Shetland Islands Health and Social Care Partnership Annual Report 2023-24

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 2024

Welcome and Introduction…

This is the eighth 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.

The work of the Partnership is governed by the Integration Joint Board (known as the IJB) which was chaired by Councillor John Fraser for the first month of the year, who then moved into the vice-chair role from 1st May 2023. Ms Natasha Cornick has chaired and led the IJB for the remainder of the year.

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.

The Health and Social Care Partnership (HSCP) has remained under considerable operational pressure over the course of 2023-24 – this had been anticipated given changing demographics with an increasing ageing population, people with more complex health and care needs, and a drive towards supporting people closer to home. Shetland has experienced these changes sooner than they have been seen elsewhere in Scotland, and it is increasingly clear current service delivery and workforce models are not sustainable.

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Contents

Welcome and Introduction….. 2
Aims of the Annual Report 4
Our Health and Social Care Partnership 5
What we are trying to achieve 6
Locality Planning 7
The Main Challenges of 2023-24 8
Our Performance 9
Scottish Health and Care Experience (HACE) Survey................. 12
Shifting the Balance of Care Programme....................................... 18
Prevention and Early Intervention 19
Primary Care Phased Investment Programme 20
Tackling Inequalities 21
The Recovery Hub and Community Network.............................. 22
Best Value 23
Shifting the Balance of Care 24
Meaningful Involvement.. 27
Financial planning and performance 30
The Balance Sheet as at 31 March 2024.................................... 33
2024/25 Budget and Medium Term Financial Outlook................. 33
Inspection of Services 34
Annual Audit.. 37
Appendix 2 - National Integration Indicators Ranked against Comparable HSCPs 41

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 2023 to 31st March 2024. 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 2023-24:

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	Urgent and Unscheduled Care	Unpaid Carers support	Care at Home
	Sexual Health Services	Renal Services	

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 £60M.

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

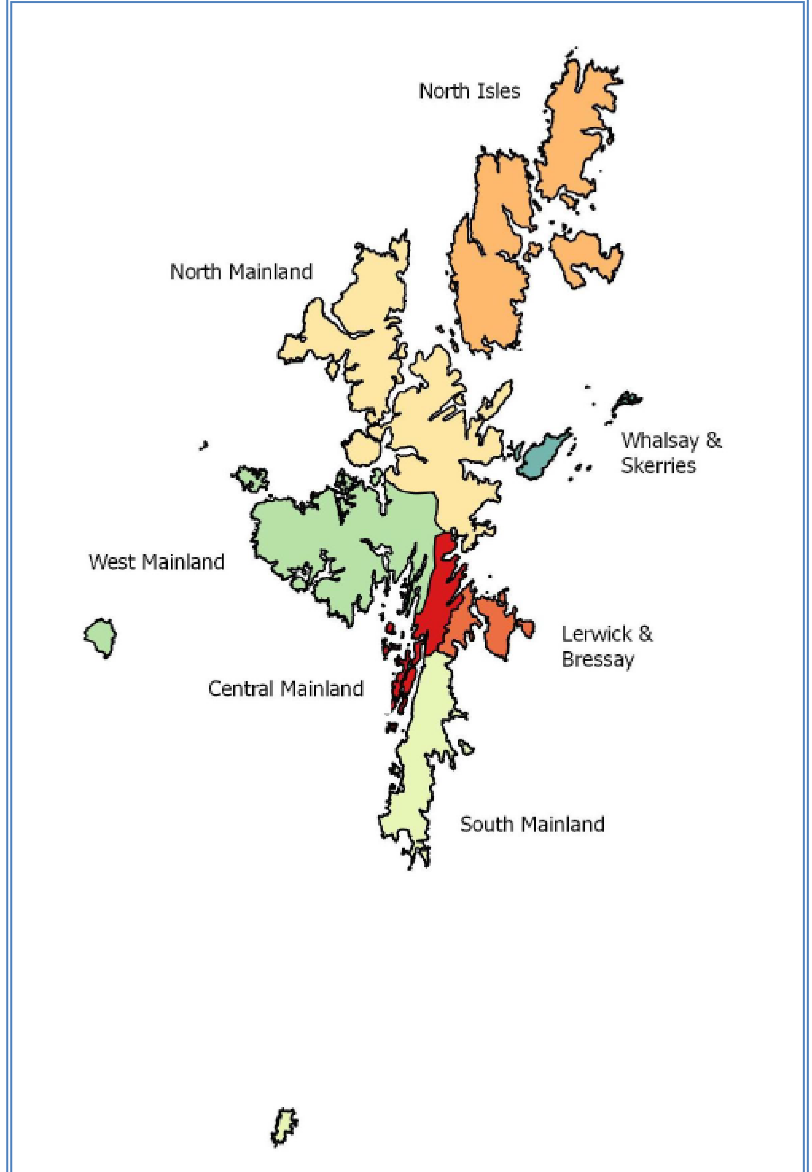
(Commissioning for Outcomes, 2023)

Locality Planning

The Health and Social Care Partnership is responsible for delivery of services across the geography of Shetland, covering a population of 22,920. 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 has taken place this year in partnership with the SIC Community Planning and Development Team, NHS Public Health and colleagues from Public Health Scotland (PHS).

The teams put together 'locality profiles' with communities to support strategic decision making, it is hoped with this collaboration around data and evidence can help to rebalance our system to provide equity of access and outcomes, and to target services and support to those with greatest capacity to benefit. The locality profiles can accessed via the Shetland Partnership website.

The Main Challenges of 2023-24

Our incredibly resilient teams and communities have continued to work through a number of challenges over the past year, however we are mindful of the ongoing pressures of increasing demand, financial challenges and workforce gaps and the impact these have 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. While Shetland HSCP continues to perform well compared to Scotland there are a number of areas of performance that have remained challenging over the year. These are largely linked to staffing shortages, and in many cases are the source of overspend on supplementary staffing to provide essential services. Some areas of challenges are highlighted below:

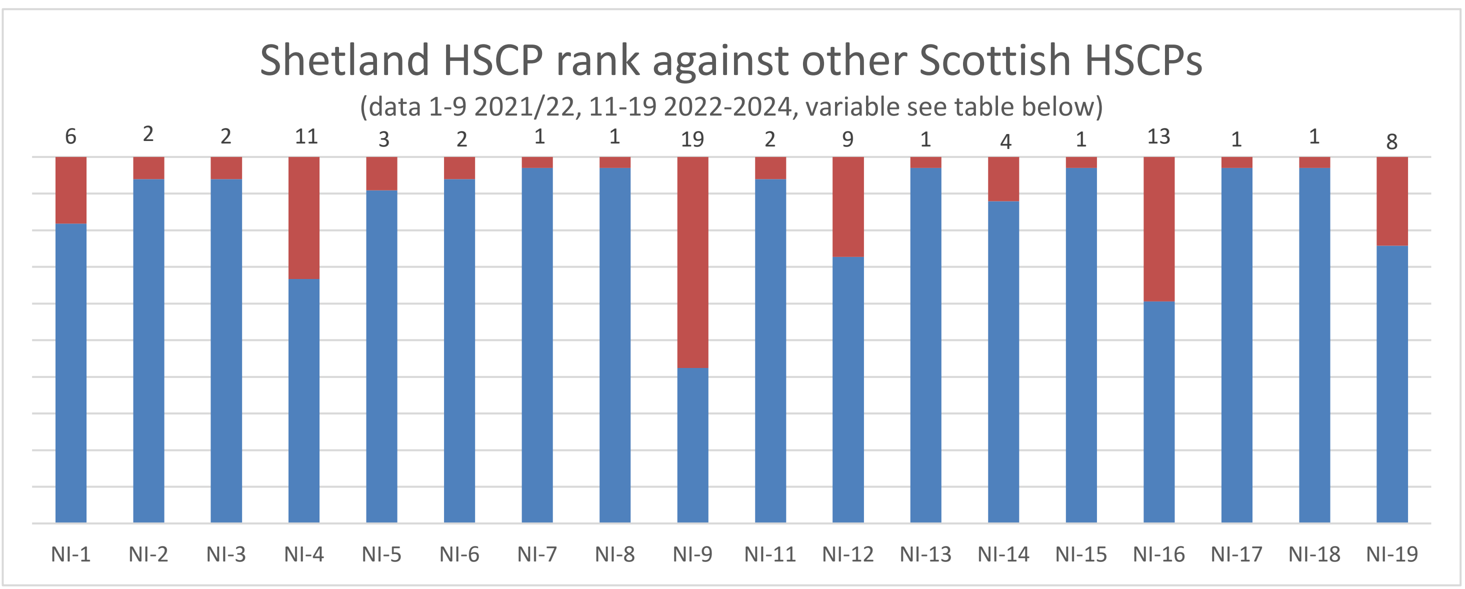
- → The Accident and Emergency access target has been challenging again this year, with an average of 86% of patients seen within 4 hrs, compared to 91% last year, against a target of 95%, while this remains significantly above the Scottish average it represents a prolonged dip in performance for Shetland.
- → When considering patient journey through the health and social care system Delayed Discharges are a common indicator of the effectiveness of integration of health and social care. Again Shetland performs comparatively well in a Scottish context, however in a small system any delays can quickly become challenging – delays have most often been due to Social Care capacity and availability. Shetland has seen an improvement in bed days occupied by those ready to be discharged from 1803 in 2022-23 to 1272 in 2023-24.
- → Psychological therapies – improving picture with increased stability in team, however further vacancies illustrate the fragility in the team and have stalled progress particularly for more complex patients accessing support. The percentage of people seen who have waited less than 18 weeks was 77% compared to 60% last year, while the team has seen more new patients than prior years – 231 compared to 197 last year, this is the highest number of new patients seen in a year since 2015-16.
- → Timeliness of access to assessment has been consistently challenging across the year for Occupational Therapy (average 25% completed on time against a target of 70%) and Intermediate Care team (average 62% completed on time, against a target of 70%) these delays have primarily been due to staffing difficulties, and also impacted by increasing complexity and demand. Teams work to see the most critical cases first, and will provide support while the full assessment is completed so waiting times are not indicative of service-users not having access to required support.
- → Delivery of Alcohol Brief Interventions (ABIs) has improved compared to last year following implementation of locally devised training, however Shetland continues to fall short of the target – a 2023-24 total of 166 represents 64% of the national target, compared to 50% in the previous year.

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. Nationally we are considered next to other HSCPs by the core suite of integration indicators, and by the Ministerial Steering Group (MSG) datasets.

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. Data included is from the management data provisionally released in May 2024, the most recent published data was released in July 2023 and 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 (percentage of adults supported at home who agreed they felt safe) 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 in this 2021-22 data, or to relations with services – the most recent publication of the Health and Care Experience Survey (May 2024) shows 85% of those surveyed who receive social care felt safe, compared to 66% in Scotland. This result has not been subject to the same statistical processing, and may not be directly comparable with the core suite data.

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.

Note a new publication is due in early July, any updated data will be included at that point where reliable, complete data for Shetland is available

Notes on data availability:

Indicators 1-9:

The Health and Care Experience (HACE) Survey for 2024 was published in May 2024 – these have not yet been updated in the Core Suite of Indicators nationally, but this is expected in the July release. The HACE is available online and will be discussed later in the report.

Indicators 12-16: red text denotes areas where there may be challenges with data completeness – these should be interpreted with caution and will be updated as revised data becomes available.

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.

