Shetland Islands Health and Social Care Partnership
Annual Performance Report 2018-19

Note: Not all the data in the Report has been finally verified through the Scottish Government's validation processes. We have used the most up to date data we have. Where that might change, when the national data is published, we shall amend the on-line versions of the Report.

Document Control

Date	Version	Contents	Author
31/05/2019	1.0	First Draft, drawing on 'Best Practice example' from the Western Isles H&SC Partnership and the Scottish Government areas of improvement - Finance, Strategic Planning, community engagement and localities	Hazel Sutherland
27/06/2019	1.0	Marked as Final	Hazel Sutherland

Welcome .... to the third Annual Performance Report for Shetland Islands Health and Social Care Partnership. This report covers our third full year as a Health and Social Care Partnership under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014.

We work hard at delivering the best possible health and care services for the community but there is still plenty of work to do. I hope you enjoy reading about our work.

Jo Robinson
Interim Director of Community Health and Social Care for NHS Shetland and Shetland Islands Council
Chief Officer of Shetland's Integration Joint Board (IJB)

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Our Vision is that by 2020 everyone in Shetland is able to live longer healthier lives, at home or in a homely setting. We will have an integrated health and care system focused on prevention, supported self management and reducing health inequalities. We will focus on supporting people to be at home or in their community with as much specialist care provided in Shetland and as close to home as possible. Care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.

This is the Vision which relates to the 2018-19 financial year

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislative framework for the integration of health and social care services in Scotland. It requires local authorities and health boards to integrate adult health and social care services – including some hospital services.

The main aim of the Act is to improve the wellbeing of people who use health and social care services. It does this by requiring local partners to:

- create a single system for health and social care services
- develop more informal community resources and supports
- put the emphasis on prevention and early intervention
- improve the quality and consistency of services
- provide seamless, high quality, health and social care services

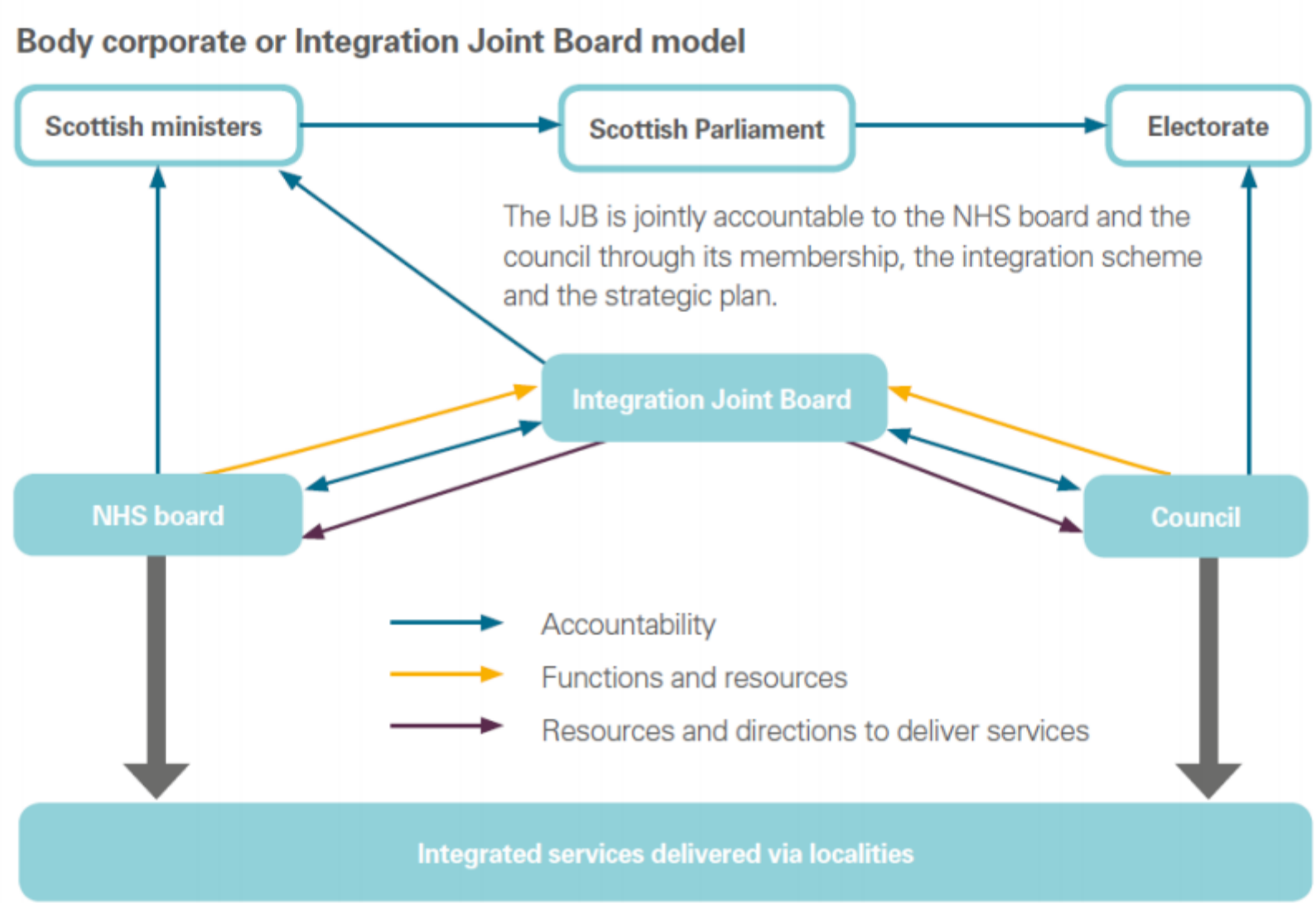
The legislation requires Health Boards and Local Authorities to establish formal partnership arrangements to oversee the integration of services. Like most partnership areas, this has been done in Shetland through the creation of an Integration Joint Board (IJB), which is a partnership body designed to take decisions about how to invest resources and deliver services.

The IJB is not an organisation which employs staff but it does have the authority to direct the two parent bodies – the Health Board and the Local Authority – to set out how it wants integrated services to be delivered. Each IJB is required to publish an annual review of its performance. This document is the Annual Report of Shetland Islands Health and Social Care Partnership for 2018/19.

A Year in the Life of the IJB

- The IJB met 7 times and its Audit Committee met 4 times
- The IJB membership includes representatives of carers, service users, trades unions, the voluntary sector, health and social care professionals, local councillors and Health Board Directors and the meetings were well attended by a broad spectrum of our stakeholders
- Several development sessions were held for all IJB members with a focus on updating the Strategic Plan and resolving the financial imbalance
- The Strategic Planning Group met 6 times during the year to support the update of the Strategic design, oversee performance and assess service redesign proposals
- The IJB fulfilled its best value and wider statutory obligations by delivering a strategic plan, providing directions to the partner bodies and closely overseeing the financial situation to secure a positive financial position by the end of the financial year
- The IJB fulfilled its governance policy obligations in respect of the implementation of a workforce strategy, a participation and engagement strategy and proactively managing risk.
- The IJB considered and provided policy guidance in respect of integrated service models for: primary care; self directed support; adult mental health; the intermediate care team, domestic abuse and sexual violence and community pharmacy.
- The IJB supported a co-production project on the future nursing provision on one of the non-doctor islands, Bressay.
- The IJB strengthened its financial policy framework by considering and approving the Medium Term Financial Plan.

The accountability arrangements are set out in legislation and demonstrated by the diagram below (source: Audit Scotland).


Body corporate or Integration Joint Board model
Scottish ministers
Scottish Parliament
Electorate
The IJB is jointly accountable to the NHS board and the council through its membership, the integration scheme and the strategic plan.
Integration Joint Board
NHS board
Council
Accountability
Functions and resources
Resources and directions to deliver services
Integrated services delivered via localities

In response to the recently published Audit Scotland Report "Health and Social Care Integration - Update on progress" (November 2018)[1], the Scottish Government asked each IJB to undertake an evaluation exercise on 22 key areas which are considered necessary for the IJB to work successfully. The IJB participated in the Scottish Government's self evaluation of integration and considered that it has established effective arrangement for 6 of the factors, but had work still to do on 16 of the recommendations. The analysis is set out below.

This is where we feel we have well established arrangements in place:

- ✓ Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration
- ✓ Each IJB must develop a transparent and prudent reserves policy
- ✓ Statutory partners must ensure appropriate support is provided to IJB S95 Officers
- ✓ Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.
- ✓ IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.
- ✓ Identifying and implementing good practice will be systematically undertaken by all partnerships.

[1] http://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress

These are the issues where we feel our arrangements are only 'partially established' so we need to do more work to embed this as a way of working:

- All leadership development will be focused on shared and collaborative practice.
- Relationships and collaborative working between partners must improve
- Relationships and partnership working with the third and independent sectors must improve
- Delegated budgets for IJBs must be agreed timeously
- Delegated hospital budgets and set aside budget requirements must be fully implemented
- IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations
- Improved strategic planning and commissioning arrangements must be put in place.
- Improved capacity for strategic commissioning of delegated hospital services must be in place
- The understanding of accountabilities and responsibilities between statutory partners must improve
- Accountability processes across statutory partners will be streamlined.
- IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.
- Clear directions must be provided by IJB to Health Boards and Local Authorities.
- Effective, coherent and joined up clinical and care governance arrangements must be in place.
- Effective approaches for community engagement and participation must be put in place for integration.
- Improved understanding of effective working relationships with carers, people using services and local communities is required.
- We will support carers and representatives of people using services better to enable their full involvement in integration

Strategic Objectives

The Integration Joint Board has a statutory obligation to agree and implement a Strategic Plan. The plan sets out the changes to services how we intend to shift resources to best meet need - move activity out of the acute sector and into community settings and invest in prevention and early intervention to help people to live in good health, for longer.

