Annual Performance Report 2024/25

Orkney Integration Joint Board

Orkney Health and Social Care Partnership.

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Foreword

I am delighted to present the latest annual performance report for the Orkney Integration Joint Board. As the newly appointed Chair of the Board, I would firstly like to say that I am really looking forward to the next two years in the role. I thank Councillor Rachael King for her tenure over the last couple of years and look forward to continuing working closely with her as she takes up the role of Vice Chair. I'd also like to take the opportunity to thank fellow Board members and officers for their tireless work over the last year in ensuring that we continue to try and do the right thing for the people of Orkney. My biggest thanks must go to the staff throughout the Partnership for their hard work and dedication in providing quality health and care to service users throughout Orkney. There is always much more for us to do and, hopefully, the report presents a balanced overview of the areas where we continue to make headway alongside some areas where we must still do better.

The quality of our island life can be significantly enhanced by the health and social care provision.

The quality of our island life can be significantly enhanced by the health and social care provision and the fact that many of us are living longer means that we need to focus on how we support older people and also those who care for them. In addition, for parents and carers of people with physical and learning disabilities, mental health or addiction issues, it is vital that we find effective and creative ways of caring for the carers as well as those who need care.

We have just published our new Strategic Plan and have mapped out a clear set of actions for delivering that plan over the course of the next year. Despite the challenge of increasing demand and finite and tightening budgets we remain optimistic about continuing to improve and develop our services in conjunction with our communities.

Joanna Kenny, Orkney Integration Joint Board Chair

The purpose of the report is to provide an insight into our progress over the last year, highlight areas of improvement, and capture the challenges we face in delivering the best quality health and care provision possible to the people of Orkney. I think this report does a really good job of doing all of this.

The detail contained within this report covers the final year of our previous Strategic Plan and we have identified new and additional measures that will track the delivery of our new plan in future annual reports.

It is testament to our existing staff teams across Orkney that we have managed to not only keep services operating but, in many instances, still managed to make improvements.

Our biggest challenge (albeit not unique to Orkney) remains our workforce gaps. There are nationwide issues in recruiting to the social care workforce, and we also have a number of vacancies across our health services too, most notably within our Allied Health Professions, community nursing and dentistry. It is testament to our existing staff teams across Orkney that we have managed to not only keep services operating but, in many instances, still managed to make improvements. There is, of course, still much to do and the financial constraints faced by all public sector bodies in the years ahead will be a real test of how we work with our communities and those who need our support.

Finally, I want to thank each and every member of the health and social care teams across Orkney, including those employed by our third sector colleagues, for their ongoing dedication and commitment.

Stephen Brown, Orkney Health and Social Care Partnership Chief Officer

Overview

Integrating health and social care services means we can make sure people in Orkney receive the best possible support and care. This is especially true of folk that need support from both health and social care services, at the same time.

The Scottish Government has nine **National Health and Wellbeing Outcomes**. These are designed to show the improvements that integrating (or "joining-up") health and social care services can make. You can read more about these Outcomes here.

The outcomes are:

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 towards 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 wellbeing.
7.	People using 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.

Back in 2016, the Orkney Health and Social Care Partnership (HSCP) was created. This allowed us to work more closely on delivering the Government's National Health and Wellbeing Outcomes.

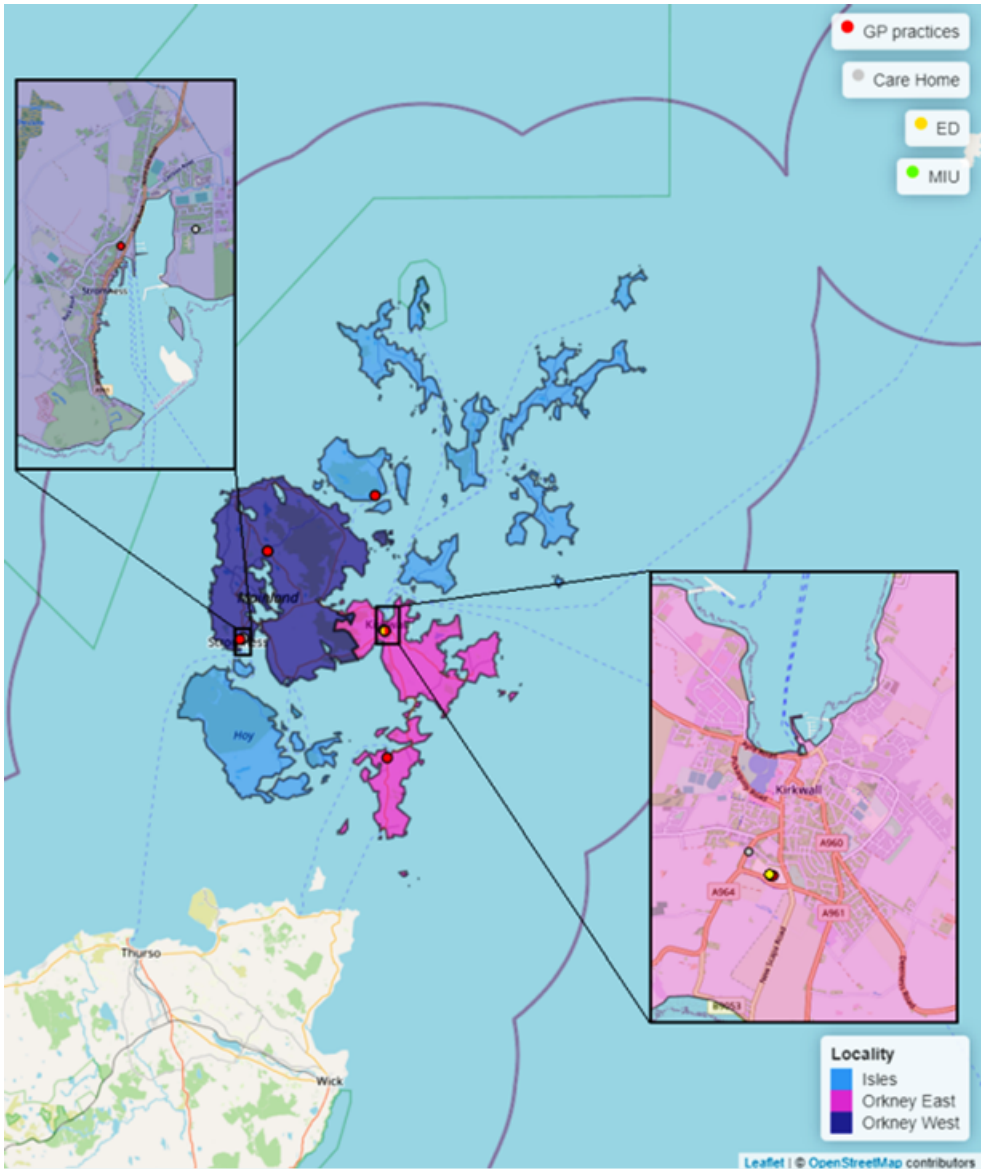
The Orkney Integration Joint Board (IJB) has the job of planning services, providing resources, and monitoring how health and social care services perform. The IJB must report to Scottish Government on how services have performed and must produce an Annual Performance Report, every year.

You can read more about what the IJB does, along with the people who are members of the IJB, here.

Every three years, the IJB must also produce a Strategic Plan. The Strategic Plan 2022 – 2025 was written in 2022 – the new Strategic Plan 2025 – 2028 can be found here.

The Strategic Plan sets out the IJB's Strategic Priorities, and this annual report shows what progress has been made when measured against these Priorities.

It covers the financial year, from 1 April 2024 to 31 March 2025.



Our Localities

Scottish Government asks IJBs to divide their area into at least two localities. In Orkney, we have three localities. They are the Isles, the West Mainland, and the East Mainland.

We think this is a common-sense approach to planning services. It allows us to work together with communities to make sure that services are designed around them. It also allows us to work alongside other services within Orkney community planning partnership, who also plan and deliver services based upon Localities.

The tables below give some information about the make-up of the population of the Orkney Islands, split across the three localities, and shows how they compare against the overall population of Orkney, as well as giving a comparison with the whole of Scotland.

In Orkney, we have three localities: the Isles, the West Mainland, and the East Mainland.

Indicators.	Data Type.	Time Period.	Isles Locality.	Orkney East Locality.	Orkney West Locality.	Orkney Islands HSPC.	Scotland.
Demographics.							
Total population.	Count.	2022.	2,718.	12,079.	7,233.	22,030.	5,477,000.
Gender ratio male to female.	Ratio.	2022.	1:0.99.	1,1.04.	1:1.05.	1:1.04.	1:1.06.
Population over 65.	%.	2022.	32.6.	22.7.	26.2.	25.1.	20.1.
Population in least deprived SIMD* quintile.	%.	2020.	0.	0.	0.	0.	20.
Population in most deprived SIMD* quintile.	%.	2020.	0.	0.	0.	0.	20.
Housing.							
Total number of households.	Count.	2023.	1,744.	6,270.	3,702.	11,716.	2,721,139.
Households with single occupant tax discount.	%.	2023.	32.1.	37.7.	32.5.	35.2.	38.5.
Households in Council Tax Band A-C.	%.	2023.	88.8.	62.	64.1.	66.7.	58.7.
Households in Council Tax Band F-H.	%.	2023.	0.51.	4.4.	3.4.	3.5.	13.8.
General Health Indicators.							
Male average life expectancy in years.	Mean.	2019 – 2023.	83.2.	79.2.	80.9.	81.	76.8.
Female average life expectancy in years.	Mean.	2019 – 2023.	81.8.	83.2.	83.8.	84.5.	80.8.
Deaths aged 15-44 per 100,000.	Rate.	2021 – 2023.	62.	136.9.	62.5.	108.2.	111.7.
Population with a long-term condition.	%.	2023/24.	27.3.	26.5.	25.5.	26.3.	22.1.
Cancer registrations per 100,000.	Rate.	2020 – 2022.	651.4.	599.9.	551.8.	596.3.	629.7.
Anxiety, depression and psychosis prescriptions.	%.	2023/24.	19.4.	20.8.	17.6.	19.6.	20.9.

Source: Public Health Scotland LIST Locality Profile April 2025.

Note: *SIMD – Scottish Index of Multiple Deprivation.

Indicators.	Data Type.	Time Period.	Isles Locality.	Orkney East Locality.	Orkney West Locality.	Orkney Islands HSPC.	Scotland.
Lifestyle and Risk Factors.							
Alcohol-related hospital admissions per 100,000.	Rate.	2022/23.	279.1.	647.	428.1.	532.7.	532.
Alcohol-specific mortality per 100,000.	Rate.	2018 – 2022.	22.5.	12.	28.1.	19.6.	21.4.
Drug-related hospitalisations per 100,000.	Rate.	2020/21 - 2022/23.	41.9.	72.	59.5.	69.9.	201.8.
Bowel screening uptake.	%.	2020 – 2022.	65.5.	70.5.	71.2.	70.	66.2.
Hospital and Community Care.							
Emergency admissions per 100,000.	Rate.	2023/24.	6,181.	8,171.	7,328.	7,649.	10,963.
Unscheduled bed days per 100,000.	Rate.	2023/24.	74,283.	67,332.	73,386.	70,177.	77,702.
A and E attendances per 100,000.	Rate.	2023/24.	12,325.	36,833.	27,872.	30,867.	27,227.
Delayed discharges (65+) per 100,000.	Rate.	2023/24.	74,379.	44,225.	46,969.	50,009.	48,494.
Potentially Preventable Admissions per 100,000.	Rate.	2023/24.	1,030.	1,465.	1,300.	1,357.	1,691.
Hospital Care (Mental Health) Indicators.							
Psychiatric patient hospitalisations per 100,000.	Rate.	2021/22 - 2023/24.	7.9.	124.1.	104.3.	105.2.	216.1.
Unscheduled bed days per 100,000.	Rate.	2023/24.	0.	14,554.	3,429.	9,106.	18,556.

Source: Public Health Scotland LIST Locality Profile April 2025.

Key Achievements and Challenges Over 2024/25

Achievements

Significant progress has been made on the 40-bed replacement residential care facility in Kirkwall, Kirkjuvagr House. It is anticipated that this will be completed and operational in early 2026 at the latest.

The hard work and dedication of our staff is consistently acknowledged by the community.

For example, in NHS Orkney's Team Orkney Awards four of the Awards went to health and social care staff within Orkney HSCP.

Two of the three Awards in the inaugural Orkney Islands Council VIP Awards went to health and social care staff, with multiple nominations in each category.

Our recruitment campaign for social work staff, in both adult and children's services, is beginning to see positive results, with some key appointments made during the last year, as well as recruitment to permananet roles, previously filled by interim workers. The 'Growing a Sustainable Social Care Workforce' project is also showing results with one service being fully recruited to for the first time in years. UHI Orkney ran an 'Introduction to a Career in Care' course which guarantees students an interview in a care setting on completion of the six-week course. The course has been completed by 24 students within 2024/25.

Overall the gradings for our care facilities and services are continuing to improve. For example, both our Residential Children's Services and our Fostering and Adoption Services have both been rated as 'Good' across all categories.

Some of the other achievements include:

- An increasing number of people receiving Care at Home services.
- A continued shift towards the use of Digital Telecare, in place of analogue equipment.
- A positive outcome of the Adult Support and Protection progress inspection.
- A reduction in the number of looked after children.
- We have launched a recruitment campaign for fostering, resulting in several interested parties coming forward.
- We have been successful in supporting several young people to return home to Orkney, from placements in mainland Scotland.
- The successful tender process for the Daisy Villa Medical Practice, following the retirement announcement of the previous Partners, with Heilendi Practice taking on a second practice.
- Significant work has been done to reduce oral surgery waiting times within the Public Dental Service.
- A new independent advocacy service has been established via Advocacy Orkney.
- We have introduced recruitment incentives to encourage people into a career in care.
- We ran a pilot within Children and Families Social Work teams via Magic Notes, which has freed up significant practitioner time. Magic Notes is a system which produces summarised discussions saving practitioners spending time writing up notes after discussions.
- We are exceeding the national target for waiting times in both our Children and Adolescent Mental Health Service and Psychological Therapy Services.

Challenges

There is no doubt that our greatest challenge remains the recruitment and retention of our workforce. It is a problem experienced by HSCPs across Scotland, and beyond, but, like our colleagues in the other island groups, we feel this pressure acutely here in Orkney.

Reliance of agency staff has placed increasing pressure on finite budgets.

