Shetland Islands Health and Social Care Partnership

1st April 2022 – 31st March 2025

JOINT STRATEGIC COMMISSIONING PLAN

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INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Act 2014 put in place a framework for integrating health and social care in Scotland. This Act required each Integration Authority to produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the medium term, using the integrated budgets under their control.

The strategic commissioning plan is designed to enable Integration Authorities to deliver the national outcomes for health and wellbeing (See Appendix A), and achieve the core aims of integration, which are:

- To improve the quality and consistency of services for patients, carers, service users and their families.
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

Strategic commissioning plans should describe how people's lives, health and wellbeing will be improved.

This plan is developed in keeping with the principles described by the Christie Commission[1], which are:

- Reforms must aim to empower individuals and communities receiving public services by involving them in the design and delivery of the services they use.
- Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve.
- We must prioritise expenditure on public services which prevent negative outcomes from arising.

[1] https://www.gov.scot/publications/commission-future-delivery-public-services/

We recognise that there are many challenges facing us, including:

- Responding to the impact of Coronavirus on mental and physical health and in particular the impact on inequalities we know our communities faced before the pandemic but which have been exacerbated.
- The economic conditions which affect public and personal finances, employment opportunities, wages, fuel, food and housing costs that lead to persistent health inequalities
- Demographic changes, including an aging population, which is living longer with complex needs. This brings a higher demand for public services and the consequent need to do more with fewer resources
- High levels of mental health problems
- Loneliness and isolation
- Increasing burden of non-communicable diseases (problematic drug and alcohol use, obesity, Type II diabetes)
- Management of increasing expectations
- The ability to shift our focus from treatment to prevention, from 'doing to' to 'doing with,' self-care and self-management
- The need to develop trust and relationships between various parts of the system
- The increasing use of and reliance on ICT to deliver services. Many services have been adapted during the pandemic, for some this has created opportunities to increase access and reach of services whilst for others this has created barriers for engagement and treatment.
- Climate change/climate resilience

There are national developments which present potential opportunities but also significant change.

- The development of the National Care Service
- The national commitment to realising human rights and proposed development of legislation embedding principles of participation, accountability, non-discrimination, empowerment and legality into the design and delivery of services

SUMMARY OF PROGRESS AGAINST PREVIOUS PLAN

Part of the process of writing a new strategic commissioning plan involves review of the previous one. The 2019-22 plan was written at an earlier stage of the integration journey and there was a strong emphasis on bringing together the separate health and care systems that existed in Shetland; qualitative and quantitative data illustrates that good progress has been made towards achievement of strategic priorities 1-3 (shown below), illustrated by reductions in delayed discharges, close working between hospital, primary and community care, and development of community based approaches to care (Community Connections is an example).

1. 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.

Integration indicators show us that 87% of adults supported at home in Shetland agreed they had a say in how their help, care or support was provided. 94% of adults supported at home agreed that their health and social care services seemed to be well coordinated. 88% of adults supported at home agreed that their services and support had an impact in improving or maintaining their quality of life. However, only 50% of carers felt supported to continue in their caring role.

2. Develop a unified primary care service: with multidisciplinary teams working together to respond to the needs of local populations

The last three years have seen the development of multidisciplinary teams within primary care, with the staff team widened to include musculoskeletal physiotherapists, extended pharmacy roles, Community link worker roles and advanced nurse practitioners. This work will continue to evolve, as envisaged in

the new GP contract, with pharmacy and health improvement practitioners working with community nursing, social care and other professionals such as Allied Health Professionals to develop a more integrated model of health and social care. Ask My GP has been rolled out to some practices in order to increases accessibility of services.

3. 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 inpatient stays

The current trend shows a slight increase in day-cases, and a decrease in inpatient stays. More recent data shows sustained decrease in inpatients during the COVID era, with day cases increasing towards previous levels. Other data shows a consistently low length of stay in hospital and low readmission within 28 days of discharge which indicates appropriate decision making around discharge, and use of services post-discharge. Again, this is an area of work which will continue to develop.

The two remaining priorities (4 and 5) present more of a mixed picture, with Healthy Life Expectancy reducing for men and increasing at a tiny rate for women, and a focus on secondary rather than primary prevention. It has not proved possible to achieve a sustainable financial position although the IJB has broken even annually.

