Shetland Islands Health and Social Care Partnership

Annual Performance Report 2017-18

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.

Welcome .... to the second Annual Performance Report for Shetland Islands Health and Social Care Partnership. This report covers our second 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.

Simon Bokor-Ingram
Director of Community Health and Social Care for NHS Shetland and Shetland Islands Council
Chief Officer of Shetland's Integration Joint Board (IJB)

Contact Details

We always welcome comments on what we do. Comments or questions about this document, including requests for support information or documentation should be made to:

Shetland Isles Health and Social Care Partnership
NHS Shetland Board Headquarters
Montfield Offices
Burgh Road
Lerwick
Shetland, ZE1 0LA
Telephone: 01595 743697
Email: simon.bokor-ingram@shetland.gov.uk or simon.bokor-ingram@nhs.net

Contents

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.

Background

Shetland Islands Integration Joint Board (IJB) was formed in July 2015 and become operational with the approval of the Strategic Plan in November 2015. Following a short period of operation, we chose to update the Strategic Commissioning Plan to make it more strategic and focused and the revised version received approval in March 2017 for the period up to 2020.

The IJB is responsible for the planning, and ensuring the delivery, of the services within Shetland Island's Health and Social Care Partnership. The IJB is a separate legal entity and operates with full autonomy. Once the Strategic Plan is agreed, NHS Shetland and Shetland Islands Council then deliver the services that are set out in the Plan.

The Plan includes **services** for:

Adults with learning disability and autistic spectrum disorder
Adult social work
Unpaid carers
Residential care, permanent, respite and short breaks
Day care support
Care at Home, including nutritional support
Community nursing
Criminal justice
Community rehabilitation and intermediate care
Dementia
Domestic Abuse
GPs
Health Improvement
Mental Health
Nutrition and Dietetics
Occupational Therapy
Oral Health
Orthotics
Pharmacy and Prescribing
Physiotherapy
Psychology
Podiatry
Aspects of hospital services, unscheduled care
Speech and Language Therapy
Substance Misuse

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

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.

Priorities and Actions

We set out to put in place arrangements to improve our services through a range of initiatives and activities, building on work from previous years.

Strategic Planning

As a key partner, the IJB has considered and contributed to a number of strategic plans during the year, at a national, regional and local level. The IJB considered:

- Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland
- The North of Scotland Regional Clinical Strategy
- The North of Scotland Regional Health and Care Delivery Plan
- The Draft Shetland Partnership Plan, known as the Local Outcome Improvement Plan (or LOIP)

Service Developments

Within its remit, the IJB oversaw the approval of several strategic initiatives which will further develop and improve services in the areas of:

- the extension of the work of the Intermediate Care Team;
- Autism Spectrum Disorder, through the approval of a new Strategy from 2016-2021; and
- Falls Prevention, through approval of new funding to extend the reach of the pilot project into all areas of Shetland.

Governance and Decision Making

The IJB also continued to improve the documents which guides the way in which it works and takes good decisions. During the year, the IJB:

- Formalised its approach to 'Directions', which is the mechanism by which the IJB passes operational delivery instructions to its service delivery Partners, NHS Shetland and Shetland Islands Council, in order to action the Joint Strategic Commissioning Plan;
- Established a formal programme and project management framework to oversee the delivery of the 'change' projects which were agreed as part of the Strategic Plan;
- Agreed a Market Facilitation Strategy, which sets out how the IJB will interact and support the work of third sector, and others, in helping to deliver good health and care outcomes;
- Agreed a Protocol to support joint working between the NHS and the Council, to help staff work in a more integrated way and help our service users to receive a seamless service; and
- Updated the Integration Scheme to take account of the Carers (Scotland) Act 2016.

Some key service changes that have happened, or continued in the year, include:

- The work to review and redesign our mental health services continues. The overall project has a number of workstreams – including skills and skills development, referral protocols and formalising the services' needs assessment. There is a particular strand of work being done to make sure that we have the right services in place to meet people's needs across a range of complementary services. The project aims to:
    - Ensure people who require services achieve better outcomes;
    - Assess service users needs, outcomes and recovery plans;
    - Ensure that services are integrated, flexible and responsive to people's assessed need;
    - Assess the extent to which services are supporting people to live safely and independently through a focus on recovery and / or maintenance of long term conditions / preventable relapse; and
    - Ensure resources are used effectively and wisely.

- The Criminal Justice Service has continued to support the development of the local Community Justice Partnership and is actively assisting with the Local Outcome Improvement Plan. Community Justice is about individuals, agencies and services working together to support, manage and supervise people who have committed offences and also to support those who are affected by crime. The service produces a separate Community Payback Annual Report which reflects trends and issues within the Service on an annual basis. Generally, key performance indicators are maintained though there are times when standards are not met due to circumstances outwith the service's control.

- A review of services for adults with learning disabilities and autism started last year with an audit of the service by a Scottish University. The review will continue during 2018-19 to redesign services to ensure that the people who need these services achieve better outcomes and that we achieve fair and equal access to services and resources. Meanwhile, it is worth noting that during 2017-18, 34% of Adults with a Learning Disability were in some form of employment – this includes voluntary, supported, paid employment and can be for only a few hours a week. This was the highest in Scotland for 2017-18. During the year 22% of people with learning disabilities have undertaken some form of education.

- The Government released their Oral Health Improvement Plan in January 2018 which reinforced their direction on dental services being provided by independent NHS providers ("high street dentists"). In Shetland, this has in the past been supported by government grants to establish NHS dental practices - similar to the arrangements in place for pharmacists and opticians. The target is to see a net rise in registration figures within the NHS Independent sector, as that brings with it the responsibility of these dental practices to provide sufficient access for patients, and decreasing the dependence of the local population on the Public Dental Service for providing their routine care. This evolution in how dental care is provided in Shetland will take time but our most recent performance shows the percentage of the adult population who are registered with Shetland dentists for NHS dental care gradually increasing; in 2018 over 96% of children and 88% of adults in Shetland were registered with an NHS dentist. In 2015, 100% of these patients were registered with the Public Dental Service. In 2018, over 25% of registered NHS patients are registered with the independent NHS practice in Lerwick.

- The investment in community pharmacists has enabled reviews to be done with patients who have complex or multiple prescriptions, to make sure that their medicines are well-managed. Not only is this better for the patient, it also helps to save money by cutting out

unnecessary prescriptions and costs. Number of polypharmacy reviews completed during the year was 307 (an increase/decrease on 2016-17 at 298).

