Shetland Islands Health and Social Care Partnership Annual Report 2022-23

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

June 2023

Welcome and Introduction…

This is the seventh 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.

This last year has been dominated by the recovery and reconfiguration of service provision following the Covid-19 pandemic. We have also had to deal with the enactment of our emergency planning on numerous occasions to deal with Shetland wide weather and connectivity issues. We are very grateful to our workforce and partners for their support in our emergency responses.

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. During 2022-23 the IJB has been chaired and led by Councillor John Fraser.

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

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for NHS Shetland and Shetland Islands Council

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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 2022 to 31st March 2023. 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. 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'.

We would like to tell the story of our year, describing key work and achievements, challenges and developments, and what this has meant for people who use services, communities, our teams and partners. The report will be organised around our five strategic priorities:

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

Prevention and Early Intervention	Tackling Inequalities	Best Value	Shifting the Balance of Care	Meaningful Involvement

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. This provision is delineated for the purposes of budgeting and setting Directions, but practically the services work as part of the health and care system, which itself operates within the wider Shetland "system": The strength of integration lies in these services working well together, and that is what the HSCP aims to do in Shetland.
Services delivered in 2022-23

Adult Social Work	Adult Services Learning Disability and Autism	Allied Health Professions	Residential Care
Adult Mental Health	Community Nursing	Primary Care	Pharmacy and Prescribing
Justice Social Work	Health Improvement	Oral Health	Alcohol and other Drugs support
Intermediate Care Team	Hospital Based Services including parts of Unscheduled Care, Sexual Health and Renal Services	Unpaid Carers support	Care at Home

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 £58M. It covers a population of 22,920.

What we are trying to achieve

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, Health and Social Care MSG (Ministerial Steering Group) indicators and through local performance reporting.

1	Health and Wellbeing	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	Living in the Community	People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3	Positive Experiences and Dignity	People who use health and social care services have positive experiences of those services, and have their dignity and human rights respected
4	Quality of Life	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 Inequalities	Health and social care services contribute to reducing health inequalities
6	Support for Carers	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	Safe	People who use health and social care services are safe from harm
8	Workforce	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	Use of Resources	Resources are used effectively and efficiently in the provision of health and social care service

The work of the HSCP is built around achieving the differences these outcomes describe, that is:

Improved or sustained health ✧ Increased or sustained independence ✧ Improved quality of life

(Commissioning for Outcomes, 2023)

Locality Planning

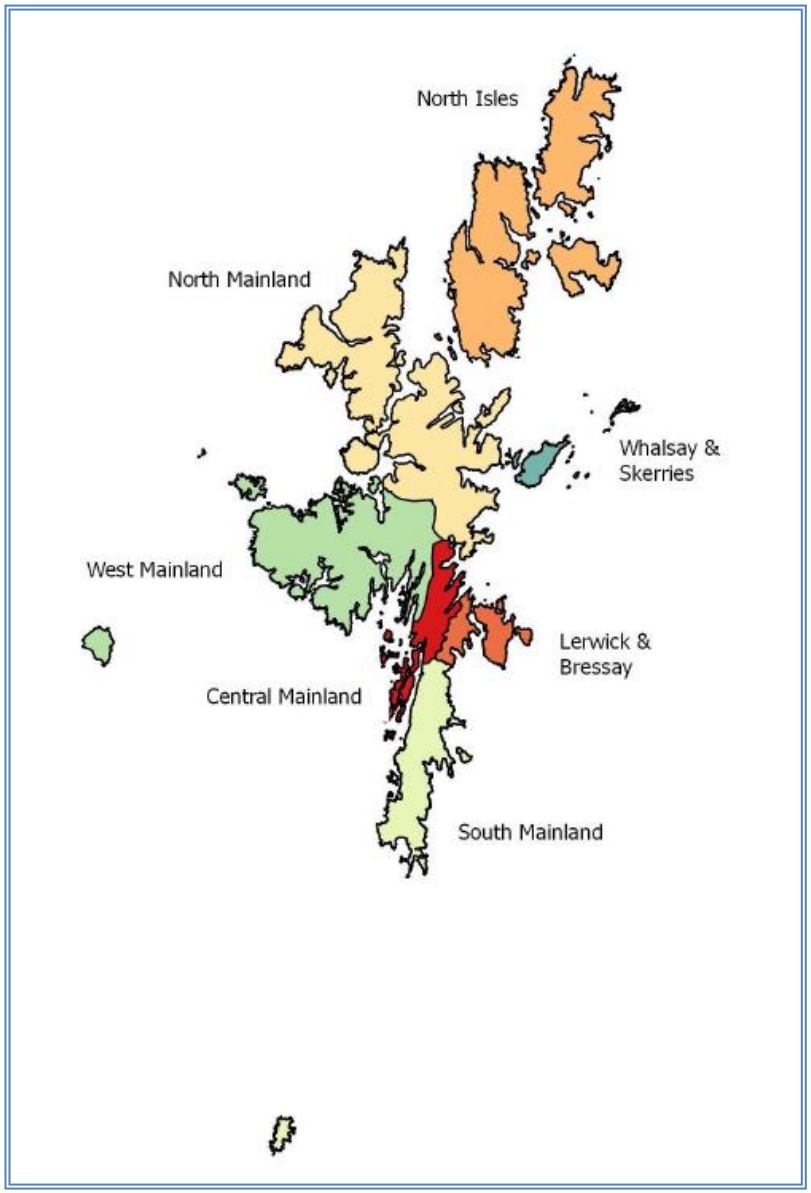
The Health and Social Care Partnership is responsible for delivery of services across the geography of Shetland. We work closely together with our partners across NHS Shetland, the Shetland Islands' Council, and the wider Shetland Partnership, recognising our shared goals and ambitions to support people in Shetland. Our strategic plan and activity is closely linked to the Shetland Partnership Plan, the SIC Corporate Plan – Our Ambition and NHS Shetland's Clinical and Care Strategy.

Our services in Shetland are planned and provided across 7 localities:

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

There is a recognition that services, experiences and outcomes can vary by geography within Shetland, and historic local and national data has struggled to helpfully explain variations or target improvement. A significant piece of work to help us better understand our communities' needs is underway in partnership with the SIC Community Planning and Development Team, NHS Public Health and colleagues from Public Health Scotland (PHS).

This data will be used with communities to support strategic decision making, rebalance our system to provide equity of access and outcomes, and to target services and support to those with greatest capacity to benefit.



The Main Challenges of 2022/23

Our incredibly resilient teams and communities have continued to overcome a number of challenges over the past year, however the ongoing pressures are a concern and we are mindful of the impact on staff wellbeing, team resilience and community outcomes – we're continuing to work closely with the Shetland Partnership to support our communities beyond our core service provision. Some key challenges in 2022/23 have been:

- Recovery and stability of services as we emerged from the COVID pandemic - this has affected service availability and staffing capacity through sickness absence of restrictions within services. The wider impacts on outcomes within our communities, and particularly on unpaid carers, is still emerging and causing concern for our teams.

  Action: Re-establishment and redesign of services, engagement with National Carers Strategy, implementation of oversight group and dataset to support best use of resources and staffing capacity.

- Workforce – recruitment and retention has continued to be challenging across health and social care, with Shetland experiencing an amplified version of national challenges with the local context of remote and rural living, increased cost of living, and housing availability.

  Action: Engagement with integrated joint workforce plan (to be developed further), recruitment drive for Modern Apprentices and development of Grow Your Own career pathways to support retention, work with Care Inspectorate to support induction, consistency and retention of agency staff, engagement with local schools and careers events, improvements in recruitment processes to optimise management and support service time.

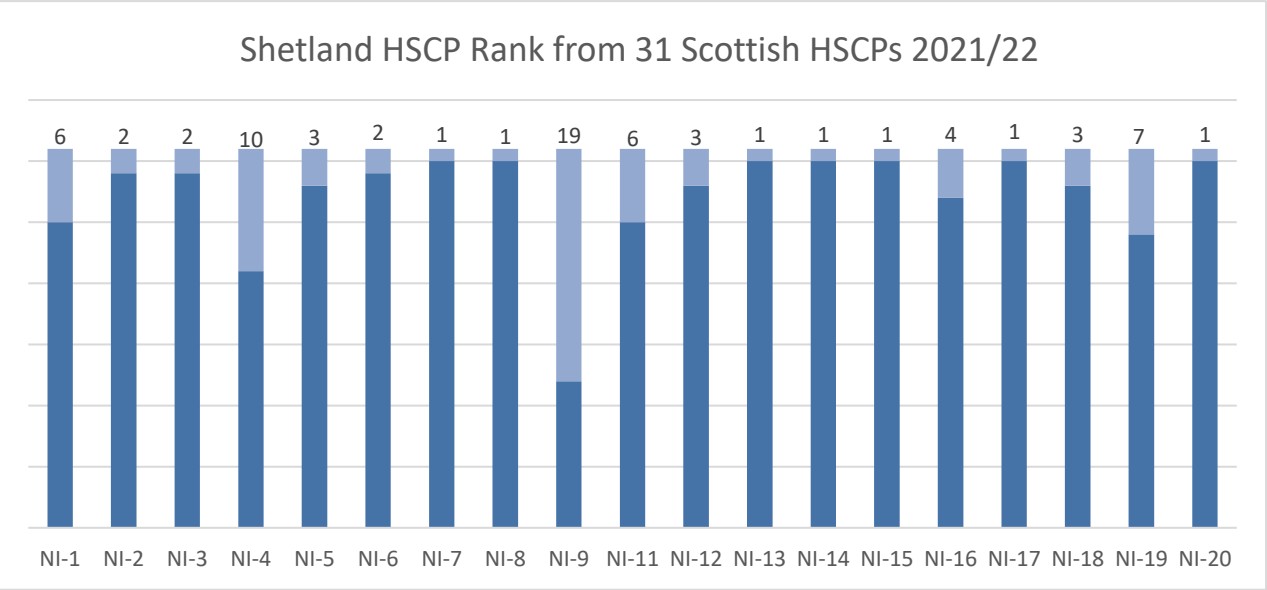
- System pressure – a period of unprecedented pressure within health and social care in Quarter 2 and 3 brought significant challenges to teams across the system

  Action: implementation of regular locality meetings and escalation opportunities, active management to anticipate and facilitate patient flow through system, ongoing engagement with acute and third sector colleagues to effectively manage risks for services and individuals

- Extreme weather and communications outages – three separate periods of emergency measures owing to external factors saw implementation of the Caring for People Plan and incredible resilience, and tireless efforts from teams and communities to support vulnerable and at risk individuals.

Our Performance

We use a variety of local and national data, alongside staff and patient stories, to understand and describe our performance as a Health and Social Care Partnership. This report cannot hope to illustrate every aspect of performance but will provide a general overview and some highlights and challenges that capture the story of our year in Shetland.



Core Suite of Integration Indicators

In addition to local measurement of performance we measure our progress towards the National Health and Wellbeing Outcomes via the Core Suite of Integration Indicators, last published in September 2022. The full set of data is openly available on the Public Health Scotland website.

This data 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 population, can be found in appendices 1 and 2. No single data source can tell a whole story and these should be interpreted with caution, within the context of other data, outcomes and experience.

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

Detail of what the indicators are, and a comparison to the Scottish average is overleaf, there is more in-depth detail to explore at Appendix 1.

Notes on data availability:

Indicators 1-9:

There are no updates to the Health and Care Experience (HACE) survey this year. This is usually updated every other year and the next update is due in May 2024.

Indicators 11-19:

These are based on most recently available complete data – time periods are detailed in Appendix 1 and 2.

Indicator 20:

NHS Boards have not been able to provide detailed cost information since 2019/20 due to changes in service delivery during the COVID-19 pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy but given the impact of the COVID-19 pandemic on activity and expenditure, PHS no longer consider this appropriate.