4. 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

During this period there have been slight improvements in some health-protecting behaviours, for example, a reduction in hazardous or harmful drinking, and in smoking rates. However, there has been a decline in healthy life expectancy in men, and a very small rise in women; 'years not in good

health' is worse than the national average and significantly worse than our neighbours.

Most preventative work, (with the exception of vaccination and immunisation) has focused on secondary prevention (e.g. screening to identify presence of disease or supporting people to stop smoking) or tertiary prevention (e.g. managing disease post diagnosis to prevent progression or worsening). An investment in primary prevention would mean that fewer poor health effects occur in the first place, meaning that scarce resources could be focused on poor health which isn't preventable. Beyond individual prevention efforts, local community actions can be particularly effective in bringing about changes that prevent or reduce environmentally-related illness and disease.

5. Achieve a sustainable financial position by 2023

The Strategic Plan 2019-22 recognised the significant financial challenges both funding partners were facing in providing funding contributions to the IJB to support delegated services. During the term of the plan, both Brexit and the response to the Covid-19 Pandemic caused further financial pressures and meant change projects to address financial sustainability did not progress.

The IJB Medium Term Financial Plan 2022-2027 (MTFP) recognises that while financial challenges still exist for both Parties, the IJB has been fully funded by Shetland Islands Council (SIC) and NHS Shetland (NHSS) since its inception. The assumption has been made that this will continue. In the planning of integrated services, the IJB must continue to support the change projects emanating from the SIC Change Programme and NHSS Programme Management Office to address overall financial sustainability of all 3 bodies.

A full report on achievements against the 2019-22 Joint Strategic Commissioning Plan is under development.

DATA

The following pages include a summary of data describing health and wellbeing within Shetland. The full data is available at Appendix D.

DEMOGRAPHICS

For the most recent time periods available, Shetland Islands HSCP (Health and Social Care Partnership) had:

- A total population of 22,870 people, where 51% were male, and 21% were aged over 65.
- Although nobody in Shetland lives in either the most deprived or least deprived SIMD (Scottish Index of Multiple Deprivation) quintiles, between 2016 and 2020 there was a shift towards more people living in deprived quintiles.

Table 1: Percentage population living in the 2016 and 2020 SIMD Data zone Quintiles

Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	0.0%	0.0%	0.0%
SIMD 2	3.2%	6.1%	2.8%
SIMD 3	32.0%	38.1%	6.1%
SIMD 4	64.8%	55.9%	-9.0%
SIMD 5	0.0%	0.0%	0.0%

SIMD Quintile 1 is most deprived, while SIMD Quintile 5 is least deprived.

HOUSEHOLDS

For the most recent time periods available, Shetland had:

- 11,374 dwellings, of which: 91% were occupied and 1.5% were second homes.

- 33% of dwellers received a single occupant council tax discount, and 1.3% were exempt from council tax entirely.
- 67% of houses were within council tax bands A to C, and 3.3% were in bands F to H.

GENERAL HEALTH

For the most recent time periods available[3], Shetland Islands HSCP had:

- An average life expectancy of 80.6 years for males and 83.2 years for females.
- A death rate for ages 15 to 44 of 74 deaths per 100,000 age-sex standardised population[4]
- 22% of the population with at least one long-term physical health condition.
- A cancer registration rate of 610 registrations per 100,000 age-sex standardised population[4]
- 16.61% of the population being prescribed medication for anxiety, depression, or psychosis.

LIFESTYLE AND RISK FACTORS

Mental and physical wellbeing has close ties with people's lifestyles and behaviours. Financial security, employment and location are influences that often have a bearing on opportunities, challenges and choices. Issues can develop when alcohol, smoking or drug use become coping mechanisms and releases from trauma and stress. This section provides data on drug-related hospital admissions, alcohol-related hospital admissions, alcohol-specific mortalities and bowel screening uptake, to give an overview of some of the lifestyles and behaviours for Shetland Islands HSCP. These can give an idea of quality of life and prosperity.

