NHS Shetland

Meeting:	**NHS Shetland Board**
Meeting date:	**26 April 2022**
Agenda reference:	**Board Paper 2022/23/06**
Title:	**Joint Strategic Commissioning Plan**
Responsible Executive/Non-Executive:	**Brian Chittick, Chief Officer, IJB**
Report Author:	**Elizabeth Robinson, Public Health & Planning Principal**

1. Purpose

This is presented to the Board/Committee for:

Decision - Approval

This report relates to:

Integration Joint Board Strategy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person-centred

2. Report summary

2.1. Situation

The Joint Strategic Commissioning Plan 2019-22 underpinned the progression of the integration agenda in Shetland over the last three years.

With the significant changes which have taken place during the pandemic, it was felt that we should take the opportunity to develop a contemporary plan with new strategic priorities reflecting the journey that our community and services have been on during this period.

The Joint Strategic Commissioning Plan 2022-2025 has been developed by the Strategic Planning Group in line with 'Strategic Commissioning Plans: Guidance' issued by the Scottish Government on 17th December 2015.

The Board is asked to review the Joint Strategic Commissioning Plan 2022-25 and approve or request amendments to it.

2.2. Background

The Strategic Commissioning Plan 2019-22 was approved by Shetland IJB on 13 March 2019 and by NHS Shetland Board on 16 April 2019 and Shetland Islands Council on 15 May 2019. This plan outlined 5 strategic priorities:

- Develop a single health and care system
- Maximise population health and wellbeing
- Develop a unified primary care service
- Streamline the patient's journey in hospital
- Achieve a sustainable financial position by 2023

The last Annual Report 2020-2021 reflected on the success of integration within the Health and Social Care Partnership demonstrated by highlighting the work done via the COVID Hub in supporting our community during the pandemic, links with the Third sector in supporting people and shifting the balance of care from hospital to the community which can only be done with an integrated approach across health and social care. Whilst this plan has served the IJB well, especially during the pandemic period, the strategic environment has evolved and a new plan is required to reflect this.

The new Plan is designed to be focused on areas of highest need, built upon measurable outcomes, and targeted but at the same time flexible enough to respond to un-anticipated challenges and pressures and the potential "system shock" that the formation of the new National Care Service may bring within Shetland.

There is an appetite to support the IJB to move towards a needs-based and outcomes-based approach to commissioning of services, with a visible and measurable shift towards provision of care in home or community settings, and an emphasis on prevention of poor health and wellbeing, and reduction of inequalities.

The plan has been developed to this stage by the Strategic Planning Group, and through stakeholder engagement, for example, with the Third Sector Forum, Hjaltland Housing Association and Shetland Islands Council Housing. IJB Members had the opportunity to influence the plan at a Seminar to be held on 24 February 2022. No amendments were requested to the Plan at this stage.

2.3. Assessment

The new Plan is intended to be agile in nature and reviewed regularly to ensure that the strategic priorities and the formation of the National Care Service remain contiguous.

Development and implementation of the Strategic Plan relies on partnership working between Shetland Islands Council, NHS Shetland, Shetland Charitable Trust, other regional and national organisations (such as the Scottish Ambulance Service, NHS Grampian, and other specialist Health Boards), voluntary sector providers and with the community, individuals, and families at the centre of decision making around their health and care needs.

The outline for the strategic planning process was presented to NHS Shetland in September 2021; this highlighted four stages for preparing the new Plan:

- Needs Assessment Phase
- Draft Plan Phase
- Consultation Phase
- Approval Phase

Although the outline described the Needs Assessment Phase as being a time-bound piece of work, in practice needs assessment is an on-going and cyclical process, and we are being supported by Public Health Scotland to undertake a large-scale needs assessment over the next six months which will influence the next iteration of this plan.

The Consultation Phase was completed and the Plan was approved by the IJB on 24th March 2022.

The new Plan is designed to be focused on areas of highest need, built upon measurable outcomes, and targeted but at the same time flexible enough to respond to un-anticipated challenges and pressures and the potential “system shock” that the formation of the new National Care Service may bring to Shetland.

2.3.1. Quality / patient care

The aim of the Joint Strategic Commissioning Plan 2022-2025 is to meet the needs of Shetland’s service users, patients, and communities in responsive and effective ways, while encouraging and developing independence and reducing inequalities.

2.3.2. Workforce

The Joint Strategic Commissioning Plan 2022-2025 will link closely to the three-year Health and Social Care Partnership Workforce Plan currently under development.

2.3.3. Financial

The Joint Strategic Commissioning Plan 2022-2025 has been developed alongside the Medium-Term Financial Plan (MTFP) 2022-2027. MTFP was approved by the IJB on 17 February 2022.

The IJB Budget 2022/23 was approved by the IJB on 24th March 2022. The total budget of £58.180m provides financial resources to facilitate the first year of the Joint Strategic Commissioning Plan 2022-2025.

2.3.4. Risk assessment/management

The IJB and Chief Officer have responsibility for risk assessment and management of the implementation of the Joint Strategic Commissioning Plan.

2.3.5. Equality and Diversity, including health inequalities

It is our intention to ensure that the Joint Strategic Commissioning Plan 2022-2025 recognises the fundamental causes of poverty and inequalities, and sets out a clear approach to reducing, mitigating, or eliminating these. The Plan will adopt a Human Rights-based approach to health and well-being, which recognises that our communities have the right to the highest attainable standard of health as a fundamental right of every human being. A rights-based approach to health also requires that health policy and programmes must prioritise the needs of those furthest behind first towards greater equity.

2.3.6. Other impacts

The Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act") established the legislative framework for the integration of health and social care services.

It is a requirement under Section 37 of the 2014 Act for the IJB to review the effectiveness of its Strategic Plan, in accordance with the provisions of the 2014 Act.

2.3.7. Communication, involvement, engagement and consultation

The IJB has carried out its duties to involve and engage external stakeholders; the IJB Strategic Planning Group led the development of the plan, including consultation and engagement with unpaid carers, staff, and the Third and independent sector.

2.3.8. Route to the meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report:

Strategic Planning Group 7 December 2021, 20 January 2022, 10 February 2022, 3 March 2022

IJB Seminar 2 December 2021, 24 February 2022

IJB Committee Meeting 17 February 2022 – Approval of draft for consultation.

IJB Approval of Joint Strategic Plan: 24 March 2022.

3. List of appendices

The following appendices are included with this report:

Appendix No 1, Joint Strategic Commissioning Plan

Appendix No 2, PHS LIST Profile Dec 2021

Shetland Islands Health and Social Care Partnership

1st April 2022 – 31st March 2025

Draft for Approval

JOINT STRATEGIC COMMISSIONING PLAN

CONTENTS

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF PROGRESS AGAINST PREVIOUS PLAN

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

1. Develop a single health and care system: We will have in place seamless services, wrapped around the needs of individuals, their families and communities, which are not restricted by organisational or professional boundaries. Where possible we aim to deliver a 'one stop shop' approach to health and care.

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

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

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

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

3. Streamline the patient's journey in hospital: we will work to make sure that people get the right care in the right place at the right time by maximising outpatient, ambulatory, day care services and minimising inpatient stays

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

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

4. Maximise population health and wellbeing: people will be supported to look after and improve their own health and well-being, helping them to prevent ill health and live in good health for longer

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

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

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

5. Achieve a sustainable financial position by 2023

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

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

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

DATA

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

DEMOGRAPHICS

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

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

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

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

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

HOUSEHOLDS

For the most recent time periods available, Shetland had:

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

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

GENERAL HEALTH

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

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

LIFESTYLE AND RISK FACTORS

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

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

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

HOSPITAL AND COMMUNITY CARE

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

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

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

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

MENTAL HEALTH RELATED UNSCHEDULED CARE

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

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

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

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

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

OUR STRATEGIC PLAN

Our Vision:

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

Our approach:

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

Our strategic priorities:

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

What we will do:

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

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

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

How will we know we are making a difference?

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

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

Changes in knowledge, skills and awareness:

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

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

Changes in decisions and practice

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

Changes in services and health and wellbeing outcomes

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

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

Next steps and implementation

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

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

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

APPENDIX A

National Health & Wellbeing Outcomes

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

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

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

APPENDIX B

The integration delivery principles are:

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

APPENDIX C

(a) Outcome indicators:

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

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

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

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

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

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

7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

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

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

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

(b) Outcome indicators based on administrative data:

11. Premature mortality

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

13. Readmissions to hospital within 28 days

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

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

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

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

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

Appendix D

Public Health Scotland

HSCP Profile 2020/21

Shetland Islands

December 2021

Table of Contents

Notes for this profile:

- All years shown are calendar years unless otherwise specified.
- Upper and lower 95% confidence intervals are shown throughout this document where available. In charts, these are displayed as shaded areas either side of trend lines, or as black error bars in bar charts. Confidence intervals show the range of possible values and a certainty that the true value falls within them.
- Definitions for the indicators shown are available in Appendix 1.
- Any zero figures for some indicators will indicate either suppression of small data or a complete lack of data available for this health and social care partnership (HSCP)

Demographics

Summary:

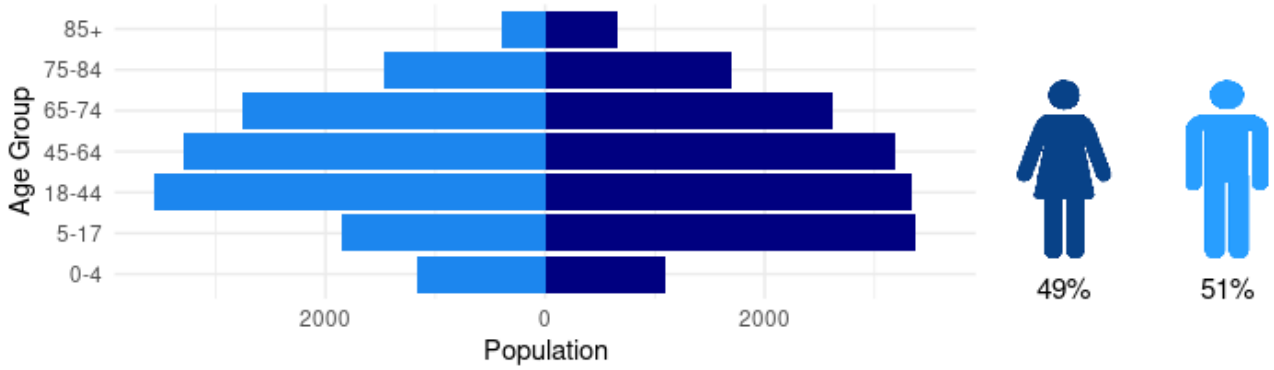
For the most recent time periods available, Shetland Islands HSCP had:

- A total population of **22,870** people, where **51%** were male, and **21%** were aged over 65.
- **0%** of people lived in the least deprived SIMD quintile, and **0%** lived in the most deprived quintile.

Population

In 2020, the total population of Shetland Islands HSCP was **22,870**. The graph below shows the population distribution of the HSCP.

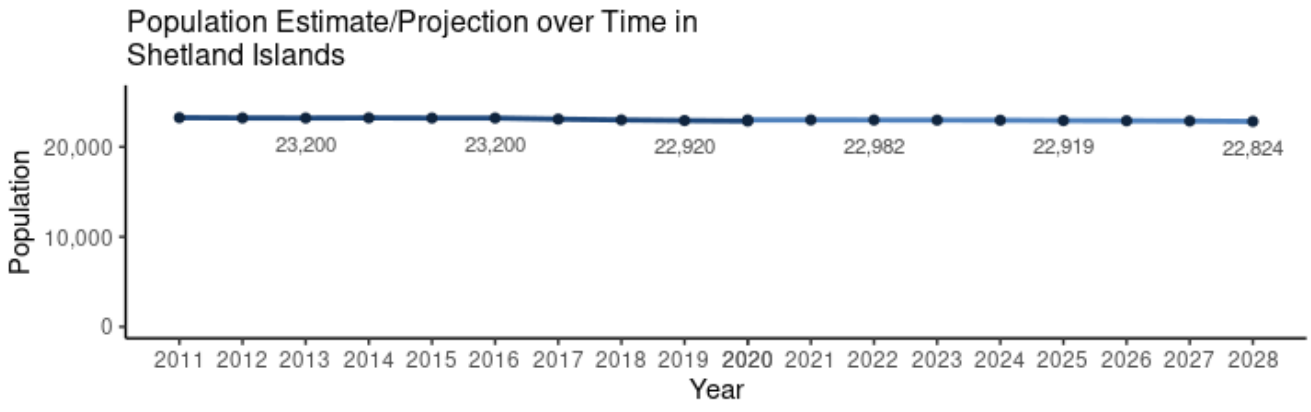
Figure 1: Population breakdown in Shetland Islands.



Source: National Records Scotland

Figure 2 shows the historical population of Shetland Islands, along with the NRS population projections. The population has been falling. The population in Shetland Islands is estimated to decrease by 0.3% from 2020 to 2025 *Please see the footnotes for more information on how the population projections were calculated*[1].

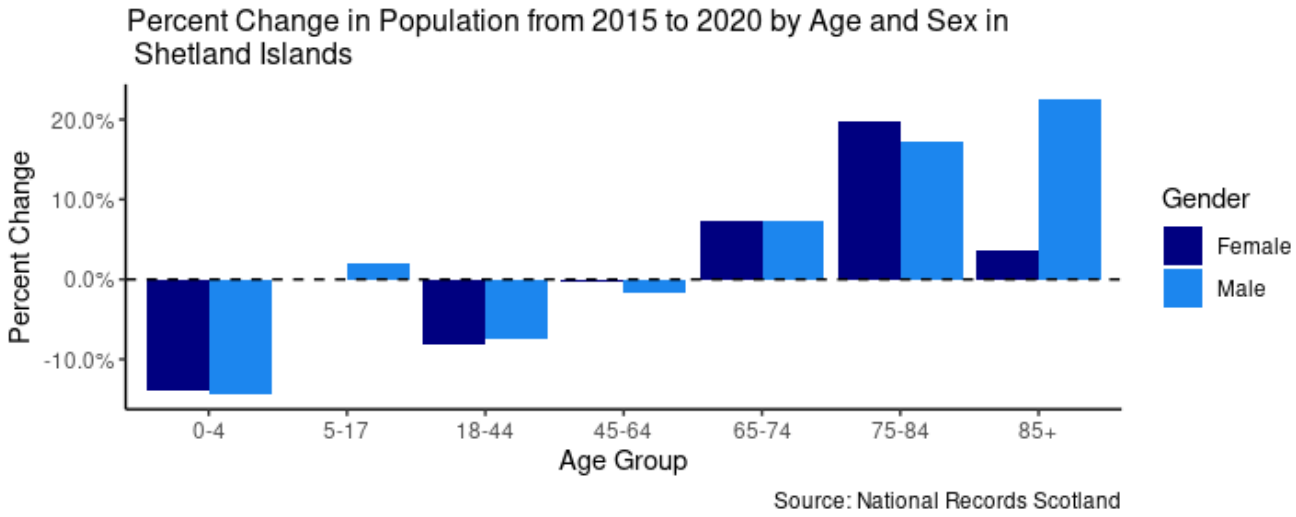
Figure 2: Population time trend and projection.



Source: National Records Scotland

Figure 3 shows how population structure has changed between 2015 and 2020.

Figure 3: Change in population structure over the last five years.



Deprivation

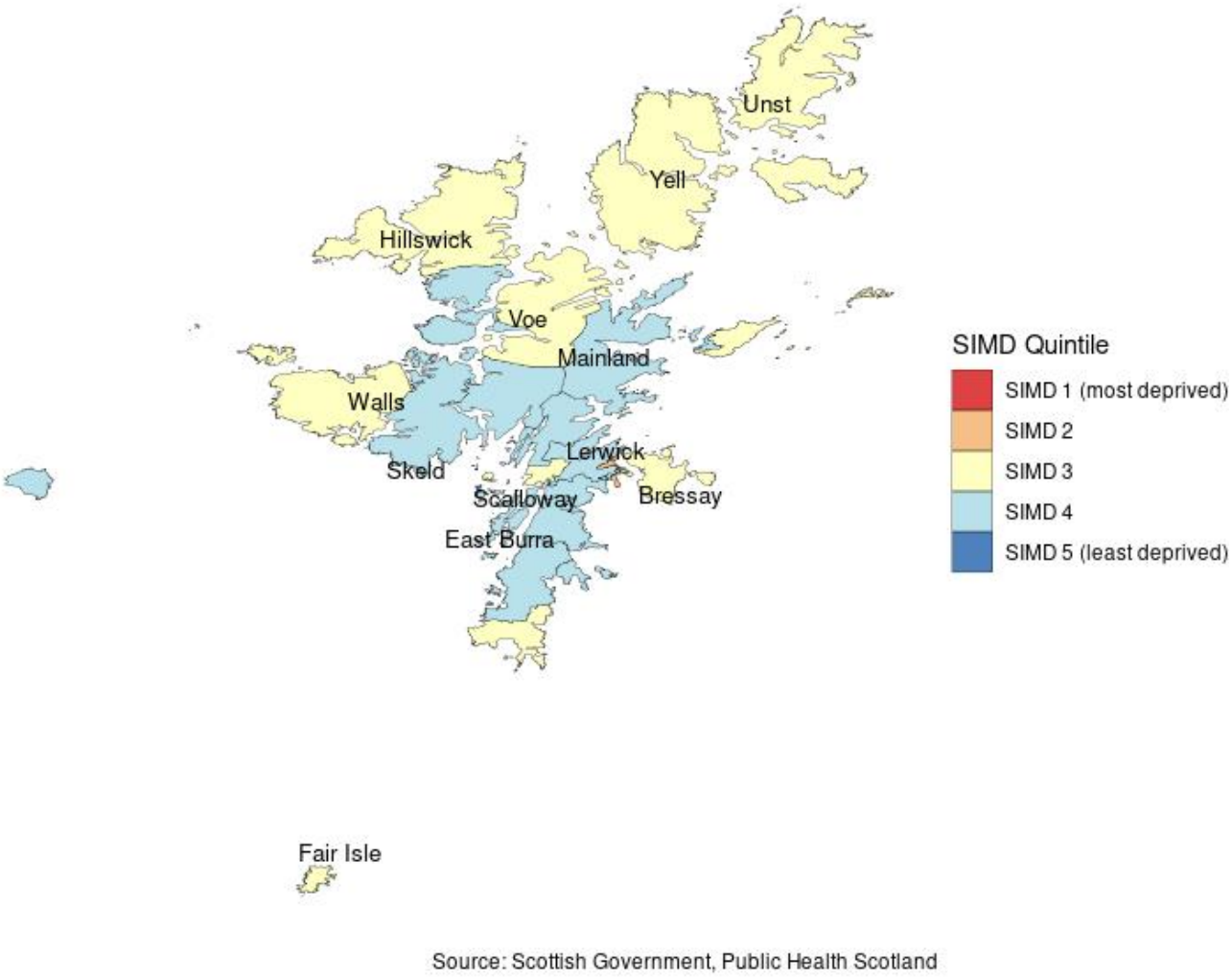
The following section explores the deprivation structure of Shetland Islands through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all datazones in Scotland by a number of factors; Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each datazone is then given an overall deprivation rank, which is used to split datazones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications, however the 2016 classifications are used to assess how deprivation has changed in Shetland Islands when compared to the rest of Scotland.