- The Intermediate Care Team pilot continued to deliver good outcomes for people moving from a period in hospital back to their home, or a community setting. The service saw about 80 clients from December 2016 – December 2017 and 89% of clients from the inception of service to March 2018 had a reduced dependency score upon discharge.

Self Directed Support continues to grow

Our continued focus on helping people to help themselves and giving people more choice and control has resulted in an increasing investment in Self Directed Support (SDS) option 1 (direct payments). The overall number of packages stayed stable at just under 50 clients. This gives service users who have assessed care needs responsibility for managing their own budget for the help they need in a way that suits them.

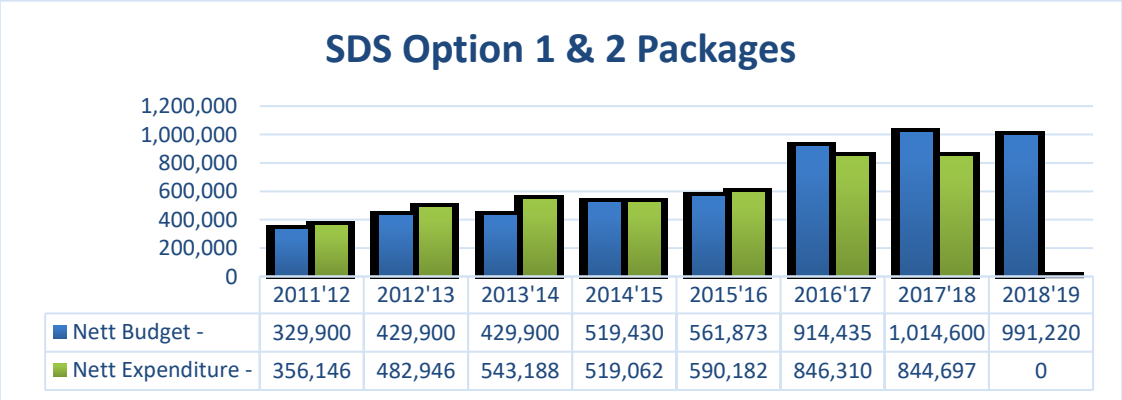
Self- directed support allows people to choose how their support is provided, and gives them as much control as they want of their individual budget. It reflects the personalised support a person purchases or arranges, to meet agreed health and social care outcomes. It offers a number of options for getting support. The person's individual (or personal) budget can be:

- taken as a Direct Payment (a cash payment);
- allocated to a provider the individual chooses (sometimes called an individual service fund, where the council or funder, holds the budget, but the person is in charge of how it is spent); or
- the council can arrange a service.

Individuals can choose a mixture of all 3 for different types of support. The national Implementation plan for 2016 – 2018 has the following strategic outcomes:

- Supported people have more choice and control
- Workers are confident and valued
- Commissioning is more flexible and responsive
- Systems are more widely understood, flexible and less complex

The number of people using Self Directed Support Options 1 and 2 to meet their support needs has doubled going from 2% (of those using **all** social care) in 2014/15 to 4% in 2016/17, as shown below.



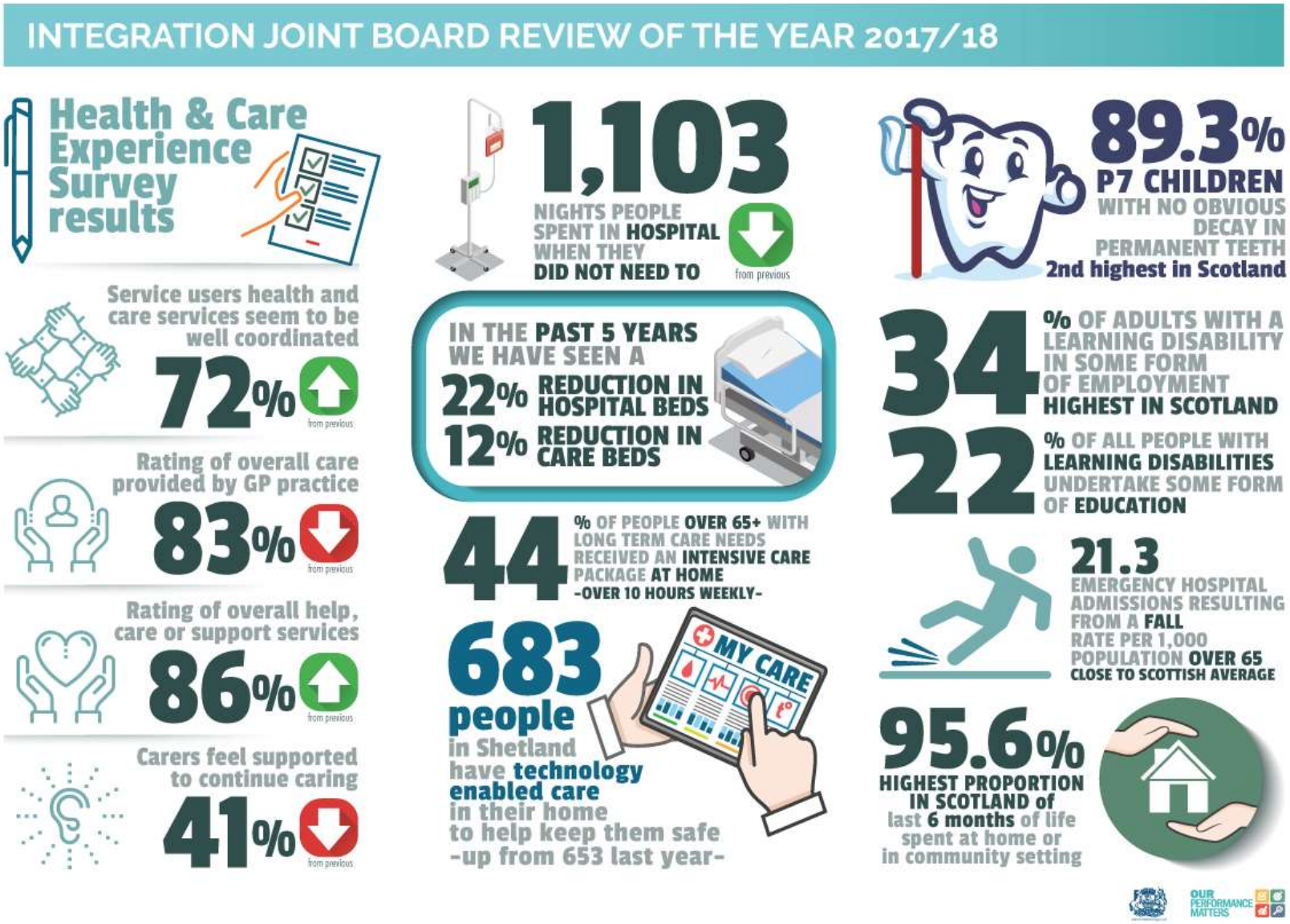
	2011'12	2012'13	2013'14	2014'15	2015'16	2016'17	2017'18	2018'19
Nett Budget -	329,900	429,900	429,900	519,430	561,873	914,435	1,014,600	991,220
Nett Expenditure -	356,146	482,946	543,188	519,062	590,182	846,310	844,697	0

However, we are still below the Scottish average in terms of those people who are choosing to manage their own support, which is 6.5% nationally compared to 4% locally.

