Shetland Islands Health and Social Care Partnership Annual Report 2021-22

Welcome and Introduction…

This is the sixth Annual Performance Report for Shetland Islands Health & Social Care Partnership, covering our work as a Health and Social Care Partnership under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014.

Shetland Health and Social Care Partnership (HSCP) was formally established in June 2015 in line with the Public Bodies (Joint Working) (Scotland) Act 2014. The Integration Joint Board (IJB) oversees the work of the HSCP and is a joint board of Shetland Islands Council and NHS Shetland.

This year has again been dominated by the Covid-19 pandemic, seeing services working together to respond to the pandemic while trying to learn from changes, improve and remobilise service provision within restrictions. This report cannot hope to detail the full range of work of all our colleagues over the past year, but we are delighted to share some of the highlights.

The work of the Partnership is governed by the Integration Joint Board (known as the IJB) which was Chaired by Councillor Emma MacDonald throughout 2021/22 – Councillor MacDonald has now moved on to be Leader of the Council, and we thank her very much for the important role she has played during her time as Chair in progressing Integration in Shetland. We look forward to working with Councillor John Fraser as the new Chair of the IJB.

We work hard to deliver the best possible health and care services for our community, and there is still plenty of work to do as we face mounting challenges nationally and locally. We are very grateful to all of the excellent teams and services who work in partnership to support our communities, and we look forward to another year working together..

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

Jo Robinson
Depute Director of Community Health and Social Care
for NHS Shetland and Shetland Islands Council

Our vision is that 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

Contents

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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:

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Aims of the Annual Report

All Integration Authorities are required to publish an Annual Report providing an assessment of their performance in line with The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. This Annual Report covers the HSCP's performance for the period of 1st April 2021 to 31st March 2022.

The purpose of the annual performance report is to provide an open account of our performance in relation to planning and delivering the health and social care services that we are responsible for. In this report for 2021-22 we have also set out to:

- Describe the key areas of work and achievements for Shetland Health and Social Care Partnership from April 2021 to March 2022.
- Acknowledge the challenges we have faced in the last year, what we have learned and how we have responded to these challenges.
- Describe the progress of the HSCP in delivering our strategic priorities, and what this has meant for the people who use our services, communities, staff and partners.
- Describe how this progress is reflected in the new Joint Strategic Commissioning Plan Priorities for 2022-25.
- Explain the leadership role of the Shetland Integration Joint Board in steering the change and progress of the HSCP to date. Through this report the HSCP also reaffirms its commitment to, and seeks to demonstrate evidence of, 'Best Value'. This is a formal duty placed on all public sector organisations to ensure 'good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public'.

Our Health and Social Care Partnership

Shetland IJB is responsible for the integrated planning and delivery of health and social care services for adults and older people. This covers a very broad and diverse range of services as set out in the Integration Scheme including, but not restricted to:

The HSCP works in partnership with the third sector via Voluntary Action Shetland (VAS) which acts as a representative on the IJB and the Strategic Planning Group. VAS supports the HSCP to develop the role of the third sector to contribute to health and social care outcomes. The HSCP has a workforce of over 1200 staff and responsibility for a budget of £53M. It covers a population of 22,920. Health and care provision is organised around 7 localities.

Policy and Strategic Context

The National Health and Wellbeing Outcomes set out the framework for all HSCPs in Scotland to improve people's experience of health and care services and the outcomes that services achieve. The work of the HSCP strives towards these outcomes, measuring progress via the National Core Suite of Integration Indicators and through local performance reporting.

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

The Shetland HSCP Joint Strategic Commissioning Plan provides the local strategic context describing how the partnership will work together to deliver integrated services and improve the health of local people. The plan was thoroughly revised through 2021/22 and the Joint Strategic Commissioning Plan 2022-25 was approved by the IJB in March, replacing the 2019-22 version. The significant revision recognises the progress towards integration locally, and the challenges still faced. Local priorities build on the National Health and Wellbeing Outcomes in an effort to make them meaningful to people and communities in Shetland. The Strategic Plan also links closely with the Shetland Partnership Delivery Plan 2019-22 which can be found here.

Local Strategic Priorities 2019-22:

1. Develop a single health and care system
2. Maximise population health and wellbeing
3. Develop a unified primary care service
4. Streamline the patient's journey in hospital
5. Achieve a sustainable financial position by 2023

Locality Planning

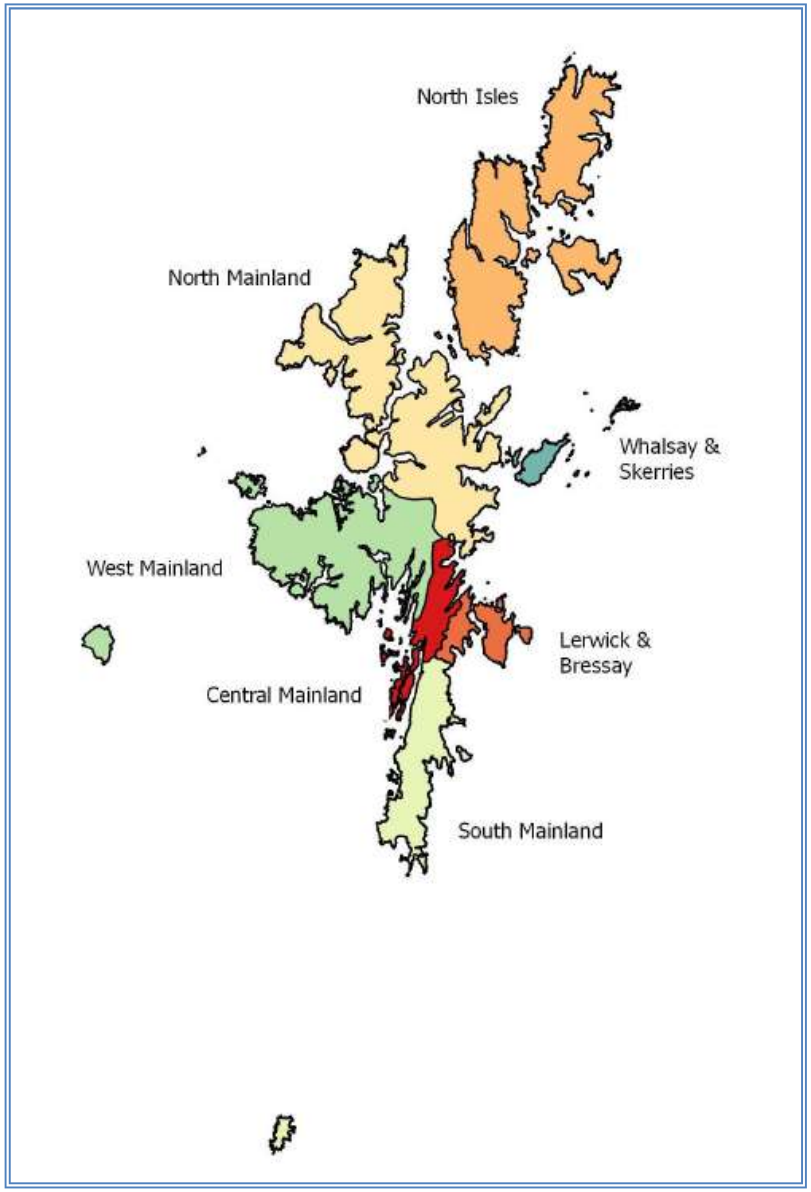
The Strategic Plan considers seven localities as shown in the map, with a set of services delivered within each locality:

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

The seven localities in Shetland are:

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

A broad range of other activity, including voluntary and private sectors, also supports individual and community wellbeing across Shetland. HSCP services look to work effectively with communities to identify strengths and solutions collaboratively making best use of all resources available.



Our Performance

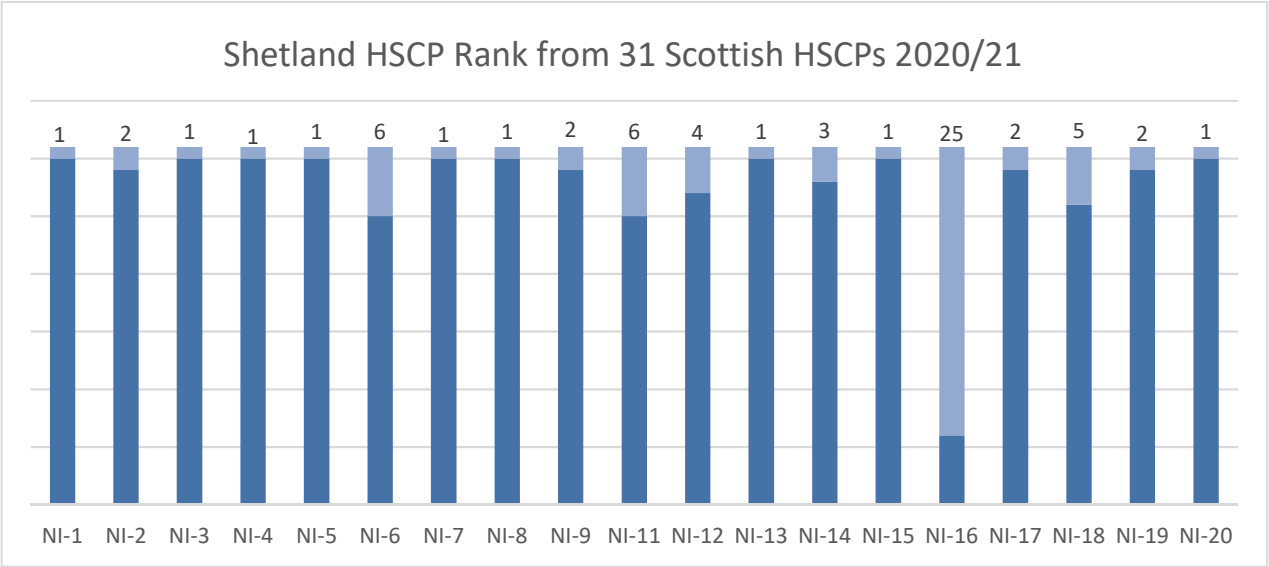
Core Suite of Integration Indicators

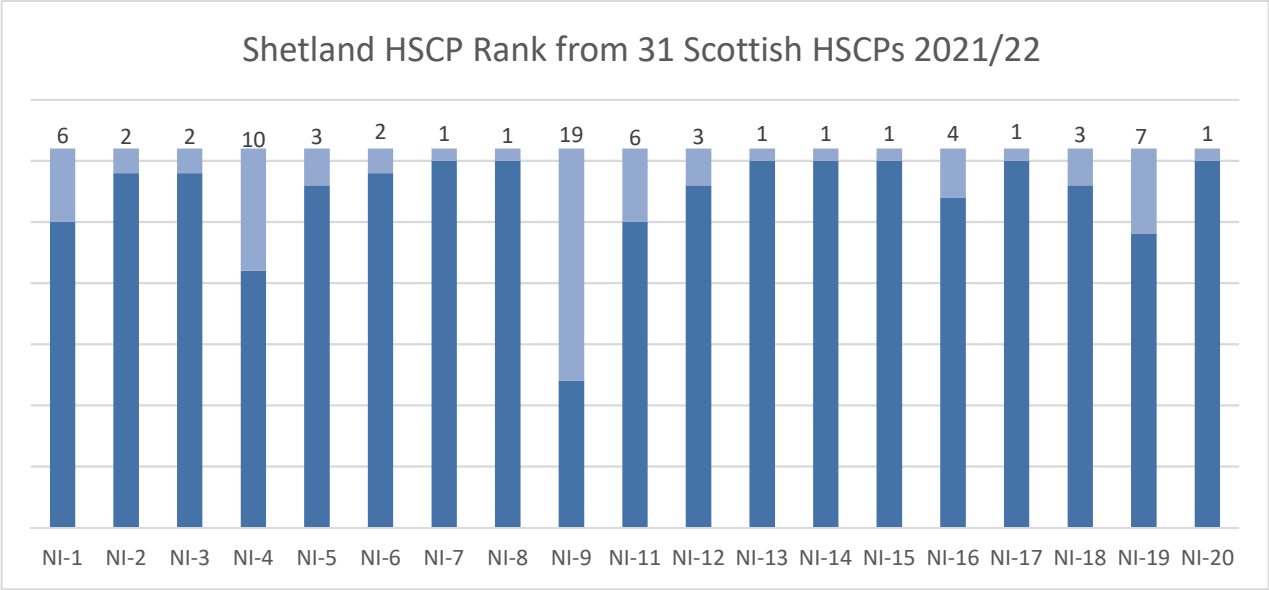
In addition to local measurement of performance the HSCP measures its progress towards the National Health and Wellbeing Outcomes via the core suite of Integration Indicators, last published in July 2022. The full set of data is openly available on the Public Health Scotland website.

