# Health Improvement **Annual Report**

## 2023- 2025

Healthy Shetland

NHS Shetland

Improving population health and wellbeing

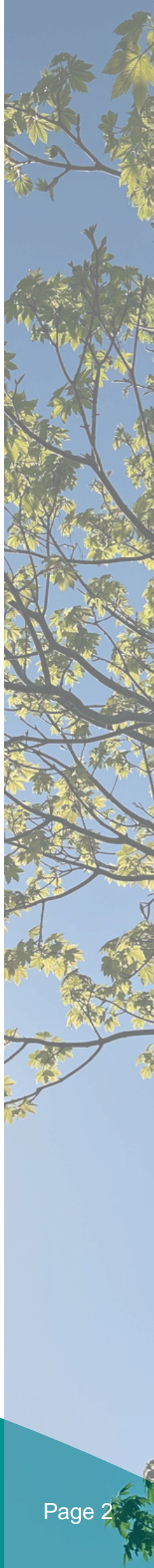
# Contents

## Introduction



## Section 1 - Patient Programmes

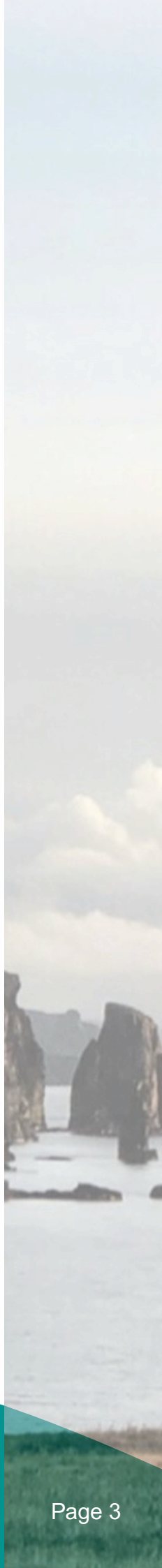




# Contents

## Section 2 - Population Health





# Introduction

**We are excited to present this comprehensive collection of the Health Improvement Team's activities spanning from 2023 to 2025.**

This marks our first standalone Health Improvement Report, separate from our contributions to the Public Health Annual Report. In it, we showcase the breadth and variety of work our team leads to drive forward public health priorities, all with the shared ambition of creating a healthier Shetland for everyone.

Our team brings together a wide range of skills and experience to support prevention and early intervention, offering health improvement programmes, training, and evidence-based campaigns that make a real difference in people's lives. By working closely with local partners and communities, we are helping to build a Shetland where everyone can feel healthy, resilient, empowered, and included.

The report is divided into two main sections:

**1. Patient Programmes**

This section details information and data about the wide array of services we provide to patients. This includes supporting individuals to make changes to smoking and vaping habits, supporting adult healthy weight management, offering diabetes prevention and education, facilitating community link work, supporting active aging and falls prevention, and supporting families in the early years.

**2. Population Health**

This section details our project-based work which focuses on areas identified to support us all to live longer healthier lives. This includes projects in physical activity, mental health and suicide prevention, poverty and financial concerns, workplace health, alcohol use, and health literacy.

We hope you find this report both informative and engaging. We welcome any feedback to improve it for future years.

# Our Team

The Health Improvement team is made up of a diverse range of roles, from health improvement advisors, practitioners and resource officer, to a weight management dietitian, community link worker, and falls prevention coordinator.

Each Advisor and Practitioner lead on a topic area with the specialist roles managing their own specific projects and workflow. The team is managed by the Health Improvement Team Lead who is responsible for specific areas as directed by local and national needs.

The Health Improvement Team also work closely with partner organisations to lead and provide expertise to projects, campaigns and activities aimed to support local communities.

# Our Team

**Nicola Balfour**
**Health Improvement Team Lead**

**Kathleen Anderson**
**Health Improvement Advisor**

**Fern Jamieson**
**Health Improvement Advisor**

**Lisa Truefitt**
**Specialist Weight Management Dietitian**

**Lauren Lavender**
**Health Improvement Practitioner**
**(Maternity leave 25-26)**

**Krissi Sandison**
**Health Improvement Practitioner**

**Claire Thomason**
**Health Improvement Practitioner**
**(Maternity Leave 25-26)**

**Jillian Charleson**
**Health Improvement Practitioner**

**Shona Harper**
**Health Improvement Practitioner**
**(Maternity Leave 25-26)**

**Verona Johnson**
**Health Improvement Practitioner**

**Laura Russell**
**Health Improvement Practitioner**

**Shelley Anderson**
**Falls Prevention Officer**

**Ingrid Sandison**
**Community Link Worker**

**Caroline Watt**
**Health Improvement Information & Resource Officer**

We operate as a hybrid working team, delivering services in a variety of settings including our main base at Montfield, as well as community venues such as leisure centres, health centres, schools, and other local facilities. Team members also work remotely from home, allowing flexibility while ensuring a strong presence across multiple locations to best meet the needs of the populations we support.