Of the 2020 population in Shetland Islands, **0%** live in the most deprived SIMD Quintile, and **0%** live in the least deprived SIMD Quintile. The following table details the percent of the population living in the 2016 SIMD Quintiles, the percent living in the 2020 SIMD Quintiles, and their difference for comparison.

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

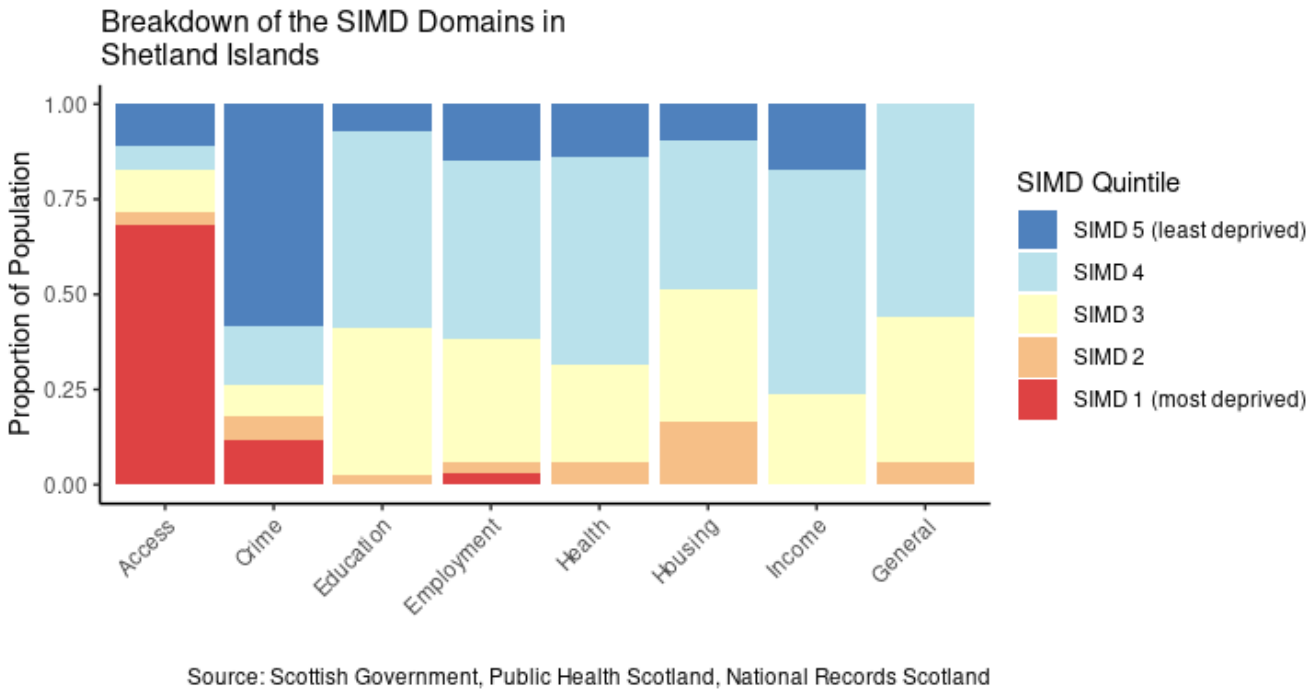
Quintile	Percent of Pop (2016)	Percent of Pop (2020)	Difference
SIMD 1	0.0%	0.0%	0.0%
SIMD 2	3.2%	6.1%	2.8%
SIMD 3	32.0%	38.1%	6.1%
SIMD 4	64.8%	55.9%	-9.0%
SIMD 5	0.0%	0.0%	0.0%

Figure 4: Map of Datazones within Shetland Islands coloured by SIMD quintiles.



Source: Scottish Government, Public Health Scotland

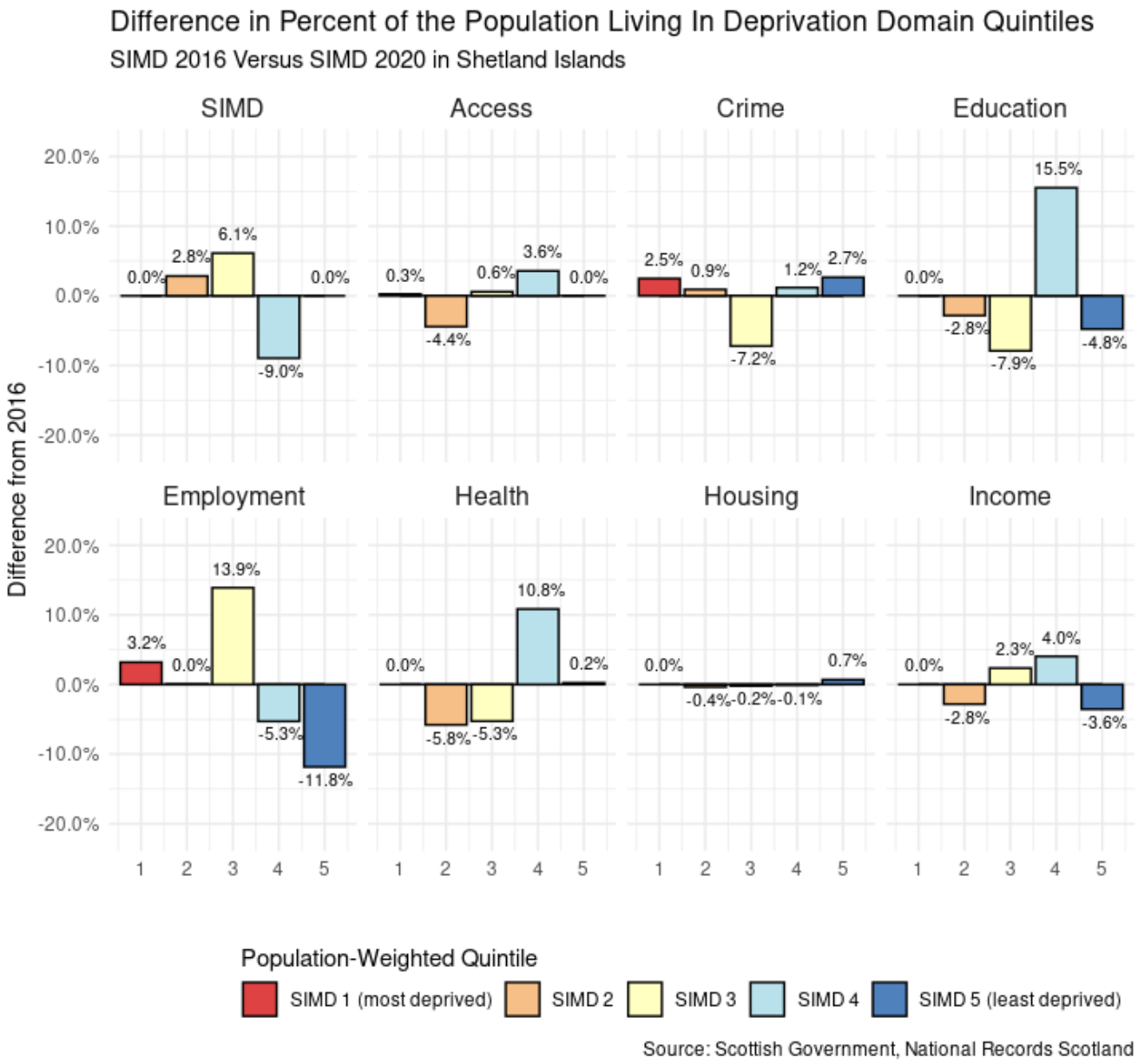
Figure 5: Proportion of the population that reside in each 2020 SIMD quintile by domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Figure 6 presents a comparison between the 2016 Scottish Index of Multiple Deprivation figures, and the new 2020 SIMD figures. The percentages of the population living within each SIMD quintile and domain quintile were calculated first using the 2016 SIMD datazone classifications, and then the 2020 SIMD classifications. The differences in these percentages are plotted in Figure 6. Negative values on the y axis indicate a decrease in percent of the population living within a quintile, while positive values indicate an increase in percent of the population living within a quintile. **Please note that quintiles have been weighted by the Scottish population so, any local changes in SIMD quintile do not necessarily indicate a difference in deprivation, but rather a difference in deprivation in comparison to the rest of Scotland.**

Figure 6: Percentage population living in the 2016 and the 2020 SIMD and Domain Quintiles



Households

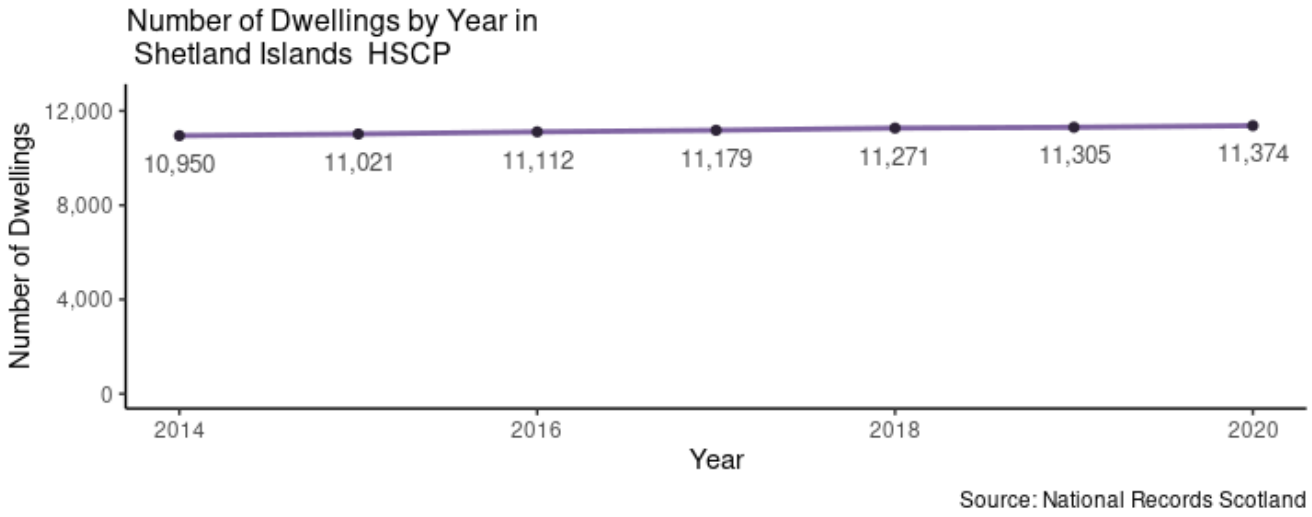
Summary:

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

- **11,374** dwellings, of which: **91%** were occupied and **1.5%** were second homes.
- **33%** of dwellers received a single occupant council tax discount, and **1.3%** were exempt from council tax entirely.
- **67%** of houses were within council tax bands A to C, and **3.3%** were in bands F to H.

The graph below shows the number of dwellings in Shetland Islands from 2014 to 2020.

Figure 7: Number of dwellings time trend.



Of the total number of dwellings in 2020, 33% (3,799 households) were occupied by an individual receiving a single occupant council tax discount. Furthermore, 1.3% (151 households) were occupied and exempt from council tax.

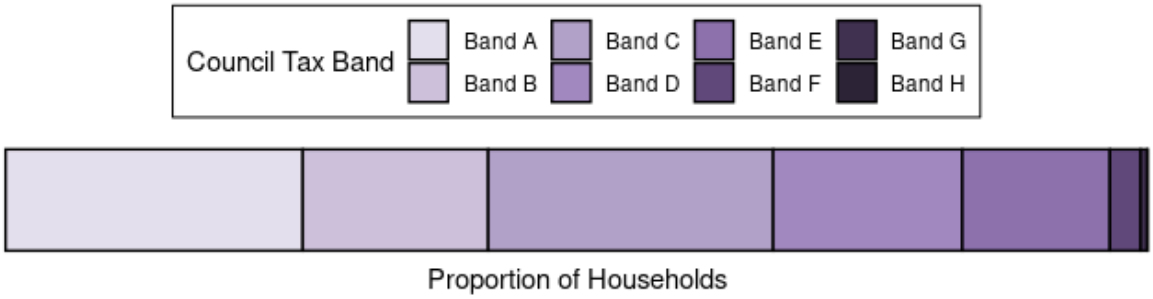
There were 173 dwellings classed as a second home in 2020, these dwellings made up 1.5% of the households in Shetland Islands.

Table 2: Breakdown of dwelling types by year for Shetland Islands HSCP.

Year	Total Dwellings	Occupied Dwellings	Vacant Dwellings	Single Occupant Tax Discount	Council Tax Exempt Dwellings	Second Homes
2014	10,950	10,108	676	3,326	94	161
2015	11,021	10,192	672	3,400	97	157
2016	11,112	10,229	716	3,430	99	164
2017	11,179	10,293	718	3,526	112	168
2018	11,271	10,329	768	3,636	137	169
2019	11,305	10,391	749	3,777	132	165
2020	11,374	10,401	800	3,799	151	173

The proportion of households within each council tax band are displayed in the chart below, figures are shown in Table 3.

Figure 8: Breakdown of households by council tax band for Shetland Islands in 2020.

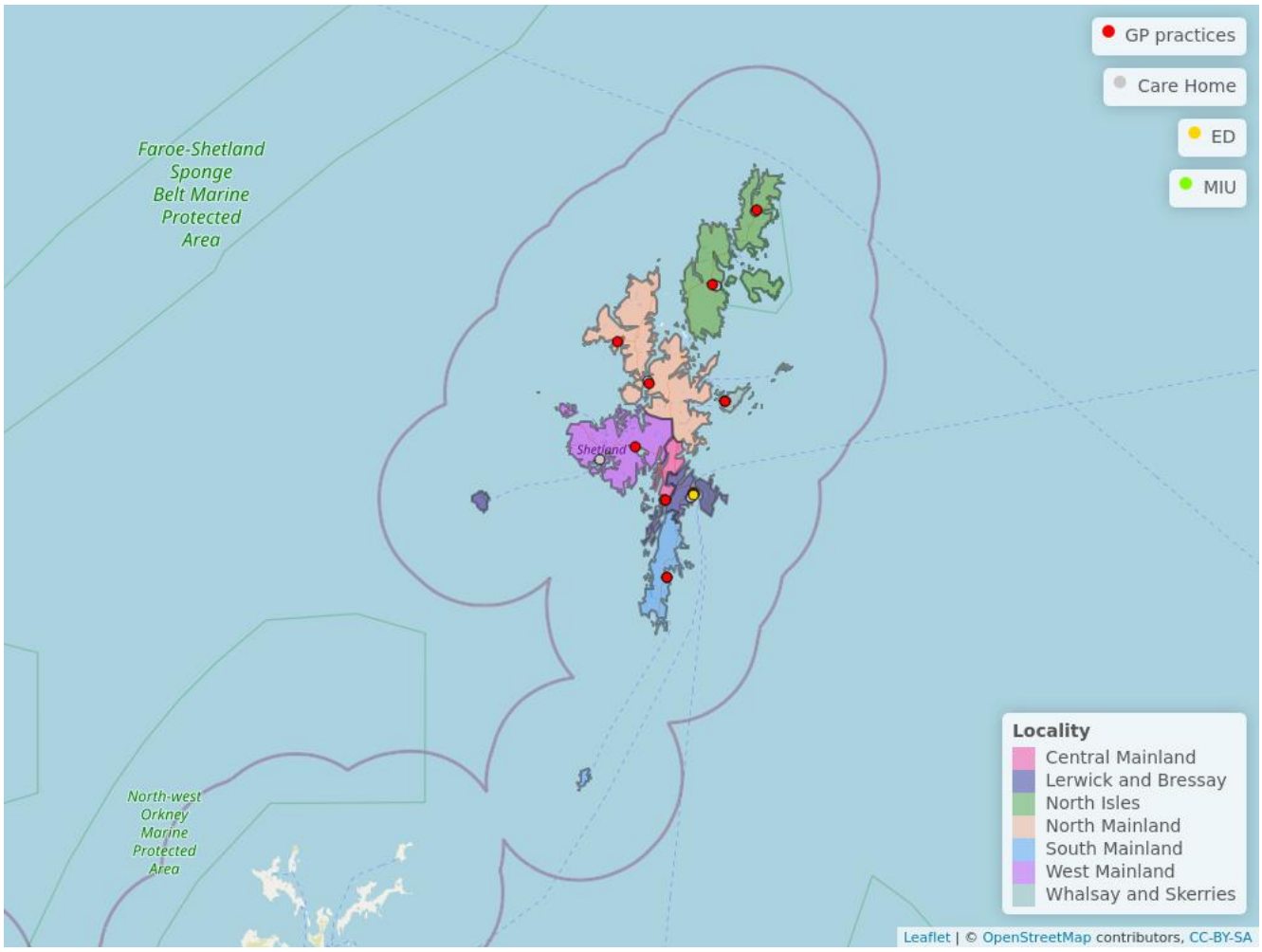


Source: National Records Scotland

Table 3: Percentage of households by council tax band for Shetland Islands in 2020.