The Strategic Plan has recently been refreshed, in March 2019, and it sets out the national policy context, the key drivers for change, a vision for future service delivery, an outline of the change programme and an explanation of what needs to change to make it happen. The Strategic Plan focuses on the changing philosophy of how we will interact with our service users and the communities we serve, through an 'asset based[2]' approach and the philosophies of 'self directed support'[3] and 'realistic medicine'[4].

We need to consider not just a clinical or care assessment of need but, also, what matters to people as individuals. This relates to the immediate relationship between a professional and the user of a service. However, it also has much wider implications for how we interact with and support communities to build strong and resilient communities, with health and care services acting as an enabler.

The approach means that as we move forward to think about changing the models of service, we need to put our service users and communities at the heart of that process. We need to make sure that we understand what our customers want and need. While we may not always be able to respond to individual and community preferences, the clear approach is that our service users are an equal part in determining the shape of future services.

[2] Asset Based approaches focus on the positive aspects of individuals and communities, valuing their capacity, skills, knowledge and connections

[3] Self-directed support (SDS) allows people to choose how their support is provided to them by giving them as much ongoing control as they want over the individual budget spent on their support

[4] Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to you so that the care of your condition fits your needs and situation. Realistic medicine recognises that a one size fits all approach to health and social care is not the most effective path for the patient or the NHS.

Our **Strategic Objectives** were more clearly defined in the recent update of the Strategic Plan and they are:

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

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

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

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

Achieve a sustainable financial position by 2023

Our **Priorities** are built on:

- Keeping people safe from harm, protecting vulnerable people
- Delivering integrated health and care pathways and single point of entry to services by continuing to shift resources to primary and community care
- Strengthening and working in partnership with individuals, their families and communities
- Reducing avoidable admission to and inappropriate use of hospital services
- Developing primary care and community responses through multi-disciplinary teams
- Supporting unpaid carers
- Tackling inequalities, with a focus on health inequality
- Prevention and early intervention
- Promoting healthy lifestyles
- Improving mental health and wellbeing
- Promoting self management and independence

Case Study – Intermediate Care - "Journey Home to 60 Degrees North and Beyond"

The Intermediate Care Team considered how to provide an equitable service across Shetland and that 'equitable' does not necessarily mean the same service. A client in Unst had fallen and fractured her hip while visiting London. The Intermediate Care Team initially worked with this client in a care home in Lerwick, where her reablement journey started. The client then transferred to Nordalea Care Home in Unst where the Intermediate Care Team continued to oversee her reablement plan. However, as it was not possible for the Rehabilitation Support Workers to provide multiple daily support visits in Unst, these were carried out by local staff, such as the care centre staff, the community Occupational Therapist and community nurses. After further reablement, the client was able to return home with a care support package. Intermediate Care provision is no longer dependent on home location and all clients who meet the referral criteria are considered regardless of their home address.

In 2018-19, we put together an overall programme of work to take forward.

<table>
<tr><th colspan="2">Whole Population</th></tr>
<tr><td>Implementing an asset based approach to health care prevention</td><td>Effective Prescribing- working with patients and prescribers to ensure that evidenced, best value, medicines are started and stopped appropriately</td></tr>
<tr><th colspan="2">Sustainable Service Models</th></tr>
<tr><td>Developing a safe and effective model of unscheduled care</td><td>Developing a sustainable hospital, acute and specialist services model for Shetland</td></tr>
<tr><td>Developing a sustainable primary care model for Shetland, with clear links to the 7 locality areas and the Gilbert Bain Hospital</td><td>Developing a sustainable model of social care resources</td></tr>
<tr><td>Developing a sustainable model for mental health services, including appropriate crisis and emergency arrangements</td><td>Developing a sustainable model for adults affected by learning disabilities and autism spectrum disorders</td></tr>
<tr><th colspan="2">Achieving Financial Balance</th></tr>
</table>

These programmes of work are progressing and the IJB receives specific proposals to take forward ‘tests of change’ to aid service redesign.

Our achievements during 2018-19 include the following activities.

- The Adult Mental Health redesign project has been progressed, with a focus on creating multi-disciplinary teams and appropriate referrals and care pathways
- The Social Care programme of work reinforced our approach to 'care at home' being the principle objective of how we care for our service users, with several 'tests of change' being developed around prevention and 24 hour care support. Innovative approaches to workforce recruitment and retention is supporting this work.
- Development of our approach to implementing the Primary Care Improvement Plan, to support how we organise ourselves to ensure that our service users get seen by the right person, in the right place to address their health and care needs
- A reinvigorated approach to Self Directed Support, with a significant investment in training and coaching to support our staff to have good conversations around choice and flexibility of services, and to them find ways to meet that need through innovative approaches and 'tests of change'.
- The Intermediate Care Team is now firmly embedded to support reablement and we invested in the Otago Falls Prevention programme to help avoid people injuring themselves and requiring treatment.
- The community pharmacy work has been developed to provide support to people to manage their own medicines in community settings and provide services within care homes to ensure residents are receiving medicines safely and that waste is avoided.
- A community co-production project has been undertaken with the support of the Scottish Health Council on the island of Bressay to explore and implement solutions to providing health and care services to a community with no resident health staff.
- Rolling out training on an asset based approach to a wide range of stakeholders - including to people outwith the health and care sectors
- The Domestic Abuse and Sexual Violence Strategy was refreshed and endorsed by the IJB, the NHS Board and the local authority with a strong platform of development work to tackle the root causes, as well as addressing acute and ongoing support needs for people affected by abuse.
- The Allied Health Professionals services continued to support acute and preventative work – some Case Studies of their work are included as Appendices to this Report.
- The IJB strengthened its approach to financial planning with the establishment of a Medium Term Financial Plan.

The work which did not progress to the timelines originally envisaged include the projects to:

- develop a safe and effective model of unscheduled care, although several 'tests of change' were able to be progressed; and
- develop a sustainable hospital, acute and specialist services model for Shetland.

Case Study - Community Care Resources - 'Please can you help me go home?'

Affordable and sustainable social care models need to be developed which ensure personal outcomes are met and enable high quality care to be delivered at home and in the community wherever possible. It is also important that community engagement events encourage individuals to 'future proof' as much as possible and with this in mind Community Care Resources attended flu clinics across Shetland last winter to provide advice and signposting with a view to encouraging older people to anticipate changing needs and circumstances.

A number of 'tests of change' are expected to commence in the near future which will provide local data to support future service redesign to ensure all services are responsive to the changing needs of the community in Shetland. These include:-

- Support for unpaid carers though the implementation of the Carers (Scotland) Act 2016 by offering extended day care provision at Edward Thomason and Taing House support Services.
- Carry out level 1 and 2 needs assessment in Whalsay to map existing resources, identify gaps and develop arrangements to best meet those needs.
- Provide geographically dispersed model of care at home (including respite at home and overnight care) in the South Mainland.
- Provide 24/7 nursing and social care within Lerwick including enhanced support to reduce unplanned hospital admissions.

In common with many remote and rural locations recruitment and retention remain problematic for social care staff. Work is ongoing in relation to developing the young workforce, MA's (in relation to social care and administration) and pathways into care as well as recruitment with relocation packages to attract staff from outwith Shetland. In addition, recruitment processes are regularly reviewed together with contractual arrangements.

Significant investment has taken place in the last year to improve lone working conditions. Investment has been made in terms of fleet vehicles and mobile phones for care at home staff. Care at Home is likely to see continued expansion of services due to changing demographics and the need for ensure that those requiring care services are central to all decision making. The efforts made by teams to ensure that client focused, high quality care are delivered in a constantly evolving environment is reflected in the Care Inspectorate grades however most of the day to day determination and flexibility required by teams to ensure good outcomes goes unreported. We know that older people want to be cared for in an environment that is not institutional care. With this in mind business justification cases will developed to increase telehealth and Telecare capacity with a particular focus on those technologies that support people to be cared for in their own homes.

These developments will also require changing attitudes to risk which emphasis the rights of older people to remain independent while challenging negative views of risk and the stereotypes and prejudices about old age and older people that exist across society (Norman, 1988 cited in Titterton M, Risks and Risk Taking in Health and Social Welfare. Jessica Kingsley Publishers.2005)

Case Study:- 'Please can you help me go home?'

A client with dementia has developed a trusting relationship with her care at home team visiting 4 times per day to ensure a safe and secure environment. This support enables the client to remain in her own home, leading an independent /self directed and fulfilled life within the community that she has lived for many years. While initially reluctant to accept any supports whatsoever the staff team worked hard to gain the client's trust and warm, personal bonds have formed with the regular carers. Following a hospital admission there were concerns from some members of the multi agency team that the client could not safely return home and required a 24 hour supported environment. A compromise position was agreed and an intermediate placement in a care home identified with a view to assessment and reablement home. Within hours of discharge from hospital the client became acutely distressed and her care at home team attended the residential centre to offer 1:1 support. She was delighted to see a familiar face and made it clear she wished to go home. The carer was able to reassure the client and indeed, spend a relaxed and pleasant evening in her company.

In view of the client's distress and having regard to relevant evidence based practice (Nothing Ventured, Nothing Gained – risk guidance for people with dementia. DOH 2010) it was agreed to accompany the client home the following morning. The client has remained at home with some enhanced supports (including assistive technology) to ensure her wellbeing and happiness. This case study is a positive example of staff having the courage to advocate on behalf of a client's rights to self determination, take positive risks, maximise independence and minimise risk.

> *'Life is never risk free. Some degree of risk taking is an essential part of good care. Self determination and freedom of choice and movement should be paramount, unless there are compelling reasons why this should not be so.'*
>
> (Mental Welfare Commission Good Practice Guide, Rights, risks and limits to freedom 2013)

Localities

The Plan is considered across seven localities based on geography and ward boundaries. The same arrangements are in place for all Shetland's strategic plans, including the Shetland Partnership's Local Outcome Improvement Plan.

A good strategic commissioning process will take account of the differing needs of each locality. We look to find ways to actively work with local communities to share problems, identify solutions and make the best possible use of all resources available.