How Have We Performed?

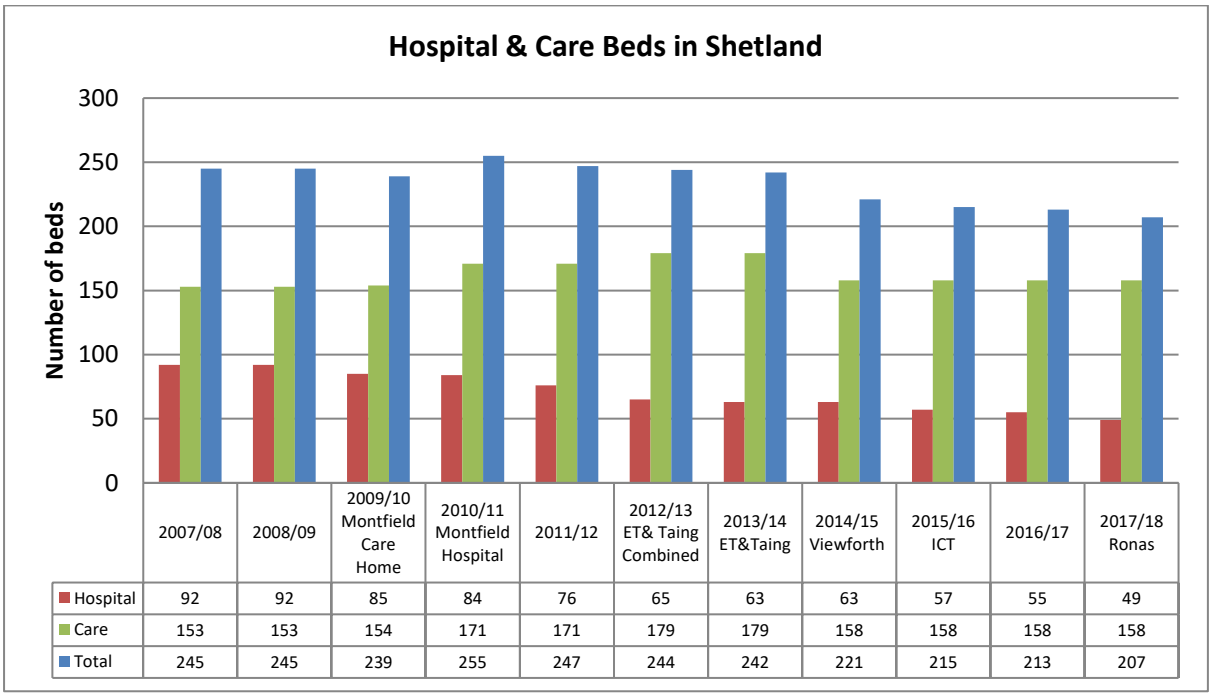
Measuring what we do to make sure that we are doing the right things is a key part of performance reporting. So, how do we know how we are performing?

The summary below is a visual snapshot of performance and activity during 2017-18, covering a range of indicators and services.


INTEGRATION JOINT BOARD REVIEW OF THE YEAR 2017/18
Health & Care Experience Survey results
Service users health and care services seem to be well coordinated
72% from previous
Rating of overall care provided by GP practice
83% from previous
Rating of overall help, care or support services
86% from previous
Carers feel supported to continue caring
41% from previous
1,103
NIGHTS PEOPLE SPENT IN HOSPITAL WHEN THEY DID NOT NEED TO
from previous
IN THE PAST 5 YEARS WE HAVE SEEN A
22% REDUCTION IN HOSPITAL BEDS
12% REDUCTION IN CARE BEDS
44
% OF PEOPLE OVER 65+ WITH LONG TERM CARE NEEDS RECEIVED AN INTENSIVE CARE PACKAGE AT HOME
-OVER 10 HOURS WEEKLY-
683
people in Shetland have technology enabled care in their home to help keep them safe
-up from 653 last year-
MY CARE
89.3%
P7 CHILDREN WITH NO OBVIOUS DECAY IN PERMANENT TEETH
2nd highest in Scotland
34
% OF ADULTS WITH A LEARNING DISABILITY IN SOME FORM OF EMPLOYMENT
HIGHEST IN SCOTLAND
22
% OF ALL PEOPLE WITH LEARNING DISABILITIES UNDERTAKE SOME FORM OF EDUCATION
21.3
EMERGENCY HOSPITAL ADMISSIONS RESULTING FROM A FALL
RATE PER 1,000 POPULATION OVER 65
CLOSE TO SCOTTISH AVERAGE
95.6%
HIGHEST PROPORTION IN SCOTLAND of last 6 months of life spent at home or in community setting
OUR PERFORMANCE MATTERS

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.

