NHS Shetland

Meeting:	**Shetland NHS Board Meeting**
Meeting date:	**19 November 2024**
Title:	**Public Health Annual Report 2023-24**
Agenda reference:	**Board Paper 2024/25/45**
Responsible Executive/Non-Executive:	**Dr Susan Laidlaw, Director of Public Health**
Report Author:	**Dr Susan Laidlaw, Director of Public Health**

1 Purpose

This is presented to the Board for:

- Support
- Awareness

This report relates to:

- Population Health

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board is provided with an Annual Report

2.2 Background

The core purpose of the Director of Public Health (DPH) is as independent advocate for the health of the population and system leadership for its improvement and protection. This independence is expressed through the DPH Annual Report – an important vehicle for providing advice and recommendations on population health to both professionals and public – providing added value over and above intelligence and information routinely available.

Traditionally we have tried to use the Public Health Annual Report to focus on specific topics of relevance to Public Health – either a topic such as tobacco, a setting such as workplace, or a community of interest such as older people or people within the community justice system. Last year's report focused on climate change.

2.3 Assessment

This year we have focused on 'Prevention' Preventing disease and ill health not only reduces suffering, distress and premature deaths but decreases demand on health and care services and costs less than treating disease. We could prevent much disease and poor health outcomes through improving the basic building blocks of health: income, good housing, meaningful (and safe) occupation, education, environment, equity, freedom from violence and abuse, inclusive communities and good relationships. But as well as focusing on the underlying social and economic determinants of health, there is a significant role for health and care services. For example, vaccination is an example of a highly effective primary prevention activity delivered by health services. And health and care professionals have a role in advocating for social and economic improvements, and in supporting and empowering their patients to change behaviours that impact on health.

There is work underway within NHS Shetland, in individual teams and organisationally, supporting the shift towards prevention, but this is not on a large enough scale, or in a coordinated enough way, to have a real impact on health outcomes and future demand on our services. We could amplify our impact through a shift in ways of working and approach in our whole workforce. We want to move towards having a prevention-focussed workforce – where everyone plays a role in 'Team Public Health'. The report looks at the barriers and challenges to working in a preventative including where there are inequalities, and how staff, services and organisations can change ways of working, illustrated by a set of scenarios.

The second part of the report looks at some of the key demographics and disease prevalence figures for the past year.

The third part looks at some of the main activities undertaken by the Public Health Directorate and the final part will link to a set of more detailed topic specific annual reports produced by the Directorate as these are published.

2.3.1 Quality/ Patient Care

The teams that deliver patient facing services or work with the general public undertake feedback and evaluation from the service users, some of which is included in the separate topic specific annual reports; and there are clinical governance processes in place for these services.

2.3.2 Workforce

The workforce within the Public Health Directorate has recently increased as the Board's Information team has moved into the Directorate. We have filled vacancies over the past year but are still short of senior public health expertise, with a consultant vacancy. Some of the teams within the Directorate are very fragile because they are small (sometimes single handed) and / or subject to short term funding and Scottish Government funding cuts.

And also, as highlighted in the Report, prevention has to be a way of working embedded across the organisation and within partner organisations - the workforce is not just those employed in the Public Health Directorate.

2.3.3 Financial

The Public Health Directorate remains within budget and year on year the teams have made savings usually because of vacancies. However as noted in the Report, wider investment in preventative work is required if we are to genuinely make a difference to population health.

2.3.4 Risk Assessment/Management

There is a major risk that the organisation will not have the capacity to manage future demand if there is not sufficient investment in preventative and population based work, to reduce ill health and inequalities.

2.3.5 Equality and Diversity, including health inequalities

Tackling inequalities is a theme which underpins and runs through our public and population health activity. The aim remains to protect and promote the health of the most vulnerable and disadvantaged within our community.

2.3.6 Other impacts

NA.

2.3.7 Communication, involvement, engagement and consultations

No communication and consultation has taken place prior to submission to the Board.

2.3.8 Route to the Meeting

This report was not considered by other committees prior to submission to the Board.

2.4 Recommendation

- **Support -**
- **Awareness -**

3 List of appendices

The following appendix is included with this report:

- Appendix 1 : Director of Public Health Annual Report 2023-24

NHS Shetland
Public Health Annual Report
2023-24

“Prevention is better than cure”

Desiderius Erasmus c1500

Forward

This is my fourth Annual Report as Director of Public Health for Shetland and as in previous years, I have focused on a theme of public health significance - prevention.

'Prevention is better than cure' is attributed to the Dutch scholar, Desiderius Erasmus, in about 1500. The quote still holds true 500 years later. Preventing disease and ill health not only reduces suffering, distress and premature deaths but decreases demand on health and care services and costs less than treating disease. This is illustrated in the 'Fence on the Hill' story, again nothing new: this story is based on a poem written by Joseph Malins in1895!

To understand how we can prevent ill health, we need to know what causes it in the first place. Often it is a combination of factors, all or some of which may be preventable, and others are not. But even if we know what preventative action we need to take, it is often much easier said than done. We could prevent much disease and poor health outcomes through improving the basic building blocks of health: income, good housing, meaningful (and safe) occupation, education, environment, equity, freedom from violence and abuse, inclusive communities and good relationships. Legislation can help to protect the population's health through prevention, especially children and young people. For example car seats and seat belts, smoking and alcohol restrictions, consumer safety regulations. Health and care services cannot tackle these issues, but can advocate for our population and push for fundamental change.

We do, of course, have many evidence based interventions for preventing disease that are within the remit of health services. A primary example is vaccination, which is second only to clean water as being the most effective public health intervention to prevent disease. In the UK we have population based and risk based vaccination programmes against 30 different infections; preventing serious illness, lifelong disability and death from infectious diseases. The HPV vaccination programme prevents cervical and other cancers.

Other preventative work includes helping people to change behaviours that may harm health such as smoking, drinking alcohol and inactivity. And if we can't prevent health problems developing, we can try to identify them early and reverse or stop them getting

worse. For example, identifying and treating high blood pressure, and pregnancy and newborn screening.

Although there have been significant successes in reducing preventable illness, disability and premature death, there is considerable scope to improve further. We continue to see an increased demand for health and care services, with rising costs. I believe there are two main issues: firstly insufficient investment in preventative activity at all levels, with an inability to shift resources from dealing with poor outcomes to preventing them. And secondly, inequity of access to preventive activity, whether that is good housing, healthy diet, smoking cessation services or vaccination.

Prevention and reducing inequity are fundamental drivers for the Public Health Directorate. But our work alone is not enough to make significant differences. We need health and care services, and our partners and communities to continue shift to a preventative approach if we are to transform the health experiences and outcomes of our population.

I would like to thank all the public health staff, our colleagues across NHS Shetland and partner organisations and our communities for all their hard work so far towards achieving our aims of improving health outcomes and reducing the health inequalities gap. As I said last year, this is not easy work and there are no quick fixes. It takes perseverance and courage to commit to long term change.

This report is split into four parts:

- Prevention
- Population Health Data for 2023-24
- Summary of Public Health activity in 2023-24
- Appendices: other annual reports produced by the Public Health Directorate

I hope you find this report informative and we welcome any feedback to help improve the next annual report.

Dr Susan Laidlaw
Director of Public Health, NHS Shetland

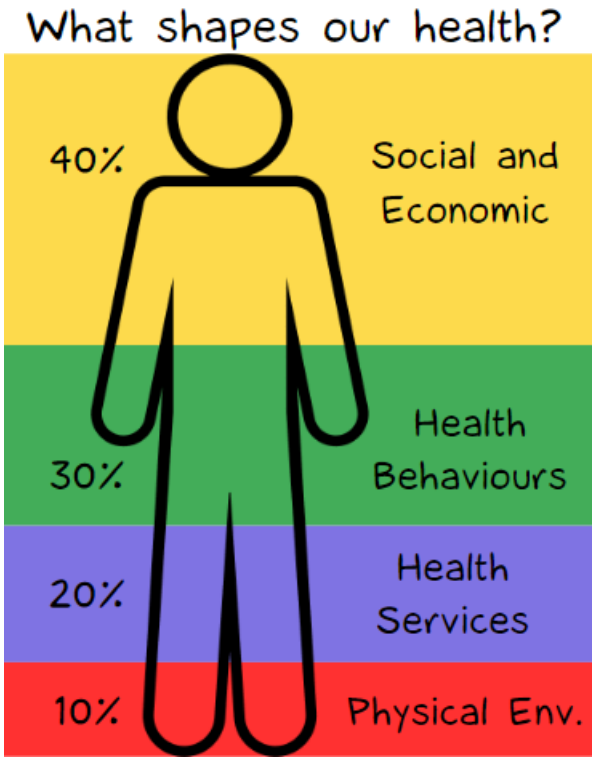
Acknowledgements

Thank you to the Public Health Directorate staff for their work on producing this annual report, in particular Nicola Balfour, Lucy Flaws, Fiona Hall, Nikki Hammerton, Melanie Hawkins, Kathleen Jamieson, James McConnachie and Katie McMillan.