	Indicator	Title	Partnership rate	Scotland rate	Year of latest
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	93.0%	90.9%	2021/22
	NI - 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	89.8%	78.8%	
	NI - 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	77.9%	70.6%	
	NI - 4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	69.8%	66.4%	
	NI - 5	Percentage of adults receiving any care or support who rate it as excellent or good	83.4%	75.3%	
	NI - 6	Percentage of people with positive experience of care at their GP practice	84.2%	66.5%	
	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	93.6%	78.1%	
	NI - 8	Percentage of carers who feel supported to continue in their caring role	44.6%	29.7%	
	NI - 9	Percentage of adults supported at home who agree they felt safe	78.3%	79.7%	
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	*NA*	*NA*	*NA*
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	363	466	2021
	NI - 12	Emergency admission rate (per 100,000 population)	9,117	11,656	2021
	NI - 13	Emergency bed day rate (per 100,000 population)	57,518	110,718	2021
	NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	72	110	2021
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	95.0%	89.9%	2021
	NI - 16	Falls rate per 1,000 population aged 65+	18.3	23.1	2021
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	89.2%	75.8%	2021/22
	NI - 18	Percentage of adults with intensive care needs receiving care at home	73.8%	64.9%	2021
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	343	761	2021/22
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	13.4%	24.2%	2019/20
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	*NA*	*NA*	*NA*
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	*NA*	*NA*	*NA*
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	*NA*	*NA*	*NA*

Local Government Benchmarking Framework (LGBF)

Local Government Benchmarking Framework (LGBF) data is published annually by the Local Government Improvement Service in partnership with COSLA and Solace. It is a set of high-level data about key council services, including those within Adult Social Care. The data is meant to help discussion about differences between similar local authorities, and changes in performance, to inform improvement and support learning.

Caution should be used in interpreting change in these indicators as a complex mix of factors can influence the outcomes – they are not a simple measure of service performance. To help interpretation a crude sense of improvement/worsening in comparison to the change we would like to see is denoted in the table. For more detail around the complexity of factors influencing these changes see the recent report to IJB from May 2023. The full dataset with interactive dashboards is available online.

More detail around performance monitoring processes and their development over 2022/23 is provided in the Planning and Performance Development section later in the report.

	Compared to Scottish average	Compared to similar areas	Shetland progress
Home care costs per hour for people aged 65 or over	HIGHER	HIGHER	
Self-Directed Support spend on adults as a % of total adult social work spend	LOWER	LOWER	
% of people aged 65+ with long term care needs who are receiving personal care at home	HIGHER	HIGHER	
% of adults supported at home who agree that their services and support has an impact in improving or maintaining their quality of life	HIGHER	HIGHER	
% of adults supported at home who agree that they are supported to live as independently as possible	HIGHER	HIGHER	
% of adults supported at home who agree that they had a say in how their help, care or support was provided	HIGHER	HIGHER	
% of carers who feel supported to continue in their caring role	HIGHER	HIGHER	
Residential costs per week per resident for people aged 65 or over	HIGHER	HIGHER	
Rate of readmission to hospital within 28 days per 1000 discharges	LOWER	LOWER	
Proportion of adult care services graded good or better	HIGHER	HIGHER	
Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)	LOWER	HIGHER	

KEY:	Improved more than 5%	No change (within 5%)	Worsened more than 5%

Shifting the Balance of Care Programme

In March 2022 the HSCP took an update of progress against the Shifting the Balance of Care programme to the IJB. Shifting the Balance of Care is the main vehicle for delivery of the Joint Strategic commissioning Plan 2022-25, and represents the bringing together of a number of pieces of work to give strategic focus, and build on their progress via the added value of partnership working. Shifting the Balance of Care aims to improve outcomes by delivering value from all our resources, and is built around the shared goal of people being able to access care and support that is right for them. The programme has been progressed under three key work streams in 2022/23:

The right care, from the right person, in the right place, at the right time.

1. Developing our ways of working

Objectives:

a. Multidisciplinary Teams (MDTs) available to all localities

b. Health and Care is provided via an effective network making best use of resources and decreasing unfair differences in provision across localities

c. We provide services based on best evidence of need and effectiveness

2. Enhancing the person-centred approach

Objectives:

a. Early Intervention – we identify and support need earlier through a systematic and targeted approach

b. A human-rights based approach where people are equal and informed partners in their own care

c. Our system supports people in the way they need, when they need it

3. Strengthening Community Ethos

Objectives:

a. We understand the health and care needs of our communities

b. Health and Care services make best use of community led support as part of their care

c. People know about, and are supported to access, support in their community

This programme of work encompasses action against all five strategic priorities, and will continue into 2023/24 following a review and update of the work streams.

Prevention and Early Intervention	Tackling Inequalities	Best Value	Shifting the Balance of Care	Meaningful Involvement

Prevention and Early Intervention

Our services aim to help people to look after their own health and wellbeing wherever possible, so that people can live in good health, maintain their independence and achieve what matters to them. This can mean giving people the tools or knowledge, supporting them where it might be more difficult, helping to build communities that support wellbeing and helping people to be connected to those communities. The shift towards early intervention and prevention is challenging in the face of immediate need and crises. Some ways in which services are delivering prevention and early intervention include:

Highlights:

- Health Improvement have continued to deliver programmes supporting behaviour change, developing their approach to offer self-referral across all areas to offer greater choice, support self-management and shift towards community access. The team are currently piloting new ways of working focussed around hosting more of their work in the community and away from build based services.

- Piloting a new Community Link Worker approach – engagement of a steering group to develop what the role should look like and how it should work to best effect for communities, this builds on existing Early Action work and the learning form the Community Led Support project

- Quit Your Way smoking cessation programme, and Healthy Shetland lifestyle change programme. While they continue to support families via the HENRY (Health, Exercise and Nutrition for the Really Young) for families approach, delivering workshops and working with Maternity colleagues to incorporate into their parenting programme.

- Training to support an improved approach to prevention and early intervention, through for example smoking and physical activity brief intervention training, the Alcohol Brief Intervention (ABI) improvement programme

- The Dietetics and Health Improvement Teams have continued work on the Type II Diabetes Reversal programme in collaboration with Primary Care

- Primary Care Teams have also rolled out the House of Care programme to improve outcomes and experience for people with Long Term Conditions by offering more systematic recall and an enhanced review process that looks to support lifestyle change in line with what is most important to the person

- The Psychological Therapies team have expanded their capacity by adding a Primary Care Team Lead and additional Psychological Therapist, and also by offering a greater variety of treatments, including group support. This has enabled the team to cut the number of long waits and improve performance against the 18-week referral to treatment target, but with increasing referrals this remains a challenging target. New team members coming into post in Q4 of 2022/23 should begin to have an impact on these targets through 2023/24.

- Health Improvement team secured short term funding to deliver the Good Mental Health for All project, this has involved setting up a Mental Health for All steering group with a view to revising the local Mental Health strategy, re-establishing the Mental Health partnership to lead implementation, and exploring needs and assets locally. Stakeholder and community engagement, strategy scoping and development of an accompanying dataset underway.

- Stress Control training – a project to deliver community based stress management training to groups within their community to support resilience, self-management and peer support – training has been completed and an implementation plan is in development, recruitment for a Project Manager to lead the roll out and support sustainable implementation is underway

- Supporting development of Managed Clinical Networks with Public Health colleagues – establishment of 3 new MCNs that will be developed by our local MCN coordinator link well with the HSCP Shifting the Balance of Care Programme. Identified MCNs are based on areas of greatest need and scoping and development has taken place towards the end of 2022/23 – MCN topics are Respiratory, Frailty and Cardiovascular. As well as service and pathway development these groups will look at the prevention and improvement work to support positive outcomes for individuals

Preventing Frailty by Improving Nutrition

Malnutrition can happen for lots of different reasons, and older people are at particular risk especially if they are experiencing difficulties with independence and daily living. Problems can be with ability to eat or feed yourself, food preparation and access, motivation to eat, and associated pain, among other things.

People providing care and support have an important role in recognising risk and preventing malnutrition. A project in the summer of 2022 was undertaken by the Dietetics department in collaboration with Shetland residential teams including social care workers, seniors, care home cooks and Care at Home staff in the community. The project included review of existing dietetic patients and their care, menu and mealtime observations and advice, training needs analysis and delivery of MUST (Malnutrition Universal Screening Tool) training.

Confidence in ability to screen for malnutrition, provide nutrition advice and care, and actioning nutritional care plans was massively increased following training, which was provided to more than 100 staff across Shetland.

Some actions identified and progressed following the project include:

- Care home/meals on wheels menu & food provision to be reviewed
- Arrangement of Dysphagia training (swallowing problems, linked to risks of choking etc.)
- Section added to community food & nutrition policy and Q&A incorporated in training sessions
- Purchase of scales and height measuring equipment to help effective monitoring
- Revised care plan to include full 5 step MUST assessment and actions and to flag other risks
- Drafted community oral nutrition support prescribing pathway
- Information sheet outlining most appropriate and cost effective oral nutritional supplements produced

Caring for Smiles

Malnutrition, and the risk of frailty, is very closely linked to how well a person is able to look after their oral health. This includes tooth brushing and denture care, and general oral health awareness.

To support staff to have often difficult conversations with clients and families around oral hygiene, and to know how to support good oral health, and when to be worried about any changes or symptoms the Oral Health Improvement team provide “Caring for Smiles” training and support to all Residential Care settings across Shetland. Training is also provided to Care at Home staff to support earlier intervention.

Families Affected By (FAB) – support for families and unpaid carers provided by the Substance Misuse Recovery Service (SMRS)

I didn't know about the FAB service at all at first – I knew about SMRS because my ex-partner went there. I phoned up out of fear, I didn't know who could help me. My ex-partner was involved in a serious level of drug dealing, and debt. I was in a place where I was extremely anxious, scared to answer the door (I still am) and back then I was also worried about his health.

I've been in touch with FAB for the past 3 years, although it's less often now because I'm managing well. It began by her just listening and giving me options about how I could make myself feel safer, but at the beginning I was too scared to do much. It was really important having that consistency, and someone who listened, to build up trust – I didn't speak to anyone else about what was going on then.

I agreed to be referred to Women's Aid with FAB doing the initial talking to them – I never would have gone otherwise, without the reassurance from FAB helping me trust them to begin with. I've now been seeing them for two years now too, and it's been really helpful.

I have some health conditions possibly triggered by stress - with FAB I have learnt how to better manage emotions. We do a lot about self-care. I haven't really needed to use a lot of other services for health stuff, I'm able to look after myself so much better with that support from FAB.

If I didn't have the support, I think I would now be quite an ill person as I was running on adrenaline all the time – I don't know how it would have ended up. Now I've built up support and connections round about me with services for me and my child, and with family and friends now I've felt safe and confident to speak more openly about what has happened. There is still a lot of stigma and people looking down on you and not understanding.

It doesn't feel like there's a lot of support for the families or partners of users and sometimes professionals, even when they are really fine and they get to know you, they maybe don't ask about it, or don't know how to speak about it – they weren't worried about me as a parent so it was maybe harder for them to step in, but I really did need that help.

> The support has been life changing, no matter what has gone on, I'm always reminded of the progress I've made and how I have progressed as a person from the beginning until now.

FAB has walked with me through life for the past few years, and with that support I really feel like I can do anything – I'm the family voice on the Alcohol and Drug Forum now, and I've done some work with the police to tell my story to raise awareness. I just really want to get involved to make sure other people in the same situation can get help that they need, and know that there is help there for them.

Tackling Inequalities

To support work to tackle inequalities locally in a Shetland wide approach it is important we have a good understanding of our local population and communities – particularly being mindful of the difficulties of small numbers when using national data. In an effort to build a robust understanding of local strengths, needs and differences the Public Health and Health Improvement teams undertook a Population Health Survey towards the end of 2021/22, which was then analysed and published in 2022/23.

The teams have been working with Community Planning and Development partners this year to build on these data to produce locality profiles to support targeting of service and empower communities to make change and access support. This work is being done as part of the Shetland Partnership and should be available later this year.