This year on year comparison shows how we are performing among our HSCP colleagues across Scotland, note that the chart indicates our performance relative to other areas rather than the size of a change in our performance, for example a steady performance for us against an increase in other areas could see us drop a few places in ranking. It is, however, appropriate to question why there have been changes, and how Shetland has been differently affected.

Full data, including local trends since the establishment of the HSCP, and comparisons against similar HSCPs by type of area and type of population, can be found in appendices 1 and 2. Comparisons should be considered alongside each other, and in the context of the narrative to understand our relative performance.

While we remain above the Scottish average in all indicators bar NI-9 where we are comparable with the





Scottish average, changes in standing against other HSCP's are seen in the following indicators:

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

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

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

NI-16 Falls rate per 1000 population aged 65+ (people who are admitted to hospital as an emergency due to a fall)

NI-19 Number of days people spend in hospital when they are ready to be discharged

A number of factors could affect these indicators and we cannot say for certain what has the caused the change, all 5 of these indicators were improving in the year prior to the pandemic.

NI-4 and NI-19 rely on services with a degree of stability in staffing communicating and sharing information, changes here could be a symptom of an overstretched care system. NI-16 has been the subject of an improvement programme, the Otago and more programme, over the past few years. Falls Prevention activity has been stalled by COVID-19, at the same time falls risk among our older population has increased as people have become deconditioned, less active and less confident. The environment and activity of older people during pandemic restrictions was so different to usual this data must be interpreted with caution. The Falls Managed Clinical Network (MCN) was relaunched last year, with the intention of considering the next steps to build on Otago and more, looking at a systems wide approach to falls prevention. Part of their work will include consideration of how to evidence the value of this work locally. NI-1 and NI-9 are broader statements which could be related to feelings around the pandemic, or to relations with services – we hope to understand local health and wellbeing in more depth through the local Health Needs Assessment which is underway, and will give direction to our response to these changes.

Outcomes Through Stories – case studies to illustrate work

Over the past year we have moved to increase the use of case studies to demonstrate outcomes and support understanding of service activity to inform the commissioning process. These case studies are highly valued by the IJB, and teams in the HSCP appreciate the opportunity to share their work. Case studies have been used in a number of ways for example to tell a story of a patient experience of a service; to describe improvement work and its impact on service users or other professionals; to share gathered user feedback; to describe new ways of working. Summary highlights of case studies shared through the year are included in Appendix 3, along with four newly published case studies:

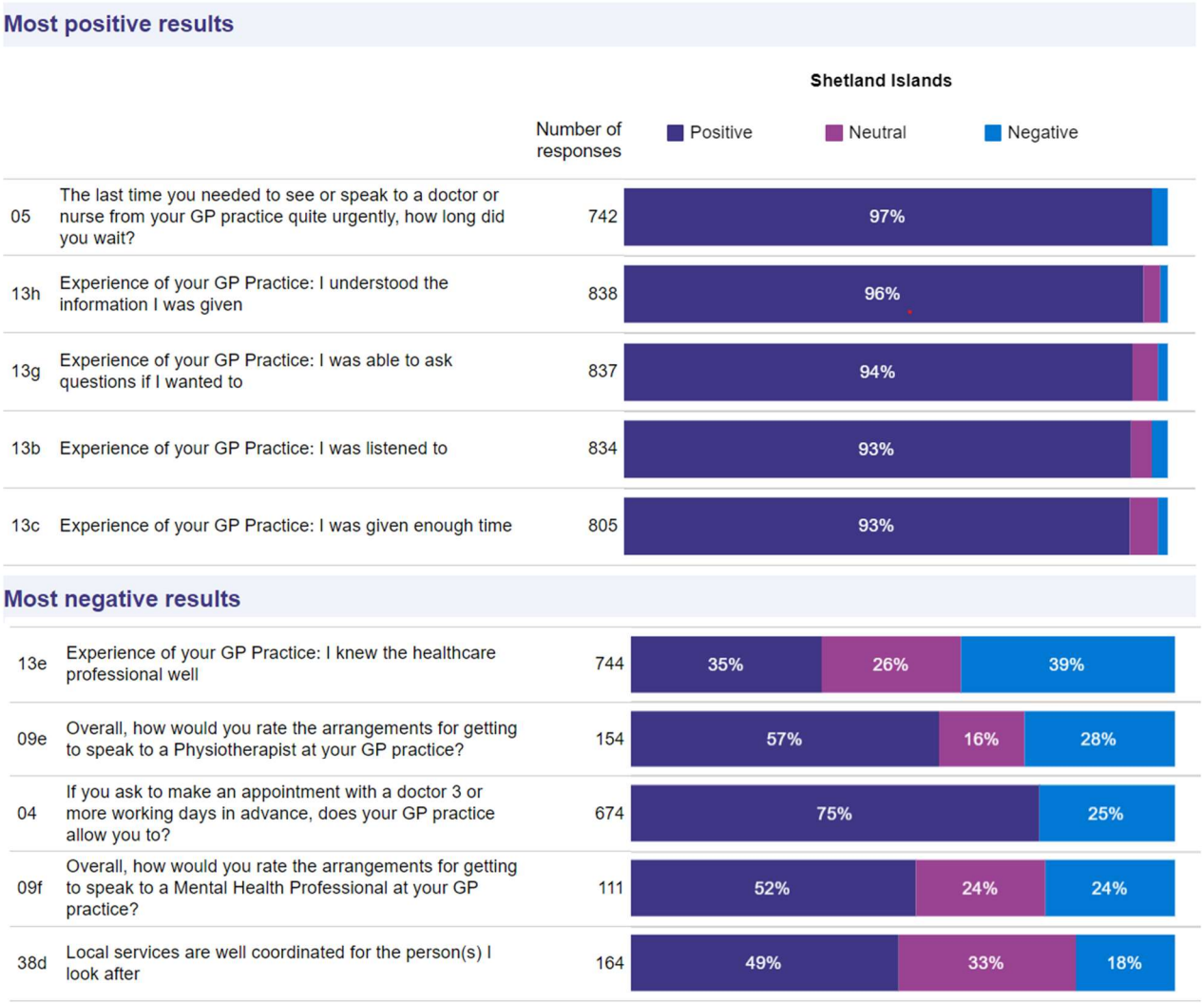
- Year of Care (House of Care) – a Primary Care pilot for people with Long Term Conditions;

- Money Worries – upskilling our workforce to support people in the face of the cost of living crisis;
- HENRY – building capacity for wellbeing in our population through parental support; and
- Supported Living and Outreach – increasing opportunities with a Local Activity Coordinator.

Health and Care Experience Survey

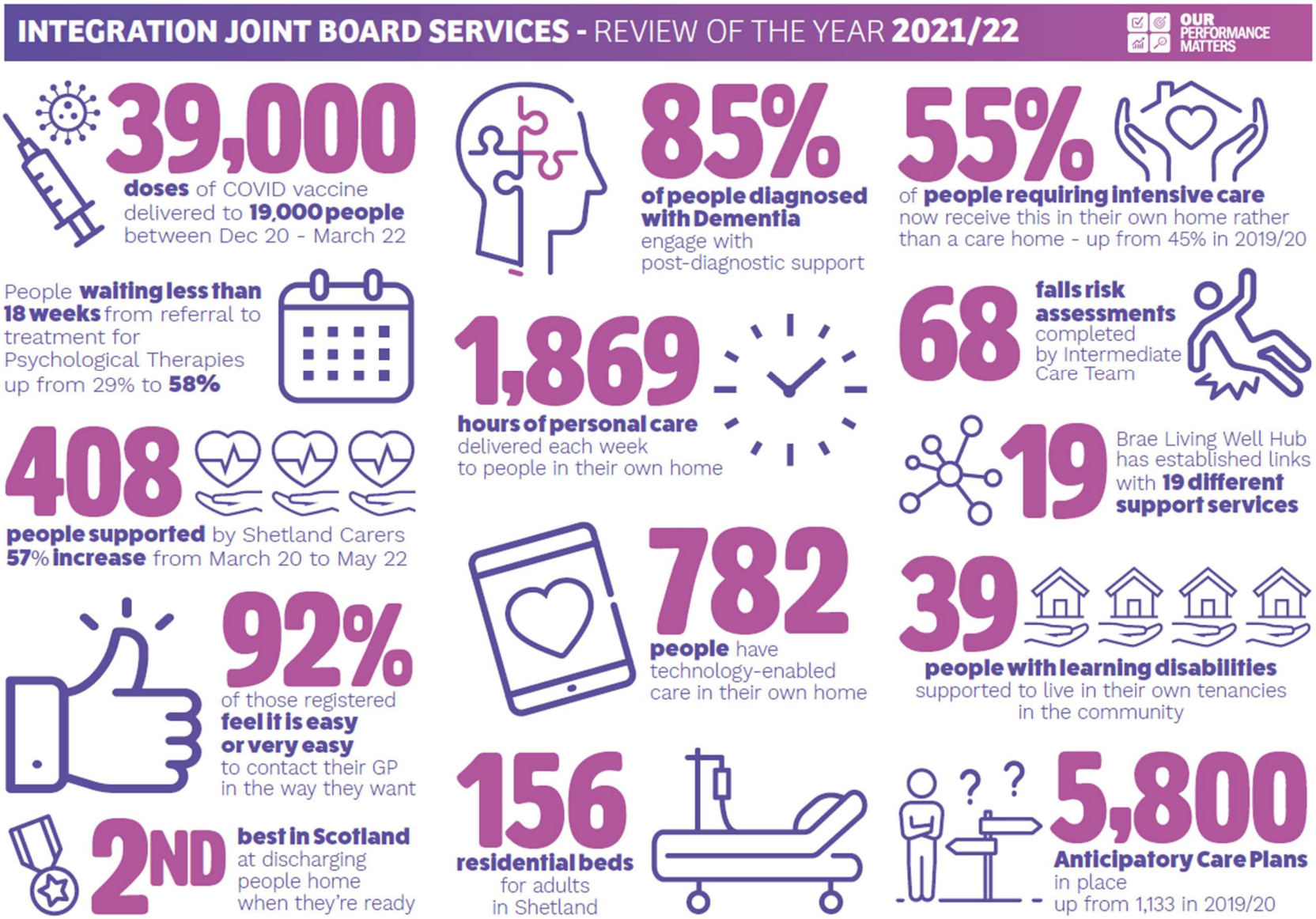
The Health and Care Experience Survey which informs NI 1 to NI 9 was published in early 2022 following the survey in November 2021. Given the ongoing COVID-19 pandemic it is worth noting these more recent outcomes as a testament to how well the teams within the HSCP have worked to maintain standards while working through the second year of a global pandemic, and progressing remobilisation /improvement work. Interactive dashboards/data tables of the Health and Care Experience Survey can be accessed on the Public Health Scotland website.

Where Shetland has performed less well are all areas of focus for current improvement programmes – increasing access to Physiotherapy within Primary Care, improving access to Primary Care and utilising other community services appropriately, to ensure people are seen by the right person at the right time, Mental Health services improvement programme, and work around stabilising the Primary Care workforce to reduce turnover and use of agency staff/locums. It is hoped that work in these areas will improve future patient experience.



5 most positive and 5 most negative results for Shetland HSCP from the Health and Care Experience Survey 2021/22

Year in Numbers



With thanks to the SIC Communications Team for preparing the infographic
(note this was prepared prior to most recent release of data, some national figures have since been updated)

Highlights from a Year of Activity

Right Person, Right Time…

Different ways of accessing services have become the norm as learning from pandemic working has been applied to develop technology enhanced care pathways. Examples include the AskmyGP service which is now available at 3 Health Centres, and Attend Anywhere remote appointments both for Shetland based care and appointments supported by mainland health boards, helping people get the help they need in a way that suits them.