Contents

Section 1 Prevention

The focus of this year's Public Health Annual Report is prevention. A shift towards prevention and early intervention to support better outcomes for people is a long established aim of NHS Shetland, Shetland Health and Social Care Partnership (HSCP) and the Shetland Partnership, but making progress is proving challenging.



To understand how we can prevent ill health, we need to know what causes it in the first place.

The illustration above shows the biggest influences on our health are the underlying social and economic determinants - such as income, good housing, meaningful (and safe) occupation, education, inclusive communities. The next biggest influence is from our health behaviours -such as physical activity, diet, smoking and drinking alcohol. (However health behaviours are themselves influenced by social and economic factors and environment). Health services have less impact but must be value based and prevention focused to maximise impact. Environment is less influential, but still important in determining health outcomes and can impact on all the other factors.

What is prevention and why is it important?

Public Health Scotland (PHS) describes prevention as “keeping people healthy and avoiding the risk of poor health, illness, injury, and early death”.

Preventing disease and ill health not only reduces suffering, distress and premature deaths but decreases demand on health and care services and costs less than treating disease. This is illustrated in the ‘Fence on the Hill’ story, based on a poem written by Joseph Malins in1895, which have used in previous annual reports.

The Fence on the Hill

Once upon a time there was a town in a valley, a valley surrounded by high, steep mountain cliffs. The town was renowned for the magnificent views available at the top of these cliffs, and many a visitor and local would risk the climb for a glimpse of the scenery. Unfortunately it was not unusual for visitors and locals alike to slip from the cliff’s edge; the view was quite literally breathtaking.

Debate raged among the community; *something* would *have* to be done. One idea that proved popular was to place an ambulance at the bottom of the cliff. That meant that any time someone fell the ambulance would be available to rescue them from their plight.
Why stop at one ambulance? Would it not be more effective to have a fleet of ambulances so they would always be ready to whisk away the wounded? State of the art, fully equipped ambulances that could rush like the wind to the nearest hospital.
Many townspeople were enthused by the idea, but had to think about ways to pay for this venture. Some proposed grant applications, others turned to government at local and national levels, others planned collections and fundraisers.

“Excuse me.”
A voice slid through from the back of the crowd.
“Ahem, ex*cuse* me…what about a fence?”
“What *about* a fence?” snapped an elder, contemplating a cluster of coffee mornings.
“We could build one.”
“What ever for?”
“Well, if we were to put up a fence along the cliff top, wouldn’t that stop folk falling down in the first place?”

A thoughtful silence became furious uproar. What a ri*dic*ulous idea! Why, it made a *mockery* of all the plans to raise the *huge* funds necessary to raise a *fleet* of ambulances to rescue all those that had fallen…oh.[1]

There are three recognised types of prevention; primary, secondary and tertiary prevention.

Primary prevention involves direct action to stop problems happening at all, this may be population level action, or action targeting the cause of a problem. This includes:

- Improving working, living and growing conditions
- Reducing risks associated with lifestyle, and
- Preventing infectious disease.

Secondary prevention focuses on early intervention and treatment of a problem, eg:

- Screening services for some types of cancer
- Health visitor checks in a child's early years
- Medication such as statins to reduce cholesterol which reduces a person's risk of developing a long-term condition

Tertiary prevention is action to reduce the harm caused by a health condition through management. This includes:

- Support with changes in diet or foot care for people living with diabetes
- Rehabilitation for people who have experienced a stroke
- Emotional, income or peer support for those living with a long-term condition or cancer diagnosis.

As shown below, primary preventative actions such as vaccination or the smoking ban have the biggest impact on the health of the whole population as the focus is on stopping the problem from happening in the first place. Secondary and tertiary prevention focus on reducing the impact of a problem through early detection and/or good management of the problem, so are much more focused on individual people.

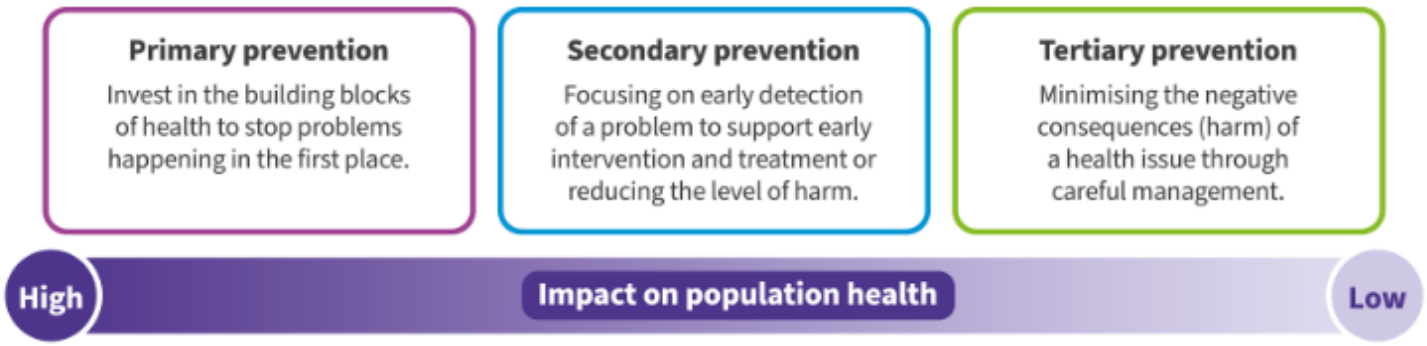


Figure 1: Three levels of prevention

Currently, most discussion around prevention focuses on finding people with health problems early and stopping the problem getting worse (secondary and tertiary prevention), which is a barrier to investing in the full range of prevention needed to improve the health and wellbeing of the people of Scotland. The best way to improve health outcomes in people is to prevent them from developing a problem in the first place by investing in primary prevention. Although this often means focusing on the underlying social and economic determinants of health, there is a significant role for health and care services. For example, vaccination is an example of a highly effective primary prevention activity delivered by health services. And health and care professionals have a role in advocating for social and economic improvements, and in supporting and empowering their patients to change behaviours that impact on health.

Primary prevention is also the most cost-effective method of prevention, but still requires investment. The cost of each additional healthy year due to preventing the progression or reducing the harm cause by a health condition through treatment (medication, lifestyle change) is around three times as much as the cost of preventing someone developing the problem in the first place (vaccination, support in living a health life).

Scotland's population is expected to fall by 2043 but the level of illness is expected to increase by 21%. This trend will combine to create greater demand for health and social care. There is strong consensus that a preventative approach is needed across healthcare and the wider system. We understand the importance of focusing on prevention in our public services and the need to invest in prevention in Shetland.

Prevention in action

Prevention and early intervention have long been shared ambitions across public services in Shetland. However, there are real challenges in moving towards prevention particularly when resource and attention, both internal and external to our organisation are focussed towards treatment and acute care. This is similar to the experience of NHS organisations across the rest of Scotland and the UK.

There is work underway within NHS Shetland, in individual teams and organisationally, supporting the shift towards prevention, but this is not on a large enough scale, or in a coordinated enough way, to have a real impact on health outcomes and future demand on our services. While specific targeted programmes and actions (for example Otago

Falls Prevention; 'Why Weight?'; breastfeeding support and parenting programmes) have an important role in prevention, we could amplify our impact through a shift in ways of working and approach in our whole workforce. We want to move towards having a prevention-focussed workforce – where everyone plays a role in 'Team Public Health'.

"The doctor of the future will give no medication, but will interest his patients in the care of the human frame, diet, and in the cause and prevention of disease."

Thomas Edison 1903

For some people and groups it can be easy to be prevention-focussed – they may find it easy to identify, access and use health information and support, and engage with any advice or interventions offered. These people and groups are more likely to have positive health outcomes due to their life circumstances. Relying on prevention activity that requires individuals to take the first step in accessing what may support them means we increase the gap between those who find it easy to access and engage and those who find it more difficult for a variety of reasons.

In every interaction we offer and have with people we are shaping their health and life outcomes – we impact how people see themselves, how they interact with services, and whether their story is heard or understood. For many people moving through our systems no extra support is needed – but we do not know who might benefit, and there is little or no cost to taking a prevention focussed approach in our day-to-day interactions.

It can be very challenging to support people (and organisations) to take action to prevent something that may happen in several decades time, or indeed may never happen. And of course sometimes there is very little or nothing that can be done to prevent some health conditions or prevent progression. We can however help people to understand risk: in health terms, prevention is more likely to be about reducing the risk of an illness for most of the population, than preventing it for everyone.

Team Public Health - what can I do?

In Shetland people's lives are being cut short, and they have poorer health, because we don't all have the same opportunities to live healthy lives. We are working with partners to try and mitigate and undo this lack of opportunity, and in the meantime there is more we can do to tackle these unfair differences in health outcomes.

These things we do well add **value to patients**, improve their experience and their outcomes going forward; they add **value to our services** by stopping unnecessary demand; and they add **value to Shetland** by building a fairer community where everyone is doing well and is able to thrive. Investing more time and attention now, in the people who can really benefit, can make a huge difference for all of us in the longer term.

The NHS was never made to go it alone: things are getting more challenging, with a changing population, changing disease and illness, and challenges for services. We need to do things differently to be able to provide services long into the future. A lot of this change will be about how we organise services, but a big part is also in what each of us does to add value to our patients and service users. We want to make sure any change is for the best for our communities and the best investment of time and attention is by preventing things happening in the first place, wherever we can.