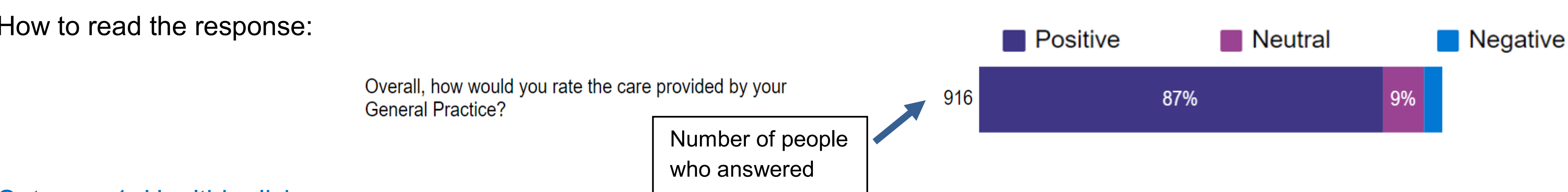
	Indicator	Title	Partnership rate	Scotland rate	Year of latest data
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	93.0%	90.9%	2021/22
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	89.8%	78.8%	
	NI - 3	Percentage of adults supported at home who agreed 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 agreed 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 on 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 agreed 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	282	442	2022
	NI - 12	Emergency admission rate (per 100,000 population)	9,746	11,273	2022/23
	NI - 13	Emergency bed day rate (per 100,000 population)	72,909	119,806	2022/23
	NI - 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	68	102	2022/23
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	93.4%	88.9%	2022/23
	NI - 16	Falls rate per 1,000 population aged 65+	24.4	22.5	2022/23
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	87.2%	75.2%	2022/23
	NI - 18	Percentage of adults with intensive care needs receiving care at home	77.7%	64.8%	2023
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	452	902	2023/24
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	13.2%	24.0%	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*

Scottish Health and Care Experience (HACE) Survey[1]

The HACE survey is a postal survey sent to a random sample of people registered with a General Practice in Scotland. It asks about people's experiences with health and care services in the previous year. The most recent survey was conducted in October/November 2023 and results were released in May 2024.

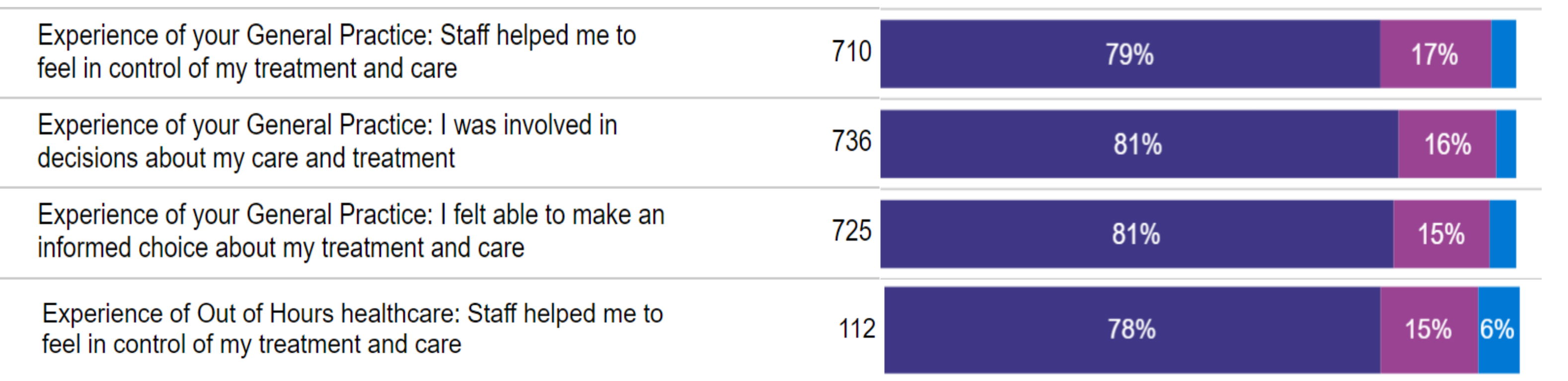
The survey questions covered five areas: general practice, treatment from GP, out-of-hours care, care for daily living, and caring responsibilities. In total, for Shetland HSCP, there were 1,063 responses which gave a 30% response rate, compared to a Scottish average 20% response rate. People only answer questions that apply to them so some questions will have a lot less than 1000 responses, for example not everyone will have used Out of Hours support, and not everyone will be receiving social care support. The questions have been made to tell us how well we are doing in trying to achieve the National Health and Wellbeing Outcomes (NHWBO, page 6), and the responses will be used to update the Core Suite of Integration Indicators (page 9-11). A selection of responses are shared below, linked to the NHWBOs. Sometimes a comparison with Scotland is shared for context – these are available for all measures on the link below.

How to read the response:



Outcome 1: Healthier living

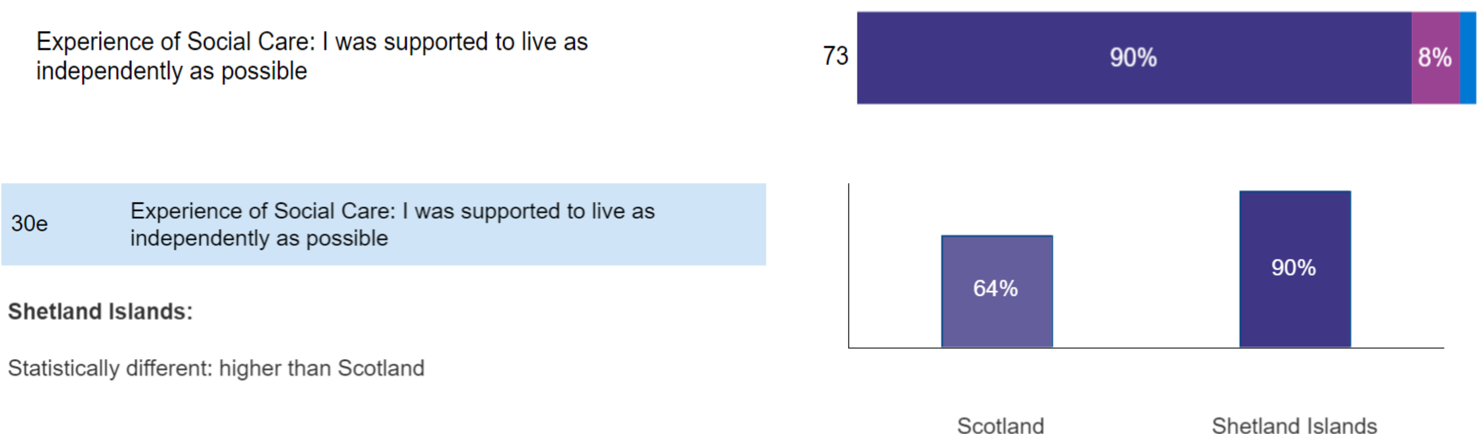
People are able to look after and improve their own health and wellbeing and live in good health for longer.



[1] Health and Care Experience survey - 2024 - Health and Care Experience survey - Publications - Public Health Scotland

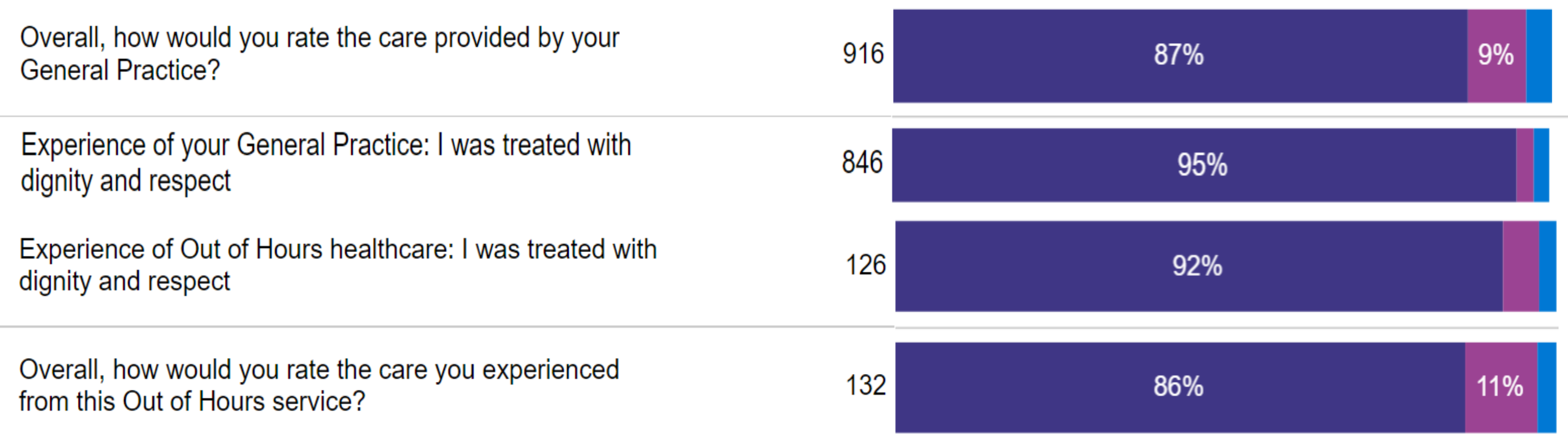
Outcome 2: Independent living

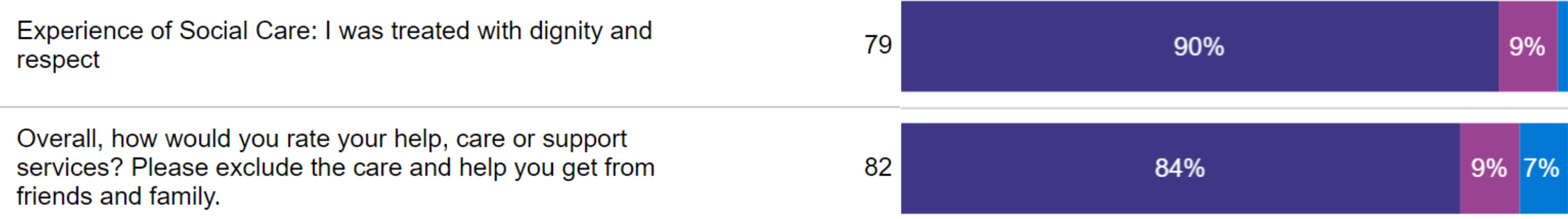
People, including those with disabilities, long-term conditions, or who are frail, are able to live as far as reasonably practicable, independently at home, or in a homely setting, in their community.



Outcome 3: Positive experiences

People who use health and social care services have positive experiences of those services, and have their dignity respected.



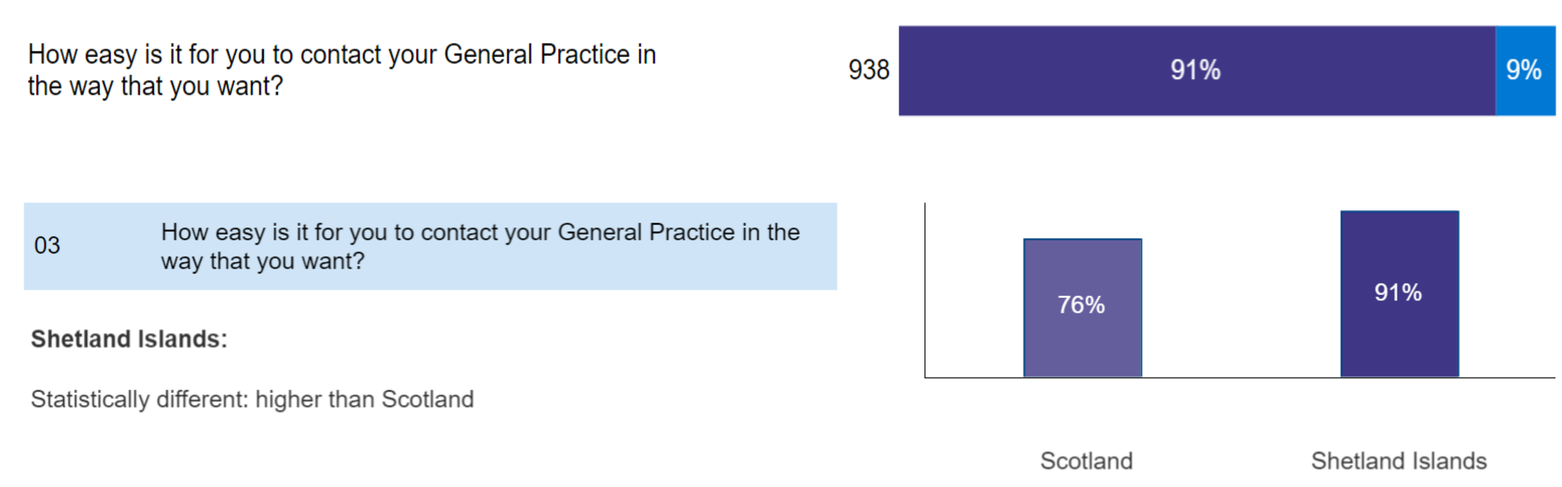


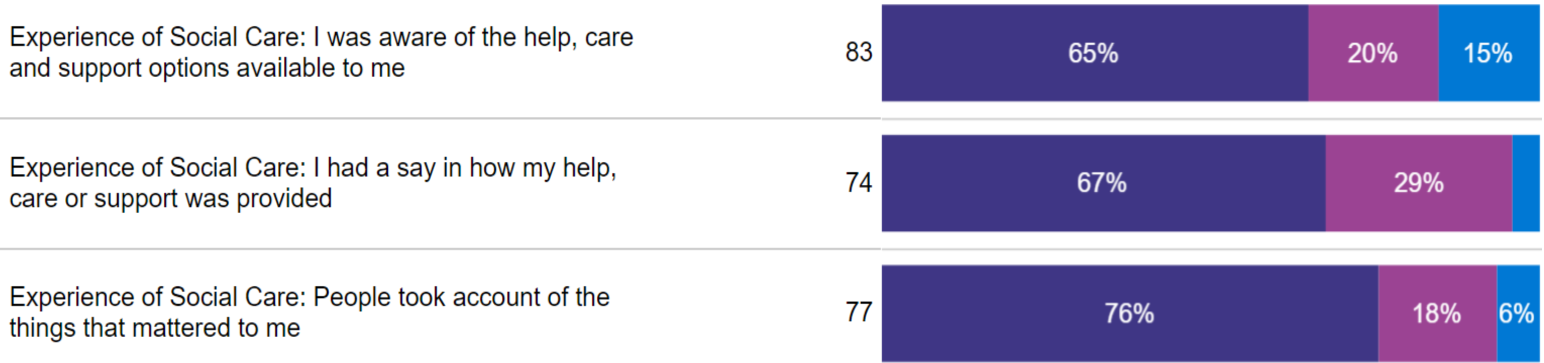
Outcome 4: Quality of life

Health and social care services are centred on helping to maintain or improve the quality of life of service users.