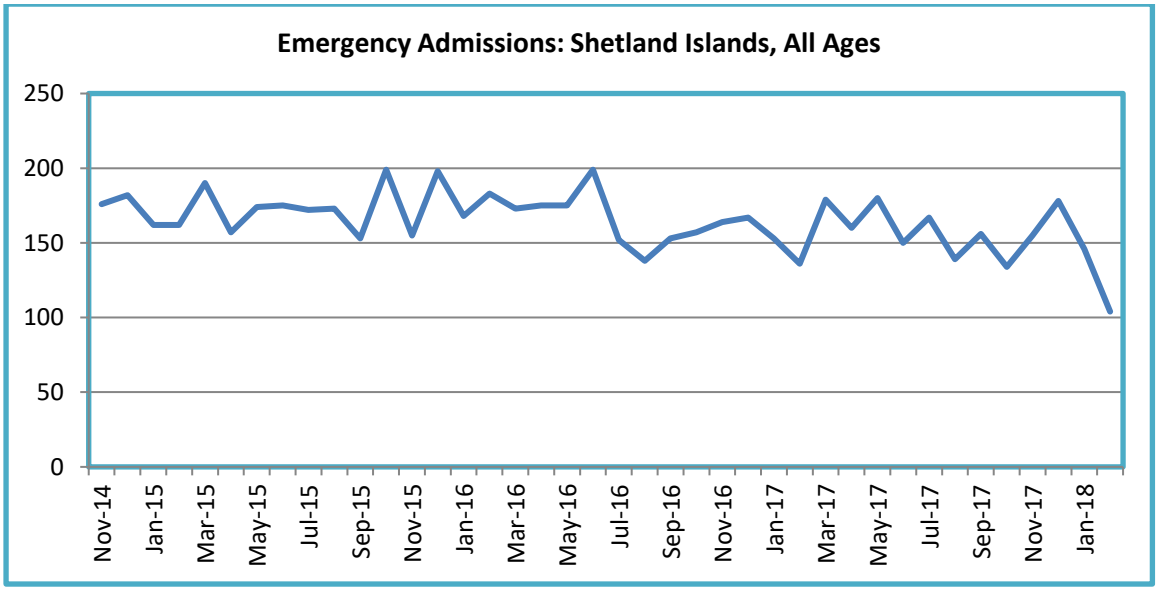


	2007/08	2008/09	2009/10 Montfield Care Home	2010/11 Montfield Hospital	2011/12	2012/13 ET& Taing Combined	2013/14 ET&Taing	2014/15 Viewforth	2015/16 ICT	2016/17	2017/18 Ronas
Hospital	92	92	85	84	76	65	63	63	57	55	49
Care	153	153	154	171	171	179	179	158	158	158	158
Total	245	245	239	255	247	244	242	221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

The Scottish Government supports a focus on six key service areas through the use of ten performance indicators covering:

- Number of emergency admissions
- Admissions from Accident and Emergency
- Number of unscheduled hospital bed days; acute specialties
- Number of unscheduled hospital bed days; long stay specialties
- Accident and Emergency Attendances
- Percentage of attendances at Accident and Emergency seen within 4 hours
- Delayed discharge bed days
- Percentage of last six months of life by setting
- Number of days by setting during the last six months of life
- Balance of care: Percentage of population in community or institutional settings

Shetland performs well across these indicators. The section below shows the trends on each of the indicators in turn, together with an explanation of the IJB's target performance. The latest data available has been used and does not all relate to the 2017-18 reporting period (as data is not yet available).



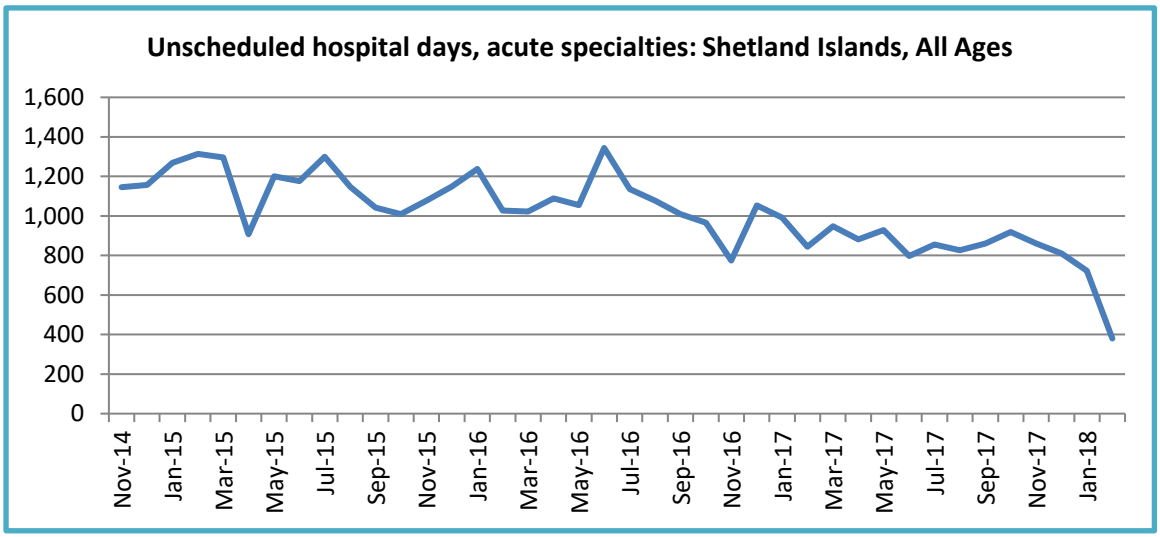
Current Performance

- The emergency admission to hospital rate is lower than the Scottish average; 2016-17 10,011 / 100,000 compared to Scottish average of 12,294

- First in Scotland 2016-17

Performance Target

✓ Maintain current position within Peer Group.