These changes are often small, but can be hugely impactful. It can be hard to see the value of them, or to reflect and understand where you could make a different choice to build better outcomes. We are going to share five profiles to help consider people and situations where doing things differently can have a significant and lifelong impact. We will consider steps you could take as a team member, steps a whole team or service could take, and steps we could take as a whole organisation that could make a difference. There are also steps service-users can take and we, as services, can support them in that.

As a service user

Think about feeding back about your experience – this is powerful and helps people and services to learn

Ask questions to help you make the right decision for you, a good start is 'BRAN':

What are the **benefits**?

What are the **risks**?

Are there any **alternative**s?

What happens if we **do nothing**?

As a person who works with people

Consider communication – is your language inclusive, non-judgemental and supportive?

Consider your approach – do you get to the root of the issue, and do you feel able to ask about money, worries at home, work, etc?

Learn how you can connect people to the other support they need – build bridges between services and support.

Consider trauma-informed practice training, stigma awareness, and motivational interviewing.

As a manager/decision maker

Understand your population, and plan for the future.

Consider access to your service – does your data and information tell you everyone who needs support is able to access it?

Do policies, processes and communication support access or reinforce barriers?

Do you know what people's experience of your service is?

Consider undertaking the Trauma Lens.

There are different ways of thinking about inequalities one common analogy is that we may all be in the same storm but we are all in different boats – some may be super yachts, some small rowing boats, some have engines, some might have no oars. People experience things differently, and have different capacity and potential to meet challenges. We are all navigating our way through life, trying to stay afloat, avoiding obstacles where possible, to reach our milestones and eventually our ultimate goals. We all need access to the things that help us navigate that journey.

Some things are outside of our control, similar to how we can't always predict the weather we don't always know when we might fall ill, or be injured; we can't always avoid the "storm". We try our best, but we can't always avoid the obstacles either: accidents, injuries or ailments happen. When we hit those obstacles, we often rely on services to help keep us afloat, throw us a lifeline, or help us rebuild the boat to get back on our way. The way this help is provided might get us past the immediate problem, or it can be provided in a way that makes us stronger and more resilient the next time we encounter a challenge ie preventing future challenges or harm.

Sometimes however, even with the best intentions, interactions with individuals, services and organisations actually only serve to weigh us down. Sometimes they even create greater barriers and obstacles along the way making it more difficult to thrive and overcome future challenges.

Having a person-centred approach, taking the time to understand and respond to what really matters to an individual can help people to get the most benefit from their interactions with our services and support them to have improved outcomes in the future by building their capacity and resilience. This can mean looking beyond the problem a person is presenting with to understand what might have caused the problem in the first place, as often if we don't address the cause any problem could occur again. Addressing these root causes might mean helping people to access other services or supports.

The scenarios provided below are fictional – they are not perfect and suggestions given are not-exhaustive – different people have different needs and no single approach will work for everyone with a condition or circumstance. However, they serve as a starting point to consider what can we all do to prevent illness, and prevent poor outcomes.

Scenarios

1. Pregnant woman - aiming to prevent serious life threatening illness and hospitalisation in the mam and the baby through vaccination.
2. Unpaid carer with chronic pain – aiming to prevent worsening pain resulting in increased use of health services, not being able to care for parents, or not being able to work.
3. Person with type II diabetes – aiming to prevent the complications of diabetes such as cardiovascular disease, eye problems, foot problems; even potentially reverse diabetes.
4. Older person developing frailty - aiming to prevent falls, hospitalisation, exacerbating other health conditions; and promote independence.
5. Person with alcohol dependence – aiming to prevent the complications of alcohol dependence such as liver disease, dementia, cardiovascular disease, mental health problems, impact on relationships and work.

Pregnant person due vaccinations

28 year old woman

16 weeks pregnant

Single Mum who has a 4 year old daughter

Not been in paid employment since daughter was born

Limited support with childcare

Has some difficulties with reading and writing

New to area – has struggled to make friends or meet other mums

Barriers to access/outcomes:

Limited childcare options – doesn't like taking daughter into appointments as feels judged if she doesn't sit quietly

Literacy issues – doesn't like telling people but finds it hard to read and write for filling in forms etc

Limited transport options

Money worries – gets some benefits

Limited social support – no parenting role models

What YOU can do

Complete relevant training and sign PDGs so you are able to provide what the person needs when they are ready

Be person-centred and non-judgemental - ask sensitively about any problems with reading or writing, and money worries to better understand circumstances.

Offer appointments at a time and location to suit e.g. to fit in with bus and nursery times

Discuss recommended vaccination schedule at every opportunity from booking appointment and ensure vaccine and resources are available in a format that works for the individual

Support access to other services as needed – understanding barriers to first access.

What a SERVICE can do

Have vaccines and consumables available in all clinics and display resources, e.g. posters in waiting rooms

Oversight of training and PGD completion for team

Monitor and record uptake for vaccination programmes to understand who is missing out

Have connections with other services and agencies, e.g. parenting classes, CAB

Make appropriate spaces child and parent friendly

What an ORGANISATION can do

Coordinating with other services and programmes e.g. pharmacy, porters

Maintain close links with national teams

Have robust governance and reporting structures in place

Person living with chronic pain who also provides unpaid care

46 year old woman, lives with partner and 2 teenage kids.

Has pain in both knees for 18 months which is starting to make walking difficult and is sore when sitting too long at work.

Works 4 days a week as an accountant and helps look after parents who live nearby – dad has Parkinson's disease and mum has Dementia. Both manage ok at home, but need help looking after the house and managing shopping, medication and appointments.

Barriers to access/outcomes:

Lack of time to prioritise herself for usual self-management activity/advice.

Doesn't like asking for time off for appointments for herself as already off occasionally for mum and dad.

Doesn't want to reduce working as is main earner in house, both kids planning to go away for university.

Previous consultation with orthopaedics – hasn't been able to lose weight or "get fitter" as instructed so doesn't want to go back – feel pain is her own fault.

What YOU can do

Patient-centred assessment – including understanding circumstances.

Take time to understand what kind of intervention or treatment might be realistic and beneficial, support engagement with these recognising barriers.

Understand support available to carers (practical, financial and social) and be able to connect with local support options.

What a SERVICE can do

Offer appointments flexibly to fit with work and caring responsibilities.

Have meaningful connections with other agencies and services locally to facilitate teams in making connections, referring on, and supporting access.

Have advice and information available in flexible, accessible formats, making use of technology where appropriate – e.g. online support at flexible times.

Review approach to non-attendance or non-engagement where this is disadvantaging people

Consider unpaid carer needs when supporting people who need care or assistance.

What an ORGANISATION can do

Support evidence-based best practice by ensuring time for development and CPD, and appropriate professional supervision.

Support the delivery of patient centred approaches by having adequate ICT and support systems in place for staff.

Support positive attitudes to health in other employers e.g. through partnership relationships.

Be a carer-friendly employer to support staff in similar circumstances.

Person with Type II Diabetes

48 year old male Lives with partner and 2 children

Diagnosed with Type 2 Diabetes 6 months ago, started medication (metphormin)

Sedentary lifestyle, family history of diabetes

Stressful management job with long hours and little control over these.

Hasn't given much thought to weight in the past

Barriers to access/outcomes:

Low confidence in being more active

Demanding job, difficult to find time for own needs.

Limited social support.

Family time revolves around meal times and unsure on making changes to whole family time.

Well paid job but worries about the future for family if he becomes unwell.

Doesn't like asking for time off work for medical appointment as it is "just diabetes" and he'll need to live with it forever.

What YOU can do

Patient centred, offer support that meets their needs. This could be undertaking some education e.g. 'Control IT' education programme to build confidence in understanding of condition.

Provide appointments that suit the patient, e.g. video appointments to fit into work schedule.

Have resources available in a variety of formats e.g. easy read or other languages

Give time to build relationship and understand the issues being faced.

What a SERVICE can do

Evidence based support, utilising all available options such as supporting use of new technologies.

Work with key partner agencies to support use of local facilities such as SRT

Have appropriate equipment such as scales and monitors.

Monitor and evaluate programme in line with quality improvement.

What an ORGANISATION can do

Coordinating with other services and programmes e.g. specialist nurses, pharmacy, GP

Maintain close links with national teams and keep up to date with new evidence.

Have robust governance and reporting structures in place

Support the delivery of patient centred approaches by having adequate ICT and support systems in place for staff.

Support positive attitudes to health in other employers e.g. through partnership relationships.

Person with falls and developing frailty

78 year old woman

Previous fall requiring hospitalisation

Lives alone in her own house.

Received care after initial fall, no formal ongoing care in place, neighbours look in on her and help with shopping.

Grown up children who do not live nearby

Barriers to access/outcomes:

Dealing with multiple long term conditions

Waiting on hip replacement – in chronic pain.

Limited transport options

Money worries living on single pension

Social isolation/loneliness

Low confidence

Worried about safety and falling again

Struggles to pay for heating so keeps it off as much as possible

What YOU can do

Understand what is available to them to access, this may be a referral to a social support as well as medical.