# Our vision

**“Shetland is home to healthy, resilient, empowered and inclusive communities.**

**The health and wellbeing of individuals and families improves for future generations, particularly for those experiencing unfair differences in life expectancy and health outcomes.”**

## Our values

- Inclusive
- Community - led
- Impactful
- Kindness
- Collaborative
- Leadership
- Empowering
- Continously improving

# Our Role

Health improvement is the process of improving the health and well-being of communities and individuals. It involves:

- **Encouraging healthy lifestyles**

This includes raising awareness of healthy eating, physical activity, and the importance of vaccinations.

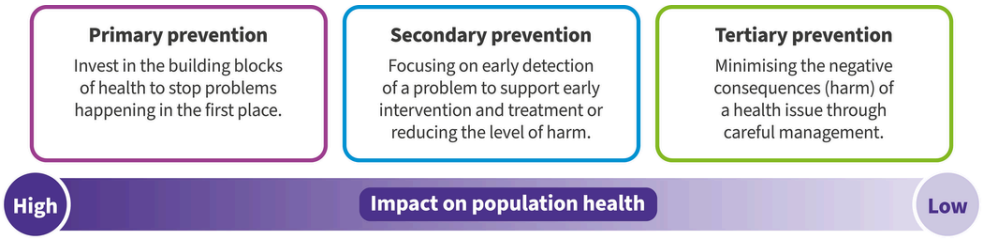
- **Addressing health inequalities**

This can include working with low-income families to improve their income, and addressing underlying issues like poverty and lack of educational opportunities.

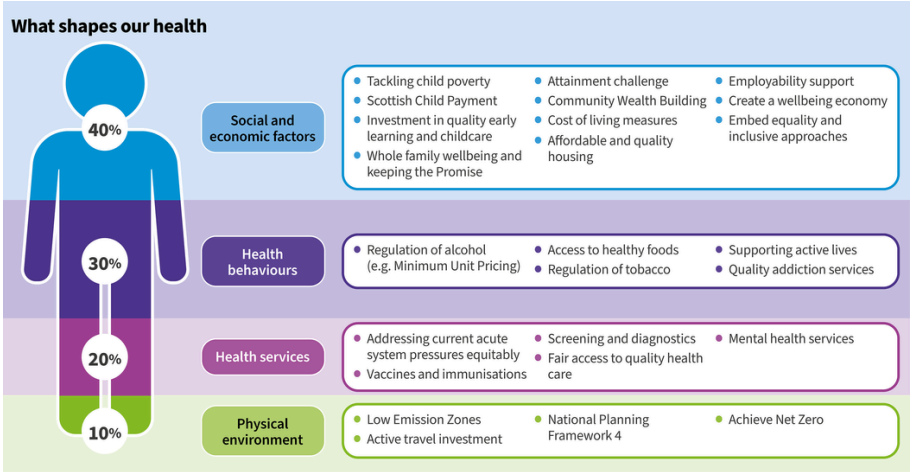
- **Developing policy and legislation**

This can include influencing national policy and legislation to promote public health.

The role of prevention is core to the 'how' and our ways of working. Public Health Scotland describes prevention as being about keeping people healthy and avoiding the risk of poor health, illness, injury, and early death. We take into account the 3 levels of prevention; Primary, Secondary and Tertiary, and work across these in our delivery as well as supporting partners and agencies to understand their role and play their part.




The diagram below, from Public Health Scotland, highlights the many factors that shape health. Recognising their interconnections helps us provide person-centred support while considering the wider determinants affecting individuals and communities that we come into contact with.



# Section 1

## Patient Service Delivery

# Patient Services Delivery: Summary

## Summary snapshot

### Weight Management – Get Started

- 120 participants (2020–2023); permanent rollout across Shetland.
- Positive outcomes: ~20% reduced weight/waist at 12 months; improved confidence, motivation, and gym use.
- High satisfaction (9.3–9.4/10).
- Dropout rate: ~32%

### Smoking & Vaping Cessation – Quit Your Way

- 2023–24: 32 successful tobacco quits (53% at 12 weeks).
- 2024–25: 18 successful tobacco quits (28% at 12 weeks); expanded to “Vaping Friendly Service”
- Challenges: staffing gaps, training needs, national data reporting inconsistencies.