For the most recent time periods available[3], Shetland Islands had:

- 113 drug-related hospital admissions per 100,000 age-sex standardised population[4]. This is a lower rate of admissions than for Scotland (221).
- 17 drug-specific mortalities per 100,000 age-sex standardised population[4]. This is a lower rate than for Scotland (25.44).
- 487 alcohol-related hospital admissions per 100,000 age-sex standardised population[4].
- 12 alcohol-specific mortalities per 100,000 age-sex standardised population[4].
- a 71% uptake of bowel cancer screening for the eligible population.

HOSPITAL AND COMMUNITY CARE

This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic.

For the most recent time periods available, Shetland Islands had:

- 7,171 emergency hospital admissions per 100,000 population.
- 39,856 unscheduled acute specialty bed days per 100,000 population.
- 21,329 A&E attendances per 100,000 population.
- 2,374 delayed discharge bed days per 100,000 population.
- 638 emergency hospital admissions from falls per 100,000 population.
- 90 emergency readmissions (28 day) per 1,000 discharges.
- 770 potentially preventable hospital admissions per 100,000 population.

- People on average spent 94% of their last 6 months of life in a community setting.

MENTAL HEALTH RELATED UNSCHEDULED CARE

For the most recent time periods available, Shetland Islands had:

- 74 emergency mental health specialty admissions per 100,000.
- 5,549 unscheduled mental health specialty bed days per 100,000.

Data in this section has been calculated per 100,000 population; this is a standard population size used by demographers to enable comparison across areas which have different sized populations.

Key aspects of this data and review of the priorities within the previous plan have been used to inform and influence the new ones.

The Needs Assessment process which underpins the development of this plan is ongoing, and will be strengthened by the Shetland Health Profile which is in progress, the development of a comprehensive needs assessment by Public Health Scotland on behalf of Shetland Islands Health and Social Care Partnership, and implementation of the Participation and Engagement Strategy.

OUR STRATEGIC PLAN

Our Vision:

The people of Shetland are supported in and by their community to live longer, healthier lives, with increased levels of well-being and with reduced inequalities.

Our approach:

Our approach will be strengths based, agile and responsive, ensuring we promote choice and control for our population. We want to listen to and work collaboratively with communities to find realistic and effective ways that enable people to live healthier lives.

Our strategic priorities:

- To prevent poor health and wellbeing and intervene at an early stage to prevent worsening outcomes.
- To prevent and reduce the avoidable and unfair differences in health and wellbeing across social groups and between different population groups.
- To demonstrate best value in the services that we commission and the ways in which we work.
- To shift the balance of care towards people being supported within and by their communities
- To meaningfully involve communities in how we design and develop services and to be accountable to their feedback.

What we will do:

- We will commission services that focus on personal outcomes, assets and relationships, and commit to a 'No Door is the Wrong Door' policy.
- We will direct service provision that increases and diversifies support at home, focusing on maximising people's independence

- We will work together to develop approaches and commission services which seek to deliver early opportunities to prevent poor health outcomes; these will include the commissioning of specialist services.
- We will work to reduce unplanned care episodes and hospital admissions by increasing support for individuals to create and use anticipatory care plans.
- We will commission services that rebalance use of Shetland's residential care estate in favour of Extra Care Housing, Intermediate Care and Respite Care, supporting people to continue to live at home.
- We will commission a system of primary care that reaches into communities, supports complex care at home, self-management and prevention
- We will commission services which support unpaid carers to maintain their own health as well as that of the person they are caring for.
- We will focus on prevention, early action and self-maintenance with predominantly community based support. This will be the focus of a comprehensive redesign of our mental health interventions.
- We will promote an ethos of community empowerment in support of improved health and well-being in our community
- We will engage with communities and service providers; commissioning services that ensure Best Value through market facilitation and consideration of services from a wider range of social and community enterprises.
- We will understand future need and the type of workforce, systems and facilities required to adapt and deliver services that meet the health and social care needs of communities throughout Shetland.

- We will target resources, commissioning services that are effective and meet the needs of vulnerable people in the Community.
- We will ensure that we improve health literacy for individuals, families and communities; supporting them to make informed decisions about their health and wellbeing and building the capacity of professionals to communicate effectively.
- We will ensure that there is close working with housing services and that collaborative approaches are adopted to meeting housing need and providing appropriate housing and housing support options for people with assessed care needs.
- When commissioning services we will ensure that Integrated Impact Assessments are carried out and that the potential negative impacts of service change/design on different population groups are identified and addressed

How will we know we are making a difference?