Tax Band	A	B	C	D	E	F	G	H
Percent of households	26%	16%	25%	17%	13%	2.7%	0.59%	0.02%

Figure 9: Map of GP practices by locality in Shetland Islands HSCP[2].



ED = Emergency Department, MIU = Minor Injuries Unit (or other)

The number of different types of services within the geographical boundary of Shetland Islands is shown in Table 4. Please note that for some areas, GP Practices may be within the boundary but included in a cluster from another HSCP or vice versa.

Table 4: Number of each type of service in Shetland Islands HSCP[2].

Service Type	Service	Number
Primary Care	GP Practice	9
A&E	Emergency Department	1
	Minor Injuries Unit	0
Care Home	Elderly Care	9
	Other	5

General Health

Summary:

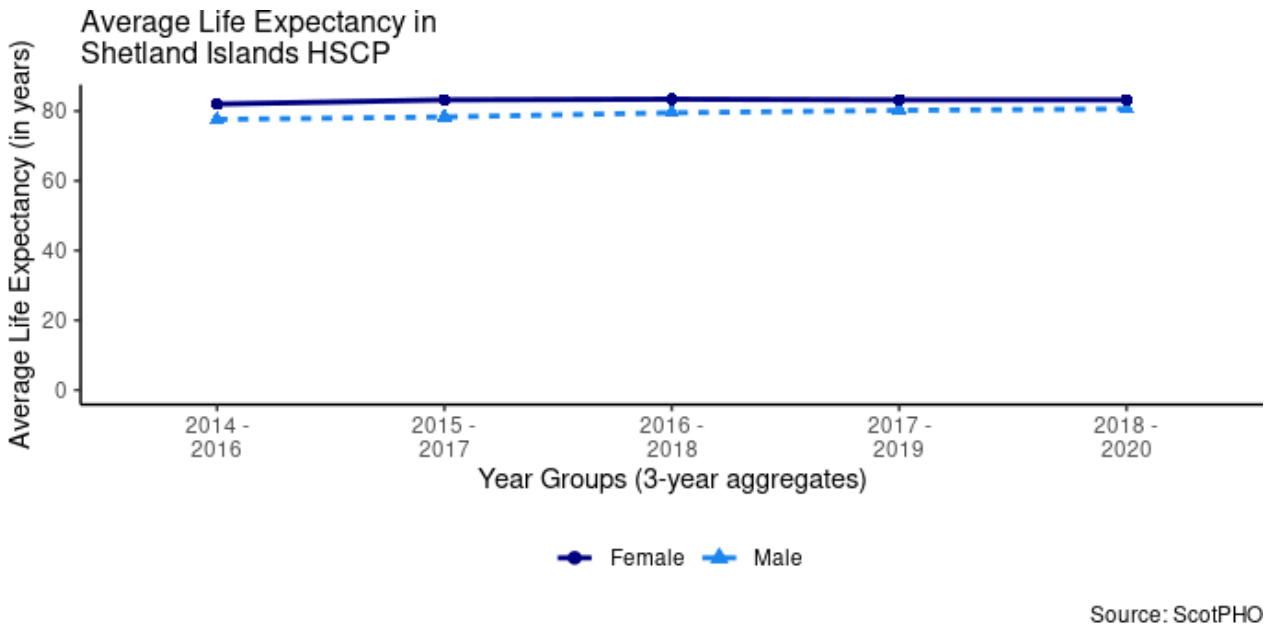
For the most recent time periods available[3], Shetland Islands HSCP had:

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

Life Expectancy

In the latest time period available from 2018-2020 (3 year aggregate), the average life expectancy in Shetland Islands HSCP was 80.6 years old for men, and 83.2 years old for women. A time trend since 2014-2016 can be seen in figure 10.

Figure 10: Average life expectancy in men and women over time.



Source: ScotPHO

Table 5 provides the average life expectancy for men and women in different areas for the latest time period available.

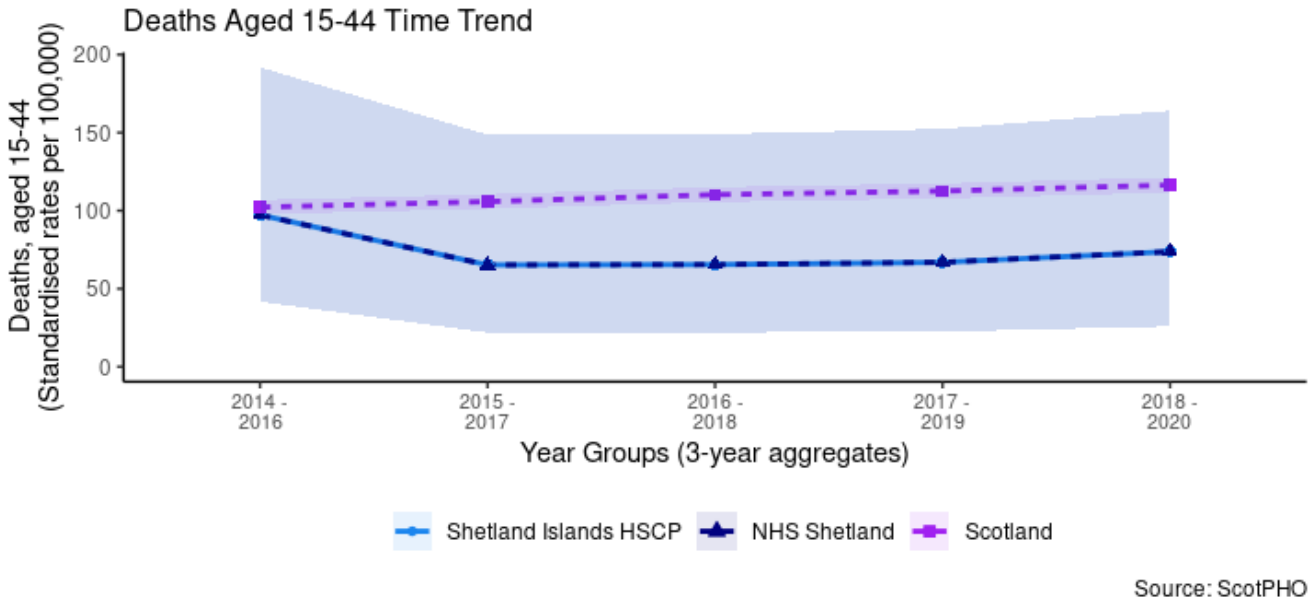
Table 5: Average life expectancy in years for the latest time periods

	Partnership	Health Board	Scotland
	83.2	83.2	81
	80.6	80.6	76.8

Deaths, aged 15-44

The following chart shows a trend of death rates among 15-44 year olds per 100,000 age-sex standardised population[4] by area (i.e. early mortality rate per 100,000). In the most recent aggregate time period available (from 2018-2020), the mortality rate in Shetland Islands HSCP was **74** deaths per 100,000 population.

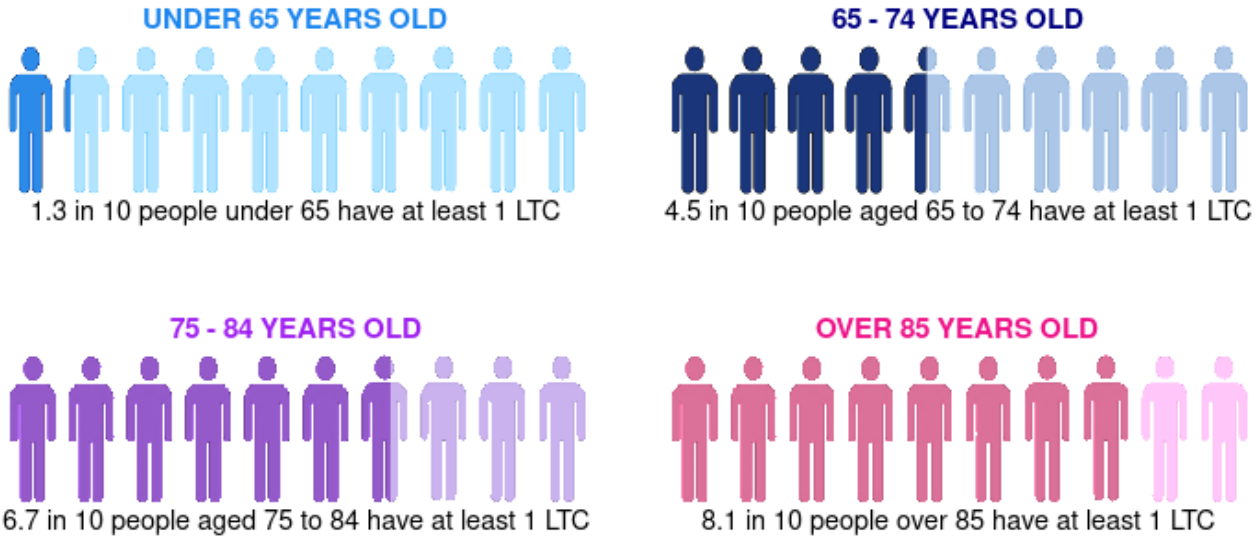
Figure 11: Deaths aged 15-44 years by geographical area and over time.



Source: ScotPHO

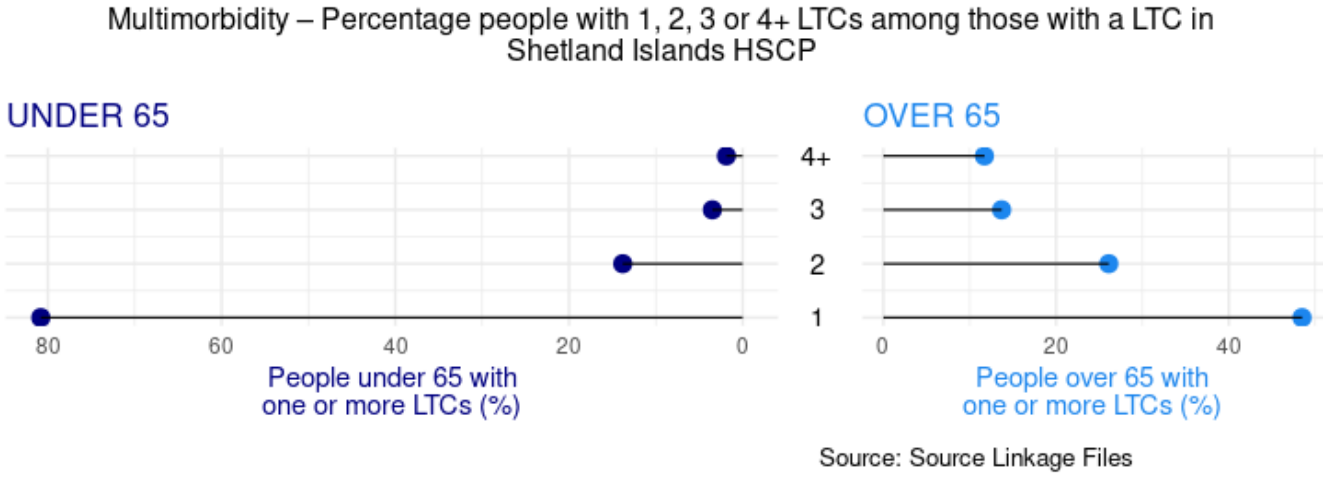
Long-Term Physical Health Conditions and Multimorbidity

In the financial year 2020/21, in Shetland Islands HSCP, **22%** of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy. *Please see footnotes for information and caveats on identifying LTCs.*[5]



The co-occurrence of two or more conditions, known as multimorbidity, is broken down in figure 12, distinguishing between age groups. Note that this chart *excludes* the population in the HSCP who do not have any physical long-term conditions. Figure 13 therefore shows that among the people who have a LTC, **19**% of those under the age of 65 have more than one, compared to **52**% of those aged over 65.

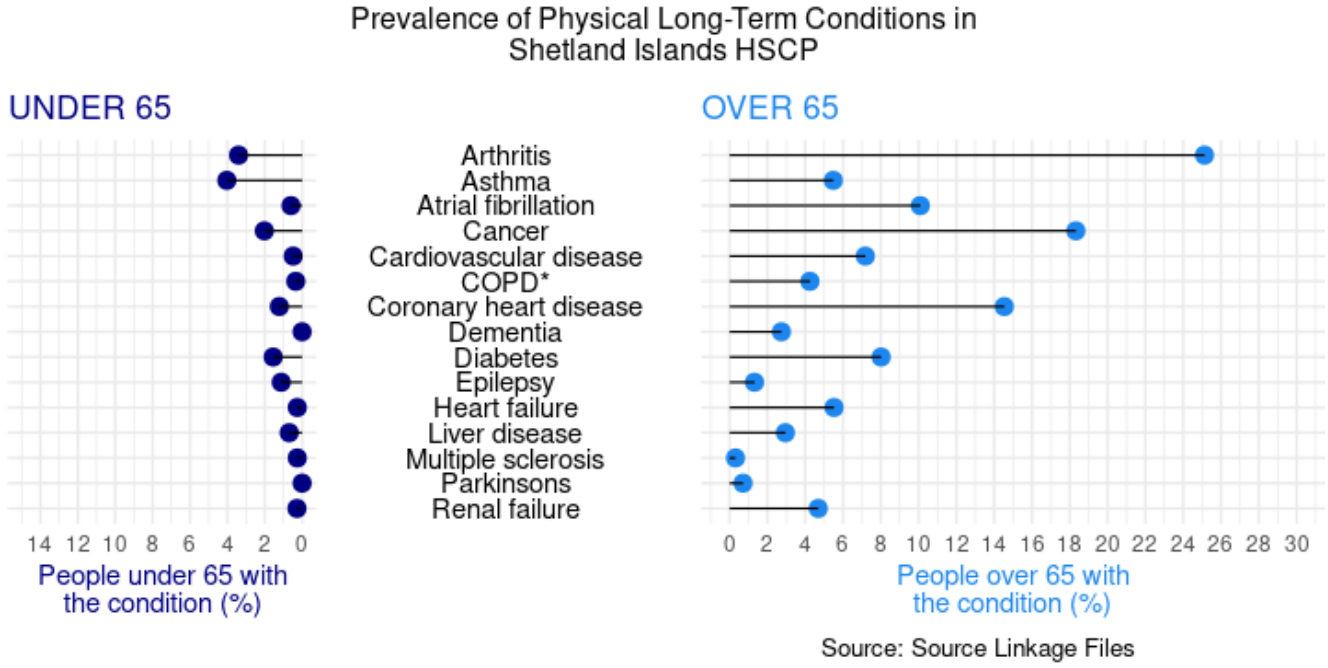
Figure 12: Multimorbidity of physical long-term conditions by age group in 2020/21.



Most common physical Long-Term Conditions (LTCs)

Below is a breakdown of the physical LTCs, for the financial year 2020/21. Figure 13 shows the prevalence of different LTCs in each age group in Shetland Islands HSCP, and Table 6 illustrates the top 5 physical LTCs across all ages at Partnership, Health Board and Scotland level.

Figure 13: Percentage people with each physical LTC, split by age group.



**COPD: Chronic Obstructive Pulmonary Disease*

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).