Teams across the HSCP have also been working on distinct projects and changes to tackle inequalities of access and outcomes within our services. Work includes:

- Recovery Hub pathways to support people who use alcohol and other drugs to access support they need
- Health Literacy projects with Health Improvement, Primary Care and Community Learning and Development
- Increasing accessibility of Primary Care to users of British Sign Language (BSL)
- Communication support for services working with people with Learning Disabilities
- Money Worries training – mitigating the Cost of Living crisis by increasing professionals' skills in understanding the impact of financial problems, and helping people get appropriate support – a joint project with Anchor for Families and Citizens Advice Bureau
- Advanced Nurse Practitioner work with Primary Care and the Recovery Hub to increase access to general health care and sexual health services for people who find it more difficult to access
- Learning Disability system improvement – work with Primary Care and Community Nursing to scope provision of LD Health Checks
- Self-Directed Support Improvement Programme – work to ensure that support is fair and proportionate to need, and people who need support are able to access what they need

Best Value

Best Value is about ensuring that there is good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public. Much of this work is delivered through the performance and financial reporting and management processes, and through the strength of leadership reflected in the annual audit report.

In relation to operational management there has been a lot of progress to improve partnership working and to redesign services to make best use of available resource – while this redesign can result in financial savings, the work is focused and designed to produce improved outcomes and to overcome challenges, for example in recruitment.

An example where effective planning and collaboration helps to improve outcomes and minimise unnecessary treatment or intervention is where the multi-agency discharge review group helps to support safer, more effective and appropriate discharge, which results in fewer readmissions to hospital. Time spent by acute hospital, social work, community health, allied health professions and pharmacy colleagues in reviewing and planning discharge supports optimal outcomes for individuals.

Re-admissions within 28 days of discharge (per 1000 discharges)

	2015/16	2021/22	
Scotland	98.1	109.6	
Shetland	79.9	71.9	
Similar LAs	90.1	98.5	

(LGBF)

Service redesign work has progressed across a number of areas in the HSCP over 2022/23, including embedding the Healthcare Support Worker model in Skerries, with remote support from Whalsay Health Centre and the Community Nursing Team; redesign of the Mental Health team to improve ability to offer support and treatment closer to home, respond to urgent need while supporting planned care, and to build service sustainability by co-designing provision with frontline staff; extending roles for Advanced Nurse Practitioners (ANPs) tests of change with ANPs delivering GP Out of Hours cover and single-handed in-hours cover.

Work in residential Social Care to reorganise provision to make time for value-adding social and enriching opportunities has been important in enhancing wellbeing during periods of pressure within services due to recruitment and retention challenges which have made delivery of core services challenging. Teams implemented a system of scheduling personal care in a similar way to how they work in the community setting, to help protect time for social activities. In other areas where COVID restrictions have seen a decline in social activities, teams have worked to provide outreach enrichment activities to those who struggle to access their community.

Shifting the Balance of Care

Shifting the Balance of Care has been an ambition in health and social care in Scotland for a number of years. Over the course of the Shetland IJB's existence, through successful partnership working we have seen a shift in where and how people are looked after in Shetland.

There are a number of different factors that make it possible, or not, for someone to remain at home, and we want to make sure we are providing quality care that is right for each person while driving improvement towards out strategic objectives. As well as monitoring the kind of support and where it takes place we want to understand the impact that care has – it is a very positive reflection of our community health and care system that people feel their care both improved their quality of life and supports them to live independently.

Working well as a team across health, care and other services is key to supporting people in a way that works for them. To facilitate this multi-disciplinary team (MDT - many different professions) working the HSCP has instigated locality MDT meetings to support communication and build relationships across the teams which has supported learning and positive outcomes for patients. These meetings were initially put in place during a period of extreme system pressure across both Health and Care during Quarters 2 and 3 of 2022/23.

The meetings were supported by Executive Management and had a clear line of escalation for challenges or issues that could not be solved within localities. These, coupled with a multi-agency Discharge group, have helped to manage Delayed Discharges, or people being held up in hospital when they are ready to go home or to a community setting. Problems identified included broken or missing equipment, bed shortages due to impact of COVID-restrictions (e.g. extra storage requirements), and staffing shortages – while not all of these could be solved the resolution of many supported flow through the system and decreased the number of Delayed Discharges.

% who agree they are support to live as independently as possible (LGBF)

	2015/16	2021/22	
Scotland	82.7%	78.8%	🟡
Shetland	74.5%	89.8%	🟢
Similar LAs	81.7%	82.9%	🟡

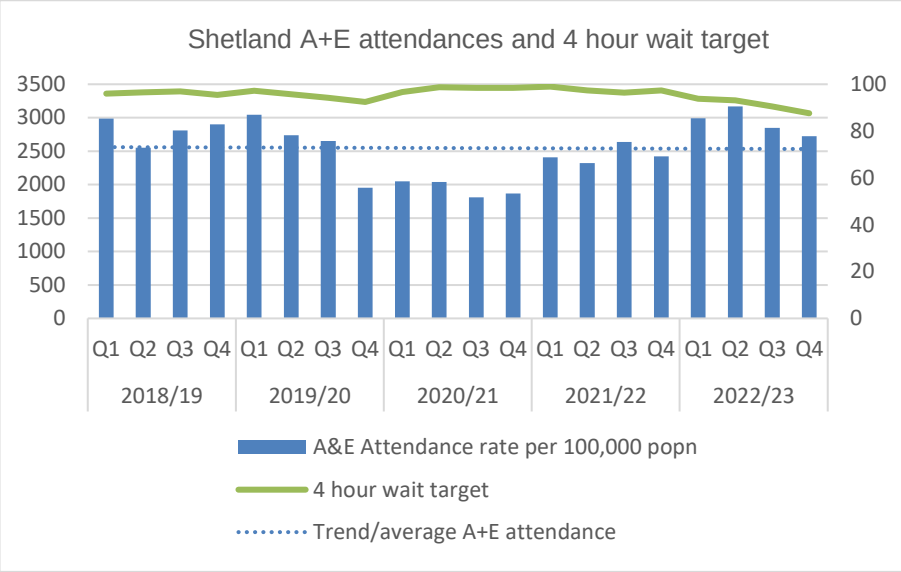
% of people with long-term care needs who are receiving personal care at home (LGBF)

	2015/16	2021/22	
Scotland	60.7%	61.9%	🟢
Shetland	72.1%	75.3%	🟢
Similar LAs	60.4%	61.5%	🟢

% of people who feel services and support helped maintain or improve their quality of life (LGBF)

	2015/16	2021/22	
Scotland	84%	78.1%	🔴
Shetland	83.6%	93.6%	🟢
Similar LAs	83.7%	80.8%	🟡

This increased pressure on the system is understood to have been caused by a number of circumstances – including A+E attendances returning to their pre-COVID levels, and increase in more medically-complex patients, and a system navigating through recovery of services and de-escalation of COVID-restrictions.



Community Nursing

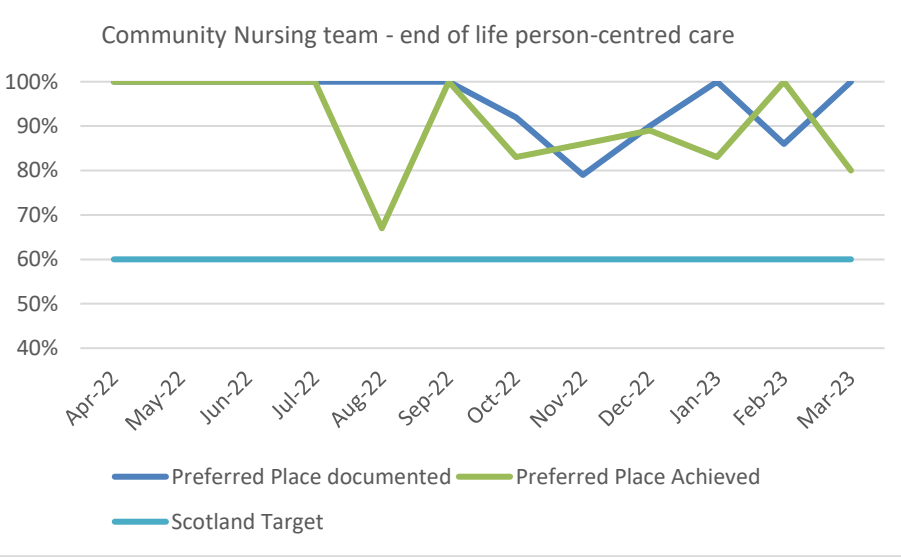
One of the key indicators the Ministerial Steering Group (MSG) monitors to understand the progress of Integration and working together is how much of the last 6 months of their life people are able to spend at home.

% of last 6 months of life spent at home

	2015/16	2021/22
Scotland	87%	89.8%
Shetland	92.5%	95.3%

(MSG)

A closely connected measure our Community Nursing team use to understand the quality of person-centred care they are providing, and make improvements where needed is whether a person's preferred place of death is recorded, and whether they are supported to achieve that.



Good Conversations

The Community Led Support hub in Brae has continued to welcome people and visiting services along and learning from the evolution of this approach has informed changes in Scalloway with a similar community led support hub, and development of the Community Link Worker pilot project in Brae and Whalsay.

The ethos is based on a strengths and asset based approach that uses Good Conversations to help people explore their own situation, and make any changes, build up their networks, and access support where needed.

In March the Adult Social Work team secured funding from IJB reserves to commission cascade training in Good Conversations that will support the training of 8 local trainers who can then upskill teams in this valuable approach.

Distress Brief Interventions (DBIs)

Work by the Mental Health team in 2022/23 to scope a sustainable option for delivery of a Distress Brief Intervention service locally has resulted in a successful application for IJB Reserves funding to match Scottish Government seed funding to establish a Distress Brief Intervention (DBI) Service. The service is being developed in collaboration with the Community MH Team and Third Sector partners Mind Your Head and will be accessible for partners to refer people into as an early action pathway for mental health and well-being.

A DBI is a short period of intensive support over approximately 10-14 days to help people in social distress.

Planning and recruitment is underway and the service is due to be live in Autumn 2023.

Levenwick Growers

A local group have come together in Levenwick to help develop the gardens around the Health Centre and Overtonlea Care Centre. Local community members have been working hard to transform the space so it can be used by residents and visitors, and the hope is that the GP Practice will use the opportunity to refer patients to take part in the group to gain the benefits of time spent outside in greenspace, being active where possible.

Overtonlea garden - pictures by report author

Network Enabled Care

Network Enabled Care (NEC) is a change in thinking about how we deliver services as a Health and Social Care Partnership. The concept builds on the idea of integration of services being a better way to support people with complex needs, by outlining how delivering services and support as part of a network can ensure sustainability of closer-to-home services in a small system, and support equity of access and outcomes across challenging geography by sharing resources, learning and systems.

NEC has been in the scoping phase in 2022/23 having emerged as a solution to workforce and service access challenges in the Shifting the Balance of Care programme. This way of working is not new and is already established within our Pharmacy and Community Nursing teams, however both would benefit from further networking of the community health and care system. Through discussions with Executive Managers, Administration teams, GP Practices, Community Councils and Regional Partners the NEC project has been aligned into four work streams which will be explored and developed in 2023/24:

- Primary Care/Community Health
- Social Care – by geography/area
- Social Care – by population (e.g. Learning Disabilities)
- Regional network – Mental Health provision and support

To illustrate the need to redesign and build sustainability and equity into our community health provision, some factors in our system that make patients vulnerable to not having access to appropriate care:

6 of 10 GP practices are single-handed practices

10 of 10 Practices have had GP vacancies in the last 2 years

6 of 10 practices MAJORITY of GP provision has been locums in the last 2 years

7 of 10 practices do not have access to First Contact Physiotherapy

Extending the capacity and scope of our Advanced Nursing services, and networking practices to make best use of GP resource while building team support around this valuable resource should help to protect service provision and our workforce.

First Contact Physiotherapist (FCP) at Lerwick GP Practice

We now have 2 whole time equivalent (2 WTE) FCPs working in Shetland, currently across three Health centres – Lerwick, Scalloway and Levenwick. The FCP project started as a pilot in Lerwick, and is part of the strategic priority to provide access to more services within communities – the right care, in the right place.