Data has shown that the AskmyGP service has been very well received with patient satisfaction averaging more than 90%, and the Health and Care Experience survey showing more than 90% satisfaction around being able to contact a GP in the way that you want. However the service, rather than redirecting demand, is answering previously unmet demand, thus clinician time remains under significant pressure in Primary Care and the AskmyGP service has had to be “offline” for periods of decreased staffing.

The Primary Care improvement plan continues to work to address these concerns around staffing and access by building resilience into Health Centre teams and looking at different models of working and supervision to make the most of technology and the staffing resources we have, looking at different ways of working across areas so communities have access to all the services they need.

The Pharmacy Team continue to contribute to improved outcomes through their change work focussing on improving medicines management and patient outcomes, and effectiveness of pharmacy input into both secondary care pathways and the Primary Care Team.

Work around input into pathways has been scoped out over 21/22, while developing the skill mix in Primary Care. This has changed how the Pharmacy Team work, including use of technology for supervision which has already started to release pharmacist time for patient facing activity. This work will be scaled up through 22/23 and will redirect considerable activity from GPs by having a consistent, appropriately staffed model for managing medicine reviews.

The Health Improvement Team are continuing to develop the Health Improvement Practitioner/Link Worker model locally, while the First Contact Practitioner (FCP) Physiotherapy service is well established in Lerwick Health Centre, to be developed in other areas in the coming year.

Covid-19 Vaccination

The vaccination programme has continued throughout 2021-2022, moving though the age ranges to include all those 12 and over and introducing a booster dose on top of the two primary doses , along with a third primary dose for those who are severely immunosuppressed. The programme continues into 2022-2023 with children aged five-11 now included, a second booster for the most vulnerable and probably further boosters in the autumn. A huge number of staff have been involved in delivering this very complex programme, by the end of 2021-2022 this had reduced to a core team, which has now become substantive delivering the programme alongside primary care and community nursing colleagues.

During 2021-22, 39,000 doses of COVID vaccine were delivered in Shetland to 19,000 people. By end March 2022, over 93% of the Shetland community aged 12 and over had received at least one dose of COVID vaccine, and over 85% of those aged 18 and over had received a third or booster dose; 92% of those aged 40 and over.

Working with Public Health to support our population

At the same time as delivering the COVID programme, the wider Public Health Team have competed the Vaccination Transformation Programme (VTP), resulting in creation of a core Vaccination Team to co-ordinate and deliver the range of vaccination programmes, including travel vaccines working together with primary care, community nursing, occupational health, school health, maternity and the sexual health clinic. An enhanced flu vaccination programme (including all adults the age of 50, health and social care workers and school staff, people at higher clinical risk and all children aged 2 to 18 - if still in school) was delivered between September 2021 and March 2022. Uptake rates for all the vaccination programmes will be published in a local annual vaccination report later in the year.

Screening Programmes: screening programmes were paused during 2020 because of the pandemic but have now started up again. The cervical screening programme continues to be delivered in GP practices, with women now having to attend less frequently because of a change from cytology to HPV testing as the first line resulting in women at risk of cancer being picked up much earlier. Bowel screening continues to have a high return rate in Shetland for the self-administered testing kits, with follow up colonoscopy delivered locally. The breast screening unit is due to return to Shetland in June 2022, only delayed by two months due to the pandemic. The Abdominal Aortic Aneurysm Screening team have visited Shetland twice in the past year.

The most recently published figures show that the uptake rates for the screening programmes were: 73.3% for bowel screening self-test kits for the period 2019-21 (64.9% for Scotland); 78.5% for cervical screening at 3.5 years for the period 20-21 (66.3% for Scotland); 85.1% for breast screening for the three year period 2017-2020 (72.2% for Scotland); 84.2% for aortic aneurysm screening - men screened by age of 66 and 3 months who turned 66 in year ending March 2021. (78% for Scotland). A comprehensive local annual screening programme report will be published later this year.

Bowel Screening uptake: Shetland 73.3% vs Scotland 64.9%

Healthy Shetland – Investing in the future:

During 2021-2022 the Health Improvement Team have played a core role in remobilisation and supporting the COVID response, as well as delivering and supporting others to deliver preventative approaches to poor health. Work included development of the focus on tackling inequalities and prevention within primary care, the Quit Your Way service, Counterweight/Healthy Shetland programme, HENRY, mental health training delivery, review of Alcohol Brief Interventions, and continuing implementation of the Type II Diabetes Framework. Our approach is trauma-informed and person centred, working with people at the speed they need to go at, in reaching the goals that they set for themselves.

HENRY is a programme, delivered by local staff in Shetland, which is about babies and children getting the best possible start in life. This means supporting the whole family to make positive lifestyle changes, creating healthier and happier home environments, and building healthier communities.

During the year we have tried out different approaches to connecting with people in order to support them in stopping smoking or in managing their weight, including on-line and telephone support. We do not have data for the end of 2021-2022 yet, but 19 people had stopped smoking for three months post quit at October 2021, in the 60% most deprived data zones in Shetland, which means we are just behind target for the end of the year. Shetland's smoking rate, as recorded by GP practices, is down to 13.1% and the percentage of mothers smoking during pregnancy is down to 10.3%, well below the national average.

Smoking rate down from 15.9% to 13.1% over past 5 years

New ways of working…

Community Led Support

The continued rollout of Community Led Support (CLS) has gone well, with the Brae Hub opening in October and establishing excellent links with partners such as Community Learning and Development Team. Implementation of the CLS plan including roll out of training in Good Conversations, capturing of learning to support development in other localities and bringing complementary work together under the Early Action Programme is supporting a system wide shift towards strengthening communities and placing emphasis early intervention and prevention.

Substance Use

Improvement work has also continued within the Shetland Alcohol and Drug Partnership to realise its vision and work towards the priorities in the Scottish Government's Rights, Respect and Recovery Strategy. This has included opening of the Recovery Hub and expansion of the support available through creation of a Harm Reduction and Outreach Worker post. This has allowed for delivery of a range of services, activities and support groups. The Hub is also now able to distribute Naloxone as part of a piece of ongoing work that will soon include Pharmacies in Shetland.

Cutting Waiting Times…

As Covid-19 restrictions continued, and the cost of living crisis emerged, the predicted increase in demand for mental health services was realised both locally and nationally. A number of improvement actions have been planned and progressed in response to continued challenges for provision of Psychological Therapies. These include: upskilling of wider staff group; establishment of Survive and Thrive group therapy; development of Clinical Associate in Applied Psychology (CAAP) () and Mental Health Occupational Therapist (MHOT) posts. The MHOT post has remained vacant, while the CAAP post has been made substantive. While there is still improvement to be made these changes have resulted in a decrease in waiting times:

158 weeks at March 2021, to 54 weeks in early 2022

Listening to understand…

Working with service users and communities is key to improving outcomes. In 2021/22 Justice Social Work undertook a Trauma-Informed service review with service users. This series of interviews with people with lived experience of the Justice system in Shetland was largely positive, reflecting a team of staff who bring their values around person-centred care to their work. An action plan developed from the service review, including improvements in how to access buildings and support around the Court process is being implemented.

Developing Solutions with Communities

Following the resignation of the Skerries Nurse in late 2020, and a series of unsuccessful recruitment efforts, Community Nursing have worked with the community, SIC Community Planning and Development, Scottish Fire and Rescue and Scottish Ambulance Services to develop a new model of working to support the community now and in the future. Changes to models in Skerries and Fetlar save around £80k per year, while improving access to services.

This 'Healthcare Support Worker model is a 'Hub' approach, meaning a trained HCSW based on island is supported by a wider team throughout Shetland. The HCSW works with people in Skerries using effective triage, remote supervision and telehealth approaches to offer the health and social care provision they need. There are some issues with digital connectivity, but a new 4G mast will help in the future.

'Hub' approach improving access to the right support, at the right time

Improvement Work by Service Area

In March 2021 it was agreed that all service "Directions" be rolled over to 2021/22 as they were current and fit for purpose. "Directions" are the means by which the IJB tells the Health Board and Local Authority what is to be delivered using the integrated budget and for the IJB to improve the quality and sustainability of care, as outlined in its strategic commissioning plan. The Directions to each delegated function include their day-to-day business and an improvement plan to detail work to be done to enhance and develop service provision to achieve better outcomes for the population of Shetland in line with our strategic priorities. Directions are due for formal review in March 2023.

There has been a great deal of change over the past two years during the COVID-19 pandemic, and services have put a huge amount of effort into responding to the pandemic, delivering existing services where safe and possible, and developing new means of service delivery where there was need in the population. Some of this work has accelerated existing priorities, for example the modernisation of AHP services and use of technology in service delivery, however such a period of disruption and uncertainty has been extremely difficult for staff and in some areas a period of stabilisation of services over the next year or so is necessary before any larger-scale improvement work can be undertaken. This stabilisation does not amount to a "return to normal" as the landscape of service delivery and population need has changed over this period, and we continue to experience considerable financial and workforce challenges. Services are providing support in different ways, and exploring the best ways of working in the future in light of all the challenges, changes take some time to get used to and can be difficult, we'll be working hard as a partnership to support our staff, teams and communities through this process.

To better understand the shifting landscape and current population need a comprehensive health needs assessment is under way, with a population health survey being administered by the Health Improvement Team, and work ongoing between the local Public Health team and Public Health Scotland to make best use of national data, and understand this in a local context.

A summary of some of the improvement work, by service area, is included below - note many of these pieces of work are ongoing, and include work between multiple teams or services.

Adult Mental Health

- Introduce a sustainable, safe, high quality nurse-led out of hours service to improve patient care and reduce presentation/admission to Gilbert Bain Hospital
- Develop local Peri-Natal Mental Health Services to improve early identification and preventative approaches
- Establish and implement pathways for particular conditions to ensure individuals are given appropriate time limited interventions. i.e pathways for Survive and Thrive group, anxiety management
- Improve data collection and reporting by the Substance Misuse Recovery Service (SMRS) through the DAISY Substance Misuse Reporting System
- Improve availability of Naloxone in the community to reduce drug-related deaths
- SMRS to review prescribing services in line with Scottish Government/nice guidelines

- Offer quicker access and enhanced therapies for individuals by increasing capacity in Clinical Psychology and developing other support locally for low level stress, anxiety and depression

Allied Health Professionals (AHPs)

Modernisation of AHP services, aiming to achieve:

- The right level of service at the right time in the right way
- Agile and flexible services that are responsive to change opportunities at a local and national level
- Supported self-management approach for patients and carers
- Staff report feeling supported and valued
- Access to electronic notes and files for all patient activity

Dietetics

- Develop and implement Child Healthy Weight programme
- Update local nutritional policies and guidelines

Occupational Therapy

- Develop access to an integrated occupational therapy mental health service
- Continue to deliver equitable and transparent access to funded housing adaptations and personal care equipment

Orthotics:

- Continue to deliver access to high quality foot splints and inserts, and hand splints using the precision, accuracy and speed provided by the 3D scanner

Physiotherapy:

- Develop the right skill mix and expertise to ensure a professional and responsive physiotherapy service for the people of Shetland
- Monitor and enhance services for musculoskeletal, paediatric and long-term conditions to continue to meet local and national standards

Speech and Language Therapy (SLT)

- Further extension of SLT services for those who require specialised services:
    - Contribute to development of Neurodevelopmental pathway for diagnosis and support in Shetland
    - Implement actions relating to Augmentative and Alternative Communication (AAC)
    - Contribute to Emerging Literacy programme
    - Work with Adult Services on Autism Diagnosis pathways

Hospital-Based Services

- Review access to emergency care and identify ways in which acute ambulatory care pathways can be delivered e.g. SDEC (Same Day Emergency Care)
- Review the workforce model for senior medical posts to develop a more sustainable approach
- Implement real time early supported discharge via Discharge Lounge and HCSW (Health Care Support Worker) team
- Review renal service workforce and model of care
- Review sexual health team capacity to support rape and sexual assault pathway and provide care in line with national standards
- Review how we delivery emergency care to children
- Review how we use digital approaches to improve emergency and planned care

Pharmacy & Prescribing

- Increase the pharmacist input into Pre-assessment and Rheumatology Clinics in GBH by placing a Pharmacist Independent Prescriber within these specialist clinics