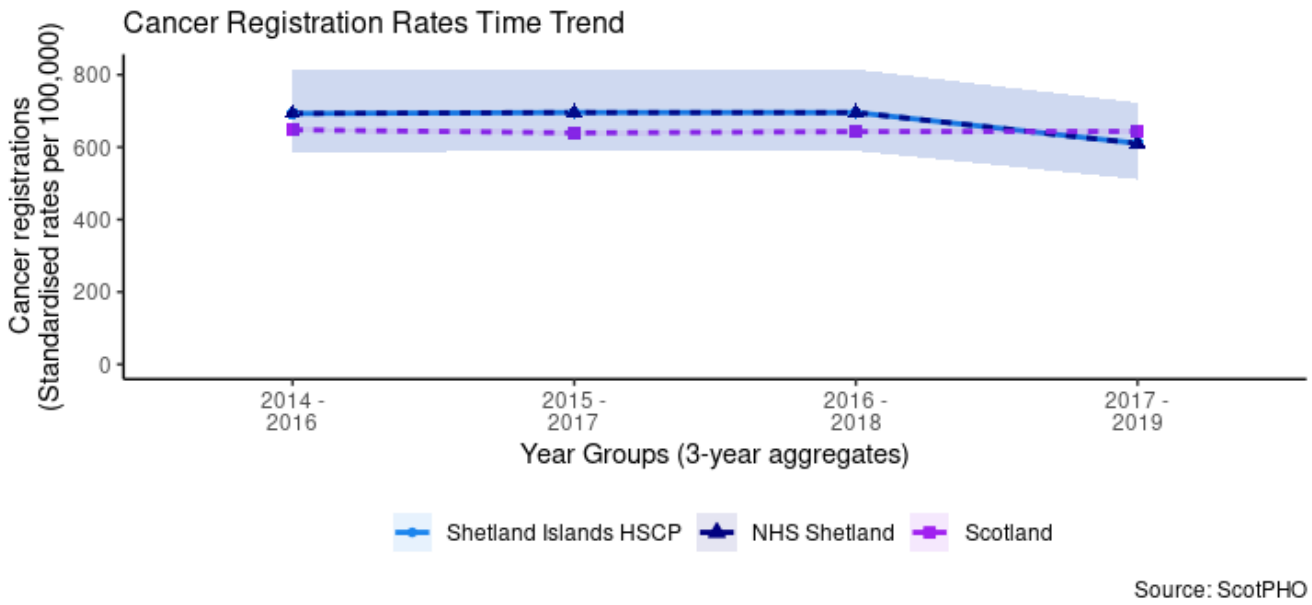
Top 5 Physical Long-Term Conditions

	Shetland Islands HSCP	*NHS Shetland*	*Scotland*
1	Arthritis 8%	Arthritis 8%	Arthritis 5.6%
2	Cancer 5.5%	Cancer 5.5%	Cancer 5.1%
3	Asthma 4.3%	Asthma 4.3%	Coronary heart disease 4.7%
4	Coronary heart disease 4%	Coronary heart disease 4%	Asthma 4.7%
5	Diabetes 2.9%	Diabetes 2.9%	Diabetes 3.2%

Cancer Registrations

For the period 2017-2019, there were 140 new cancer registrations per year on average (**610** registrations per 100,000 age-sex standardised population) in Shetland Islands HSCP. This is a **12%** decrease in cancer registrations rate from the previous aggregate period 2016-2018. Figure 14 shows changes over time since 2014-2016.

Figure 14: Cancer registration rate over time and by geographical area.

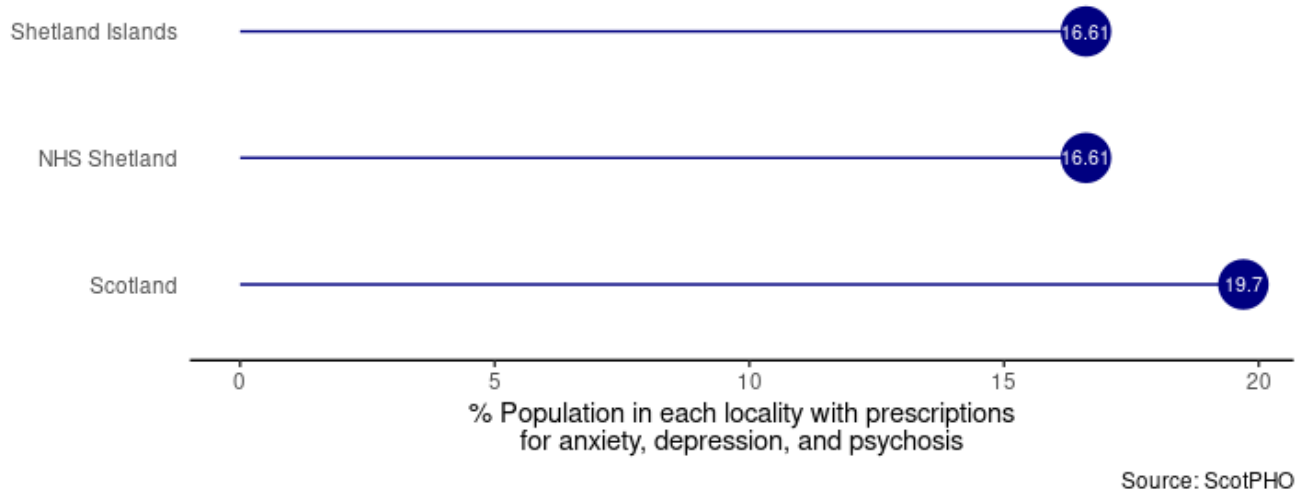


Source: ScotPHO

Anxiety, Depression, and Psychosis Prescriptions

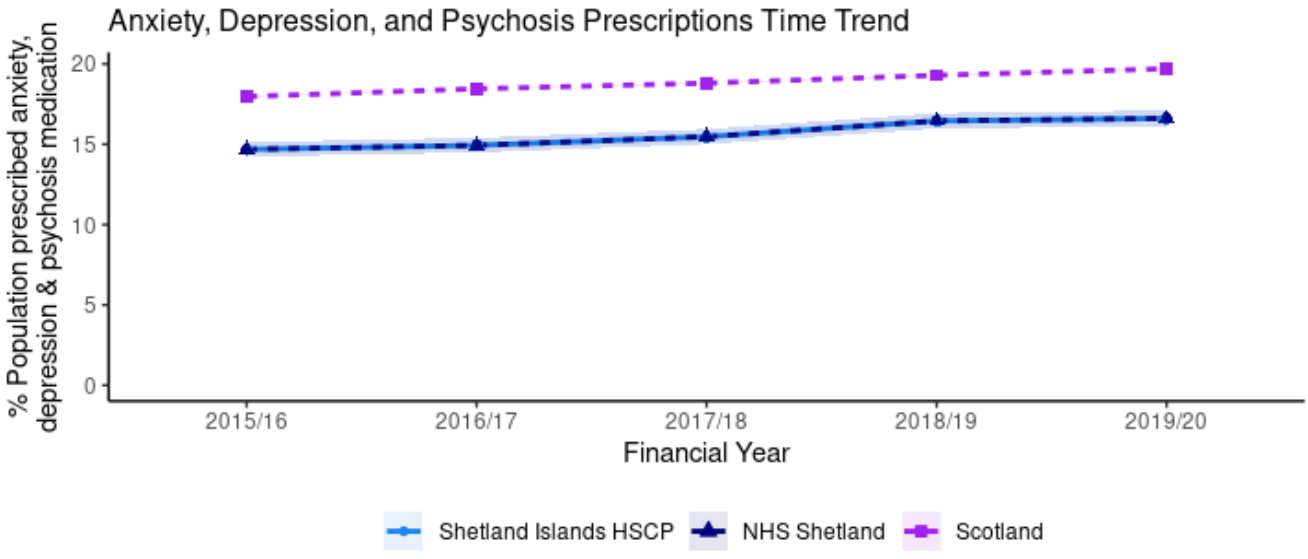
In the 2019/20 financial year, 16.61% of people were prescribed medication for anxiety, depression, or psychosis (ADP) in Shetland Islands HSCP. This is a 0.97% increase from the previous financial year.

Figure 15: Percentage population prescribed ADP medication in Shetland Islands HSCP.



Source: ScotPHO

Figure 16: ADP prescriptions over time and by geographical area.



Source: ScotPHO

Lifestyle and Risk Factors

Summary:

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

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

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

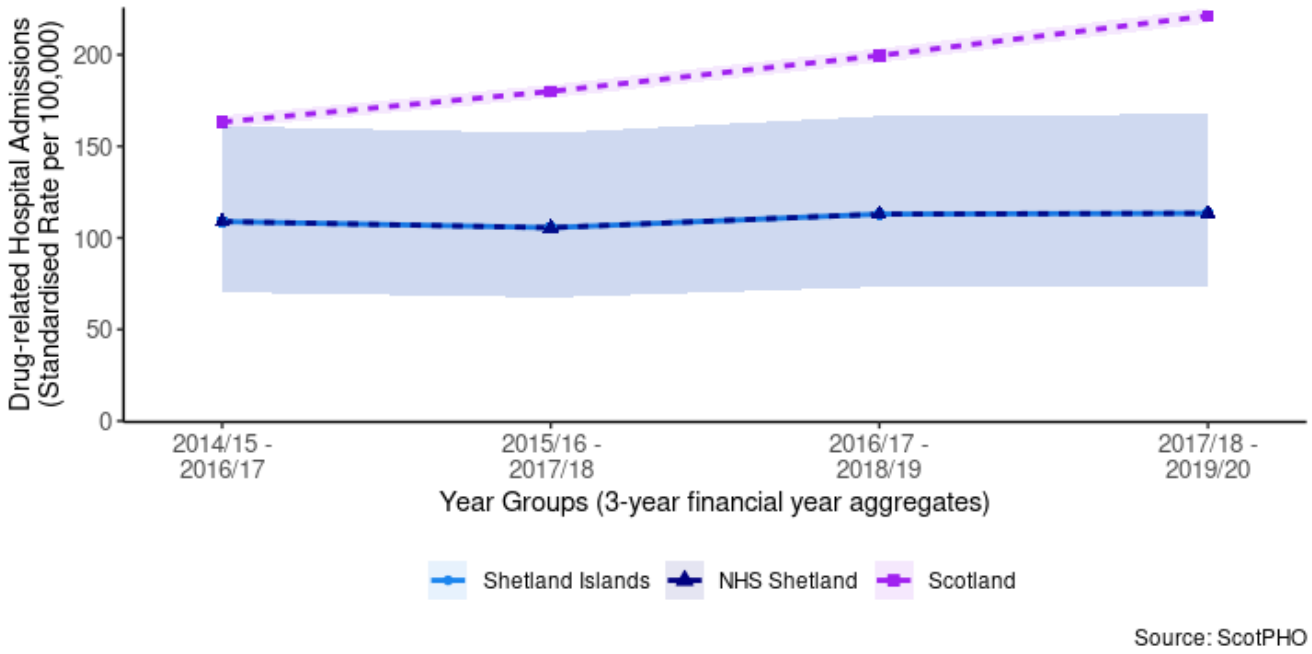
Drug-related Hospital Admissions

There were 113 drug-related hospital admissions per 100,000 age-sex standardised population[4] in Shetland Islands HSCP for the most recent time period available (3 year financial year aggregate for 2017/18 - 2019/20).

This is a 3.7% increase since 2014/15 - 2016/17 (3 financial year aggregates).

A trend of the change in drug-related hospital admissions for Shetland Islands HSCP compared with Scotland and NHS Shetland is shown in the chart below from 2014/15 - 2016/17 onwards.

Figure 17: Trend of Drug-related Hospital Admission Rates by geographical area.

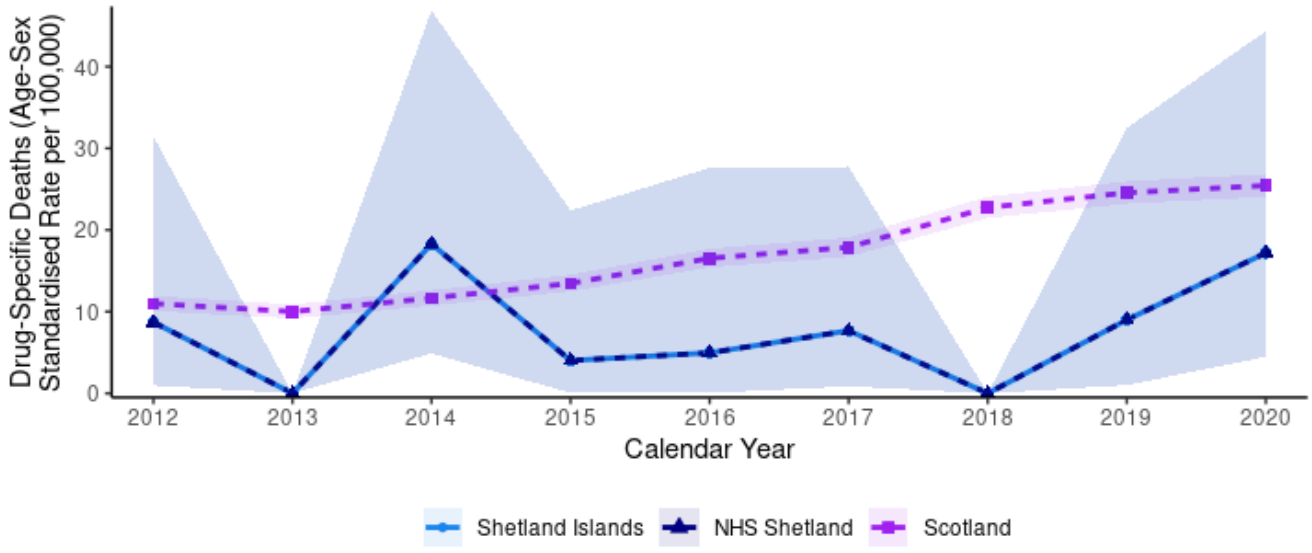


Source: ScotPHO

Drug-Specific Deaths

Data on alcohol-specific deaths is available per calendar year. The rate of drug-specific deaths is currently higher in Shetland Islands than the rate in 2015 (328% change).

Figure 18: Trend of Drug-Specific Death Rates by geographical area.



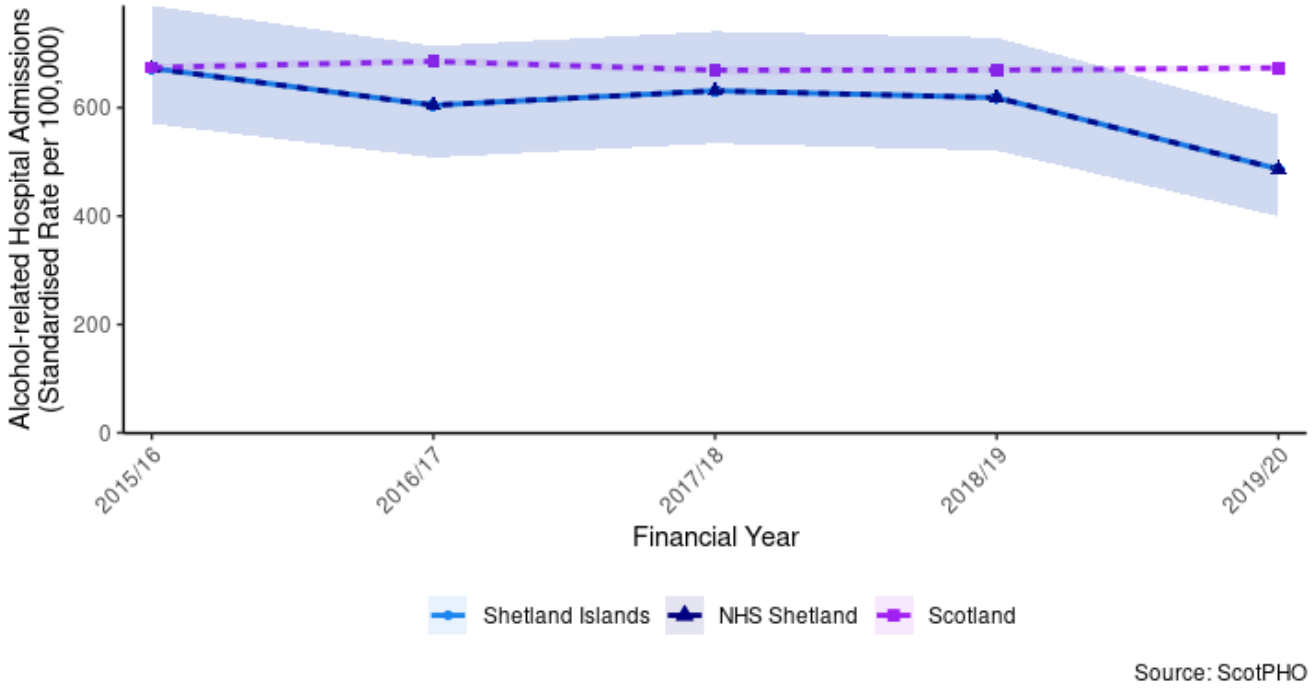
Source: ScotPHO

Alcohol-related Hospital Admissions

The 2019/20 alcohol-related admissions rate is 487 per 100,000 age-sex standardised population[4], which is a 28% decrease overall since 2015/16.

The chart below shows a trend of alcohol-related hospital admissions for Shetland Islands HSCP compared with Scotland and NHS Shetland from financial year 2015/16 to 2019/20.

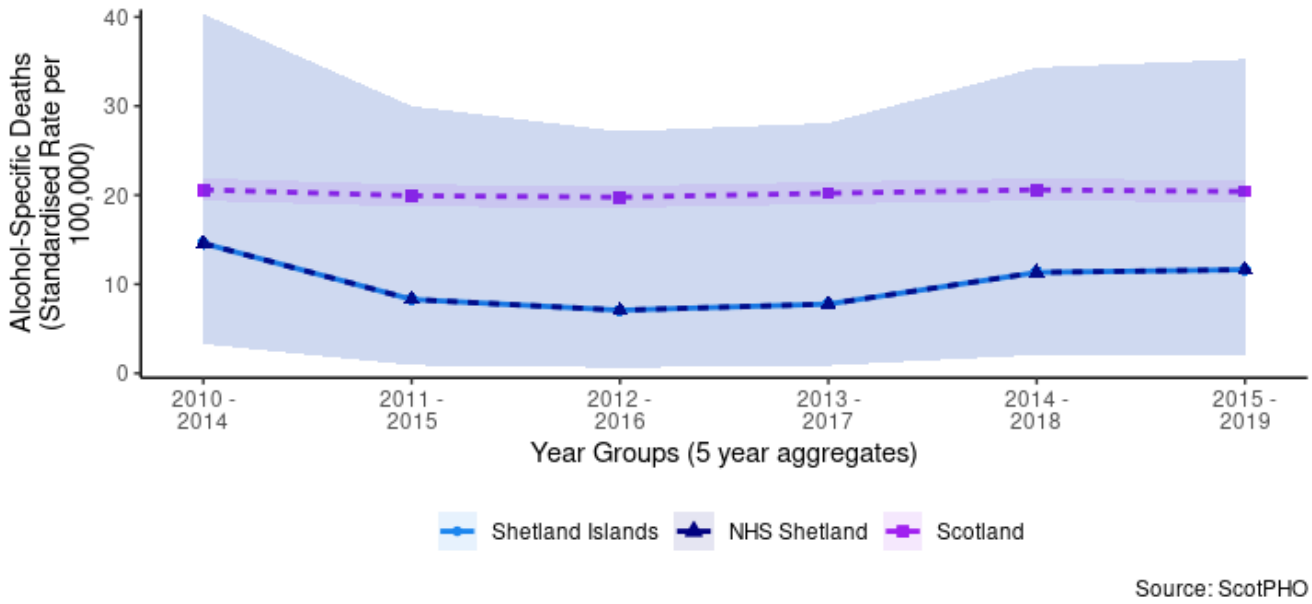
Figure 19: Trend of Alcohol-related Hospital Admission Rates by geographical area.



