced inspection of our Older Peoples Care in the Hospital was undertaken and the recommendations have been incorporated into the quality dashboard so that progress can be monitored.

QuEST funding has been aligned to improvement programmes to support the redesign of elective pathways (e.g. access to visiting services from NHS Grampian) including projects aligned to the ‘Orthopaedic Quality Drive’ and ‘Transforming Outpatient Pathways’. Resources have also been allocated to drive improvements in dementia and mental health services.

### 3. Continue to work to improve access to dental and other primary care services

Access to GP services across Shetland has had a continued focus during 2013/14. In 2013, the Patient Partnership Forum flagged the issues they believed to be the “top issues” for NHS Shetland. In discussion with the PPF members, they kindly agreed to undertake a piece of work with the Lerwick practice, to explore these patient issues. The questionnaire developed by the PPF was widely distributed and nearly 1000 responses were received. After sifting through the data, PPF developed a report and presentation, which was given to the Board of NHS Shetland in December 2013. The PPF have also developed a series of “Cases for Change” and we have worked with the PPF to develop these into tangible action plans. It was also noted as part of this work that whilst the walk in clinics at Lerwick Health Centre are not universally popular, there has been a month on month decrease of attendances at A&E of primary care patients since these clinics were introduced and efforts will be required to ensure that this trend continues.

Access across practices has been challenging given the level of vacancies within GP practices. Lerwick and the island of Whalsay continue to have vacancies, although there was successful recruitment to the island of Yell in October 2013. That has unfortunately proven to be the exception; Lerwick continues to have recruitment issues, whilst Whalsay has had three rounds of advertising, with no applicants and as a result different models of care are being investigated for both these practices.

The dental service has continued to focus on access and quality, and whilst the waiting list for registration is now at 1000 people waiting, the service has nonetheless continued to work the waiting list down from its historical high. We remain hopeful with the levels of recent interest that independent practice/s will become a feature again in the dental economy, which would increase access and choice.
In line with prescription for excellence, we are improving access arrangements for patients in Shetland who are registered with dispensing doctor’s practices. A locality pharmacist is now linked to the Yell surgery. Additionally patients registered with the Yell and Whalsay dispensing practices now have access to the Chronic Medication Scheme provided by remote community pharmacies.

4. Sustain performance against all HEAT targets and standards

Progress against individual targets is set out elsewhere in the self assessment and our “At a glance” guide.

NHS Shetland believes our overall performance continues to be good although there are some specific targets that have remained challenging (see individual sections).

NHS Shetland Board retains a close oversight of performance with a report submitted to every Board meeting. This report includes HEAT targets, standards and a range of local balancing measures (i.e. quality measures) so that the Board has an overall perspective on performance. For a number of HEAT targets (for example Breastfeeding rates) we measure our performance against a local target that is more challenging than the HEAT target. The performance report rates progress against all Targets with only a 5% tolerance and this ensures all deviation from targets/standards is scrutinised.

As part of the work on H&SC Integration it is expected we will further develop our performance reporting to align this with our Council colleagues and we will also use this to identify whether we can improve the content of our Performance reporting.

5. Continue to engage with the mental health team and sustain improved performance in dementia diagnoses

A review of Shetland Mental Health Services took place during November and December 2013 and was reported in January 2014. A comprehensive Implementation Plan was established. Actions include:

- Recruitment of a second psychiatrist (out to advert)
- Recruitment of additional CPNs (employment offers made)
- Refresh of PEP (work ongoing with stakeholders – est. Nov 2014)
- Development of an “Out of Hours” Service (work ongoing with stakeholders – est. Nov 2014)
- CSI support to CMHT

As of June 2014 the Dementia register stood at 184 which compares with the standard of 173.

Community Nurses continue to use cognitive screening as part of their assessment process for older people if memory issues are suspected. Nursing staff in A & E are also conducting cognitive screening on all people aged 65 plus and referring onwards if dementia is suspected. In addition, our Occupational Therapists are incorporating a
MMSE as part of their Falls Strategy assessments.

The tele-psychiatry memory assessment clinic has gained international recognition and continues to offer a local diagnosis service, negating the need for travel to Aberdeen. The referral rate to this service has shown steady growth since its inception; 31 people in 2010, 47 in 2011, 69 in 2012, 88 in 2013 and 30 in the 4 months to 31st August.

We continue to build upon the Shetland Dementia Partnership which involves statutory and voluntary sector partners, including the Alzheimer Scotland funded post diagnosis dementia advisor and a clinical nurse specialist, supported locally by the Dementia Champion programme developed by NES/SSSC in association with the University of the West of Scotland. We also maintain our strong links with Stirling University’s Dementia Services Development Centre.

6. Continue to work with planning partners on the integration agenda, and to ensure that local staff are fully engaged and involved in this process

We have maintained progress with our Integration project. This is overseen by a Joint Integration Board (NHS Shetland and Shetland Island Council (SIC)) that reports into our Community Health & Care partnership. The CHCP includes staff representatives and we have also regularly reported to our APF and Joint Staff Forum.

In the first 6 months of the year we worked on agreeing with SIC the favoured model for Integration and this was agreed at the July Board and Full Council meetings. In preparing this we ensured all staff were provided the opportunity to be involved and ran staff sessions and set up an Integration Intranet page.

We are now working to deliver a detailed transition plan and this includes appropriate staff engagement in the individual elements of work.

We are working to develop a draft Scheme of Establishment for the local partnership by December 2014 and have developed a Localities project with pilots in 2 localities.

7. Continue to achieve financial in-year and recurring balance, and keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme

NHS Shetland delivered all its key financial targets in 2013/14 (see separate section). This included a small revenue underspend as agreed with the Finance team at the SGH&SCD.

Within this the Board delivered all its required savings although further progress is required to deliver recurrent savings (for further detail see separate section).

Progress was regularly reported to the SGH&SCD through the standard reporting mechanisms and fully discussed at our Mid Year review.
At a Glance Outcomes

- Patients beginning treatment within 18 weeks of referral consistently above 94% over the past year.
- Seven MRSA/MSSA infections and three C. Diff infections for the year – missing our SAB target and meeting our C Diff target.
- Overall Healthcare Experience - 82.0 rating of overall experience from people using the NHS which is above the Scottish average.

- Smoking rate is 17.0% which is the lowest level in Scotland and 6% lower than the national average.
- 45.8% increase in alcohol related hospital admissions since 2003-04.

- 73.8% of people with complex care needs are cared for at home. Highest percentage in Scotland.
- Consistently achieving over 98% of people being seen in A&E in 4 hours or less.
Emergency admission rate has remained steady and consistently lower than the national rate.

Quarterly Hospital Standardised Mortality Ratios have not changed significantly over recent years.

58.8% reduction in CHD mortality in under 75s since 2000.

No significant trend in Cancer mortality in under 75s, but has recently returned below the Scottish rate.

79.7% reduction in Stroke mortality in under 75s since 2000.

Recent drop in percentage of time spent at home or in a community setting during last 6 months of life. Lowest percentage in Scotland.