The seven localities in Shetland are:

- North Isles
- North Mainland
- West Mainland
- Whalsay and Skerries
- Central Mainland
- Lerwick and Bressay
- South Mainland

Each area currently has a set of services delivered within the locality:

- primary care;
- community nursing;
- care at home; and
- care home resources

alongside a broad range of voluntary activity to support individual and community wellbeing.

The Occupational Therapy and Health Improvement teams have practitioners allocated to deliver services and work with partner services within the locality. The Adult Social Work team has identified link professionals for each locality and the Pharmacy and Prescribing service are developing their community based support to GP practices.
Many services, although located in Lerwick, will provide outreach services throughout the islands to wherever the patients and service users live. An example of this way of working is the podiatry service.

There is in place a considerable range of voluntary and community provision in each area to support well being. Examples of this will include: support for individuals with dementia; befriending; lunch clubs; craft circles; leisure and learning opportunities. These deliver invaluable social benefits to those attending and form an intrinsic part of the network of provision to support individual health and wellbeing and community resilience.

A community co-production project has been undertaken with the support of the Scottish Health Council on the island of Bressay to explore and implement solutions to providing health and care services to a community with no resident health staff. The project has made use of the Ketso[5] model; a method for making sure that everyone has their say and can focus on moving forward. A summary of the approach is shown below and a wider description of the project included as a Case Study.

It is hoped that the engagement model that has been developed through undertaking the 'Caring for Bressay' project will be used elsewhere across Shetland. It is currently being considered by another outer island Community Council and an invitation has been sent for members to attend a 'Caring for Bressay' Project Board meeting to witness the joint approach this project has had from the start.

Caring for Bressay - Health and Care project – Extract from Community Council update – 18 October 2018

"The 24 September saw 17 participants take part in a group session using a tool called Ketso to explore the topic of 'Caring for Bressay'. The participants included: island residents; Bressay community council members; the Community Planning and Development Officer; and an elected Council member.

Using the Ketso approach participants were asked to consider the following questions:

- What do you think is important to the Bressay Community?
- What are the current challenges?
- How do we overcome the challenges? What can we do differently?
- Describe your ideal vision for Caring for Bressay?

The event was facilitated by the Scottish Health Council. All who attended evaluated the session very positively, including those who had been a little uncertain at the start of the event. A report from the session, capturing all views and ideas expressed, has been written up and will be shared with the participants. The report will then be used to help inform the work of the Project Team as they consider future models of care for the residents of Bressay."

[5] https://ketso.com/

How Have We Performed?

The Scottish Government has a key purpose to increase healthy life expectancy. This is so that people live longer in good health, increasing their capacity for productive activity and reducing the burden of ill health and long term conditions on people, their families and communities, public services and the economy generally.

Shetland has traditionally had a good life expectancy and a level of health amongst the best in Scotland, reflecting the high quality of life in Shetland, as well as the quality of local services. Recently, the year on year improvements in life expectancy have slowed down across the UK, including Shetland. The reason for this slowdown is under investigation by universities and other academic institutions. For men the life expectancy at birth using the three year rolling average for 2013-15 was 77.6 years, down from 78 and for women was 81.9 years, down from 82.45. We are yet to reach the ambitious local targets of 79.2 and 86.2 years respectively. 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.

The Health and Social Care Partnership has a role in preventing ill health and promoting good health. In practice, much of this service is delivered via health improvement practitioners who are based in localities across Shetland.

- Over the last year, Shetland's smoking rate (based on GP data) has decreased from 15.8% to 14.6% and 20 people had successfully stopped smoking by March 2018.
- The target for delivering Alcohol Brief Interventions in primary care was not met; this remains a key strand of the government's alcohol strategy and will require increased focus next year.
- Work on increasing physical activity, especially amongst the most inactive, and healthy diet is continuing but outcomes are difficult to measure on a short term (annual) basis.
- Work is underway to develop and deliver the government funded diabetes prevention programme.
- The role of the community link worker has expanded to include low level psychological therapies, social prescribing (for example, nature prescriptions), and walks for health, now re-branded as Peerie Wanders.

However, our population is aging rapidly, which is and will cause an increase in demand for health and care services.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Authorities to report against the National Health and Well-being measures, which draw on a mix of qualititative and quantitative measures. The qualitative measures come from the annual Care Experience and Staff survey administred by the Scottish Governement. For most of these, Shetland performs well compared to Scottish levels. The full range of indicators is set out at Appendix 1. In terms of system measures, we have performed well against the national benchmarks, as shown below.

National Outcome Indicators	Current Performance	Scotland Rate
Premature mortality rate (per 100,000)	323	425
Rate of emergency admissions for adults (per 100,000)	10,350	12,183
Rate of emergency bed days for adults (per 100,000)	65,137	123,035
Readmissions to hospital within 28 days of discharge (per 1,000)	69	102
Proportion of last 6 months of life spent at home or in a community setting	94.2%	89.2%
Falls rate per 1,000 population in over 65s	18	22
Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	97%	Not Known
Number of days people (75+) spend in hospital when they are ready to be discharged (rate per 1,000)	505	762
Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency	14%	25%

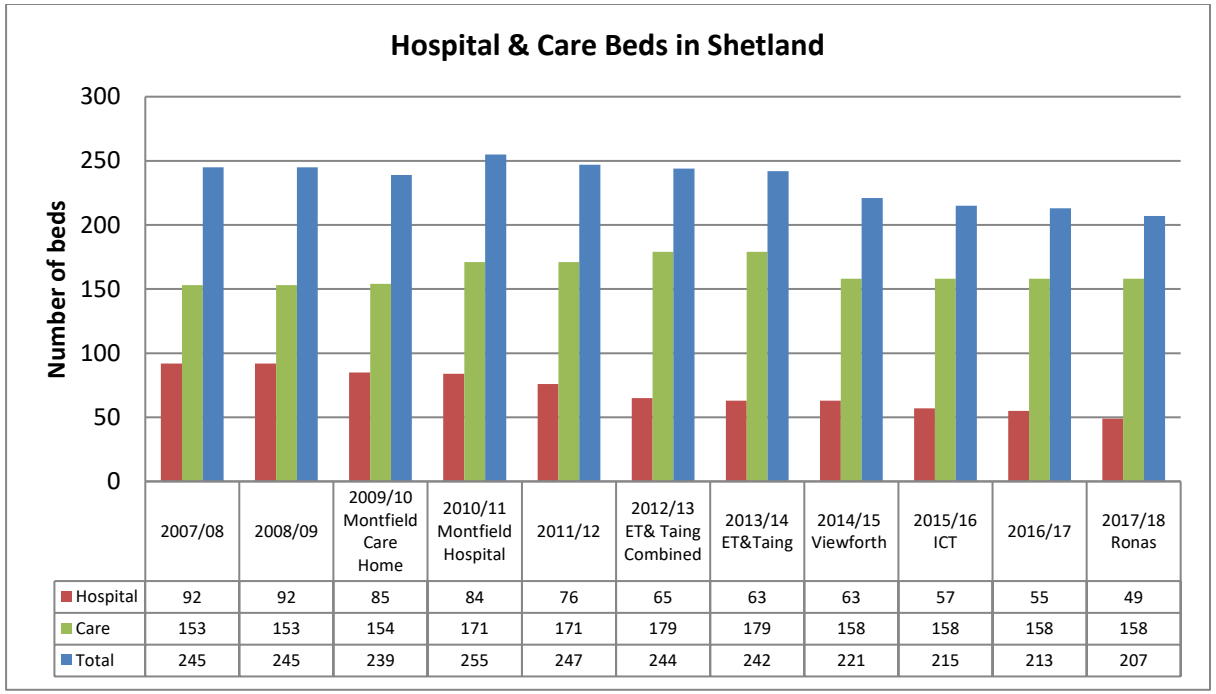
There are, however, areas where the indicators suggest performance below the national average. This suggests that the IJB needs to do more to: support people to live as independently as possible and to help people to feel safe. Whilst slightly above the national figure, our rate of percentage of carers who feel supported to continue in their caring role (at 41%) is lower than we would wish.

Indicator	Shetland Current	*Shetland* Previous	*Scotland Current*
8. Percentage of carers who feel supported to continue in their caring role. (2017-18)	41%	54%	*37%*
9. Percentage of adults supported at home who agree they felt safe. (2017-18)	80%	79%	*83%*

A visual snapshot of performance and activity during 2018-19, covering a range of indicators and services is included at Appendix 2.

Our primary driver of performance is built around the 'Shifting the Balance of Care' philosophy – moving care from hospital to community settings, and from community settings to peoples' own homes to help improve their health and wellbeing.

As a result, over the past few years, it has been possible to reduce the overall number of hospital and care beds, as shown in the graph below.



	2007/08	2008/09	2009/10 Montfield Care Home	2010/11 Montfield Hospital	2011/12	2012/13 ET& Taing Combined	2013/14 ET&Taing	2014/15 Viewforth	2015/16 ICT	2016/17	2017/18 Ronas
Hospital	92	92	85	84	76	65	63	63	57	55	49
Care	153	153	154	171	171	179	179	158	158	158	158
Total	245	245	239	255	247	244	242	221	215	213	207

The actions to maintain and / or improve performance are set out below:

- robust and responsive community services
- hospital admissions only happen where appropriate.
- focus on reducing lengths of stay in hospital
- better liaison and integration between community based services and the hospital
- clear pathways for specialist assessment of conditions
- advanced practitioner model
- determine how best to deliver healthcare services 'Out of Hours' and overnight
- community based services where 24/7 care is required
- clear pathways of care where a person has escalating care needs
- falls prevention programme
- improving the capacity and responsiveness of care at home services
- early supported discharge from hospital
- better co-ordination of the discharge planning process
- anticipatory care planning
- improving the capacity and responsiveness of care at home services
- shared information systems, records and assessments
- explore how paramedic practitioners could enhance local services
- third sector organisations are active in reducing isolation and loneliness, and supporting vulnerable groups including those with dementia
- supporting more people at home with technology enabled care

Case Study – Do we really need it?