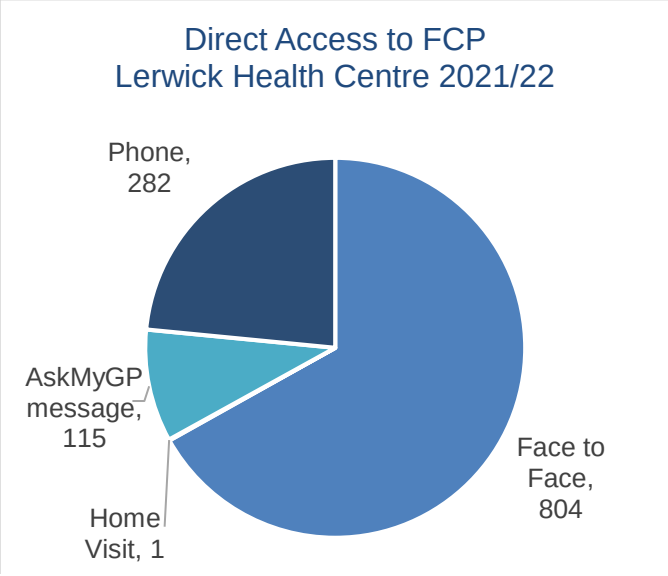
"An excellent service. Easy to use and quick follow up from professionals who provided reassurance and advice"

The FCP is there to assess, diagnose, and plan any treatment and investigations for patients with musculoskeletal (MSK) conditions – that is anything affecting muscles, bones and joints. Up to 30% of the usual primary care workload is related to MSK conditions.

What difference has it made?

An evaluation of the service at Lerwick GP Practice over 2021/22 gathered feedback from both patients and staff, and reviewed activity level for the service, including how patients were seen and referrals made to the hospital Physiotherapy team, and to the Orthopaedic Clinic. Note activity has been impacted by COVID restrictions, and evaluation will continue to support improvement and scaling of the FCP work.

"It has transformed the quality of MSK diagnosis and treatments for LHC patients"



Note this only includes self-referrals, and does not include people who were referred by another health professional

2021 Calendar Year:

2,507 patient contacts

73 referrals to hospital physio

41 referrals to orthopaedic clinic

Includes both self-referrals and professional referrals

95% of patients dealt with at first contact with FCP

Next steps…

To make the FCP service available across all communities in Shetland fairly, and to understand the impact the service is having on traditional hospital physiotherapy services, and the patient journey after working with the FCP.

The Independent Living Centre – 10 years on

The Independent Living Centre (ILC) was a joint project commissioned by NHS Shetland and the Shetland Islands' Council designed to be a multi-use space to facilitate the strategic drive to try and care for more people at home, and support them to live as independently as possible.

Image: Malcolmson Architects (2014)

The three-storey building opened its doors in 2013 and was initially planned to house Occupational Therapy (OT), Speech and Language Therapy (SLT) and Care at Home services. However, the space was designed to be flexible with a view to incorporating different services as needed over the lifespan of the facility.

The ILC provides office accommodation, equipment storage and maintenance space and clinical areas for service users to try out various adaptive and supportive equipment in a space replicating a home environment, modelled to be dementia friendly giving service users and families the chance to see how different spaces, tips and adaptations can support them.

The teams had been used to their own assessment, storage and office spaces so moving into a multi-use building was a big change – but they've found that working beside services who have a similar user group has supported multi-disciplinary team work, initiating discussions and sharing of practice which has been beneficial for patient outcomes.

Understanding the need for flexibility at the outset has allowed the building to evolve and adapt to its users' changing needs relatively easily. This flexibility meant the building could house the Test and Protect team during the pandemic, while still supporting essential services to work within COVID restrictions, it has also supported longer term changes with the inclusion of more specialist clinical space including Podiatry, Orthotics, Paediatric OT, Speech and Language Therapy and Learning Disability Nursing. Being co-located has had a significant positive impact in development of the Neurodevelopmental and Autism pathway work, and also helped with whole family support and coordination of services to improve experience for people with more complex needs.

Demand for services that support independence at home has continued to grow with the success of work to shift the balance of care. This has resulted in space and workforce pressures for OTs and technicians who are working to find creative solutions to use space most effectively with an ever increasing need for home equipment and adaptations.

Meaningful Involvement

Following the approval of the HSCP Participation and Engagement Strategy in March 2022 engagement around key pieces of change work has continued in 2022-23. This has been invaluable to the HSCP in progressing thinking around Shifting the Balance of Care and Network Enabled Care in particular. Conversations with Community Councils and wider community members has supported development of services and informed redesign in Skerries, Yell, Bressay and the Westside. We value all interactions with our communities and services are also mindful of the "consultation fatigue" reported across multiple agencies in Shetland, and are working wherever possible to share outcomes of engagement and learning with other agencies, and participate in locality engagement events when the opportunity arises, for example the Nort Natters project in the North Mainland.

We have also worked to strengthen the diversity of voice and experience within our planning and development structures, working to actively share progress and engage partners in key work streams to optimise impact. This has included:

- Expansion of the Strategic Planning Group has further strengthened voices of lived and living experience in planning processes with representation from the Recovery Hub alongside our active Unpaid Carer representatives
- Reinvigoration of HSCP/Third Sector Liaison group
- Inclusion of Third Sector data and representation within the Clinical and Professional Oversight Group to manage system pressure
- Strengthening Community Ethos working group and forum to support shared learning and partnership working

Particular projects, working to progress complex and challenging work are making the most of local voices and experience to shape outcomes, for example:

- Good Mental Health for All stakeholder and community engagement
- Pre-diabetes working group optimising implementation of brief intervention toolkit with support of patient and staff feedback
- Evolution of the Community Led Support model from Brae Community Hub to understand key success factors and next steps
- Development of appropriate local action towards MAT (Medication Assisted Treatment) standards by the Alcohol and Drug Partnership informed by services and service users
- Scoping of a lived and living experience panel by the Recovery Hub to help tackle inequalities experienced by those who use alcohol and other drugs

There is still work to be done around the wider communications strategy for the HSCP – this will be explored in conjunction with SIC and NHSS Communications teams in 2023-24.

Up to **20%**

of all healthcare is of no value to the people receiving it

(Tackling Wasteful Spending on Health, OECD, 2017)

Practicing 'Realistic Medicine' helps to reduce this by taking a personalised approach and sharing decision making between patients and clinicians.

Pharmacy team: Person-centred care

The Primary Care Pharmacists have been working hard to learn and improve by gathering feedback from the patients they see. Rather than feedback about the service, department or organisation, they've been asking for personal feedback to try and improve how they work with patients every day.

The questionnaire has been adapted from one used by the royal College of GPs (RCGP) and includes questions like:

- Did this pharmacist make you feel relaxed and welcome?
- Do you feel this pharmacist listened to you?
- Do you have confidence in the decisions made about your condition or treatment?
- Do you know what will happen next with your care?
- Do you trust this pharmacist?

"I was pleased shared decision making was highlighted as a strong point"

Primary Care Pharmacist

As individuals reflect and learn from their feedback it is expected the team as a whole will improve as the Pharmacists share their experience and learning. It can be challenging hearing such personal feedback about your manner, style or approach, but improvements in these areas have a huge impact on a patient's experience of health and care.

The team have been sharing their experience of using the questionnaire and have further adapted the questionnaire so that it could be used across all areas of health in Shetland.

"I sent out to patients that I had more challenging conversations with - it would have been easy to pick and choose patients that you felt would give good feedback."

Primary Care Pharmacist

VALUE BASED HEALTH & CARE

Is part of the Realistic Medicine approach and is closely linked with the 'Good Conversations' work we are also taking forward in Shetland. For more on Value Based Health & Care see:
Delivering value based health and care: a vision for Scotland
Realistic Medicine

Planning and Performance Development

The HSCP works hard to nurture a culture of improvement within its teams, share learning between services and support change for the better in the wider Shetland system. To support all these aims we need robust performance information and monitoring, that is engaging and can lead to improvement.

The regular performance reporting format to the IJB has been developed over the course of the year to make information provided more accessible and support understanding and robust discussion to inform improvement. This has included a review of indicators provided, improvement of contextual information/narrative, addition of relevant ad-hoc data, and expansion of case studies to include “spotlight” focus on service provision, improvement work, or deeper understanding of targets/indicators.

Case studies provided across the year have included:

- Learning Disability Nurse work with Dental and Acute hospital services to improve access and outcomes
- Supported Living and Outreach Local Activity Coordinator role enhancing access to meaningful activity
- Bruce Hall Terrace – extra support housing perspective from resident, family and staff
- Initiatives to support staff and improve retention
- Quit Your Way – spotlight on smoking cessation targets and service improvement
- Skerries Healthcare Support Worker model update – Staff Story

Performance and Planning processes have been embraced and supported by the Executive management team, support services and wider partners through engagement in the Clinical and Professional Oversight Group which has developed a robust dataset to support improvement in system flow and identification of challenges, Performance Monitoring Group who have worked to develop performance reporting and link planning, performance, finance and risk in a more meaningful way, and the Strategic Planning Group who have worked to support development in areas including discussion on the new National Carers Strategy which has led to improvement of the Unpaid Carers Direction and inclusion of Unpaid Carers as a distinct workstream within the Shifting the Balance of Care programme for 2023/24; progress towards a fit-for-purpose Housing Contribution Statement based on the recently published Local Housing Strategy; review and input into Mental Health service re-design.

An Internal audit of Performance Information and Scrutiny Arrangements was published in March 2023. The audit was generally positive, and identified some areas for improvement aligned to our existing identified areas for action following approval of the Joint Strategic Commissioning Plan – the one recommendation and 2 service improvements are summarised overleaf.

Recommendation	Priority	Management Response
• Ensure that, following the completion of the review, the final suite of performance information being reported to IJB members is aligned to the strategic priorities of the IJB and that performance management information is reported to the IJB in line with the agreed frequency stated in the PMF. • Remind responsible officers that narrative should be included within the performance reports for cases where data or targets are not being reported, or where performance is not in line with expectations. If required, additional guidance and / or support should be provided to officers responsible for providing the data to ensure that they are aware of their responsibilities in this area. • Ensure that data completeness is checked as part of the verification process, prior to the information being reported to the IJB.	Medium	A reviewed version of the suite of data audited is now presented to the Performance Management Group to provide assurance against operational activity. A trial set of Quarterly reports including more case study narrative, “deep dive” data review for service understanding, update on service status and improvement work undertaken in line with the Strategic Commissioning Plan will be presented to the IJB for the next Quarterly cycle (Q3, 18/05/2023). Feedback will be sought from the IJB, and further improvements made. A more systematic process for data checking and narrative gathering is in place following the audit process. Through the process of Direction updates gaps in knowledge or understanding of responsibilities will be identified, and support offered as required, via the Management Learning Board or on an individual basis. To be implemented by: 30 September 2023
Service Improvement		
• As part of the future review of the Performance Management Framework (PMF), management should consider whether the current format of the PMF should be updated to ensure that information, which is not relevant to the IJB performance management arrangements is not included.		The PMF is due for review in 2024, the review process will begin this year with partners across NHS Shetland and Shetland Islands Council to update the document to be relevant and useful. Streamlining information included, and whether there is a need for an IJB-specific version will be part of the process.
• Management should utilise the annual self-assessment process to collate IJB member views on their role in relation to the scrutiny of performance information. Additional training / support should be offered to IJB members to address any skills or development gaps identified.		The annual self-assessment is due to be repeated in May 2023 an additional section/self-assessment that includes their role in the scrutiny of performance information and seeks to identify any training or development needs will be included at that point. In order to try to measure the impact of the induction process on Board member self-assessed performance the original self-assessment will be repeated in as close a format to last year as possible to allow comparison.

Financial planning and performance
Financial Transactions 2022/23

For the year-ended 31 March 2023, the IJB generated a deficit of (£2.812m) (2021/22: surplus £2.118m), after adjustment has been made for additional contributions made by SIC and NHSS.