Key: ↑ Improving trend or performing well  ■ No change/trend  ↓ Worsening trend or not performing well
# NHS Shetland Annual Review 2014
## At a Glance HEAT 2013/14 Target Performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance</th>
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<tbody>
<tr>
<td>The number of <strong>Child Healthy Weight interventions</strong> delivered reached 72 by the end of March 2014, which <strong>met our final target</strong>.</td>
<td><strong>G</strong></td>
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<tr>
<td>Within <strong>smoking cessation services</strong>, at the end of March 2014 we had helped 127 people to successfully quit at 4 weeks. This is <strong>met our final target</strong> of 104.</td>
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<td><strong>40.0%</strong> of pregnant women in each SIMD quintile have booked for antenatal care by the 12th week of gestation. This is behind trajectory but the low figure is due to issues with our data which are being addressed. (Note: Oct – Dec 12 data.)</td>
<td><strong>R</strong></td>
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<td>The <strong>suicide rate</strong> in Shetland was 21.55 per 100,000 population in 2013. This is just <strong>missed the target of 20.7</strong>, though the rate does vary above and below the target due to the small numbers involved.</td>
<td><strong>A</strong></td>
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<td>At the end of December 2013, <strong>71.83%</strong> of 3 and 4 year olds in worst performing SIMD quintile had received <strong>2 fluoride varnish applications</strong>. This is <strong>well ahead</strong> our target of 60%.</td>
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<td><strong>Carbon emissions</strong> were at <strong>430.3 tonnes</strong> for the period April 2013 to March 2014 meeting the target for the year.</td>
<td><strong>G</strong></td>
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<tr>
<td><strong>Energy consumption</strong> was at <strong>13729.4 GJ</strong> for the period April 2013 to March 2014 meeting the target for the year.</td>
<td><strong>G</strong></td>
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<td>At the end of December 2013, <strong>16.4%</strong> of people were <strong>diagnosed and treated in the first stage of breast, colorectal and lung cancer</strong>. This was <strong>behind</strong> our trajectory of 22.9%.</td>
<td><strong>R</strong></td>
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<td>At the end of March 2014, <strong>88.2%</strong> of patients waited less than 18 weeks from referral to treatment for specialist <strong>Child and Adolescent Mental Health Services (CAMHS) services</strong>, just missing the year end target. (Note: national HEAT data)</td>
<td><strong>A</strong></td>
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<tr>
<td>At the end of March 2014, <strong>60.0%</strong> of patients waited less than 18 weeks from referral to treatment for <strong>Psychological Therapies</strong>, missing the target of 90%. (Note: national HEAT data)</td>
<td><strong>R</strong></td>
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<td>At the end of March 2014, we had seven <strong>Staphylococcus aureus bacteraemia (including MRSA) infections</strong> in the previous year, which gave us a rate of 0.33 cases per 1000 acute occupied bed days. This <strong>missed</strong> our target of 0.20.</td>
<td><strong>R</strong></td>
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- At the end of March 2014, we had three **C Diff infections** in the previous year, which gave us a rate of **0.28** cases per 1000 total occupied bed days. This **met** our target of 0.32.

- **The rate of attendance at A&E** was **2846** in March 2014. This **meets** our target of 2977 due by that date.

- At the end of February 2014, the **emergency inpatient bed day rate** for people aged 75 and over was **3711**. This is **ahead of** our trajectory of 3920 bed days per 1,000 population aged 75+.

- In April 2014 **no patients waited more than 14 days to be discharged from hospital** into a more appropriate care setting, once treatment was complete, meeting the target.

- All people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan – no national data available yet.

- Eligible patients will commence IVF treatment within 12 months by 31 March 2015 – no national data available yet.

**Key:**

<table>
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<th>B</th>
<th>Well ahead of trajectory or met early</th>
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<tbody>
<tr>
<td>R</td>
<td>Not meeting and not within trajectory limit</td>
</tr>
<tr>
<td>A</td>
<td>Not meeting but within trajectory limit</td>
</tr>
<tr>
<td>G</td>
<td>Meeting or better than trajectory</td>
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AGENDA 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 2013/14

Suicide
Suicide remains a challenge in Shetland, with a rate of 30/100,000 population at March 2014 against a target of 20. This is well above the national average, though local numbers are small. In 2013/14 this was due to seven people completing suicide or dying of undetermined intent. 6 of these deaths were males, continuing the worrying trend of young to middle-aged men who complete suicide in Shetland. We have revised and published our Choose Life Action Plan in light of this analysis, with immediate implementation. Recent suicide planning events have identified eight local outcomes (for instance targeted work with high risk groups) to reduce suicide in Shetland with agreed multi-agency actions.

Keep Well
The target of 250 Keep Well checks was massively exceeded with 443 achieved. The Keep Well programme locally is the core of our health improvement work on tackling inequalities, linking into the Healthy Working Lives programme, targeting particularly men who do not access mainstream general practice or other preventative programmes, and extending beyond CHD risk factors to local priorities such as alcohol misuse and mental health (suicide prevention). The programme is also now linking into localities work in Shetland to develop sustainable community responses to unmet need.

Alcohol Brief Interventions
The local programme of delivering Alcohol Brief Interventions exceeded the target of 240 with 433 achieved by the year end. This very successful programme has engaged hospital staff as part of the Health Promoting Health Services programme, as well as being delivered in general practice and community settings, and is seen as being a key part of local culture change on the misuse of alcohol in Shetland (the local Drink Better initiative).

Progress in reducing health inequalities and early years outcomes

Reducing Health Inequalities
Progress on reducing health inequalities is being achieved through the Keep Well programme and a focus on workplaces where employees are lower paid, predominantly men who do mainly manual work as employment rates in Shetland are high. NHS Shetland is a key partner in the Shetland anti-poverty programme (through the Fairer Shetland Partnership), with health inequalities as the priority topic from the Single Outcome Agreement included in the Board’s Local Delivery Plan. Work continues to understand and mitigate the adverse impacts of welfare reform, training staff and raising awareness across the Shetland community. In addition, the local project on Health Inequalities for people with Learning Disabilities has completed a local Support Needs Survey and is developing a toolbox of resources and training for staff to use with patients with communication difficulties.

We recognise the role that early booking in pregnancy has in potentially reducing health inequalities. Local figures suggest that the rate in Shetland is 85%, so although this would meet the target, there are still 15% of women who are not booked by 12 weeks. Occasionally this may be due to pregnancy not being recognised early, but it is also important to identify if there are issues about equality of access: women who are more disadvantaged due to poverty, mental health issues, language or literacy problems for example may be less aware of the need to access early antenatal care, or less able to access it. Current work is focusing on the
remaining 15% to ensure that these women are able to access antenatal care at an early stage in order to maximise their health during pregnancy and to give their babies the best possible start in life.

**Early Years**  
The Early Years Collaborative in Shetland continues with four projects delivering in the first year: antenatal education for vulnerable women and their partners, transport (how we enable more excluded children to access mainstream activities), parenting support for Dads, and access to information. Outcomes from all four were reported in 2013/14 and the Collaborative is now a key strand within the local Children’s Plan. Other local priorities include the implementation of Getting it Right for Every Child, delivery of the multi-agency Parenting Strategy, and a commitment to refresh the local Child Health Strategy during 2014/15.