Whole person approach, including asking about money and finances, then providing the individual with the information they need to make choices.

Understanding their circumstances will impact their health.

Provide appointments at a time and location that suits the patient, this may be aligning with other services they access or appointments they travel to so they can make fewer trips.

What a SERVICE can do

Understand the challenges faced by patients, be flexible and go at their pace.

Ensure that services offered meet best practice standards, when working with partner agencies having a shared learning and development agreement.

Support partner agencies, keeping the individual at the centre of activity, taking opportunities to understand and act on challenges, including with information sharing

Have information available in an accessible format.

What an ORGANISATION can do

Provide equitable services

Develop supportive and realistic information sharing agreements with partner agencies.

Be supportive of teams working in a person-centred way.

Be aware of the challenges faced by these groups and proactively engage to improve services.

Person with Alcohol Dependence

It is not all about choices-two people who drink more than the recommended units will have different impacts on their health-the outcome is predicted by how much money you have, not by what you do. These unfair differences are health inequalities.

Barriers to access/outcomes:

Stigma – "I don't deserve help, I just need to change", "they choose to drink-I'll help them when they try harder", "they're costing the health service because they make poor choices"

Assuming drinking is the root cause of all problems, or not asking, because they don't look like they are dependent on alcohol.

Mental load of navigating services if need more than one input.

Trauma, trust and fear.

Time to travel and attend appointments around parenting and caring.

Service expectations or understanding of needs "they did not attend, they must not need/want support"

Anonymity or confidentiality-worries about being seen to access certain services and what that might mean for family.

What YOU can do

No judgement, no stigma-curious, caring enquiry and a whole person, whole family view

Support into other services where needed.

Understanding what is available in the system-of helping to find out and navigate

Take responsibility-support people to get what they need even if it is not you (be the link or connector)

What a SERVICE can do

Be flexible and responsive to what the person needs – even if that doesn't fit with usual protocol. Give clinicians/individuals room to be responsive.

Work together across services – appropriate information sharing, guiding and supporting access, joint planning

Consider stigma in team training, reflection and supervision.

Trauma Lens for service access-may include missed appointment policies, where and who we see, etc.

What an ORGANISATION can do

Have clear values and expectations around stigma

Visibility and engagement with destigmatising activity, for example presence at awareness and community events.

Equitable engagement across inequality challenges

Expectations of management and leadership to be active bystanders

Availability and prioritisation of stigma and trauma training.

Bibliography and Further Reading

What is prevention? - Public health approach to prevention - What we do and how we work - About us - Public Health Scotland

Prevention Rather Than Cure | The King's Fund

A Vision For Population Health | The King's Fund

Health inequalities | The Health Foundation

Tackling Health Inequalities | Seven Priorities For The NHS | The King's Fund

Health Equity in England: The Marmot Review 10 Years On - The Health Foundation

Section 2 Population Health Data 2023-24

Population estimates

The population of Shetland Islands is **23,020.**

This is an **increase of 0.3%** from 22,940 in 2021.

Population structure

The 0-15 year age band has seen the biggest decrease over the last 20 years, **-9.1%.**

The 65-74 year age band has seen the biggest increase over the last 20 years, **60.3%.**

Life expectancy at birth

Life expectancy at birth in the Shetland Islands is higher for females than males

Male

79.4 years

Female

83.7 years

Over the last ten years life expectancy has **increased by 2.1%** among males and **1.3%** among females.

Healthy life expectancy at 65 years*

Healthy life expectancy at 65 in the Shetland Islands is higher for females than males

11.0 years

Over recent years healthy life expectancy at 65 has **increased by 2.6 years** among females and **decreased by 0.77 years** among males.

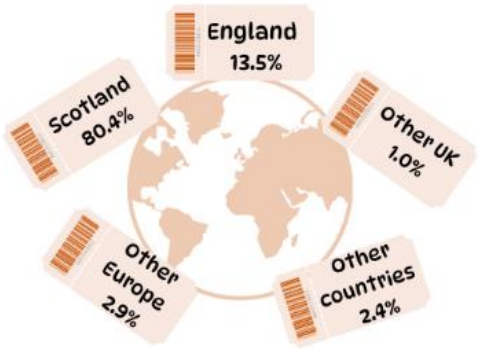
14.5 years

*there is no update on this data since the previous annual report

Scotland's Census

Almost 30% of households have dependent children, with the majority of these being households of those aged 35-54 years.

The majority of households have one person living in the household. While very few households had 5 or more people living in it.



The majority of the population were born in Scotland. Less than 3% were born in Europe (outside the UK) and 2.4% were born in countries outside Europe.

Almost 95% of the population are able to speak, read ande write English.Speaks, reads and writes

English language skills

Over 90% of the population are hetrosexual/straight and over 2% are gay/lesbian or bisexual

Births and deaths

The birth rate in the Shetland Islands is **7.7 per 1,000** population.

This is an **decrease** from 9.0 per 1,000 population in 2022.

The death rate in the Shetland Islands is **10.9 per 1,000** population.

This is a **increase** from 10.0 per 1,000 population in 2022.

Premature mortaliity

The rate of premature mortality in the Shetland Islands **fallen by 22.2%** to **282.3 per 100,000** population in 2022.

It has **decreased by 20.1%** among males, and **by 24.9%** among females.

Cancer - premature mortality

The rate of premature mortality due to caner in the Shetland Islands has **decreased by 43.3%** to 90.8 per 100,000 population in 2022.

Circulatory disease - premature mortality

The rate of premature mortality due to circulatory diseases in the Shetland Islands **decreased by 9.1%** to 69.7 per 100,000 population in 2022.

Respiratory disease - premature mortality

The rate of premature mortality due to respiratory diseases in the Shetland Islands has **increased by 51.2%** to 12.7 per 100,000 population in 2022.

COVID-19 - premature mortality

The rate of premature mortality due to COVID-19 in the Shetland Islands has **decreased by 1.2%** to 8.3 per 100,000 population in 2022.

Joint Strategic Needs Assessment

The population is predicted to **decline** by **2.8%** between 2020 and 2035.

Child poverty has been consistently **lower** than Scotland but there is an **increasing trend** since 2014/15.

Hypertension was the most **prevalent** long term condition, 27.9% **higher** than Scotland.

Recent years have witnessed the **lowest care home occupancy** rate estimates since 2011.

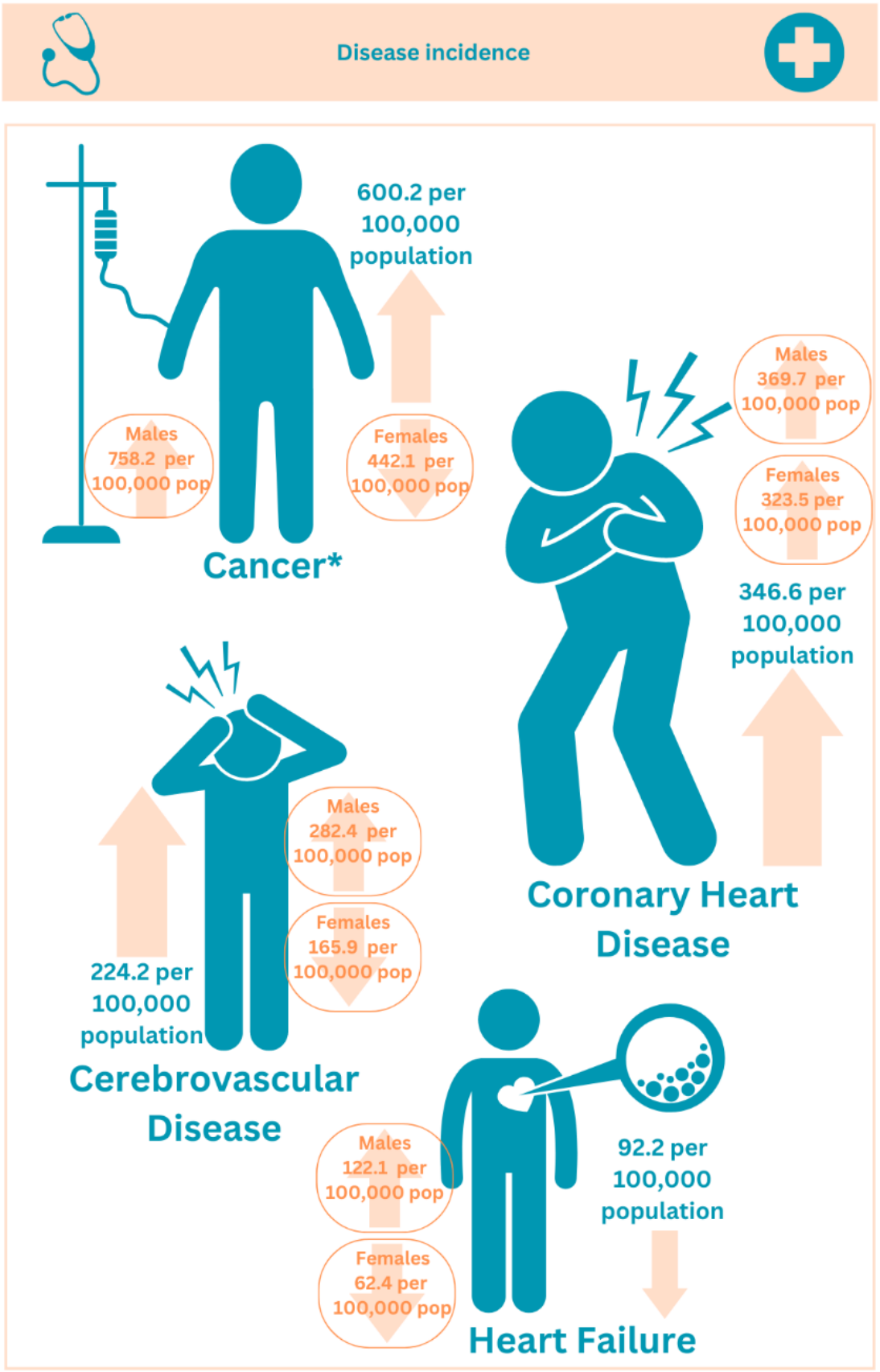
Over half of long stay residents have a diagnosis of **dementia,** 39% **physical disability or chronic illness,** and 46% require **nursing care.**

Average hourly rate for home care in the 5-year period up to 2019/20 was **£37** compared to **£24** across Scotland.