- Development of the pharmacy technician role within secondary care to provide a clinical role, decreasing burden on nursing and medical staff, and improving patient outcomes
- Recruit to Primary Care Pharmacy technician post to increase appropriate skill mix in Primary Care and free up time for pharmacists to concentrate on patient-facing work, while maintaining quality of service
- Implement electronic prescribing and medicines administration in acute care
- Ensure appropriate use of medicines Polypharmacy reviews and reduction in waste

Substance misuse

- Reduction in harm from substance misuse
    - Develop an additional, comprehensive IEP service with capacity for outreach and additional harm reduction interventions.
    - Enhance information sharing protocols to create a near fatal overdose alert system and implement procedures to review near fatal overdose incidents.
    - Increase the number of outlets that distribute naloxone to include pharmacies and other nondrug treatment services.
- Improve outcomes for people who experience problems with alcohol or other drugs
    - Conduct and evaluate a pilot tier 2 support service with accessible, client centred, recovery focused support (The Recovery Hub).
- Protect vulnerable people from harm and exploitation
    - Raise awareness and provide information in the community about drug related crime, coercion, and exploitation. Encourage people to report suspected exploitation to the police.
- Ensure high quality alcohol and drug education is delivered in schools/young people's settings
- Develop ABI training for appropriate staff groups

Unpaid Carers

- Roll out Community Led Support programme to offer easy access to support with staff using 'Good Conversations' to offer strengths based, empowering support in communities.
- Explore and implement alternative safe and effective models of flexible and responsive services to support shift away from crisis intervention to planned and preventative supports
- Staff are provided with autonomy and delegated decision making
- Explore extended Day Care at ET and Taing House to include extended hours and 'drop in' facility to offer enhanced support for carers in a way that works for them

Adult Social Work

- Roll out of Community Led Support programme with the Living Well Hub in Brae – hubs are designed to be easy access to support with staff applying "Good Conversations" relationship based support.
- Shift in balance of care/support – more use of community assets/ resources, reduced demand on H&SC system, more flexible supports for service users and carers
- Ensure staff are provided with autonomy and delegated decision making to enable shift away from crisis intervention to planned and preventative supports

Adult Services (Learning Disability and Autism (LD&ASD))

- Explore and implement alternative safe and effective models of flexible and responsive service to meet assessed eligible need in relation to adult LD & ASD
- Explore and implement alternative safe and effective models of flexible and responsive service in relation to supported living: support for people with LD/ASD living with aging carers; and those with unsustainable living arrangements

- Work collaboratively to ensure continual improvement of support for young people with additional needs making the transition to young adult life
- Strengthen local clinical support to reduce health inequalities of people with LD/ASD

Community Care Resources

- Introduce scheduled overnight care at home across mainland Shetland
- Offer Enhanced Nutritional Support to reduce the impact of frailty
- Explore extended Day Care at ET and Taing House to include extended hours and 'drop in' facility to offer enhanced support for carers in a way that works for them

Justice Social Work

- Revise Bail and Information Scheme.
- Review process for promoting work and how we consult with communities for work requests.
- Partners plan and deliver services in a more strategic and collaborative way.

Health Improvement

- Build capacity across NHS and IJB for prevention by: Reviewing skill mix of staff to potentially create a tiered model of staff who are qualified to deliver health behaviour change
- Implement Type II Diabetes Prevention Framework
- Complete training of pharmacy counter staff as smoking cessation advisors and roll out tiered approach to smoking cessation practitioner training to other organisations e.g. Housing support workers, Third Sector
- Train front line staff to understand the importance of Alcohol Brief Interventions and commit to deliver positive/motivational conversations.
- Delivery of extended (alcohol) brief interventions by HI practitioners in Primary Care
- Establish Health Check programme for Justice Social Work clients, extend to offer to other vulnerable groups affected by inequalities who typically have poorer outcomes.
- Continue to deliver and work towards mainstreaming of Otago Falls prevention programme
- Continue to embed weight management programme jointly delivered with SRT

Primary Care

- Work to reduce locum costs – increased use of "GP Joy Project" to provide more sustainable, consistent cover
- Complete "AskmyGP" pathfinder project to advise action plan to improve access.
- Year of Care (House of Care) pilot project
- Increase skill mix in Primary Care, increasing access to the right person, in the right place, at the right time, through work with Physiotherapy, Pharmacy, and continued development of ANP roles.

Oral Health

- Improve Access to Oral Health services
- To review access to PDS services including the use of Remote consultations and "care in the Community" for health promotion programmes like Childsmile and targeted patient support programmes.
- To sustain annual training for all care home staff and older person's carers in alignment with the Caring for Smiles Programme (C4S) and to develop Caring for Smiles 'Champions' in the care community.
- To review and update the Oral Health Strategy and Clinical Governance framework to provide clearer direction of travel for

dental services with linkages to the National Oral Health Improvement Plan implementation.
- To oversee the delivery plan for the long term provision of a sustainable Orthodontic Service for Shetland by the training of a PDS dentist to provide future care.

Community Nursing

- Implement 24 hour shift based nursing and care at home service
- Explore potential remodel of OOH service to be ANP led
- Review model of service provision in remote areas, with respective communities, to ensure sustainable, safe, effective, person-centred services are in place
- Offer enhanced Infection Prevention & Control (IP&C) support across Health and care services / premises both routinely and in outbreak situations

Challenges

While there are a number of achievements to celebrate, there are still many challenges, and a great deal of work remains to be done. Some key challenges over this year, which we are still working hard to tackle include:

Health Inequalities

We recognise that health inequalities have worsened considerably during the pandemic and will continue to do so. We continue to deliver Money Worries sessions to people within Shetland, in partnership with Citizens Advice Bureau, and have gained commitment from the Integration Joint Board to consider the impact on inequality of any decisions taken by the Board. Work continues with our partners on the Child Poverty Strategy. The population health survey that we are currently undertaking will help us to target our work more effectively.

Supporting unpaid carers

There are concerns around Unpaid Carers not feeling supported to continue in their caring role (45% feel supported, compared to a national average of 30%). The roll out of Community Led Support and the hub approach, identifying and building on strengths within communities to provide more accessible, holistic support will improve this. The number of people registered with Shetland Carers in the 3rd sector has increased by 57% over the 2 years of the pandemic, suggesting more carers are receiving much needed support, which is positive though we know the numbers registered are a small minority of those who have regular caring responsibilities. There is a hope that census data released next year will give clearer information about the number of unpaid carers in Shetland allowing us to work with the third sector to help better target our support.

Care homes/care at home

This year has been an extremely challenging one for Care Homes and care delivered within community settings. Teams have worked incredibly hard to protect the vulnerable people that they care for, juggling pressures on staffing, increased levels of Personal Protective Equipment, intensive Infection Prevention and Control requirements and frequent adjustment to ways of working, including access to visitors and day care as part of their response to Covid-19 outbreaks. The work on protecting the residents of care homes was overseen by the EACH (Enhanced Assurance for Care Homes) group, as part of the oversight roles held by the Chief Nurse, Director of Public Health and Chief Social Work Officer for Shetland. We need to work hard to support our staff, and to understand from them how to build more resilient, ever improving services for the future.

Planning and Performance Development

In line with audit feedback from 2019/20 the HSCP has been working to develop the way it monitors and reports progress to the IJB over the previous two years. This has been done in an effort to improve assurance and transparency, and increase interaction with performance information to drive improvement. These changes have also been reflected in the performance management processes within the HSCP aiming to provide better scrutiny, make better use of data and align planning processes across operational, workforce and finance domains. This work is ongoing and is linked to changes in performance monitoring in both NHS Shetland and Shetland Islands' Council.

A significant piece of work undertaken in 2021/22 was development of the revised Joint Strategic Commissioning Plan 2022-25 by the IJB's Strategic Planning Group. Following ongoing engagement and development with a number of stakeholders this plan was approved by the IJB in March 2022 and is grounded in the following:

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.

The plan is closely connected to the Shetland Partnership Plan, the SIC Corporate Plan and NHS Shetland's Clinical and Care Strategy. An approach for effectively measuring our progress against these strategic priorities is under development, and will be informed by the comprehensive Health Needs Assessment being undertaken by the local Public Health Team.

Financial planning and performance

Financial Transactions 2021/22

For the year-ended 31 March 2022, the IJB generated a surplus of £2.118m (2020/21: £1.220m), after adjustment has been made for additional payments to/from SIC and NHSS.

The final IJB surplus of £2.118m for 2021/22 represents the underspend of Scottish Government Additionality Funding and other specific funding allocations during the year off-set by expenditure that the IJB agreed would be met from its Reserve. Some of the specific funding allocations were agreed late in the year, giving no opportunity to spend in 2021/22. The surplus will be carried forward and the IJB can then make decisions on how best it can be utilised to further its objectives, in line with its Strategic Commissioning Plan.

	2021/22			2020/21		
	SIC £000	NHSS £000	TOTAL £000	SIC £000	NHSS £000	TOTAL £000
Budgets delegated to the Parties from the IJB	27,967	32,642	60,609	26,550	29,831	56,381
Contribution from the Parties to the IJB (against delegated budgets)	(28,151)	(35,222)	(63,373)	(25,440)	(31,171)	(56,611)
Outturn Position	(184)	(2,580)	(2,764)	1,110	(1,340)	(230)
Additional contributions from Parties to meet IJB Direct Costs	(15)	(16)	(31)	(15)	(15)	(30)
IJB Direct Costs (Audit fee, Insurance & Members Expenses)	15	16	31	15	15	30
Additional contributions (to)/from the Parties to/(from) IJB	(2,871)	7,753	4,882	(1,081)	2,531	1,450
Final Surplus/(Deficit) of IJB	**(3,055)**	**5,173**	**2,118**	**29**	**1,191**	**1,220**

Financial Transactions 2021/22

The outturn position at 31 March 2022 for the IJB is an overall deficit against budget of (£2.764m) (2020/21: (£0.230m)), which represents an overspend in relation to services commissioned from SIC of (£0.184m) (2020/21: £1.110m underspend) and an overspend in relation to services commissioned from NHSS of (£2.580m) (2020/21: (£1.340m)). The £2.764m deficit (which includes 'set aside budget) is detailed in Row 3 in the table.

In order to achieve the final IJB surplus of the year of £2.118m (2020/21: £1.220m), NHSS made a one-off additional contribution of £7.753m to the IJB. The additional contribution from NHSS is non-recurrent in nature and does not require to be paid back in future years. The SIC received a one-off additional contribution from the IJB of £2.871m.

Significant Budget Variance Table

Full explanations for significant budget variances can be seen in the Financial Review section of the IJB Annual Accounts 2021/22.

The IJB Parties continue to experience difficulty in recruiting to specialist posts, necessitating the use of locums to continue delivering services, notably in Mental Health, Primary Care and Unscheduled Care.

Location	2021/22 £000	2020/21 £000
Yell	(164)	(85)
Whalsay	(30)	(26)
Unst	(62)	(75)
Brae	(217)	(210)
Bixter	(51)	(22)
Scalloway	(178)	(78)
Walls	(89)	Nil
Out of Hours	(173)	(39)
Total	**(964)**	**(535)**

Budget overspend by area

Service	2021/22 £000	2020/21 £000
Community Care Resources	(773)	(416)
Adult Services	(125)	(61)
Community Nursing	(172)	Nil
Adult Social Work	Nil	(54)
Total	**(1,070)**	**(531)**

Agency Staffing costs

Due to difficulty in recruiting to specialist posts it has been necessary to continue to contract Consultant Mental Health locums in 2021/22, at a cost (including flights and accommodation) of (£0.513m) (2020/21: (£0.427m)).

Locum cover was also required in Primary Care for General Practitioners (£0.964m) (2020/21: (£0.535m)) where it was not possible to fill vacant posts, with notable overspend against budgets at the locations as per table left.

Within Unscheduled Care, Locum use has been required to cover junior doctors and consultants (£0.868m) (2020/21: (£0.591m)). Ward 3 and A&E also incurred high bank and overtime cost throughout the year of (£0.137m) (2020/21: (£0.047m)).