The use of agency staff and high vacancy rates have had an impact upon the continuity of the services we deliver to people in Orkney, so we will do everything possible to improve recruitment of our staff.

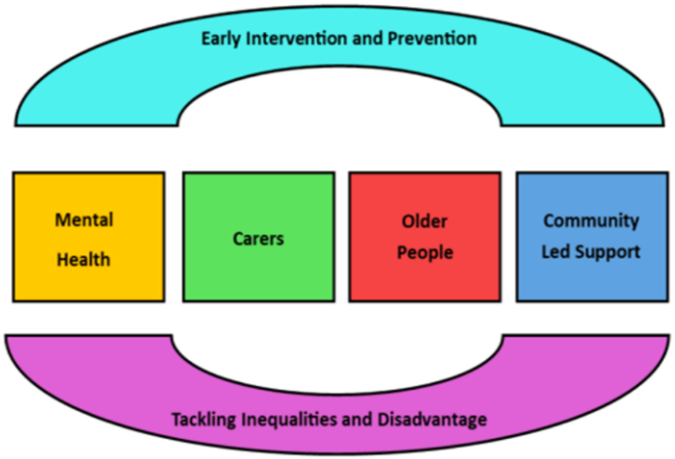
It should also be mentioned that we are seeing unprecedented demand on our services; this at a time when public services, across all sectors and all areas of the country, face huge pressures on the money they have to provide quality services to their communities.

It should also be mentioned that uncertainty remains about the proposals for a National Care Service in Scotland. Whilst some of the elements of the original proposals have been dropped from the Bill, doubts remain about the financial impact of the remaining proposals. You can read more about the proposals for the National Care Service here.

Our Strategic Priorities

Our Strategic Plan covers a period of three years, laying out the IJB's priorities for community health and social care service commissioning.

The Strategic Plan 2022 – 2025 identified six Strategic Priorities. The IJB believes these priorities best address the most relevant and urgent health and social care issues, here in Orkney. The six priorities are:



1. **Unpaid Carers.**
2. **Supporting Older People to Stay in Their Homes.**
3. **Community Led Support.**
4. **Mental Health and Wellbeing.**
5. **Early Intervention and Prevention.**
6. **Tackling Inequalities and Disadvantage.**

You can read the Strategic Plan 2022 – 2025 **here**. Our new Strategic Plan was launched in May of 2025. You can read the new Plan **here**.

We asked a selection of services to tell us about their service and what has been happening during the past year and, especially, how their work has contributed to one (or more) of the Strategic Priorities. We have included their contributions in the following sections.

But this is by no means exhaustive: there are many other teams, throughout NHS Orkney, Orkney Islands Council and the Third Sector, who contribute daily to delivering community health and social care services, across Orkney.

The Performance Management Framework 2021 – 2025 helps the Orkney IJB to assess how effective the Orkney HSCP is in achieving the objectives highlighted in the Strategic Plan 2022 - 2025. You can read more about the Performance Management Framework **here**.

We also have a Delivery Plan to help us measure our progress. Each Strategic Priority includes something we call Milestones: these are things we must do if we are to deliver our objectives. These Milestones each include at least one action, often several

actions, with each describing how we will know if we have achieved the declared Milestone. We call these actions Measures, or Outcomes.

Every three months, we report to the IJB's Performance and Audit Committee on how we are doing and the progress we have made.

This might sound a little complicated, but we have included a table at the beginning of each Strategic Priority description, and this should make it a lot clearer.

Below is the key to the table:

Key to RAG.	**Complete.**	**On Target.**	**Risk of Delay in Completion.**	**Severe Risk of Delay in Completion.**

Priority Area 1 – Supporting Unpaid Carers

Milestone	Outcome/Measure	Status	RAG
Hold an Orkney Carer Conference, where the essential role of unpaid carers in delivering social care support, in Orkney, will be highlighted and celebrated.	Hold the Carer Conference during Year One.	The Carer Conference was held in May 2023.	
Consult and engage with unpaid carers, following the conference, learning what it is we need to do so that they feel supported in their lives.	Undertake a post-Carer Conference Survey.	The survey was completed in October 2023. The results were published alongside the new Orkney Unpaid Carers Strategy, in March 2024.	
Use the responses and information gained from carers through this engagement to draft a new Carer Strategy that properly reflects the needs and aspirations of unpaid carers.	Prepare and publish new Carer Strategy before the end of business year 2023/24.	The new Orkney Unpaid Carers Strategy was presented to the IJB in February 2024.	
We will reach more people delivering care to family or friends, who have not sought carer services, and measure that number.	Increase the number of unpaid carers contacting Crossroads Care Orkney, for support, from 78, in the 2022/23 financial year.	There were 77 new referrals to Crossroads Care Orkney during the last financial year. Whilst this is 77 new carers who were unaware of, and/or not accessing support services previously, this figure is actually one lower than the previously reported figure. It is clear we must increase and widen our efforts to reach carers in Orkney who are currently unsupported.	

Some Facts and Figures:

800,000	The estimated number of unpaid carers in Scotland[1].
30,000	The estimated number of young carers in Scotland[2].
3 out of 5	The number of us who will become carers at some stage in our lives[3].
£15.9 Billion	The value of care delivered by unpaid carers in Scotland[4].
400	The approximate number of carers supported by services in Orkney.
3,200	The estimated number of unpaid carers in Orkney.

Note: 1-4 – Carers UK.

It is estimated that there are more than 3,000 unpaid carers in Orkney.

Promoting Unpaid Carers

We are currently supporting around 400 unpaid carers, meaning nearly 3,000 carers in Orkney are unaware of the services available to them, so we have worked hard this year to reach these “unknown carers”.

A social media campaign has supported the efforts of Crossroads Care Orkney (the Third Sector organisation commissioned by NHS Orkney and Orkney Islands Council to deliver carer support services) to promote the work of unpaid carers, helping people to understand who unpaid carers are, as well as the support services available to them.

But we must work much harder to reach our carers here in Orkney. The latest figures show that Crossroads Care Orkney received 77 new contacts during the last year, a figure almost identical to the previous year.

Perhaps even more disappointing is that just 34% of carers in Orkney report feeling supported in their caring role. Whilst it is unclear whether all the respondents to this biennial survey are aware of the support options available to them, this figure has slipped during the last few years.

The biggest challenge, though, is to make sure that our unpaid carers can get a break from caring, something which is called respite. It's been difficult for us to provide planned respite, so we are now working on new ways of helping unpaid carers to get the break they need.

Crossroads Care Orkney

The Partnership's carer support service is provided by Crossroads Care Orkney. Crossroads Care Orkney supports unpaid carers of people with any disability, or illness, throughout Orkney. Support is tailored to meet the needs of everyone; is person centred and considers the carer and service user's goals.

Crossroads delivered over 13,000 hours of care during the last year, in Orkney!

Telephone and email support is vital in supporting this 'unseen workforce'. Crossroads Care Orkney provide emotional support, information, and advice, daily. Support takes many different forms and is wide and varied. Respite is provided, free of charge, in, or outwith the home, giving the carer time to themselves, on a regular or occasional basis. Crossroads Care Orkney also provides support to people who don't have a carer, and this is either purchased by the Local Authority or the service user themselves.

In addition to this, Crossroads Care Orkney operates a lending library and has different resources for loan, along with activities such as jigsaws, and a Komp. You can read more Komp **here**. The Carers Drop-in Centre is open 9am-5pm, Monday to Friday. Face to face support and advice is also offered as and when people need it.

The Carers Support Group is held on the second Wednesday of the month, in the Crossroads Care Orkney Office at the Travel Centre, Junction Road, Kirkwall, and dedicated time with office staff is available. This group is very much about supporting carers, of course, but also gives them the opportunity to have a break, to mix with other carers, and the opportunity and potential for friendships to form, and strengthen support networks.

Orkney Carers Centre is the delivery partner for the Time to Live fund. You can read more about the Time to Live fund **here**. This project enables carers to access funds and support to help them take short breaks that meet their specific needs. This funding is provided by Scottish Government through Orkney Health and Social Care Partnership.

Shared Care Scotland. Examples of how this has been achieved is through the purchase of a garden bench and chairs, art and craft kits, magazine and Picky Centre subscriptions, relaxation and beauty treatments, and fiddle lessons.

The Young Carers' Support Worker continues to give unpaid young carers the opportunity to have a break and mix with their peers. This service is highly valued by all who take part, giving opportunities to young people that they potentially would not have had otherwise. You can read more about the Orkney Young Carers' Service **here**.

During 2024/25, Crossroads Care Orkney provided support to **261** new unpaid carers and service users through the various methods of support on offer. The total number of referrals throughout 2024/25 was **227**. This is inclusive of new and existing service users and carers. **150** referrals were from existing carers/service users for whom Crossroads Care Orkney provide occasional or extra respite.

There were **77** new referrals to the service, and this was for a mix of respite, privately purchased, purchased, or following an assessment of need, if it was identified that alternative support was required.

In total, over **13,000** hours of care were provided across mainland Orkney and four of the isles.

Crossroads Care Orkney is very highly valued by people in Orkney. Here are just a tiny number of the messages they have received during the last year:

"The respite provided was a godsend for us, because we got time together."

'Thanks to everyone who provides a fantastic service to so many folks in Orkney'.

'Thanks for all your support'.

'Many thanks once again for the respite cover you provided to Mum when we were on holiday. For us, this is very much appreciated and gives us great peace of mind.'.

'What a difference it makes to me, to know Dad is in safe hands when I'm out.'.

'*I really appreciate all the support Crossroads have provided, you are all amazing!'.*

Orkney Health and Social Care Partnership.

‘A heartfelt thankyou for everything. We appreciated having the games and jigsaws and bits to stimulate Dad’s cognition. The respite provided was a godsend for us because we got time together.’.

Priority Area 2 – Supporting Older People to Stay in Their Homes

Milestone.	Outcome / Measure.	Status.	RAG.
Engage in the Getting It Right For Everyone (GIRFE) national pathfinder programme, with a focus in Orkney on Frailty and Ageing Well Project.	Number of hospital avoidance due to early intervention and support for people with frailty.	Toolkit launched. Utilising the tools in practice and continuing to participate in national development. Development of outcome measures is the current focus nationally. Next step for local partnership is to create an implementation board.	
Support more older people to live safely at home for longer.	Reduction in rate of falls in older people population.	With an ageing population and more people living longer with complex needs, there continues to be an integrated approach in Orkney with regards to Falls prevention and management. The Care Inspectorate's Care about Physical Activity (CAPA) Improvement programme continues to be utilised across the care homes, care at home, housing support and other support services for older people. From November 2024 to April 2025, the Telecare Team responded to 246 activations, across the communities, for individuals who had utilised their Telecare/Community Care Alarm equipment due to a fall. This is an increase of 101 more activations and visits since the last reporting period. Of those 246 visits 50 resulted in Scottish Ambulance Service attending (20.3%).	
	Expand the range of technology that contributes	The variety and choice of Telecare/Digital solutions on the market changes and improves at a great pace. Within Orkney Health and Care, the Telecare/Digital equipment allocated to individuals is person-centred and	

Milestone.	Outcome / Measure.	Status.	RAG.
	to older people living safely at home.	based on a needs-led assessment.The referrals for Telecare/Digital equipment and peripherals have continued to increase and, alongside that, the Telecare team maintain their networking with existing and new suppliers, ensuring they remain current and up-to-date on new/different models and products. This, in turn, ensures there is an extensive range of equipment and peripherals available to meet the varying needs of Orkney's population. The Analogue to Digital Project continues to be a focus of the service, despite the switchover date being delayed to January 2027.The service has continued to see a year on year increase in referrals for Telecare/Community Care Alarm equipment.	
	Increase in use of Telecare/Digital solutions to support early intervention and prevention and increase flexibility for individuals to remain at home.	In early November 2024 there were 883 individuals utilising Telecare/Digital equipment and peripherals. At the end of February 2025 that had dropped to 865 individuals. The reasons for the decrease were due to (i) individuals who had sadly passed away and (ii) some individuals who had asked for their Telecare/ Community Care Alarm equipment to be removed, as a consequence of the letters that were issued, alongside a survey, regarding the potential introduction of charges for Telecare/ Community Care Alarm equipment.	
	Waiting List of unmet need hours for care at home provision is reduced.	Waiting list management and the re-cycling of care at home capacity remains a significant focus of day-to-day operations. As well as those individuals waiting on care at home provision, the service is responsive to crisis	

Milestone.	Outcome / Measure.	Status.	RAG.
		intervention work, thereby preventing hospital admissions and/or admissions to long term care establishments. At the start of November 2024, the unmet need hours for care at home provision within the community was 223 hours overall. From November 2024 to April 2025, those hours have fluctuated - highest unmet need hours have been 277 hours, which was in the week beginning 10 March 2025, whilst the lowest was 204.1 hours, in the week beginning 7 April 2025. The service has continued to focus on ensuring minimal delayed discharges, as well as supporting individuals within the communities to prevent hospital and/or long term care admissions, where possible. The service has responded well to crisis situations and stepped up to packages of care for existing service users, when they have sadly had a deterioration in their long term condition, or reached the end stages of their lives.	
	The percentage of telecare users who have switched to digital from analogue is increased.	At the start of November 2024, there were 230 individuals who had switched over from analogue to digital. At 30 April 2024, that figure had increased to 306 individuals. This is a further increase of 76 digital transfers in the six-month period, November 2024 to April 2025.	
	Number of service users receiving care at home support is increased.	In early November 2024, 166 individuals were in receipt of care at home provision across the communities of mainland Orkney and the Isles. This number fluctuates by the very nature of the service and, within the six-	

Milestone.	Outcome / Measure.	Status.	RAG.
		month period of November 2024 to April 2025, the highest number of individuals using the service was during the week of 24 March 2025, when 174 individuals were in receipt of care at home provision. The lowest number of individuals in receipt of care at home provision was in the week of 16 December 2024 where there were 163 individuals receiving care at home provision at that time.	
	Number of care at home packages of 10 hours + rise to reflect the responsiveness to increased complexity/frailty and demonstrates flexibility to changing needs.	At the beginning of November 2024, there were 60 individuals with care packages in excess of 10+ hours. At 30 April 2025, that number had decreased, by two, to 58.	

Care at Home

The number of people receiving support in their own homes from our Care at Home service continues to increase significantly. In April 2024, there were 163 people receiving Care at Home services; this had increased to 174, a year later.

The service has been trying to increase the number of people who receive packages of care, exceeding 10 hours per week. This might seem a strange goal, but that means people are receiving care in their own homes, rather than in residential care. In April 2024, there were 58 people receiving more than 10 hours of care per week, By April of this year, this had increased to 63.