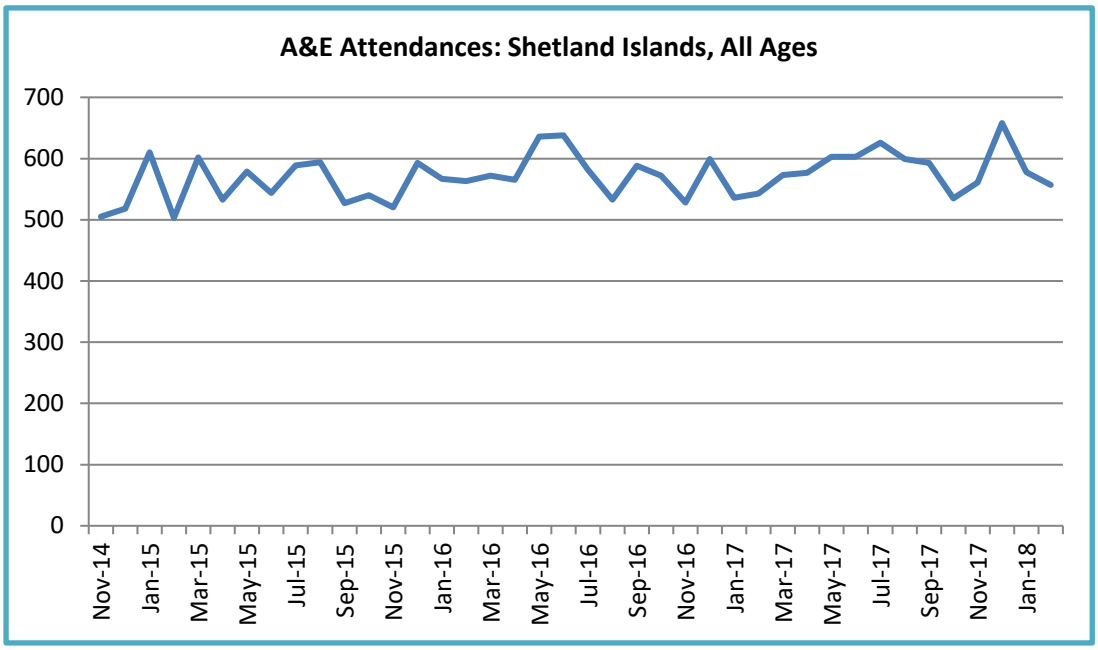


Current Performance

- Rate of Emergency Bed Days for Adults - 2016-17 72,509 per 100,000 population compared to Scottish average of 125,634
- Emergency Bed Day Rates for People Aged 75+ - Target 500 (per month) - at December 2017, 352, range within 1 year period is 223 – 410
- The rate of emergency bed days is low indicating fewer days are spent in hospital after an emergency admission.
- Second best in Scotland 2016-17 (Adults)

Performance Target

✓ Maintain current position within Peer Group



A&E % seen within 4 hours

Year	2015-16	2016-17	2017-18
Average Performance	96.2	96.0	96.5

Current Performance

- Consistently meeting target of 96%

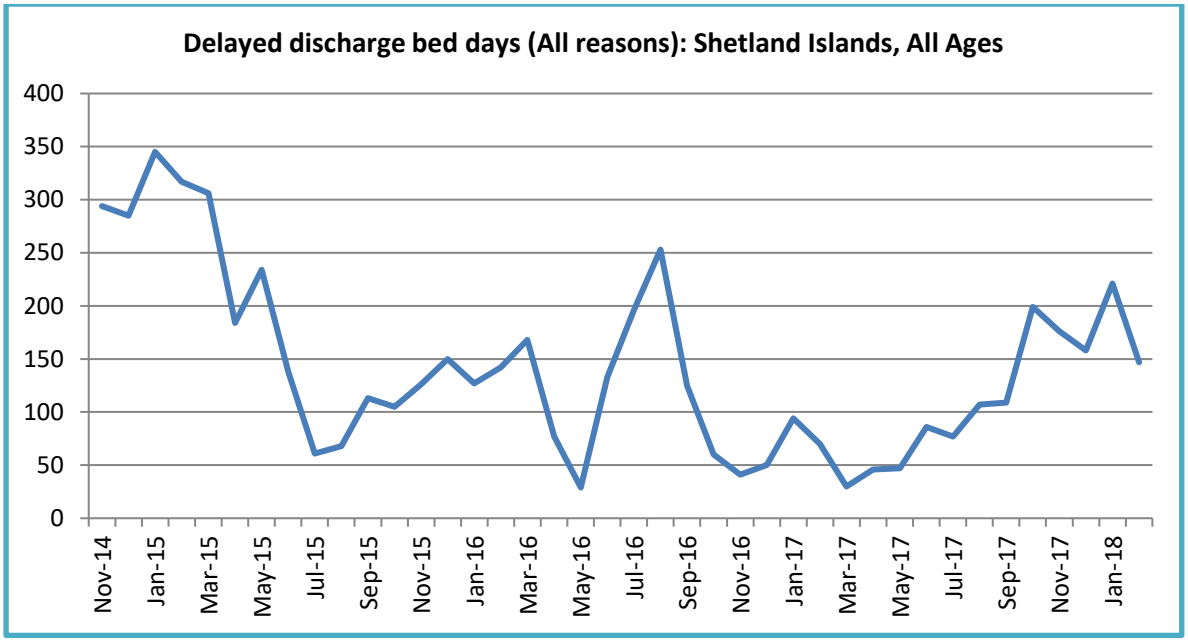
Performance Target

✓ To maintain current position and achieve the 96% target by March 2019.

Case Study

A client with significant and critical care needs lives alone, on one of our remote islands with secure broadband connections. His care needs require 4 visits a day to enable him to live safely in his own home. There are no care staff on that island to provide a personal service. Through a European funded project, called REMOAGE, a software package has been developed to provide a remote service between the client and the care hub, which is on another island. This allows care staff to remotely 'check in' with the client, to make sure he, for example, takes his medication, eats regularly and is moving safely around his own home.

For more details on the Remoage project, watch the attached video clip, which shows some real life examples of how it has helped our clients to continue to live safely in their own homes https://www.youtube.com/watch?v=zOZpbo1VGBk.



Current Performance

- Number of days people spend in hospital when they are ready to be discharged 2016/17 528 / 1,000 population, compared with 842 Scottish average

- Delayed Discharge - Total Number of People waiting to be discharged from hospital into a more appropriate care setting, once treatment is complete January – March 2018, range from 0 – 8 people.

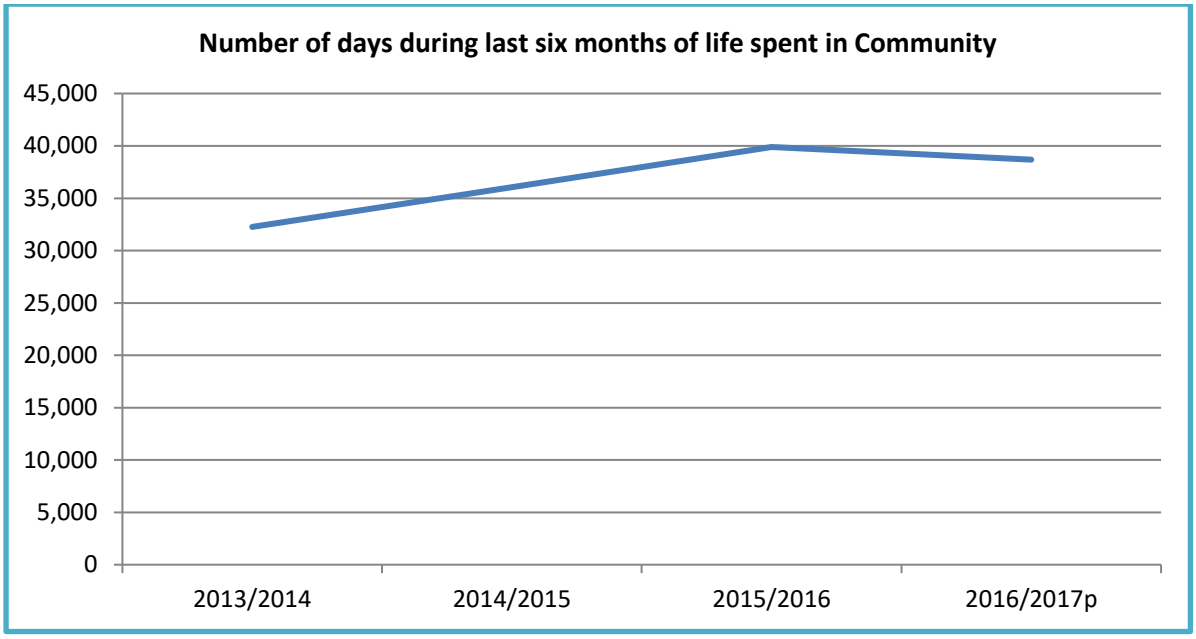
- The readmission rates to hospital within 28 days of discharge is low, indicating that services are working at discharging people when they are ready and then keeping them in the community thereafter.