Themes	2021/22 Budget Variance £000	2020/21 Budget Variance £000	Variance £000
Locum Costs	(2,482)	(1,553)	(929)
Agency Staffing	(1,070)	(531)	(539)
Vacancies & Other Staffing underspends	444	529	(85)
Increased Service Demand	(296)	(302)	6
External Service Provider	221	215	6
Pharmacy & Prescribing Savings	238	121	117
Maintenance Delayed	170	294	(124)
Vehicles/Mileage savings	66	174	(108)
Pay award impact	(439)	0	(439)
Overachievement of Income	0	526	(526)
Funding allocation unspent	53	130	(77)
Other	331	167	164
Total	**(2,764)**	**(230)**	**(2,534)**

Significant Budget Variances

Improvement work is underway in areas mentioned above to reduce requirement for agency and locum staff in this coming year. This includes work on approaches to recruitment and retention, redesign of processes considering skill mix and means of delivery, and exploration of regional solutions to support out of hours cover.

Covid-19 Costs and Funding

The total cost of Covid-19 to the IJB was £3.706m (2020/21: £2.826m), the Scottish Government have provided funding to cover the full cost impact of Covid-19 to the IJB in 2021/22, basing this on the January 2022 NHSS Financial Return. They have also provided additional allocations late in 2021/22, which they have asked be carried forward in IJB Reserve, to be utilised in 2022/23 to meet the continuing cost impacts of Covid-19.

Covid-19 Funding	NHSS £000	SIC £000	TOTAL HSCP £000
Earmarked Funding c/f In IJB Reserve at 1 April 2021	**582**	**38**	**620**
Funding received 2021/22	3,252	2,118	5,370
Total Funding available in year	3,834	2,156	5,990
Less: Covid-19 Costs 2021/22	(1,951)	(1,755)	(3,706)
Earmarked Funding c/f In IJB Reserve at 31 March 2022	**1,883**	**401**	**2,284**

Covid-19 Cost Heading	NHSS £000	SIC £000	TOTAL HSCP £000
Additional PPE	0	59	59
Testing	0	98	98
Covid-19 Vaccination	0	30	30
Additional Capacity in Community	0	892	892
Community Hubs	195	0	195
Additional Infection Prevention and Control Costs	44	376	420
Additional Equipment and Maintenance	45	102	147
Additional Staff Costs	485	123	608
Staff Wellbeing	48	0	48
Additional FHS Prescribing	58	0	58
Social Care Provider Sustainability Payments	0	71	71
Digital & IT Costs	68	0	68
Other	1,008	4	1,012
TOTAL COVID-19 COSTS 2021/22	**1,951**	**1,755**	**3,706**

The IJB will carry-forward £2.284m (2020/21: £0.620m) funding within the IJB Reserve as Earmarked Reserves.

IJB Reserves

The IJB carried a General Reserve of £2.198m as at 1 April 2021. This Reserve was created from previous years underspending in the Scottish Government Additionality Funding of £0.564m and underspend in specific NHSS Funding which were carried forward as an earmarked element of the Reserve £1.634m.

During the year there has been a draw on the IJB Reserve of £0.814m, £0.756m of earmarked reserve and further spend against a number of projects which the IJB have agreed to fund from its Reserve, £0.058m.

Underspend in Scottish Additionality Funding and specific NHSS Funding in 2021/22 (including Covid-19 Funding) of £0.053m and £2.879m, respectively have been added to the Reserve.

As at 31 March 2022, the General Reserve has a balance of £4.316m, of which £3.757m is earmarked, leaving £0.559m uncommitted Reserve available to be spent in line with the IJB Strategic objectives.

2022/23 Budget and Medium-Term Financial Outlook

The IJB approved the proposed budget for 2022/23 of £58.180, on 24 March 2022, subject to NHSS Board approval of their delegated budget which was given at its meeting on 26 April 2022. The IJB noted the risks associated with Covid-19 and the impact this may have on 2022/23 budgets and costs.

The IJB approved its Medium-Term Financial Plan 2022-2027 (MTFP) on 17 February 2022. The MTFP assumes that the IJB will be fully funded for the medium term, based on the track record since its inception of full funding being provided by SIC and NHSS to meet the cost of service provision. Despite this balanced position it is recognised that both funding partners are facing significant financial challenge over the term of the plan and beyond.

Inspection of Services

Self-Directed Support

Audit Glasgow completed an audit of Self-Directed Support (SDS) in February 2022. SDS is operated by Adult Social Work (ASW) and Children and Families Social Work (CFSW) locally.

SDS is the process which allows service users to choose the type of support they require to meet their social care needs within an allocated individual budget. During the last financial year (2021/22) direct payment budgets totalling £2.5 million were approved for 115 service users. There are four options available to service users when using their individual budget to purchase care:

1. The service user receives a Direct Payment (DP) and arranges their own support and manages their budget;
2. The Council pays the service provider selected by the service user;
3. The Council arranges and directly pays the support for the service user; or
4. A combination of options one to three.

The Audit was generally positive, finding that many of the key controls are in place and operating effectively. The audit identified some scope for improvement and reported 5 recommendations and one service improvement action to be implemented. A summary of these is detailed in the table on the following two pages.

Recommendation	Action	Timescale
ASW and CFSW management should: • Review and update the DP procedures to reflect current practice. As a minimum this should address the areas highlighted in the observation; • Introduce documented procedures which provide guidance for staff on the arrangements to be followed for non-DP SDS options; and • Ensure all new and updated procedures are made available and communicated to all relevant staff. ASW and CFSW management should also consider introducing a mechanism in which to share good practice.	The service areas have identified that the procedures do not accurately reflect current practice and is mainly adult focused. We also accept that they do not cover non-DP options sufficiently and have arranged to review and update the procedure. ASW and CFSW have been involved in the national pilot looking at worker autonomy and the decision was made to delay updating the procedures until this work was complete. The pandemic has seen a disruption to the existing SDS Steering Group. The EM's will revisit the TOR for this group and re-establish regular meetings and include a focus on sharing good practice and improvement across ASW and CFSW.	30/04/22 (steering group) 31/07/22 (procedures)
ASW and CFSW management should: • Formally remind staff that they must comply with the agreed procedures and any divergences from these should be fully documented and, if required, approval obtained from the Executive Manager; • Share the findings of the audit sample testing with staff so they are aware of the specific issues identified (as noted in the observation); and • Consider how to communicate with service users to remind them of the importance of retaining receipts and documentation and ensuring that this is provided with monitoring returns.	Executive Managers will share the findings of this audit with the extended Social Work Governance Group, and also across relevant teams. The audit report and action plan will be presented at the Integrated Joint Board (IJB) and the Education and Families Committee. A reminder for service users of the need to provide receipts will be added to the grant offer letter.	28/02/22
ASW and CFSW management should ensure that reconciliations of payments made to service users are undertaken on at least a six-monthly basis. This should be completed by an officer that is not involved in the calculation or processing of payments.	The Executive Managers will discuss and agree method to ensure reconciliation is carried out 6 monthly across DP packages.	30/09/22

ASW and CFSW management should ensure that the Financial Regulations and other documentation provided to service users in receipt of DPs is updated to include information relating to potential recovery of misspent funds and the requirement to notify the Council of changes in circumstances.	We will update the existing information sheets to reflect potential for recovery of misspent funds and the requirement to notify the Council of changes in circumstances.	28/02/22
ASW and CFSW should consider introducing a checklist of induction training requirements, such as procedures and documentation, which is signed off and retained once complete.	Creation of an induction and training checklist to support staff and provide assurance that staff have access to necessary training and information.	31/07/22
Senior management should consider putting arrangements in place to record the outcomes and any required actions arising from the 'wraparound' meetings to enable these to be easily monitored and reviewed at subsequent meetings.	This will be raised with senior management to ensure they are aware of the recommendation and to take this forward.	31/03/22

Annual Audit

Audit Scotland published their 2020/21 Audit of the Shetland Islands IJB in September 2021, the audit was largely positive with a small number of recommendations for improvement to be completed in 2021/22. The audit noted:

The IJB continues to have strong leadership in place, and remains committed to being an open and transparent organisation. Significant improvements were noted in the governance and scrutiny arrangement during the year and the IJB acted to ensure it was no longer non-compliant with legislation under the Public Bodies (Joint Working) (Scotland) Act 2014.	The IJB has delivered improvements in key areas in the year and has sufficient arrangements in place to secure best value with a strong focus on continuous improvement it has a clear understanding of areas which still require further development.

Areas identified for improvement include focussing on Board member development, which has begun to be addressed by implementing an annual Board member self-assessment, the first of which took place in March 2022, to understand self-assessed progress of the board and any development needs. The outcomes of the survey informed the induction process for Board members in June and are shaping development sessions for the coming year.

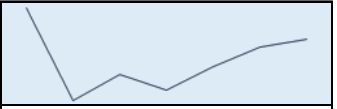
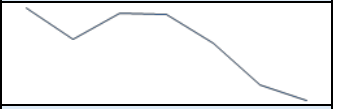
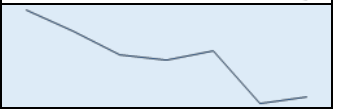
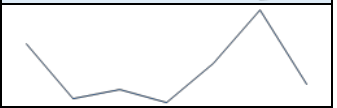
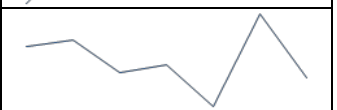
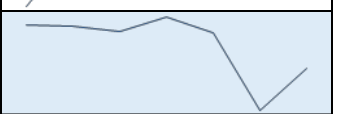
Feedback around linking use of resources with the delivery of outcomes and consideration of savings is being taken forward in the changes to our planning processes to better align financial, service and workforce planning. This should allow better realisation of areas for savings, and improve clarity around linking of resources to outcomes.

Appendix 1- National Integration Indicators Shetland HSCP 5 year trends

Note: 2021/22 results for indicators 2, 3, 4, 5, 7, and 9 are comparable to 2019/20 but not to results in years prior to this. This is due to changes in survey wording introduced in 2019/20 and affects both the HACE publication and the Core Suite Integration Indicators. Due to this change, to ensure the methodology used to produce figures for 2019/20 and 2021/22 is as similar as possible to previous years, results in the Core Suite Integration Indicators are based only on responses where services received were either NHS or council funded, although please note figures are still not comparable.

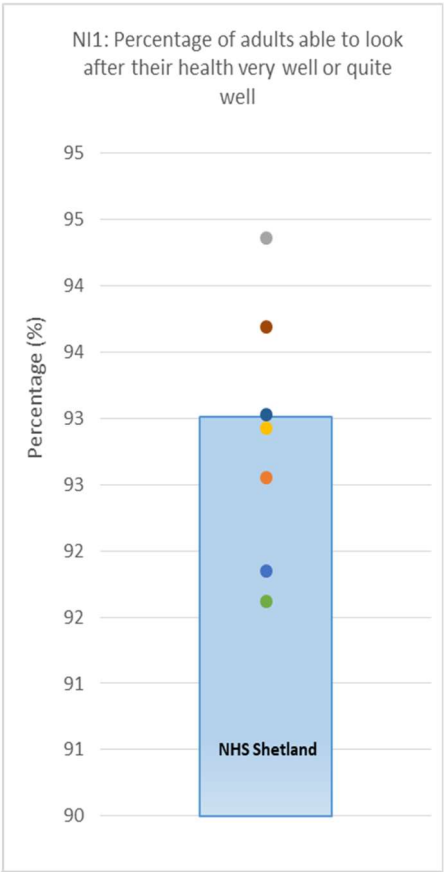
		Indicator						Trend
Outcome Indicators	NI-1	Percentage of adults able to look after their health very well or quite well	2013/14	2015/16	2017/18	2019/20	2020/21	
			97.98	95.40	94.14	95.31	93.01	
	NI-2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	2013/14	2015/16	2017/18	2019/20	2020/21	
			74.10	74.54	77.89	93.85	89.84	
	NI-3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	2013/14	2015/16	2017/18	2019/20	2020/21	
			75.66	77.94	74.50	87.27	77.89	
	NI-4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	2013/14	2015/16	2017/18	2019/20	2020/21	
			66.23	60.20	72.26	93.57	69.82	
	NI-5	Percentage of adults receiving any care or support who rate it as excellent or good	2013/14	2015/16	2017/18	2019/20	2020/21	
			76.71	77.33	85.54	96.87	83.39	
	NI-6	Percentage of people with positive experience of care at their GP practice	2013/14	2015/16	2017/18	2019/20	2020/21	
			80.88	88.33	83.34	85.81	84.18	
	NI-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	2013/14	2015/16	2017/18	2019/20	2020/21	
			85.94	80.86	82.53	88.24	93.60	
	NI-8	Percentage of carers who feel supported to continue in their caring role	2013/14	2015/16	2017/18	2019/20	2020/21	
			45.61	51.12	40.94	49.90	44.64	
	NI-9	Percentage of adults supported at home who agree they felt safe	2013/14	2015/16	2017/18	2019/20	2020/21	
			82.31	71.07	79.55	95.71	78.33	
	NI-10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA		