The deficit of (£2.812m) represents expenditure incurred during the year that the IJB agreed would be met from its Reserve off-set by underspend of Scottish Government Additionality Funding and other specific funding allocations.

The outturn position at 31 March 2023 for the IJB is an overall deficit against budget of (£1.432m) (2021/22: £2.764m), which represents an overspend in relation to services commissioned from SIC of (£1.435m) (2021/22: (£0.184m) underspend) and an underspend in relation to services commissioned from NHSS of £0.003m (2021/22: (£2.580m)). The £2.812m deficit (which includes 'set aside budget) is detailed in the following table.

In order to achieve the final IJB deficit of the year of (£2.812) (2021/22 surplus of £2.117m), SIC made a one-off additional contribution of £1.435m to the IJB. The additional contribution from SIC is non-recurrent in nature and does not require to be paid back in future years. The NHS received a one-off additional contribution from the IJB of 0.003m.

	2022/23			2021/22		
	SIC £000	NHSS £000	TOTAL £000	SIC £000	NHSS £000	TOTAL £000
Budgets delegated to the Parties from the IJB	29,976	37,606	67,582	27,967	32,642	60,609
Contribution from the Parties to the IJB (against delegated budgets)	(31,411)	(37,603)	(69,014)	(28,151)	(35,222)	(63,373)
Outturn Position	(1,435)	3	(1,432)	(184)	(2,580)	(2,764)
Additional contributions from Parties to meet IJB Direct Costs	(17)	(16)	(33)	(15)	(16)	(31)
IJB Direct Costs (Audit fee, Insurance & Members Expenses)	17	16	33	15	16	31
Additional contributions (to)/from the Parties to/(from) IJB	(243)	(1,137)	(1,380)	(2,871)	7,753	4,882
Final Surplus/(Deficit) of IJB	**(1,678)**	**(1,134)**	**(2,812)**	**(3,055)**	**5,173**	**2,118**

	2022/23			2021/22		
	SIC £000	NHSS £000	TOTAL £000	SIC £000	NHSS £000	TOTAL £000
Additional contributions (to)/from the Parties to/(from) IJB to meet Outturn of IJB delegated services	1,435	(3)	1,432	184	2,580	2,764
Transfer of Scottish Government Additionality funding between the Parties	(1,277)	1,277	0	(3,396)	3,396	0
Draw from Reserves	(401)	(2,606)	(3,007)	(60)	(755)	(815)
Pass back to Reserves	0	195	195	401	2,532	2,933
Additional contributions (to)/from the Parties to/(from) IJB	**(243)**	**(1,137)**	**(1,380)**	**(2,871)**	**7,753**	**4,882**

Significant Budget Variance Table

Full explanations for significant budget variances can be seen in the Financial Review section of the IJB Annual Accounts 2022/23.

The IJB continues 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.

Due to difficulty in recruiting to specialist posts it has been necessary to continue to contract Consultant Mental Health locums in 2022/23, at a cost pressure (including flights and accommodation) of (£0.427m) (2021/22: (£0.513m)).

Location	2022/23 £000	2021/22 £000
Yell	(155)	(164)
Whalsay	(42)	(30)
Lerwick	(312)	Nil
Unst	(59)	(62)
Brae	(170)	(217)
Bixter	(35)	(51)
Scalloway	(56)	(178)
Walls	(104)	(89)
Out of Hours	(125)	(173)
Total	**(1,058)**	**(964)**

Locum cover, including travel and accommodation, was also required in Primary Care for General Practitioners (£1.058 m) (2021/22: (£0.964m)) where it was not possible to fill vacant posts, with notable overspend against budgets at the locations as per table below:

The recruitment of GPs is ongoing, with adverts continuing during summer 2023. A rotational model, at a lower cost than agency staff, is now in place in Unst and Whalsay following successful recruitment during 2022. NHS Shetland has been successful in again attracting a GP fellow to Shetland and GP training continues in the Lerwick practice. Accommodation for both rotational and new staff remains an ongoing issue.

Themes	2022/23 Budget Variance £000	2021/22 Budget Variance £000	Variance £000
Locum Costs	(2,584)	(2,482)	(102)
Agency Staffing	(2,778)	(1,070)	(1,708)
Vacancies & Other Staffing underspends	1,785	444	1,341
Increased Service Demand	(395)	(296)	(99)
External Service Provider	182	221	(39)
Pharmacy & Prescribing	(325)	238	(563)
Maintenance Delayed	417	170	247
Vehicles/Mileage savings	74	66	8
Pay award impact	(709)	(439)	(270)
Overachievement of Income	239	0	239
Funding allocation unspent	0	53	(53)
Additional funding	2,998	0	2,998
Other	(336)	331	(667)
Total	**(1,432)**	**(2,764)**	**1,332**

Within Unscheduled Care, Locum use has been required to cover junior doctors and consultants (£1.021) (2021/22: (£0.868m)). Ward 3 and A&E also incurred high bank and overtime cost throughout the year of (£0.078m) (2021/22: (£0.137m)).

Recruitment to consultant and junior doctor posts actively continues, working closely with the Deanery, Universities and NHS Education for Scotland to look at ways in which training can be developed to support remote and rural practice and encourage doctors to take up posts in Shetland. There has been success in the use of a proleptic (anticipatory) appointment and flexible contract models for consultants in order to broaden the appeal of the generalist role.

Agency Staffing Cost

Shetland has low unemployment, but rising demand for health and social care services. Over recent years, this has led to challenges for the IJB in recruiting local people to work in Community Health and Social Care roles and the need to employee agency staffing to ensure service delivery. This has been further exacerbated by the COVID-19 Pandemic, which has placed greater stress on the existing workforce and additional need to cover for absence due to sickness and adherence to COVID-19 isolation rules.

In order to continue to safely deliver services and meet the level of demand, it has therefore been necessary to use agency staff during the year, leading to a total overall spend of (£2.778m) (2020/21: (£1.070m)), to cover various service areas. It is hoped that use of agency staffing can be reduced during 2023/24, as COVID-19 restrictions are lifted and work continues to encourage people to take up roles in social care.

Service	2022/23 £000	2021/22 £000
Community Care Resources	(1,676)	(773)
Adult Services	(767)	(125)
Community Nursing	(106)	(172)
Adult Social Work	(206)	0
Occupational Therapy	(23)	0
Total	**(2,778)**	**(1,070)**

Full detail of the underspend by service area related to vacancies that have resulted in agency usage can be reviewed in the annual accounts.

Pay Award Impact

The underspends in staffing budgets, are off-set by an overspend of (£0.709m) (2021/22: £0.439m) in respect of agreed pay uplifts to SIC staff. In setting the 2022/23 budget, an uplift of 2% had been assumed for all paygrades in year. During the year an equivalent of 3% was released from contingency in relation to this, however the agreed uplift was:

- An increase to the Scottish Local Government Living Wage rate to £10.85 per hour;
- A £2,068 increase in salary for those earning between £19,133 and £20,523; and
- An increase of either £1,978 or 5% of base salary, whichever is larger, for other employees

The impact of this pay award was that in staff working in Social Care received an average pay rise of approximately 8%. Budgets for 2022/23 only allowed for an increase of 5%.

Covid-19 Costs and Funding

The total cost of COVID-19 to the IJB was £2.134m (2021/22: £2.826m), which is set out in the table below.

The Scottish Government provided funding to cover costs of COVID-19 late in 2021/22 that was carried forward in IJB Reserve. This funding has been utilised in 2022/23 to meet cost impacts of COVID-19. A remaining balance of £0.150m has been carried forward in the IJB Reserve to be utilised in 2023/24.

The IJB will carry-forward £0.150m (2021/22: £2.284m) funding within the IJB Reserve as Earmarked Reserves.

Covid-19 Funding	NHSS £000	SIC £000	TOTAL HSCP £000
Earmarked Funding c/f In IJB Reserve at 1 April 2022	**1,883**	**401**	**2,284**
Funding received 2022/23	0	0	0
Total Funding available in year	1,883	401	2,284
Less: Covid-19 Costs 2022/23	(1,733)	(401)	(2,134)
Earmarked Funding c/f In IJB Reserve at 31 March 2023	**150**	**0**	**150**

Covid-19 Cost Heading	NHSS £000	SIC £000	TOTAL HSCP £000
Additional PPE	0	27	27
Covid-19 Vaccination	511	0	511
Additional Capacity in Community	0	170	170
Community Hubs	42	0	42
Additional Infection Prevention and Control Costs	0	17	17
Additional Equipment and Maintenance	0	12	12
Additional Staff Costs	1,077	155	1,232
Additional FHS Prescribing	103	0	103
Social Care Provider Sustainability Payments	0	17	17
Other	0	3	3
TOTAL COVID-19 COSTS 2022/23	**1,733**	**401**	**2,134**

The Balance Sheet as at 31 March 2023

The IJB carried a General Reserve of £4.316m as at 1 April 2022. This Reserve was created from previous years underspending in the Scottish Government Additionality Funding £0.559m and underspend in specific NHSS Funding which were carried forward as an earmarked element of the Reserve £3.757m.

During the year there has been a draw on the IJB Reserve of £3,007m, £2.952m of earmarked reserve and further spend against a number of projects which the IJB have agreed to fund from its Reserve, £0.055m.

Underspend in Scottish Additionality Funding and specific NHSS Funding in 2022/23 of £0.083m and £0.112m, respectively have been added to the Reserve.

As at 31 March 2023, the General Reserve has a balance of £1.504m, of which £0.939m is earmarked, leaving £0.565m uncommitted Reserve available to be spent in line with the IJB Strategic objectives.

2023/24 Budget and Medium Term Financial Outlook

The IJB Board approved the proposed budget for 2023/24 of £60.389m, on 27 April 2023, subject to NHSS Board approval of their delegated budget which was given at its meeting on 22 June 2023.

The 2023-24 budget contains a savings target of £1.610m (2.6%) with outline schemes on how this will be delivered. These schemes, aligned to the work streams detailed in the Operational Review, have been categorised into high, medium and low risk with the high risk category accounting for £1.091m.

General Reserve is also available to support the strategic objectives of the IJB, as detailed in Note 6 to the Accounts (page 34). Since the inception of the Shetland IJB, like other health and social care partnerships, it has faced significant financial challenges and has anticipated that it will be required to operate within tight fiscal constraints into the future, due to the continuing difficult national economic outlook and increasing demand for services.

Additional funding for Health and Social Care Partnerships has been made available from the Scottish Government. Despite this additional funding, pressure continues on public sector expenditure at a UK and Scottish level with further reductions in government funding predicted in future years.

The IJB approved its current Medium-Term Financial Plan 2022-2027 (MTFP) on 17 February 2022. This plan will be updated during 2023 and will include an annual savings target in the region of 3%. This target is in addition to the ongoing cost pressures associated with temporary staffing and together will represent a significant financial challenge over the medium term.

Inspection of Services

Adult Support and Protection

A joint inspection of Adult Support and Protection arrangements in Shetland took place between October 2022 and March 2023. The inspection was carried out jointly by the Care Inspectorate, Healthcare Improvement Scotland and HM Inspectorate of Constabulary in Scotland. The focus of the inspection was whether adults in Shetland who may be at risk of harm are safe, protected and supported.

The inspection findings were very positive and highlighted some key strengths:

- Adults at risk of harm nearly always experienced improvements to their safety, health and wellbeing;
- There were strong investigation and case conference processes in place for managing risks for adults;
- There was strong collaborative working between services to support adults at risk of harm;
- Processes for addressing financial harm were effective, including raising awareness in the community of financial scams;
- Arrangements for providing adult support and protection services during the COVID-19 pandemic were well organised, and adults at risk of harm remained a priority throughout this challenging period;
- The strategic leadership team worked effectively to identify priorities for improvement in the delivery of services to adults at risk of harm.

There were two areas for improvement identified:

- To strengthen some of their initial inquiry processes once referrals were made into Social Work
- To update the vision and improvement planning which is led by the Shetland Public Protection Committee, to give more focus to adult support and protection.