- First in Scotland 2016-17

Performance Target:

- ✓ Maintain current performance

Note: Whilst our target is zero, 3 in number is the point at which managerial action is taken.



Percentage of last six months of life by setting in community:

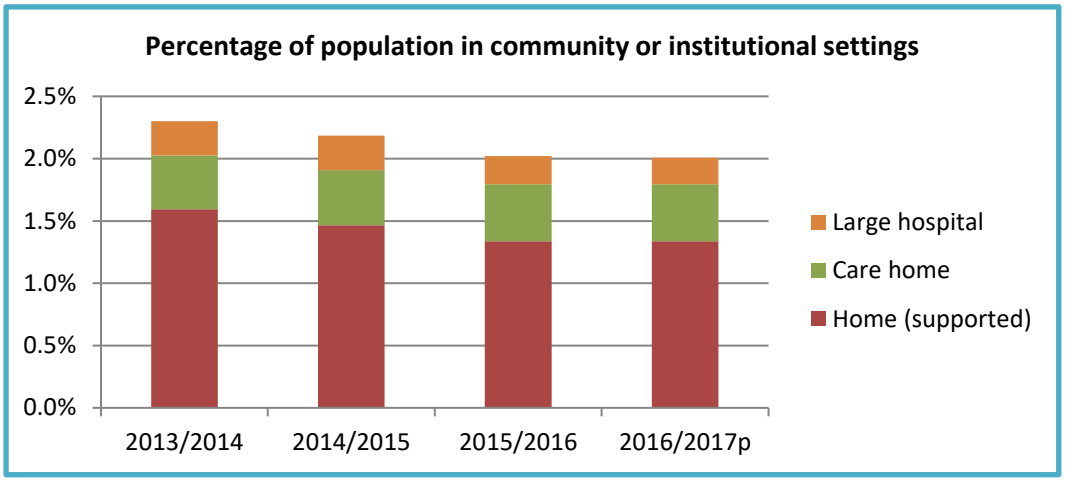
	2013/2014	2014/2015	2015/2016	2016/2017
Average Per Year	92.1%	92.3%	92.6%	93.8%

Current Performance

- Proportion of last 6 months of life spent at home or in community setting 2017-18 96%, compared to Scottish average of 89%
- Shetland is the best in Scotland for the percentage of the last six months of life spent at home or in a community setting (2016-17 data)
- The percentage of adults with intensive needs receiving care at home is well above the Scotland average.

Performance Target:

- ✓ Maintain current performance



Note: The 'Home (unsupported)' setting is not shown on the chart

Balance of care: Percentage of population in community or institutional settings

Setting	2013/2014	2014/2015	2015/2016	2016/2017[p]
Home (unsupported)	97.7%	97.8%	98.0%	98.0%
Home (supported)	1.6%	1.5%	1.3%	1.3%
Care home	0.4%	0.4%	0.5%	0.5%
Large hospital	0.3%	0.3%	0.2%	0.2%

Current Performance

- Percentage of adults supported at home who agree that they are supported to live as independently as possible. 2017-18 - 78% compared to Scottish average of 81%

- Eleventh in Scotland 2015-16

Performance Target

- ✓ To improve this outcome to be in line with peer group average of 86% (+8% by next survey date 2017-18).

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

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.

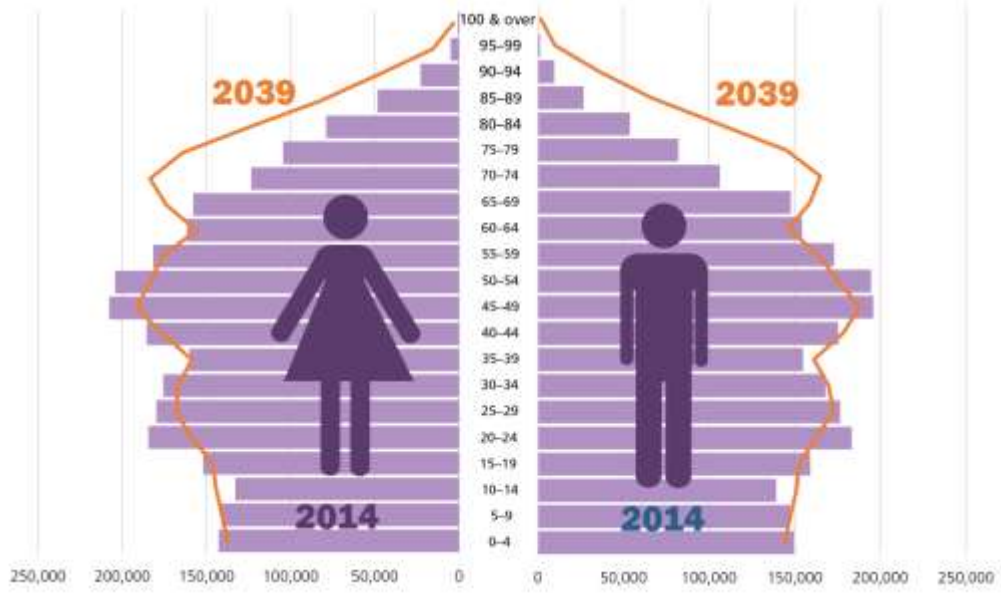
Shetland has traditionally had a good life expectancy and a level of health amongst the best in Scotland, reflecting the high quality of life in Shetland, as well as the quality of local services. Recently, the year on year improvements in life expectancy have slowed down across the UK, including Shetland. 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 24 people had successfully stopped smoking by January 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 required 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.

However, our population is aging rapidly, which is and will cause an increase in demand for health and care services. This is a diagram for the population of Scotland and Shetland's population is predicted to age at a faster than average rate to Scotland as a whole.