### Diabetes Framework

- Gap analysis of adult healthy weight services improved completion from 40% (2023) to 80% (2025).
- Pre-diabetes Brief Interventions embedded into screenings; low referral numbers but structured support in place.
- Tier 3 specialist services reintroduced in 2024/25.

### Falls Prevention – Otago

- 2023–24: 97 referrals; 74–81% improved functional test scores.
- 2024–25: 96 referrals; maintained high improvement rates (72–97% depending on test).
- Challenges: high dropout, transport barriers, rural uptake.

### Early Years – HENRY

- 9 programmes delivered (2021–24), reaching 47 parents and 55 children.
- Workshops (e.g., Starting Solids) boosted parental confidence from 57% to 92%.

# Get Started Started Programme

## Rationale

In 2019 the Standards for the delivery of tier 2 and tier 3 weight management services in Scotland were released. Following local gap analysis work, the Get Started programme, formally known as Healthy Shetland, was developed by Claire Thomason & Lauren Lavender, Health Improvement Practitioners with support from Fern Jamieson, Health Improvement Advisor.

The Get Started programme is designed to support adults aged 18yrs+ to make healthy lifestyle changes, that are important to them. The programme provides supportive, holistic guidance on healthy living and physical activity for individuals who are motivated to make healthy changes and are safe for exercise.

## Introduction

Individuals are referred to the programme via self-referral or professional referral. They have an assessment appointment with a Health Improvement Practitioner and, if suitable, gain access to an upcoming Get Started group at their local leisure centre. The programme is 12 months and consists of 8 fortnightly sessions, known as the active phase, followed by 4 review sessions, known as the maintenance phase.

The following intended outcomes were agreed when developing the programme:

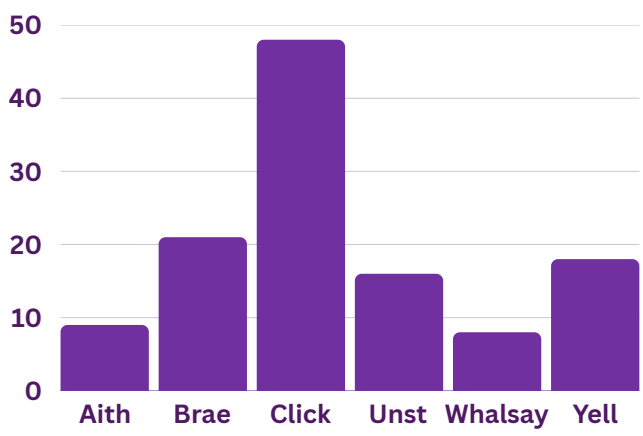
1. Changes in participant health outcomes
2. Participant satisfaction
3. Staff satisfaction
4. Changes in engagement with Shetland Recreational Trust (SRT) by participants

The initial implementation of the programme began in 2020 and the final evaluation report is now complete. Following positive feedback and outcomes, the Get Started programme has been permanently rolled out across Shetland, with Health Improvement and SRT staff jointly leading groups at all leisure centres.

The final report includes data collected across three Get Started cohorts, which took place between 2020-2023.

A total of 120 participants were assessed as part of the programme.

The number of participants ranged from 8 participants in Whalsay and 48 participants in Clickimin (Lerwick).



# Get Started - Results

## Main Findings

88.6kg

At assessment recorded weight ranged from 56.5 kg to 126.0 kg, with the average weight being 88.6 kg.

17.4

Recorded T2DM risk ranged from 3 to 35, with the average risk score being 17.4.

102.0cm

Recorded waist measurements ranged from 62.0 cm to 134.0 cm, with the average waist measurement being 102.0 cm.

31.7%

A total of 38 participants (31.7%) dropped out of the programme after assessment or never engaged with the programme.

BMI 32.3

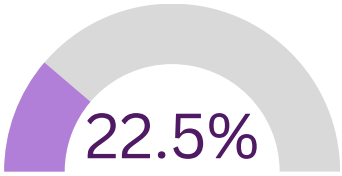
Recorded BMI ranged from 20.2 to 49.4, with the average BMI being 32.3.

45.6

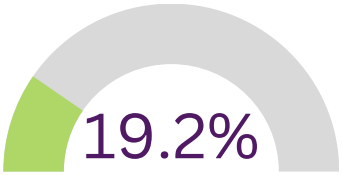
Recorded WHO-5 score ranged from 9 to 100, with the average score being 45.6.

## Weight (kg)

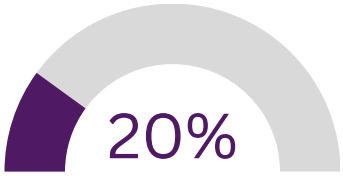
Over a fifth of participants reported a decrease in their weight between their assessment and the 4-month review compared to just under a fifth between their assessment and their 8-month review. At the 12-month review, 20% of participants had reported a decrease in their weight.