The full report can be accessed online: Joint Inspection of Adult Support and Protection, Shetland Partnership 2023.

Residential Care

A number of unannounced inspections took place across our residential settings in 2022/23 – full reports are available from the Care Inspectorate website, reports for all settings included a number of positive key messages about the teams, people's experience in the setting and the engagement in the inspection and improvement process. The results of inspections and recommendations for improvement are summarised below:

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Montfield Support Services	14th June	3 - Adequate	3 - Adequate			

Recommendations for improvement:

- ensure that people have opportunities to engage in meaningful and stimulating activities in the home
- ensure people's hygiene and appearance are supported to a high standard
- ensure that effective medication management systems are in place and being adhered to by all staff involved in the administration of medications
- ensure that personal plans are updated and have sufficient detail to reflect people's individual needs, rights, choices and wishes
- strengthen leadership and governance in relation to infection prevention and control by introducing a regular environmental walkaround and ensuring that staff practice is regularly evaluated

Requirements:

- support positive outcomes of the people living in the service through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes
- ensure that service users experience a service which is well led and managed

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Walter & Joan Gray	15th June	4 - Good	5 – Very Good	5 – Very Good	4 - Good	5 – Very Good

Noted action had been taken on all requirements and recommendations for improvement from 2019 inspection

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Newcraigielea	1st August	4 - Good	4 - Good			

Recommendations for improvement:

- ensure staff are using person-centred language throughout their daily recordings and information is stored in the appropriate records
- ensure staff competency through regular assessment and supervision
- Infection prevention and control practice should be regularly evaluated by the service
- ensure that timescales and responsibility for agreed actions are identified through quality assurance processes and that these are used along with feedback from people, relatives, and staff to inform the continuous improvement plan

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Wastview	5th August	4 - Good	4 - Good			

Recommendations for improvement:

- consider how to make the most of all moments when staff are with people, building on their interests and providing short periods of activity throughout the day
- ensure that effective medication management systems are in place and being adhered to by all staff involved in the administration of medications

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
ET & Taing	8th August	3 - Adequate	4 - Good			

Recommendations for improvement:

- ensure the consistent use of best practice documentation to allow the service to clearly record the support provided to individuals in terms of managing pressure care
- ensure that effective medication management systems are in place and being adhered to by all staff involved in the administration of medications, including evaluating and recording the effectiveness of “as required” medications
- implement an effective process for visiting to minimise waiting time for people and their visitors
- strengthen leadership and governance in relation to infection prevention and control by introducing a regular environmental walkaround and ensuring that staff practice is regularly evaluated
- support continuous improvements to ensure people have the best quality of care and support

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Overtonlea	5th October	4 - Good	4 -Good			

Recommendations for improvement:

- maintain a high standard of infection prevention and control by ensuring up to date guidance and training is available to all staff
- ensure all notifiable events are submitted to care Inspectorate timeously
- bring everyone up to date with their training needs

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
North Haven	5th October	4 - Good	3 - Adequate	3 - Adequate	4 - Good	4 - Good

Recommendations for improvement:

- maintain a high standard of infection prevention and control by ensuring up to date guidance and training is available to all staff
- ensure all notifiable events are submitted to care Inspectorate timeously
- ensure all staff are, at a minimum, up to date with initial training and refresher courses covering all basic areas of support

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Isleshavn	14th October	3 - Adequate	3 - Adequate			

Recommendations for improvement:

- implement a falls prevention and management protocol ensuring that multifactorial falls risk assessments are up to date and regularly reviewed, and that learning from any falls is shared with the team
- ensure that effective medication management systems are in place and being adhered to by all staff involved in the administration of medications, including the administration and evaluation of “as required medications."
- ensure that people have opportunities to engage in meaningful and stimulating activities in the home
- maintain a high standard of infection prevention and control by ensuring up to date guidance and training is available to all staff
- ensure processes are in place to regularly ask people their views and use this to inform the service development plan
- strengthen leadership and governance in relation to staff engagement with support, supervision and training by introducing a system which supports oversight and ensures that staff practice is regularly evaluated

Requirements:

- support positive outcomes of the people living in the service through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Nordalea	17th October	4 - Good	4 - Good			

Recommendations for improvement:

- ensure that effective medication management systems are in place and being adhered to by all staff involved in the administration of medications
- maintain a high standard of infection prevention and control by ensuring up to date guidance and training is available to all staff
- ensure processes are in place to regularly ask people their views and use this to inform the service development plan

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Fernlea	25th November	4 - Good	4 - Good			

Recommendations for improvement:

- ensure that effective medication management systems are in place and being adhered to by all staff involved in the administration of medications
- submit relevant and prompt notifications to the Care Inspectorate in line with its notification guidance

The Care Inspectorate noted challenges around staffing and recruitment in a number of settings, and the impact this has on the team's ability to provide consistent, high quality care.

All recommendations and requirements have been included within action plans by the relevant teams.

Where themes were identified across inspection reports action has been taken as an HSCP system – this includes development of a new "Medication Administration in Care and Education Settings" policy, targeted support from the Infection Prevention and Control team, work to support teams to access all necessary training.

Annual Audit

Audit Scotland published their Shetland Islands Integration Joint Board annual audit 2021/22 in December 2022. The audit was largely positive with a small number of recommendations for improvement. The audit noted:

The HSCP reports strong performance in delayed discharges, unlike many other HSCPs across Scotland. This has been achieved through focussed daily monitoring as part of the partnership working, with dedicated social work input to support the hospital and the development of an Intermediate Care Team. This has allowed the HSCP to focus on early intervention and prevention work.

There is a long-standing, good working relationship between the council, the NHS and the HSCP. There are good examples of the partners working together to transform services, for example the nursing models for Islands with Small Populations.

The IJB continues to have effective budget setting and monitoring arrangements in place. This is supported by an experienced finance team and a robust internal audit function, as well as appropriate arrangements for the prevention and detection of fraud and error

The IJB continues to have strong leadership, with robust governance arrangements in place and recent induction training for new members. It also demonstrates a commitment to remain open and transparent around its decision making and performance. Further work remains to implement a formal self-assessment process

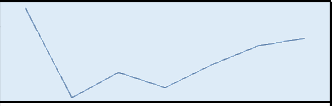
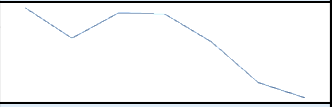
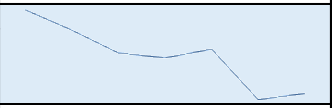
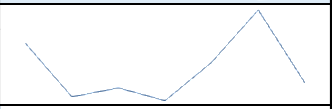
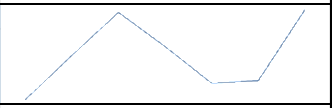
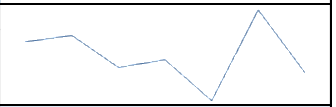
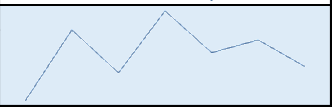
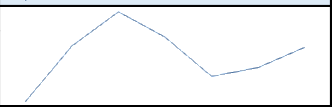
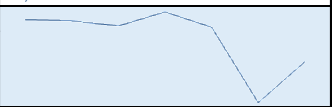
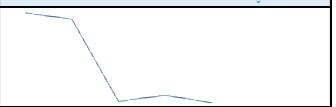
Areas identified for improvement include: increased involvement with review of workforce planning; a formal, ongoing approach to IJB members' development; community engagement in the budget setting process – all of these areas have been incorporated into development work over the course of the year and will continue to be progressed.

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. These data will not be updated until 2024.

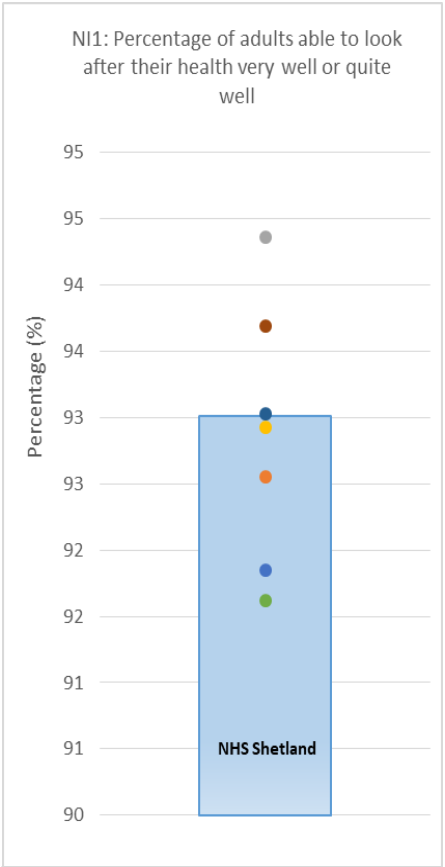
	Indicator						Trend
Outcome Indicators	Percentage of adults able to look after their health very well or quite well	2013/14	2015/16	2017/18	2019/20	2021/22	
		97.98	95.40	94.14	95.31	93.01	
	Percentage of adults supported at home who agree that they are supported to live as independently as possible	2013/14	2015/16	2017/18	2019/20	2021/22	
		74.10	74.54	77.89	93.85	89.84	
	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	2021/22	
		75.66	77.94	74.50	87.27	77.89	
	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	2021/22	
		66.23	60.20	72.26	93.57	69.82	
	Percentage of adults receiving any care or support who rate it as excellent or good	2013/14	2015/16	2017/18	2019/20	2021/22	
		76.71	77.33	85.54	96.87	83.39	
	Percentage of people with positive experience of care at their GP practice	2013/14	2015/16	2017/18	2019/20	2021/22	
		80.88	88.33	83.34	85.81	84.18	
	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	2021/22	
		85.94	80.86	82.53	88.24	93.60	
	Percentage of carers who feel supported to continue in their caring role	2013/14	2015/16	2017/18	2019/20	2021/22	
		45.61	51.12	40.94	49.90	44.64	
	Percentage of adults supported at home who agree they felt safe	2013/14	2015/16	2017/18	2019/20	2021/22	
		82.31	71.07	79.55	95.71	78.33	
	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA	N/A	

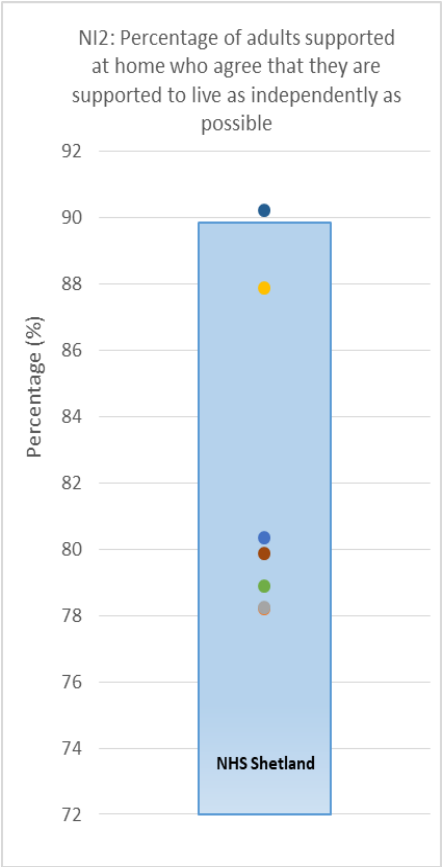
NOTE: These data are due to be updated in July 2023 – figures will be included if available within that publication. Availability depends on data completion which has been challenging for NHS Shetland in previous years.