Source: UK Parliament - https://publications.parliament.uk/pa/cm201617/cmselect/cmscotaf/82/8205.htm

One of our principle aims is to help people to live longer and healthier lives, at home, or in a homely setting. Here is how we help people to do that...

111 people enjoyed support with nutrition in their own homes.	We have fitted technology into 683 people's houses.
We enabled 59 people to continue to live safely in their own home through intensive care at home provision each week, a small reduction on the previous year.	We kept the number of people who were fit to leave hospital but waiting for a care package at below single figures all year.
An Anticipatory Care Plan is a record of the preferred actions, interventions and responses that care providers should make following a clinical deterioration or a crisis in the person's care or support. At March 2018, 1,119 Anticipatory Care Plans were in place, an increase of 58 over the previous year.	Increased use of permanent beds for enablement and respite care means occupancy levels decrease for care homes. Effectiveness of care provided at home also results in less demand for residential beds. For 2017-18, we achieved an occupancy level of 83%, a reduction over the previous year at 86%.
About 170 people regularly attend Day Care settings each month.	We deliver over 1,800 hours of home care every week across Shetland.

We measure access to treatment for a whole range of services. In 2017-18 ...

For people needing treatment to support recovery from alcohol dependency, over 96% of our clients waited no more than 3 weeks from referral.	Our advance booking for GP and other appointments saw a decline in performance from 76% to 61%. This pattern is similar to the whole of Scotland, but our decrease is more significant and is likely to be a reflection of the overall undersupply of doctors.
We achieved 100% compliance for those patients who need to speak to a healthcare professional on the day and 100% compliance for those patients who request an appointment within 48 hours.	For people waiting for their first Consultation for Physiotherapy Services, we were able to see 99.3% of patients within 18 weeks.

The Health and Care Experience survey (HACE) was sent to a random sample of patients who were registered with a GP in Scotland in October 2017 for completion.

The 2017-18 results have been published and four indicators have moved significantly, albeit we are still close to the national position:

- 'Service users health & care services seem to be well coordinated' has improved by 12%
- 'Rating of overall help, care or support services' has improved by 7%
- 'Rating of overall care provided by GP Practice' has decreased by 6%
- 'Carers feel supported to continue caring' has decreased by 13%

More detail is available from the attached weblink.

http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18/

Focus on the Intermediate Care Team

The Intermediate Care Team's aim is to deliver high quality patient centred reablement to patients. The service was initiated in September 2014, initially as a pilot project. There were difficulties initially in recruiting due to the temporary nature of the posts and due to redeployment processes. The enhanced team has been fully staffed from November 2017.

The team comprises: Nurses – team lead and advanced nurse practitioner, Occupational Therapists and Rehabilitation support workers.

The team works closely with primary care colleagues and unpaid carers – pharmacy, physiotherapy, social work, dietician, podiatry, audiology, GPs and Unpaid Carers.

Individuals are supported to:

- *remain at home, avoiding unnecessary admission to the hospital or care centre (including falls prevention assessment)*
- *return home from a hospital admission*
- *return home from a care home interim placement*

through:

- *Comprehensive detailed assessment (incl. telecare)*
- *Strong case management and interdisciplinary communication - create a virtual team individual to a clients needs.*
- *Strengths based – what can they do?, what support systems do they have?*
- *Person centred and goal orientated*
- *Rehabilitation supports workers can deliver intensive enabling support 8am-10pm, 7 days a week.*
- *Time limited*
- *Onward referral to the most appropriate services*

The team works across Shetland:

- *In Lerwick Central -Provision of enabling support from rehabilitation support workers is provided within the Lerwick Central area.*
- *Shetland wide - For individuals outside of Lerwick Central, clinicians will assess and support staff in their locality to create and provide an enabling program. Recently, the team has supported clients from the islands of Unst, Fetlar, and Yell.*

The current activity is shown below.

- *Referrals – 258 in total (up to 31 December 2017)*
- *Accepted into service – 212, Declined - 46*
- *Discharged – 200*
- *Dependency score maintained or reduced 139 (79%)*
- *Falls assessments – 11 (5%)*

Readmissions – 12 in total (5.6%)

- *7 medically unwell*
- *2 falls / fracture*
- *1 joint pain*
- *2 unspecified*

The services plans for the future include:

- *Promote communication and smooth transition from hospital and care home settings*
- *Continue to educate and promote the role of the team widely*
- *Focus on addressing individuals health and wellbeing needs and participation in their community*
- *Continue to expand across Shetland*
- *Share knowledge and skills*
- *Falls prevention*
- *Positive risk taking*

The following Table shows our Performance against the key indicators which measure how we are achieving the Health and Wellbeing Outcomes. It provides a comparison against our Peer Group and against the average for Scotland as a whole.

We use the latest available data and several of the indicators have a time delay in recording, or the data is taken from surveys that only happen every few years.

Indicator	Shetland	*Scotland*
1. Percentage of adults able to look after their health very well or quite well. (2017-18)	94%	*93%*
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible. (2017-18)	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%	*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%	*74%*
5. Percentage of adults receiving any care or support who rate it as excellent or good. (2017-18)	85%	*80%*
6. Percentage of people with positive experience of care at their GP practice. (2017-18)	83%	*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%	*80%*
8. Percentage of carers who feel supported to continue in their caring role. (2017-18)	41%	*37%*
9. Percentage of adults supported at home who agree they felt safe. (2017-18)	80%	*83%*
11. Premature mortality rate (per 100,000 population) (2016)	289	440
12. Rate of emergency admissions for adults. (per 100,000 population) (2016-17)	10,011	12,294
13. Rate of emergency bed days for adults. (per 100,000 population) (2016-17)	72,509	125,634
14. Readmissions to hospital within 28 days of discharge. (per 1000 population) (2016-17)	69	100
15. Proportion of last 6 months of life spent at home or in community setting. (2017-18)	96%	89%
16. Falls rate per 1,000 population in over 65s. (2016-17)	21	22
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. (2016-17)	94%	84%
18. Percentage of adults with intensive needs receiving care at home. (2016-17)	74%	61%
19. Number of days people spend in hospital when they are ready to be discharged. (per 1,000 pop) (2016-17)	528	842
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. (2016-17)	15%	25%

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

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. As at March 2018, all but two elements of our care services were graded 4 or above, which is a decrease of the 100% we achieved last year.

Care Homes

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

What resources did we use?

We aim to use money, staff and assets wisely and make sure that we do the right things, for the right price.