<table>
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<tr>
<th>Performance against child healthy weight interventions, smoking cessation and drug and alcohol waiting times targets</th>
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| **Child Healthy Weight**  
The target to achieve 70 child healthy weight interventions over the three years from 2011-14 was exceeded with 72 achieved. The local programme continues in schools and nurseries, and with one-to-one support for children and families. |
| **Smoking Cessation**  
The local target of 104 quits in the most deprived areas of Shetland by the end of March 2014 was exceeded with 125 successful quits. We continue to deliver very successful smoking cessation activities through both the local specialist health improvement team and with staff working in a range of settings. |
| **Drug and Alcohol Waiting Times target**  
Shetland has maintained a 100% achievement throughout 13/14. The recent redesign of the Substance Misuse Service was undertaken to ensure sustainability, focus on recovery and cost effectiveness. |

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<thead>
<tr>
<th>Performance against the waiting times standard and early diagnosis and treatment targets under the Detect Cancer Early campaign</th>
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<tr>
<td>We have a Detect Cancer Early implementation team including the Director of Nursing &amp; Acute Services (Executive Lead for Detect Cancer Early Programme for NHS Shetland), the Medical Director, a Consultant in Public Health Medicine and Cancer Audit Officer, which is working with the Cancer Lead Team and other established mechanisms to implement this programme.</td>
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<tr>
<td>We have continued to promote national awareness raising campaigns with publicity materials widely distributed across Shetland with the aim of reaching all communities, especially the most remote and rural, and ensuring that the materials were available in a variety of settings including local rural shops and post offices, leisure centres and public halls.</td>
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<tr>
<td>In 2013, we worked closely with UCAN and Prostate UK to promote urology and prostate cancer awareness and provide additional training for GPs to support the detect cancer early programme.</td>
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<tr>
<td>We have also worked closely with community pharmacists and other community based practitioners to identify people with potential cancer trigger symptoms who are using these services e.g. following medications reviews.</td>
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We have had consistently good uptake rates for all three cancer screening programmes, generally the best uptakes in Scotland.

The figures for Detect Cancer Early take into account both the effectiveness of the screening programme and the number of people who present with early symptoms, but the statistics are influenced by small number variations. Bowel cancer screening uptake rates in Shetland increase each year and have consistently been the highest in Scotland (the most recent published figures show an uptake of 65.8% for Shetland and 56.1% for Scotland overall). With bowel cancer, it is possible that, because we have high screening uptake, a number of early cancers were picked up in the first few years of screening and so the ones that are diagnosed now tend to be more advanced, probably amongst people who have not been screened.

Similarly for breast screening, we have the highest rates along with Orkney. (The most recent published figures show an uptake of 86.0% for Shetland and 73.5% for Scotland overall). Because the breast screening is only carried out every three years in Shetland, uptake figures are averaged out over a three year rolling period so they can be compared with the rest of Scotland. The Detect Cancer Early figures are for two year periods, and so breast screening is included in some but not all the sets of figures.

Challenges

There are challenges in Shetland meeting the DCE HEAT target. These include:

- Data capture of stage of cancer at treatment to measure improvement of early detection. We are reliant on NHS Grampian for much of this and are working with them to ensure that their implementation meets our need.
- We already have among the highest, if not the highest, uptake in both breast and bowel screening programmes which leaves little room for improvement in the areas likely to provide the most stage 1 cancers.
- Our GP referral rates are amongst the highest in Scotland, so low GP referrals does not seem to be a specific issue.
- There are no capacity issues for diagnostics and even if there were, one or two weeks is unlikely to make any difference to the stage of the cancer, particularly if the patient has waited two years before going to their GP.
- There is no screening tool available for lung cancer at present and as things stand over 50% of Shetland lung cancers are presenting with stage 4 disease and it is difficult to see how we could improve this. Using the presence of a cough for a certain number of weeks to identify patients for further investigation such as a CT scan would be very difficult to justify, especially in winter. Another option would be to target smokers with a cough, but there is concern about stigmatising smokers.
AGENDA ITEM 3:

Healthcare is safe for every person, every time

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

In terms of Board assurance, there are a number of 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 Single Shared Outcome agreement, 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 Governance Committee (CGC) and the Strategy and Redesign Committee. The committees have a remit for ensuring that there is appropriate scrutiny of performance measures and patient outcomes and local policy development. This also includes the review of service provision, delivery and quality where we have shared services with other providers e.g. Scottish Ambulance Service, NHS 24 and NHS Grampian. The standing committees receive reports on specific topics such as risk management and incident reporting, corporate risks, complaints, adverse events and investigations as well as our locally developed service improvement and audit score card. This sets out the quality improvement work which is being taken forward across the organisation which is mapped to specific headings such as patient experience, safe, effective etc.

A revised Adverse Event Investigation policy was approved by the Board in May 2014 noting that the national framework is evolving rapidly and that it will be necessary to revise the policy again later in 2014 in the light of national changes.

The Board has agreed a draft joint governance framework to include social care within integrated services. The Medical Director, Director of Nursing and the Chief Social Work Officer will act in partnership to provide professional leadership for governance.

Pathway development is managed through clinical networks, the Acute Services Management Team, the CHCP Management Team and specific groups such as the Admissions and Discharges Group and the Commissioning Group. 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 CGC and/or the CHCP committee depending on the topic. For example, service developments which are aligned to the Change Fund and may well include projects/services which are being delivered by a number of partner organisations e.g. Mental Health are now reported to the Joint CHCP and Social Services Committee.

At an operational level, results of audits (e.g. falls, pressure care, food/fluid and nutrition), patient feedback surveys and patient safety interventions such as SSKIN, HAI and nutritional audits are discussed at regular meetings with Senior Charge Nurses, Heads of Departments and team leaders and are also reviewed through the Clinical 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.
In the last year we have restructured our operational meeting for Clinical Governance to provide this with increased focus and support for the Clinical Governance Committee. This will also support the ongoing development of our draft framework for Clinical Governance in Integrated services.

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

We also have active professional committees which take a lead quality assurance role as part of our clinical governance arrangements, in particular the Area Clinical Forum has ‘quality’ as a standing item and has commented extensively on local clinical matters in 2013-14.

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

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

In 2013/14 NHS Shetland’s MSSA/MRSA infection rates (0.33 per 1000 bed days) were close to the national average (0.31) although this was above the target of 0.24. We were below both the national average and target for C. Diff. infections (at 0.24 per 1000 bed days). However these numbers need to be seen in the context of small number variation and the figures can change significantly from quarter to quarter with just one event.

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 2013-14 and two norovirus outbreaks were well managed resulting in no transmission of infections to staff or other patients. We have not needed to instigate outbreak management protocols in 2014 but we have undertaken tabletop exercises so that staff remain familiar with procedures and policy changes.

The unannounced HAI inspection in November 2013 demonstrated that we were compliant with most procedures and patients all stated that the environment was clean and staff followed key procedures e.g. hand hygiene. We completed the actions in our improvement plan within 16 weeks of the inspection. The results of the inspection were widely reported across the organisation and through standing committees and the Board. 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 infection control committee.

We have continued to roll out local surveillance, prevention and management strategies.

In terms of the organisational patient safety agenda, NHS Shetland participates in all of the national programmes and has shown good compliance with the implementation of patient safety interventions and patient outcomes (e.g. low Clostridium Difficile Infection and Staphylococcus aureus bacteraemia infection rates, low surgical site infection rates, high days
between pressure sore development etc).

NHS Shetland is using patient safety methodology to undertake improvement work in primary care, mental health, healthcare associated infections, older peoples care, learning from adverse events/significant case reviews, and participating in a number of the national improvement collaboratives.

We have also undertaken a local review of data presented in the hospital scorecard and Hospital Standardised Mortality Ratios (HSMR) data. NHS Shetland HSMR has been within the expected limits and the review of all inpatient deaths forms part of our local governance arrangements. In addition to this, we have also reviewed our procedures for managing adverse events and we are in the process of ensuring that our policy is in line with the recently published national framework.