All our elective hip and knee replacement surgery takes place at the Golden Jubilee Hospital in Glasgow. One of our Occupational Therapist Assistants went on a study tour to shadow their approach. It became apparent that NHS Shetland was over prescribing equipment for patients receiving knee replacements. Previously, NHS Shetland issued equipment to 67% of patients receiving knee surgery and after the study visit this reduced to 22% of patients. Our new approach is enabling patients to be as independent as possible and making sure there is enough equipment for everyone who needs it. No patients reported they were not managing at home, so providing us with confidence this new approach was workable. This has also had a positive impact on the budget - making a saving for the service.

Inspection of Services

Our care services undergo a regular inspection programme from the Care Commission. The tables below show the latest available care grades awarded. One of the Scottish Government's suite of National Indicators is the proportion of care services graded 'good' (4) or above in Care Inspection Grades. At March 2019, all but three elements of our care services were graded 3 or above (in 2017-18, two elements were graded as adequate and in 2016-17 we achieved 100%).

Care Homes

Service	Care and Support	Environment	Staffing	Management and Leadership
Nordalea	5- Very Good	5- Very Good	4- Good	5- Very Good
Isleshavn	5- Very Good	4- Good	4 – Good	4 – Good
North Haven	4- Good	4- Good	3 - Adequate	4-Good
Wastview	5- Very Good	4- Good	4- Good	4-Good
Fernlea	5- Very Good	5 – Very Good	4 – Good	4-Good
Walter and Joan Gray	3- Adequate	4- Good	3- Adequate	4- Good
Edward Thomason and Taing House	5 – Very Good	5 – Very Good	4 – Good	5 – Very Good
Overtonlea	4- Good	4 – Good	4 - Good	4- Good
Newcraigielea	5- Very Good	4- Good	5- Very Good	5- Very Good

Support Services

Service	Care and Support	Environment	Staffing	Management and Leadership
Nordalea	6 – Excellent	5 – Very Good	5 – Very Good	5 – Very Good
Isleshavn	4- Good	4 – Good	4 - Good	4- Good
North Haven	4- Good	4 – Good	4 - Good	4- Good
Wastview	5 – Very Good	5 – Very Good	5- Very Good	4 – Good
Fernlea	5 – Very Good	5 – Very Good	4 – Good	5 – Very Good
Walter and Joan Gray	4- Good	4- Good	4 – Good	4- Good
Edward Thomason and Taing House	5 – Very Good	4 – Good	4 – Good	4 – Good
Montfield	5 – Very Good	4 – Good	5- Very Good	5 – Very Good
Overtonlea	5 – Very Good	4- Good	4- Good	5 – Very Good
Newcraigielea	5 – Very Good	4 – Good	4 – Good	4 – Good

Other Services

Service	Care and Support	Environment	Staffing	Management and Leadership
Eric Gray Resource Centre	6 – Excellent	5 – Very Good	5 – Very Good	6 – Excellent
Mental Health Support Services	5 – Very Good	No grade available	5 – Very Good	5 – Very Good
Support at Home	5 – Very Good	No grade available	6- Very Good	5 – Very Good

Equalities and Human Rights

The public sector equality duty requires the IJB, in the exercise of its functions, to publish a set of equality outcomes. An equality outcome is the result which we want to achieve in order to eliminate discrimination, advance equality of opportunity and foster good relations. The public sector equality duty covers: age; disability; gender; gender reassignment; pregnancy and maternity; race; religion or belief; and sexual orientation.

We have sought to specifically involve people who share a relevant protected characteristic and their representatives in two projects.

- Our approach to Self Directed Support has involved engagement with service users, and their unpaid carers in a way which seeks to genuinely understand their needs and how we can best support them. The creation of a new third sector entity - Shetland Community Connections – will further support this philosophy. Shetland Community Connections exists to provide a brokerage service for social care users in Shetland. This includes person centred planning to identify personal outcomes and help to plan and organise support. A targeted training event, with wide participation helped us to explore how we help people to live 'ordinary lives' rather than considering solutions from a service perspective.
- The project to redesign short breaks services for adults with learning disabilities and autism spectrum disorder has put service users, their unpaid carers and families at the centre of the redesign project. Through workshops and interviews, the team has explored taking an asset based approach to service delivery. Family members of service users are part of the core project team. Engagement with the service users, and their families, is seen as an essential element of achieving good outputs and ideas to take forward.
- The Shetland Partnership's Voices for Equity project is providing a means of learning directly from people in Shetland experiencing challenges as a result of Shetland's inequalities. It is providing a means for them to be more involved in planning and designing services by sharing their knowledge directly with decision makers within Shetland's public bodies. In contrast to consultations and anonymous feedback structures, the focus is on building relationships and bridging the gap between people living within Shetland. Representatives from the IJB have participated in this project.

The Strategic Plan has been assessed for equality impact and we will continue to assess each service redesign proposal for equality impact and make that an integral part of the options put forward for decisions.

CASE STUDY - VOICES FOR EQUITY: BRINGING LIVED EXPERIENCE INTO DECISION-MAKING

The project has recruited people, including parents of children and young people, who are paired in a learning relationship with people responsible for developing, approving and delivering Shetland's future. Together they meet monthly, in their one-to-one learning relationship, to discuss and share their personal stories and experiences on inequality issues in Shetland. Both participants contribute with their personal experiences, and are equally responsible for empowering and challenging each other; the aim is to broaden each other's horizons and understandings. Their personal learnings are nurtured by the exchange of these stories and experiences, and their feedback to each other. Confidentiality is ensured and sufficient facilitation is provided to support the relationships and their learning journeys.

The participant's learnings, both on the method of participation, as well as on experiences of inequalities in Shetland, is fed into the Shetland Partnership Improvement Projects and the wider learning of partner organisations.

Shetland Partnership, 2018

What resources did we use?

The effective and efficient use of resource in the delivery of services is a crucial indicator of success.

In accordance with the Integration Scheme – which determines the work of the IJB – the IJB is required to approve a balanced budget on the basis of funding delegated by NHS Shetland the Shetland Islands Council. This was – and remains – a challenging process with both of the IJB's parent bodies experiencing significant financial pressures. NHS Shetland carried a funding gap at the beginning of 2018-19 of £3.455M (7%), while Shetland Islands Council experienced an overall cash reduction of £1.768M (2.2%) in core revenue funding.

Consequently, the IJB faced an opening budget gap of £2.276M, which was brought into balance through a series of savings and efficiencies schemes throughout the year and additional balancing payments from both NHS Shetland and Shetland Islands Council at year end.

The year end position for 2018-19 included:

- Underachievement of savings target of £1.850m
- Additional one off contributions from SIC and NHS of £3.657m to achieve financial balance
- Overspends on locums in acute hospital services, mental health and primary care
- Underspend in Primary Care as a result of £1.2m island harmonisation funding being received from the Scottish Government

Reserves

The IJB approved its Reserves Policy on 6 September 2017. The balance as at March 2019 was £0.905M. During the year, the IJB made one strategic investment from Reserves during the year in regards to Falls Prevention.

Where did the Money come from and how did we spend it?

The flow of money into and out of the IJB is shown in the Table below. The overall income to the IJB was £49.912m against expenditure of £49.371m, leaving a surplus for the year of £0.541m.

Financial Year 2018-19	SIC	NHSS	Total	2017-18	2016-17
	£000	£000	£000	£000	£000
Income					
Budget delegated to the Parties from the IJB	(22,396)	(23,830)	(46,226)	(44,222)	(43,450)
Additional Contributions from Parties to meet direct costs (Audit fee, Insurance & Members Expenses)	(15)	(14)	(29)	(28)	(25)
Fortuitous underspend repaid to SIC	0	0	0	310	367
Additional contribution from NHS and SIC to IJB to meet overspend	(144)	(3,513)	(3,657)	(2,941)	(1,431)
Sub Total Income	**(22,555)**	**(27,357)**	**(49,912)**	**(46,881)**	**(44,539)**
Expenditure					
Actual expenditure against delegated services	22,553	26,789	49,342	46,614	44,389
Direct Costs	15	14	29	28	25
Sub Total Expenditure	**22,568**	**26,803**	**49,371**	**46,642**	**44,414**
Final position of IJB	**13**	**(554)**	**(541)**	**(239)**	**(125)**