Alcohol-Specific Deaths

Data on alcohol-specific deaths is available as 5 year aggregates. The rate of alcohol-specific deaths is currently lower in Shetland Islands than the rate in 2010 to 2014 (-20% change).

Figure 20: Trend of Alcohol-Specific Death Rates by geographical area.



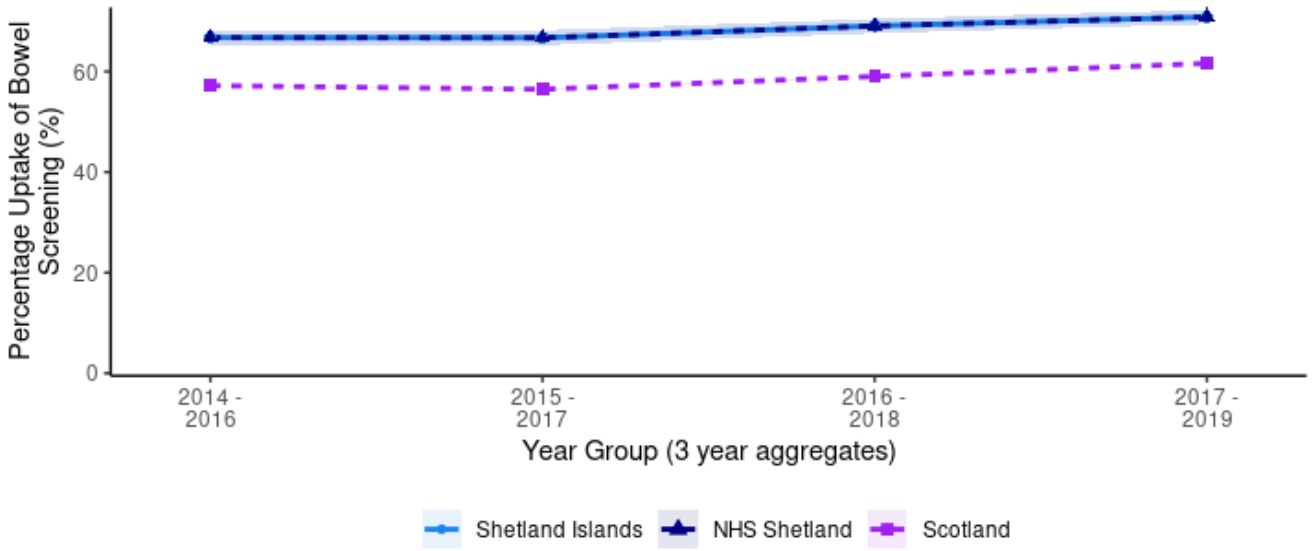
Source: ScotPHO

Bowel Screening Uptake

Bowel screening is offered every two years to eligible men and women aged between 50-74 years old. Eligible people are posted a test kit which is completed at home. Since 1st April 2013, those aged 75 and over can also self-refer and opt into screening. The uptake target for this program is 60%.

A trend of the percentage uptake of bowel screening among the eligible population is shown below for Shetland Islands HSCP compared with Scotland and NHS Shetland. Data is suppressed into 3 year aggregates. The 2017 - 2019 uptake rate for Shetland Islands is **71%**.

Figure 21: Trend of Bowel Screening Uptake for eligible men and women, by geographical area.



Source: ScotPHO

Hospital and Community Care

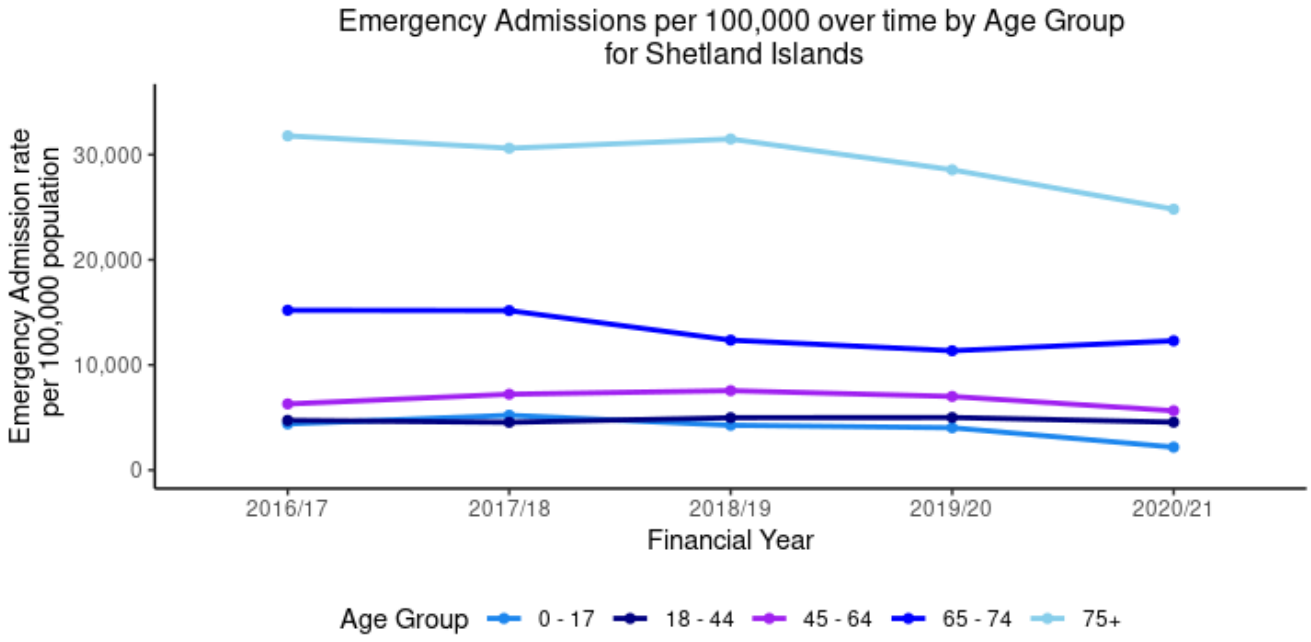
This section includes acute hospital data, delayed discharge bed days and A&E attendances. Please note that for 2020 onwards, hospital activity would have been severely affected by the COVID-19 pandemic. Information on how this has had a wider impact is provided in Footnote 6 at the end of the document.

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

- **7,171** emergency hospital admissions per 100,000 population.
- **39,856** unscheduled acute specialty bed days per 100,000 population.
- **21,329** A&E attendances per 100,000 population.
- **2,374** delayed discharge bed days per 100,000 population.
- **638** emergency hospital admissions from falls per 100,000 population.
- **90** emergency readmissions (28 day) per 1,000 discharges.
- **770** potentially preventable hospital admissions per 100,000 population.
- People on average spent **94%** of their last 6 months of life in a community setting.

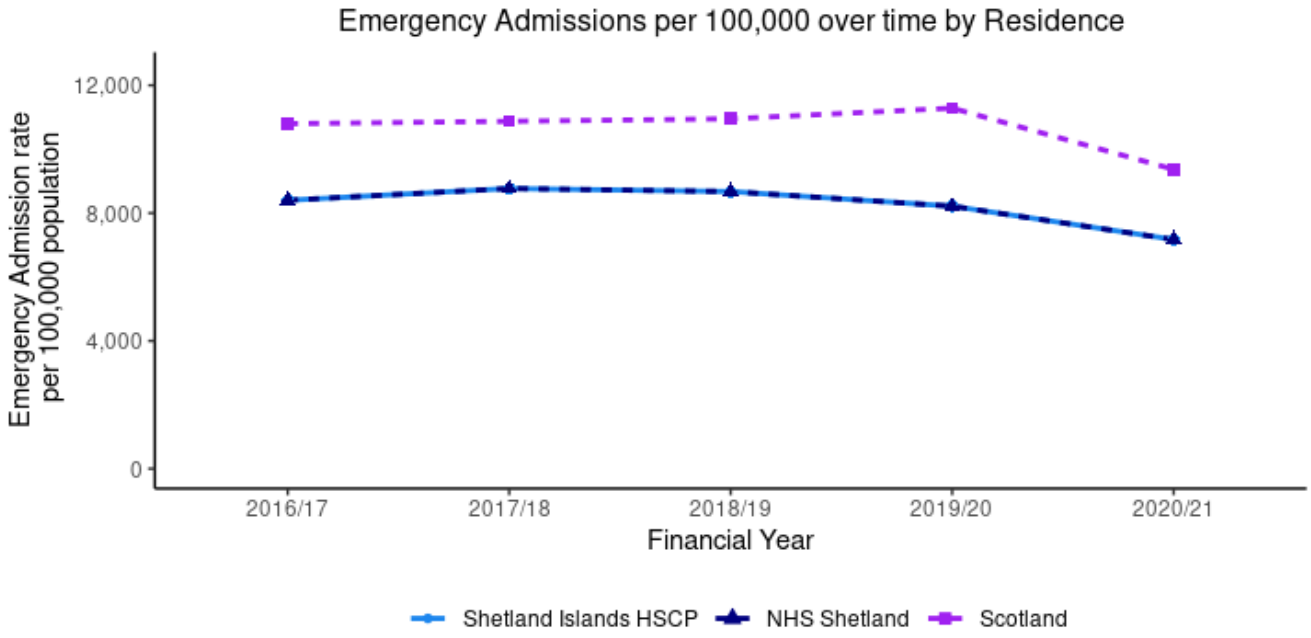
Emergency Admissions

Figure 22: Emergency admissions by age group



Source: PHS SMR01

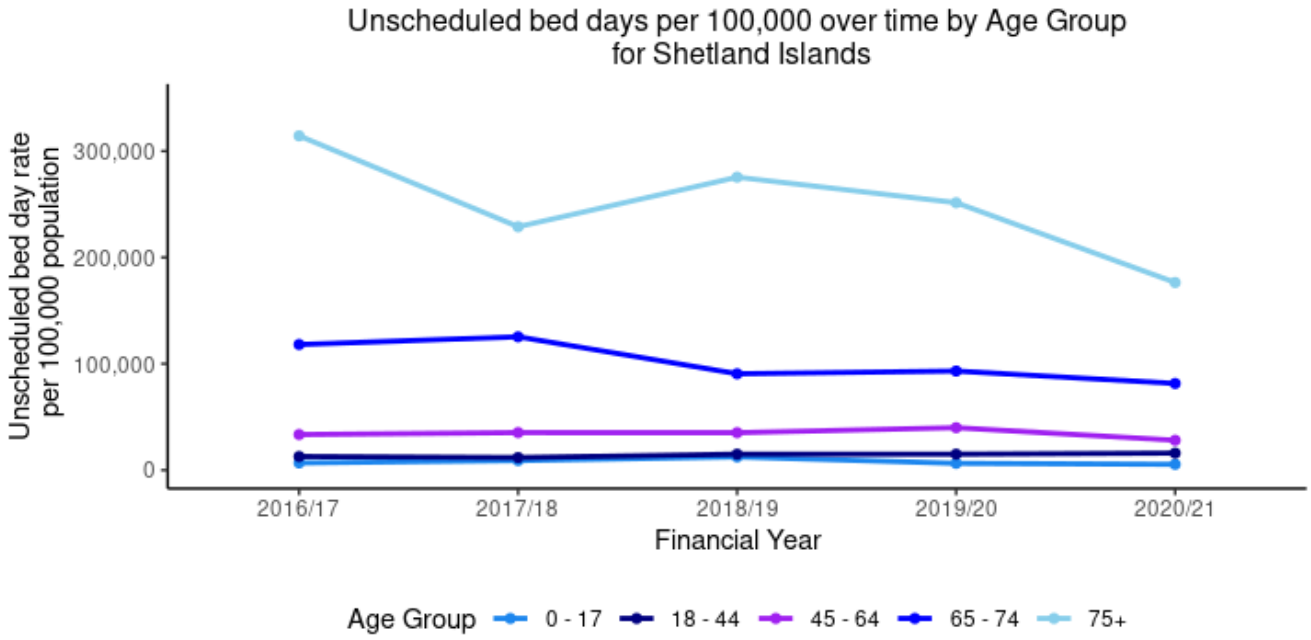
Figure 23: Emergency admissions by geographical area



Source: PHS SMR01

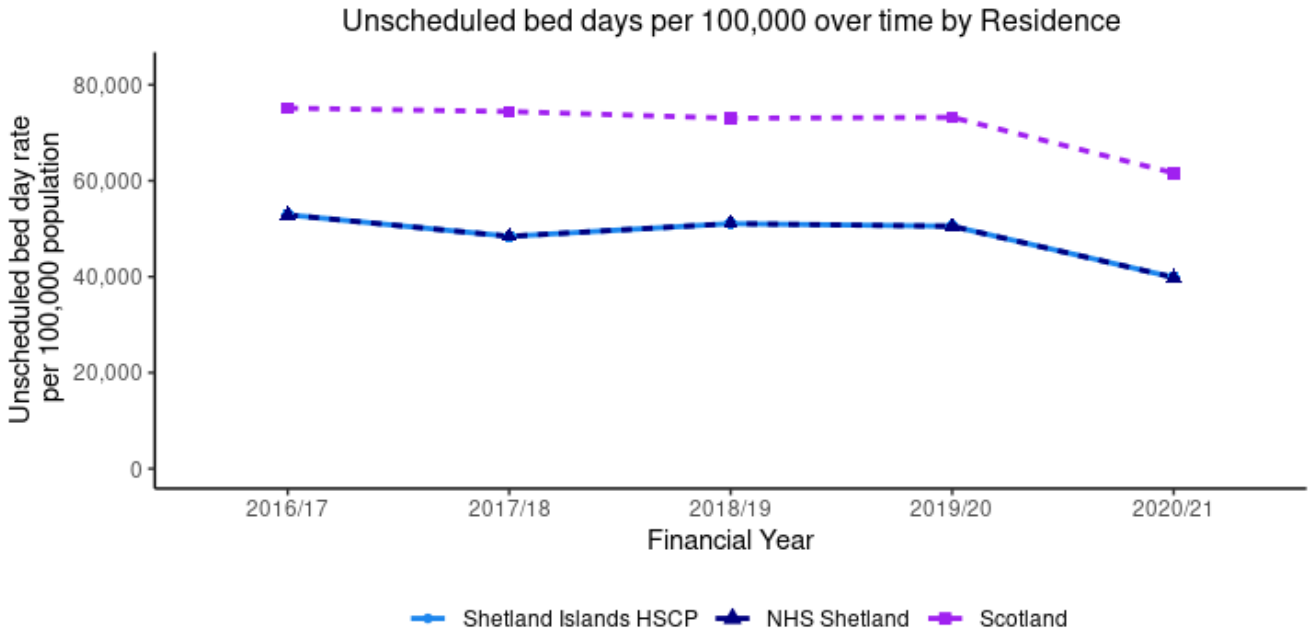
Unscheduled Acute Bed Days

Figure 24: Unscheduled bed days by age group



Source: PHS SMR01

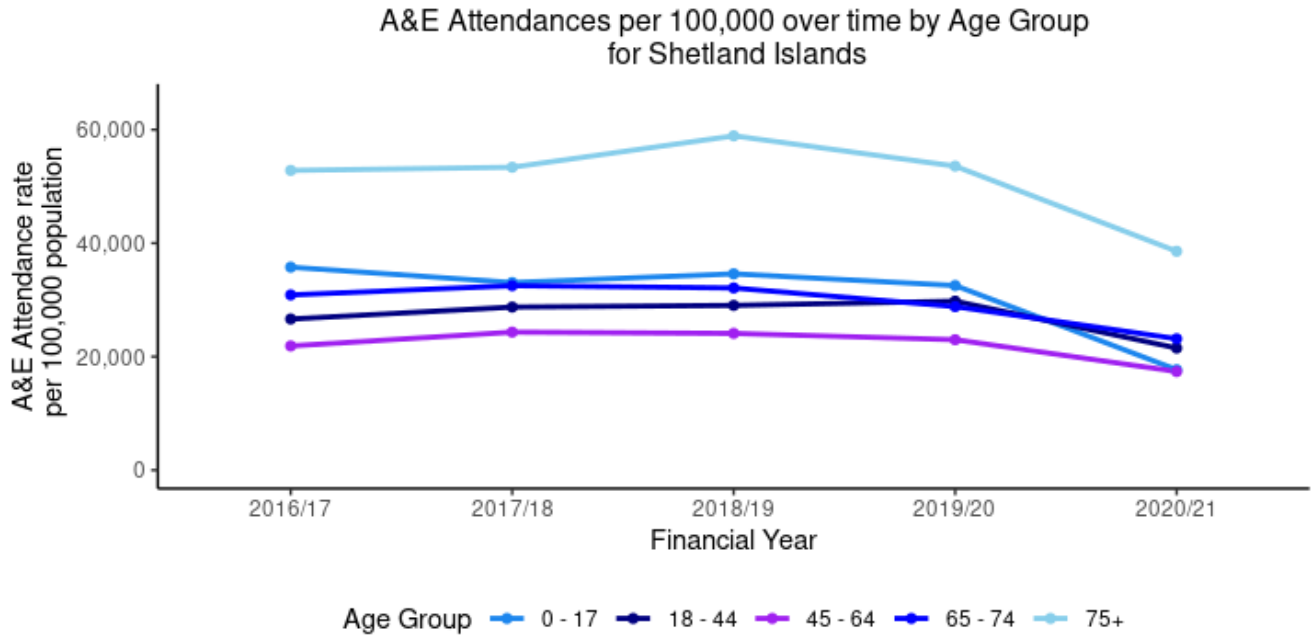
Figure 25: Unscheduled bed days by geographical area