Departmental level governance groups have been in place for a number of years where multidisciplinary clinical teams review compliments/complaints, adverse events, in hospital deaths and care standards every two weeks. The meeting is a shared governance arrangement with senior managers present periodically, to discuss cross cutting issues and provide corporate support to address challenges. Recommendations arising from prominent reports e.g. Healthcare Improvement Scotland (HIS) national inspections, Keogh and Francis reports have been discussed at all levels of the organisation, particularly in relation to our own priorities for governance and safety.

The key challenges for us are the breadth of improvement work, which is supported and implemented by small clinical teams and how to ensure that we focus on interventions which are evidence based and improve patient outcomes. In order to set priorities for patient safety locally, we have undertaken a ‘stock take’ exercise to review all of the improvement data which is being collected by clinical teams.

Our current priorities are to:
- Implement the patient safety index;
- Continue to participate in the national improvement agenda through collaborative programmes;
- Focus on interventions which improve patient outcomes associated with the older peoples care, early years and mental health programmes;
- Promote a culture of ‘delivering safe care at all times’.

Three members of staff completed a local leadership fellowship programme in 2013-14 and they are continuing to spread their knowledge across the organisation and are leading specific redesign projects, focussed on delivering person centred pathways (which are safe and efficient).

We are using the QuEST funding to build improvement knowledge and capacity to support the quality, safety and service improvement priorities and working with NHS Grampian on shared pathway design where it is feasible to do so.
AGENDA ITEM 4:

Everyone has a positive experience of healthcare

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<tr>
<td>• Performance against access targets has been challenging. We are working with local and visiting teams to deliver Stage of Treatment and Treatment Time Guarantee performance.</td>
</tr>
<tr>
<td>• Whilst the walk in clinics at Lerwick Health Centre (our largest practice with 9,200 registered patients) are not universally popular, there has been a month on month decrease of attendances at A&amp;E of primary care patients since these clinics were introduced and efforts will be required to ensure that this continues. All practices are sustaining same day access for urgent need.</td>
</tr>
<tr>
<td>• We continue to expand self referral into services, and Allied Health Profession services have focused on this over the last year.</td>
</tr>
<tr>
<td>• We have a system being piloted where patients attending community pharmacies in Lerwick can have an appointment arranged the same day in the Lerwick Health Centre by the consulting pharmacist. This is reducing workload for GPs and also providing the right intervention for patients, many of whom can be treated for a minor ailment by the pharmacist, and those who cannot have a speedy referral process, still receiving their treatment on the same day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance in relation to waiting time targets and the legal treatment time guarantee</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have achieved delivery of the 18 Week Referral to Treatment Standard over the last twelve months, with the exception of June 2013 when we were experiencing significant pressures in a number of visiting specialties.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18 Week RTT Performance figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS board of treatment</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Mar-13</td>
</tr>
<tr>
<td>Apr-13</td>
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<tr>
<td>May-13</td>
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<tr>
<td>Jun-13</td>
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<td>Jul-13</td>
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<tr>
<td>Feb-14</td>
</tr>
<tr>
<td>Mar-14</td>
</tr>
</tbody>
</table>

Outpatient performance has also been challenging with some breaches throughout the year. Again, this is indicative of the pressures within the visiting services. Local services have been delivered within the target.
Information taken from the data warehouse census

12 Weeks (outpatients)

<table>
<thead>
<tr>
<th>Date / NHS board of treatment</th>
<th>Shetland</th>
</tr>
</thead>
<tbody>
<tr>
<td>31-Mar-13</td>
<td>76</td>
</tr>
<tr>
<td>30-Jun-13</td>
<td>38</td>
</tr>
<tr>
<td>30-Sep-13</td>
<td>33</td>
</tr>
<tr>
<td>31-Dec-13</td>
<td>20</td>
</tr>
<tr>
<td>31-Jan-14</td>
<td>20</td>
</tr>
<tr>
<td>28-Feb-14</td>
<td>25</td>
</tr>
<tr>
<td>31-Mar-14</td>
<td>38</td>
</tr>
</tbody>
</table>

There has been a considerable amount of work to support and understand this performance in both Stage of Treatment standards, both locally and in partnership with NHS Grampian. Capacity remains a pressure in some key specialties and solutions are actively being sought, including close liaison with special Health Boards and national services. Although the numbers involved are relatively small there is no room for complacency and these targets, and potential solutions for the pressures, remain under close local scrutiny.

Treatment Time Guarantee

We have maintained good performance around this guarantee, with one patient breaching the TTG guarantee in 2013-14.

<table>
<thead>
<tr>
<th>Date</th>
<th>Completed waits for patients seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-13</td>
<td>-</td>
</tr>
<tr>
<td>May-13</td>
<td>-</td>
</tr>
<tr>
<td>Jun-13</td>
<td>-</td>
</tr>
<tr>
<td>Jul-13</td>
<td>1</td>
</tr>
<tr>
<td>Aug-13</td>
<td>-</td>
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<tr>
<td>Sep-13</td>
<td>-</td>
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<tr>
<td>Oct-13</td>
<td>-</td>
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<td>Nov-13</td>
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<td>Dec-13</td>
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<td>Jan-14</td>
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<tr>
<td>Feb-14</td>
<td>-</td>
</tr>
<tr>
<td>Mar-14</td>
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</tr>
</tbody>
</table>

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 met the 98% target consistently and 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 LUCAP.

Although the number of patients attending A&E has fallen slightly, we have a higher conversion
rate of patients requiring hospital admission and higher inpatient bed utilisation. Whilst it is not reflected in our A&E performance, there is greater pressure on the overall hospital system, including activity which is supporting the international energy industry presence in Shetland.

<table>
<thead>
<tr>
<th>Date</th>
<th>Shetland</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-13</td>
<td>99.5%</td>
<td>91.6%</td>
</tr>
<tr>
<td>May-13</td>
<td>97.7%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Jun-13</td>
<td>99.1%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Jul-13</td>
<td>99.7%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Aug-13</td>
<td>99.2%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Sep-13</td>
<td>98.4%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Oct-13</td>
<td>99.1%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Nov-13</td>
<td>99.3%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Dec-13</td>
<td>98.4%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Jan-14</td>
<td>97.7%</td>
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</tr>
<tr>
<td>Feb-14</td>
<td>96.8%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>98.7%</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

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.

Approach to person centred care and patient experience

In respect of our local arrangements for Patient Focus Public Involvement (PFPI), we have an active Public Participation Forum (PPF) which meets every six weeks to discuss health and wellbeing related topics and provide advice/feedback on proposed service change and/or development. The PPF has an established lay representative Chair (where it was previously co-ordinated by NHS staff) who has led a major project to review service user opinions regarding access to primary care services in the Lerwick area.

We have also worked with the PPF and local Community Councils to engage the local community in discussions about health and social care services, including topics such as integration, older people’s care, dementia care, transport options and palliative care strategy development.

Our PFPI Steering Group is chaired by a Non Executive Director and reports to the Board. The development of strategies to gather patient experience and patient satisfaction feedback has been discussed at Board level as well as with clinical teams and ACF and a local framework is under development to bring various strands of work together (e.g. utilising feedback from complaints, Patient Opinion, local and national surveys, person centred health and care collaborative).