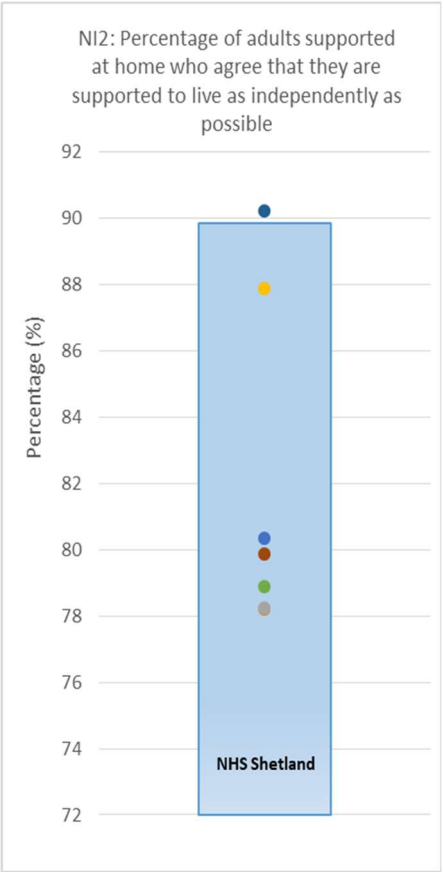
NOTE: Issues with data completeness for NHS Shetland from August 2021 onwards is likely to have an impact on Indicators 12,13,14,15,16 for calendar year 2021 and will affect comparisons with previous years – care should be taken when interpreting trend information.

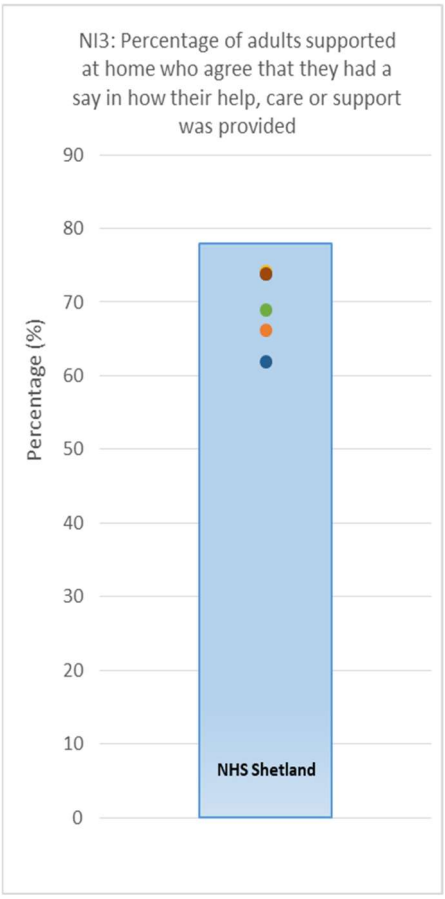
Data indicators			2015	2016	2017	2018	2019	2020	2021	
	NI-11	Premature mortality rate per 100,000 persons	406.6	289.4	322.5	301.7	331.1	356.3	366.8	
	NI-12	Emergency admission rate (per 100,000 population)	2015/16 10601.94	2016/17 10033.15	2017/18 10508.49	2018/19 10469.37	2019/20 9967.63	2020 9238.03	2021 8974.50	
	NI-13	Emergency bed day rate (per 100,000 population)	2015/16 75214.98	2016/17 70569.05	2017/18 65683.54	2018/19 64597.56	2019/20 66536.84	2020 55504.96	2021 56765.22	
	NI-14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	2015/16 79.90	2016/17 69.07	2017/18 70.89	2018/19 68.27	2019/20 75.92	2020 86.77	2021 71.86	
	NI-15	Proportion of last 6 months of life spent at home or in a community setting	2015/16 92.48	2016/17 93.76	2017/18 94.99	2018/19 94.01	2019/20 92.97	2020 93.04	2021 95.10	
	NI-16	Falls rate per 1,000 population aged 65+	2015/16 20.8	2016/17 21.3	2017/18 18.7	2018/19 19.3	2019/20 16.0	2020 23.5	2021 18.3	
	NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2015/16 84.38	2016/17 94.29	2017/18 88.24	2018/19 97.06	2019/20 91.18	2020/21 92.86	2021/22 89.19	
	NI-18	Percentage of adults with intensive care needs receiving care at home	2015 69.0	2016 73.8	2017 76.9	2018 74.6	2019 71.2	2020 72.0	2021 73.8	
	NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2015/16 534.0	2016/17 528.1	2017/18 505.0	2018/19 572.7	2019/20 499.0	2020/21 158.4	2021/22 342.8	
	NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2015/16 14.96	2016/17 14.84	2017/18 13.47	2018/19 13.58	2019/20 13.45			
	NI-21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA		
	NI-22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA		
	NI-23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA		

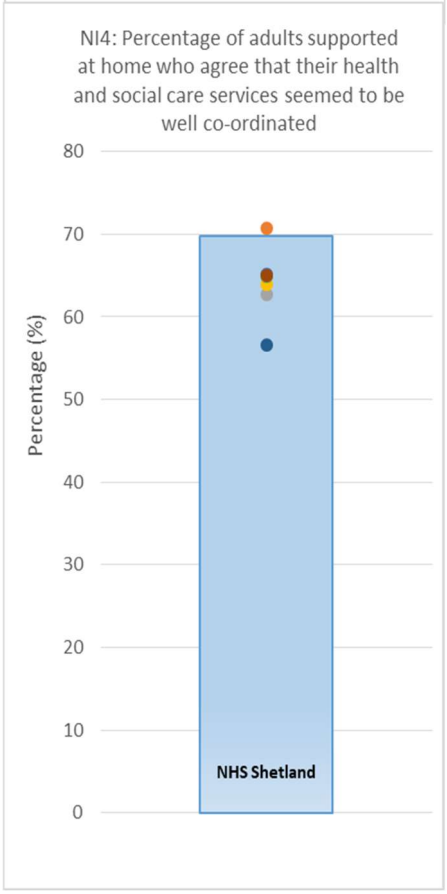
Appendix 2 - National Integration Indicators Ranked against Comparable HSCPs

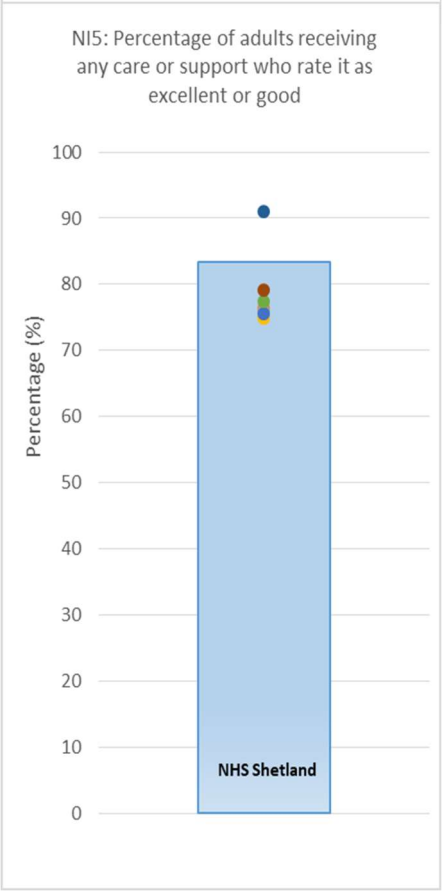
National Integration Indicators shown with Shetland HSCP ranked against comparable HSCPs as advised by the Local Government Benchmarking Framework. Data shown is most recent published – 2020/21 for Ni 1-9, 2021 for NI 11-16 and 18, 2021/22 for NI 17 and 19, and 2019/20 for NI-20, depending on source and publishing schedules. Dates for each NI can be seen on Trend data tables.