Since 2017/18 an average of **1,124 food parcels** were distributed annually with **1 in 5** given to **children.**

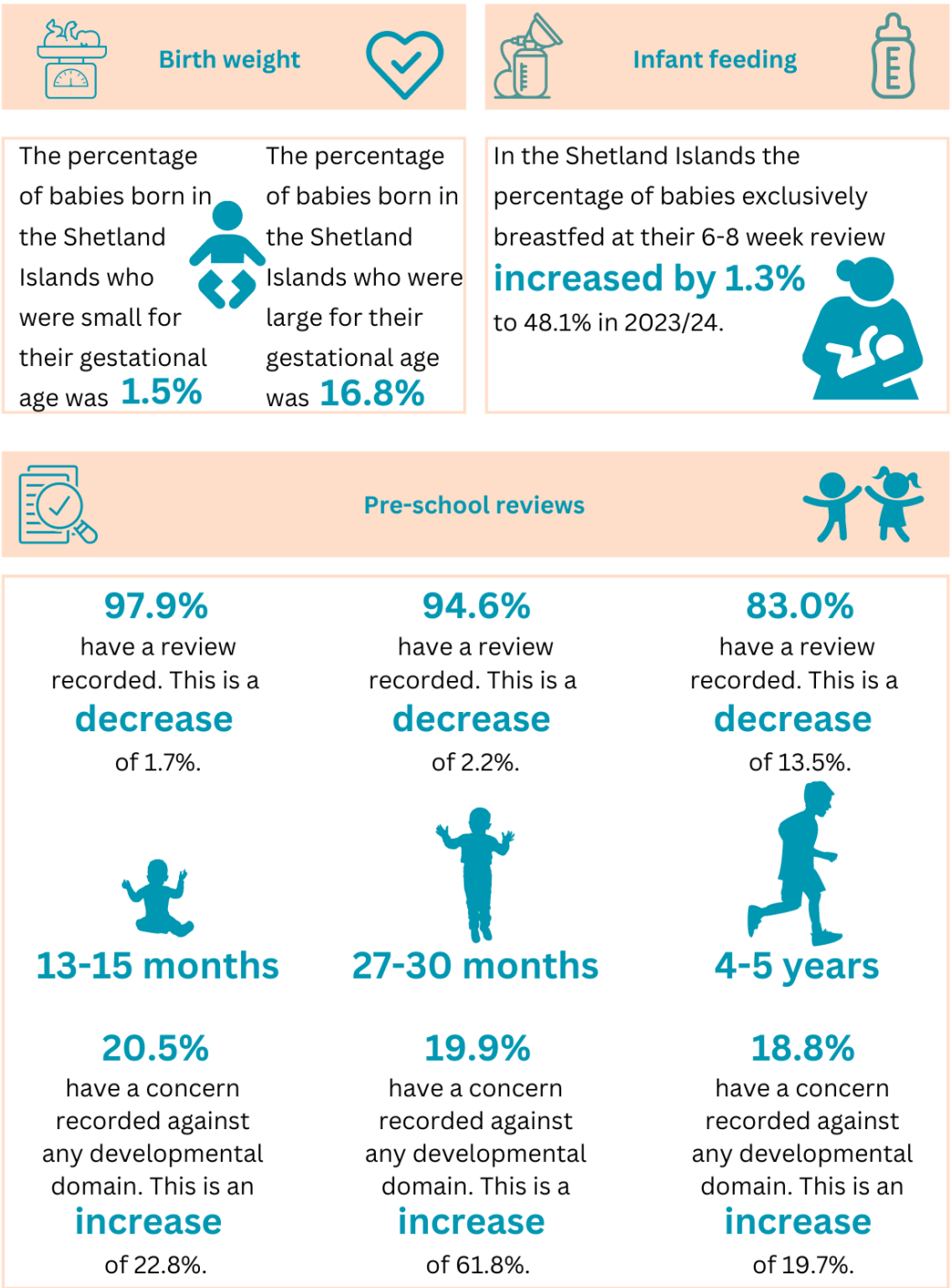
The rate of GPs is consistently **above 1 GP per 1,000 population.** Nationally, the rate is **below 1 GP per 1,000 population.**

Anti-depressant prescribing **increased by 99%** between 2010/11 and 2019/20.



*there is no update on this data since the previous annual report

Children and Young People



For further information on the health and wellbeing of children and young people in Shetland see: Shetland Children's Plan Year Three 2023-24 and annual-child-poverty-action-report-2023-24 .

Section 3 Population Health Activity 2023-24

The teams within the public health directorate have continued to co-ordinate and deliver health protection, population health and health improvement functions. These include preventing and controlling communicable diseases; vaccination programmes; population screening; behaviour change and preventative services; strategic planning; business continuity planning and resilience work; collaborative working with community planning partnership and other partners. In terms of healthcare public health, we led the development of three MCNs (frailty, cardiovascular and respiratory) with a strong focus on prevention and adhering to the principles of Realistic Medicine. This year we have also taken a focus on climate change, which cuts across all our areas of work, both within the Health Board and working with partners, including on a Shetland Climate Change Strategy and raising awareness of the health impacts of climate change.

Health Improvement Programmes

During 2023-24 the health improvement team continued their work throughout Shetland to improve the health and wellbeing of individuals or communities. A key theme is enabling and encouraging healthy choices as well as addressing underlying determinants of health such as poverty, housing, working conditions, educational opportunities and life/work skills. We work with a wide range of partners to influence policy, service provision and wider environmental factors that help support positive health outcomes for our population, especially those in greatest need. We continue to work with partners in the areas of mental health, substance misuse, community justice, violence against women / gender based violence, child poverty and cost of living crisis. In 2023 we undertook a review of our services through the 'trauma informed lens' to support trauma informed practice.

There has been further work publicising and producing bespoke reports from the population health survey completed last year; and this work is being built on to produce a population health needs assessment , due to be published early next year.

There has been significant work during 2023-24 focusing on harm cause by vaping amongst children, including sessions delivered across a number of schools. We also

continue to develop the Health Improvement Practitioner/Community Link Worker model, which we are currently evaluating and a report will be completed early next year. Behaviour change and preventative work has continued through delivery of the Quit Your Way service, Get Started with Healthy Shetland and HENRY programmes, along with awareness raising campaigns and community activities.

In 2023 a project led by Health Improvement Team was completed with the installation of a shelter made of four upturned boats along the Sletts path for patients, staff and the public to use.

Anchors Strategic Plan

We have developed a local Anchors Strategic Plan for progressing NHS Shetland's role as an Anchor Institution in the next three years with the aim of supporting community wealth building (CWB) and reducing inequity and health inequalities in Shetland. The plan covers three main areas for work as an Anchor Institution - as an employer; procurement of goods, services and infrastructure; and land and assets. Environmental sustainability is a fourth area that Anchor Institutions can influence, which links with the other parts of the plan, and we are also progressing through climate change work. A work plan is being developed and the first annual report will be published in 2025.

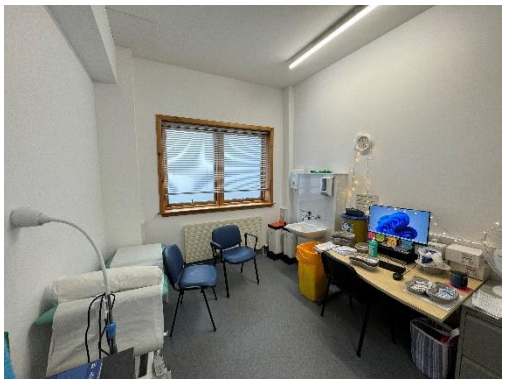
Good Mental Health for All

Good Mental Health for All' is a multi-agency project which aims to develop a refreshed mental health and wellbeing strategy for Shetland. The steering group leading the project includes representation from NHS Shetland, Shetland Islands Council, the third sector and people with lived experience. During 2023 we undertook and published an evidence base as Phase 1 of the project. The local evidence gathering was approached in four ways: community engagement; a desk review; workforce engagement and analysis of a mental health and wellbeing dataset. The general aim for the engagement work was to get a response from 1% of the affected population. In total there were 456 responses - 373 from the community engagement, 58 from the staff survey and 25 from the managers' survey, giving a total response rate of 2%. In addition there were 3497 respondents to the range of surveys that were analysed as part of the desk review - although the same individuals may have contributed to several surveys. The next phase of the project is to use this evidence to develop an outcomes based Good Mental Health for All Strategy, with a priority focus on higher prevalence areas, early intervention, health inequalities and mental health through the life course.