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 are successfully completed the Investors in Volunteering award (revalidation) in 2013 and we are continuing to roll out our local improvement plans.
As part of our person centred approach, we have developed a local framework describing how we use patient feedback to drive quality improvements. This includes implementing systems which improve the quality of patient care and care experiences (e.g. safety bundles, comfort rounds, Must Do With Me information gathering, patient stories etc).

We have also developed a professional framework 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.

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). 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.
AGENDA ITEM 5:
Best use is made of available resources

### Financial balance and efficiency savings

**Main Achievements in 2013-14**
- Revenue under spend £88k, equivalent to 0.16% under spend upon the RRL.
- Capital expenditure £1,339k, resulting in an under spend of £2k on CRL
- Delivered recurring Efficient Government savings of £1,274k (local plan at start of year of £2,234k)
- Delivered non recurring Efficient Government savings of £1,382k (local plan at start of year of £325k)

Work on best value characteristics included:

During 2013/14 we continued to update and refine our more formal Best Value framework in order to assure ourselves that we were demonstrating the required characteristics – this was based on the framework developed by NHS Fife and adapted locally. 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

<table>
<thead>
<tr>
<th>Characteristic (Sub-Characteristic)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sound Governance (Performance)</td>
<td>Continued improvement in the performance reporting to the Board</td>
</tr>
<tr>
<td>Accountability</td>
<td>Patient focus public involvement, seeking feedback and using both local radio and newspapers to engage with local community</td>
</tr>
<tr>
<td>Sound Management of Resources (Risk Mgt/Assets/Procurement)</td>
<td>Significant work on procurement through implementation and rollout of PECOS to deliver value for money maximised from national and local procurement hubs</td>
</tr>
<tr>
<td>Use and Review of Options Appraisal</td>
<td>Establishment of projects groups under the Efficiency and Redesign Project which includes a review of the acute hospital to predict and reflect in planning the changing circumstances</td>
</tr>
<tr>
<td>Contribution to Sustainable Development</td>
<td>Various measures to reduce energy consumption</td>
</tr>
<tr>
<td>Equal Opportunities Working</td>
<td>Equality Annual Report approved by Board</td>
</tr>
<tr>
<td>Joint Working (Planning)</td>
<td>Partnership working through the change fund initiative and other projects with Shetland Island Council.</td>
</tr>
</tbody>
</table>
Main Challenges

- Challenging savings target for 2013/14 – while there was slippage on initial savings schemes these were covered by the use of reserves/under spends on expenditure budgets.
- Requirement, in addition to “efficient Government savings target (3%), to reduce underlying deficit (currently £625k) over the course of 14/15; now planning to bring back into recurrent balance in phased way by 2016/17.
- Maintaining progress and momentum on delivery of recurring savings to address underlying deficit and achieve annual 3% target (currently assumed to continue year on year which from 2015-16). This will be around £1,200k each year.

Target Savings Profile 2014-2019

<table>
<thead>
<tr>
<th>Shetland Health Board New Savings Targets 2014-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
</tr>
<tr>
<td>39,650</td>
</tr>
<tr>
<td>New Savings Target</td>
</tr>
<tr>
<td>-1,170</td>
</tr>
<tr>
<td>Target as a Percentage</td>
</tr>
<tr>
<td>3.0%</td>
</tr>
</tbody>
</table>

- Removing reliance on non-recurrent additional allocation for Primary Care medical services whilst still supporting remote and rural single handed practices that have to provide 24/7 service throughout the year. The current national funding model is unable to reflect the true underlying cost of this requirement. Recruitment difficulties to practices cause high unavoidable locum costs to maintain essential services, (£450k in 2013-14.)

- 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. 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 board’s formal CO2 target this will also reduce the carbon footprint of patient journeys.

- Managing potential issues with the Highland and Island travel scheme. Incurring some cost pressures out with the Board’s control e.g. SERCO decision to reduce discount from 25% to 10% for Senior Citizens will increase costs by around £50k on the life line ferry service to Aberdeen and change to ADP charge on flights back to Shetland. Also due to NHS Grampian Orthopaedics waiting list issues there will be an increase in flights to Glasgow.

- Progressing the development of a new Health Centre for Scalloway jointly with Shetland Islands Council the tender process completed during 2013-14 with project completion date scheduled for May 2015.

- Maintaining recent good progress in managing a variety of estates, medical equipment and IT issues (including backlog maintenance and repairs) within the current challenging Capital position.

- Outline five year plan for Capital investment agreed.
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>IT Projects</td>
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<td>100</td>
<td>100</td>
<td>400</td>
<td>100</td>
</tr>
<tr>
<td>Medical Equipment</td>
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<td>200</td>
<td>150</td>
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<tr>
<td>Projects</td>
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<tr>
<td>Capital Projects</td>
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<td>500</td>
<td>100</td>
<td>100</td>
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<tr>
<td>Projects</td>
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<td></td>
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<tr>
<td>Backlog Projects</td>
<td>350</td>
<td>300</td>
<td>250</td>
<td>400</td>
<td>700</td>
</tr>
<tr>
<td>Projects</td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>1050</td>
<td>1050</td>
<td>1050</td>
<td>1050</td>
<td>1050</td>
</tr>
</tbody>
</table>

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

**Main Achievements**
- Delivered agreed Capital Plan of £1.34m including £0.5m to upgrade Infrastructure (i.e. flat roofs improvements, replacement steam pipes); £0.47m on minor capital schemes (including the relocation of Board headquarters to reduce the ongoing property costs for the Board/HQ costs); £0.27m for Equipment replacement/upgrades (i.e. ultrasound scanner, day surgery trolleys) and £0.16m for IT projects
- Finalise schemes and the opening of the new clinic facilities in Fair Isle and Foula.
- Maintain investment in sustainable development including further work to improve energy efficient lighting.
- Agreement with Shetland Island Council a £2m scheme (via a Capital Grant) to relocate Scalloway GP Practice and community services within the Scalloway school campus. Project commenced on site in 2014 completion due by Summer 2015.
- Outline 5 year Capital Plan approved.

**Main Challenges**
- Difficult to support scale of change required to deliver Clinical Strategy and financial plan within a limited capital budget (as part of a small health system).
- Balancing need to maintain investment in Backlog Maintenance and Infrastructure upgrades while also supporting Redesign priorities from our Clinical Strategy and financial plan.
- Finalise affordable scheme for the redevelopment of theatre and day surgery to be progressed in 2015/16 and 2016/17.
AGENDA ITEM 6:
Staff feel supported and engaged

Progress made in staff engagement and development

Key Achievements

- Staff Governance and the role of Area Partnership Forum is part of the Corporate Induction training programme so that all new staff in the organisation understand both the organisational responsibilities and their own role in supporting the Staff Governance Standards. At this session staff are made aware of the 2020 Workforce Vision “Everyone Matters” and our actions and progress against this. Staff are actively encouraged to participate in all consultation and engagement mechanisms. The sessions are delivered jointly by the Employee Director and the Director of Human Resources and Support Services.
- Revamped Teambrief (Organisational Newsletter)
- Staff sessions and workshops to improve understanding and engagement have been held for each of the service redesign topics. Clinicians have been engaged in the redesigns.
- The CHCP Agreement has been updated in partnership – Section 8 (the HR section) stipulates that the way that we jointly conduct our business with staff follows the principles of the NHS Staff Governance Standard. This has been approved and adopted by the Joint Staff Forum (NHS and local Council integrated partnership group)
- Adoption of the Respect Charter and communications work with teams around this, both in defining the Charter and in its implementation.