We will work towards achievement of the National Health and Wellbeing Outcomes (Appendix A)

Within these there are some shorter-term outcomes that we will aim to achieve, broken down into three broad areas:

Changes in knowledge, skills and awareness:

- People are asked what matters to them and involved in or able to make decisions about their care and support
- Everyone knows where and how to access the resources (information, technology, equipment, advice, clinical or social support) they need to self-manage, receive or deliver care

- The skills and experience of each member of the multi-disciplinary team are fully utilised
- The workforce has access to the information, equipment, technology, and the clinical, social care and wider community support and resources needed to provide holistic, person-centred care
- The workforce has the knowledge, skills and confidence to fulfil their roles and responsibilities and we have greater levels of retention and career progression.

Changes in decisions and practice

- People receive the right support, delivered by the right person, in the right place at the right time
- Increased primary and secondary prevention
- Increased levels of anticipatory care
- Increases in supported or facilitated self-management
- Improved management of long-term conditions
- Care is delivered in a compassionate, person-centred way that takes account of individual's life and circumstances.

Changes in services and health and wellbeing outcomes

- People are able to start life, live, age and die well
- Increased involvement of third sector and community resources
- Improved quality and safety of care

- Services provide a model of care and support that builds on people's expertise in living with their conditions and the resources available to support them in their own communities
- Improved independence and resilience
- Improved health and wellbeing of the population
- Reduction in unnecessary use of urgent and secondary care
- Reduced over-treatment and medicalisation

Next steps and implementation

Specific objectives, outcomes, action plans, and performance indicators, relating to each delegated function are set out in Directions the IJB issues to the constituent authorities.

Following approval of this plan, the next steps will include:

- Completion of a report on progress against the 2019-22 Strategic Commissioning Plan
- Development of a Housing Contribution Statement
- Development of a Joint Workforce Plan to support implementation of the Strategic Commissioning Plan (due July 2022)
- Completion of the Needs Assessment which will enable further refining of future Strategic Commissioning Plans
- Development of performance indicators to ensure that we are able to monitor and evaluate our work
- Implementation of the Participation and Engagement Strategy

APPENDIX A

National Health & Wellbeing Outcomes

There are nine national health and wellbeing outcomes which apply to integrated health and social care.

Health Boards, Local Authorities and Integration Authorities will work together to ensure that these outcomes are meaningful to people in their area.

1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7	People who use health and social care services are safe from harm.
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9	Resources are used effectively and efficiently in the provision of health and social care services.

APPENDIX B

The integration delivery principles are:

- that the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,
- that, as far as consistent with the main purpose, those services should be provided in a way which, as far as possible:
    - is integrated from the point of view of service-users
    - takes account of the particular needs of different service-users
    - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
    - takes account of the particular characteristics and circumstances of different service-users
    - respects the rights of service-users
    - takes account of the dignity of service-users
    - takes account of the participation by service-users in the community in which service-users live
    - protects and improves the safety of service-users
    - improves the quality of the service
    - is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
    - best anticipates needs and prevents them arising
    - makes the best use of the available facilities, people and other resources

APPENDIX C

(a) Outcome indicators:

1. Percentage of adults able to look after their health very well or quite well

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.

3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.

4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

5. Percentage of adults receiving any care or support who rate it as excellent or good

6. Percentage of people with positive experience of their GP (General Practitioners) practice

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

8. Percentage of carers who feel supported to continue in their caring role

9. Percentage of adults supported at home who agree they felt safe

10. Percentage of staff who say they would recommend their workplace as a good place to work

(b) Outcome indicators based on administrative data:

11. Premature mortality

12. Rate of emergency admissions for adults (including proposal to also look at rate of emergency bed days for adults)

13. Readmissions to hospital within 28 days

14. Proportion of last 6 months of life spent at home or in community setting

15. Falls rate per 1,000 population in over 65s

16. Proportion of care and care at home services rated 3 or above in Care Inspectorate Inspections

17. Delayed discharge - 14 days, 72 hours, bed days lost

18. Percentage of adults with intensive needs receiving care at home