Outcome 5: Reducing health inequalities

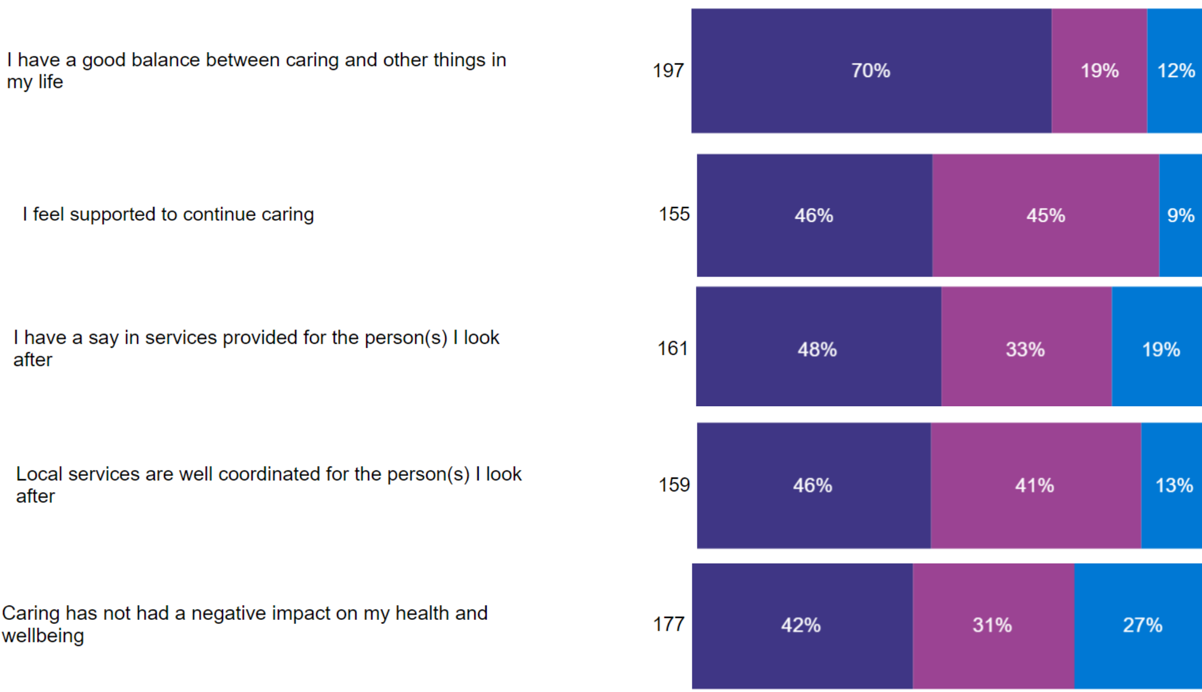
Health and social care services contribute to reducing health inequalities.

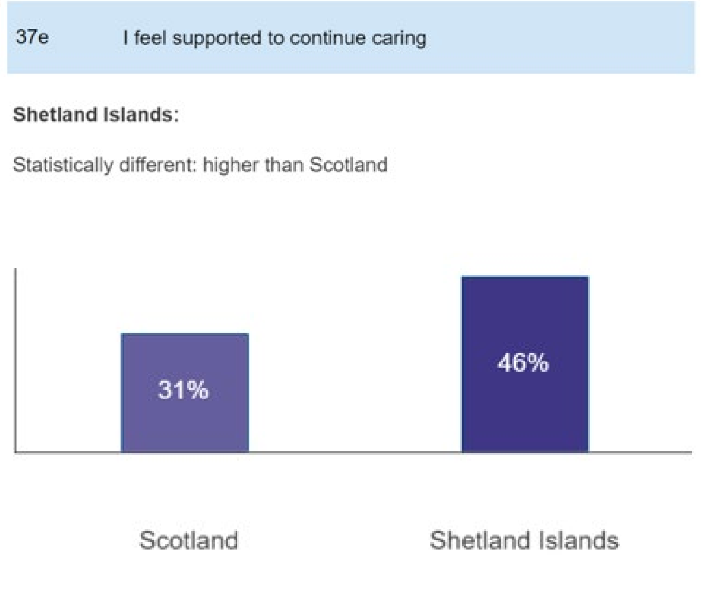




Outcome 6: Carers are supported

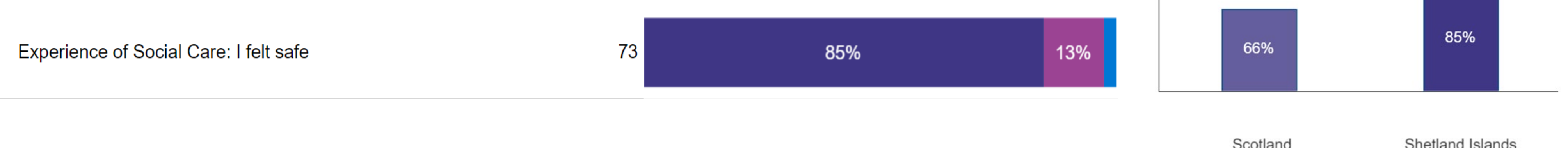
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.





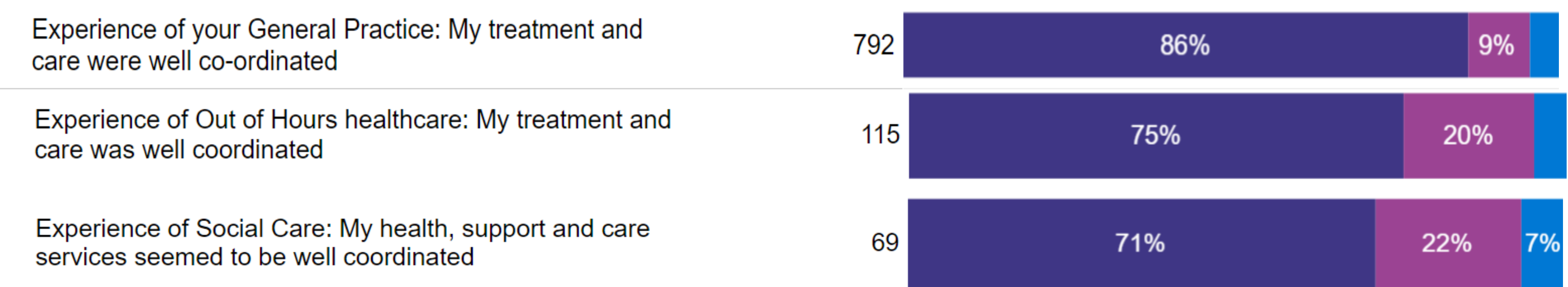
Outcome 7: People are safe

People are safe: People who use health and social care services are safe from harm.



Outcome 9: Resources

Resources are used effectively and efficiently: To deliver best value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.



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. The full dataset with interactive dashboards is available online.

Note as with the Core Suite of Indicators some of these measures are taken from the HACE survey and have yet to be updated

	Compared to Scottish average	Compared to similar areas	Shetland change
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	HIGHER	
% 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 2023/24:

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 encompassed action against all five strategic priorities:

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:

The Health Improvement team continue to focus on training and collaborative work to help upskill other teams, for example in the development of Alcohol Brief Intervention Training which has seen an improvement in delivery of these against national targets. The team are also working closely with Primary Care to continue to develop Diabetes reversal work locally through Public Health Dietitian expertise – this work can have a huge impact on individual health outcomes, stopping progression to more complex health conditions.

Our local Learning Disability Nurse Consultant has also been working to improve the skills and knowledge of the wider workforce in Shetland to support improved outcomes for Adults with Learning Disabilities, by conducting bespoke training with Police and other colleagues he has helped to improve their confidence in responding to adults with LD. Service user and carer feedback has been incredibly positive about experiences with the police following training, in situations which previously would have been very stressful and potentially caused harm.

A piece of innovative work, developed by Pharmacy and NHS Information colleagues in Primary Care, was granted IJB Reserves funding in 2023, following successful trial of the “Shetland Health Intelligence Platform” (SHIP) in Brae Health Centre.

This approach to managing and analysing Primary Care patient data enables targeting of support to those most likely to benefit and will help teams to intervene early to minimise complications and worsening of health problems related to long term conditions.

This piece of work will also support best use of resources and sustainable approaches in Primary Care, ensuring people get the right care, at the right time, from the right person.

Residential Care teams have been working with Dietetics colleagues around provision and monitoring of appropriate hydration and nutrition for older people. This is a key risk factor in escalation of frailty and can be implicated in many falls – by building a key contact model and offering training Residential Care have felt more supported and confident, the teams continue to look at how to measure and monitor improvement.

Primary Care Phased Investment Programme

One of the significant challenges in trying to shift towards a preventative and proactive approach within the health and social care system is continuing to manage existing demand while implementing change. The Primary Care, Community Nursing and Pharmacy Teams put together a bid for extra funding from Scottish Government, supported by Healthcare Improvement Scotland, to become a demonstrator site for full implementation of Pharmacotherapy and Community Treatment and Care (CTAC) services in Primary Care, while maintaining high quality delivery of existing services.

A project team from Primary Care, Community Nursing, Pharmacy, Planning/Projects and Finance were successful in securing funding after a rigorous application and interview process in late autumn 2023. The proposed work builds on existing service plans and detailed workload and workforce modelling to ensure change is feasible. The proposed changes would allow delivery of care closer to home, improved management of long-term conditions, with improved access and outcomes, and decreased inequalities. Shetland was one of three sites selected in Scotland.