Source: PHS SMR01

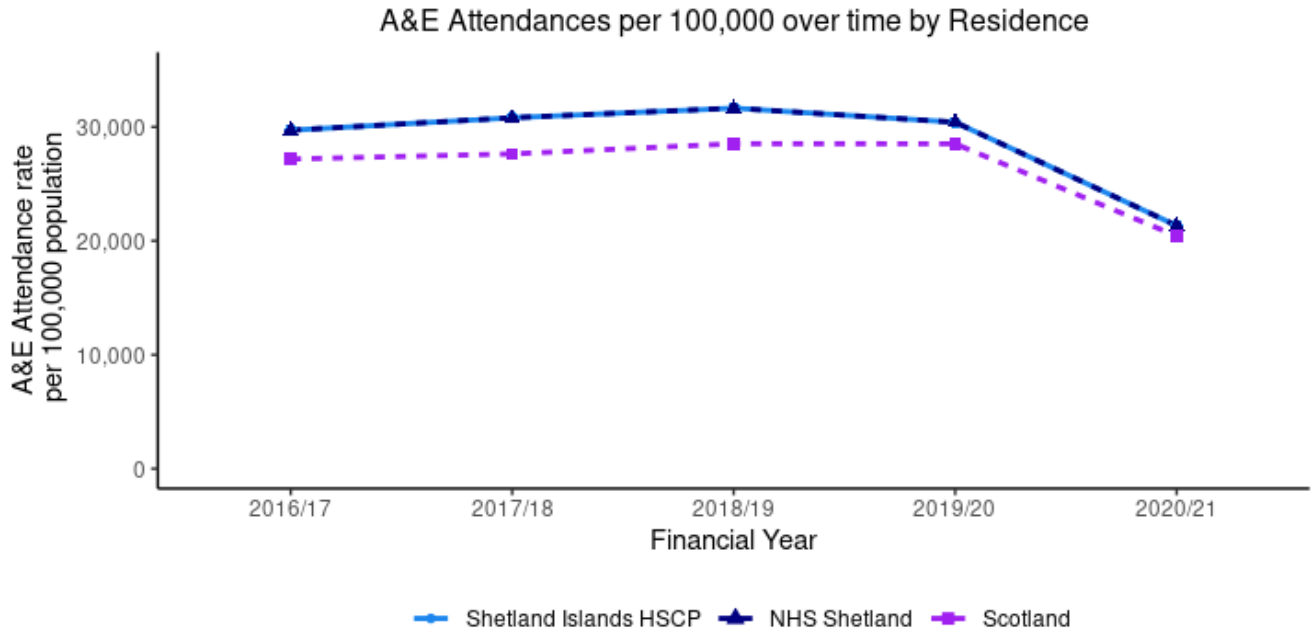
A&E Attendances

Figure 26: A&E attendances by age group



Source: PHS A&E Datamart

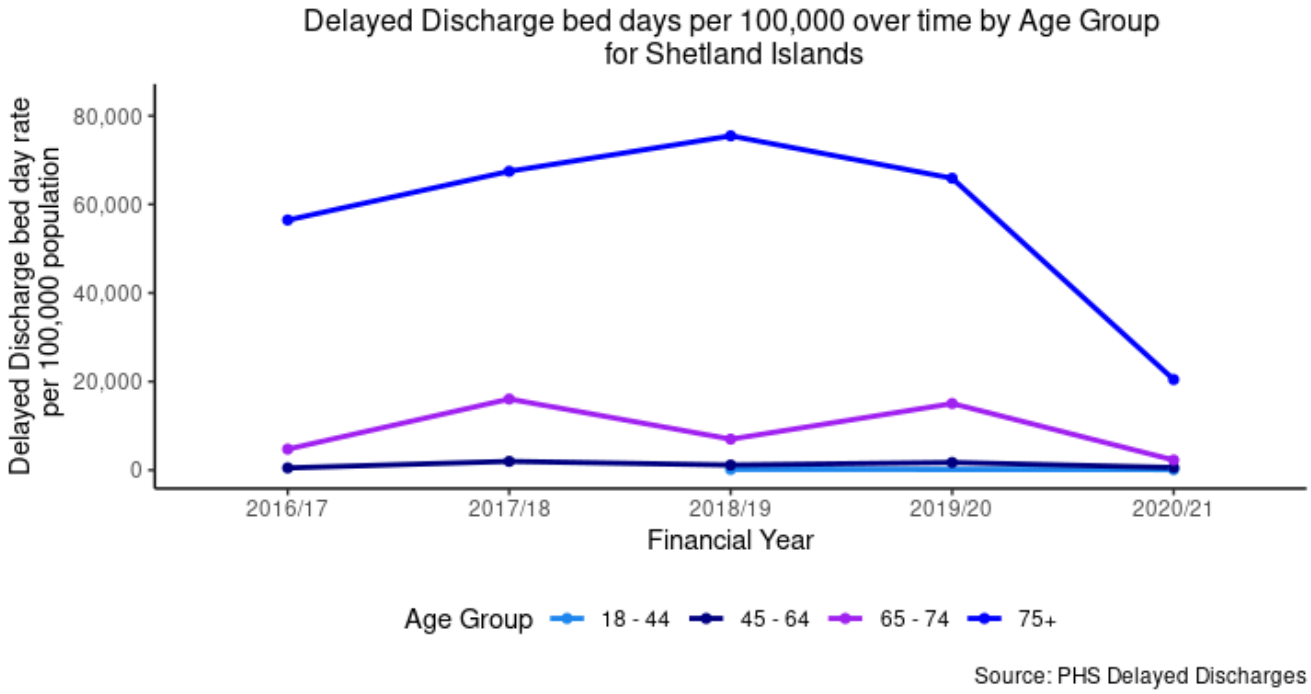
Figure 27: A&E attendances by geographical area



Source: PHS A&E Datamart

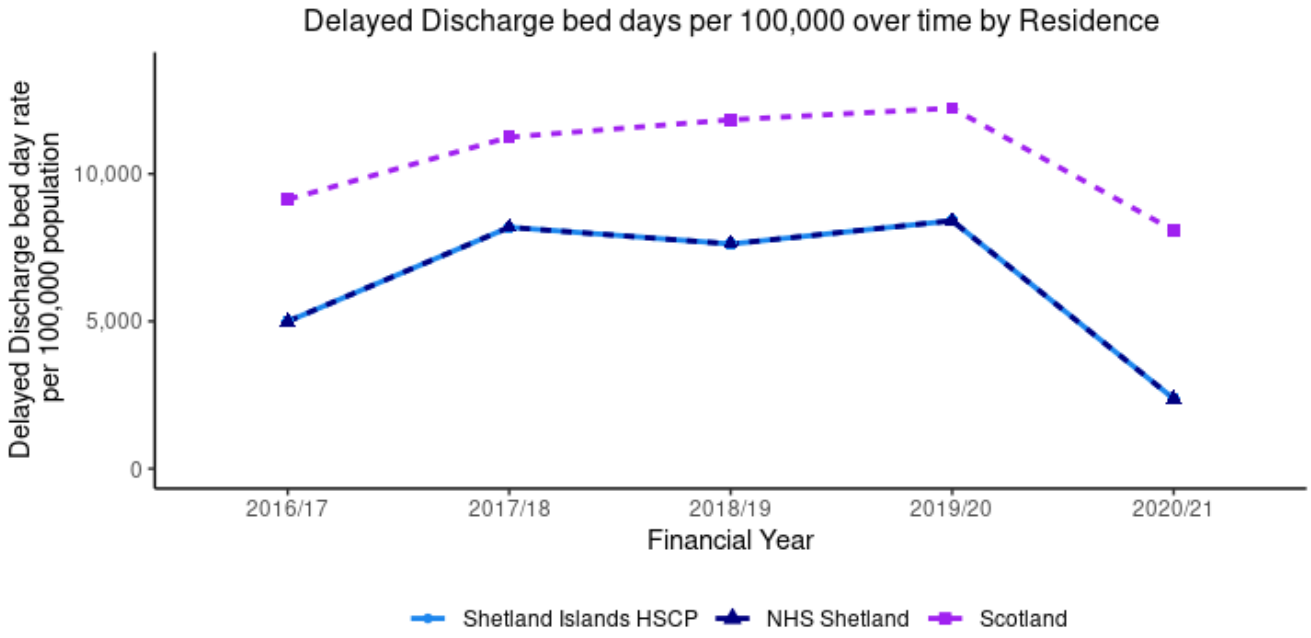
Delayed Discharge Bed Days

Figure 28: Delayed discharge bed days by age group



Source: PHS Delayed Discharges

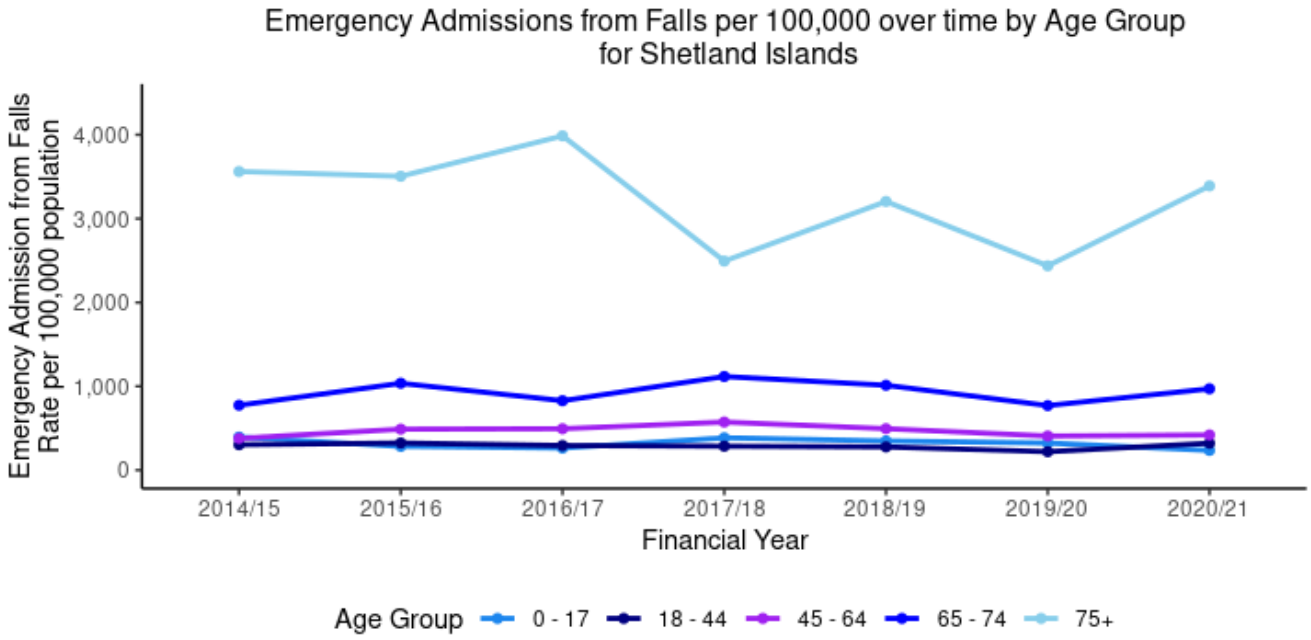
Figure 29: Delayed discharge bed days by geographical area