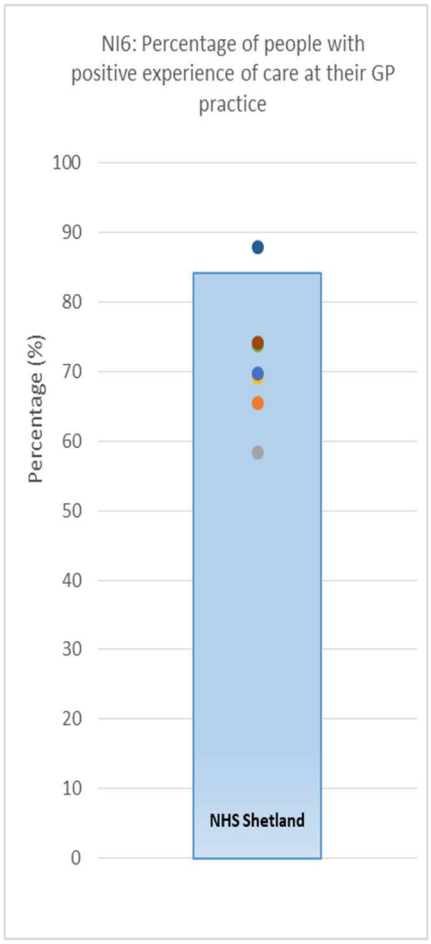


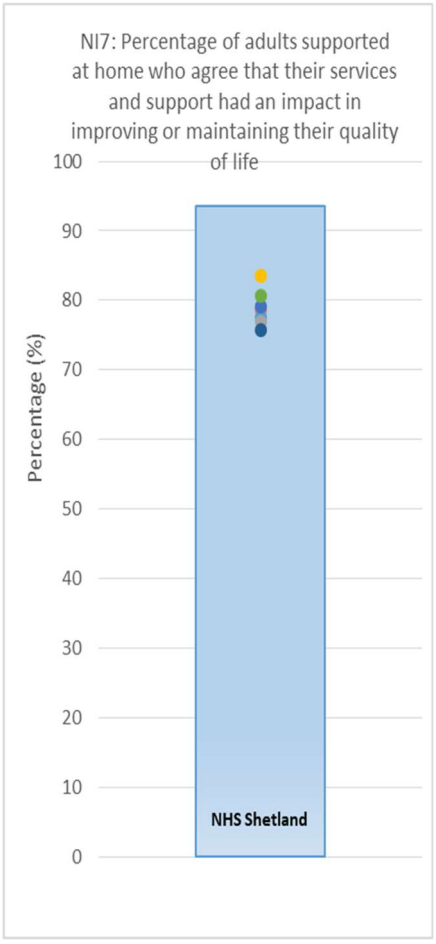


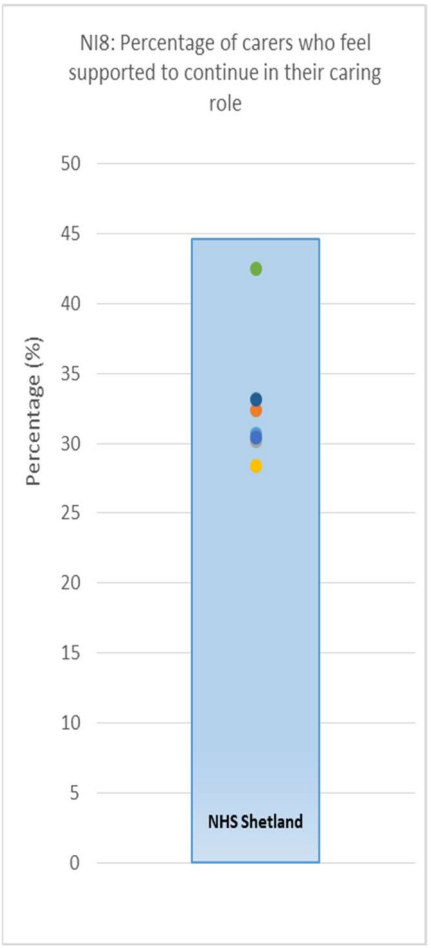


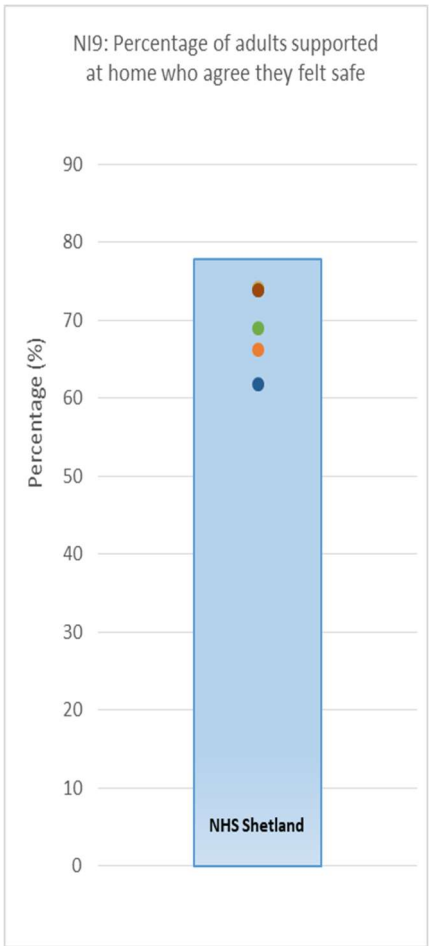


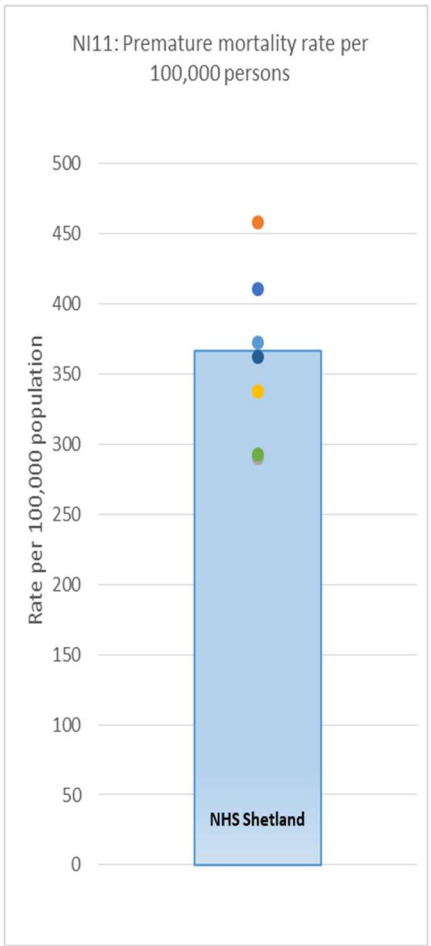


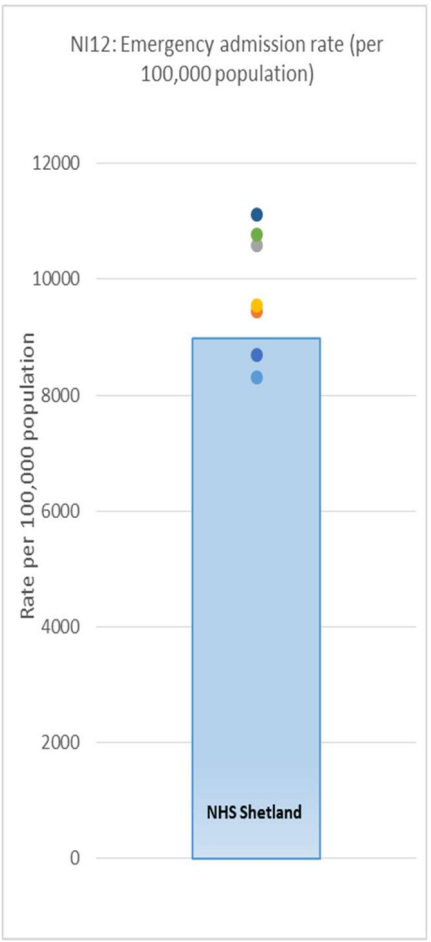

NI6: Percentage of people with positive experience of care at their GP practice
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland

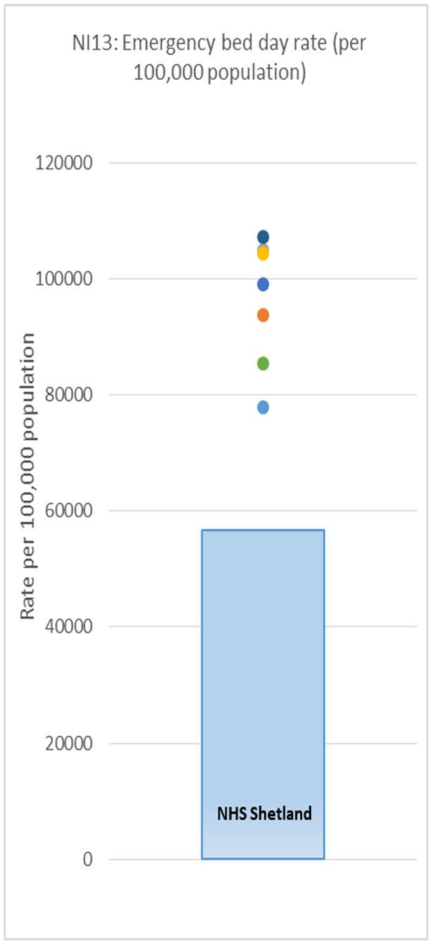

NI7: Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland

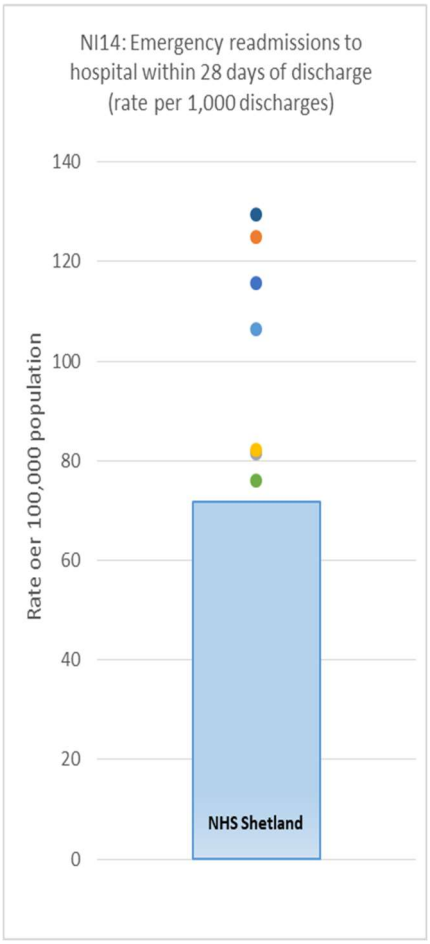

NI8: Percentage of carers who feel supported to continue in their caring role
Percentage (%)
50
45
40
35
30
25
20
15
10
5
0
NHS Shetland

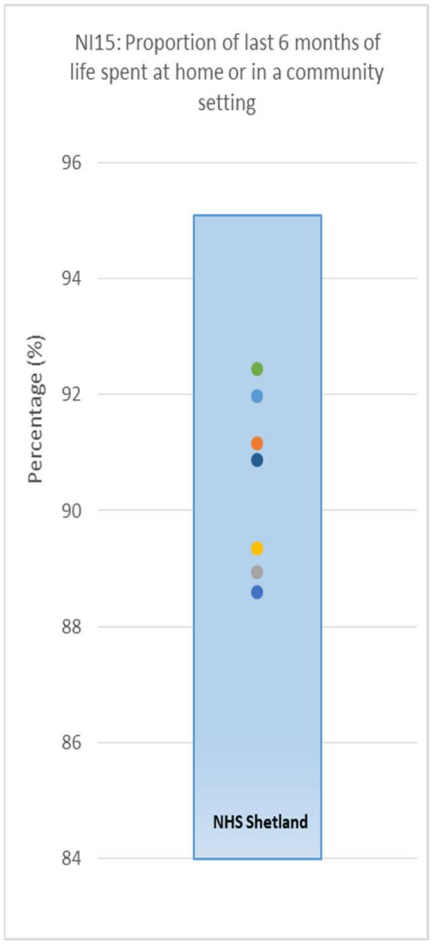

NI9: Percentage of adults supported at home who agree they felt safe
Percentage (%)
90
80
70
60
50
40
30
20
10
0
NHS Shetland

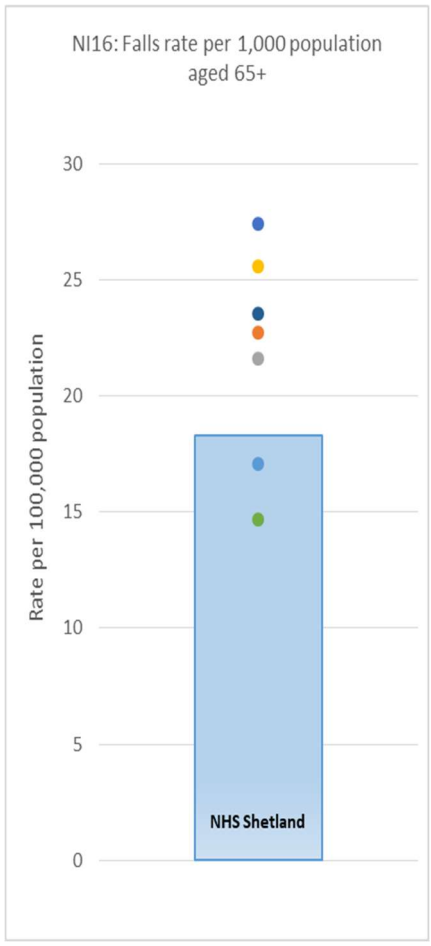

NI11: Premature mortality rate per 100,000 persons
Rate per 100,000 population
500
450
400
350
300
250
200
150
100
50
0
NHS Shetland

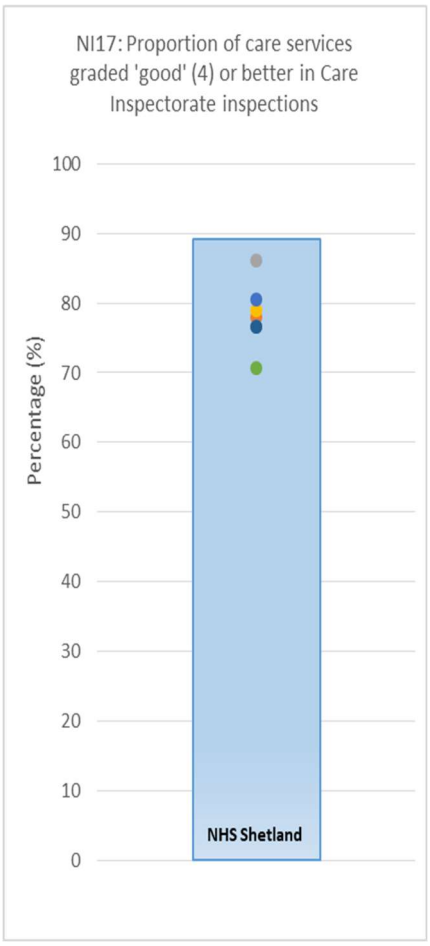

NI12: Emergency admission rate (per 100,000 population)
Rate per 100,000 population
12000
10000
8000
6000
4000
2000
0
NHS Shetland