In April 2025, 174 people were receiving Care at Home Support.

However, owing to the nature of the service, the numbers can vary very quickly, both in terms of people receiving care, as well as the number of individuals with care packages of more than 10 hours.

Unmet Need

As of April 2024, the unmet need hours for Care at Home stood at 209.5 hours. Those hours of unmet need were a mix of new referrals, as well as people receiving existing services, but requiring a further increase in their provision. In April of this year, the unmet need hours were standing at 260 hours. Although this is an increase in the previous year, at that point in time, the unmet need hours, throughout 2024/25 were as low as 180.25 hours in September 2024.

Falls Reduction

The Care Inspectorate's Care about Physical Activity Improvement programme has been shared across all our care homes, the Care at Home service, housing support, and other support services for older people. This equips our staff to promote "moving more", as we know that our older people are less likely to suffer a fall if they are used to moving around, regularly.

Between just November 24 and April 25, the Telecare Team responded to 246 alarm activations.

Between November 2024 and April 2025, the Telecare/Community Care Alarm Team responded to 246 activations, across mainland Orkney communities, for people who had activated their Telecare/ Community Care Alarm equipment, owing to a fall. This is an increase of 101 activations over the period of June 2024 to October 2024. Of those 246 visits, 50 resulted in Scottish Ambulance Service (SAS) attending (20.3%), with 196 visits preventing the need to call out SAS (79.7%). Of those that the service know were taken to hospital (31 out of 50 people), 18 were admitted to hospital (36%) and 13 were non admissions (26%). There were 19 out of 50 people (38%) where the service was not aware of the outcome. This is because family were present and were able to release the Responders before the ambulance arrived.

Care at Home and Telecare teams continue to promote the prevention of falls using the guidance of the Care Inspectorate's Preventing Falls booklet and, across all service areas, the Community Physio Falls Team provide support to reduce fall numbers.

Telecare/Community Care Alarm and Mobile Responder Service

The Telecare/Community Care Alarm equipment used by our service users is based entirely upon their needs, as equipment suitable for one person may be completely inappropriate for another.

The Telecare team maintain a knowledge of the most up-to-date models and products available, making sure there is a comprehensive range of equipment and peripherals available to meet the varying needs of folk in Orkney.

The service offers a range of practical solutions for our frail and older people, enabling them to live meaningful lives and to offer peace-of-mind, both to the user and their family. This has created a proactive, rather than reactive, approach to Telecare/digital care packages, and a more robust structure to early intervention and prevention.

Analogue to Digital Switchover

The date for switchover from analogue equipment to digital equipment was originally to be December 2025; however, this has been pushed back, with the deadline now January 2027. In April 2025, the service had 39% of service users transferred over to Digital equipment. The service is also working towards Silver Accreditation by the Scottish Digital Office. You can read more about the Digital Telecare Implementation Award Scheme **here**.

The Telecare Service is working towards Silver Accreditation with the Scottish Digital Office.

Occupational Therapy

Occupational Therapy (OT) services help people to stay in their own homes, rather than having to move to residential accommodation, like a care home.

We receive a lot of feedback from people to say that they would like quicker access to our OT service. This will also give us the opportunity to help people before they get to the stage of needing more complicated support. During the last year, we have begun to offer something called a Duty System. A Duty System just means someone will normally be available, to offer help and advice, at the same time, on the same days, every week. Our service is now available, Monday to Friday, from 9am to 1pm, at our Selbro facility, in Hatston.

Our OT service offers a Duty System, five-days a week.

Frailty - We have been working with our colleagues from our Pharmacy services in a quality improvement project. This involved making sure we were checking our service users for their vulnerability and frailty..

Chronic Fatigue/Long COVID/Functional Neurological Disorder - Rates of referral to the OT service continue to increase. This has prompted us to consider the way we approach these conditions and the resources we use to offer support to our service users. This approach has reduced the waiting times for access to our services and has prompted us to plan and create more resources to help people self-manage their condition.

Goal Setting and Action Planning Framework (G-AP) – G-AP is a new approach to how services work with the people they are rehabilitating and involves setting realistic goals for their recovery. You can read more about the G-AP process and framework **here**. We are currently trialling this approach with a small number of service users and, if the results are as expected, we will adopt this approach, across all our OT teams, over the coming year.

Physiotherapy

Physiotherapy services help people improve, maintain, or restore the physical functioning of their bodies, as well as their mobility, after an illness, injury, or because of ageing or disability. The Physiotherapy team support and deliver a range of different services, within the Hospital and community settings.

PHIO is a new app that helps people to look after their condition, at home.

Digital Progress - A new digital platform called PHIO was recently introduced, as a one-year pilot project, to support people to manage their condition, whilst waiting for Physiotherapy. PHIO is a digital app that is user-friendly, supported by medical professionals, and helps people to manage musculoskeletal conditions from the comfort of their own home. From June 2025, PHIO will also be available to everyone in Orkney, over the age of 16, who requires support for a muscle or joint problem. Patients can still access all the current physiotherapy services in Orkney, as well as use the new app, if they wish.

Ageing Well - Ageing Well continues to deliver a Strength and Balance programme, across the mainland, connecting participants with community-based exercise and social groups, on completion of the programme. We have worked closely with our Occupational Therapy colleagues and Isles Wellbeing Co-ordinators to improve service delivery to the Isles, offering drop-in sessions and co-ordinated visits, throughout the year.

In Patient Activity Sessions - Our in-patient rehabilitation team have been working with our friends at Age Scotland Orkney to deliver weekly activity sessions, to support the health and wellbeing of people whilst they are staying in hospital.

Dementia

Some of our challenges in Orkney are the same as those across the country:

- People are often reluctant to seek a diagnosis for their condition.
- A shortage of consultant psychiatrists qualified to diagnose dementia.
- Difficulties in recruiting.
- The slow recovery from the pandemic, which is getting better, but has left its mark on people's lives and service delivery.

We have, however, made good progress with several of the aims included in our Orkney Dementia Strategy 2020 –2025, of which we are now in the last year. For example, we have increased the sessions provided by our GP with Special Interest to assist with diagnosing dementia.

We have also seen big reductions in the waiting time for diagnosis. In March 2023, the waiting time between referral and diagnosis was an average of 14 months. In March 2025, this had reduced to just three months.

94 people were diagnosed with dementia, in Orkney, in the last year, up from 56 in the previous year.

There has been a large increase in the number of diagnoses, too, from 56 dementia diagnoses in 2023/24, to 94 in 2024/25.

With the help of Dementia UK and Age Scotland Orkney we were delighted to appoint our Admiral Nurse, in September 2024. Admiral Nurses are specialist Dementia Nurses – you can read more about them **here**. The Nurse is based at Age Scotland Orkney. This new role will improve the support and services we can provide for those living with more complex dementia, as well as those who care for them.

The wait for a diagnosis is down to three months. It was 14 months in 2023.

We have worked hard over the last year to reduce the stress, and distress, associated with dementia. This often involves an earlier intervention, which can reduce the number of people that have to be admitted to a hospital in mainland Scotland.

Dementia information, advice and support, specific to Orkney, is now available on the Right Decisions App, and is designed for both professionals and patients/service users. You can read more about the Right Decisions App **here**.

We are in the early days of our initiatives to link and pilot support services in the isles. We have made connections with the current support services; the next step will be to collaborate with these services. This work begins with a visit to Westray in May 2025.

The Partnership has increased the sessions provided by our *GP with Special Interest (Dementia).*

The current Dementia Strategy reaches the end of its life, this year, and we are considering our next steps. We will reflect upon what we have learned during the life of the strategy and, especially, we will consider the experiences of our patients and service users, and how we can improve our services. You can read the current Orkney Dementia Strategy **here**.

Age Scotland Orkney continues to provide Post Diagnostic Support to people diagnosed with dementia, their families, and their carers. The growing number of people attending has increased opportunities for social activity at the Age Scotland Orkney Hub in Kirkwall, a place that supports a single “point of access” for support and services before, and after, diagnosis.

Age Scotland Orkney continues to run weekly Cognitive Stimulation Therapy sessions and, in addition, has expanded their Hub capacity, as well as what they do and the activities they deliver. For example, they now run Hubs which support befriending, social connectedness, reduce loneliness, promote independence and wellbeing, and provide access to information and signposting. This may develop further, as people have suggested the need for additional sessions on fun physical activity, digital equality and access, building confidence, and cyber safety.

The dementia friendly all-weather garden has been completed, along with major alterations inside the main building, improving access and creating a homely, warm space for people to enjoy and feel safe in.

For the last year Age Scotland Orkney has been managing and delivering the Independent Living Support Service (ILSS) for people living in Orkney in receipt of Self Directed Support (SDS). The service has been upgraded, restructured and reorganised, to make sure that people have the right support at the right time.

You can read more about Age Scotland Orkney **here**.

Priority Area 3 – Community Led Support

Milestone.	Outcome / Measure.	Status.	RAG
Community Engagement Officer recruited.	Staff member in post.	Funding has been identified; however, establishing this post whilst the service is asked to identify significant savings is difficult. Furthermore, given the current recruitment hiatus at the Council, it is unlikely that this action can be progressed anytime soon.	
Explore options to develop Community Led Support across Orkney using a co-designed approach (Aligned with Orkney Islands Council's Delivery Plan).	Co-designed project plan developed by end September 2024.	Health and social care officers are continuing to work with colleagues from other services, within the Council, to develop multi-service approaches to Community Led Support. Results from the recent public consultations (Orkney Matters) will inform development of the plan. Whilst it is anticipated that a plan that reflects this multi-service approach will be completed, this is now considered extremely unlikely before the end of March, with a more realistic target being the end of Summer 2025.	

Community Led Support
an NDTi programme

Community Led Support (CLS) is all about co-production and collaboration. You can read a full introduction to CLS **here**.

Although we have not been able to build on the early success of the initiative in the last few years, CLS remains a key priority for the Partnership.

We are disappointed with the progress made against the declared Milestones; however, whilst there have been challenges around taking CLS forward, the partnership has been working closely with our colleagues from the Third Sector and NHS Orkney to maintain and expand two initiatives that deliver the intentions of CLS.

Island Wellbeing Project

The first of these initiatives, the Island Wellbeing Project, is a partnership between Voluntary Action Orkney (VAO), Highlands and Islands Enterprise (HIE), Orkney HSCP, and the Development Trusts of Hoy, Sanday, Shapinsay, Stronsay, Westray, and Rousay, Egilsay and Wyre. Most recently, Eday joined the partnership in April 2025.

The project is managed and administered by VAO and is currently funded by Esmee Fairbairn, the IJB, and the Island Development Trusts.

On each of the islands, the Development Trust employs a Community Wellbeing Co-ordinator. Their role is to support the development of community-led initiatives and provide generalised 1:1 support. This dual role enables co-ordinators to respond to the immediate needs of the community, whilst also developing longer term, sustainable solutions.

The Wellbeing Coordinators have supported 291 people over the last year.

Over the last year, the co-ordinators have supported 45 groups, with hundreds of attendees, such as companion groups, play and stay, health walks, Men's Sheds, and wellness pool sessions. They have also supported 291 individuals, over 800 separate support sessions, with areas such as signposting to financial, physical, and mental wellbeing support, and social activities.

The Island Wellbeing Project also looks to identify gaps in services for the ferry-linked isles and arrange ways for residents to access much needed services. For example, on five of the islands, and in response to feedback from residents, the co-ordinators have arranged for a mobile podiatrist to visit the islands on a regular basis. They consulted the community and worked with the Development Trusts to instigate, co-ordinate and where appropriate, secure funding for the service.

The project continues to look to the future, with sustaining the project in the long term as a priority. The service is currently administered by VAO, but this arrangement will end in September 2025. The development of a strategic partnership, that will oversee the valuable work of the co-ordinators and ensure it continues for years to come, is currently being explored.

Community Link Practitioners

Orkney's Community Link Practitioners (CLPs) work alongside GP Practices and are part of the practice team. This role is funded via the Primary Care Improvement Plan, through the Scottish Government. Employed by VAO, CLPs provide a crucial role in bridging the gap between GP Practices and communities, working individually with clients, who are referred directly from the GP Practices.

Those practices who currently have a CLP are: Heilendi, Skerryvore, Stromness Surgery, Dounby Surgery, Daisy Villa, Westray and Papa Westray. They are covered by a team of three CLPs, two of whom are full-time, and one part-time post.

The role is very varied and can include linking clients with community groups, services, and resources, available locally and nationally, to support with issues such as debt, housing, social isolation, loneliness, and low mood. The highest proportion of referrals we receive just now are for support with mental health, finances, housing, and loneliness and isolation, which remains very common in our community. Owing to pressures on other services, the CLPs are frequently finding that they are supporting more clients until a specialist service becomes available.

CLPs have the time to explore what issues are really important to each person.

CLPs have the time to sit with a client and explore what issues are really important to each person. They consider all the various services that are available to provide the best possible result for their client. This is called a holistic approach.

Often the client is very vulnerable, and CLPs work to empower them, building their self-esteem and self-confidence, until they are able to receive treatment or support from health or social services.

CLPs work closely with GPs and other health professionals, helping to reduce the workload on GPs, by focusing on the client's non-medical issues – allowing the GP to focus on the medical ones.

CLPs frequently map the services offered, both locally and nationally, to make sure they have a good knowledge of what is available, which is then shared with both their clients and GP practices.

The service goes from strength-to-strength, supporting 178 clients during the last year, and we expect this to increase again during the coming year.

Priority Area 4 – Mental Health and Wellbeing

Milestone.	Outcome / Measure.	Status.	RAG.
Develop a Suicide Prevention Plan.	Suicide Prevention Plan published.	The Suicide Prevention Action Plan was presented to the Integration Joint Board on 30 April 2025 for awareness. Progress against the Plan stated the Outcomes will be reported in April 2026.	
Establish a Psychiatric Liaison Service. Once in place, deliver a reduction in the overall patient impact as a result of staffing the mental health transfer bed.	Psychiatric Liaison Service model developed and IJB approval sought. Reduce the overall patient impact as a result of staffing the mental health transfer bed.	The Band 7 Nurse Team Leader's post has completed the Job Evaluation process and is now with the Vacancy Panel, for final authorisation, for advertisement on Job Train. This post should be out to advert by the end of the month (May 2025). The other team posts remain in the Job Evaluation process for review for banding, following which these will also be processed to advert on Job Train.	
Deliver a high performance against Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies (PT) HEAT, now called Local Delivery Plan (LDP), targets.	High performance against CAMHS and PT LDP targets.	CAMHS and PT continue to perform well against the national LDP targets. CAMHS again, continues to consistently achieve 100% of young patients being seen within the 18-week target time, since August 2023.	