Challenges

- A key challenge remains around consistent clinical engagement in service delivery planning – this has been a key focus over the year and it has improved. It is hoped that this will be strengthened as part of the restructure within the acute setting and the creation of a Deputy Medical Director post.

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

Achievements

- Implemented the revamped Bullying and Harassment Policy and Action plan
- Carried out a number of awareness raising sessions which included developing a team meeting discussion paper and offered this to all teams to enable discussion and engagement
- Received feedback from teams around Bullying and Harassment to enable a deep dive understanding of perception of staff
- Specific bespoke interventions in place for some teams who have identified themselves or been identified as needing support
- Staff provided specific and detailed examples of where/whom and impact of Bullying and Harassment in the workplace
- Created a number of stories from these examples
- SMT personnel have reviewed their own behaviours in relation to staff perceptions and are working on their development programme
• Working with managers around understanding their styles and stressors and the differences between firm and fair management practices and bullying/harassment behaviours

Challenges
• Engaging with senior clinicians around their behaviour and its impact on staff
• Building momentum in having courageous conversations
• Leading by example in a consistent way around how we deal with bad behaviour organisationally
• Organisationally deciding what to do with the ‘in confidence’ conversation where information becomes known but the individual doesn’t want to progress

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

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

Challenges
• Enabling managers to think of what roles are needed and how to do this differently and to look at emerging service delivery models and how to create career structures and sustainability.
• Reviewing AfC grades across the organisation to ensure a specific standard at each level.
• Promoting attendance and delivery against the HEAT standard – supporting staff with chronic illness.

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
• Introduced and rolled out values-based recruitment – this supports our cultural shift programme.
• Developing key staff and delivering 150 training courses with 4159 training attendances.
• Becoming an ALS (Advanced Life Support) accredited centre.
• Continued support for staff development awards linked to service delivery e.g. a CT Radiographer was awarded £2,760 to undertake a Postgraduate certificate in computed tomography.
Challenges

- % completion rates on eKSF – whilst we understand that conversations are taking place this is not evidenced via the process in place.
- 65% of staff have attended Mandatory Refresher against a target of 100% across a 3-year period.

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

Achievements

- Number of joint managers in post
- Health and Social Care staff co-habit the one office building (Montfield Board HQ)
- Developed joint HR plan to support the integration and the move to Body Corporate

Challenges

- Resourcing the joint HR plan
- Defining a model that will work locally for workforce planning, succession planning, career mapping, redeployment and secondments – when NHS clearly defined policy structure and Council more flexibility

Effective leadership and management has focused on developing people skills

Achievements

- SMT development continues with work on building SMT as a team, culture and behavioural work, leadership and consistent leadership.
- Board development continues looking at creating a high performing team.
- Supporting three staff secondments in a newly created leadership programme working closely with a member of SMT to deliver a service improvement programme.

Challenges

- How to sustain investment in creative training plans whilst maintaining services.
- Releasing the right managers to participate in leadership programmes resulting in postponement of local development programme offered by NES (National Leadership unit).

Local staff governance

The outgoing 2013/14 action plan was signed off by the Staff Governance Committee: out of 24 milestones, 20 of those were fully completed, two not yet achieved but on target as spanning more than a 12 month period, and two on red. 2013/14 action plan submitted to Scottish Government Health Directorates (SGHD) along with the draft 2014/15 Action plan linked to Everyone Matters.

The following policies were approved during 2013/14:
Preventing and Dealing with Gender Based Violence, Managing Conduct, Managing Violence
and Aggression in Primary Care, Locum policy, Staff Induction Policy, Staff Development Policy, Eliminating Bullying and Harassment, Term Time Only Working, Healthy Eating Policy. The HR/OD Strategy 2013-2017 was also approved.

The Staff Governance Committee is the lead committee not only for the Staff Governance Action Plan but also the Health and Safety and the Equality agendas. The Committee supported and approved the Equalities Outcome joint document between the NHS and Shetland Islands Council, approved the gender pay gap paper and signed off the equal pay statement. The Committee received the Equality Annual Update report and the Monitoring Report. The Committee also received and supported the Health and Safety Action Plan and Annual report.

During 2013/14 the Committee’s Terms of Reference were reviewed and approved by the Board.
AGENDA ITEM 7:

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

<table>
<thead>
<tr>
<th>How we are developing primary care services through the CHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Improvement colleagues have worked with Primary Care to do outreach work in local businesses and this has proven beneficial. Health Improvement colleagues have now been assigned to each Health Centre to work collaboratively with Primary Care staff to focus on local issues and that community’s particular needs.</td>
</tr>
</tbody>
</table>

A Primary Care Strategy is currently in development. The project aims to deliver a strategy that creates sustainability, ensures quality and improves 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.

A local enhanced service (LES) has been developed with local Optometry colleagues for the provision of foreign body removal. There is good engagement at the monthly meetings of the Eyecare Network.

All ten Shetland practices are using the ePCS system; the KIS system became available in May and practices are starting to populate the information fields. This is proving particularly useful in the development of Anticipatory Care Plans, which we are accelerating with support from the Change Fund.

The localities project, which is part of the Integration of health and social care programme, will be a key driver in primary care development and how services will respond to particular geographic and patient population needs.

<table>
<thead>
<tr>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lerwick and the island of Whalsay continue to have GP vacancies, although there was successful recruitment to the island of Yell in October 2013. That has unfortunately proven to be the exception; Lerwick continues to have recruitment issues, whilst Whalsay has had three rounds of advertising, with no applicants. Through the CHP we are engaging with the communities, and as a result different models of care are being explored for both these practices. We are recruiting Advanced Nurse Practitioners to improve choice and access in the Lerwick Health Centre, who along with GPs will offer same day appointments particularly for urgent need. We continue to engage with the Whalsay Community Council, and are in ongoing discussions about how best to provide primary care services for their community.</td>
</tr>
</tbody>
</table>

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. Following the recruitment of a substantive GP to the island of Yell, NHS24 was introduced to the island during the Out of Hours period to support service provision; patients now call NHS24 first out of hours and if a GP visit or advice is required, the call is passed to the resident GP.

<table>
<thead>
<tr>
<th>Implementation of long term conditions action plans</th>
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</thead>
<tbody>
<tr>
<td>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:</td>
</tr>
<tr>
<td>• Hospital and care centres - more proactive planning for earlier discharge from hospital, with</td>
</tr>
</tbody>
</table>
focused therapy packages to support customers and to develop a long term strategy to ensure make the best use of our resources in the community.

- Preventative and anticipatory care - accelerating the rate of Anticipatory Care Plans being developed to support people living at home
- Effectiveness of interventions - Pharmacy input to support care staff in care centres and community at home for medicines administration
- Supportive enablers - increasing stock of adapted housing to support people to live in the community (including the continuation of the use of telecare)
- 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
- Reviewing dementia care services to ensure they are fit for purpose and meeting need
- Carers - continue to develop and support existing carers and carers groups throughout the islands (with a refresh of our Carers Strategy in 2014/15)
- 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 Telecare is key, as is the continuing involvement and support of carers. Shetland’s innovative single shared assessment process With You For You is fundamental to our integrated approach to supporting people in the community. To ensure the continued effectiveness of our approach we are reviewing the With You For You process, alongside the work to further embed self directed support.