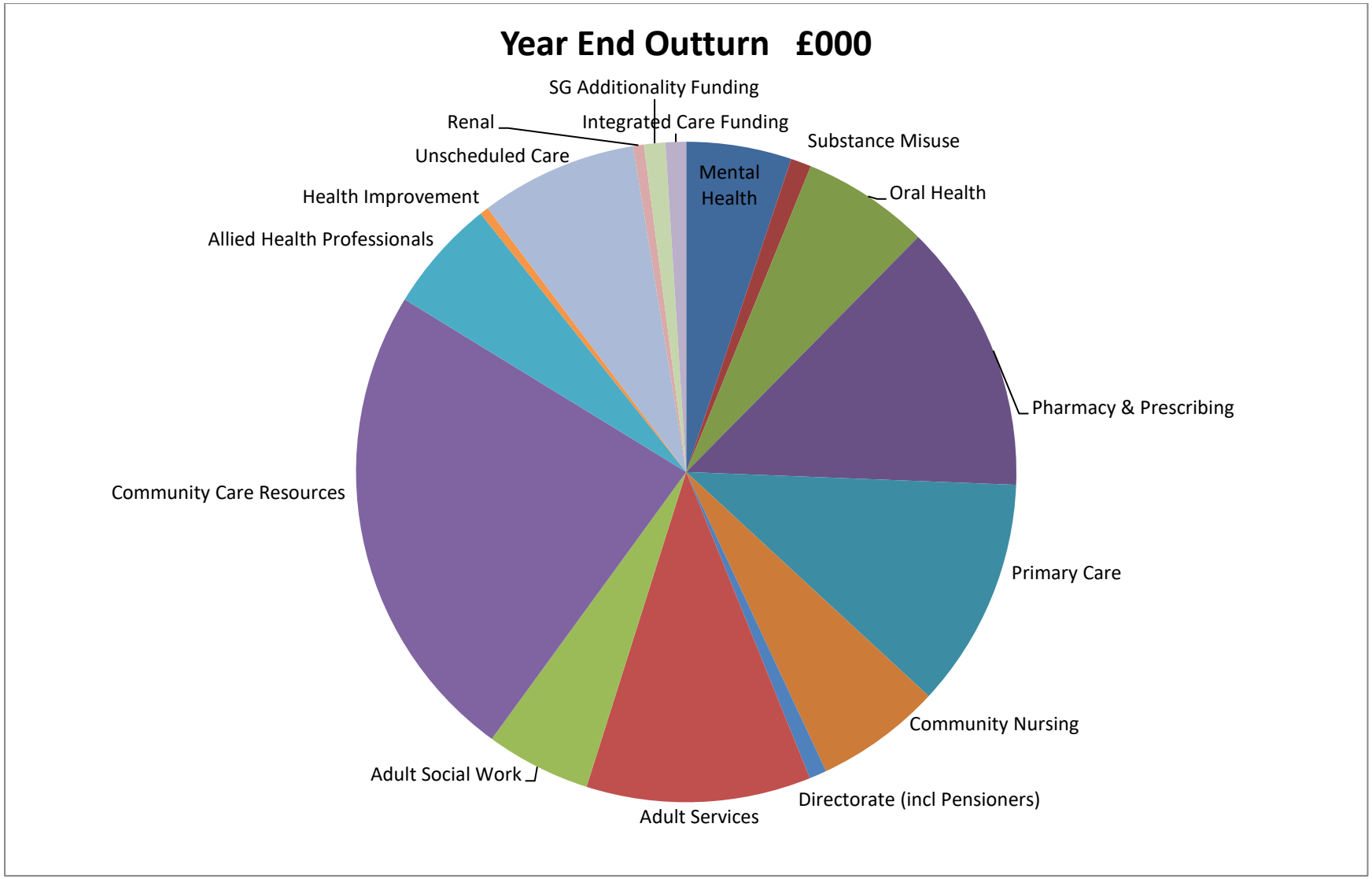
We spent £49.267m on the following services (which also compares the actual expenditure to the revised budget in the year).

Service (£000)	2018/19 Revised Annual Budget	Year End Outturn	Budget v Outturn Variance (Adv)/ Pos
Mental Health	2,071	2,534	(463)
Substance Misuse	543	496	47
Oral Health	3,084	3,071	13
Pharmacy & Prescribing	6,477	6,502	(25)
Primary Care	5,676	5,537	139
Community Nursing	2,862	3,034	(172)
Directorate / Pensioners	590	418	172
Sexual Health	45	43	2
Adult Services	5,472	5,407	65
Adult Social Work	2,530	2,530	0
Community Care Resources	11,350	11,748	(398)
Criminal Justice	58	27	31
Speech & Language Therapy	81	78	3
Dietetics	116	98	18
Podiatry	236	232	4
Orthotics	138	125	13
Physiotherapy	570	561	9
Occupational Therapy	1,664	1,635	29
Health Improvement	259	211	48
Unscheduled Care	2,964	3,787	(823)
Renal	202	261	(59)
SG Additionality Funding	592	512	80
Integrated Care Funding	496	495	1
Efficiency Target	(1,850)	0	(1,850)
Grand Total	**46,226**	**49,342**	**(3,116)**

The reason for the main variances (>£0.050m) is detailed in a separate document "The Annual Accounts (Draft)[6]" and summarised in the Table below.

Service	2018/19 Revised Annual Budget	Year End Outturn	Budget v Outturn Variance (Adverse)/ Positive	Reason for Variance
	£000	£000	£000	
Mental Health	2,071	2,534	(463)	Cost plus flights and accommodation for a Consultant Mental Health locum, partially off-set by an under spend against NHS Grampian Mental Health SLA due to reduced activity.
Primary Care	5,676	5,537	139	Overspend on GP locums offset by £1.2m island harmonisation funding received from the Scottish Government.
Community Nursing	2,862	3,034	(172)	Nursing bank use plus the cover for an ANP being provided by a GP from May to July 2018.
Adult Services	5,472	5,407	65	Mainly due to vacant posts at both Eric Gray Resource Centre and across Supported Living and Outreach.
Community Care Resources	11,350	11,748	(398)	Agency staff requirements and the increased cost of off-island placements during the year.
Unscheduled Care	2,964	3,787	(823)	Due to the cost of two medical consultant posts being covered by locums during the year.
Efficiency Target	(1,850)	0	(1,850)	Savings of only £0.426m, against a target of £2.276m achieved during the year. (£0.247m recurrent)

[6] https://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=24175


Year End Outturn £000
SG Additionality Funding
Renal
Integrated Care Funding
Substance Misuse
Unscheduled Care
Mental Health
Oral Health
Health Improvement
Allied Health Professionals
Pharmacy & Prescribing
Community Care Resources
Primary Care
Community Nursing
Adult Social Work
Directorate (incl Pensioners)
Adult Services

The Integrated Care Fund

Shetland Island's Health and Social Care Partnership received specific funding from the Scottish Government, called the Integrated Care Fund. The Fund is intended to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen our approach to tackling inequalities for adults. The funding helps the partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity is common in adults under 65, as well as in older people.

The table below explains what we spent the money on.

Product	**2018/19Integrated Care Fund Expenditure £**	**2017/18 Integrated Care Fund Expenditure £**
Proactive Care and Support		
Intermediate Care Service	401,444	304,171
Medical input and clinical expertise to support community initiatives including Intermediate Care and Anticipatory Care Planning.	30,000	30,000
	431,444	**334,171**
Supportive Enablers		
Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	22,338	29,778
Post Diagnostic Dementia	42,176	0
TOTAL : Integrated Care Fund Spend	**495,958**	**363,949**

The benefits to our service users that we were able to secure from this money were as follows:

- we helped more people to live independently in their own home;
- more people were able to be discharged from hospital at the right time;
- more people were able to receive early rehabilitation and enablement services, helping them to regain their function;
- people were able to be seen earlier for some specialist interventions;

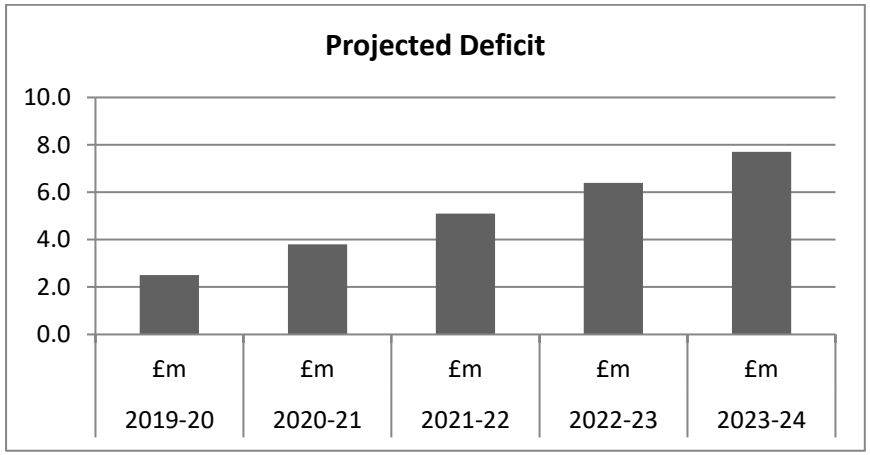
- we maintained a focus on enabling people to live within their own communities; and
- we were able to support the role of the unpaid carers in continuing care.

Financial Outlook

The financial outlook is very challenging. For the incoming financial year, the IJB will need to find savings of £2.533M on the current cost of NHS and SIC Funded services in order to balance the books. The future years are even more challenging. This is why the IJB has undertaken to look afresh at sustainable models of service delivery across the isles. The Medium Term Financial Plan sets out the gaps in funding for the current models of service delivery.

Table: Projected IJB Financial Position (Deficit) 2019-20 – 2023-24

	2019-20	2020-21	2021-22	2022-23	2023-24
	£m	£m	£m	£m	£m
Projected Deficit	(2.5)	(3.8)	(5.1)	(6.4)	(7.7)



What risks did we deal with?

Managing risks in a positive, realistic and dynamic way will help the IJB to be pro-active in ensuring that the objectives of the Strategic Plan are met. The IJB therefore maintains a Strategic Risk Register, which is a description of the things which could cause the strategic objectives to not be met (for example, outcomes not achieved or timescales not met). During 2018-19, the IJB successfully managed some key strategic risks around:

- the operation and ongoing evolution of the new IJB Board; and
- the effectiveness of the strategic plan and the ability of services to meet the needs of service users and communities.

This might have resulted in, for example:

- decisions not being made in a timely manner;
- the strategic objectives not being met; or
- service users and/ or patients not getting the services they need.

In Shetland, like other places, partnership working for health and social care has been in operation since 2004. Strong relationships and connections have been made between staff and service providers in each community, as well as at political level. The introduction of legislation to formalise the partnership arrangements, through the Public Bodies (Scotland) (Joint Working) Act 2014, continues to need effort to make sure the new arrangements are effective. The IJB have continued to pro-actively manage the key risks to make sure that decisions were made when needed, service delivery was maintained and good performance achieved.

What areas still need work?

We had an ambitious programme of work for 2018-19 and some areas will need continued and ongoing attention, sometimes over a longer period of time, to keep making a difference.