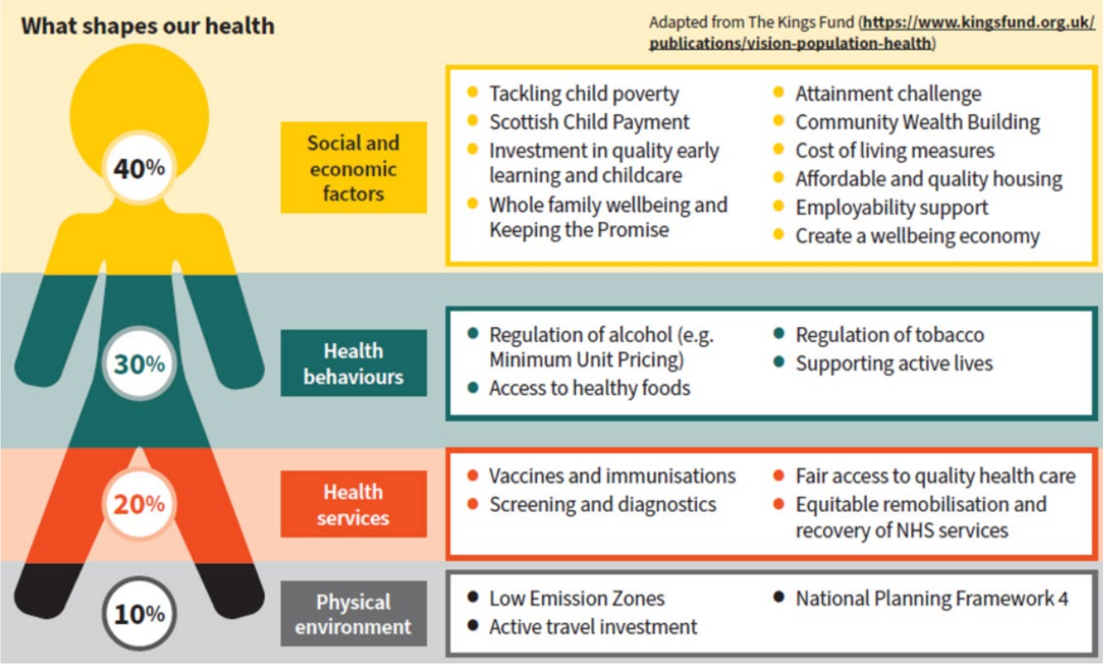
Following selection the team has worked through a rigorous process to identify their delivery team, co-design a bespoke local improvement plan, and confirm funding arrangement to allow commencement of recruitment of fixed-term staff to support implementation of the project. The improvement work will run for 18 months from April 2024, with final reporting of the project in December 2025.

One Stop Shop –supporting people to live independently

Being able to remain safely at home is about more than just social care services. Having a safe environment is a key part of reducing the risk of falls, and supporting people to manage day-to-day tasks. As we continue to 'Shift the Balance of Care' we expect to see more need for adaptations to support people to live safely at home, and to support unpaid carers to continue to support their loved ones.

The One Stop Shop is a service for homeowners to receive assistance with adaptations, repairs and maintenance to their properties. There has been a gradual increase in minor adaptations undertaken over the past decade.

Tackling Inequalities



We know that people experience unfair differences in health outcomes depending on their circumstances and who they are. While these inequalities are on the whole influenced by the building blocks of health – such as money, housing, work, education, family and social connections - many of these differences are exacerbated by the current setup of health and care services which can make it difficult for some people to access what they need.

A significant part of tackling inequalities is better understanding our communities and what they need, and supporting them to access that. The Health Improvement and Planning Teams in Public Health have been working on a Joint Strategic Needs Assessment for Shetland which will be completed in early 2024-2 and will support appropriate targeting of resource, understanding of current inequalities and the need for change. This is closely linked to work the Chief Officer and Public Health and Planning Teams have been involved in with Community Planning and Development colleagues to develop locality profiles, and progress the Shetland Partnership Plan. Fundamental to making any change is how we share and understand this information and use it to make better decisions, and our IJB and leadership teams have been actively involved engaging in seminars about “Exploring Impact” and understanding the “Building Blocks of Health” to support this.

Our Adult Services, Primary Care, Community Nursing and Social Work Management Teams have also been working closely together to understand specific populations. As part of the national “Coming Home Report” implementation the team have been working around the complexities of sharing data and understanding the local needs of our local population with complex needs. While nationally this has been focussed primarily on people living within institutions and away from home, the team locally have taken the opportunity to improve understanding of support needs and build better systems of appropriate information and intelligence sharing across services which will support improved experience of transitions, and better understanding of need to inform service redesign over the coming year.

The Recovery Hub and Community Network

The Recovery Hub and Community Network ("The Hub") is now well established having started during COVID in July 2020. It currently has three members of staff, 1 full time Project Manager, and 2 part time staff – a Substance Use Recovery Worker and an Administration Support worker.

The Hub gives a space for people to meet. It is a friendly place, and all are welcome at the hub, which helps to break down barriers. This approach helps to bridge the gap to services, enabling accessibility to services for those with alcohol and drug issues. These people are a vulnerable, stigmatised group, which can make accessing services more challenging. People who experience prejudice, stigma or have bad experiences, may fear what someone may think of them or lead them to feel they are not worthy of support, and the hub acknowledge this, they will work with the person to get the support they need, and they can be supported to make contact with services they need.

Being a hub environment has benefits for someone who has anxiety about attending an appointment. The Hub looks at what the issues the person is facing and what can be done to support them, taking a holistic approach identifying what the person wants and needs, and what can they do, what support they have, and what support can they can access.

A key benefit of the Recovery Hub and Community Network is that there are no waiting times or referrals, it is a walk in service. The Recovery Hub and Community Network treat everyone with respect and will work with the person to provide the support that works best for them as an individual, recognising that everyone is unique. The support is non-conditional and outcomes based, focused on what the individual wishes to achieve.

"Lived and Living Experience"

Improving services and support beyond the individual one-to-one experience is best done in partnership with those who need or access services, as they are most informed about the challenges and areas for improvement.

The Recovery Hub and Community Network have a Peer group that meet every Tuesday, and members sit on the Alcohol and Drug Partnership, giving them a voice to say what 'we need and want' and help inform development of services and support.

Tackling Health Inequalities by Supporting Access

People who use alcohol and other drugs often have other factors in their lives meaning they experience unfair differences in health outcomes. These outcomes are worsened because of barriers to getting the health and care support needed.

The Community Nursing team have been working with the Hub and Community Network through their Outreach ANP (Advance Nurse Practitioner) to provide vital health services, and also to support people to access the mainstream services they can benefit from. This often means directly supporting individuals, and working with staff, for example in Health Centres, to offer a trauma-informed, non-stigmatising service.

The ANP Outreach service ran throughout 2023-24 and has recently secured further funding from the Alcohol and Drug Partnership to continue.

Best Value

With ongoing financial and workforce challenges, paired with increasing demand and complexity from an ageing population, we are continuing to work hard to review ways of working and models of delivery to ensure best use of resources and build sustainable approaches to service delivery. There is a general agreement that it is no longer reasonable or feasible to deliver services in the way we currently do. There are a number of different steps to ensuring best value from resources we have – some examples of ongoing work are shared below.

Improving Oversight

Work by Finance, HR and management teams has facilitated improved consistency and oversight of supplementary staffing in social care which has been used alongside service demand and capacity data to better understand system pressures. Use of agency staffing, alongside vacancy pressures, is now routinely reviewed within the Clinical Professional and Oversight Group to support more consistency of approach and improved decision making.

Understanding Changing Need

The Adult Social Work and Adult Services teams engaged support from In Control Scotland via IJB Reserves funding, to plan a comprehensive review of Self Directed Support in Shetland. The funding and external expertise supported the planning and groundwork for the review, engaging service-users, families and unpaid carers as well as services in a meaningful review process which will take place into 2024-25.

Rethinking Capacity

The Community Nursing Team undertook a series of tests of change trialling Advanced Nurse Practitioner (ANP) cover of the Out of Hours (OOHs) period which is ordinarily covered by a GP.

Challenges in finding appropriate medical staffing means this OOHs period has often been covered with an expensive locum staffing model, so the advancement of ANP cover which has proved successful represents significant cost-avoidance in the short term and longer term recurrent savings if the model proves sustainable.

This work is currently being evaluated to inform next steps.

In response to recruitment difficulties and challenges managing demand the Dietetics team have looked to change the skill mix in the department to improve caseload management, this has included a test of change with a Dietetic Assistant, Healthcare Support Worker role, which has supported an increase in preventative work particularly supporting Residential and Care at Home staff, releasing time for Dietitians to manage more complex presentations.

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Shifting the Balance of Care

Shifting the balance of care describes working towards a different way of supporting people – in terms of Place, Power, Prevention, and type of delivery. We know people will always require support in many different ways, and taking a person-centred approach means we will always have to be flexible and adaptable as services and commissioners. Broadly we would hope to be delivering:

- → closer to home, in people's homes or communities, rather than in hospitals and residential care
- → supporting people earlier to prevent deterioration and complications
- → support that is led by people and supported by professionals – that is person centred, not service centred
- → asset based – building on a person's strengths, assets and aspirations, rather than their weaknesses or deficits.

In Shetland we have made significant progress towards shifting the balance of care, with more short term and respite use of residential care rather than long stay residents; we support people with intensive care needs to remain at home when that is their wish; we have short stays in hospital; and low rates of emergency readmissions suggesting we are looking after people well in communities, and working well together between our hospital and community services. However, there are still challenges particularly where capacity issues cause delays in discharge from hospital. While the numbers of delayed discharges in Shetland are small, they are significant in terms of capacity in the system, and can have a negative impact on the individuals who are delayed in getting home with the support they need.

Progress in 2023-24 included development of a Shetland Hospital at Home model, looking at early supported discharge as a collaboration between acute services, local

Rate of readmission to hospital within 28 days

	2022/23	2023/24	
Scotland	10.5%	10.2%	
Shetland	7%	7.3%	

Multiple emergency admissions –aged 65+ with 2 or more emergency admissions (per 1000 popn)

	2021/22	2022/23	
Scotland	47.3	47.9	
Shetland	36.8	35.3	

Days spent in hospital when ready to be discharged, due to HSC capacity, aged 75+

	2022/23	2023/24	
Shetland	1492	857	

A+E Attendances (per 1000 popn)

	2022/23	2023/24	
Scotland	263.8	270.6	
Shetland	314.7	330.2	

Consultant Geriatrician and Community Nursing teams. This small test of change has supported a small number of patients to return home early, with short term resource from Scottish Government to increase ANP time available.

The Mental Health Team, with support from IJB Reserves funding, supported the local third sector to develop a Distress Brief Intervention service for the community, which was launched in the second half of the year. More will be reported on this work through 2024-25 as information is collected to inform next steps.

A further initiative funded through IJB Reserves was the engagement of Good Conversations training locally. Funding secured at the end of 2022-23 was used to run training locally and to develop local trainers to make the "Good Conversations" approach sustainable locally. This is one approach to asset based, relationship focussed practice, supported by the Adult Social Work team, which will support the shift in power and focus to be person-centred rather than service-led. This is also supportive of a Value Based Health and Care approach.

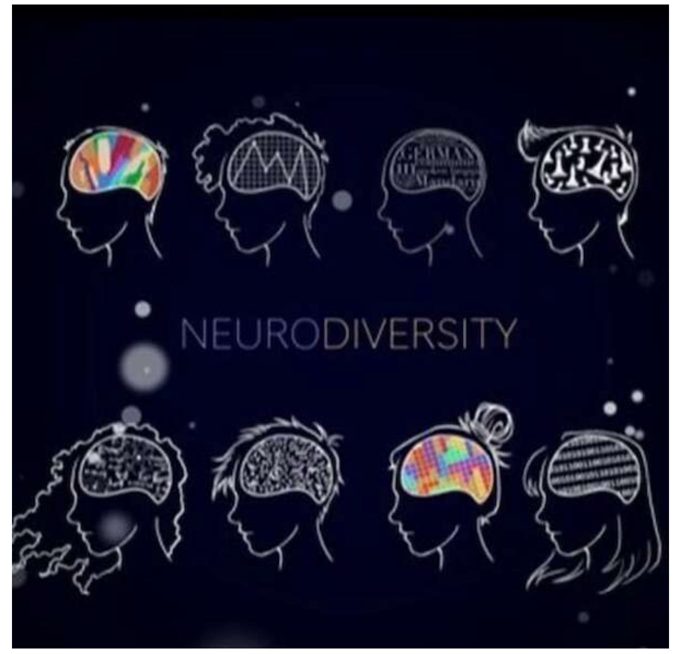
Oral Health Strategy

There have been ongoing challenges around access to Dentistry in Shetland for a number of years, this has worsened since the Covid-19 pandemic and levels of provision have not recovered to pre-pandemic levels due to workforce challenges.

In response to the ongoing challenges around the model of provision in Shetland a new Oral Health Strategy for Shetland has been developed which looks at a novel model of provision to address the sustainability of dental services in a remote, rural, island setting. The new Oral Health Strategy as approved by the IJB on 5th October 2023, discussions around implementation and funding are ongoing.

Creative approaches to improving outcomes

The local Learning Disability Nurse developed the Embrace project with a young service user and Shetland Arts. This project shifted focus away from service provision into meaningful work for the young person and an outlet for their creative talents. The project developed a film, and has increased social connections and supported work to raise awareness of Neurodivergence.