Assess → 4 months



Assess → 8 months

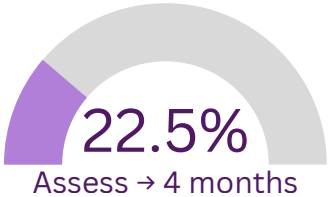


Assess → 12 months

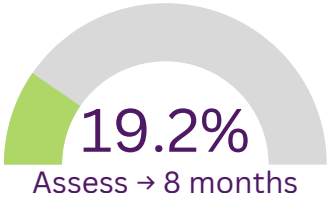
Between assessment and 12-month review, median weight had decreased by 1.4kg and the majority of participants had gone from weighing between 75 - 105kg to 75 - 90kg.

## Waist (cm)

A quarter of participants had a reported decrease in their waist measurements between their assessment and 4-month review and between their screening and their 8-month review. At the time of the 12-month review, 23.3% of participants has a reported decrease in their waist measurements.



Assess → 4 months



Assess → 8 months

Assess → 12 months

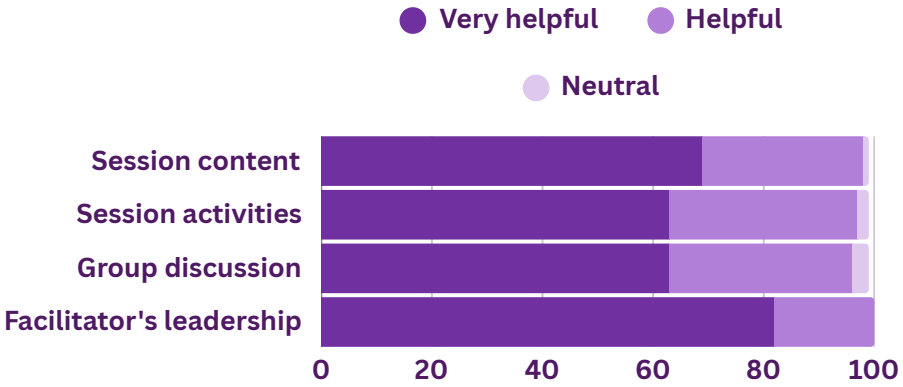
Between the time of assessment and the 12-month review, median waist measurement had decreased by 7.0cm and the majority of participants had gone from having a waist measurement of between 90cm – 110cm to 85cm – 105cm.

# Get Started - Feedback

## Active Phase

During the active phase, sessions 1-7, participants are asked to provide feedback on how helpful they have found the sessions. Across the seven sessions, 69% of participants reported that they found the content of the session very helpful, with a further 29% reporting that it was helpful.

63% reported that they found the activities to be very helpful and 34% found them to be helpful. The same proportion (63%) reported that they found the group discussions and interactions to be very helpful and 33% found them helpful.




All participants reported that they felt the group leader's teaching and leadership of the group over these sessions were either very helpful (82%) or helpful (18%).

Participants were also asked how they felt after each session, with a large proportion reporting that they felt 'good', 'motivated', 'positive', 'confident', 'happy' and 'informed'.

Participants reported that they felt motivated to do the programme; they felt informed, educated, and more confident to make healthier choices. And overall, they felt happy with what they had already achieved.

> "That I am capable of using gym equipment"

> "The difference between physical and emotional eating"

> "Food for thought, motivation to get fitter"

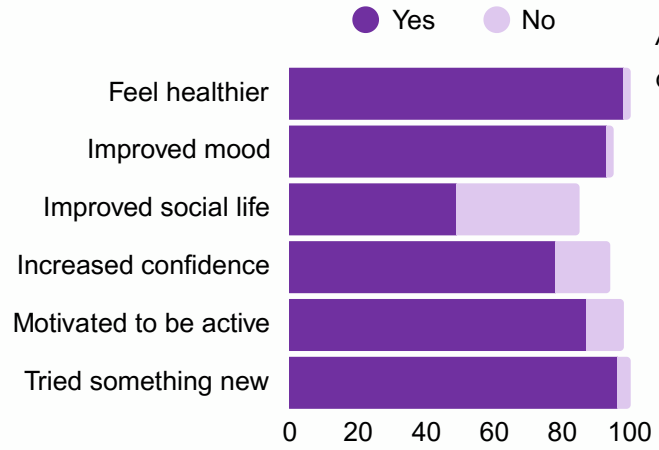
When asked what they would take away from the sessions the participants again stated things like confidence to use gym equipment and book classes; determination and motivation to make change; awareness of their body and needs; mindfulness of things such a portion sizes and food labels.