For mental health in old age, we have developed our older person mental health and psychiatric pathways to enable and support people to remain living in their community. We are achieving this via the Old Age Psychiatry TeleHealth/Visiting service we commission from NHS Grampian. This service provides diagnosis/support to local clinicians. Without the specialist advice more people would need to travel to Aberdeen, which can be hugely disruptive, particularly for those with dementia.

Challenges

- To continue with a whole systems approach to support early hospital discharge; appropriate admission avoidance; and achieve the target for delayed discharges as the population ages.
- To promote re-ablement across the community and embed the philosophy in all areas.
- To build on the integrated and joint management arrangements that are already in place.
- To 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 a shift over a number of years to carry out more diagnostics in primary care, particularly with the advances in near patient testing equipment that has made this possible.

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 staff and the use of telecare.

We recognise the need to improve the availability and responsiveness of primary care mental health services. In May, NHS 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 expected to be “live” Shetland wide by January 2015. We are also working in partnership with Health Improvement Practitioners to deliver guided self help/mental health support in health centres. We are also developing a programme of mental health training for those who deliver services in primary care.

Integrating pharmaceutical care into care homes has been a substantive benefit and has resulted in the introduction of a new person centred medicine management system. Workforce planning, developing and introducing new pharmacy skill sets has resulted in the new system of medicine management which is transferrable, safer and more efficient.

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

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

Psychological Therapies Waiting Times
- As of 31st July 2014 there were 84 people waiting to start treatment. There are 20 people who have waited more than 18 weeks. Longest wait is 48 weeks.
- The complexity of presentations and increased demand for the service (GPs are reporting increased mental health presentations) has continued throughout 2013/14 and this has adversely impacted waiting times performance. To address these issues we have sought the support of the QuEST National Improvement Advisor and in addition the Board has committed local service improvement resources to improve the deployment of our current resources.
- The challenge of providing an appropriate range of on island interventions continues. There is an obligate network in place with NHS Grampian that gives us access to some of the required specialist higher tier advice and services. Discussions are underway with NES to explore the development of local psychology capacity.
- Whilst we continue to work with 3rd Sector Partners to develop the range of available tier 2 services, it is important to note that these partners have a reduced capacity to respond, and in some cases have ceased delivery of services because of difficulties in accessing funding.

CAMHS Waiting Times
- As of 31st July 2014 there were 15 people waiting to start treatment. There are three people who have waited more than 18 weeks. Longest wait is 27 weeks.
- There has been a marked increase in local demand for CAMHS services (similar picture across Scotland) and this has increased the pressures on the service (reflected in decreased waiting times performance). The team is now comprised of a CPN Team Leader, Primary Care Mental Health Worker, Associate in Applied Psychology, Visiting Consultant Psychologist and visiting Consultant Psychiatrist. Plans to redesign the service within existing resources will increase resilience by providing additional CPN support and the ability to respond more effectively to Tier IV presentations.
- Efforts to secure a replacement for the retiring visiting Consultant Psychiatrist are progressing, with a visit from a prospective replacement due in September.
- The CAMHS team continues to make valued contributions to the work and development of the wider children’s workforce.
Dementia services performance

- As of June 2014 the register stood at 184 which compares with a 2013 standard of 173. The standard for Shetland remains at 173.
- Community nurses continue to use cognitive screening as part of their assessment process for older people if memory issues are suspected. Nursing staff in A & E are also conducting cognitive screening on all people aged 65 plus and referring onwards if dementia is suspected. In addition, our Occupational Therapists are incorporating a MMSE as part of their Falls Strategy assessments.
- The tele-psychiatry memory assessment clinic has gained international recognition and continues to offer a local diagnosis service, negating the need for travel to Aberdeen. The referral rate to this service has shown steady growth since its inception; 31 people in 2010, 47 in 2011, 69 in 2012, 88 in 2013 and 30 in the 4 months to 31st August.
- We continue to build upon the Shetland Dementia Partnership which involves statutory and voluntary sector partners, including the Alzheimer Scotland funded post diagnosis dementia advisor and a clinical nurse specialist, supported locally by the Dementia Champion programme developed by NES/SSSC in association with the University of the West of Scotland. We also maintain our strong links with Stirling University’s Dementia Services Development Centre.

Reshaping care for older people

Inspectors from the Healthcare Environment Inspectorate undertook an announced inspection of the care of older people’s services at the Gilbert Bain Hospital in March 2014. The inspection was carried out on Ronas ward, Ward 1 and Ward 3 and highlighted a number of areas of strength and some areas for continued improvement.

A number of areas for improvement were highlighted about ensuring consistency in completing record keeping, clinical assessments and discharge planning. In terms of action plan priorities we have agreed the following areas of work that we are currently progressing:

- Reviewing record keeping in relation to care planning and nursing assessments
- Reviewing discharge planning arrangements, including how we assess care needs to support discharge from hospital
- Ensuring that we implement actions to support dementia care in hospital (e.g. consistent dementia screening tools) across all ward areas
- Reviewing training requirements for staff who assess patient capacity (in the hospital and the community)

Some of the actions are more complex and will take longer to deliver. We are developing a model for providing appropriate support to practitioners who are assessing capacity and the subsequent training required.

We are also at the early stage of identifying success factors to measure partnership working and co-operation to deliver shared services that support alternatives to hospital and reduce unnecessary delays in hospital. In the first instance, we have focussed on how well we use the current discharge planning process to better understand areas for improvement and we are developing audit tools to look at this. A review of the single shared assessment is also being undertaken to understand how well it is working and where self directed support will sit within the delivery of health and social care services.

Reducing the number of people who are delayed in hospital is a key priority, particularly in terms of ensuring we have safe, person-centred pathways and being able to deliver effective
elective and emergency care to patients accessing hospital services.

We steady progress in all of the priority areas and we have submitted our ‘16 week post inspection’ action plan to HIS as requested in July 2014.

Change Plan 13/14
The Change Plan 2013/14 builds on the plan for 2012/13. The detail was worked up through engagement with stakeholders and consultation through staff groups and with the third sector on the draft plan.

Work streams include:
- Hospital and care centres - more proactive planning for earlier discharge from hospital, with focused therapy packages to support customers and to develop a long term strategy to ensure make the best use of our resources in the community.
- Proactive care and support – virtual wards in the community
- Preventative and anticipatory care - accelerating rate of Anticipatory Care Plans being developed to support people living at home
- Effectiveness of interventions - pharmacy input to decrease need for care staff input to medicines administration
- Supportive enablers - increasing stock of housing adapted to support people to live in the community (including the continuation of the use of telecare)
- Explore use of MIDAS as a single care record
- Mental health in old age - develop older person’s mental health and psychiatric pathways to enable and support people to remain living in their community.
- Review dementia care services to ensure fit for purpose and meeting need
- Carers - continue to develop and support existing carers and carers groups throughout the islands and complete a revised Carers Strategy in line with the Carers Strategy for Scotland 2010 -2015 (20% of change fund allocation is to support carers).
- Community capacity building - support communities and Third Sector to develop a range of services to assist in the delivery of health and wellbeing of older people.