Supporting Unpaid Carers

People who care for and support their family, friends and networks in their communities (“Unpaid Carers”) are vitally important to those they care for, and help them maintain their health and independence throughout their lives. Unpaid Carers can often experience poorer health outcomes related to their circumstances, and it is important that services are coordinated and provided in a way that is supportive to carers as well as beneficial to individuals accessing the service. Services try to do this in a number of ways, including providing support to fit with working patterns, providing respite support and developing carer plans.

Shetland Care Attendant Scheme (SCAS)

SCAS is commissioned by the Health and Social Care Partnership, and one of their aims is to relieve stress on the person or family caring for a person with a disability, or otherwise requiring support. An example of the impact of this support is shared below:

The outcome desired was for the carer to go away to mainland Scotland with her daughter to have an extended respite break with some quality time to themselves.

The lady brought her elderly parents who could no longer live alone, to live with her in her home. Her father had advanced dementia and her mother had very poor mobility and used a wheelchair. SCAS provided a Care Attendant to visit 3 times per week and took her father out for a run in their car for 2 hours. This allowed the daughter to go to work for a few hours and the mother to have a rest. It also elevated the father’s mood and he was happy upon his return.

The father didn't sleep well during the night and got up several times, confused and wandering around. This in turn woke his wife and daughter. The daughter had to get up and encourage and persuade him to return to bed. Also, his wife often needed support to go to the toilet during the night. The daughter was exhausted. She would benefit from an extended break to have a complete rest. Respite in residential care was not available. SCAS was in a position to provide Care Attendants to stay with them for 5 nights so that the daughter could go away for a long weekend and have peace of mind that both parents were being cared for and kept safe and happy in their own home. The Care Attendants all stayed over one night each before the daughter went away to ensure they knew the routine exactly and that they were familiar with both parents and knew exactly their support requirements.

“I can’t thank SCAS highly enough. Everything was excellent. The Care Attendants were brilliant and it meant I was able to have a break from caring for my folks. I definitely felt the benefit from having some down time and my folks enjoyed seeing everyone! Thank you so much”

Meaningful Involvement

Working towards sustainable delivery means exploring changes with communities to understand what is needed and what is feasible. To do this effectively and understand the best approach in each instance requires meaningful discussion with communities. One way we can make this involvement and engagement meaningful and actionable is by having a good understanding of our communities and populations, so we have reliable data and information to inform our conversations.

Some of this engagement and evidence gathering is at a community or Population level, for example the Good Mental Health for All project, and locality profiles, to understand needs and assets, and some is at an individual or service level, for example gathering feedback, compliments and complaints to understand outcomes and how well services are working for people.

The Planning and Performance team have been working to continually improve the performance reports provided to the IJB for assurance. Complaints have formed a longstanding part of the performance reports, and this year the team have been working to include compliments and feedback to services other than complaints – supporting service-users to feedback about services gives us very valuable information about how we are doing, and can also support them to achieve better outcomes.

Conversations about Change

We have been working hard to change how we engage, towards having ongoing conversations, to answer some of the frustrations communities have voiced about being asked and never hearing any outcomes.

Work has continued in Primary Care to move towards a Network Enabled Care model, where we connect our different community sites in terms of systems and teams. Using our resources more effectively across Primary Care sites will give people better access to the right care, from the right person, when they need it.

The Community Health and Social Care teams have worked with Community Councils to share the purpose of this work, and the plan to add stability by strengthening multi-disciplinary teams, and the work is progressing well in the first phase of networked practices. These conversations will continue with each area as the plans progress.

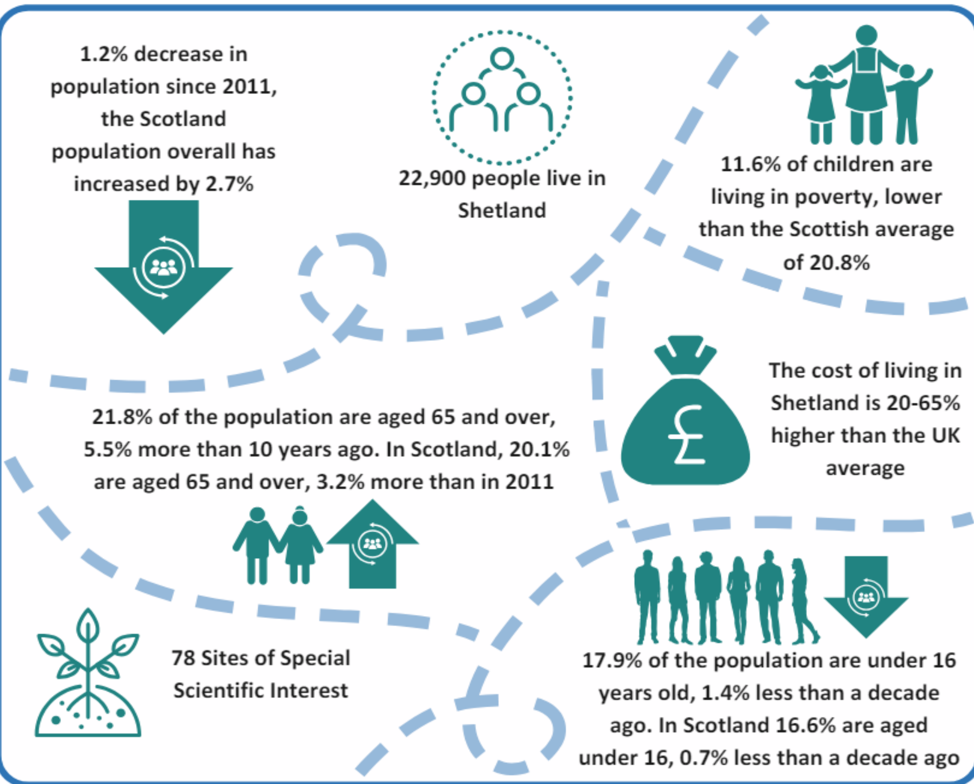
Shetland in the National Context

We were lucky to host a National Care Service engagement session in the summer of 2023. This was an opportunity to showcase how we deliver services locally, and some of the excellent services we provide, to be considered in the context of development of the National Care Service, and to help the national team better understand how changes would impact us as a remote, rural, island partnership. The national team recognised the value of doing things differently in Shetland and the benefits of having a local approach particularly where we have been successful in ‘Shifting the Balance of Care’.

Understanding our Communities

Planning and Public Health teams have been working with Community Planning and Development colleagues to develop locality profiles to better understand the differences between areas and to support discussion with communities about their needs.

These profiles give a wealth of data and have been used in our Islands with Small Populations to develop local action plans, supported by the Community Planning and Development Team. Our islands with small populations have had particularly pressing challenges driven by difficulties in recruiting Community Nurses for single-handed posts, this has led to the expansion of the Healthcare Support Worker model in a number of areas in discussion with communities on a case-by-case basis. The needs and assets of each island are unique and a change in provision such as this is always preceded by discussion with the community to explore options and develop solutions.



Example excerpt from Shetland profile

Dementia Voices – Lived Experiences

Our AHP colleagues secured funding from Alzheimers Scotland to undertake a local project to work towards the Connecting People, Connecting support ambitions to better understand the local experience of people living with dementia when accessing health services. The project has progressed towards its 3 intended outcomes:

- Lived Experience - Engagement with people with lived experience to understand the support needs of those in Shetland
- Promoting Excellence - A local scope of the skills of the AHP workforce from across both health and social care as mapped to Promoting Excellence
- Local Context - Development of local engagement events, integrating appreciative inquiry and review current delivery of ambitions

Population Mental Health – understanding what Shetland needs to thrive

The IJB commissioned work, via Reserves funding, to help understanding Shetland's population health needs through the Good Mental Health for All project. This project was completed by the Health Improvement Team supported by Information colleagues and was an evidence gathering project which included engagement with various groups across Shetland, including public and workforce surveys, attendance at events, work with children and young people and engagement with existing community and third sector support services. This engagement approach helped to ensure a broad range of participation, with a focus on gathering views from people who we know experience an unfair difference in outcomes, and who may find it more challenging to take part in project or engagement events.

The main areas where people identified a need for change and/or more support included:

- → help with cost of living well - including food/fuel, leisure activities, off-island travel and advice
- → help with the impact of poor weather - more connection, support, activities and advice
- → more things being available and accessible locally - mental health support and services, wellbeing activities, transport and childcare provision
- → less stigma and discrimination - more understanding, equality and acceptance at school, work and in community
- → finding a trusted personal connection -less loneliness, someone to talk to, peer support, early intervention
- → more education and literacy - more information, more training, more knowledge around signposting and referral
- → a change in life expectations - better work/life balance, more time for self-care, more energy, less pressure, less focus and drive toward academic achievement
- → better relationship with self - more self-confidence, self-worth, better body image, better relationship with food

The evidence has been collated and processed and published online. This work will support the development of a population mental health and wellbeing strategy in the coming year, and is closely connected with the Shetland Partnership workstreams of Compassionate Communities and Person-Centred Support.

Financial planning and performance
Financial Transactions 2022/23

For the year-ended 31 March 2024, the IJB generated a deficit of (£0.556m) (2022/23: £2.812m), after adjustment has been made for additional contributions made by SIC and NHSS. This deficit (which includes 'set aside budget) is detailed in Row 7 in the following table.

The deficit of (£0.556m) 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 2024 for IJB delegated services is an overall deficit against budget of (£7.432m) (2022/23: (£1.432m)), which represents an overspend in relation to services commissioned from SIC of

(£6.273m) (2021/22: (£1.435m)) and an overspend in relation to services commissioned from NHSS of (£1.158m) (2021/22: an underspend of £0.003m).

In order to achieve the final IJB deficit of the year of (£0.556) (2022/23 deficit of £2.812m), SIC made a one-off additional contribution of £4.995m to the IJB. The additional contribution from SIC is non-recurrent in nature and does not require to be paid back in future years. NHSS made a one-off additional contribution of £2.437 to the IJB. The additional contribution from NHSS is non-recurrent in nature and does not require to be paid back in future years.

	2023/24			2022/23		
	SIC £000	NHSS £000	TOTAL £000	SIC £000	NHSS £000	TOTAL £000
IJB Budget	32,570	34,242	66,812	29,976	37,606	67,582
Cost of Services of the IJB (Contribution from the Parties)	(37,565)	(36,679)	(74,244)	(33,329)	(37,603)	(70,932)
Budget Variance	(4,995)	(2,437)	(7,432)	(3,353)	3	(33,350)
IJB Direct Costs (Audit fee, Insurance & Members Expenses)	19	18	37	17	16	33
Contributions from Parties to meet IJB Direct Costs	(19)	(18)	(37)	(17)	(16)	(33)
Additional contributions (to)/from the Parties to/(from) IJB	3,718	3,158	6,876	1,675	(1,137)	538
Final Surplus/(Deficit) of IJB	**(1,277)**	**721**	**(556)**	**(1,678)**	**(1,134)**	**(2,812)**

	2023/24			2022/23		
	SIC £000	NHSS £000	TOTAL £000	SIC £000	NHSS £000	TOTAL £000
Additional contributions (to)/from the Parties to/(from) IJB to meet budget variance	4,995	2,437	7,432	3,353	(3)	3,350
Transfer of Scottish Government Additionality funding between the Parties	(1,277)	1,277	0	(1,277)	1,277	0
Draw from Reserves	0	(584)	(584)	(401)	(2,606)	(3,007)
Pass back to Reserves	0	28	28	0	195	195
Additional contributions (to)/from the Parties to/(from) IJB	**3,718**	**3,158**	**6,876**	**1,675**	**(1,137)**	**538**

Significant Budget Variance Table

Full explanations for significant budget variances can be seen in the Financial Review section of the IJB Annual Accounts 2023/24.

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.

In prior years Locum costs were calculated net of savings from related staffing vacancies. In this year's Accounts the savings from staffing vacancies have been included in the Vacancies and Other Staffing Underspends amount.

Due to difficulty in recruiting to specialist posts it has been necessary to continue to contract Consultant Mental Health locums in 2023/24, at a cost pressure (including flights and accommodation) of (£1.233m) (2022/23: (£0.427m)).

Efforts continue regarding ways to reduce the requirement for expensive locums in Mental Health including the redesign of urgent care pathways, a move to better use of skill mix in the out of hours period and scoping the potential for remote models for consultant out of hours cover.

Locum cover, including travel and accommodation, was also required in Primary Care for General Practitioners (£1.405m) (2022/23: (£1.058m)) where it was not possible to fill vacant posts.