A large number of participants also reported that they would take away a lot of hints, tools and tips.

# Get Started - Feedback

## Maintenance Phase

### 4-month review

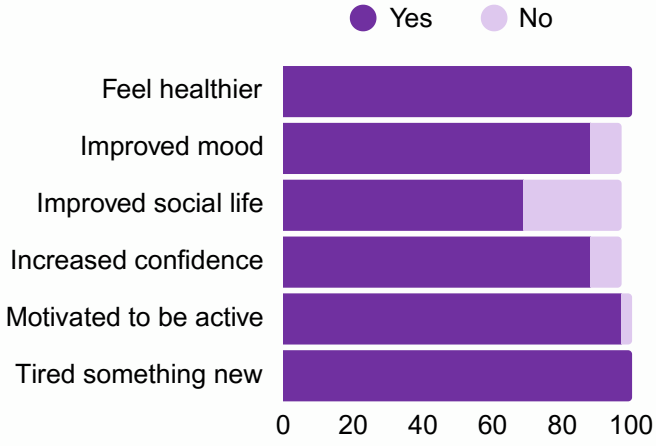



At the **4-month review**, the overwhelming majority reported that they:

- felt healthier
- their mood had improved
- they have tried something new

The overall satisfaction score out of 10 was 9.3.

### 8-month review

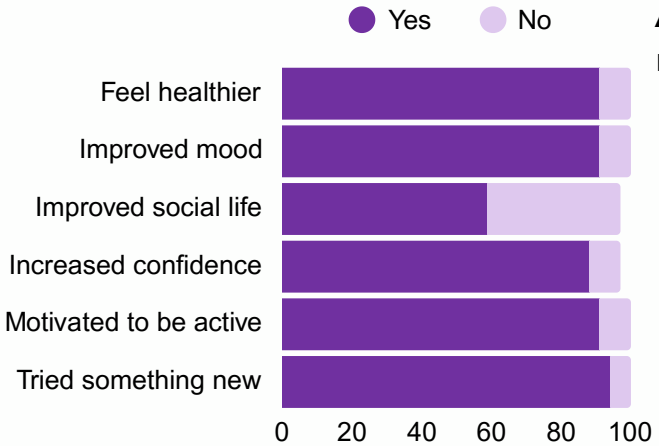



At the **8 month review,** participants reported:

- Making better food choices
- Being physically active in leisure centres
- Drinking more water.
- 81.3% reported their diet was healthier than when they started.

The overall satisfaction score out of 10 remained stable at 9.3.

### 12-month review




**At the 12 month review** participants reported:

- Making healthier choices since attending the programme.
- 87.5% felt their diet was healthier since attending the programme.

The overall satisfaction score out of 10 was 9.4.

# Quit Your Way - Stop Smoking Service

## Service update

2023–2024

Quit Your Way Scotland is a free advice and support service for anyone trying to stop smoking. The service is delivered in Shetland by Health Improvement Practitioners, alongside Community Pharmacy and the Maternity teams.

During this period we saw the smoking cessation lead practitioner move on leaving a vacancy in the service. This gap in capacity and leadership, as well as reduced practitioner staffing and challenges securing suitable space to see patients, meant there was less availability of appointments.

This inadvertently led to a longer waiting time for some patient contacts and we endeavoured to keep in touch and provide self-support information and signposting to other local services. We streamlined our waiting list management and patient communications; to include listing where patients could access NRT provision at local pharmacies, and online advice.

Challenges included:

- Staff identified training gaps which may have affected the capture of our data.
- Losing patients to follow up

Service developments:

- 1) Develop a protocol and data collection system for users wishing to quit vapes.
- 2) Quality and governance of service delivered across HI, Pharmacy, and Maternity.

## Referrals and quits*

**19 referrals for smoking cessation support**

**9 new service users**

**32 successful quits**

**20/32 quits were in the SIMD range in 23/24**

**17 quits were successful at 12 weeks (53.1% of quits )**

**24 shared care quits across: Health Improvement, Community Pharmacy, Primary Care and Maternity (75% of quits)**

**gaps in data submitted to the National Smoking Cessation Database look to be skewing our output figures and should not be directly compared with previous years.* Figures shown here and for 24/25, are a selection of the best representation of our service that could be gathered at the present time and are not categorically comparable.