The Governance of the IJB and the partner bodies, NHS Shetland the Shetland Islands Council continue to evolve. Based on a strong history of effective partnership working, the self evaluation supported by the Scottish Government has presented the IJB with an opportunity to take stock and see where focused improvements could be made. The area of work which would warrant attention include: governance and accountability; roles and responsibilities; strategic priorities; resource allocation; and participation and engagement.

Evidence has suggested that there is a persistent, and widening, inequality gap in Shetland. The Commission on Tackling Inequalities in Shetland heard evidence relating to socio-economic equalities and geography in Shetland and the foreword of their Report states that,

> *"Shetland doesn't exhibit the extreme disparities in wealth, health and other indicators that characterise some communities. Nevertheless, the evidence gathered by the Commission confirms that, in 2016, inequality is an inescapable feature of Shetland life. Some of our fellow citizens are struggling. Their circumstances differ, but lack of sufficient money to live a decent life is a common factor. The causes of their difficulties are not simple but it's clear that a variety of influences, including changes in welfare policies, are making their position steadily more precarious".*

Tackling these issues will require new and innovative approaches, rooted in community based solutions, working across all services areas, not just in health and care.

Mental illness is one of the major public health challenges in Scotland. Around one in three people are estimated to be affected by mental illness in any one year. Improving wellbeing, resilience and mental health is therefore a priority for Shetland Islands Health and Social Care Partnership.

There are some lifestyle choices and behaviours which persist within society that may impact negatively on people's ability to look after their own well-being and live in good health for longer. We need to move away from doing things to people to working with them on all aspects of their care and support, to one based on anticipation, prevention and self management. This is an ongoing programme of behavioural and cultural change which needs to continue. This work will include, amongst other things, tackling issues around alcohol or substance misuse, obesity and physical activity.

Public sector reform over many years has focused on the need to move away from organisations working in isolation to service models being built up from the needs of individual and communities. This approach has recently been strengthened through the Community Empowerment (Scotland) Act 2015. The

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

Effective community planning focuses on where partner's collective efforts can add most value for their local communities, with particular emphasis on reducing inequalities. Shetland's Partnership Plan therefore focuses on a small number of local priorities where we will make the most difference for our most vulnerable individuals, families and communities and by moderating future demand for crisis services. Whilst all areas need to continue to deliver effective services for the Plan to work as a cohesive whole, the focus of activity for health and care will be 'People' and 'Participation'.

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

- Tackling alcohol misuse
- Healthy weight and physical activity and obesity
- Low income / poverty

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

- Satisfaction with public services
- Community participation activity and impact
- People's ability to influence and be involved in decisions which affect them

The Health and Social Care partnership recognises its role in tackling health inequalities; that that there can often be invisible barriers to people being as healthy as they can be. On this basis, we work with partners to make services as accessible as possible to people; for example, providing space for Citizen's Advice Bureau and other financial management/debt services through our health centres throughout Shetland. We will build on this type of partnership working over the next year, increasing the level of social prescribing in order to help to prevent ill health, reduce further our rates of crisis management, and reducing the demands on public services.

What next – our plans for 2019-20

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

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

The Shetland Islands Health and Social Care Strategic Plan for 2019-2022 sets out the arrangements which we intend to put in place to reconsider the level and type of service that we can sustain. This reflects the funding available and recognises some specific issues around the recruitment and retention of staff to various specialist posts. The overarching intent of our Strategic Plan is shown diagrammatically below.

The strategic change programme for 2019-20 is included below.

Whole Population Health	**Integrated and Collaborative Working**
• Mainstreaming self care / self management and early intervention and preventative services • Effective Prescribing	• Management of Long Term Conditions (eg Diabetes Pathway) • Unscheduled Care • Primary Care Improvement Plan
Enablers	
Leadership Workforce Development, Skills Mix and Recruitment and Retention Islands (Scotland) Act 2018 Technology Enabled Care Asset Based Approach / Realistic Medicine / Self Directed Support Stakeholder Engagement	

CASE STUDY - PODIATRY FOOTNOTES

By Chris Hamer— Podiatry Manager

"What's the point in asking for an appointment?
You'll have massive waiting lists like the rest of the NHS."
"There's no point in referring, you'll only have to wait ages to be seen."

The first comment came from a member of the public, while standing in the aisle of a supermarket. The second was from a healthcare professional regarding NHS Shetland Podiatry services.

They got the Podiatry service thinking:

- What is the public's and colleagues' perception of waiting times?
- What are the actual waiting times for NHS Podiatry Services in Shetland?
- What are the factors that affect our waiting times?
- What are we doing to assist our waiting times?
- What do our NHS colleagues know about Podiatry Services?

Podiatry like all other AHP services, contributes massively to the health and wellbeing of the Shetland population. The contributions made by podiatrists have been possible due to the hard work of the team, not only in isolation, but working together with and in multi-disciplinary teams. Continual service redesign, development, transformation, investment in workforce, disinvestment and redirection of resources and skills have enabled the podiatry service to increase their contributions. Not all service redesign has to be massive. Small incremental changes often bring about positive results for the Board, the service, colleagues and most of all service users. At every stage of change, podiatry has striven to explain to service users the benefits and reasons driving the change. Team members have taken on greater roles in the service and multidisciplinary teams. Skills have increased enabling seamless crossover with other services.

All Podiatrists can now directly refer to Medical Imaging (reducing GP/ANP referral and therefore freeing GP/ANP appointments). Podiatrists triage orthopaedic referrals to ensure only those patients needing orthopaedic intervention progress to orthopaedic clinics. Independent Prescribing by a team member reduces the patient journey and allows quicker pharmacological intervention.

Working with the Intermediate Care Team and the Falls MCN has had positive benefits. The instigation of the High Risk Foot Clinic in Outpatients at the GBH has allowed those most at risk to attend a speciality hub, where rapid access to podiatry and other relevant services and professionals is essential and available.

MSK Podiatry now regularly uses video technology while patients are in motion on the treadmill to assist in assessment, diagnosis and intervention. Podiatrists in Shetland continue to grow their contacts and working relationships with podiatry groups and individuals on the mainland.

In the recent past podiatry has transformed the way it works and how service provision is delivered.

Ongoing work at health centres, out with Lerwick, has shown that by providing treatments at the health centre in the morning and then visiting patients at home and in care centres in the afternoon, enables the service to be more responsive to treatment requirements. It also dovetails with NHS Shetland's drive to provide services at a local level. Redesigning and rationalising the minor surgery service within Podiatry has resulted in waiting times reducing by 30%. Further reduction in waiting times is forecast to continue into 2019.

Patients are able to self refer into the service. Self referral reduces the workload on GP, Practice Nurse and ANP services. All referrals to Podiatry are triaged by clinical staff. The Podiatry Assessment and Referral Matrix clearly indicates what the service does and doesn't provide to patients. This ensures that the referrals are relevant and sign-posted to the most appropriate clinician and/or clinic. New referrals and review MSK patients are contacted by letter to "opt in" to the service. Evidence indicates that this "opt in" method reduces DNA and CBP rates.

Podiatry administrative team members work tirelessly to match patients' appointments with patients' availability and maximise the clinician's time. Analysis indicates that the number and complexity of the service's caseload is within the range of other Scottish mainland NHS Podiatry services. Podiatry operates a robust but fair domiciliary policy, therefore reducing the number of time consuming home visits only to those truly in need of this service. Joint visits with community nursing teams, joint assessment with physiotherapists, case discussions with GPs, membership of the Falls MCN, Diabetes Advisory Group, Non Medical Prescribers Group, Tissue Viability Group and Otago programme input among others, allow Podiatry to increasingly provide a more holistic and multi-dimensional service.

Between November 1, 2017 and October 31, 2018 the podiatry service saw over 500 new patients. The Scottish Government's target is to have 95% of all AHP outpatient referrals seen within 18 weeks. The Scottish Government's target is to have 90% of new AHP MSK referrals seen within 4 weeks. The average waiting times for new NHS Shetland Podiatry patients from referral to treatment were:

- General outpatients – 3.4 weeks

- Podiatry MSK – 3.3 weeks
- High risk Foot Clinic – 3.4 days
- Podiatry DNA rates:
- New patients - 5.1 % (average Shetland NHS AHP rate – 6.5%)
- Return patients – 6.3% (average Shetland NHS AHP rate – 8.7%)

Podiatry continues to face challenges such as clinical facility availability, ageing population, increased expectation from the public, potential service fragility due to WTE staffing levels, accessing relevant training, government strategies and of course financial constraints.

Finally, a comment from a patient following their appointment:

“Following my diabetic foot screening by the Podiatrist, I now no longer feel afraid. I feel empowered, not only to look after my feet, but to make positive changes to my life style. The Podiatrist’s knowledge and skill in describing how diabetes can affect my whole body was of great use. The Podiatrists do a lot more than I thought.”

CASE STUDY - POST DIAGNOSTIC SUPPORT

By Clare Serginson

Audit of Post Diagnostic Support (PDS) Paperwork 2019: Results

As part of the PDS in Primary Care project, the provision of post diagnostic support (PDS) changed to a new model in Shetland in May 2018. The intervention is now co-ordinated through the Community Occupational Therapy service with a single PDS Practitioner working 35 hours per week and holding a caseload of clients receiving PDS.

The aim of this audit was to:

- Evaluate if this new model of PDS has improved the recording of the PDS intervention data.
- Evaluate if the current paperwork is appropriate to the task requirements.
- Evaluate the personal outcomes focus of the current system of PDS using the Essential 5 Bundle.

The main documents that make up the current paperwork for the service are:

1. Ongoing recording on the Swift electronic records system.

2. An outcome focussed care plan.

3. The national anticipatory care plan.

4. The Getting to Know Me document.

It was therefore within these four areas that the data was audited.

Audit numbers:

There were 32 client records included in the audit. These are all current clients on the PDS Practitioners caseload. Any clients closed since the new model started were not included. One client record was also excluded as they had declined to participate in the PDS process since referral. Of the 32 clients records, 8 of the outcome focussed care plans were chosen at random to complete the Essential 5 Bundle.