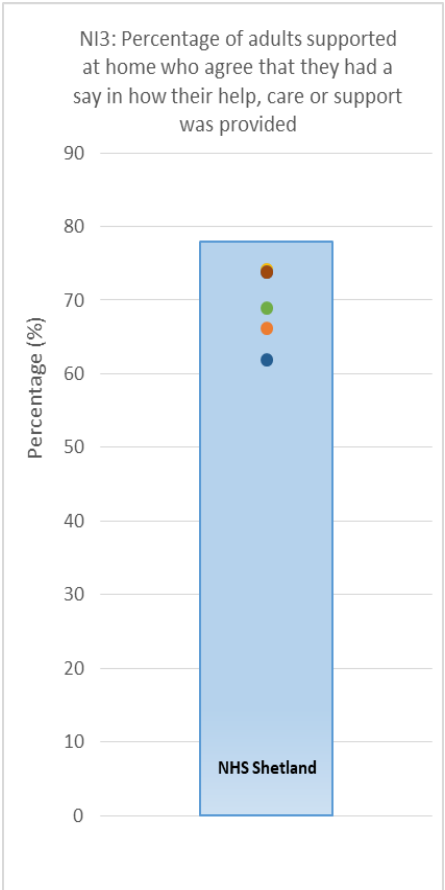
Data indicators			2015	2016	2017	2018	2019	2020	2021	
	NI-11	Premature mortality rate per 100,000 persons	406.6	289.4	322.5	301.7	331.1	356.3	366.8	
	NI-12	Emergency admission rate (per 100,000 population)	2015/16 10601.94	2016/17 10033.15	2017/18 10508.49	2018/19 10469.37	2019/20 9967.63	2020 9238.03	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		

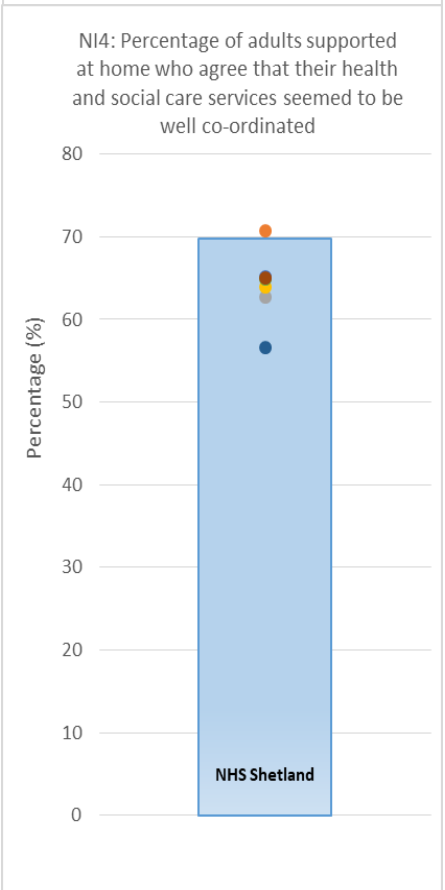
Appendix 2 - National Integration Indicators Ranked against Comparable HSCPs

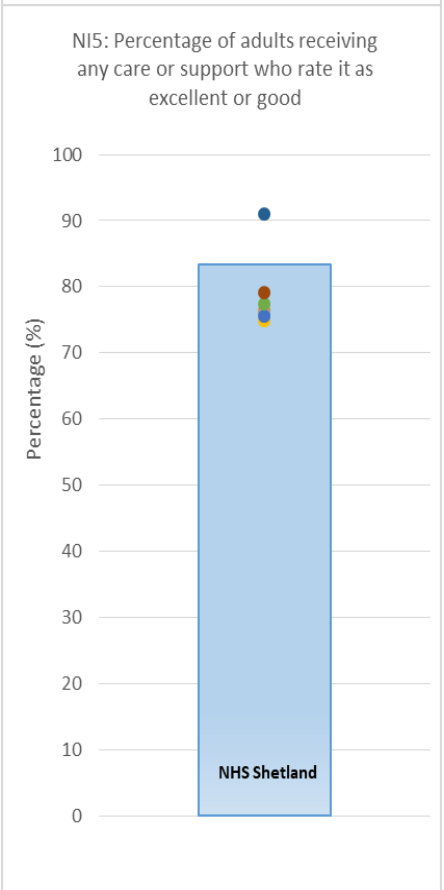
National Integration Indicators shown with Shetland HSCP ranked against comparable HSCPs as advised by the Local Government Benchmarking Framework. Data shown is most recent published – 2021/22 for NI 1-9, 2021 for NI 11-16 and 18, 2021/22 for NI 17 and 19, and 2019/20 for NI-20, depending on source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

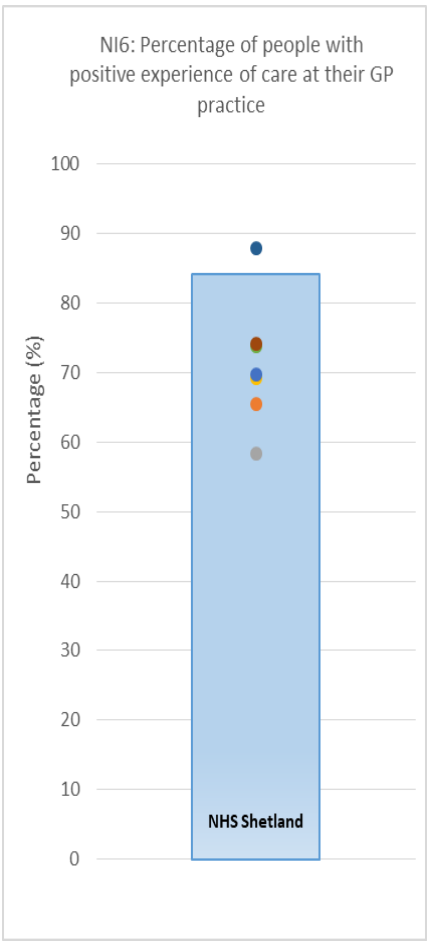


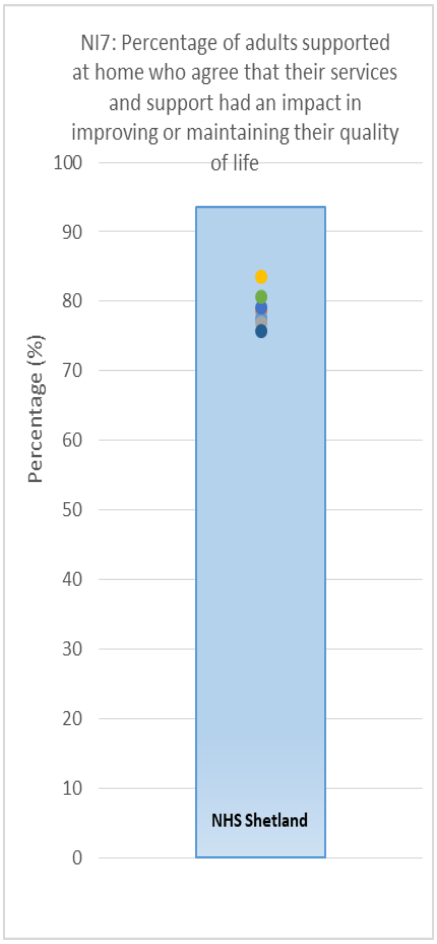


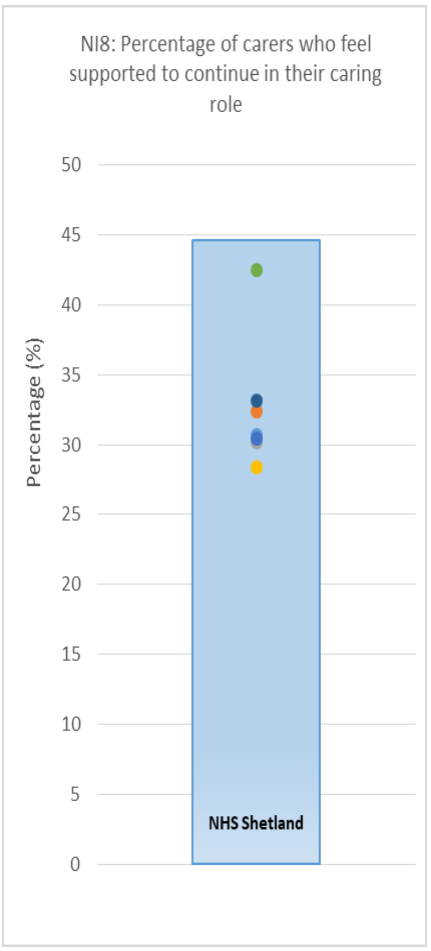


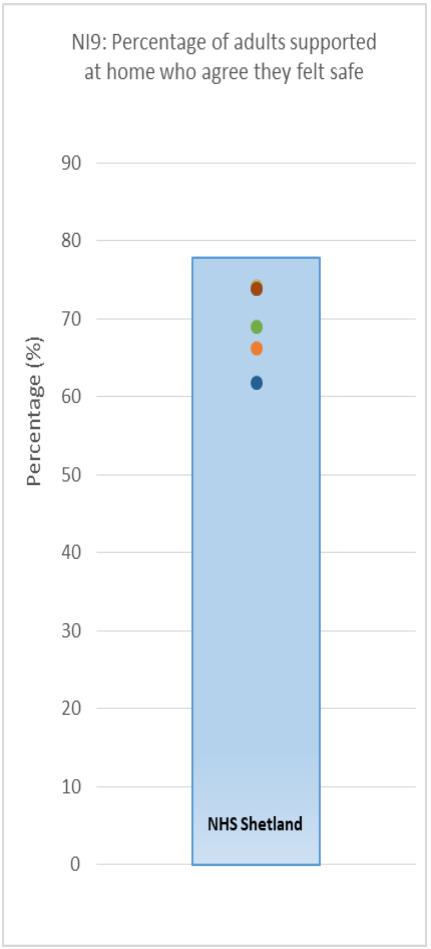


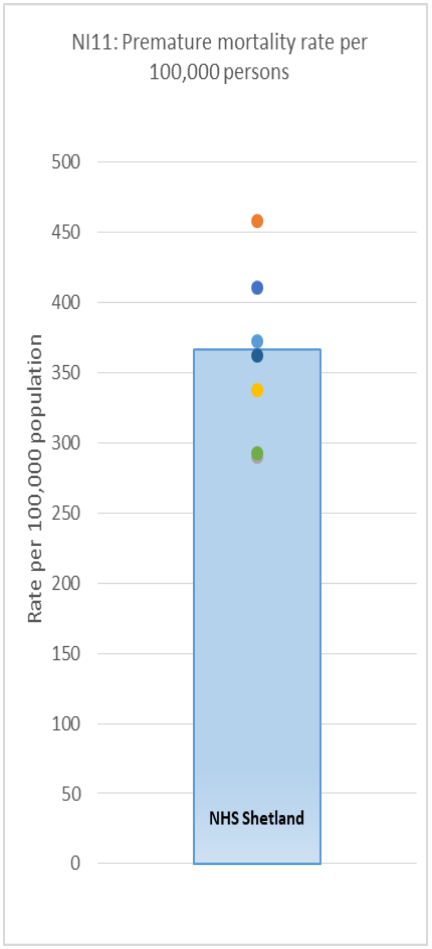


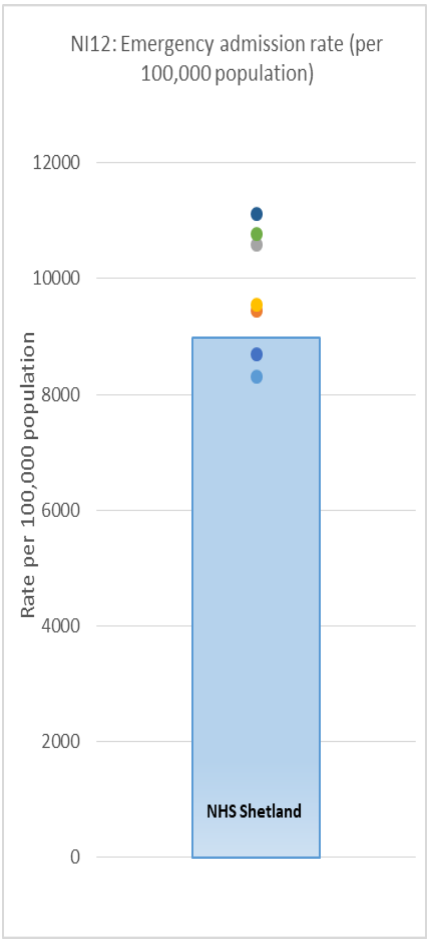

NI6: Percentage of people with positive experience of care at their GP practice
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland

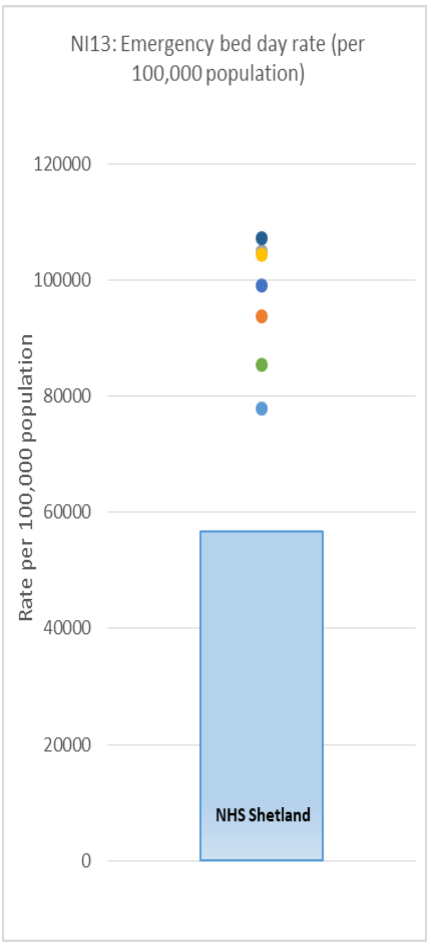

NI7: Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland

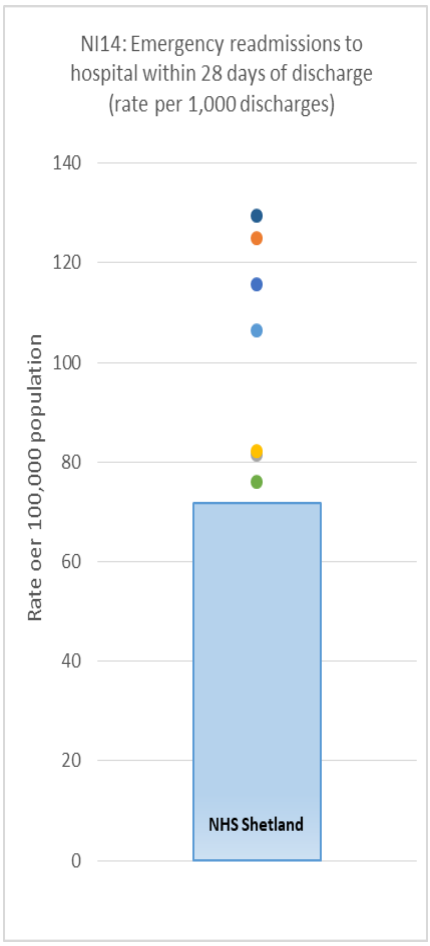

NI8: Percentage of carers who feel supported to continue in their caring role
Percentage (%)
50
45
40
35
30
25
20
15
10
5
0
NHS Shetland

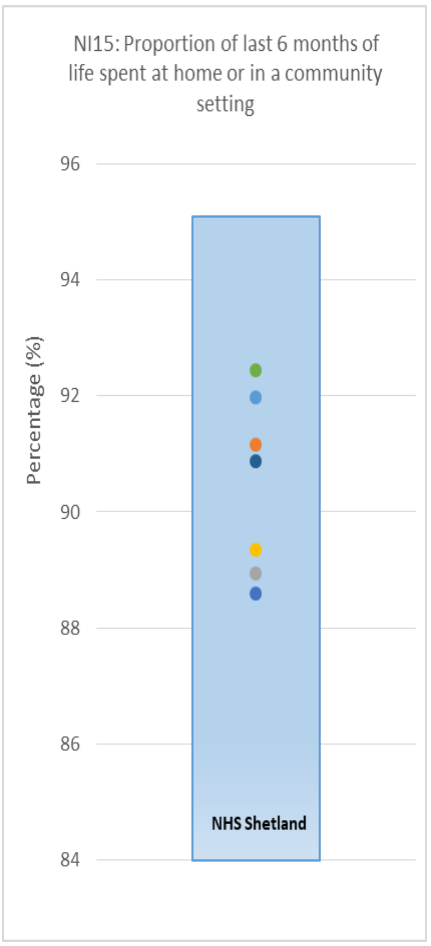

NI9: Percentage of adults supported at home who agree they felt safe
Percentage (%)
90
80
70
60
50
40
30
20
10
0
NHS Shetland

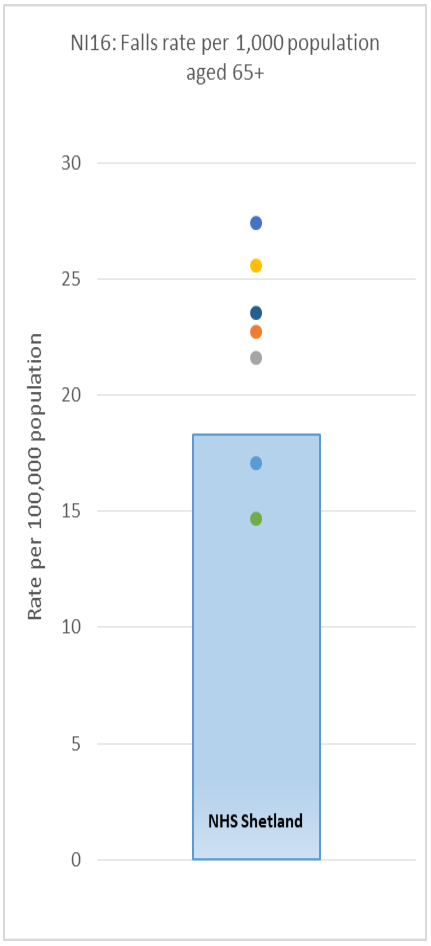

NI11: Premature mortality rate per 100,000 persons
Rate per 100,000 population
500
450
400
350
300
250
200
150
100
50
0
NHS Shetland

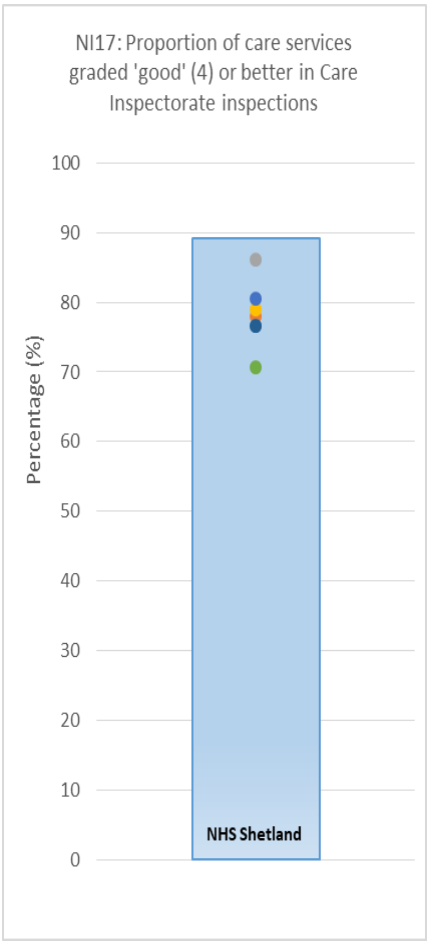

NI12: Emergency admission rate (per 100,000 population)
Rate per 100,000 population
12000
10000
8000
6000
4000
2000
0
NHS Shetland

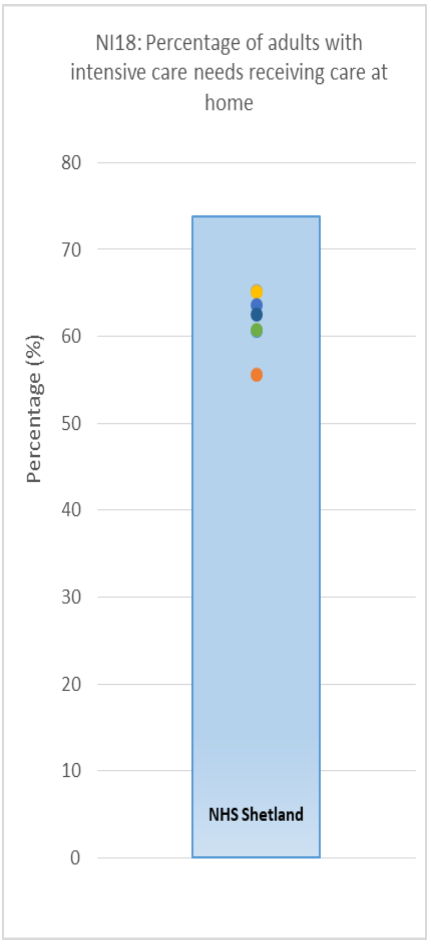

NI13: Emergency bed day rate (per 100,000 population)
Rate per 100,000 population
120000
100000
80000
60000
40000
20000
0
NHS Shetland

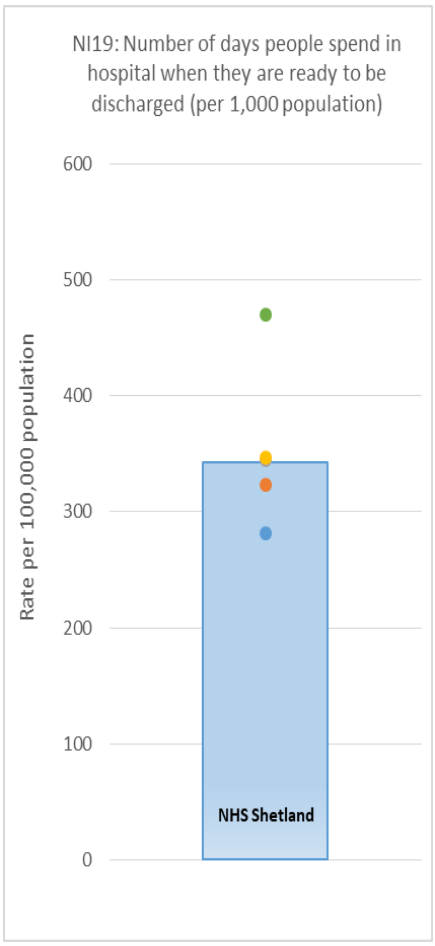

NI14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)
Rate oer 100,000 population
140
120
100
80
60
40
20
0
NHS Shetland

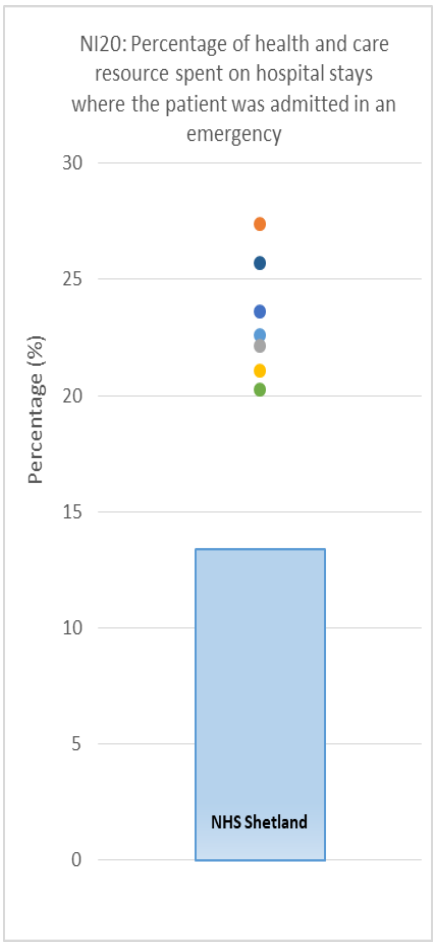

NI15: Proportion of last 6 months of life spent at home or in a community setting
Percentage (%)
96
94
92
90
88
86
84
NHS Shetland


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