# Quit Your Way - Stop Smoking Service

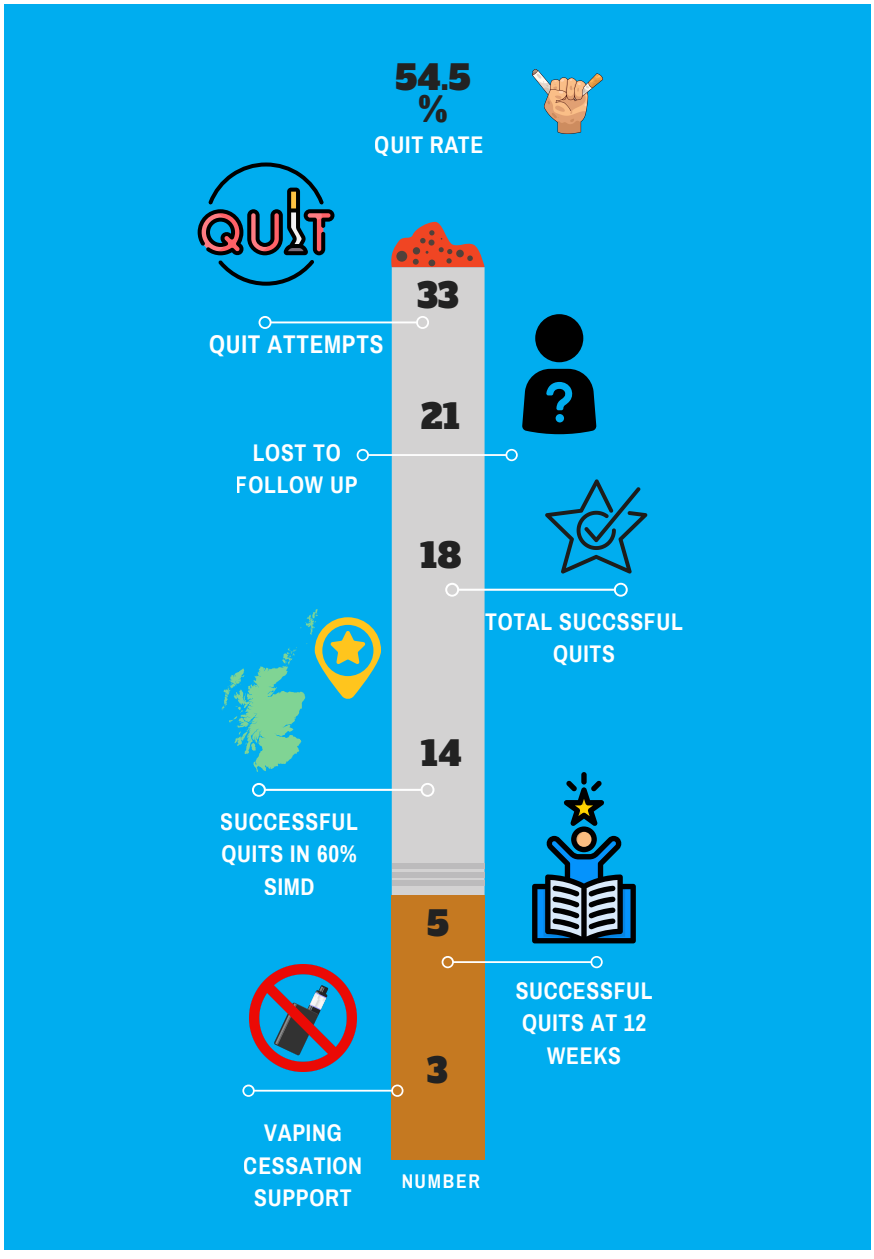
## Service update

2024–2025

685,000 - 14% of adults in Scotland, are current smokers and two-thirds of people in Scotland who smoke say they would like to stop smoking (Scottish Health Survey 2024), so there is a continuing clear need for the QYW programme in Scotland.

This year brought a few changes to the team delivering the service and saw some restructuring to the patient triage and waiting list. A concentrated focus on QYW referrals saw the waiting time for patients rapidly reduce and the administration process begin to streamline efficiently.

## Referrals and quits*




**14/18 quits were in the SIMD range in 24/25**

**Note: the national database is based on quit attempts, not clients, some figures may include repeat quit attempts for the same client.**

**gaps in data submitted to the National Smoking Cessation Database look to be skewing our output figures and should not be directly compared with previous years.*

# Quit Your Way - Stop Smoking Service

## Challenges

2024–2025

- A few gaps remained in our capacity for delivering patient services due to new staff training requirements and staff on maternity leave.
- Alignment of our service delivery with maternity and community pharmacy; the need to re-establish regular communications and shared resources.
- Enquiries for vaping cessation support increased and the team began to gather and reflect on experience, patients needs and how to develop and deliver a 'vaping friendly service' going forward. National guidance on how to support patients with vaping cessation remains limited.
- The LDP target of 38 quits has not been reviewed for several years and remains a challenge to meet across Shetland and other areas of Scotland, due to the disparity and diversity of SIMD postcodes in Shetland.