Results:

1. Swift electronic records –

100% of all individuals had ongoing, relevant and up to date records of PDS visits, emails, phone calls and all other PDS interventions. This is a significant improvement as the previous audit demonstrated that only 21% of clients had fully completed notes.

2. Completion of Outcome focussed care plans:

A new document introduced as part of the new model has been an outcome focussed care plan. This document forms a record of the goals agreed in partnership between the PDS practitioner and the individual as they relate to the 5 pillars of dementia support. It also provides an opportunity for these goals to be updated and reviewed.

All individuals entering the service are offered an opportunity to create a care plan. Of the 32 clients, 4 have declined to create such a plan. However, 84% of clients now have an outcome focussed care plan and 3% of clients are working on one with the PDS practitioner.

3. Completion of Anticipatory Care Plan:

In the previous audit, only 31% of individuals had an ACP recorded.

At this current time 53% of clients have a completed ACP and 44% are working on their plan. When complete 97% of clients receiving PDS will have a ACP in place. The other 3% of clients have currently declined. However, this may be revisited during future PDS visits as for some clients, completing an ACP can be a difficult, emotional task that requires sensitivity in the timing and development.

4. Completion of Getting to Know Me –

Previously 26% of individuals had the Getting to Know Me document completed. At this audit this has only increased by 2 percent to 28%. It was also noted that most of the clients completing the Getting to Know Me had done so in the early months of the new model.

5. Essential 5 Bundle: When looking over the data in the last audit the use of the essential 5 bundle was swiftly abandoned as there did not appear to be enough rich quality personal outcome focussed data to use this tool successfully. Within this audit 8 outcome focussed plans were reviewed.

The bundle looks at 5 areas against which the plans are measured: the person at the centre of the plan; personal outcomes; if person has ownership of the plan; personal resilience; and that the plan is reviewed. There are 17 questions in the bundle.

Each of the 8 care plans reviewed scored 15 out of 17 demonstrating a high level of focus on developing the personal outcomes of each individual. The format of the plans was developed with a consideration of the essential 5 bundle and this has been helpful in assisting the PDS Practitioner in facilitating outcome focussed conversations with the clients on their caseload. The paperwork therefore reflects the wishes, strengths and experiences of the individual named in the plan.

Areas for development:

- It is not always clear who has helped to develop the plan and when the creation of the plan started and ended.
- It is not explicitly stated who can amend the plan.
- None of the plans have yet been reviewed due to the youth of the service.
- The above areas will be reviewed with the PDS Practitioner.

Discussion:

- Gaps in the data:

Unlike the previous audit no gaps were found in the data. All the information was saved securely on the network.

- Accessibility of information:

Also unlike the previous audit, the PDS swift notes are accessible to other staff groups involved in the individual's care within social work. The creation of a referral process involving swift has increased the visibility of the PDS Practitioner to the wider social care team, increasing the scope of the role and the support that the practitioner can provide. In addition, with the consent of the individual or the power of attorney, the PDS Practitioner has been routinely sharing the ACP and care plan with the local primary care and social work teams. This ensures that this crucial information about the individual's long-term wishes is being utilised appropriately.

- Different staff:

During the previous audit it was noted that having 21 different staff members completing the PDS role significantly impacted on the continuity and quality of the paperwork completed. It is clear from this audit that having an identified PDS Practitioner who is supported and supervised in this role significantly improves the quality and consistency of data produced. This would suggest a similar increase in the quality and consistency of the intervention provided.

- Getting to know me:

This document has only been completed with 28% of clients. However, it is not clear that this needs to be considered an essential document as part of the PDS intervention. Having an open outcome focussed conversation allows the care plan and the anticipatory care plan to be completed as evidenced by their high levels of completion. The Getting to Know Me is useful to use with clients who are more reticent to speak and it gives the PDS practitioner another tool to use when needed. Its use will be monitored at the next annual audit.

- Anticipatory Care Plan:

Before Christmas the PDS Practitioner asked for verbal feedback from clients and their families about their experience of filling in the new national ACP. The general consensus from clients and carers was that the form was quite a task to complete, repetitive and quite depressing to consider at an early stage of dementia. This had led several clients and families to refuse to complete it. It was therefore agreed to trial the use of the Key Information Sheet from the national ACP document. This gives enough information to be helpful for primary care practitioners and is sufficiently detailed but is not off putting. This has increased the uptake in completion of ACP's to its current level and will remain current practice.

Final Summary:

This audit provides clear evidence that the new model of PDS is providing significantly improved outcomes in recording, client support and outcome focussed care planning. 97% of clients have an ACP document completed or in progress. 100% of clients have contemporaneous records on swift. The current paperwork appears to be providing sufficient guidance and direction to the outcome focused conversations that are key to the PDS intervention. Some small adjustments in the wording on the care plan form will improve this even further. It is therefore clear that employing an identified PDS Practitioner who is supported and fully trained provides better outcomes for clients, for the clinical governance of the service and is the most effective use of available resources.

CASE STUDY – COUNTERWEIGHT PLUS

By Stefanie Jarzemski — Deititian

The Scottish Health Survey 2012-2014 identified that 69% of the adult population in Shetland was overweight, above the national average. The same survey identified that 33% of the adult population was obese. In 'Keep Well' checks carried out locally in 2015-16, 38% of those who had checks were overweight and 29% were obese. Average health care costs for people with a body mass index (BMI) of 40 (severe obesity) are estimated to be at least twice those for people with a BMI of 20 (within normal weight range).

The Counterweight Plus Programme combines a total diet replacement with a structured programme of food reintroduction and weight loss maintenance, behavioural therapy and anti-obesity medication. The programme is delivered by dieticians.

The Programme Objectives were set as:

- Two Counterweight plus programmes will be run.
- Ten (10) individuals will be targeted for starting the programmes; these will be selected in consultation with the Consultants at the Gilbert Bain Hospital.

Success will be measured in line with the published data as:

- 57% of patients continued to Weight Loss Maintenance (6 no.)
- Mean weight loss of 12.4kg
- Mean weight loss for those who continued to Weight Loss Maintenance of 14.7kg
- of all 10 patients who started 64% lost some weight (6 no.)
- 33% of all patients enrolled maintained a weight loss ≥ 15kg (3 no.)
- Plus reduction in demand for long term prescription costs, as well as community care costs.

The actual number of people participating was 8. Of those 8, 1 person was unable to complete the programme and 7 were able to finish and all of them achieved positive outcomes.

The assessments to start the programme were appropriate and the reason for the drop out of one patient was unforeseen.

The Table below summarises the achievements of the programme as at November 2018.

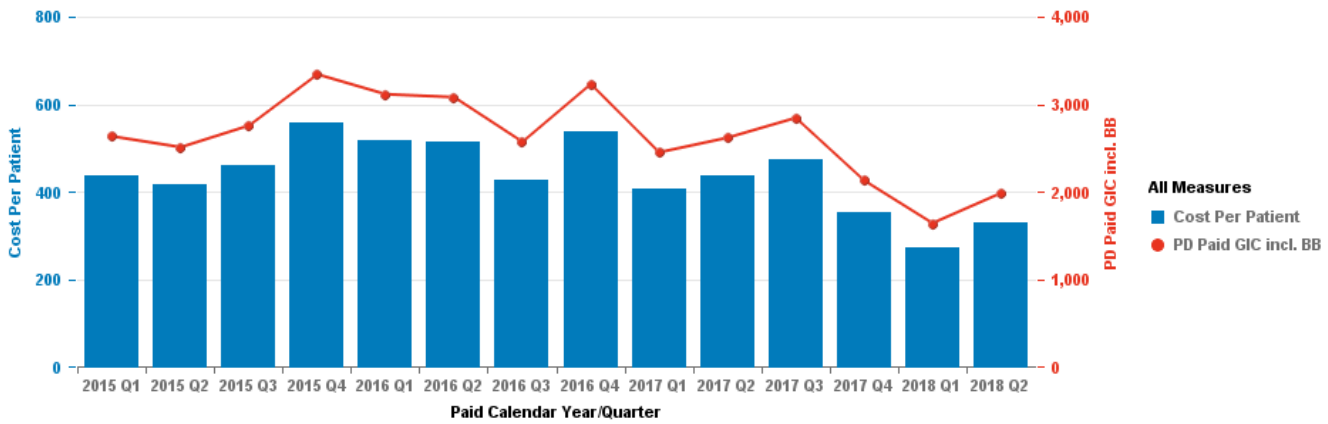
Programme Objective	Target	Actual	Notes / Comments
No. Counterweight Plus Programmes	2	2	
No. Individuals starting programme	10	8	
No. Individuals completing programme	8	7	
No. Individuals who lost 'some' weight	6	8	
No. Individuals Achieved Weight Loss Maintenance	6	6	
Mean Weight Loss (Overall)	12.4 kg	21.1 kg	Based on 8 individuals starting
Mean Weight Loss (Weight Loss Maintenance Patients)	14.7 kg	25.6 kg	Based on 6 individuals completing the programme
No. Patients who maintained a weight loss of ≥ 15kg	3	5	
Reduction in prescribing costs	No target set	£5,865 pa[1]	For 4 patients
Potential savings from Bariatric Surgery	No specific target set	Estimated at potential future cost of £9,700 - £11,500	1 Patient - Surgery not booked so seen as avoiding future costs.
			2 Patients on list and going through assessment for Bariatric Surgery (not yet confirmed whether surgery will be required in future).

[1] SAVINGS:

1. £5,865 is for insulin reductions only in 4 patients, retrospectively calculating yearly insulin costs at the start (assuming same dose in preceding 12m), then prospectively calculating yearly insulin costs after intervention (assuming same dose for next 12m). This should only be seen in context of insulin and for the 4 patients it was calculated for.
    a. T2DM patients are already given relaxed criteria for entry as far as I'm aware (reduced BMI threshold >30, vs >35 for non T2DM).
    b. Would avoid using prescribing savings potential as criteria for inclusion, but that insulin dependent T2DM patients are likely to be higher risk and prioritised based on their morbidity burden.