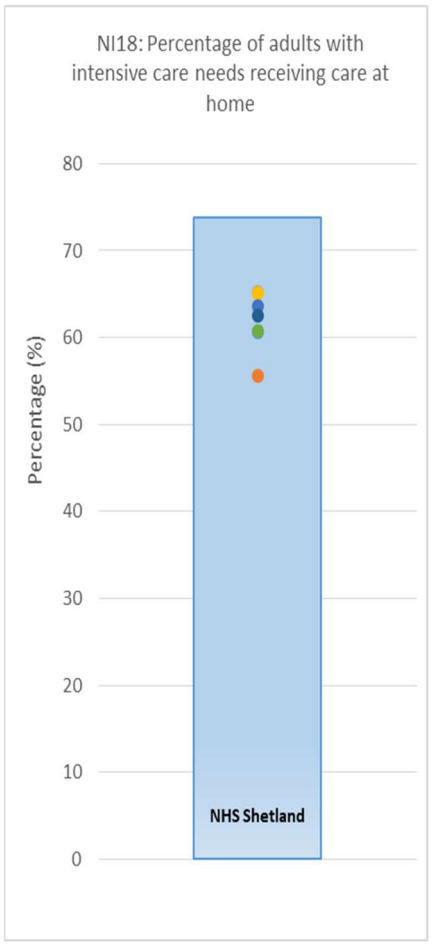

NI13: Emergency bed day rate (per 100,000 population)
Rate per 100,000 population
120000
100000
80000
60000
40000
20000
0
NHS Shetland

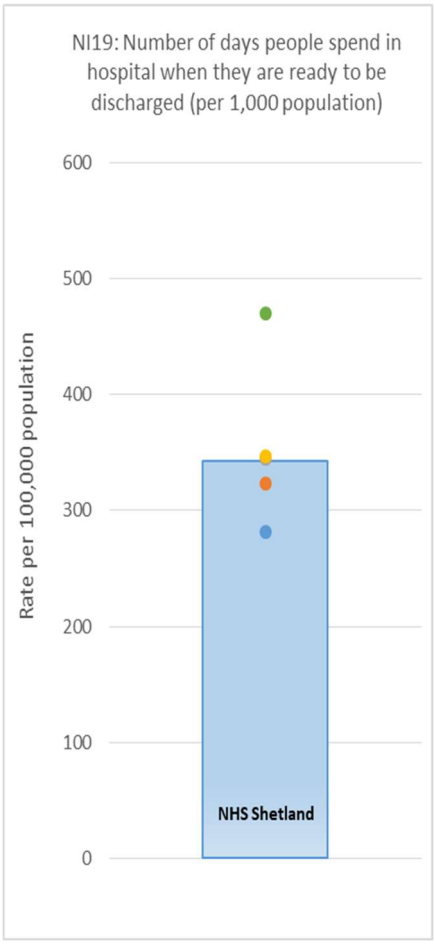

NI14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)
Rate oer 100,000 population
140
120
100
80
60
40
20
0
NHS Shetland

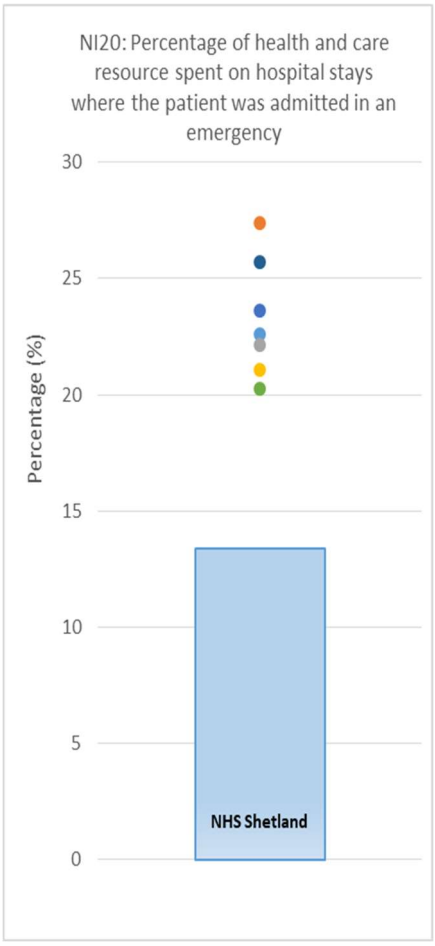

NI15: Proportion of last 6 months of life spent at home or in a community setting
Percentage (%)
96
94
92
90
88
86
84
NHS Shetland


NI16: Falls rate per 1,000 population aged 65+
Rate per 100,000 population
30
25
20
15
10
5
0
NHS Shetland


NI17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland


NI18: Percentage of adults with intensive care needs receiving care at home
Percentage (%)
80
70
60
50
40
30
20
10
0
NHS Shetland


NI19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)
Rate per 100,000 population
600
500
400
300
200
100
0
NHS Shetland


NI20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency
Percentage (%)
30
25
20
15
10
5
0
NHS Shetland

Appendix 3 – Case Studies:

A number of diverse case studies have been reported throughout this year – these are linked below with a short summary. Due to other pressures on services the full range of case studies has not been published as planned. In a continuing effort to improve our performance reporting this will be revisited over the coming year. Four new case studies are included to illustrate some of the diversity of work within the HSCP.

Urinary Catheter Passports – an overview of improvement work aiming to reduce infections associated with urinary catheters.

Community Mental Health Team CPN – patient case study of an urgent referral to the Community Mental Health Team.

Recovery Hub and Housing – an overview of how the Recovery Hub works to support people by bringing services together around a person to solve complex problems together, with the person at the centre.

Justice Social Work Trauma Informed Lens – a service review undertaken with clients to help support engagement, whilst avoiding re-traumatisation and contributing to poorer outcomes for those within the Justice System.

Health Improvement Practitioners – an overview of this role within Primary Care, including short patient case studies.

Community Care Resources Lived Experience – feedback from residents, customers and families with experience of our community care services.

A Primary Care pilot for people with Long Term Conditions; (with thanks to Joan Hughson, Dr C Evans and Lisa Watt for sharing)

Year of Care (House of Care) is a programme set up by House of Care Partnerships which is an NHS based organisation that is dedicated to the implementation of personalised approaches to care. One strand of the work is care and support planning for Long Term Conditions (LTCs). The Scalloway Health Centre became a pilot site for Year of Care (House of Care) locally in August 2021.

The Scalloway Practice team felt patients with Long Term Conditions were not getting the best possible service because the practice recall system to arrange review appointments with patients was out of date and inconsistent. This had happened over a number of years due to changes in staffing, staff shortage and increasing daily workload. The existing system relied on staff using specific wording and codes, and finding patients who needed review was a lengthy, unreliable and complicated process. When patients were called for review they had one appointment for data collection and no follow up unless results were abnormal and they needed to be seen by a GP.

The Pilot project had two parts – a new recall system, and a new appointment setup. The recall system generates a list of patients with long term conditions whose birthday falls within the month of the search, so a single monthly search by admin should generate that month's list of review patients.

A first appointment of 15 minutes with a healthcare support worker (HCSW) is arranged by the admin team. The HCSW gathers information and performs any initial tests needed including BP, height, weight and blood tests. The patient returns after 3 weeks for their Part 2 appointment with a General Practice Nurse (GPN), by which time they'll have had their results letter and a resources sheet developed together with the Health Improvement Team about local and national support available for various lifestyle factors.

The second appointment lasts around 30 minutes with the GPN. Results are reviewed and discussed giving patients an opportunity to voice any concerns, or ideas about management that they have. The patient works with the GPN to prepare a summary plan for the coming year for managing their condition. Any abnormal results that require GP input are discussed at an appointment with the GP, but the patient still attends the GPN appointment to consider their condition as a whole.

Feedback has been gathered from patients attending, some is shared below:

> ''I didn't know how to approach the conversation, it was good to have the letter to indicate to the nurse my problem that was personal, I would never have spoken otherwise"
>
> "appointment wasn't rushed and had time to speak about concerns – nurse was a good listener"
>
> "Pleasantly surprised how informative it was"
>
> "Forms were simple to read and useful"
>
> "This is what long term condition management should look like"

Money Worries – upskilling our workforce to support people in the face of the cost of living crisis; (with thanks to Jill Charleson and Katrina Reid, Health Improvement, for sharing)

Online Money Worries workshops have been developed and delivered over the past 2 years with the aim of supporting people to see the role they can play in raising the issue of money worries, and to improve knowledge and understanding of the support offered by the Shetland Islands Citizens Advice Bureau (SICAB). The Money Worries sessions have been run virtually as a joint venture between SICAB, the Anchor Early Help team and NHS Shetland's Health Improvement team.

There is an established link between poorer health outcomes and money worries (explained in this helpful video, with more information about wider health inequalities from Public Health Scotland online). We know from anecdotal feedback that our workforce can find it difficult to discuss finance and money worries with their patients or clients, and if it is discussed there are concerns about what is the right advice to give. Understanding the growing concern around fuel poverty and the impact of the cost of living crisis locally we wanted to offer sessions as widely as possible to tackle stigma around poverty and support our workforce to have meaningful conversation with people to help them get the support they need.

The sessions begin by setting the scene in the context of health inequalities associated with poverty and discuss the impact of stigma as a barrier to both services raising the issue, and individuals seeking support. Details of the support that CAB offer are discussed, and real life case study examples are shared to illustrate the beneficial impact of engaging with the service. The Anchor Early Help team give examples of how they have engaged with families during the pandemic and use this to facilitate discussion on how people can go about raising the issue of money worries with families they are working with.

People from a variety of roles undertook the training during the period April 2021-March 2022. These included: schools staff, Health Improvement staff, Youth and Employability staff, Child Health staff and staff from the 3rd sector. Attendees report increased confidence in raising the issue of money worries, better links with the local CAB team, and a better understanding of the types of support CAB can offer.

HENRY – building capacity for wellbeing in our population through parental support;

(with thanks to Lauren Peterson, Health Improvement, for sharing)

HENRY is a strengths-based, solution-focused, partnership approach creating the conditions for change within families. As the UK's leading healthy start provider HENRY offer a range of flexible family support and practitioner training services designed to support parenting efficacy and family wellbeing, giving parents a positive interaction with service providers, building confidence to seek support when needed, and tackle challenges as a family.

The project in Shetland has been led by the Health Improvement Team after funding was secured in October 2020 to offer training through early 2021, with online HENRY groups beginning in June 2021. Further funding was secured in October 2021, to secure another round of training, and expand the programme to include "Planning for Parenthood" supporting families in the antenatal period. We currently have 11 facilitators trained to run groups online or in person, with 6 of those trained to support people 1:1, 23 people from various sectors have completed the Core training, with further places available in 2022/23.

HENRY training opportunities build the skills of practitioners in a variety of settings to have supportive, enabling conversations with families, which fits well with our HSCP ethos of "Good Conversations" on which the Community Led Support "hub" approach is based. The Core Training in the HENRY approach equips participants with the knowledge, skills, techniques and confidence to establish partnership-based relationships with families, and support them in their parenting.

An independent evaluation by The Lines Between in March 2022 demonstrated a positive impact on both families and people working with families of the available training and support services. The outcomes for parents show increases in confidence, wellbeing, and feeling able to deal with problems – illustrating the benefits of the relationship-based ethos.

The Health Improvement Team continues to work to build connections between services, and explore, implement and promote effective approaches to prevention and early intervention in Shetland.

Supported Living and Outreach (SL&O)– increasing opportunities with a Local Activity Coordinator

(with thanks to Anna Thomson and Diane Colvin for sharing)

'T' is an SL&O customer who worked with the Local Activity Coordinator (LAC) hoping to gain a sense of purpose, having been made redundant from his full time job as a cleaner during the pandemic his goal was to get full-time employment and have other meaningful activities to go to. T was receiving support from Shetland Community Connections but no job opportunities had arisen.

The LAC worked with T, their key worker, Shetland Community Connections, Mental Health Community Support Services and Supported Living staff to explore possible options, maintain communication with T and keep things progressing through regular contact and advocating for T in his search for employment. This way of working, coordinating all involved services and supports, has been beneficial for T, minimising any frustration or confusion between services.

In 6 visits, and additional phone contact over the next 7.5 months the LAC and T's key worker have supported T to become involved as a regular at walking rugby, and he is now working part time, with a potential for increased hours in the future. The confidence gained through securing employment and a renewed sense of purpose has helped T get involved with more group activities with other SL&O tenants.

Timeline:

May 2021 – Shetland Community Connections start looking for opportunities for T to improve his wellbeing. SCC link with Community Care Social Work to try and find a job opportunity.

June 2021 – Mental Health Community Support Services identify a job opportunity for T

August 2021 – LAC starts working with T to take forward his job application

September 2021 – T attends Job interview

March 2022 – T starts part time job as a cleaner with the SIC.