## Service developments

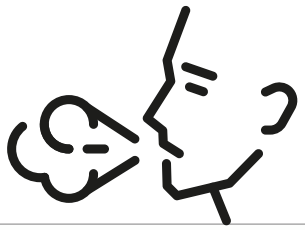
1) Prevention work with the vaping friendly service, planning and research; SBAR
2) Scoping exercise and training with community pharmacies
3) Admin pathway review and introduction of streamlined paperwork and online files.
4) Training and patient programme resources for smoking and vaping cessation

"...having your help was a game changer. I still don't smoke and never will again."

"...the best...support as you did not go on about the cons, you were focused on what I felt would help me so thank you."

## VAPING FRIENDLY SERVICE DEVELOPMENT

We began to develop our service to give wider assistance to patients with any nicotine dependencies who requested behaviour change support. Our 'Vaping Friendly Service' offers support to smokers who want to use vapes to quit tobacco (note we do not provide vapes as aids) and we also support people to quit vaping, offering behavioural support as the first line alongside NRT, where appropriate.


# Community Link Worker

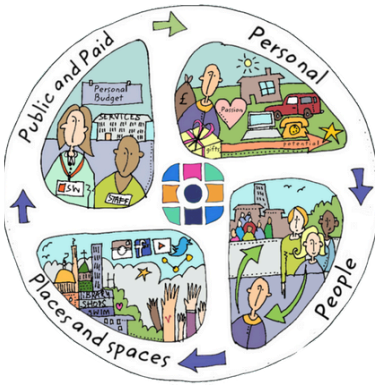
## Pilot Project

The Community Link Worker (CLW) initiative was introduced by the Scottish Government in 2016 to strengthen connections between community resources and primary care. CLWs were identified as a priority in the 2018 General Medical Services (GMS) contract, aiming to provide non-clinical support within GP practices, helping patients navigate services and address social determinants of health.

In Shetland, Health Improvement Practitioners (HIPs) have historically played a similar role, focusing on holistic health improvement. NHS Shetland began redeveloping its community-based health support to enhance collaboration between primary care, social work, and third-sector organisations. As part of this effort, a working group was established in 2021 under Shetland's Primary Care Transformation Programme to explore how CLWs could be integrated.

A pilot project was launched in 2022, placing a full-time CLW in two health centres, Brae and Whalsay, alongside the existing HIP role. The initiative aimed to reduce pressure on GPs, improve health outcomes, and strengthen primary care-community connections while identifying gaps in local support. The pilot aimed to lay the groundwork for expanding community-driven healthcare, ensuring a preventative, joined-up approach to health and wellbeing in Shetland. A full evaluation has been completed. For more information or a copy please get in touch.

The CLW focuses on exploring what matters to people and supports them to make positive changes. The Resource Wheel is a tool used by the CLW to guide strengths-based conversations and explore solutions.




The CLW role has been made permanent in Health Improvement with plans for extending into other areas being reviewed as part of the Community Link Worker Working Group.

## Evaluation Data

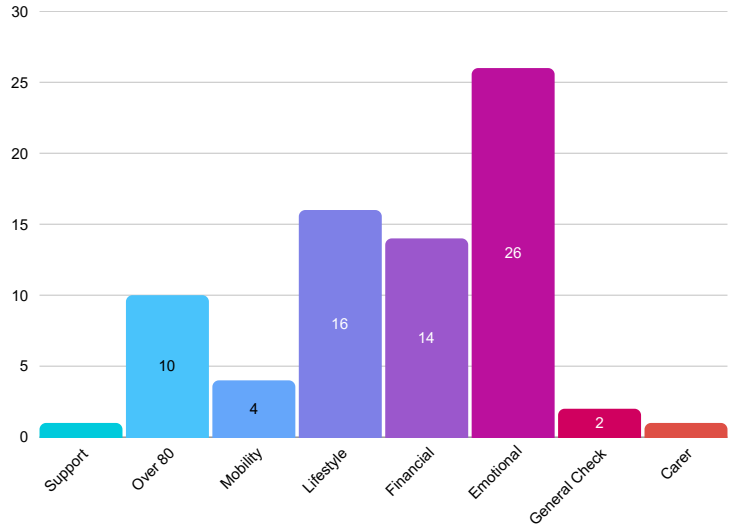
A suite of monitoring and evaluation tools were established in the planning phases of the project. The tools developed built on risk mitigation identified, a national minimum core dataset for CLWs and mapping of indicators against each of the intended outcomes. A CLW dashboard was created to collate and analyse the pilot data. This part of the project has been led by a Senior Public Health Intelligence Adviser, Fiona Hall who has been invaluable in their expertise and continued support.