Vaccination and Immunisation

Vaccination is one of the most effective public health interventions to prevent ill health and premature mortality. The Public Health and Vaccination Teams are responsible for the co-ordination of multiple population vaccination programmes involving colleagues in primary care, community nursing, school nursing, maternity, the sexual health clinic, occupational health and pharmacy. During 2023-24 we delivered the following programmes: Spring covid; Autumn / Winter flu and covid; pneumococcal; shingles; baby and pre-school immunisations; HPV, teenage booster and meningitis vaccinations in schools; BCG for high risk individuals; pertussis for pregnant women; HPV, Mpox and hepatitis vaccination in the sexual health clinic; and occupational vaccinations. Uptake of covid vaccination during the Autumn/ Winter programme was 62.8% (56.6% for Scotland) amongst all eligible groups. And it was 59.1% for flu for adults (53.7% for Scotland).

We commenced a rolling audit of pre-school vaccination uptake in order to ensure accurate recording and pro-actively offer catch up vaccinations, including MMR. During early 2024, the temporary vaccination centre at Grantfield was converted to a dedicated centre and base for the vaccination team, with clinical space, a waiting area and office space. This has increased efficiency of the service already and there are plans to ensure the space is fully utilised for vaccination and potentially other preventative services such as screening. We are also undertaking further work o understanding inequalities in screening, including close working with the Learning Disabilities Team and looking at health literacy with the Community Learning and Development Team.



Measles, Mumps and Rubella (MMR) vaccine

91.5% of children had the first dose of MMR vaccine by **24 months**

This is an **increase of 3.5%** from 88.4% in 2022/23.

Uptake remains **lower** than the **Scotland rate** by approximately 1.3%.

Human Papillomavirus (HPV) immunisation

From 1 January 2023, the HPV vaccine moved to a one-dose schedule.

The proportion of completed doses in eligible **S2 pupils** was **higher** among **females** than **males.**

88.3%   **77.6%**

Overall uptake **increased by 3.8%** to 82.6%.

COVID-19 vaccination

Uptake for the COVID-19 winter booster was **62.8%.** This was over **6% higher** than across **Scotland.**

Uptake for the COVID-19 spring booster was **71.2%.** This was **6% higher** than across **Scotland.**

Adult Flu vaccination

Uptake of the adult Flu vaccination was **59.1%.** This was one of the **highest** across **Scotland.**

Vaccine uptake in Shetland was over **5% higher** than across **Scotland.**

Screening

The Public Health Team is responsible for co-ordinating and monitoring population screening programmes in Shetland including those for breast, cervical and bowel cancer; abdominal aortic aneurysm (AAA); diabetic retinopathy and the pregnancy and newborn programme. These aim to detect disease, or the risk factors for disease, early in order to treat, prevent progression and improve outcomes. We work with colleagues in primary and secondary care, maternity and from NHS Grampian, as well as the national teams. During 2023-24 a project looking at inequalities in access to screening and uptake amongst people with learning disabilities and autism was completed; with recommendations shared with the national teams as well as local services. There has also been work with people attending recovery services to support access to screening.

We completed our part of a very extensive national audit to review all women who had been taken out of the cervical screening programme (usually due to surgery to remove the uterus and cervix). This involved reviewing records of over 500 patients, and offering clinical follow up where the records where unclear. During June 2023, we hosted a very successful visit from Jo's Trust, a national cervical cancer charity, which included training for staff, community engagement and awareness raising.

The most recently published screening programme figures show that we continue to have uptake rates compared to the rest of Scotland, although there is scope for improvement. These included a 74% uptake for bowel screening during May 2021-April 2024 (66.1% for Scotland); 79% uptake for cervical screening during April 2021-March 2022 (73.7% for Scotland) and 84% uptake for AAA screening for men during April 2022-M arch 2023 (70,7% for Scotland).

There is further information in the Population Screening Annual Report.

Abdominal Aortic Aneurysm (AAA) screening

84.0% of the eligible population were tested before the age of 66 years and 3 months.

This is an **decrease of 5.8%** from 89.2% in 2022.

Bowel screening

Uptake in the period, 2021 - 2023, was **74.0%.** This is **higher** than the **Scottish rate.**

Uptake was **higher** among **females** than **males,** though both were **above** the **60% standard.**

Breast screening

Over the three year period, 2020/21 to 2022/23, uptake was **86.2%.**

Over the last ten years uptake has consistently been **over 80%.** and at least **10%** higher than the **Scottish uptake rates.**

Cervical screening*

The percentage of eligible women recorded as screened within the specified period was **79%.**

This is **1.2** percentage points **down** when compared to 2020/21. But still remains **highest** across **Scotland.**

*there is no update on this data since the previous annual report

Sexual Health and Blood Borne Viruses

Sexual Health and Blood Borne Viruses (BBVs)

Our dedicated **Sexual Health Clinic** operates 9-10hrs per week in Lerwick, in addition to this, service is provided across Shetland at local GP practices. The clinic reports a wide age-range in attendees although the majority were **aged 18-35 years** old.

Sexual Health Clinic report **274** attendances and Primary Care **120** attendances with requests for STI screening.

In addition to this, opportunistic testing will account for a portion of the **45 cases** confirmed as having either **Chlamydia** or **Gonorrhoea.**

Sexual Health Clinic prescribed **36 treatments** to STI cases and their contacts; others may be have been treated within primary care

More **Hepatitis C** cases were detected this year than in any previous year; this is likely due to **increased testing activity.**

Substance Misuse and Recovery Service have **improved access** to testing for those at higher risk, meaning more people can access treatment, reducing the risk of infection transmission.

A small number of vaccinations were administered for protection against **Hepatitis A and B, HPV** and **MPox.**

The Sexual Health Clinic are now able to dispense **PrEP** to protect against **HIV;** a small number of people have had this prescribed.

The Sexual Health Clinic also provides long-acting reversible contraception.

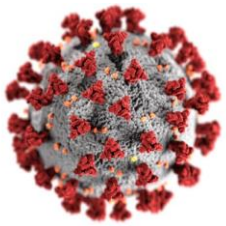
They fitted **183** coils and **155** implants.

The number of terminations was low with an overall rate of **2.4 per per 1,000 women** aged 15-44 years.

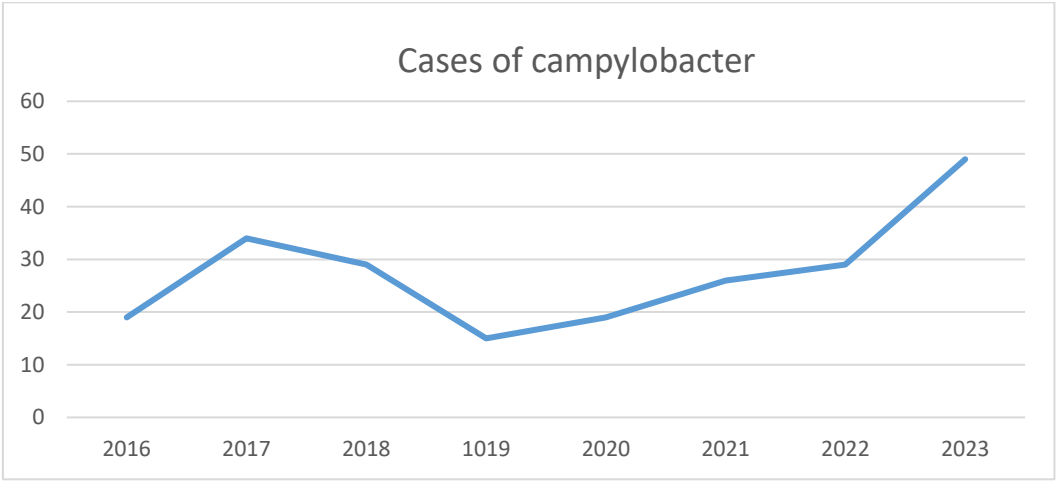
Health Protection

The following communicable disease cases were recorded in 2023-24:

- 55 campylobacter, 2 salmonella, 2 bacillus cereus
- 4 cryotosporidium, 2 giardia
- 9 shiga toxin producing E Coli (STEC) - includes E Coli 0157
- 5 enterotoxigenic E Coli (plus one probable)
- 5 TB cases (3 active, 2 latent)
- 95 covid-19, 32 flu A and 9 flu B
- 3 hepatitis B and 5 hepatitis C
- 2 Lyme disease (acquired outwith Shetland)
- 1 case each of legionella (acquired outwith Shetland), pertussis, toxoplasmosis, norovirus (although most people who have this do not get tested), yersinia enterocolitica.