2. Group savings are illustrated below (CHI linked prescription data), along with average saving per patient. If calculating change, compare Q1+2 2016 with Q1+2 2018 as there's some seasonality in prescribing costs. This is **calendar** year data, so Q1 is Jan-Mar.

COST PER PATIENT AVG (BARS) WITH GROUP COST OVERLAID (LINE)



The progress which the patients have made can best be described by personal life / case studies.

Patient 1:

Before the programme started, the patient had a BMI of 55.2kg/m2 and intended to lose weight in order to be considered for surgery on his right knee due to the severity of pain. At this time, he has lost a total of 34.7kg and has a BMI of 39.8kg/m2 which is a significant reduction. He reports he no longer requires surgery for his knee at this time as the pain levels have significantly improved and he has also been discharged from physio. He also reports noticing a marked improvement in overall fitness levels including being able to cut the grass in one session within a couple of hours which would have previously taken two days of broken attempts to complete this in full.

Patient 2:

Before the programme started, the patient had a BMI of 48 kg/m2 and his weight was 153.7kg. Due to Counterweight Plus programme he was able to reduce his weight to 117kg and his BMI is now 36.5 kg/m2. His overall weight loss is 36.7kg. He is now able to do exercise and he could reduce blood pressure, diabetes medication. His sleep apnoea has also improved. His story was reported in the Shetland Times and is included at Appendix 3 for ease of reference.

One client was unable to continue with the programme after lack of compliance resulted in symptomatic malnutrition and it was deemed unsafe to continue with a very low calorie diet at this stage.

Case Study: Primary Care Pharmacy and Telehealth

By: Community Pharmacy

Introduction & Background

An 86 year old lady was referred to primary care pharmacy for medicines management assessment after arriving home having had a total knee replacement. Upon discharge, the lady was started on 7 new medicines. Most of the medicines were prescribed in an acute form to treat a short term issue, in this case:

- Dalteparin – Prevents DVT after being discharged
- Ferrous Fumarate – Iron to help increase haemoglobin after blood loss during her procedure
- Nefopam and Paracetamol – post –op pain management
- Laxido and Docusate – To help with constipation caused by the iron
- Ranitidine – Protect the stomach

Presenting Problems

1. **Compliance Issue**-According to her family, Mrs X has always been non compliant with her medicines, prior to her surgery she was only prescribed a once daily medicine for her blood pressure. She has also been referred to the dementia team to due memory problems.
2. **Lack of social care**- a referral was sent to the care at home team in that locality to provide medication visits to ensure this lady received her medicines , however this was quickly sent back by the service as an 'unmet need' due to limited resources.
3. **Pain** – pain was mainly from the wound and sight of operation, she was prescribed 2 medicines for pain but chose not take them.
4. **Anaemia**- as a result of the operation, this lady was anaemic and was feeling low and tired as well as in pain. She was prescribed iron which she chose not to take.
5. **Re-enablement**- due to her age, this lady was at risk of not improving after her procedure, she needed to be able to engage with OT once her pain was under control.

Aim:

We aimed to help enable Mrs X to be more compliant with her medicines in order for her to recover as quickly as possible after her operation. This was made difficult due to her memory problems, polypharmacy and general distrust that her medicines would improve her life.

Method:

An automated carousel Telehealth device was chosen. This is a locked device which the family fills with the prescribed medicines; it is programmed to alarm and pivot so the medicines for that dose only can be taken by the person independently.

Training and support was given to the patient's family member who was to take responsibility for filling and managing the device. This was done over a series of device fills with the Community Care Pharmacy Technician observing.

Results:

Six months later the Community Care Pharmacy Technician carried out a telehealth review with Mrs X and her family. By this point things had improved greatly; she was much brighter and happier than previously, she was mobile, driving her car, her pain was significantly improved and she was relatively independent with the support of her family.

As an added benefit to this case, we have managed to save £4,712.15 per year (less the cost of the device and sundries) in the originally proposed social care visits for this lady with the introduction of the telehealth device and support from the Primary Care Pharmacy Team.

Case Study: 'Caring for Bressay'

By: Community Nursing

The 'Caring for Bressay' Health and Care Project is jointly sponsored by Bressay Community Council and Shetland Health and Social Care Partnership. The project is looking at the health needs of its resident population and the provision of health and social care services on the island.

The Island of Bressay, which has a population of approx 320 people, is a non-doctor island that was previously served by a resident nurse who was the first point of contact for all healthcare needs on a 24/7 basis. Bressay, however, has experienced a recent turnover in resident nursing staff, with the most recent postholder resigning from the position in 2017, having ceased to provide a service on a residential basis to islanders from July 2017.

Additional issues and challenges have been identified with working in non-doctor island posts, such as professional isolation, changes in career structure and expectations, as well as living in remote communities and difficulties maintaining a work-life balance, on call and Working Time Directive challenges are all acknowledged as additional drivers for change. Over the same time period, in addition to the difficulty experienced in recruiting and retaining individual nurses in this post, the NHS Board also received various expressions of concern over the service provided. Due to recruitment challenges, and subsequently through the travel challenges posed by sending care staff from Lerwick, difficulties have also been experienced in the provision of social care services to residents on Bressay.

A Project Board was formally established in 2018 comprising of Bressay Community Council reps, Chief Nurse (Community), Service Manager (Primary Care), Practice Manager (Lerwick Health Centre, covering Bressay), Advanced Nurse Practitioner, Executive Manager Community Care Resources, voluntary/third sector rep, carers rep, Elected member (Shetland Islands Council), Community Planning and Development Officer, Scottish Health Council Local Officer (with guidance and support received from the Service Change Advisor as and when needed), SAS rep, Scottish Fire and Rescue Service rep, NHS 24 rep.

During 2018 regular Project Board meetings have taken place to look at the health and care provision for Bressay residents. In addition, discussions have focused on possible approaches to use to engage with the island residents.

The following activities have been undertaken:-

- A service information leaflet was jointly produced by the Health and Social Care Partnership and Bressay Community Council and delivered to each household on the island of Bressay.

- A public survey was conducted by way of a questionnaire that was jointly developed by the members of Bressay Community Council and the Health and Social Care Partnership, with input from the Scottish Health Council. Seventy four responses were received which was a response rate of 41% of households. The questionnaire displayed both the logos of the Community Council and the HSCP to illustrate that this project is being carried out in partnership.

- An Open drop in session for the residents of Bressay was held in September, this was jointly planned and hosted by the Community Council and the HSCP staff. This was an opportunity to share information about the project to date including some of the feedback received so far from the survey. It also provided residents with an additional opportunity to have a say. A number of information stalls provided information to islanders about the many services available. The session also introduced Ketso and invited people to sign up to the Ketso session that was being held later that month. Fifty people attended the drop in session, feedback received was very positive.

- A follow up Ketso session took place , jointly hosted by the Health and Social Care Partnership and Bressay Community Council. The Scottish Health Council facilitated the Ketso session along with Health and Social Care Partnership staff. Seventeen participants attended, with Ketso being well received.

- Action Planning sessions are now in place.

The Project Board is continuing to meet to review the findings of all of the engagement activities that took place.

A new service model is currently being developed by the Project Board, which will be circulated to the wider Bressay community to seek their views. The final model will then be presented to the Integrated Joint Board for approval.

It is hoped that the engagement model that has been developed through undertaking the 'Caring for Bressay' project will be used elsewhere across Shetland. It is currently being considered by another outer island Community Council and an invitation has been sent for members to attend a 'Caring for Bressay' Project Board meeting to witness the joint approach this project has had from the start.

Appendix 1, Performance on Health and Wellbeing Outcomes

Indicator	Shetland Current	*Shetland* Previous	+/- Shetland	*Scotland Current*	+/- Scottish Rate
1. Percentage of adults able to look after their health very well or quite well. (2017-18)	94%	95%	-	*93%*	+
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible. (2017-18)	78%	78%	=	*81%*	-
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. (2017-18)	75%	81%	-	*76%*	-
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. (2017-18)	72%	60%	+	*74%*	-
5. Percentage of adults receiving any care or support who rate it as excellent or good. (2017-18)	86%	85%	+	*80%*	+
6. Percentage of people with positive experience of care at their GP practice. (2017-18)	83%	89%	-	*83%*	=
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. (2017-18)	83%	84%	-	*80%*	+
8. Percentage of carers who feel supported to continue in their caring role. (2017-18)	41%	54%	-	*37%*	+
9. Percentage of adults supported at home who agree they felt safe. (2017-18)	80%	79%	+	*83%*	_
11. Premature mortality rate (per 100,000 population) (2017)	323	289	-	425	+

Indicator	Shetland Current	*Shetland* Previous	+/- Shetland	*Scotland Current*	+/- Scottish Rate
12. Rate of emergency admissions for adults. (per 100,000 population) (2017-18)	10,350	10,011	-	12,183	+
13. Rate of emergency bed days for adults. (per 100,000 population) (2017-18)	65,137	72,509	+	123,035	+
14. Readmissions to hospital within 28 days of discharge. (per 1000 population) (2017-18)	69	69	=	102	+
15. Proportion of last 6 months of life spent at home or in community setting. (2018-19) (provisional)	94.2%	96%	-	89.2%	+
16. Falls rate per 1,000 population in over 65s. (2017-18)	18	21	+	22	+
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. (2017-18)	88%	94%	-	85%	+
18. Percentage of adults with intensive needs receiving care at home. (2016-17)	74%	73%	+	61%	+
19. Number of days people spend in hospital when they are ready to be discharged. (per 1,000 pop) (2017-18)	505	528	+	762	+
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. (2017-18)	14%	15%	+	25%	+

Note: using latest available data; some national surveys are only undertaken every 2 years.

Appendix 2, Infographic

Approved Version, IJB Board 27 June 2019