Mental Health Officer

We have five Mental Health Officers (MHO) who provide a service 24 hours per day, 365 days per year, on top of their main jobs, and who fulfil the statutory responsibilities of the Council. These responsibilities include:

- Protecting health, safety, welfare, finances, and property.
- Safeguarding of rights and freedom.
- Duties to the Court.
- Public protection in relation to mentally ill offenders.

Our MHOs supported more than 100 people during the last year.

Type of Order and Intervention (Adults)	2020/21	2021/22	2022/23	2023/24	2024/25
Mental Health Compulsory Treatment Orders.	6	*	*	7	8
Short-term detentions	*	*	20	9	9
Emergency detentions	7	16	12	11	13
Other MHO assessments (those not leading to detentions, assessments to extend or vary orders, and social circumstances reports)	23	62	62	56	66
Mental Health Tribunals	6	*	*	8	8

Please note that * indicates a number less than five, which cannot be published.

Orkney Blide Trust

Orkney Blide Trust (everyone knows them as “The Blide”) is a charity that supports people who have, or have had, experience of mental ill health. Orkney HSCP commissions services from the Orkney Blide Trust.

The Blide are open every day, 365 days per year, and, in the last year, they welcomed 85 new members/ service users. This number is pretty consistent, as we had 86 new members in 2023/24, and 80 in 2022/23.

In total, they had 260 members in the last year, up again, from 240 in 2023/24, and 187 in 2022/23, whilst they welcomed an average of 660 members and professionals, per month, to their premises.

Members have been supported, both informally and in 1:1 meetings at their Victoria Street premises, in Kirkwall, and in the community, by the Housing Support Service and Befriending projects. The Blide organised a range of active, therapeutic and purposeful activities, as requested by members to support their mental health recovery.

This year, The Blide supported members to get access to outdoor activities, through the Community Health and Wellbeing Fund, and was able to continue the service for Care Experienced Young People (age 16 to 25), for an additional year. They have also converted an outbuilding into a workshop, helping members to learn to use tools, and have developed an enthusiastic and active gardening group.

Orkney’s Distress Brief Intervention service continued to provide timely and compassionate support to around 50 people, from our local community, who were in distress and had come into contact with the Police.

Over the past year, The Blide has been focussing on outreach work, challenging the stigma often associated with poor mental health. This has helped to tackle some of the barriers that people in our community face to accessing mental health support. and their opportunities for recovery”

You can read about The Blide **here**.

“Being able to come into the Blide and talk, face-to-face, with my key worker has been a huge help to me, personally. Opening up is something I have struggled with for many years, so having an environment where I can share feelings and thoughts that I would otherwise let build up and cause issues in my life, has been invaluable to me”

Priority Area 5 – Early Intervention and Prevention

Milestone.	Outcomes / Measure.	Status.	RAG.
Create additional frontline resource in Speech and Language Therapy.	Waiting times for assessment and treatment reduced.	Children and Young People team has been strengthened at the beginning of 2024 with the addition of one whole full time equivalent. The team has progressed and implementing universal specialised and targeted intervention for children and young people with speech, language and communication needs. Within the adult team the speech and language therapy post has remained vacant, and hard to fill, however gaps in service provision were supported by a specialist speech and language therapy on secondment from another Board, the secondment ended end of January. The substantive post is currently in the recruitment process and the services is optimistic for successful recruitment. In the interim, high risk and urgent referrals are continuing to be addressed through remote only service.	
Embed a new Neuro-developmental assessment pathway.	Neuro-Developmental Pathway (NDP) waiting times improve.	On 4 March 2025, an inter-agency workshop is being held to consider the best model of a single point of access for children and young people awaiting neuro development assessment and intervention. This will include paediatricians, education, Child and Adolescent Mental Health Services and other key Orkney Health and Care services.	

Milestone.	Outcomes / Measure.	Status.	RAG.
Increased provision of family support provision across Orkney (linking to Whole Family Wellbeing Fund Project).	Whole Family Wellbeing Support project plan and outcomes agreed by end March 2024.	The model of care to be agreed, identified the resources required to address the backlog and further service development requirements for duty of care ongoing following assessment.	
A collective agreement from partners to collaborate on a whole system approach to physical activity, with a working group established to take this approach forward.	An Orkney Systems-Based Approach to Physical Activity – Action Plan developed.	A draft copy of the Orkney Physical Activity and Wellbeing Strategy together with a delivery plan has now been developed and is ready for approval by stakeholders. A delivery group will then require to be put in place with the aim of prioritising and delivering against the key actions. The delivery plan will be reported upon annually.	
Continue to improve oral health and opportunities for routine oral care through delivery of population and targeted oral health programmes (e.g. Childsmile, Caring for Smiles, Open Wide, National Dental Inspection Programme (NDIP)).	Report on delivery and reach of oral health improvement programmes.	Childsmile Programme continues to provide and support toothbrushing and fluoride varnish programmes in nurseries and schools in the county. The majority of nurseries and schools participate in the toothbrushing programme. Toothbrushing is the core of the Childsmile Programme. Recruiting toothbrushing staff to ensure toothbrushing takes place continues to be a challenge from some schools. Caring for Smiles training is provided to care home and home care staff. Three training sessions were delivered for care home staff over October and November. Training has been delayed this calendar year due to availability of care home staff.Annual oral health screening in care homes has been delayed to staffing issues but is underway.The National Dental Inspection Programme inspections,	

Milestone.	Outcomes / Measure.	Status.	RAG.
		focusing on P7 children's oral health will be completed by end March 2025.	

Prevention and early intervention are becoming increasingly important across all health and social care services. Whatever their age, background, or circumstances, we want everyone in Orkney to be aware of their own health and wellbeing, doing their best to keep themselves healthy.

The local environment and the communities where people live are vitally important to both promoting and delivering good health, as well as keeping people active and connected.

Speech and Language Therapy

The team have been developing their services for people with speech sound disorders and stammering, during the last year, to make sure treatments and support are in line with the current research. This has had a real, positive impact on how they deliver their services, as well as breaking down the barriers and stigma that affect people with these conditions.

Collaboration has been at the heart of developing services, especially with regard to early language and communication. This has enabled the team to work with education and early years colleagues on delivering services locally. This is also true of the ongoing expansion of treatment and support for children and young people.

Our schools have been taking part in a national joke telling competition. We even had a finalist!

For the second year in a row, Orkney has been involved in a national Royal College of Speech and Language Therapists campaign called 'Voice Box'. This a joke telling competition, for children of primary school age, which helps them realise the fun and importance of communication. There were lots more schools involved, this year, and we even had a finalist!

Services and support for adults with learning disabilities have resumed, with the team working closely alongside the wards.

Some of the challenges the team have had with staff shortages have been addressed by arranging locum, and longer-term secondment, which has made sure that they can deliver the full range of services. They have also made student placements available in the team.

Infant Feeding Team

The Infant Feeding Team have maintained their Gold Status for the UNICEF Breast Feeding Initiative. This was achieved during the previous year and has been recognised worldwide, with a case study of their journey published by UNICEF online. You can read about this **here**.

To try and make access to services more straightforward, there has been a trial of antenatal sessions, for new parents, outwith normal working hours, as well as at the weekend. This has been a joint venture between the infant feeding team, maternity staff, and peer supporters.

Health Visiting

The team continues to make links with nurseries and our partner organisations to provide the best service for families. Our two trainee Health Visitors are now qualified, and now, with a full complement of staff, we are pleased to be offering the full range of health visiting services to all families, across Orkney, including the Isles.

One member of our team is now working with our maternity colleagues and is delivering an antenatal workshop, which has been a great success with families and much appreciated.

The team were nominated for several NHS Orkney Awards, with one member of the team shortlisted in her category and two members of the team shortlisted in the Bookbug Hero Awards. You can read more about Bookbug **here**.

You can find out more about what we are doing, on our Facebook page, **here**.

Vaccination Service

The Spring COVID Programme 2024 started on 1 April 2024, with the Team visiting the Care Homes. GP Practices in Westray and Sanday began using the NIVS National Portal for arranging appointments for their patients. NIVS is a web-based tool that can be used for booking and managing vaccination appointments. Stromness, and all the other isles, continued to appoint and vaccinate their own patients.

We vaccinated 2,356 eligible folk in Orkney, against COVID, in the last year.

A total of 2,356 Orkney residents out of an eligible 3,308 were vaccinated, an uptake of 71.2%.

August 2024 saw the introduction of the new Respiratory Syncytial Virus (RSV) vaccination. You can read more about RSV **here**. It was recommended for adults aged 75-79 years old, and for pregnant women (from 28 weeks), to protect their babies after birth.

Orkney had the highest uptake in Scotland of the Winter Covid and Flu Vaccination, last year.

The Winter COVID and Flu 2024 programme quickly followed the RSV programme, with an uptake of 58.7%: the highest rate of any NHS Board in Scotland. The School Flu programme ran alongside the adult programme, with a lower uptake in this age group.

Throughout this period the service has covered the monthly Multiple Sclerosis Clinic in the Outpatient Department at The Balfour.

School Nursing

In another busy year for the School Nursing team, we have successfully launched the school-age continence service, which is already having a positive impact.

We were delighted when one of our school nurses was nominated for the Queen's Nurse Programme. She has even been shortlisted to attend Holyrood to meet Queen Camilla, in July 2024.

We were equally delighted when another member of the team secured funding to attend an international conference about something called Trauma Informed Care. The things she learned at the conference were shared with all her colleagues, on her return, and has significantly improved our service.

We were proud when our student school nurse was selected as a Student Ambassador. She is doing great work sharing her knowledge with the community.

We have been busy elsewhere, too, where we are now involved with the Realistic Medicine programme. You can read more about the programme **here**. We are also supporting delivery of sessions educating the Clinical Education Team. You can read about their work **here**.

One of the School Health nurses has been nominated for the Queen's Nurse Programme.

Neurological Services

We have named points of contact at NHS Orkney for people affected by Multiple Sclerosis, Motor Neurone Disease and Parkinson's Disease. These services offer comprehensive assessments and reviews, which guide plans for treatment, care and support, and are developed by shared decision making, with the person and their family/carers always at the centre of this process.

This way of working helps staff to identify opportunities for:

- Improved symptom management.
- Reduction of risks.
- Early intervention.
- Reduction or avoidance of hospital admission.
- Ways to support people to live as meaningful a life as possible.

Team work and communication with other services and agencies, both locally and nationally, is key to this approach.

Some clinicians suggest there are gaps in services for people with some neurological conditions, and are considering a strategic overview of all neurological conditions and treatment pathways, provided by NHS Orkney.

Priority Area 6 – Tackling Inequalities and Disadvantage

Milestone.	Outcome / Measure.	Status.	RAG.
Secure the sustainability of the Islands' Wellbeing Project and Island Co-ordinators.	Integration Joint Board (IJB) funding to be sought and secured for Wellbeing Co-ordinators, to continue beyond October 2023.	**Complete** - The IJB, through additional investment, agreed to fund the request from VAO to continue the Islands' Wellbeing Co-ordinators.	
Develop targeted, creative and appropriate community-based responses to support oral health improvement, based on Community Challenge fund model, supporting positive oral health behaviour and access to dental services when needed. The Board will monitor dental access needs throughout Orkney and be ready to respond to increased demand and changes in delivery.	Report on growth of activities to support oral health improvement in community, e.g. visits to toddler, community groups in Orkney.	At March 2025, community wide oral health improvement activity continues to develop for children and young people. Visits to toddler groups continue reaching out to young families. There have been 14 toddler group visits between September 24 and March 25. Work continues with the early years team, nurseries and schools, including secondary and Papdale Halls of Residence to reach children, young people and families needing some extra support. Increasingly community-based activity is a focus for the oral health improvement programme. Sub-group of the Child Healthy Weight Steering group last met in September 2024. Healthy eating guidance for parent of nursery aged children has been circulated. This group provides a network for discussing healthy eating issues for children and young people, including school meals. Areas of interest for this group are healthy food choices for active children, and school snacks.	

Milestone.	Outcome / Measure.	Status.	RAG.
		Delivery of HENRY started in August 2024 with the Healthy Families Right from the Start 8-week programme which was delivered face to face to a group of parents of children aged 0-5. A closed group who invited us along (also face to face) has been delivered and an online delivery is underway and going well. Currently scheduled are two workshops, Understanding Children's Behaviour (4 March 2025 (Face to Face) and 6 March 2025 (Online)) and Fussy Eating (18 March 2025 (Face to Face) and 20 March 2025 (Online)) and further workshops will be scheduled soon. Finally, Healthy Families Growing Up 8-week programme which is for families of children aged 5-12years of age is about the be advertised. The first of these will be face to face and there will be a further programme held online following this. The Public Dental Service continues to face difficult and challenging time in terms of staffing and recruitment. Progress has been made in recruiting a dental officer, and recruitment is underway for a dental therapist. This is being managed, and monitored closely, and recruitment efforts continue to ensure that the best service can be provided for patients.	
	Based on the demonstration of increased needs, the Public Dental Service to	The Public Dental Service has finally recruited to one of the vacant Dental Officer posts, with the person starting in post Summer 2025. A 6-month temporary post has been successfully filled for the interim and long-term options for this person are also being explored. Further	

Milestone.	Outcome / Measure.	Status.	RAG.
	recruit required additional dental officer.	recruitment is planned for a Dental Therapist, Dental Nurses, Dental Officer and Senior Dental Officer, to bring the service closer to full establishment and better serve the dental needs of Orkney. News of some successful recruitment in the independent sector is also welcome.	
Work with islands communities to co-design and develop models of care and services that are tailored, effective and sustainable.	First three islands (Papa Westray, Eday and North Ronaldsay) will have plans developed and actioned by March 2024.	**Complete** – The Papa Westray work was completed and an update of outputs provided to the Orkney Partnership Board. Work with North Ronaldsay has been completed with a recognition that further engagement with the Community Council and Development Trust will provide more opportunities to be explored. Work with Eday was completed as far as possible, owing to challenges with community representation.	

Tackling inequalities and disadvantage is directly linked with all our Strategic Priorities.

We will continue to address this by:

- Making access to services easier for everyone.
- Keeping children, young people and vulnerable adults safe.
- Working with our statutory and Third Sector partners to address financial hardship.
- Partnering with other agencies and services to address financial hardship.
- Making sure Orkney is a happy and safe place for everyone.