This is a significant increase in gastrointestinal infections (especially campylobacter); TB and flu. But lower number of pertussis that anticipated (given a significant outbreak across the UK). The number of covid cases is much lower than previous as expected with the changes to testing and management of covid cases.



The Health Protection Team have managed one outbreak of enterotoxigenic E coli (shellfish food poisoning); six covid outbreaks and two clusters in care homes, one in another care setting and two flu outbreaks in care homes. There was also a covid outbreak in the hospital.

The team also responded to a confirmed avian influenza (H5N1) in a small domestic chicken flock, involving monitoring and investigation of the people exposed. And also a number of individual episodes of dead seabirds found to have avian flu.

In addition to the public health management of queries, cases, clusters and outbreaks, the team have also been developing operating procedures and reviewing plans for managing individual communicable diseases, environmental threats and incidents. These include TB and blood borne virus testing pathways, due for completion later in 2024.

Communications with both the public and colleagues is a core part of our work . We have undertaken both reactive and proactive media work including public communications regarding preventing spread of gastrointestinal infections.

Resilience and Business Continuity

The winter of 2023 and 2024 challenged most NHS services due to adverse weather and ongoing business continuity issues. The Resilience and Business Continuity Officer continues to hold focused sessions for departments to develop their business continuity measures into plans that are used-friendly, scalable and can be enacted quickly. The focus for the coming year will be to automate some of the management functions to improve efficiency of the business continuity management system. A fact-finding project is being carried out, governed by the Transport and Logistics Working Group to understand the movement of patients, staff, samples and supplies throughout Shetland to see where resilience can be increased and costs reduced.

A new Major Incident Plan reflecting the modern working practices in Primary and Secondary Care is under development. This involves widening the scope of the plan from a hospital focused mass-casualty plan into one including the community and community services, with flexibility and scalability being key. The plan uses learning from past incidents and new collaborative ways of online working, building them into the command and control processes developed during the Pandemic.

There has been significant progress in work developing plans to respond to chemical, biological, radiological, nuclear (CBRN) and explosive incidents, and those involving hazardous materials. The 'Initial Operation Response' involves the use of ‘first-strike’ kits for dry decontamination, these are being made available in publicly accessible locations. However, the requirement for wet decontamination remains and NHS Shetland is working with Ambulance, Coastguard and Fire Service partners to develop an Islands Model in which the CBRN response does solely rest with NHS Shetland.

The NHS Shetland Information & Communication Technology Team has purchased a 'Starlink' system which will further enhance connectivity, and a Cyber Incident Response Plan is currently being developed in response to the ongoing threat of cyber-attack.

As part of the Islands with Small Populations workstream, the Outer Isles were visited to identify gaps in community resilience in Shetland's most remote island communities. Resilient communities are a key feature of the Shetland Partnership Plan and NHS Shetland is working with other Category One responders to deliver tailored solutions for the more fragile communities. A Community Emergency Plan template has been developed with the intention to progress this work with the assistance of Shetland Islands Council Community Development Team.

Realistic Medicine

Realistic Medicine is an approach to healthcare that aims to put the patient at the centre of decisions made about their care. It supports and empowers people, and their families, to discuss and consider their treatment options and the associated risks and benefits. Two of the six key principles are shared decision making and a personalised approach to care. The other principles are reducing harm and waste; reducing unwarranted variation; managing the risks associated with healthcare better; and championing innovation and improvement.

In his most recent Annual Report, the Chief Medical Officer focuses on "*enabling careful and kind care*" and the importance of "*understanding what matters to the people we care for*".

Realistic Medicine is relevant to all health and social care professionals, and a multi-disciplinary approach is essential to ensure that it becomes standard care for people in Scotland. There are also cross cutting themes of climate change and sustainability, reducing inequalities, prevention and leadership to support staff to practice Realistic Medicine.

More recently, the focus has been on delivering Value Based Health and Care (VBHC) in Scotland in order to build a more equitable and sustainable health and social care system in Scotland. VBHC will be delivered by practising Realistic Medicine and focusing on the principles of person-centred care, reducing harm and waste, reducing unwarranted variation, managing the risks associated with healthcare better, and championing innovation and improvement.

During 2023-2024 the local Realistic Medicine steering group worked on the following:

- Promoting Shared Decision Making and VBHC training to Staff
- Producing articles for the monthly NHS Shetland Staff Newsletter
- Successfully piloting the ReSPECT process
- Embedding Realistic Medicine into Board strategies and plans
- Promoted the use of the BRAN questions in clinical settings to staff and public
- Co-ordinating the Managed Clinical Networks that were implemented last year
- Sharing and promoting Realistic Medicine projects including 'Green' initiatives

Appendices

A Health Improvement Annual Report 2023-24

B Vaccination & Immunisation Annual Report 2023-24

C Population Screening Programmes Annual Report 2023-24

D Control of Infection Committee Annual Report 2023-24

E Realistic Medicine Annual Report 2023-24

F Resilience and Business Continuity Annual Report 2023-24

Realistic Medicine

Annual Report 2023-24

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- Embedding Realistic Medicine into Board strategies and plans
- Promoting Shared Decision Making and Value Based Health and Care Training to Staff
- Producing an article for the monthly NHS Shetland Staff Newsletter
- Promoted the use of the BRAN questions in clinical settings to both staff and the public
- Established three local MCNs.

Embedding Realistic Medicine in NHS Shetland

In 2023-24, NHS Shetland developed the Strategic Delivery Plan (2024-2029) and the Digital Strategy (2024-2029) which set out clearly the strategic direction of the organisation with the principles of Realistic Medicine embedded into the development of both.

Throughout the year the Shared Decision Making and Value Based Health and Care training available to staff was promoted regularly via the staff newsletter, heads of department and members of the local Realistic Medicine Steering Group. At the end of 2023-24, 41 people across NHS Shetland had completed the Shared Decision Making training on Turas. Options for making the training mandatory for staff in NHS Shetland were explored, however it was decided that this was not practical or necessarily the best way to encourage staff to complete the training.

Additionally, a Realistic Medicine article was produced for the monthly newsletter, focusing on promoting a project, staff training or information sharing on the different principles and priorities of Realistic Medicine and Value Based Health and Care with the wider workforce.

Projects

Below is a summary of some of the projects, as well as some more in depth case studies showing some of the projects that took place in 2023-24. These projects range from smaller tests of change to larger transformational changes in ways of working and all of them focus on the principles of Realistic Medicine.

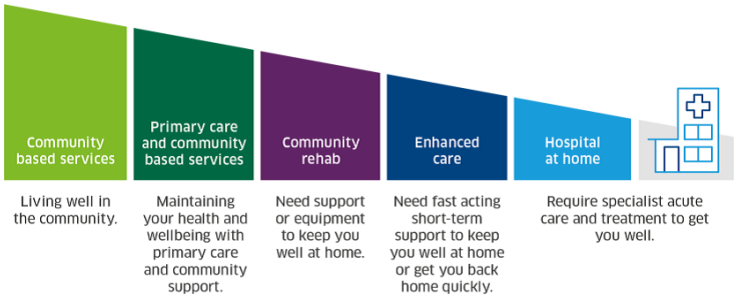
Short Summaries

Managed Clinical Networks

In January 2023 an Managed Clinical Network (MCN) co-ordinator was recruited with the remit of developing and establishing three local MCNs using RM principles; incorporating value based health and care; and including a focus on prevention, equity of access & outcomes and sustainability. This was successfully achieved by December 2023, will all three MCNs, along with sub-groups established.