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	2023/24 Budget Variance £000	2022/23 Budget Variance £000	Variance £000
Locum Costs	(4,173)	(2,584)	(1,589)
Agency Staffing	(3,894)	(2,778)	(1,116)
Vacancies & Other Staffing Underspends	5,201	1,785	3,416
Increased Service Demand	(532)	(395)	(137)
External Service Provider	112	182	(70)
Pharmacy & Prescribing	(403)	(325)	(78)
Maintenance and Inspection Works	(299)	417	(716)
Vehicles/Mileage savings	58	64	(6)
Pay award impact	0	(709)	709
Overachievement of Income	622	239	(383)
Additional funding	1,552	2,998	(1,446)
Unmet Savings Targets	(1,487)	0	(1,487)
Move to Board Run Practice (Levenwick)	(186)	0	(186)
Recharges	(2,013)	(1,917)	(96)
Other	(563)	(326)	(237)
Budget Adjustments	(1,427)	0	(1,427
Total	**(7,432)**	**(3,349)**	**(4,083)**

Within Unscheduled Care, Locum use has been required to cover junior doctors and consultants (£1.535m) (2022/23: (£1.021m)).

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.

Service	2023/24 £000	2022/23 £000
Community Care Resources	(2,035)	(1,676)
Adult Services	(1,557)	(767)
Ward 3 Agency Nurses	(202)	0
Adult Social Work	(100)	(206)
Community Nursing	0	(106)
Occupational Therapy	0	(23)
Total	**(3,894)**	**(2,778)**

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 (£3.894m) (2022/23: (£2.778m)), to cover various service areas.

During 2023/24 a review of a number of Social Care posts was completed, which resulted in pay uplifts across the service. Efforts have also been made to encourage applications by attending local career fairs and promoting opportunities for modern apprenticeships. Recent recruitment exercises have seen an increase in the number of positive outcomes, which suggests the actions taken in year have had a positive impact.

Work continues to find ways to attract people to take up jobs within Health and Social Care and retain them, including offering relocation packages in Social Care. Success has been found via Modern Apprenticeships and efforts to "grow our own". It is also hoped that the recent pay uplift for a number of Social Care Worker posts will help to increase the attractiveness of working in this area.

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

The Balance Sheet as at 31 March 2024

The IJB carried a General Reserve of £1.504m as at 1 April 2023. This Reserve was created from previous years underspending in the Scottish Government Additionality Funding £0.565m and underspend in specific NHSS Funding which were carried forward as an earmarked element of the Reserve £0.939m.

During the year there has been a draw on the IJB Reserve of £0.584m, £0.531m of earmarked reserve and further spend against a number of projects which the IJB have agreed to fund from its Reserve, £0.053m.

Underspend in Scottish Additionality Funding in 2023/24 of £0.083m and £0.028m, has been added to the Reserve.

As at 31 March 2024, the General Reserve has a balance of £0.948m, of which £0.408m is earmarked, leaving £0.540m uncommitted Reserve available to be spent in line with the IJB Strategic objectives.

2024/25 Budget and Medium Term Financial Outlook

The IJB approved its budget for 2024/25 of £68.032m, on 23 April 2024.

The 2024-25 budget contains a savings target of £0.610m (0.9%) and anticipates additional significant cost pressures related to temporary workers. The budget contains outline savings and cost reduction schemes on how this challenge will be addressed. Progress on these schemes, along with the ongoing development of further schemes, will be regularly reported in the IJB's quarterly Financial Monitoring Reports.

The IJB approved its current Medium-Term Financial Plan 2024-2029 (MTFP) on 22 May 2024. This plan presents an extremely challenging financial outlook for the IJB over the next five years. If services remain in the current model, the IJB will face a cumulative financial deficit of £9.196m (13%) by 2028-29. Addressing this deficit will require strategic financial planning and decisive action to ensure the long-term financial sustainability of IJB delegated services.

Savings and cost reduction schemes will continue to be progressed and developed during future years with continued IJB scrutiny in this area.

Inspection of Services

Care Settings

A number of unannounced inspections took place across our residential settings in 2023/24 – 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 key messages are collated below, note not every domain is assessed in each inspection:

6 Excellent | 5 Very Good | 4 Good | 3 Adequate | 2 Weak | 1 Poor

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Support@Home	2nd June 2023	5 – Very Good	5 – Very Good			

Key messages:
- People were highly satisfied with the support provided.
- The service was reliable and flexible in responding to people's changing needs.
- Staff were highly motivated and well-trained.
- Records relating to some people who received support with medication needed improvement.
- The management team was accessible, supportive and responsive to ensuring people's needs were being met.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Newcraigielea	3rd Aug 2023	5 – Very Good	5 – Very Good			

Key messages:
- People were treated with kindness, dignity and respect.
- Support was planned and delivered in a person-centred way.
- Members of staff share responsibility for identifying and carrying out improvements to the service.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Eric Gray	12th Oct 2023	5 – Very Good	5 – Very Good			

Key messages:

- The service provides high quality support and activities to people with a wide range of needs.
- The building was purpose built and ensures people have a high-quality environment that supports them be supported in a way that suits them.
- People participated in a wide range of activities that suited their needs and preferences.
- There were very good processes in place to ensure that the quality of the service provided was maintained.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Taing House	12th Oct 2023	5 – Very Good	5 – Very Good			

Key Messages:
- People enjoyed attending the centre.
- People enjoyed participating in the variety of activities available.
- People were supported by a team who knew them well.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Montfield Support Services	2nd Aug 2023	4 - Good	4 - Good	4 - Good	4 - Good	4 - Good

Key messages:
- The staff knew people well and treated them with kindness and respect.
- The service was well led with the manager being approachable and supportive.
- People's wellbeing could benefit more from regular activity.
- People received regular visits from friends and relatives.
- Families reported being happy with the care and support their loved ones received.
- The home was clean and welcoming.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Edward Thomason & Taing - Inspection	3rd Aug 2023	3 - Adequate	4 - Good	3 - Adequate	4 - Good	4 - Good

Key Messages:
- Staff were caring and compassionate and were working hard to ensure people's needs and outcomes were met.
- People were encouraged to maintain their independence.
- Families were very satisfied with the care their loved ones received.

- The service works collaboratively with a range of multi-disciplinary colleagues.
- The service was unable to provide sufficient meaningful activity for people.
- There were vacancies in the staff team which could impact on provision of care and additional working hours for others, including managers.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Edward Thomason & Taing – follow up	10th Oct 2023					

Key Messages:

- Progress had been made on the requirement in regards to night shift staff.
- Progress had been made in areas for improvements that were previously advised.
- All staff were receiving regular supervision.
- The staff training plan was up-to-date.
- Staff recruitment is slow and agency staff are still being used regularly.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Edward Thomason & Taing – follow up	29th Jan 2024			3 - Adequate		

Key Messages:

- Meaningful engagement for people using the service has improved.
- An improvement plan of refurbishment is now taking place within the service.
- The service is unable to move forward with required staffing plans due to Shetland Island Health and Social Care Partnership current staffing review decisions.

Name	Date	Wellbeing	Leadership	Staff team	Setting	Planning
Annsbrae	11th Oct 2023	5 – Very Good	5 – Very Good			

Key Messages:

- People experienced kindness, compassion and empathy in how they were supported.
- People were supported to get the most out of life and to maintain and develop their interests and strengths.
- Staff had good knowledge of the people they were supporting.
- People received appropriate help and support in a timely manner.
- Managers promoted a learning and continuous improvement ethos within the service.
- Managers and staff reflected the organisational values and aims of the service.

Annual Audit

The Shetland Islands Integration Joint Board annual audit report 2022/23 was approved in November 2023. The audit was largely positive with a small number of recommendations for improvement. These recommendations were:

1. Working papers used in the preparation of the annual accounts should be subject to quality review and retained as evidence for audit review
2. The IJB should engage with NHS Shetland/ Scottish Government to clarify whether the £150,000 unspent covid-19 funding should be returned or can be applied for other purposes.
3. The format and content of the management commentary in the annual accounts should be reviewed to ensure that it includes focused and balanced reporting of performance for the year.
4. The current projections in the medium-term financial plan should be updated to reflect the ongoing budget increases and implementation of the saving targets.
5. The content available through the Health and Social Care Partnership website should be regularly reviewed to ensure it is up to date.
6. An organisational self-assessment against the Best Value characteristics should be undertaken and reported to the Board annually

Self-Assessment and Skills Audit

The IJB carried out a self-assessment and skills audit in November 2023 which was presented to the IJB Audit Committee on 30 November 2023.

The results have been used to inform the induction process for incoming IJB members, and to design the programme of upcoming IJB seminars to support informed decision making.

The self-assessment considered the following areas:

- Thriving leadership, collaborative engagements and relationships
- Understanding of finances, budgets and financial planning
- Beneficial approach, strategic planning and continuous improvement
- Effective governance, accountability and assurance
- Robust meetings, information and induction process

The process received 9 responses, a response rate of just under 50%.

Delayed Discharges from Hospital – Internal Audit

In January 2024 an internal audit of Delayed Discharges from hospital was completed for the Shetland HSCP. The audit was generally positive and presented three recommendations for action, which are detailed below.

Recommendation	Planned Action
IJB management, in conjunction with NHS Shetland and CHSCP management, where appropriate, should: • Review and agree the process to be followed for the capture of discharge and referral data to ensure that the data is recorded and reported accurately. • Consider whether more structured arrangements are required for handing over cases when staff are absent, as well as following up referrals and case conferences in AWI cases. • Share details of any revised processes with staff and consider if training is required.	Work with staff in acute where the records are held to review and agree the process for capture of data. More structured arrangements are not considered necessary for handing over cases locally given the small numbers with the current processes working whilst we recognise that the delay in cases reviewed was longer than we would want.
IJB management, in conjunction with NHS Shetland and CHSCP management, should review, and where necessary update, the referral process to ensure that formal referrals are being sent at the earliest appropriate time.	Executive Manager Adult Social Work/Interim Depute Chief Officer will meet with Chief Nurse Acute to review this process and ensure that formal referrals are being sent at the earliest time. Once this review has been completed information will be shared with teams.
Management should ensure that the Terms of Reference for the Clinical and Professional Oversight Group is reviewed, updated, and circulated for approval. Once agreed, the updated Terms of Reference should be made available to all relevant parties.	Executive Manager Adult Social Work/Interim Depute Chief Officer will review Terms of Reference and circulate updated version with relevant parties once approved.

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 have not yet been updated nationally with 2024 HACE publication.

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

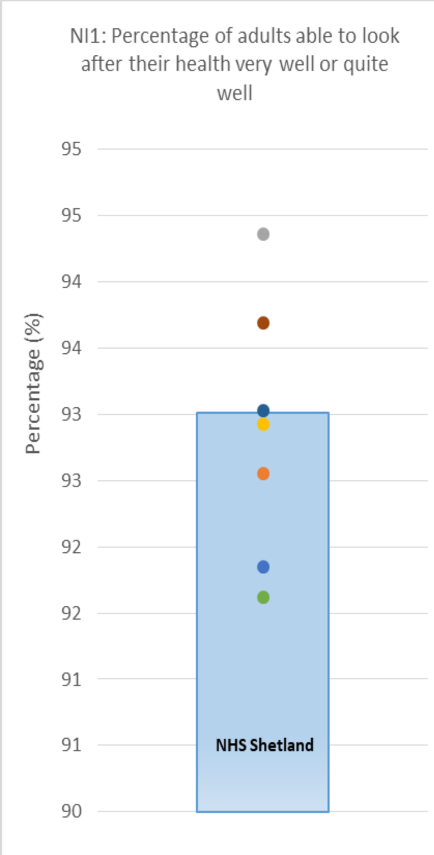
NOTE: These data are due to be updated in July 2024 – figures will be included if available within that publication.