Most of the previous sections include many examples of services that also fit this priority area.

The Isles

Access to services in the isles can be challenging for people, so we continue to try to bring services to the isles, wherever possible.

Where this is not possible, we will try to arrange Mainland appointments that make travel to and from the isles convenient, or use technology to avoid the need for folk to travel to Kirkwall or the Scottish mainland.

There are regular meetings for the Joint Isles Community Council Chairs/Vice Chairs/Health and Care Representative with members of the Partnership's Senior Management Team, to ensure regular engagement.

Improving the Cancer Journey

At the beginning of 2025, NHS Orkney's Public Health department, in partnership with Macmillan Cancer Support, launched the Improving the Cancer Journey (ICJ) service. ICJ is a dedicated service to support anyone in Orkney affected by cancer, with their non-clinical needs. This may be the person with the diagnosis, or anyone affected by that diagnosis, such as family and friends.

When someone is referred into ICJ, they are offered something called a Holistic Needs Assessment (HNA). This is a 72-point checkbox style questionnaire, that finds out what the person's concerns are, and what matters most to them. The key categories of concern are financial, practical, physical, spiritual, and emotional. The HNA can be offered electronically, or as a paper copy, and recognises that any area of someone's life, and the lives around them, can be affected by cancer.

Since launching a few months ago, the ICJ service has received 19 referrals from across Orkney.

Based on the HNA and conversations with the ICJ Link Worker, a care plan will be created to make sure they are receiving all the support they require. Services most often referred and signposted by ICJ include Citizens Advice Bureau, THAW, CLAN Cancer Support, Macmillan Cancer Support, Crossroads Care Orkney, and supporting patients to receive a blue badge.

The ICJ service is offered over the phone, video call, via Near Me (NHS online meeting platform), or in-person, where possible. This allows the ICJ service to support patients in a way that works for them, whether that is providing home visits, telephone appointments, or linking in with pre-existing appointments in the Balfour Hospital.

Since launching, ICJ has received 19 referrals for patients across Orkney. Through continued promotion and support from stakeholders, the ICJ service will become an essential service in the care and support of patients affected by cancer, in Orkney.

Financial Performance and Best Value

Within the functions delegated to it, the IJB commissions a range of services and approves a budget for them to operate within. IJB financial governance includes:

- Approval of high-level strategies and plans.
- Quarterly financial monitoring reports.
- Publication of the annual Statement of Accounts.

In 2024/25 the IJB controlled the direction of £66,706,000 of financial resource to support the delivery of its strategic objectives. The table, below, shows the original budgeted contributions from each organisation:

NHS Orkney	NHS Orkney Set Aside	Orkney Islands Council	**Orkney IJB**
£29,369,000	£8,639,000	£28,698,000	**£66,706,000**

The IJB was responsible for £66,706,000 in 2024/25.

The Scottish Government requires Public Authorities to assess whether Best Value has been achieved in terms of the planning and delivery of services. You can read more about Scottish Government's definition of Best Value **here**. This should include, where applicable, identification of whether there are opportunities for further efficiencies. Best Value ensures that we have services in place that are efficient, economic, are sustainable, and that deliver improved outcomes for Orkney.

Revenue Expenditure Monitoring reports were presented to the Orkney IJB throughout the year. The reports set out information on the actual expenditure and budget for the year to date and the forecasted outturn against annual budget. Additionally, explanations of significant variances were included along with details of any action required.

This section of the report will be updated once the final accounts for 2024/25 are approved and audited.

Audit and Inspection Reports

The IJB's Performance and Audit Committee met on the following dates over 2024/25 and discussed the subjects, below, that relate to this report. You can read each report by clicking on the links, below:

IJB Performance and Audit Committees 2024/25

26 June 2024:

Internal Audit Charter.

Internal Audit: External Communications.

Internal Audit: Annual Report and Opinion.

Registered Services with Orkney Health and Care - Inspection Assurance Report.

Strategic Plan Priorities Progress Update.

25 September 2024:

External Audit Annual Report.

Internal Audit: Internal Communications.

Strategic Plan Priorities Update.

11 December 2024:

Internal Audit Actions Progress Report.

Registered Services with Orkney Health and Care - Inspection Assurance Report.

Strategic Plan Priorities Progress.

19 March 2025:

Internal Audit Strategy and Plan.

Internal Audit Charter.

Indicative External Audit Annual Plan.

Internal Audit: Strategic Commissioning.

Strategic Plan Priorities Progress.

In addition to the attached a further audit report was considered in private by the Performance and Audit Committee in relation to health and care payment processes.

In February 2025, the Integration Joint Board received the Joint Inspection of Adult Support and Protection Progress Review. This Progress Review looked at the six priority areas for improvement which were previously identified. All six areas were graded as 'significant progress made'. You can find a copy of the report **here**.

In July 2024, the Joint Clinical and Care Governance Committee received an update on the Action Plan following the Mental Welfare Commission Local Visit to Orkney which took place in Spring 2023. The second annual visit took place in July 2024, with the published report being made available in February 2025. Both Mental Welfare Commission reports can be found **here**.

Local Government Benchmarking Framework

The Local Government Benchmarking Framework (LGBF) brings together a wide range of information about how all Scottish councils perform in delivering services to local communities. It breaks down the information into four family groups of eight, depending on which performance figures, or metrics, are being looked at.

The Adult Social Care Services information, which falls in the People Services group of metrics, is grouped by affluence of each partnership, as shown in the table below:

People Services	Children, Social Work and Housing Indications			
	Family Group 1	Family Group 2	Family Group 3	Family Group 4
	East Renfrewshire	Moray	Falkirk	Eilean Siar
	East Dunbartonshire	Stirling	Dumfries and Galloway	Dundee City
	Aberdeenshire	East Lothian	Fife	East Ayrshire
	City of Edinburgh	Angus	South Ayrshire	North Ayrshire
	Perth and Kinross	Scottish Borders	West Lothian	North Lanarkshire
	Aberdeen City	Highland	South Lanarkshire	Inverclyde
	Shetland Islands	Argyll and Bute	Renfrewshire	West Dunbartonshire
	Orkney Islands	Midlothian	Clackmannanshire	Glasgow City

The least deprived HSCPs are shown on the left, the most deprived on the right.

In contrast to last year's reporting period, the metric for SDS spending on adults aged 18 and over, SW02, has now been split according to the deprivation family group rather than by rurality.

Orkney Health and Social Care Partnership.

As none of the metrics set out here are displayed by rurality, the explanation has been left out of this report. An explanation of the grouping can be found on **here**.

All 11 indicators were updated from the figures reported in last year's report.

Six indicators showed a drop in national ranking, one ranking position stayed the same, and four measures showed an improvement in ranking.

The table on the next page shows Orkney HSCP's performance in the 11 Adult Social Care Services metrics, compared with the other HSCPs, and compares the ranking with the previous year. Position one of 32 would be considered top performer with 32 of 32 as the worst.

Since publication of the 2023/24 report, Public Health Scotland has adjusted the benchmarking data, to bring figures into line with other Scottish Government reports, which means that the national ranking for some indicators has changed, and as a result, Orkney HSCP's position in some measures for the previously reported period has changed. This is reflected in the table with an asterisk after the 'Previous Rank' indicating a number that has been updated by the Improvement Service.

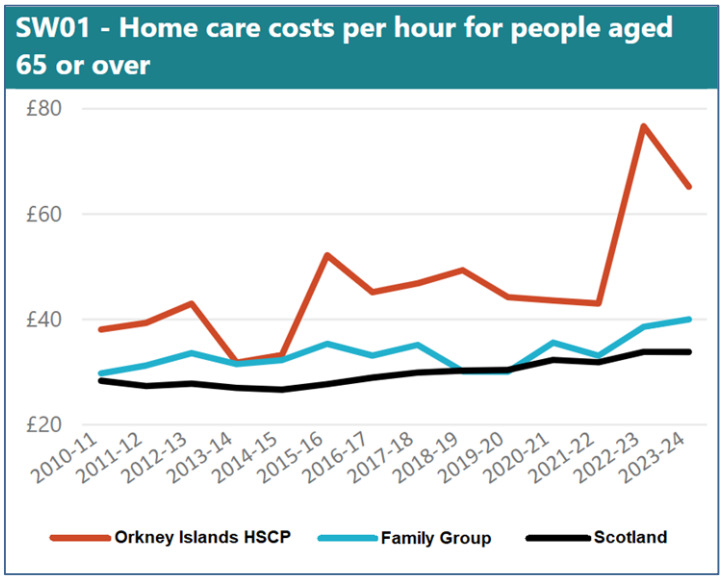
An upward arrow  indicates improvement in ranking, an arrow pointing side to side  indicates no movement, while a downward arrow  indicates deterioration in ranking.

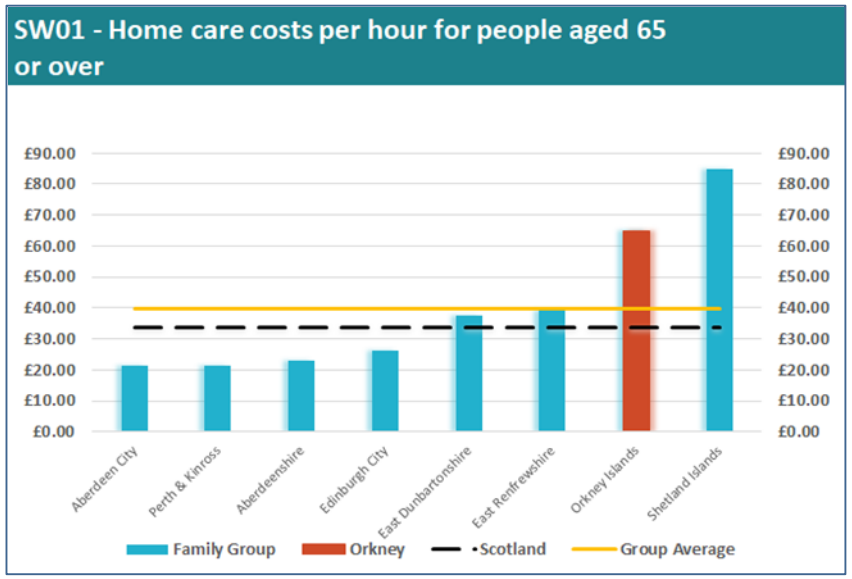
No.	Measure.	Ranking Direction of travel.	Previous Rank.	Current Rank.	% Above / Below National Average.
SW01	Home care costs per hour for people aged 65 or over.		**31**	**30**	**+ 93%**
SW02	Self-directed support (direct payments & managed personalised budgets) spend on adults 18+ as a percentage of total social work spend on adults 18+.		**16**	**17**	**- 40%**
SW03a	The percentage of people aged 65 and over with long-term care needs who are receiving personal care at home.		**31** *)	**26**	**- 7%**
SW04b	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.		**9**	**2**	**+ 14%**
SW04c	Percentage of adults supported at home who agree that they are supported to live as independently as possible.		**1**	**8**	**+ 7%**
SW04d	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.		**2**	**4**	**+ 14%**
SW04e	Percentage of carers who feel supported to continue in their caring role.		**2**	**10**	**+ 9%**
SW05	Residential cost per week per resident for people aged 65 or over.		**31**	**31**	**+ 81%**
SW06	Rate of readmission to hospital within 28 days per 1,000 discharges.		**2** *)	**1**	**- 38%**
SW07	Proportion of care services graded ‘good’ or better in Care Inspectorate inspections.		**30**	**29**	**- 8%**
SW08	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+).		**9**	**22**	**+ 13%**

The last reporting year was 2023/24; however, * denotes a figure adjusted since publication of the 2023/24 Annual Performance Report.

SW01 – Home care costs per hour for people aged 65 and over

Public Health Scotland has adjusted previous years' cost for an hour's home care to be in line with other Government reporting. This change has not resulted in a change in ranking for Orkney HHSCP, but does mean that the hourly rate we reported last year increased slightly, from £72.46 to £76.48.



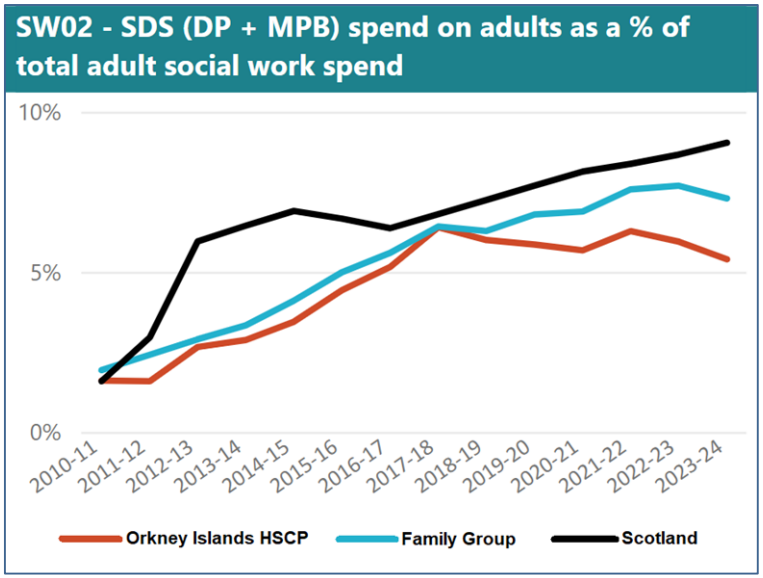


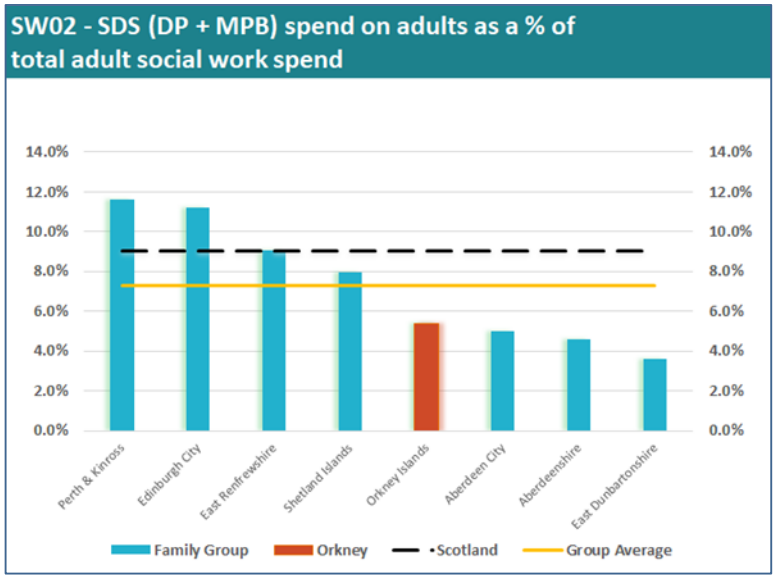
Following last year's sharp increase, the cost of an hour's care at home has reduced from £76.48 (after adjustment), for 2022/23, to £64.99 for 2023/24, a reduction of 15% on the previous period.