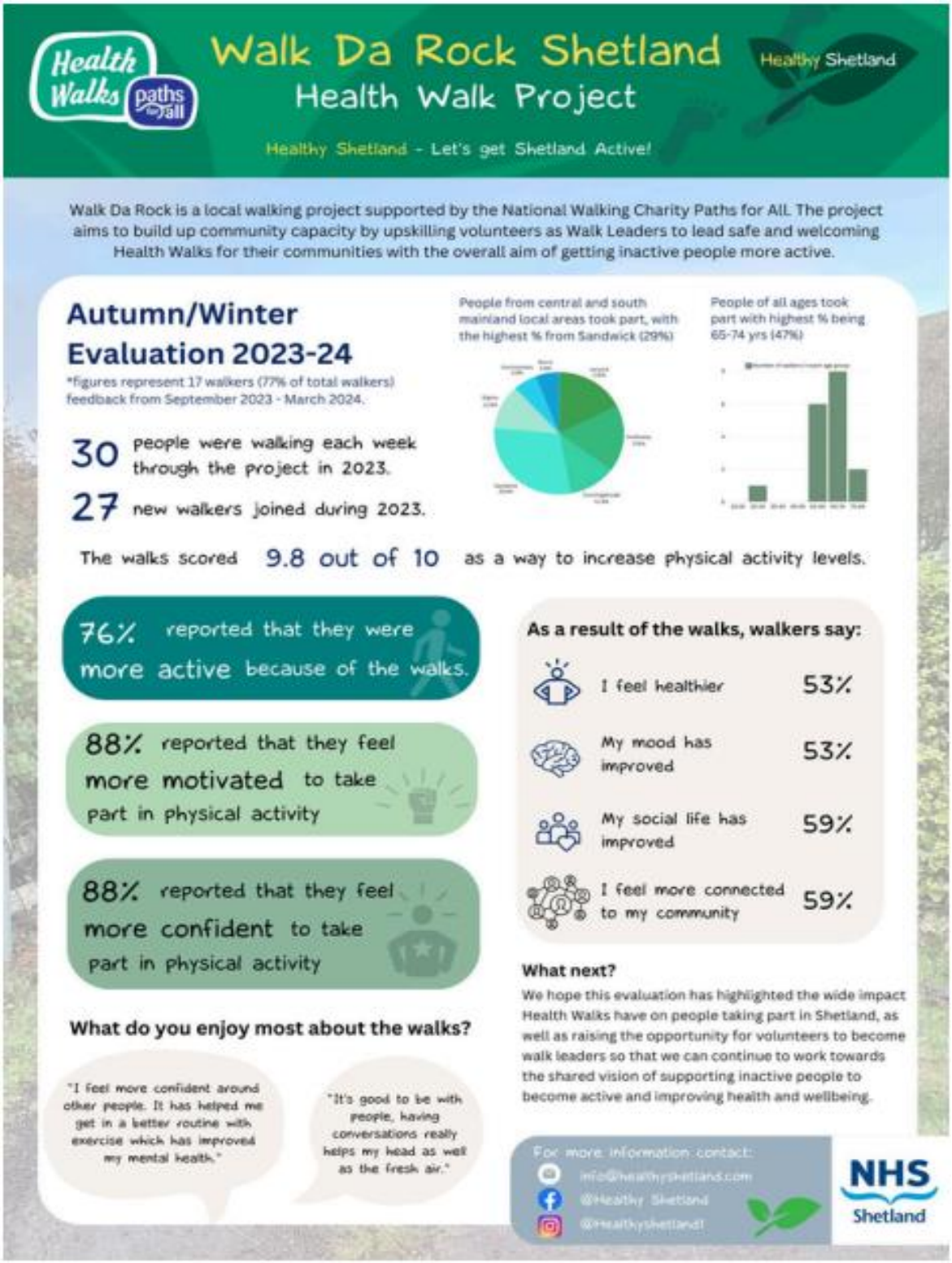
Hospital @ Home

In June 2023, NHS Shetland applied to be part of the Hospital at Home expansion programme to develop, test and refine a local Hospital at Home (H@H) service. H@H has been shown to be a safe and patient-centred alternative to acute hospital admission where care is delivered by a multi-disciplinary team in the Community.



H@H was successfully piloted in Shetland from September 2023, which started with the establishment of a H@H MDT who met regularly. Each patient was used a test of change as part of a PDSA cycle to ensure continuous learning and improvement. The focus was on finding a suitable H@H service that would be sustainable in Shetland.

Walk da Rock Shetland



Case Studies

Greener Spaces

The Primary Care Greener practice team have been working with Healthy Shetland, Walk Da Rock and the RSPB to promote the use of green spaces in the community. I'm sure many of you recognize the benefits of being in green spaces, being active and outdoors to your own personal health and it would be fantastic if we could enable more of our patients and community members to access this as well.

Being able to access and enjoy green spaces is important for our physical and mental health, and staff, patients and community members at Levenwick surgery and Overtonlea care home have really seen the benefits for this. The Levenwick Growers Gardening for Health group meet every Wednesday morning in the spring/summer and monthly in the winter. They have been nurturing the grounds of the GP surgery and care home and have transformed an overgrown walled garden into a beautiful space with wheelchair accessible paths, benches and a sensory garden. They have been a real inspiration to us all and shown what can be achieved for so many to enjoy with teamwork, camaraderie and spirit. They welcome all who want to come visit, help or come along to get some ideas for transforming a green space near you.

RSPB Shetland is launching a new programme, 'Wintering Wild' to enhance people's health and wellbeing. The programme will be launched soon and encourages participants to connect with nature through guides, journalling workshops, online talks, walks and a calendar of suggested activities and events.

Helen Moncrieff, RSPB Scotland’s Shetland manager said:

“*There have been many studies showing the role nature has in supporting our mental and physical health. We want to help people deepen their connection with nature and through doing so, that helps us deepen our connection with ourselves, place and community*.”

Evaluation of Entonox® use in A&E at the Gilbert Bain Hospital

The NHS contributes to around 5% of the UK's total carbon footprint. NHS Scotland has committed to becoming a Net Zero organisation by 2040 and sets out various goals and actions in its latest climate emergency and sustainability strategy 2022-2026 report.

Sustainable Care is one of the five priority areas for NHS Scotland; promoting and empowering healthcare workers to make environmentally sustainable clinical choices wherever possible. Within this priority, medical gases have been identified as a 'carbon hotspot', and thus, are a key target area for improvement.

Entonox®, a 50:50 mixture of nitrous oxide (N2O) and oxygen is commonly used across maternity, pre-hospital and emergency settings as an effective analgesic agent. It is estimated that 30 minutes of Entonox® use is equivalent to 38kg of carbon dioxide (CO2e) emissions. To put this in context, this is the same as driving a medium sized petrol car over 120 miles.

This project focused on the use of Entonox® in A&E at the Gilbert Bain Hospital and was inspired following the discovery of a portable Entonox® cylinder stored with a valve left open and a surprising lack of awareness amongst staff of the harmful environmental impacts of medical gases.

This was a quality improvement project collecting quantitative data on the clinical indication for Entonox® use in A&E in March and May 2023. Data collected in March 2023 was collected retrospectively via TrakCare searches. In May 2023, nurses and doctors working in A&E were asked to complete a data collection sheet. Additionally in May baseline data was gathered on the storage and maintenance of the 700L sized Entonox® cylinders in A&E.

Overall, this study showed that emissions from nitrous oxide, in the form of Entonox® continues to contribute to the carbon footprint of NHS Shetland. The review found that only a small number of patients received Entonox® (<2% of monthly admissions), which was deemed clinically appropriate in the majority of cases (89%). An assessment of the storage and maintenance of portable Entonox® cylinders identified substandard practice with equipment found to be past expiry date use and cylinder valves left open following clinical use on several occasions. Lastly, opportunistic data collection has shown that in the pre-hospital setting, the greener analgesic alternative Penthrox® is already being administered.

The above conclusions indicate that both an educational intervention alongside practical intervention to improve storage and maintenance practice of portable Entonox® cylinders may help address system waste and losses and thus reduce overall N2O emissions.

It is hoped that conducting this project has raised awareness of the environmental impacts of medical gases amongst staff working in the Emergency Department at the Gilbert Bain Hospital.

Frailty Managed Clinical Network (MCN)

'Frailty' is a term that's often used but sometimes misunderstood. It describes someone's overall resilience to physical and mental stressors, and in turn their chances of recovering quickly following health problems. Frailty affects around 10% of people over age 65, and 50% of people over age 85. (Age UK)

Frailty typically presents as one or more of five syndromes: falls, immobility, delirium, incontinence or medication-related harm. Although frailty isn't inevitable as we age, Shetland's changing population - with an ever increasing proportion of older people – means taking a population health approach to prevention, early intervention and reducing the progression of frailty is particularly important here.

In April 2023, a new Managed Clinical Network (MCN) for frailty was established, led by geriatrician Alice Einarsson. The MCN has met four times so far and has participants from across health and social care. Following a survey of members, there are now three subgroups taking forward specific pieces of work:

Frailty prevention and early intervention

This group first met in September and is developing an action plan around improving how we identify and record frailty, how we engage with our population to prevent and manage frailty earlier, and how we provide support. It aims to start by building on learning from existing good multidisciplinary team work in the north mainland.

Hospital at Home

The MCN obtained funding from Scottish Government and support from Healthcare Improvement Scotland to develop a pilot of Hospital at Home – short-term acute hospital care delivered in an individual's own home. This project is starting very small, through close collaboration between our geriatrician, Advance Nurse Practitioners and Intermediate Care Team to establish how Hospital at Home could work to help deliver personalised care and potentially reduce the impact of frailty in our remote and rural context.

Future Care Planning

This subgroup is linked with both the Frailty MCN and Palliative Care MCN, and works to share learning between professionals and develop multi-agency approaches to person-centred future care. The group has worked with NHS Education Scotland to consider how the digital ReSPECT process could help improve communication, encourage shared decision making and potentially reduce harm in future emergency situations. Again, this is starting small with an initial three-month pilot using the ReSPECT form, starting with care home residents in Scalloway and medical patients who are being discharged to care homes.

Conclusion

The principles of Realistic Medicine continue to be embedded in ways of working in NHS Shetland with a clear planning and reporting structure established. There is a wide variety of work ongoing across the health board, some of which has been described in this report.

A focus this year has been on communicating better with staff about Realistic Medicine and Value Based Health and Care and promoting the training available to them.

Focus for 2024-25 will be on maintaining and building on that engagement through a local Realistic Medicine Symposium to enable staff from across the Health and Social Care Partnership to come together to hear examples of best practice, at a national and local level, and consider how they might apply the learning to their everyday practice and approach.