Challenges
- To continue with a whole systems approach to support early hospital discharge and achieve new target for delayed discharges on schedule as the population ages
- To promote re-ablement across the community and reassure patients and their families/carers that this leads to better individual outcomes
- To build on the integrated and joint management arrangements that are already in place
- To ensure an appropriate skill mix in our remote island communities
Shetland Area Clinical Forum Report (August 2014)

During 2013-14, the ACF has continued to implement the actions from CEL 16 (2010) with the aim of maximising the contribution of the ACF to the Board. After some problems during the previous year with members being unable to attend meetings, we have had better attendance during 2013-14 and held eight quorate meetings during the year. The main areas of work for the ACF have been to continue to provide input to the local clinical staffing review and the senior management review; the local response to the Francis Report, and local work on the integration of health and social care. In particular we have been looking at governance issues for integration and work in localities specifically. We have had social work representation on the ACF for the latter half of the year.

We continue 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 with the Strategy. In particular we have looked at patient feedback and the variety of methods now available to encourage patients, carers and families to feedback to individual services and engage with the Board. We have also been involved in the local Health Promoting Health Service work, facilitated by the ACF chair being the Public Health Consultant with health improvement responsibility.

Other specific areas of discussion and input by the ACF in the past year have included the development of a primary care strategy; bed utilisation in the hospital and hospital planner work; and the revised Adverse Events Policy.

We have also continued to further develop joint working with the Area Partnership Forum (APF). In August 2013, we held a joint event with colleagues from ACF, APF and the Staff Governance Committee, looking at organisation culture within NHS Shetland and different models of working for the future (specifically the Nuka primary care model). This formed part of the Board’s work on responding to the Francis Report. In January 2014 we joined with colleagues in the APF, Area Medical Committee and other clinical colleagues to consider the Local Delivery Plan; finance and savings; and the outcome of the clinical staffing review.

There have been a number of changes in membership of the PACs and ACF during the past year. The ACF chair, who had been in post for four years, stepped down and the new chair took over in June 2014; there have also been changes in the chairmanship of a number of the PACs. The PACs are continuing to encourage more professional staff to take an active part in the Committees, and we are continuing to raise awareness of the ACF and the professional advisory groups with all NHS Shetland staff. We had a section in the staff newsletter last August, and we will have a webpage on the Board intranet.

During 2014-15 we are planning to review the ACF constitution to ensure the membership reflects the local health and social care integration agenda. Currently there is formal representation from the Community Health and Social Care Partnership, but not necessarily social work as a profession. In preparation for this we have invited representation from the local Social Work Professional Group on the ACF. We are also in the initial stages of looking at a PAC, or other formal link, for optometrists.

The work of the ACF during 2014-15 will continue to focus in particular on governance issues related to health and social care integration and ongoing implementation of the Quality Strategy. We will also be engaging with the development of a Primary Care Strategy and an Older Person’s Strategy; and considering progress against the Mental Health Strategy and the staffing and management reviews.
Area Partnership Forum update 2013/14 and proposed areas for development 2014/15

During 2013/14, the APF has continued to meet on a six weekly basis with representatives from RCN, Unison, Unite, Society of Physiotherapy, Society of Radiography, BMA and RCM.

There are a number of standing agenda items at each APF to ensure a partnership approach following debate and discussion around future direction and priorities that will deliver the objectives of the Board and be consistent with the five guiding principles of the Staff Governance Standard. Standing Agenda Items are:-

- Board performance: National HEAT targets and local priorities
- Financial position: savings targets and progress
- Sickness absence and progress on the HEAT standard of 4%
- Strategy redesign and service review
- Delivery of the workforce plan and current and future staffing projections
- Local Delivery Plan formulation and outcomes
- Shared services and outsourcing, engagement with partners around future direction of supporting services – Health and Social Care Integration
- Training and education (6 monthly and interventions in management and leadership development), overview of eKSF levels and what interventions may be needed
- PIN consultation and approval of feedback to SGHD
- Staff Governance action planning and out-turn reports
- Workforce planning

During the course of the year APF has also considered and agreed various policies and procedures and supported implementation plans.

The new Employee Director and two new members from Unison have been inducted and are working well supporting the Staff Governance agenda.

APF actively engages in the change and efficiency programme, sending circulars and information to members to support the organisational/management communications. APF has supported work around a cultural shift and our work on changing behaviours within the organisation.

Putting context around the delivery of the clinical business, APF has continued to develop joint working with the Area Clinical Forum by sharing proposed actions/agenda(s) for the Staff Governance Action Plan and running an annual joint event.

The APF agenda is varied and includes health promotional activities and plans to support the Wellbeing agenda that plays into our promoting attendance initiatives and staff resilience. An identified gap was on issues that impact on the external environment and APF participated in a video link on Climate Change.

Training and development is another important strand of work for APF and is linked into ensuring an appropriate skills mix across the Board in its workforce. APF considers six-monthly training and education reports.

A short life working group has been developed in partnership looking at absence/performance management and exit interview analysis to look at correlation across teams/departments and what needs to happen to support teams.

Other specific work undertaken during 2013/14 has supported the Equalities Agenda including the Equalities Outcome Report/Equal Pay Report and Gender Pay Gap. The
APF has also been engaged in the work of volunteers and the support that they provide within the service along with Youth Employment.

We have also started some work, through our Joint staff Forum, with Shetland Island Council, on strengthening our joint staff/HR work to support the Integration agenda.

**Areas for focus in 2014/15**

- Embed further joint working with the integration agenda;
- Support the engagement and uptake of the national staff survey;
- Participate and promote iMatters Phase 1;
- Support the ongoing review of change of service delivery models;
- Reinforce the value of eKSF and its benefits to staff and managers;
- Support work on staff resilience; and
- Progress work on Integration and embedding the Staff Governance principles within our joint services.

Lorraine Hall - Director of Human Resources and Support Services
Ian Sandilands - Employee Director
PFPI Update 2013-14

During 2013/2014 a number of key achievements were made. These included

- Appointment of a lay Chairman for the PPF was achieved in March 2013/2014.

- The PFPI Steering Group Non-executive Board member instituted a process that ensures PFPI Steering Group minutes, along with a verbal update of the work of the group, are presented at each NHS Board meeting thus ensuring that public engagement activity is brought to the heart of the Board.

- Improvement support from the Scottish Health Council Local Officer has enabled a number of individuals and departments to conduct audit activity which has led to developments in the way services are delivered or has provided information to inform future service provision. For example, the Additional Support Needs survey was conducted to identify how well people with additional support needs were supported in attending their hospital appointments locally and in NHS Grampian. An action plan has been developed to address gaps in our current service.

- A number of key frameworks were developed/revised to progress the PFPI agenda, for example drafting of the new PFPI Strategy, development of the Gathering Feedback Framework.

- Topical and sensitive issues were presented to lay members at both the PFPI Steering Group and PPF. Through these opportunities, lay members were able to understand and contribute to the organisation’s position on, for example, end of life care and the Liverpool Care Pathway, orthopaedic follow up for patients undergoing surgery at a regional centre, and development of an art therapy project for women following breast surgery.

Challenges

One of the main challenges we face is in the role and function of the local Patient Advice and Support Service (PASS). The service is provided via the Citizen’s Advice Bureau. We are provided with feedback on the service, however, there are only small numbers of people who use the service each quarter/year and therefore it is very difficult to gain information from the feedback that could enable us to either understand what could be done better/differently or how we could increase the number of people who use the service to access support for information about health services and/or making a complaint. We have asked the local PASS Officer to raise this point nationally as we feel that we are not currently able to make the best use of this resource locally.

The other main challenge remains around trying to increase the amount of patient and public engagement and involvement that is undertaken across the organisation in a climate of increasing clinical activity and reducing resources. This will also be a consideration as we move forward with the integration of health and social care services.