Orkney HSCP went from 31st out of 32 HSCPs to 30th, with only Shetland Islands and Eilean Siar being more expensive, at £84.77 and £92.43, respectively. In the family group, Orkney's rank has gone up from eighth, to seventh out of eight partnerships, with an hour's home care costing around 93% more than the national average of £33.61, and 63% more than the group average of £39.81.

SW02 – SDS spend on adults aged 18+ as a percentage of total social work spend on adults aged 18+

In contrast to last year's report, the SDS family grouping has been changed to the Deprivation comparison rather than Rurality.



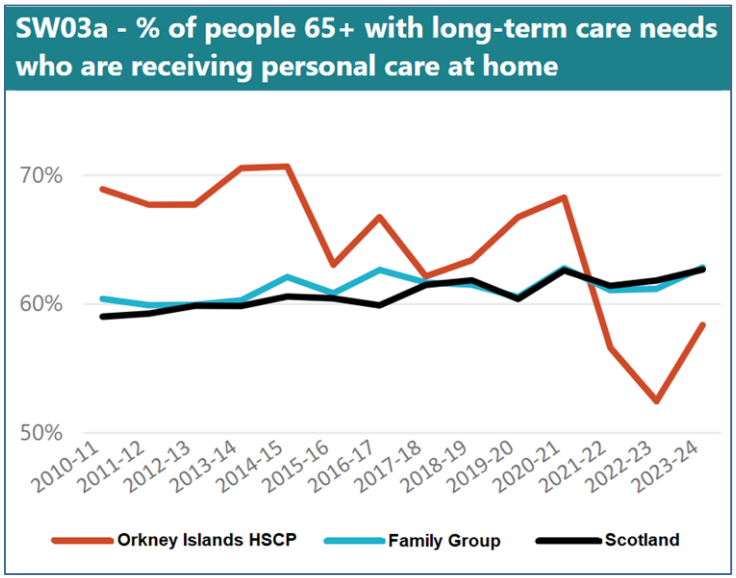


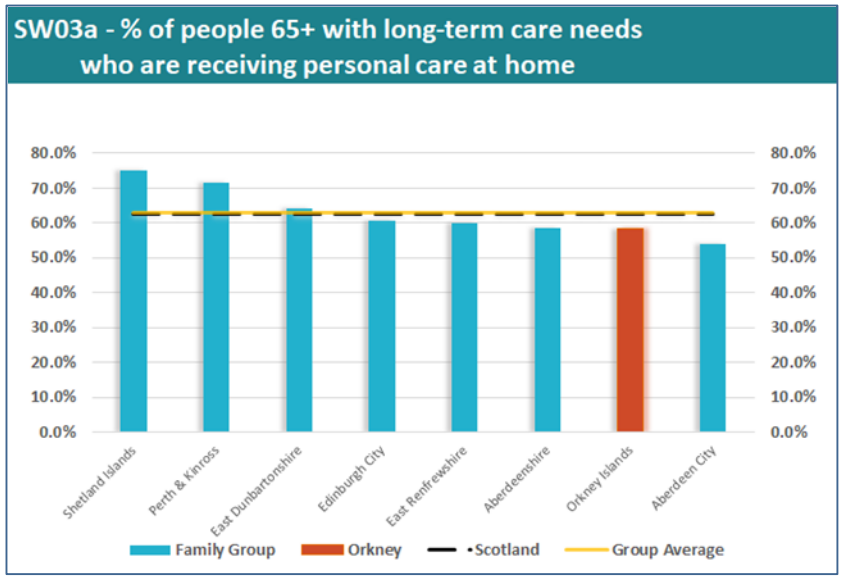
Nationally, Orkney HSCP went from the 16th highest percentage of total social work spending on Self-directed Support, to 17th highest, with SDS representing 5.4% of total social work spending during 2023/24, down from 5.9% in 2022/23.

By comparison, the national average for 2023/24 is 9.0% (up from 8.7%), while the family group average is 7.3% (reduced from 7.7%). In the family group, Orkney HSCP was ranked fifth out of eight for 2022/23 and remains there for 2023/24.

SW03a – Percentage of people aged 65 and over with long term care needs receiving personal care at home

The data for indicator SW03a has been updated between the publication of last year's report and this year's data becoming available, meaning the graphs have changed from that shown in last year's report, and now show a rather more erratic progress over time of the percentage of people with long term care needs receiving care at home.



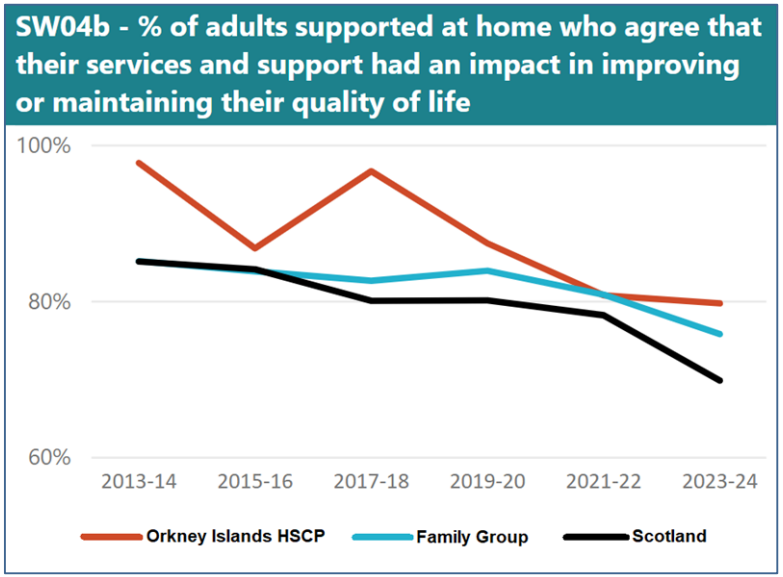


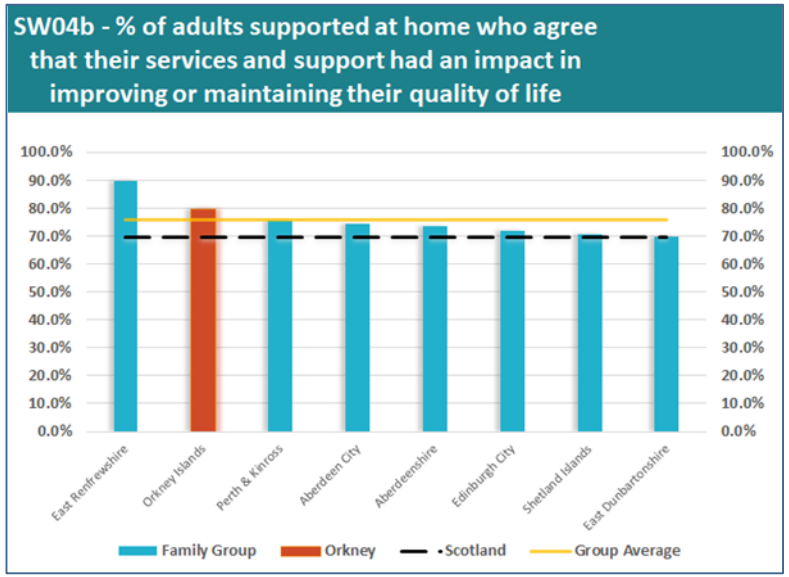
There has been an increase in the percentage of people aged 65 and over who have long term care needs receiving care at home, from 52.4% (adjusted) to 58.3%, an increase of 5.9% on the previous period, and sees Orkney's place in the national rankings go from 31st to 26th.

Orkney's place in the family group has not changed, meaning Orkney has the second lowest percentage of people receiving care at home, behind Aberdeen City, where the figure is 54.1%.

SW04b – Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

This indicator was not shown in last year's report, due to data for the SW04 group of indicators coming out every second year, and the fact that the survey result wasn't available in time for the report.

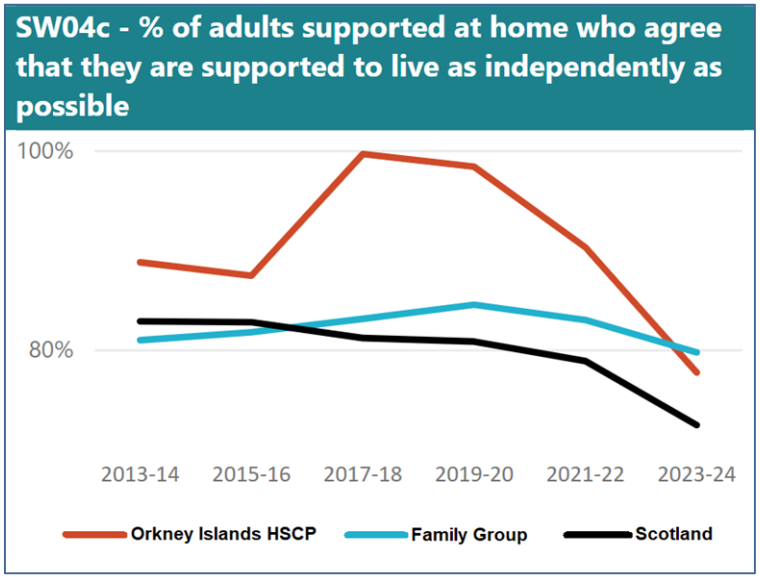


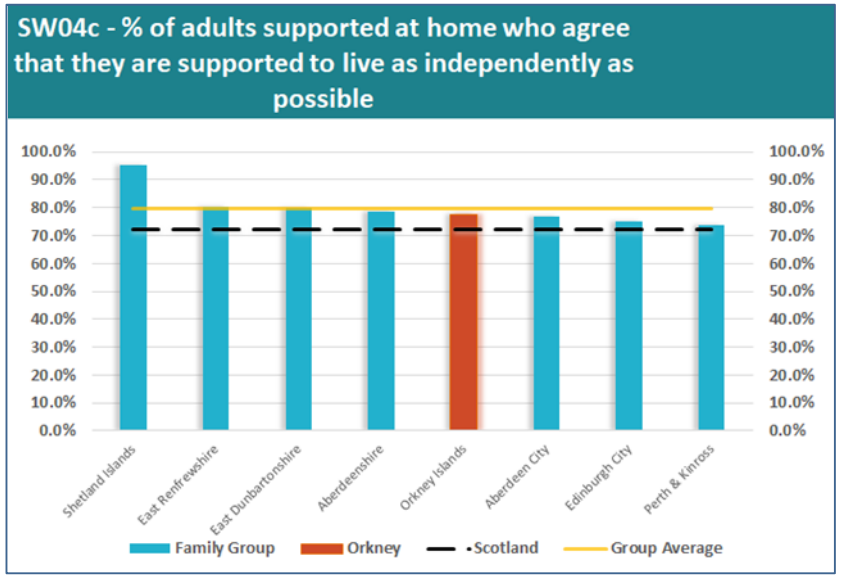


Orkney HSCP's performance in this indicator reduced slightly when compared with the previous period for which data is available, from 80.7% to 79.6%. Despite this drop, Orkney has climbed the national rankings from ninth to second and has moved from having the third highest percentage in the family group, to having the second highest percentage of supported adults who agree that their support improved or maintained their quality of life, behind East Renfrewshire, which comes in at 89.6%.

SW04c – Percentage of adults supported at home who agree that they are supported to live as independently as possible

This indicator was not shown in last year's report, due to data for the SW04 group of indicators coming out every second year, and the fact that the survey result wasn't available in time for the report.



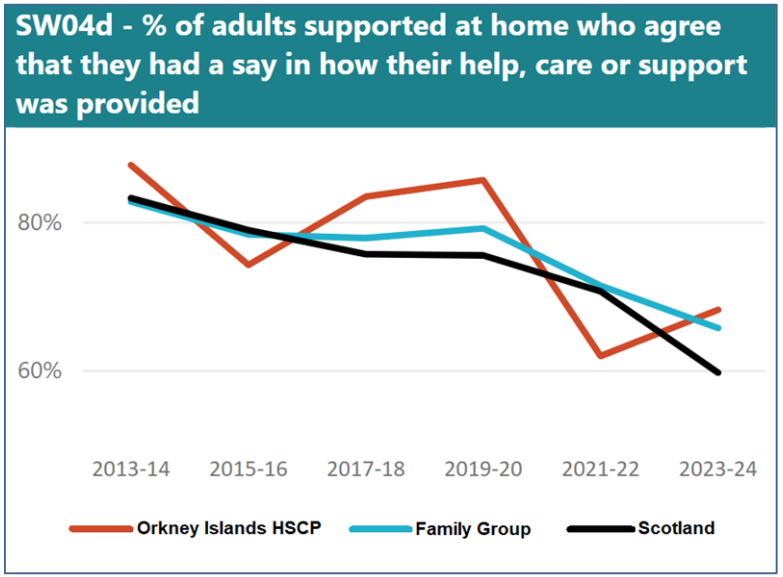


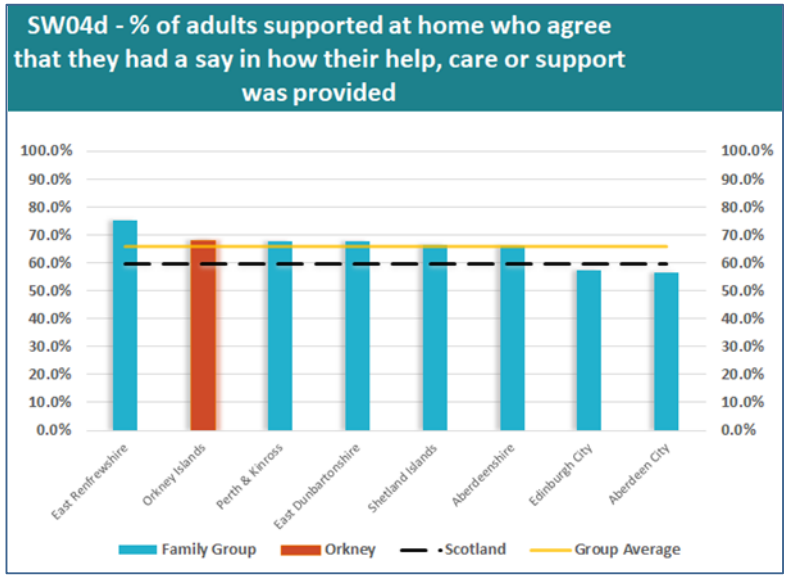
Orkney's percentage of adults who agree they are supported to live as independently as possible has reduced from a high of 99.6% in 2017/18 to 77.7% for 2023/24, dropping from 90.2% in the previous census period, a drop of 12.6%.