Overall, the IJB spent about £47m on health and care services.	We provided services from nearly 50 community health and social care buildings and facilities, across all areas of Shetland.
We secured services and provided grants to a wide range of third sector organisations to the value of £1.5 million.	The number of posts needed to deliver the services included in the budget delegated to the IJB is just under 880 whole time equivalent posts.
During the year, 140 Council staff undertook training and development opportunities, ranging from degree level qualifications to service specific training on topics such as dementia.	In 2017-18, 78 staff were successful in achieving their SVQ qualifications, with 49 securing a SVQ Level 2 in Health and Care.

The flow of money into and out of the IJB is shown in the Table below. The overall income to the IJB was £47.2m against expenditure of £47.0m, leaving a surplus for the year of £0.2m.

Financial Year 2017-18	SIC	NHSS	Total	2016-17
	£000	£000	£000	
Income				
Budget delegated from the Parties to the IJB	(22,154)	(22,068)	(44,222)	(43,450)
Additional Contributions from Parties to meet direct costs (Audit fee, Insurance & Members Expenses)	(14)	(14)	(28)	(25)
Additional contribution from NHS to IJB to meet overspend	0	(2,941)	(2,941)	(1,431)
Sub Total Income	**(22,168)**	**(25,023)**	**(47,191)**	**(44,906)**
Expenditure				
Actual expenditure against delegated services	21,708	24,906	46,614	44,389
Direct Costs	14	14	28	25
Fortuitous under spend repaid to SIC	310	0	310	367
Sub Total Expenditure	**22,032**	**24,920**	**46,952**	**44,781**
Final position of IJB	**(136)**	**(103)**	**(239)**	**(125)**

We spent £46.6m on the following services (which also compares the actual expenditure to the revised budget in the year).

Service	**2017/18 Revised Annual Budget**	**Year End Outturn**	**Budget v Outturn Variance (Adv)/ Pos**
	£000	**£000**	**£000**
Mental Health	2,090	2,263	(173)
Substance Misuse	625	568	57
Oral Health	3,317	3,248	69
Pharmacy & Prescribing	6,349	6,346	3
Primary Care	4,497	5,318	(821)
Community Nursing	2,669	2,710	(41)
Directorate	645	223	422
Pensioners	79	76	3
Sexual Health	44	46	(2)
Adult Services	5,225	5,150	75
Adult Social Work	2,520	2,397	123
Community Care Resources	10,972	11,277	(305)
Criminal Justice	27	16	11
Speech & Language Therapy	71	72	(1)
Dietetics	104	97	7
Podiatry	223	218	5
Orthotics	140	120	20
Physiotherapy	551	544	7
Occupational Therapy	1,664	1,641	23
Health Improvement	232	203	29
Unscheduled Care	2,976	3,534	(558)
Renal	188	214	(26)
SG Additionality Funding	622	383	239
Integrated Care Funding	447	400	47
Efficiency Target	(2,055)	(450)	(1,605)
Grand Total	**44,222**	**46,614**	**(2,392)**

The reason for the main variances is detailed in a separate document "The Annual Accounts" and summarised in the Table below.

Service	2017/18 Revised Annual Budget	Year End Outturn	Budget v Outturn Variance (Adverse)/ Positive	Reason for Variance
	£000	£000	£000	
Mental Health	2,090	2,263	(173)	Higher Staff Costs due to locum cover
Substance Misuse	625	568	57	Lower Staff costs due to vacancies
Primary Care	4,497	5,318	(821)	Higher Staff Costs due to locum cover and TUPE commitments
Directorate	645	223	422	Project and recruitment delays and variance due to where budget and actual was accounted for on training.
Adult Services	5,225	5,150	75	Lower staffing and commissioning costs and higher income.
Adult Social Work	2,520	2,397	123	Lower staff costs due to vacancies and grading
Community Care Resources	10,972	11,277	(305)	Staffing variances (up and down), use of agency cover and under achievement of income assumptions.
Unscheduled Care	2,976	3,534	(558)	Increased staff costs due to redeployment and locum cover.
SG Additionality Funding	622	383	239	Timing of projects and application of funds; carry forward to reserves requested.
Integrated Care Funding	447	400	47	Intermediate Care Team; timing of recruitment to posts.
Efficiency Target	(2,055)	(450)	(1,605)	Timing of implementation of change projects.
Other Minor Variances	15,658	15,551	107	
Grand Total	**44,222**	**46,614**	**(2,392)**	

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	**2017/18 Integrated Care Fund Expenditure £**
Proactive Care and Support	
Intermediate Care Service	304,171
Medical input and clinical expertise to support community initiatives including Intermediate Care and Anticipatory Care Planning.	30,000
	334,171
Supportive Enablers	
Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	29,778
TOTAL : Integrated Care Fund 2017/18 Spend	**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 £2.3m on the current cost of NHS and SIC Funded services in order to balance the books. This is why the IJB has undertaken to look afresh at sustainable models of service delivery across the isles.

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 2017-18, 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, resulted in a great deal of work to get the new organisation up and running. 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 2017-18 and some areas will need continued and ongoing attention, sometimes over a longer period of time, to keep making a difference.

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 Local Outcome Improvement 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
- 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 2018-19

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 Stategic Plan for 2017-2020 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.

These projects will look at:

- the hospital model, to determine what services need to be provided locally and which are best provided by our partner health boards, such as NHS Grampian in Aberdeen, and the associated staffing levels required to maintain a safe, high quality and effective service;
- the primary care model, to align with the new GP contracts, to determine an equitable distribution of primary care resources across Shetland, recognising the particular recruitment challenges in this area; and
- developing an affordable and sustainable social care model for Shetland, which builds on the network of social care services, and responds to the need to promote self care and multi-disciplinary teams working to support individuals and families to live well for longer in their own home, or a homely setting.

The strategic change programme for 2018-19 is included below.

<table>
<tr><th>Whole Population Health</th><th>Integrated and Collaborative Working</th></tr>
<tr><td rowspan="3">• Mainstreaming self care / self management and early intervention and preventative services</td><td>• Management of Long Term Conditions</td></tr>
<tr><td>• Planned / Elective Care</td></tr>
<tr><td>• Unscheduled Care</td></tr>
<tr><td>• Effective Prescribing</td><td>• Primary Care Implementation Plan</td></tr>
<tr><td colspan="2">Enablers</td></tr>
<tr><td colspan="2">Leadership
Workforce Development and Skills Mix
Islands Bill
Technology Enabled Care</td></tr>
</table>