Source: PHS Delayed Discharges

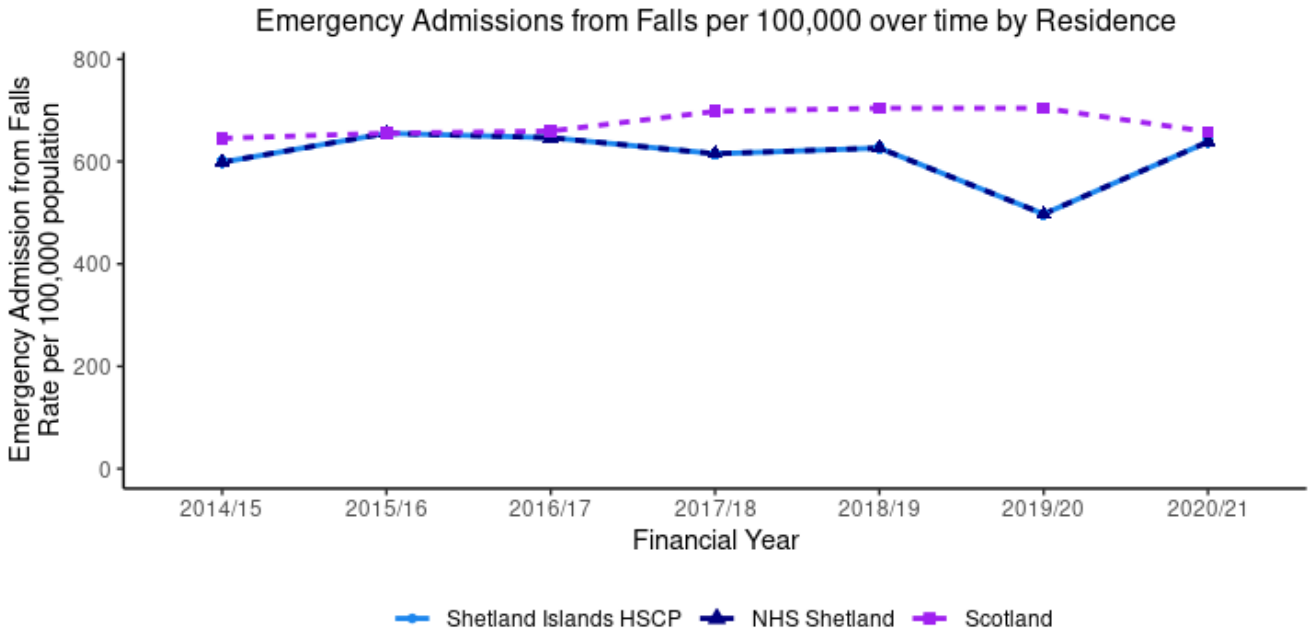
Emergency Admissions from a Fall

Figure 30: Falls by age group



Source: PHS SMR01

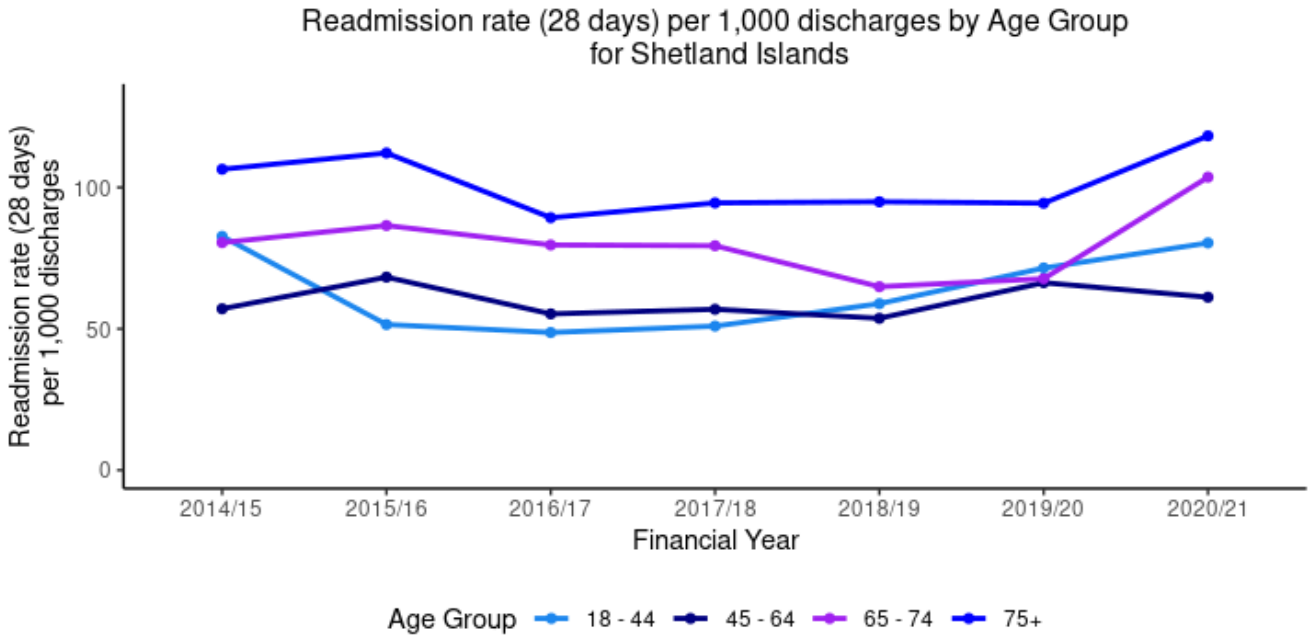
Figure 31: Falls by geographical area



Source: PHS SMR01

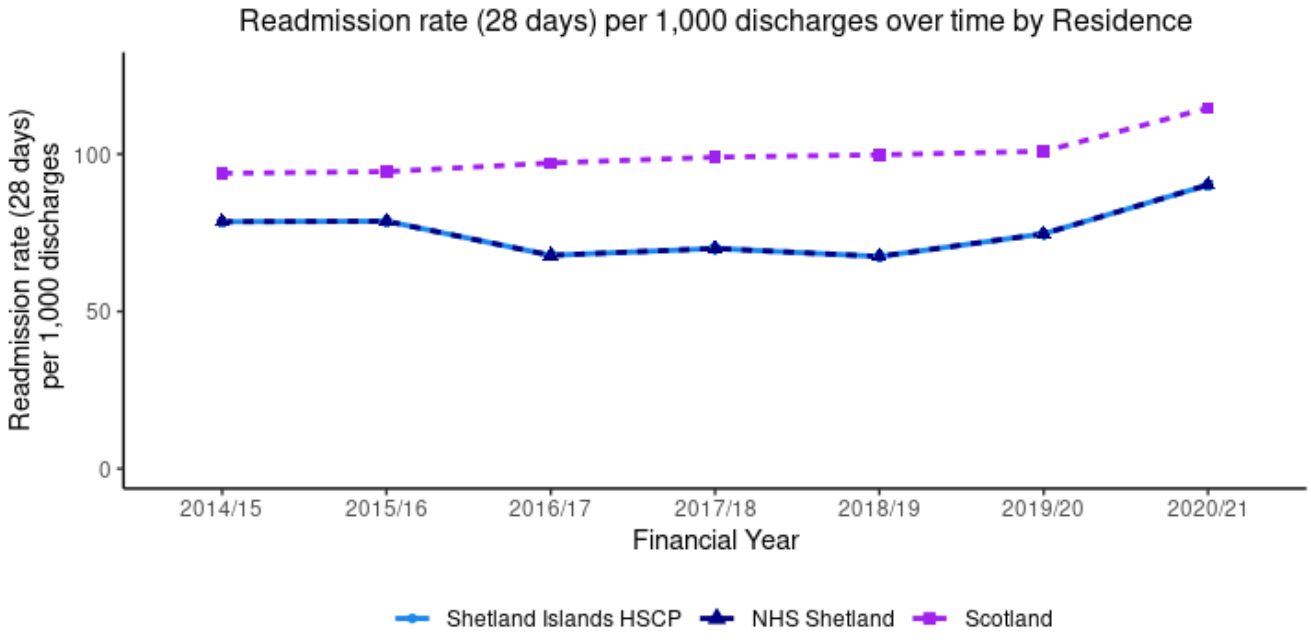
Emergency Readmissions (28 days)

Figure 32: Emergency readmissions by age group



Source: PHS SMR01

Figure 33: Emergency readmissions by geographical area

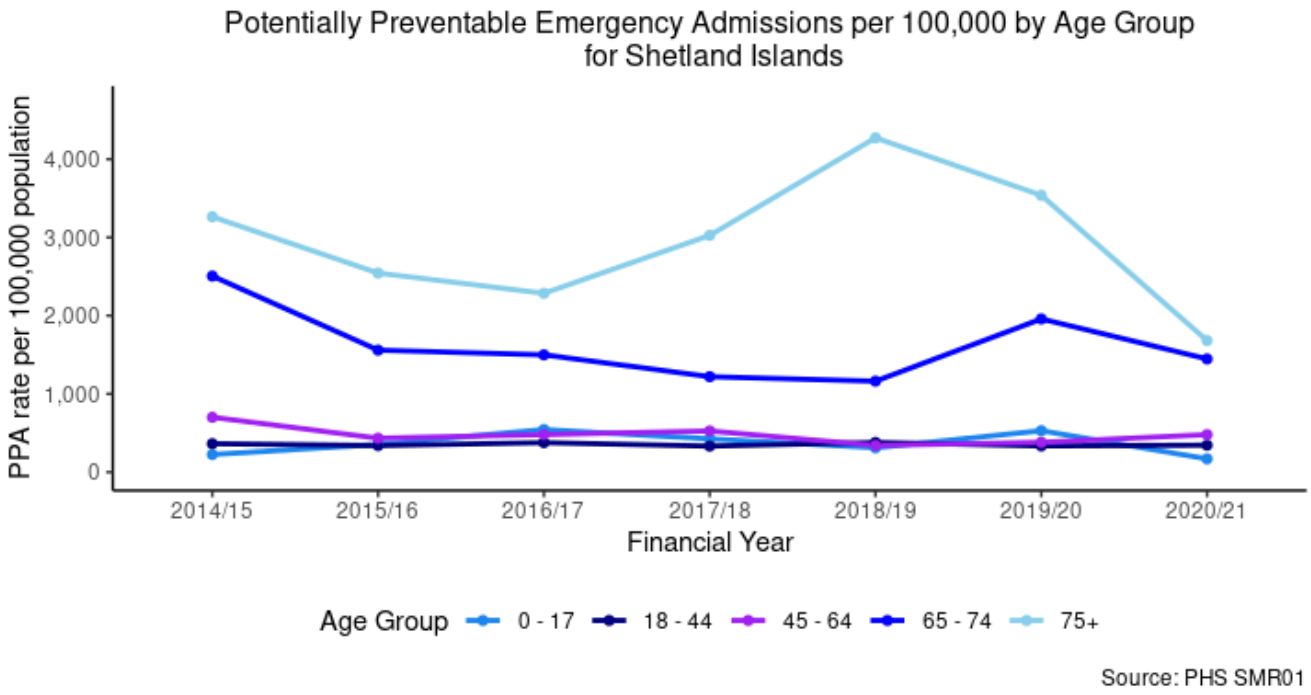


Source: PHS SMR01

Potentially Preventable Admissions (PPAs)

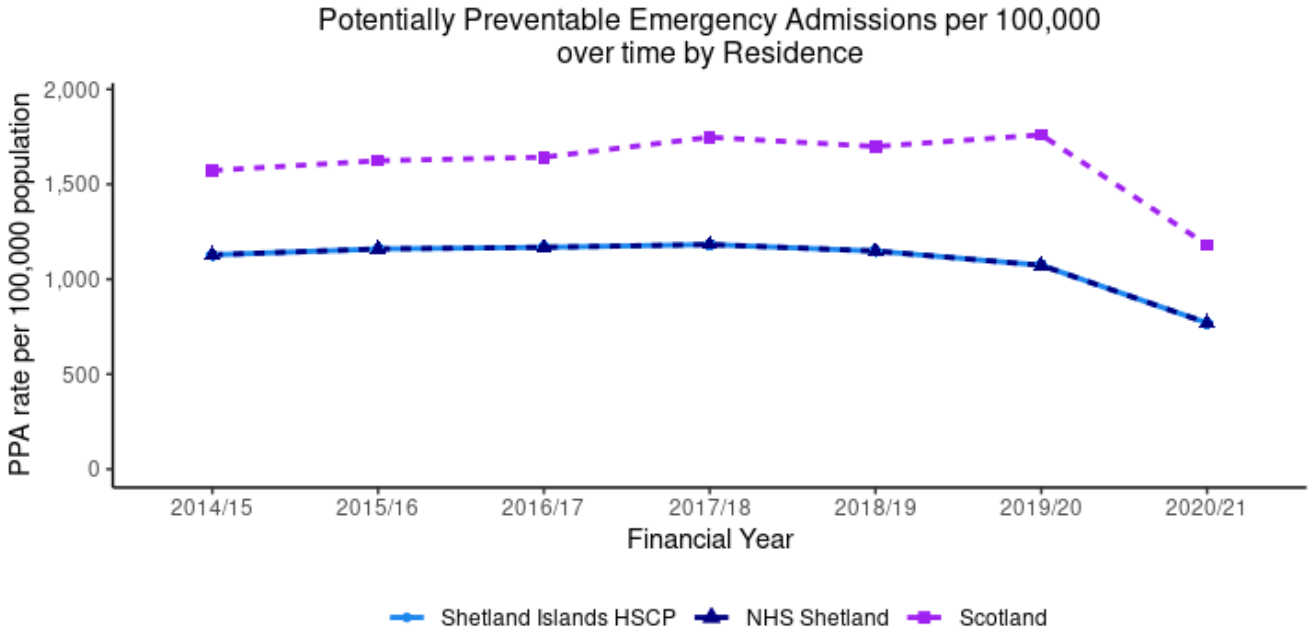
Information on which conditions are counted as PPAs is available in Appendix 3.

Figure 34: PPAs by age group



Source: PHS SMR01

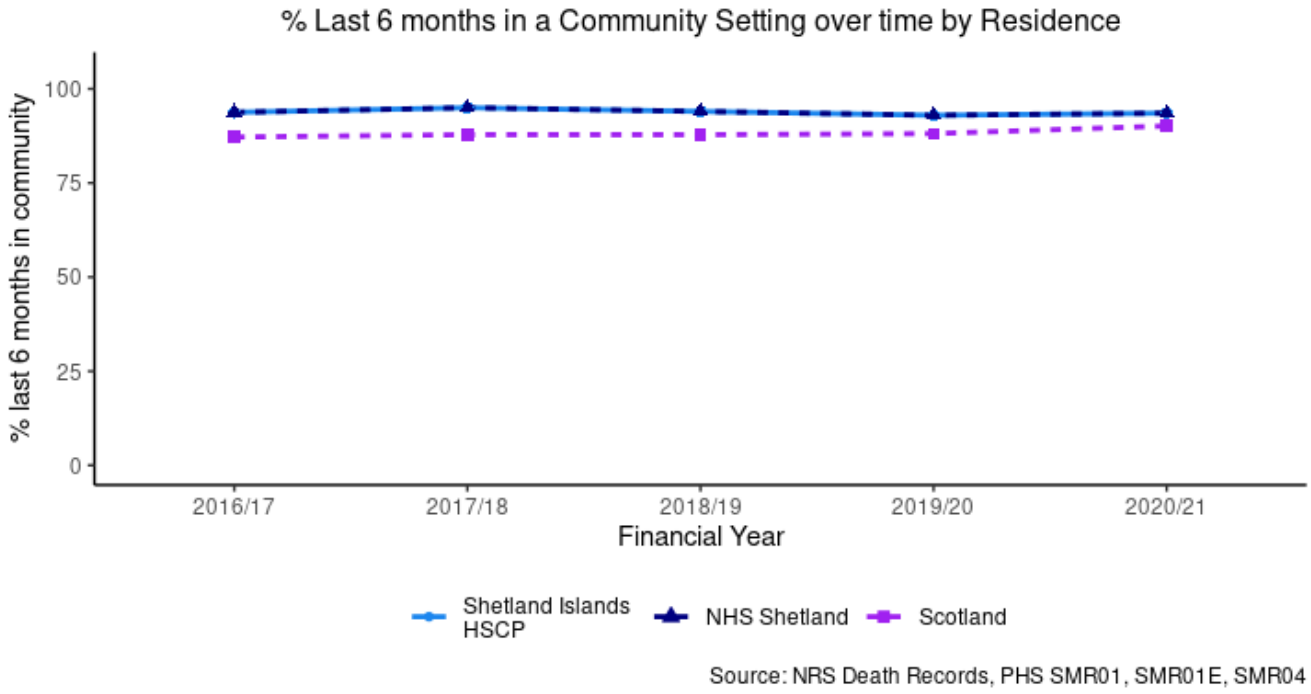
Figure 35: PPAs by geographical area



Source: PHS SMR01

% Last 6 months in a Community Setting

Figure 36: Last 6 months in a community setting by geographical area



Mental Health related Unscheduled Care

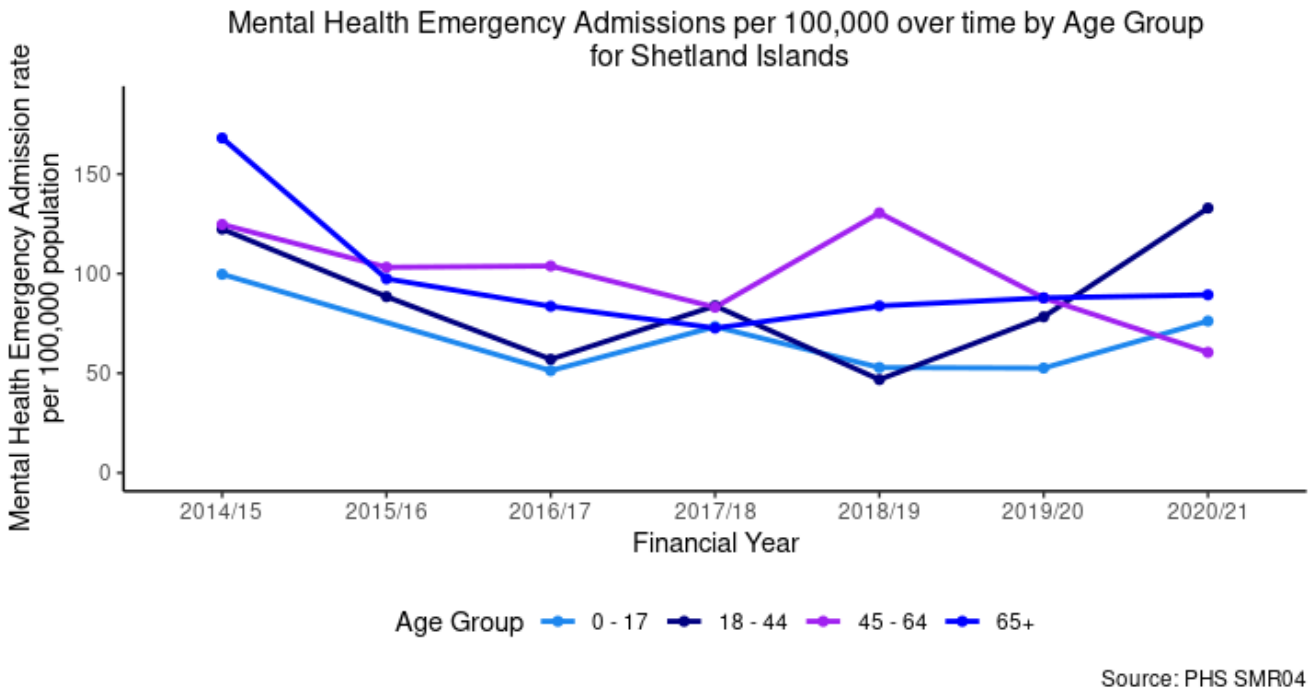
This section looks at mental health related unscheduled care indicators.

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

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

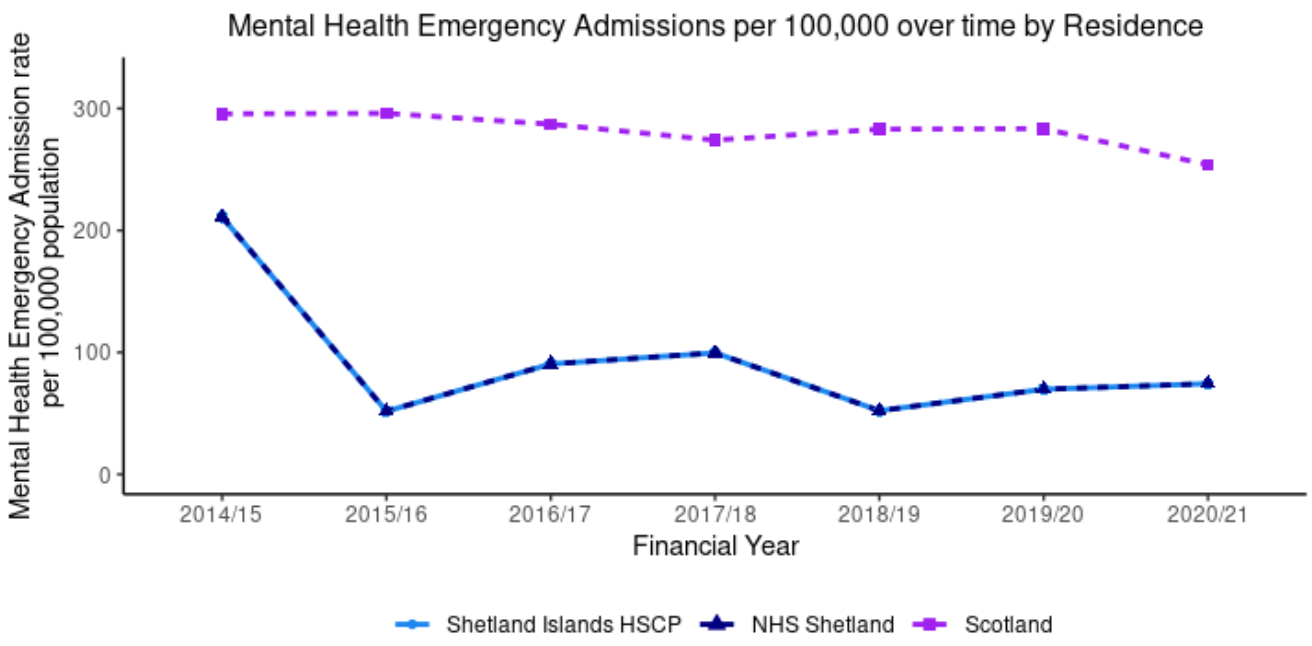
Emergency Admissions (MH)