While Orkney's performance is slightly below the group average of 79.7%, it is still above the national average, which has reduced over time to 72.4%. Orkney's position in the national rankings has reduced from first to eighth position between the 2021/22 and 2023/24; the group ranking has reduced from first to fifth.

SW04d – Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided

This indicator was not shown in last year's report, due to data for the SW04 group of indicators coming out every second year, and the fact that the survey result wasn't available in time for the report.



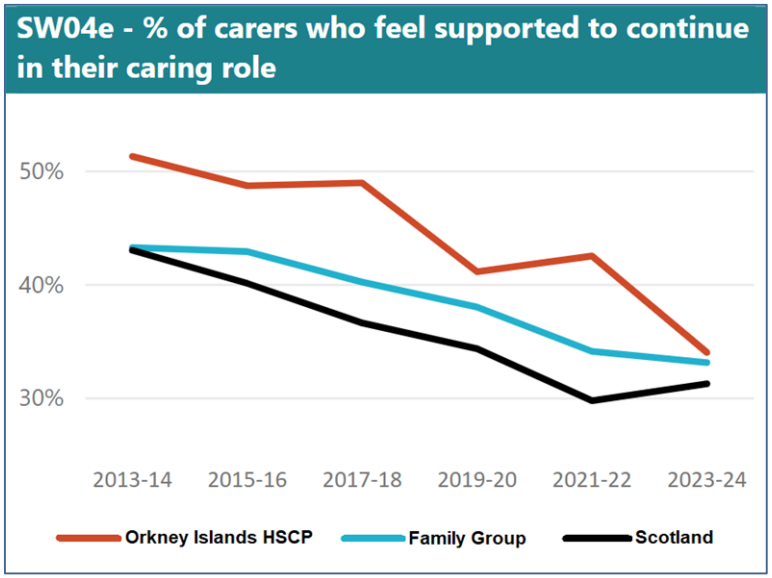


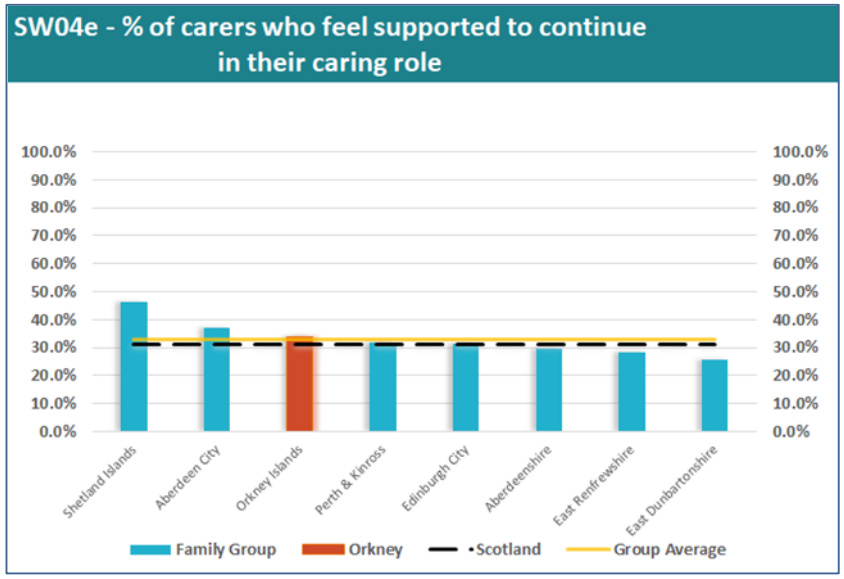
The percentage of adults who agree that they had a say in how their help was provided has generally followed the national and group averages, although Orkney's percentage has swung around these averages, and has been on a downward trajectory, with 2021/22 having the lowest figure, at 61.9%. For 2023/24, the percentage has increased to 68.1%, an increase of 6.2%.

In terms of national and family rankings, the overall reduction in percentages across the board, paired with an improvement in Orkney's number, means that Orkney HSCP now ranks fourth out of 32 partnerships nationally (up from 30th), and second instead of eighth in the family group; East Renfrewshire tops both the national and family group rankings, with 75% of supported adults agreeing they had a say in how their support was provided.

SW04e – Percentage of carers who feel supported to continue in their caring role

This indicator was not shown in last year's report, due to data for the SW04 group of indicators coming out every second year, and the fact that the survey result wasn't available in time for the report.



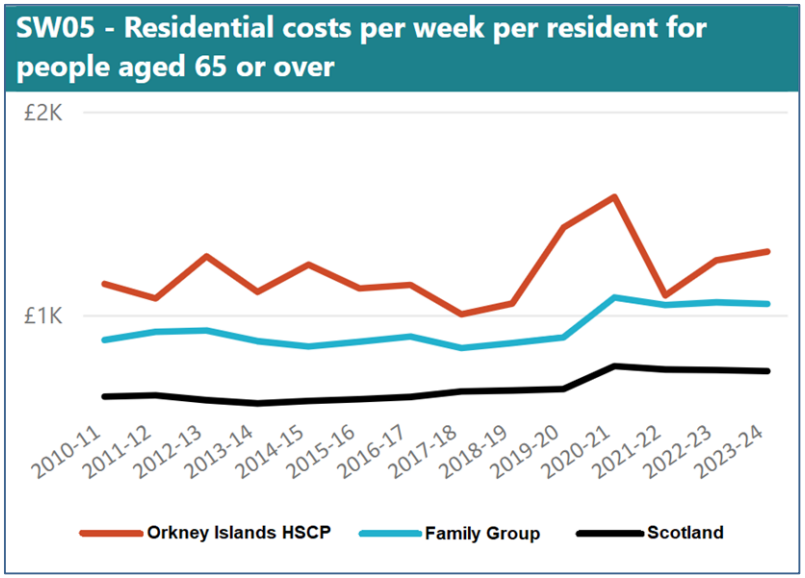


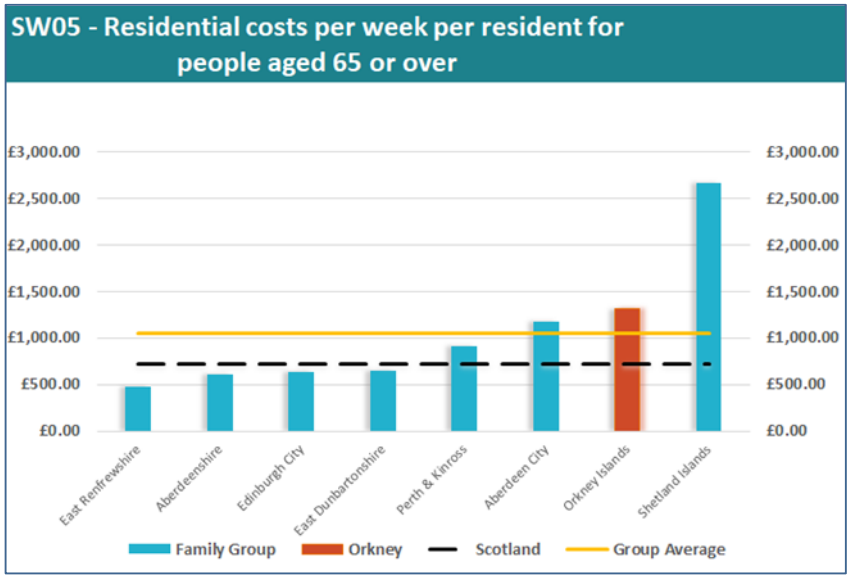
Orkney HSCP shows a higher percentage of carers who feel supported to continue in their caring role than both the national and family group averages over time, although there has been a reduction from 51.2% in 2013/14, to 34% in 2023/24. There was a small increase from 41.1% to 42.5% from 2019/20 to 2021/22, followed by a further drop to the final number.

In the family group, Orkney moved from second to third out of eight partnerships, behind Shetland Islands and Aberdeen City, while nationally, Orkney's ranking went from second to tenth out of 32 partnerships.

SW05 – Residential costs per week per resident for people aged 65 or over

The figures for this indicator have been adjusted since publication of last year's report, which has meant a slight lift for all previous years, except from 2018/19 and 2021/22, which were reduced by 12.8% and 22.3% respectively from the figures reported last year.



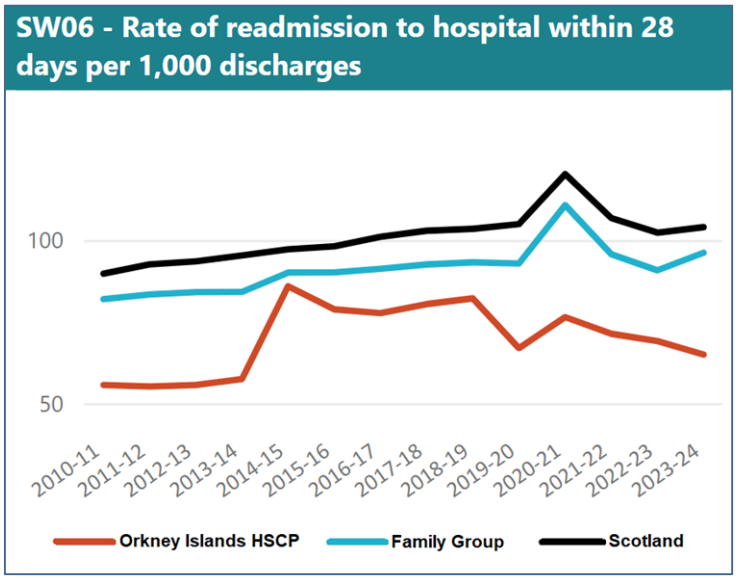


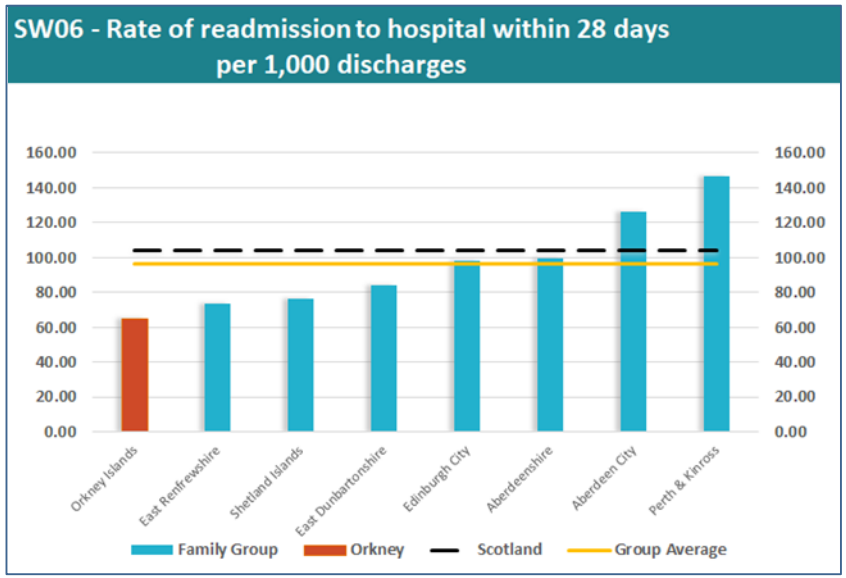
A week's residential care in Orkney during 2023/24 costs approximately £1,310, which is an increase of £42 over last year's price, an increase of 3.3%.

Orkney's place in the national rankings has stayed unchanged, at 31st out of 32 partnerships. Likewise, the placing in the family group has not changed, and Orkney remains the second most expensive partnership for a week's residential stay, with only Shetland being more expensive, at £2,660 per week.

SW06 – Rate of readmission to hospital within 28 days per 1,000 discharges

As with last year's report, Public Health Scotland has amended historic information for this indicator, meaning that Orkney HSCP's ranking for last year's report has improved from third to second, in both the national and family group ranking, despite Orkney's historic readmission numbers not being affected by the amendment.



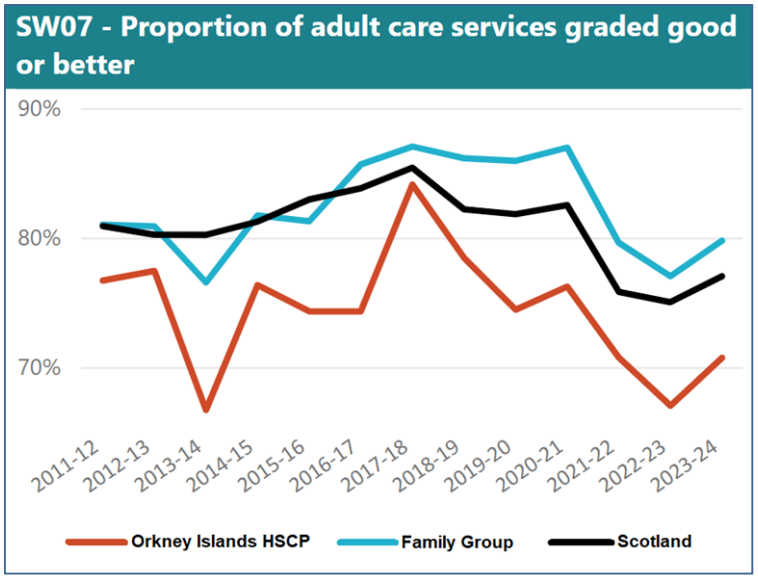


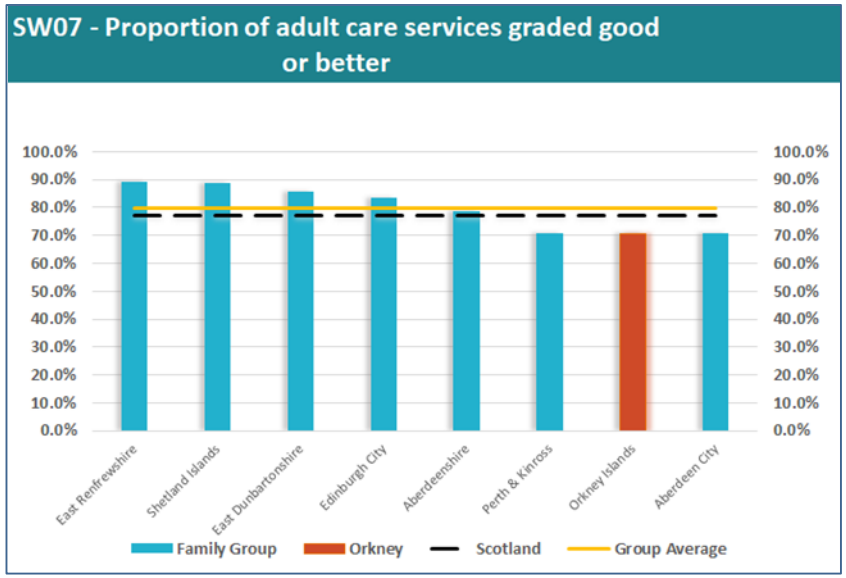
Orkney's rate of readmission to hospital within 28 days per 1,000 discharges for 2023/24 has again remained below the national and family group averages, and has shown a slight reduction compared to last year figure, going from 69 readmissions per 1,000 discharges to 64.9 per 1,000; a reduction of 6%.