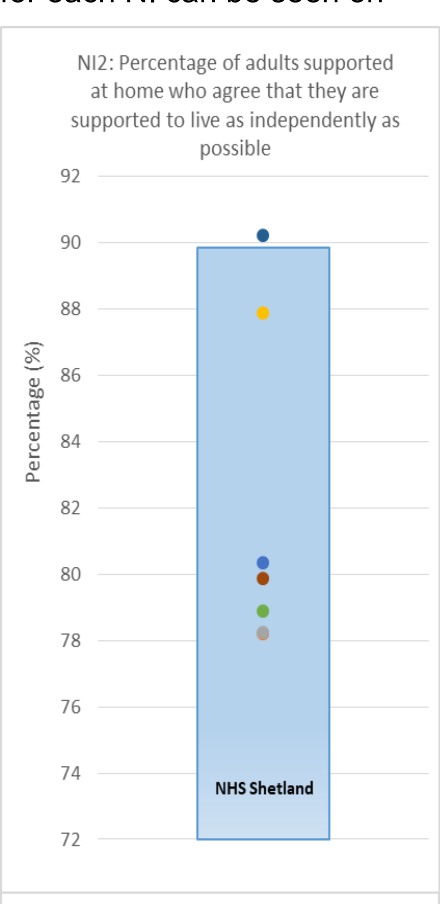
Data indicators

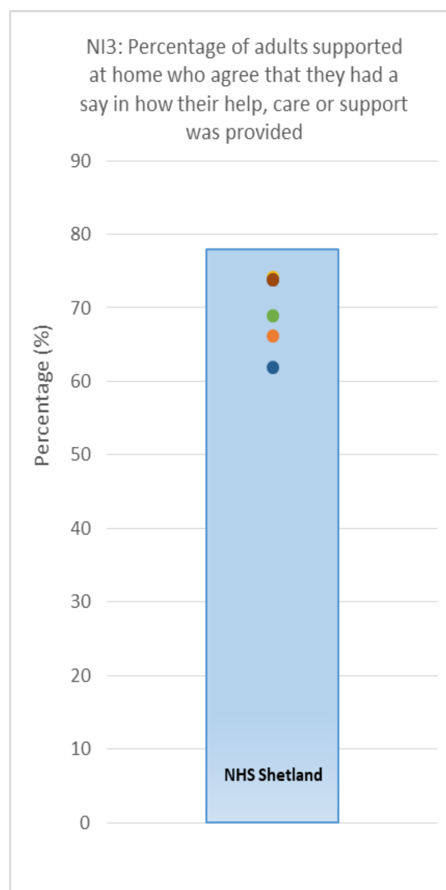
Indicator									Better
Premature mortality rate per 100,000 persons	2015	2016	2017	2018	2019	2020	2021	2022	Lower is better
	406.6	289.4	322.5	301.7	331.1	356.3	363	282	
Emergency admission rate (per 100,000 population)	2015/16	2016/17	2017/18	2018/19	2019/20	2020	2021	2022/23	Lower is better
	10364.69	10093.40	10593.81	10253.14	9255.84	9854.42	9423.45	9745.58	
Emergency bed day rate (per 100,000 population)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Lower is better
	75520.41	65110.06	65682.98	68317.12	59943.99	66057.81	71549.46	72908.93	
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Lower is better
	72.98	68.83	71.65	72.85	86.77	80.90	65.39	68.19	
Proportion of last 6 months of life spent at home or in a community setting	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Higher is better
	93.3	95.2	93.8	93.6	92.9	94.6	93.9	93.4	
Falls rate per 1,000 population aged 65+	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Lower is better
	21.8	21.4	16.2	16.2	22.9	20.5	23.4	24.4	
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22		Higher is better
	84.38	94.29	88.24	97.06	91.18	92.86	89.19		
Percentage of adults with intensive care needs receiving care at home	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Higher is better
	73.8	76.9	74.6	71.2	72.0	74.2	80.1	77.7	
Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Lower is better
	528.1	505.0	572.7	499.0	153.0	333.3	732.1	452.4	
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2016/17	2017/18	2018/19	2019/20					
	15.4	13.5	13.5	13.5					
Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA			
Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA			
Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA			

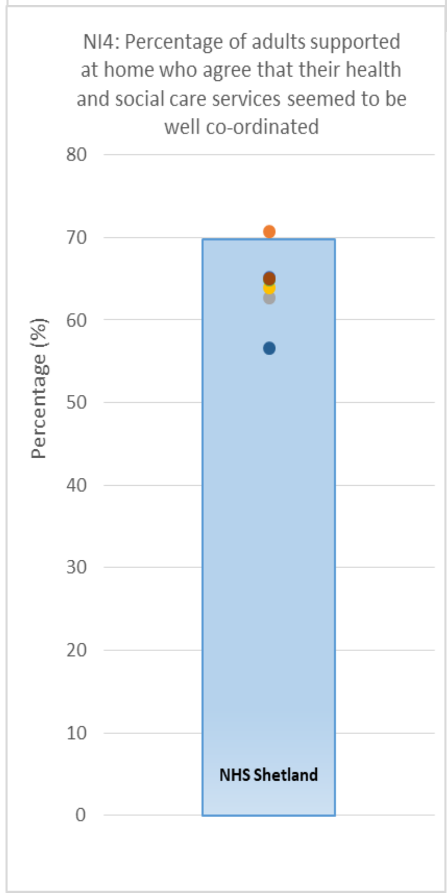
Appendix 2 - National Integration Indicators Ranked against Comparable HSCPs

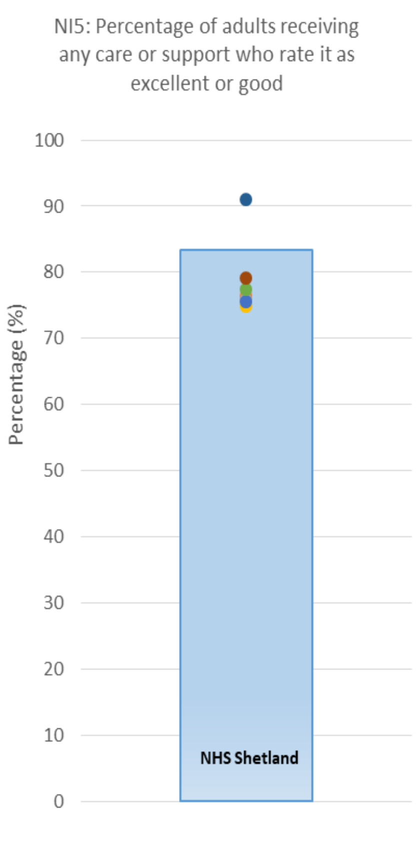
National Integration Indicators shown with Shetland HSCP ranked against comparable HSCPs as advised by the Local Government Benchmarking Framework. Data shown is most recent published depending on source and publishing schedules. Dates for each NI can be seen on Trend data tables.

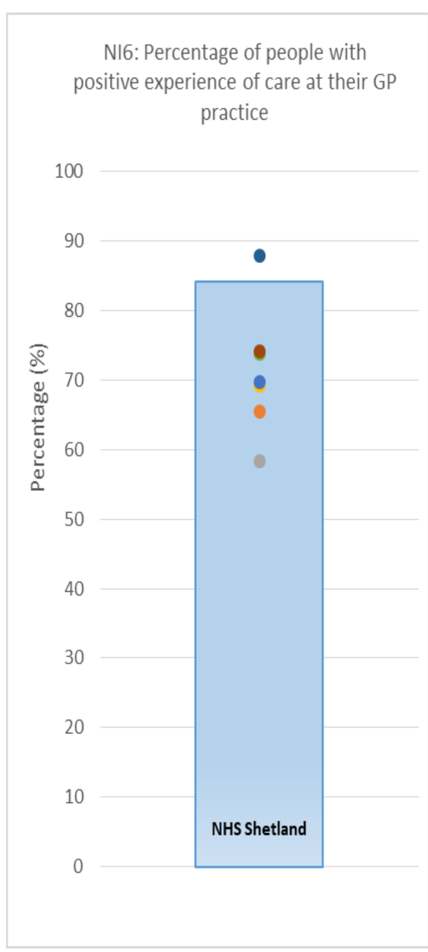


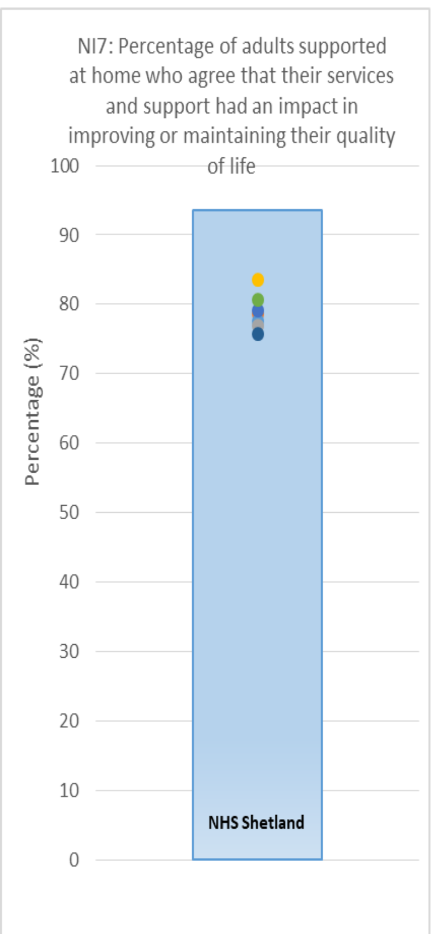


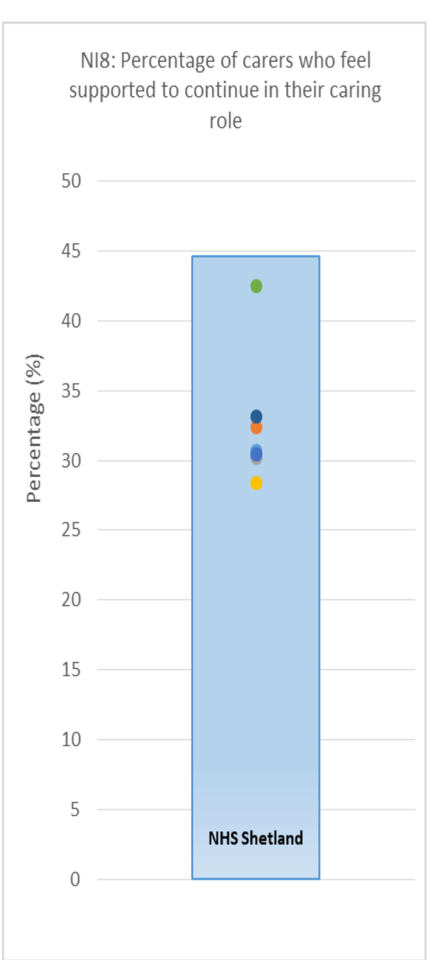


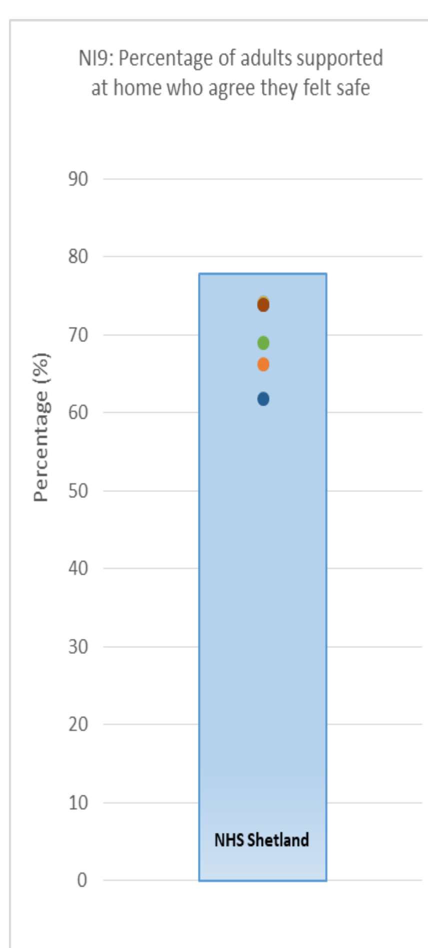


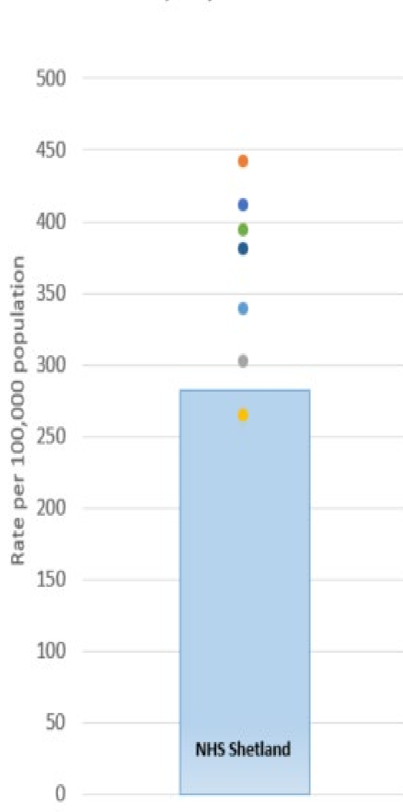


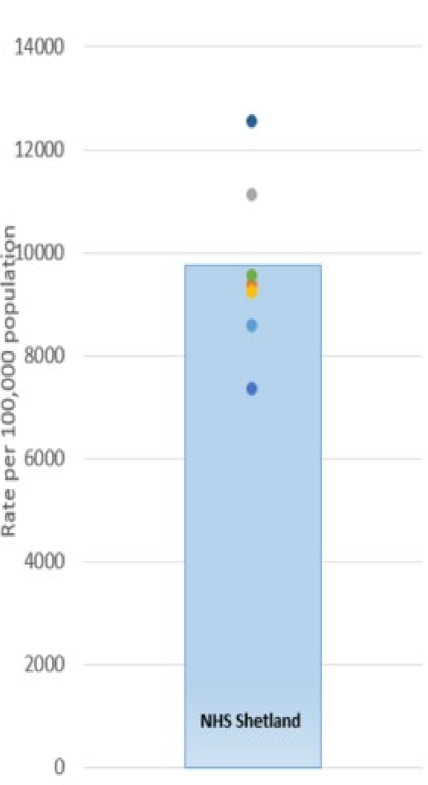

NI6: Percentage of people with positive experience of care at their GP practice
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland

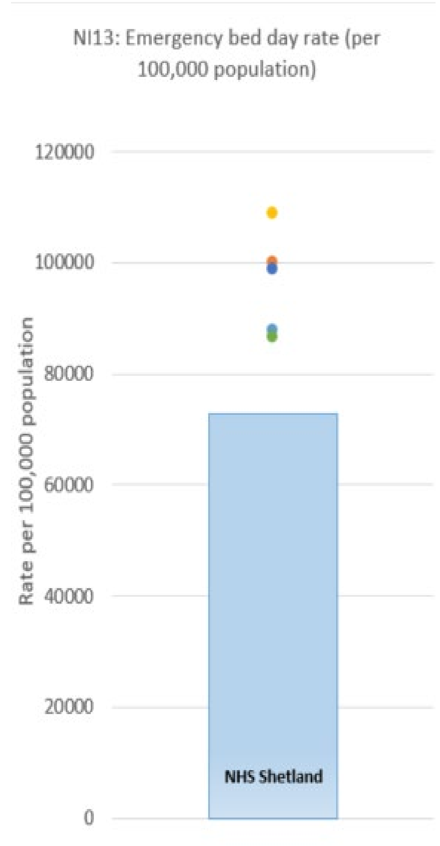

NI7: Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
Percentage (%)
100
90
80
70
60
50
40
30
20
10
0
NHS Shetland

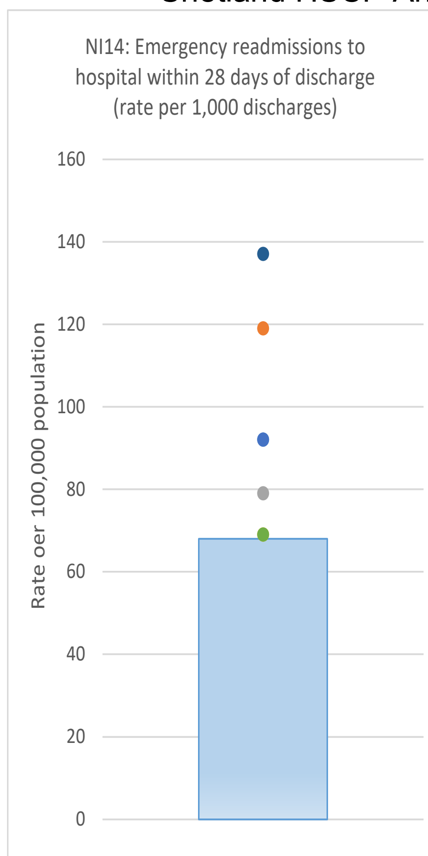

NI8: Percentage of carers who feel supported to continue in their caring role
Percentage (%)
50
45
40
35
30
25
20
15
10
5
0
NHS Shetland

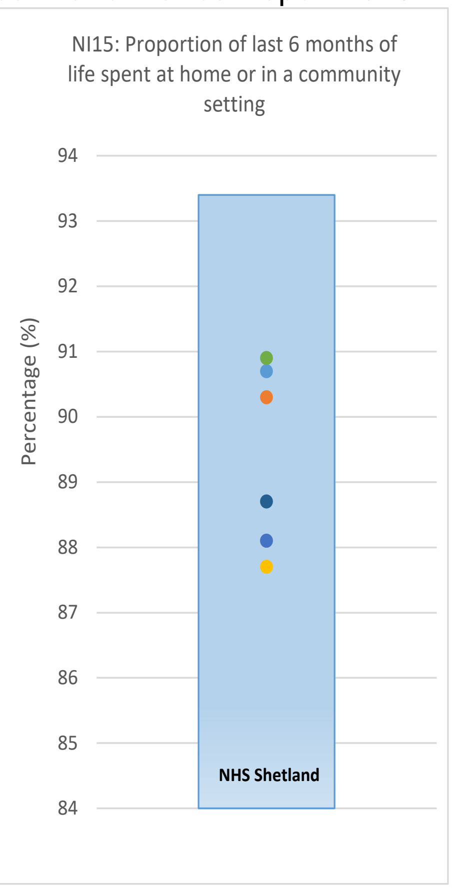

NI9: Percentage of adults supported at home who agree they felt safe
Percentage (%)
90
80
70
60
50
40
30
20
10
0
NHS Shetland

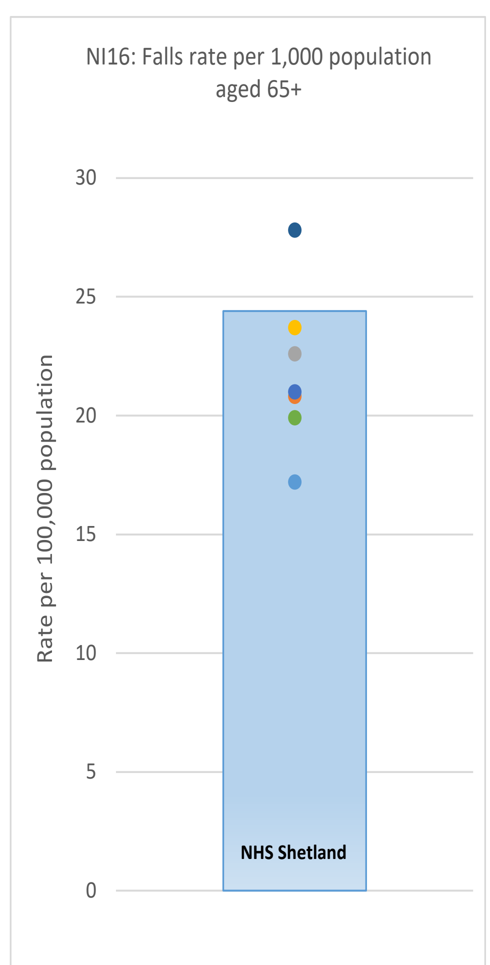

NI11: Premature mortality rate per 100,000 persons
Rate per 100,000 population
500
450
400
350
300
250
200
150
100
50
0
NHS Shetland

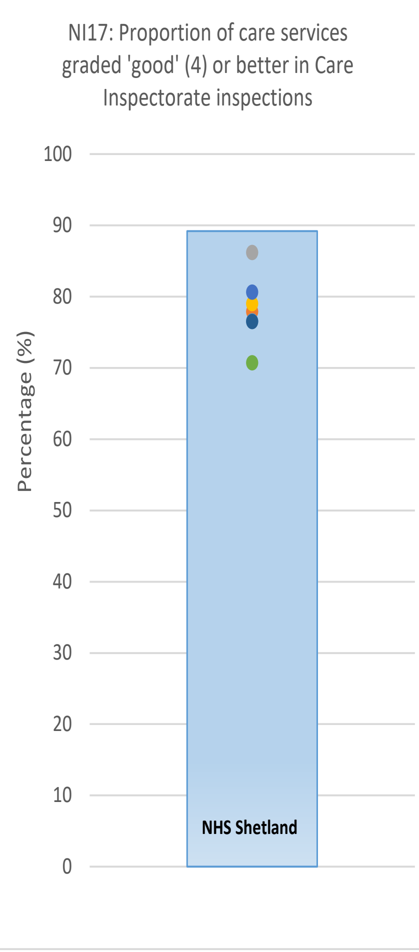

NI12: Emergency admission rate (per 100,000 population)
Rate per 100,000 population
14000
12000
10000
8000
6000
4000
2000
0
NHS Shetland

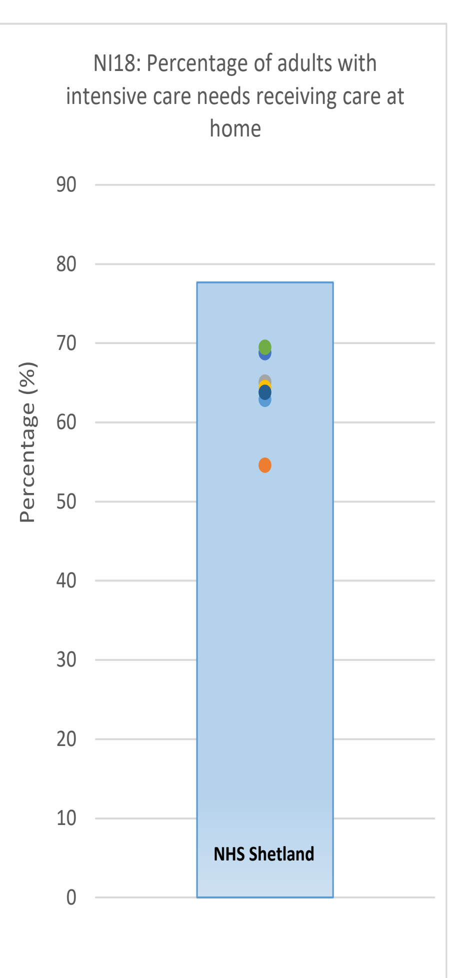

NI13: Emergency bed day rate (per 100,000 population)
Rate per 100,000 population
120000
100000
80000
60000
40000
20000
0
NHS Shetland

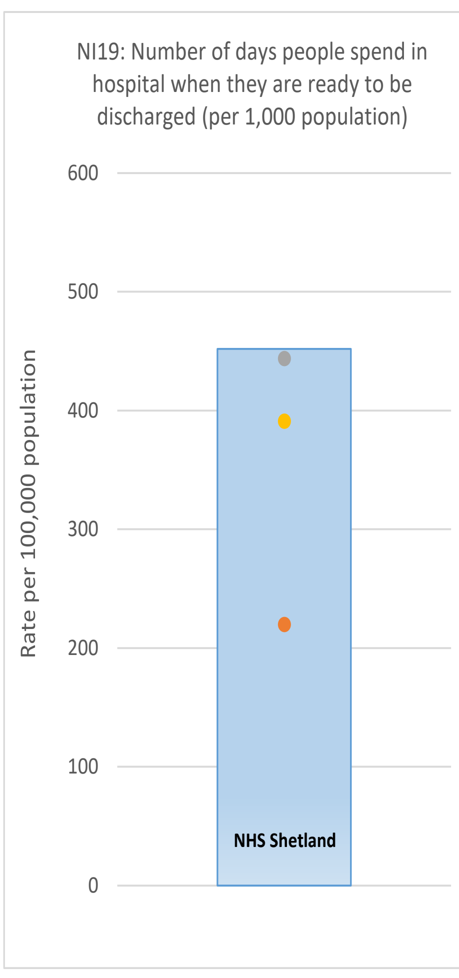

NI14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)
Rate oer 100,000 population
160
140
120
100
80
60
40
20
0


NI15: Proportion of last 6 months of life spent at home or in a community setting
Percentage (%)
94
93
92
91
90
89
88
87
86
85
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 (%)
90
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