Figure 37: MH Emergency admissions by age group



Source: PHS SMR04

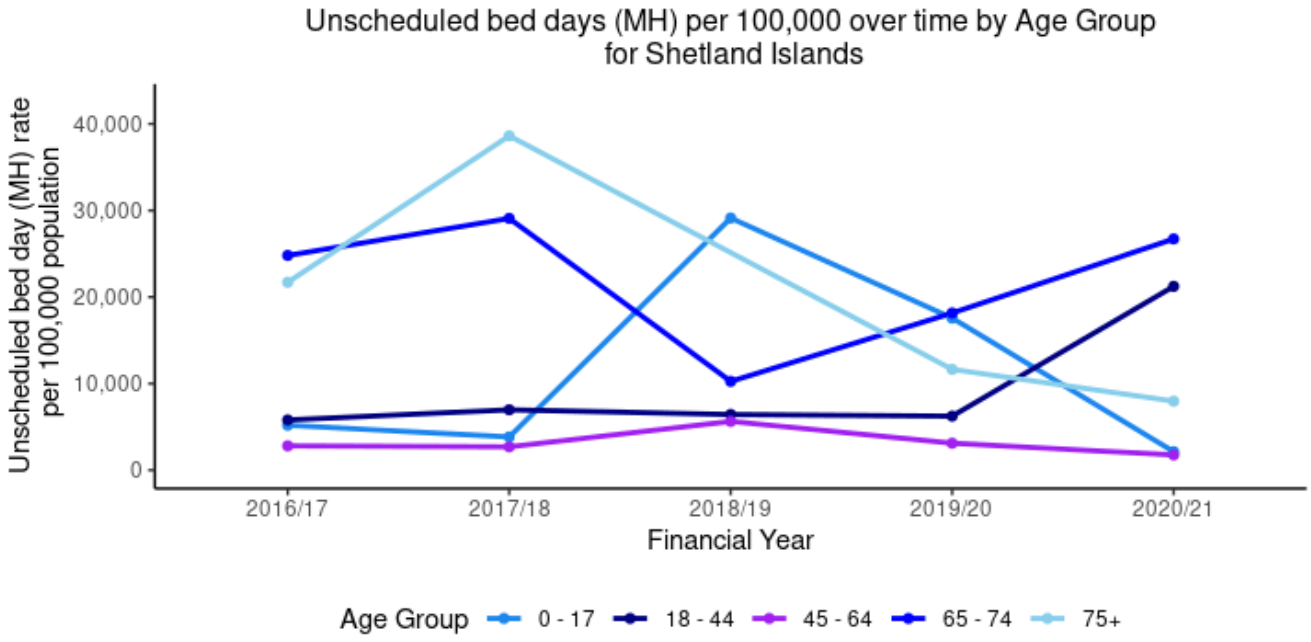
Figure 38: MH Emergency admissions by geographical area



Source: PHS SMR04

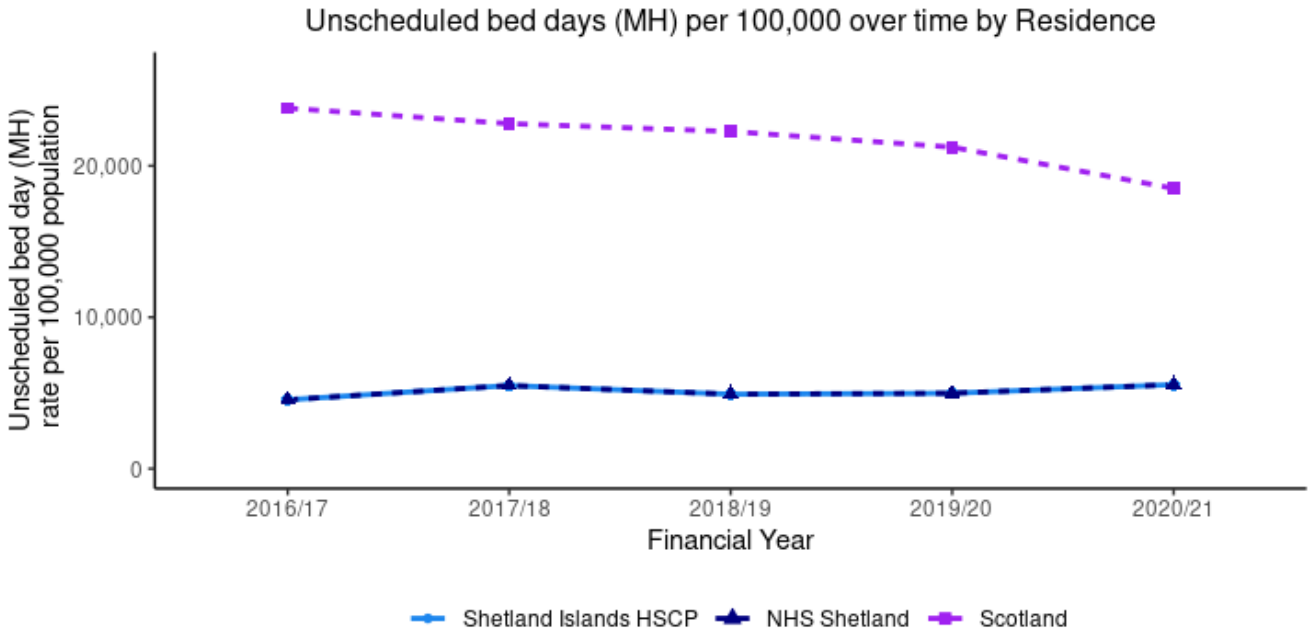
Unscheduled Bed Days (MH)

Figure 39: MH Unscheduled bed days by age group



Source: PHS SMR04

Figure 40: MH Unscheduled bed days by geographical area



Source: PHS SMR04

Footnotes

1. Care Home Data included in the Table was sourced from the Care Inspectorate. GP Practice data from October 2021, and Hospital and A&E data was sourced from Public Health Scotland Open Data. Only services that are within the physical boundary of the HSCP are included in the map and table, so there may be services outside Shetland Islands which people may use but are not shown.
2. The data used in General Health and Lifestyle & Risk factors sections (except for long-term conditions) of this HSCP profile are taken from ScotPHO. There may be more recent data available for the indicators elsewhere.
3. Data taken from ScotPHO is often reported using the European Age-Sex Standardised Rate per 100,000. This allows for comparisons across different areas to be made. For more information on how these rates are calculated, please refer to www.isdscotland.org/Products-and-Services/GPD-Support/Population/Standard-Populations/
4. Physical long-term conditions data comes from the Source Linkage Files, and the conditions are identified using ICD-9 and ICD-10 codes in the diagnosis fields. Please note that the Source Linkage Files data only contains information on people who have had contact with the NHS through either inpatient admissions, outpatient attendances, day case attendances, A&E attendances or through prescribed items, the data does not show all service users in Scotland who have been diagnosed with an LTC as not all of these individuals will have used these services. Also note that LTC rates are based on an adjusted population indicator in the Source Linkage Files so that population sizes are closer to the official estimates.
5. The 2020 COVID-19 pandemic will have had an effect on the most recent data available. A dashboard has been created by PHS which show the wider impacts of COVID-19 over many areas. You can access this here: https://scotland.shinyapps.io/phs-covid-wider-impact/

Appendices

Appendix 1: Indicator Definitions

Indicator	Definition
% last 6 months of Life Spent in a Community Setting	The percentage of time spent by people in their last 6 months of life in the community. Community includes care home residents as well as those living in their own home. Considers all hospital activity (e.g. geriatric long stay (GLS), mental health, acute). Inpatient activity with a care home location code recorded in SMR is included within the Community percentage for all years presented. This activity represents beds funded by the NHS which are located within a care home.
A&E Attendances	Attendance rates to A&E departments for patients by residence per 100,000 population. Includes all ages.
Alcohol-related hospital admissions	General acute inpatient and day case stays with diagnosis of alcohol misuse in any diagnostic position (ICD-10 code: E24.4, E51.2, F10, G31.2, G62.1, G72.1, I42.6, K29.2, K70, K85.2, K86.0, O35.4, P04.3, Q86.0, R78.0, T51.0, T51.1, T51.9, X45, X65, Y15, Y57.3, Y90, Y91, Z50.2, Z71.4, Z72.1). All rates have been standardised against the European standard population (ESP2013) and 2011-based population estimates.
Alcohol-specific deaths	Alcohol related deaths (based on new National Statistics definition): 5-year rolling average number and directly age-sex standardised rate per 100,000 population. (ICD-10 codes from the primary cause of death: E24.4,F10,G31.2,G62.1,G72.1,I42.6,K29.2,K70,K85.2,K86.0,Q86.0,R78.0,X45,X65,Y15).
Bowel Screening Uptake	Bowel screening uptake for all eligible men and women invited (aged 50-74): 3-year rolling average number percentage. Eligible men and women are posted a guaiac-based faecal occult blood test kit (FOBT) which should be completed at home. This involves collecting 2 samples from each of 3 separate bowel movements. The kit is returned in a pre-paid envelope to the central screening centre in Dundee and tested for hidden traces of blood in the stool. Individuals who have a positive FOBT result are referred to their local hospital for assessment and, where appropriate, offered a colonoscopy as the first line of investigation.
Cancer Registrations	New cancer registrations: 3 year rolling average number and directly age-sex standardised rate per 100,000 population. All rates have been standardised against the European standard population (ESP2013) and 2011-base population estimates. ICD10: C00-C96 excluding C44 (principal diagnosis only).
Death, aged 15-44	Deaths from all causes (ages 15-44 years), 3 year rolling average number and directly age sex standardised rate per 100,000

	population. All rates have been standardised against the European standard population (ESP2013). Deaths assigned to year based on death registration date.
Delayed Discharge Bed days	Number of days people aged over 18 spend in hospital when they are ready to be discharged per 100,000 population. Note that this may not always reflect the council area responsible for the person's post hospital discharge planning. The HSCP total is based on the area responsible for the person's post hospital discharge planning, which reflects what is published nationally.
Drug-related hospital admissions	General acute inpatient and day case stays with diagnosis of drug misuse in any diagnostic position (ICD10: F11-F16, F18, F19, T40.0-T40.9), 3-year rolling average number and directly age-sex standardised rate per 100,000 population. All rates have been standardised against the European standard population (ESP2013) and 2011-based population estimates.
Emergency Admissions	Rate of emergency (non-elective) admissions of patients of all ages per 100,000 population. This has been separated into two indicators – one for acute specialty and one for mental health specialty stays. An emergency admission is defined as being a new continuous spell of care in hospital where the patient was admitted as an emergency. The total number of emergency admissions is then calculated by counting the number of continuous spells in hospital within a financial year. (See also the "Hospital Care in Mental Health Specialities" definition).
Emergency Admissions from a Fall	Rate of acute emergency admissions (non-elective) of patients of all ages where a fall was logged as an ICD-10 code. ICD-10 codes W00-W19 were searched for in all diagnostic positions, in conjunction with the admission type codes 33 (Patient injury, home accident), 34 (Patient injury, incident at work) and 35 (Patient injury, other).
Emergency Readmissions (28 day)	The rate of readmissions of all adults (18+) within 28 days of an admission per 1,000 discharges. An emergency readmission is where the subsequent admission is an emergency and occurs up to and including 28 days from the initial admission. The initial admission can be of any type but must end within the time period of interest
Hospital Care in Mental Health Specialties	Mental health admission data is taken from SMR04, which holds records on patients receiving inpatient care in mental health (psychiatric) facilities. Episodes beginning with a transfer have also been included in these figures, as well as emergency admissions as many of these episodes will have started as unplanned acute admission. Therefore the initial unscheduled admission need not have been to a mental health long stay speciality.
Life expectancy, females	Estimated female life expectancy at birth in years, multi-year average (over 3 years for NHS Boards and Local Authorities, 5 years for Intermediate zones). Mortality data are based on year of

	registration. They also include non-Scottish residence so the number of deaths match those produced by NRS.
Life Expectancy, males	Estimated male life expectancy at birth in years, multi-year average (over 3 years for NHS Boards and Local Authorities, 5 years for Intermediate zones) Mortality data are based on year of registration. They also include non-Scottish residence so the number of deaths match those produced by NRS.
Physical Long-Term Conditions	Health conditions that last a year or longer, impact a person's life, and may require ongoing care and support. The LTCs presented are: Arthritis, Atrial Fibrillation, Cancer, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Cerebrovascular Disease, Dementia, Diabetes, Epilepsy, Heart Failure, Liver Failure, Multiple Sclerosis, Parkinson's, and Renal Failure.
Population prescribed drugs for anxiety/depression/psychosis	Estimated number and percentage of population being prescribed drugs for anxiety, depression or psychosis.
Potentially Preventable Admissions (PPA)	Emergency admissions (non-elective) of patients of all ages for conditions based on 19 “ambulatory care sensitive conditions” from “The health of the people of NEW South Wales - Report of the Chief Medical Officer". These conditions result from medical problems that may be avoidable with the application of public health measures and/or timely and effective treatment usually delivered in the community by the primary care team. Please see complete list of ICD-10 codes included in Appendix 3.
Unscheduled Bed days	Rate of unscheduled bed days of patients of all ages per 100,000 population. Takes the bed days spent only within the year of measurement – stays that overlap financial years will have their respective days counted either side. This has been separated into two indicators – one for acute speciality and one for mental health specialty stays.
Mental health A&E attendances	Rate of MH-related A&E attendances of patients of all ages per 100,000. Filters the initial diagnosis code upon arrival as 'Psychiatric'
Mental health NHS24 calls	Rate of MH-related NHS24 calls of patients of all ages per 100,000. Filtered using the Mental Health grouping category in the call nature field of the Unscheduled Care database

Appendix 2: Date of Indicator Data Extractions

Section	Indicator	Date of data extraction
Demographics	Population structure	2021-09-09
Demographics	Population projection	2021-09-09
Demographics	SIMD2016	2021-09-09
Demographics	SIMD2020	2021-09-09
Households	Household estimates	2021-10-06
Households	Household in each council tax band	2021-10-06
Services	GP Practice locations	2021-10-08
Services	Care Home locations	2021-10-08
Services	A&E locations	2021-10-08
General Health	Life expectancy males	2021-10-08
General Health	Life expectancy females	2021-10-08
General Health	Deaths ages 15-44 years	2021-10-09
General Health	LTC multimorbidity	2021-10-09
General Health	New cancer registrations	2021-10-09
General Health	% and number of people with a prescription for anxiety, depression or psychosis	2021-10-09
Lifestyle & Risk Factors	Drug-related hospital admissions	2021-10-18
Lifestyle & Risk Factors	Alcohol-related hospital admissions	2021-10-18
Lifestyle & Risk Factors	Alcohol-specific mortality	2021-10-18
Lifestyle & Risk Factors	Bowel screening uptake	2021-10-18
Hospital and Community Care	Emergency Admissions (Acute)	2021-10-18
Hospital and Community Care	Unscheduled bed days (Acute)	2021-10-18
Hospital and Community Care	A&E Attendances	2021-10-18
Hospital and Community Care	Delayed discharge bed days	2021-10-18
Hospital and Community Care	Fall emergency admissions	2021-10-18
Hospital and Community Care	Emergency Readmissions (28 day)	2021-10-18

Hospital and Community Care	% last 6 months in community setting	2021-10-18
Hospital and Community Care	Potentially Preventable Admissions (PPAs)	2021-10-18
Hospital Care (Mental Health Specialty)	Emergency Admissions	2021-10-18
Hospital Care (Mental Health Specialty)	Unscheduled bed days	2021-10-18
Hospital Care (Mental Health Specialty)	A&E Attendances	2021-11-01
Hospital Care (Mental Health Specialty)	NHS24 Calls	2021-11-01

Appendix 3: Conditions included as Potentially Preventable Admissions (PPAs)

Condition	ICD10 codes included	Comments
Ear Nose And Throat	H66, J028, J029, J038, J039, J06, J321	NA
Dental	K02, K03, K04, K05, K06, K08	NA
Convulsions And Epilepsy	G40, G41, R56, O15	NA
Gangrene	R02	NA
Nutritional Deficiencies	E40, E41, E43, E550, E643, M833	NA
Dehydration And Gastroenteritis	E86, K522, K528, K529	NA
Pyelonephritis	N10, N11, N12	NA
Perforated Bleeding Ulcer	K250, K251, K252, K254, K255, K256, K260, K261, K262, K264, K265, K266, K270, K271, K272, K274, K275, K276, K280, K281, K282, K284, K285, K286	Excludes episodes with following main OPCS4 codes: S06, S57, S68, S70, W90, X11
Cellulitis	L03, L04, L080, L088, L089, L980	NA
Pelvic Inflammatory Disease	N70, N73	NA
Influenza And Pneumonia	J10, J11, J13, J181	NA
Other Vaccine Preventable	A35, A36, A370, A379, A80, B05, B06, B161, B169, B26	NA
Iron Deficiency	D501, D508, D509	NA
Asthma	J45, J46	NA
Diabetes Complications	E100, E101, E102, E103, E104, E105, E106, E107, E108, E110, E111, E112, E113, E114, E115, E116, E117, E118, E120, E121, E122, E123, E124, E125, E126, E127, E128, E130, E131, E132, E133, E134, E135, E136, E137, E138, E140, E141, E142, E143, E144, E145, E146, E147, E148	NA
Hypertension	I10, I119	Exclude episodes with following main OPCS4 codes: K01 - K50, K56, K60 - K61
Angina	I20	Exclude episodes with main OPCS4

		codes: K40, K45 K49, K60, K65, K66
COPD	J20, J41, J42, J43, J44, J47	J20 only included if secondary diagnosis has one of J41 - J44, J47
Congestive Heart Failure	I110, I50, J81	Exclude episodes with following main OPCS4 codes: K01 - K50, K56, K60 - K61