The national and family group rankings have improved, with Orkney climbing from second to first for both.

SW07 – Proportion of adult care services graded good or better

No adjustments were made to this indicator between the last report and this one.



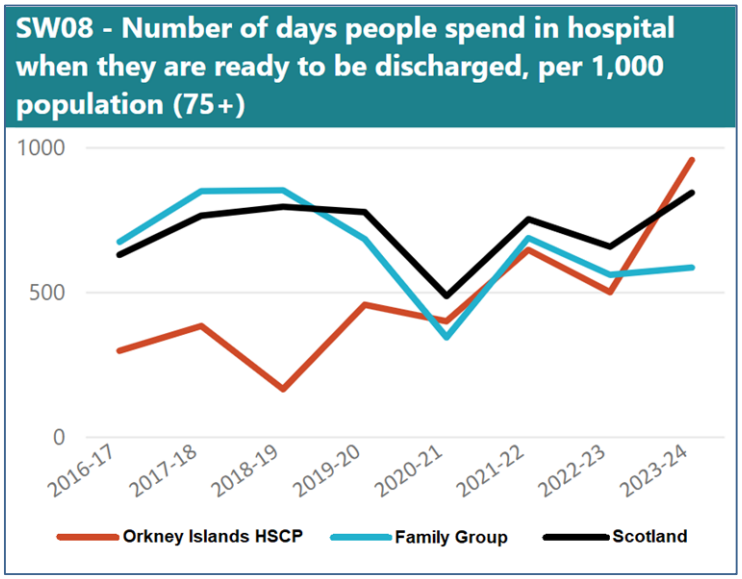


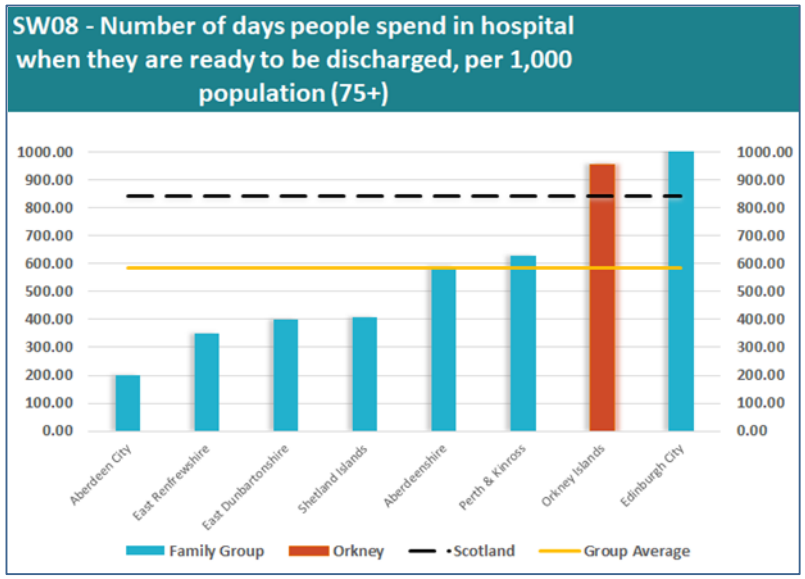
Orkney HSCP's percentage increased from 67% of adult care services being graded good or better, to 70.7% of services receiving a good or better marking. Orkney's position in the national ranking improved from 30th to 29th out of 32, and is tied with Aberdeen City, which improved its ranking from 32nd.

Orkney's position in the family group has not changed, and has remained at seventh out of eight partnerships, again finding itself tied with Aberdeen City, at 70.7% of adult care services being graded good or better.

SW08 – Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)

The numbers for this indicator have been adjusted since publication of the previous performance report, and while the first five years are identical for Orkney HSCP, 2020/21 is now shown to be slightly higher than the number reported last year (644 instead of 619), while 2022/23 was reduced slightly, from 510 to 498.





Orkney HSCP's number of days people spend in hospital when they are ready to be discharged has increase from the previous period, from 498 to 954 days, nearly doubling the number of days spent in hospital, with a 91.8% increase on the last year.

As a result of this, Orkney's position in the national ranking has dropped from ninth place in 2022/23 to 22nd place in 2023/24. In the family group, Orkney's ranking went from fifth to seventh, with only Edinburgh showing people spending longer in hospital when they are ready to be discharged, at 1,020 days per 1,000 population.

Health and Wellbeing Indicators

Nine National Health and Wellbeing Outcomes have been set by the Scottish Government and each IJB uses these outcomes to help them set their local priorities. You can read more about the nine National Health and Wellbeing Indicators **here**.

Underpinning the National Health and Wellbeing Outcomes there is a set measures, called integration indicators, and all HSCPs have to report their performance against these indicators.

These National Indicators (NI) have been developed using data sources from across the country, which ensure consistency in measurement.

There are a total of 23 indicators, but four of them (indicators 10, 21, 22 and 23) have not yet been finalised for reporting. Indicators 1 to 9 are based on the Scottish Health and Care Experience Survey (HACE) commissioned by the Scottish Government. The survey is carried out every two years.

The primary source of data for indicators 12 through to 16 are Scottish Morbidity Records which are nationally collected discharge-based hospital records. Following recommendations made by Public Health Scotland and communicated to all HSCPs, the most recent reporting period available is calendar year 2024; this ensures that these indicators are based on the most complete and robust data currently available.

National indicators 1 – 9 as reported for 2023/24

Indicator	Title	Orkney	Scotland	Orkney West	Isles	Orkney East
NI – 1	Percentage of adults able to look after their health very well or quite well.	93.7%	90.7%	95%	88%	95%
NI – 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible.	77.7%	72.4%	…	…	…
NI – 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided.	68.1%	59.6%	…	…	…

Indicator	Title	Orkney	Scotland	Orkney West	Isles	Orkney East
NI – 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated.	68.2%	61.4%	…	…	…
NI – 5	Percentage of adults receiving any care or support who rate it as excellent or good.	82.5%	70.0%	…	…	…
NI – 6	Percentage of people with positive experience of care at their GP practice.	90.1%	68.5%	93%	96%	89%
NI – 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life.	79.6%	69.8%	…	…	…
NI – 8	Percentage of carers who feel supported to continue in their caring role.	34.0%	31.2%	45%	51%	22%
NI – 9	Percentage of adults supported at home who agreed they felt safe.	84.1%	72.7%	…	…	…

Please note that results for questions have been suppressed where there were fewer than 20 responses as they may be unrepresentative and may risk identifying respondents.

National Indicators 11 – 20, reported for year indicated

Indicator	Title	Orkney (previous data)	Orkney	Scotland rate	Year of latest data
NI – 11	Premature mortality rate per 100,000 persons.	393	356	442	2023
NI – 12	Emergency admission rate (per 100,000 population).	9,117	9,975	11,446	2024 [1)]
NI – 13	Emergency bed day rate (per 100,000 population).	92,819	81,589	109,823	2024 [1)]
NI – 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges).	65	64	103	2024 [1)]
NI – 15	Proportion of last 6 months of life spent at home or in a community setting.	90.4%	91.4%	89.4%	2024 [1)]
NI – 16	Falls rate per 1,000 population aged 65+.	18.2	13.6	22.4	2024.[1)]
NI – 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections.	77.9%	70.7%	77.0%	2023/24
NI – 18	Percentage of adults with intensive care needs receiving care at home.	69.5%	64.0%	64.7%	2024
NI – 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population).	1,002	1,023	952	2024/25
NI – 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.	26.8%	20.1%	24.0%	2019/20[2)]

Source: Public Health Scotland Core Suite of Integration Indicators May 2025
[1)] Data for 2024/25 is incomplete at time of writing, so 2024 has been used as a proxy for the financial year.
[2)] NI-20 information is not being published beyond 2019/20.

Orkney HSCP Localities data for National Indicators 12 to 16 between 2015/16 and 2023/24

Data for these indicators are not yet available at locality level for 2023/24. The numbers will be added when they become available; in the meantime, the year has been marked as 'N/A' (not available) for these indicators.

NI – 12 – Emergency admission rate for adults (per 100,000 population).

Locality	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Isles	10,545	8,964	10,286	11,582	9,718	8,290	10,800	7,917	N/A
Orkney East	12,604	9,994	11,214	11,682	11,142	10,592	10,874	10,338	N/A
Orkney West	8,839	8,990	7,881	8,909	8,310	8,749	9,880	8,884	N/A

NI – 13 – Emergency bed day rate for adults (per 100,000 population).

Locality	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Isles	97,560	75,326	77,300	94,123	86,508	82,335	72,375	86,901	N/A
Orkney East	94,882	89,217	92,465	80,502	99,108	72,696	89,419	90,689	N/A
Orkney West	87,380	83,784	74,743	89,594	73,323	71,394	82,770	86,901	N/A

NI – 14 – Emergency readmissions to hospital within 28 days of discharge (per 1,000 discharges).

Locality	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Isles	63	76	85	75	69	65	73	44	N/A
Orkney East	90	76	86	85	73	85	74	74	N/A
Orkney West	67	81	67	81	54	66	65	69	N/A

NI – 15 – Proportion of last 6 months of life spent at home or in a community setting.

Locality	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Isles	93%	90%	92%	93%	88%	92%	94%	90%	N/A
Orkney East	90%	92%	91%	88%	90%	92%	92%	92%	N/A
Orkney West	94%	92%	90%	91%	91%	94%	92%	90%	N/A

NI – 16 – Falls rate per 1,000 population aged 65+.

Locality	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Isles	13	13	13	10	5	10	6	16	N/A
Orkney East	27	23	19	21	22	17	16	21	N/A
Orkney West	20	21	15	11	16	17	18	20	N/A

Looking Forward

April 2025 saw the publication of our new three-year Strategic Plan. We have continued to speak to and engage with our communities, hosting a number of events so that we could hear from unpaid carers, Third Sector and community groups, staff teams working within health and social care, Community Councils, elected members, and many others.

Overwhelmingly, people have told us that the six Strategic Priorities from our previous plan are still relevant and cover the most pressing issues facing health and social care services in Orkney, so these Priorities have been retained.

All our Strategic Priorities are directly linked, with the work we do to address one priority having a direct impact on the others. For example, a lot of our work to support unpaid carers, and the help available to them, is because of work done to develop Community Led Support.

Our Strategic Priorities sit within the context of significant and ongoing demographic changes. For example, the 2022 census found that 49% of our population is aged 50 or above, compared to a national average of 42%. Furthermore, the National Records of Scotland predict that, by 2043, the number of working age people will decrease by 8%, whilst those aged 75 and over will increase by 86%. Not only do these figures suggest that demand for care services for older people will increase markedly, but also that the numbers of people available to deliver the care and support needed will decline.

It is also no secret that the financial constraints on public agencies, including local authorities and health boards, are unlikely to ease in the short or medium term. It is, therefore, inevitable that we must find creative solutions for delivering services for an increasing number of service users, by a decreasing number of staff.

Technology will play its part, but initiatives such the Islands Wellbeing Project and the Community Link Practitioners will have an increasing role to play. Preventative services, too, will become more common, as health and social care models of care move towards promoting and maintaining healthy lifestyles, as well as providing the tools to allow people to remain independent, for as long as possible.

Our younger people are also at the forefront of new approaches to preventative care and support, with fewer children now Looked After (you can read more about Looked After Children **here**) and more of our young people supported here in Orkney, rather than in facilities in mainland Scotland.

All are examples where a preventative approach can deliver better outcomes for people of all ages, but perhaps the best example is support for unpaid carers. As more people care for family members or friends, they delay, or even remove, the need for formal care services. Recognising this, we will increase our efforts to support unpaid carers, raising awareness of the support available, as well as developing options for allowing carers to take a break.

Our new Strategic Plan allows us to continue our focus on our six Strategic Priorities, whilst our Strategic Plan Delivery Plan 2025/26 details the actions we will take in the first year of the Strategic Plan 2025 – 2028 to support those Priorities. You can find the Strategic Plan Delivery Plan **here**. We will also report to each meeting of our Performance and Audit Committee, where we will show the progress made against three of our Strategic Priorities.

This focus on our Strategic Priorities, along with our Plan to support those Priorities, will make sure that we do all we can to work with our communities and partner organisations to deliver the care and support that folk in Orkney deserve.

Contact Us

If you need this document in another format or language, please contact us at OHACfeedback@orkney.gov.uk or telephone 01856873535 (extension 2601).

Jeśli potrzebujesz tego dokumentu w innym formacie, skontaktuj się z nami pod adresem OHACfeedback@orkney.gov.uk lub telefonicznie 01856873535 (rozszerzenie 2601).

Якщо вам потрібен цей документ в іншому форматі або мовою, будь ласка, зв'яжіться з нами за адресою OHACfeedback@orkney.gov.uk або телефоном 01856873535 (збільшення 2601).

Si necesitas este documento en otro formato o idioma, póngase en contacto con nosotros en OHACfeedback@orkney.gov.uk o en el teléfono 01856873535 (extensión 2601).

Please tell us your story - good or bad - about your experience of Orkney HSCP services.

www.careopinion.org.uk.

For further information:

Website: https://www.orkney.gov.uk/Service-Directory/S/OHSCP.

Telephone: 01856873535 extension 2601.

E-mail: OHACfeedback@orkney.gov.uk.

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