# Community Link Worker

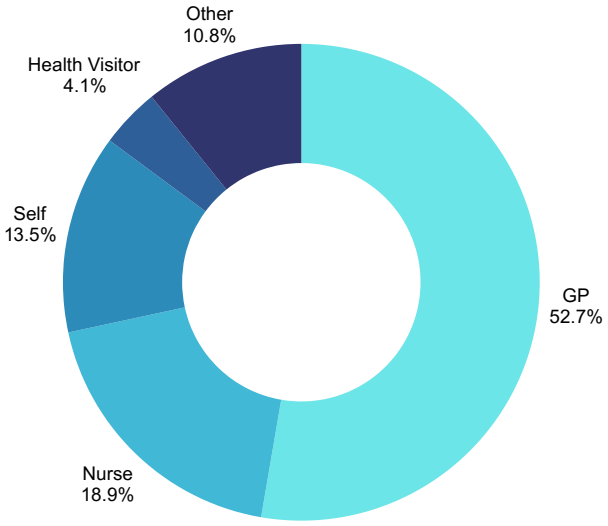
## Evaluation Data

Pilot project evaluation data was collected between March 23 - Feb 24 , this is represented in the figures below. Since substantiation of the Community Link Worker role, data has continued to be collected and available on a locally held dashboard for continuous monitoring and evaluation purposes.

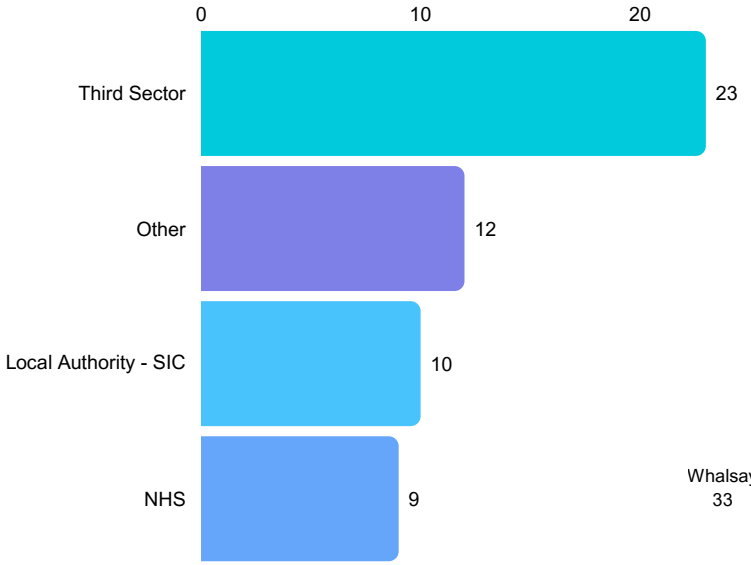
### Reason for Referral



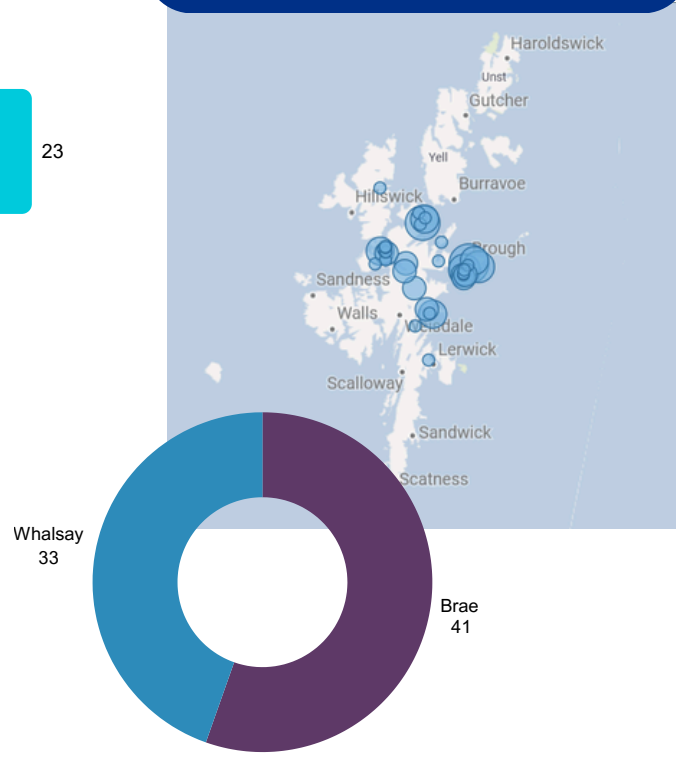

### Referral Source




### Services referred to




### Referrals by area



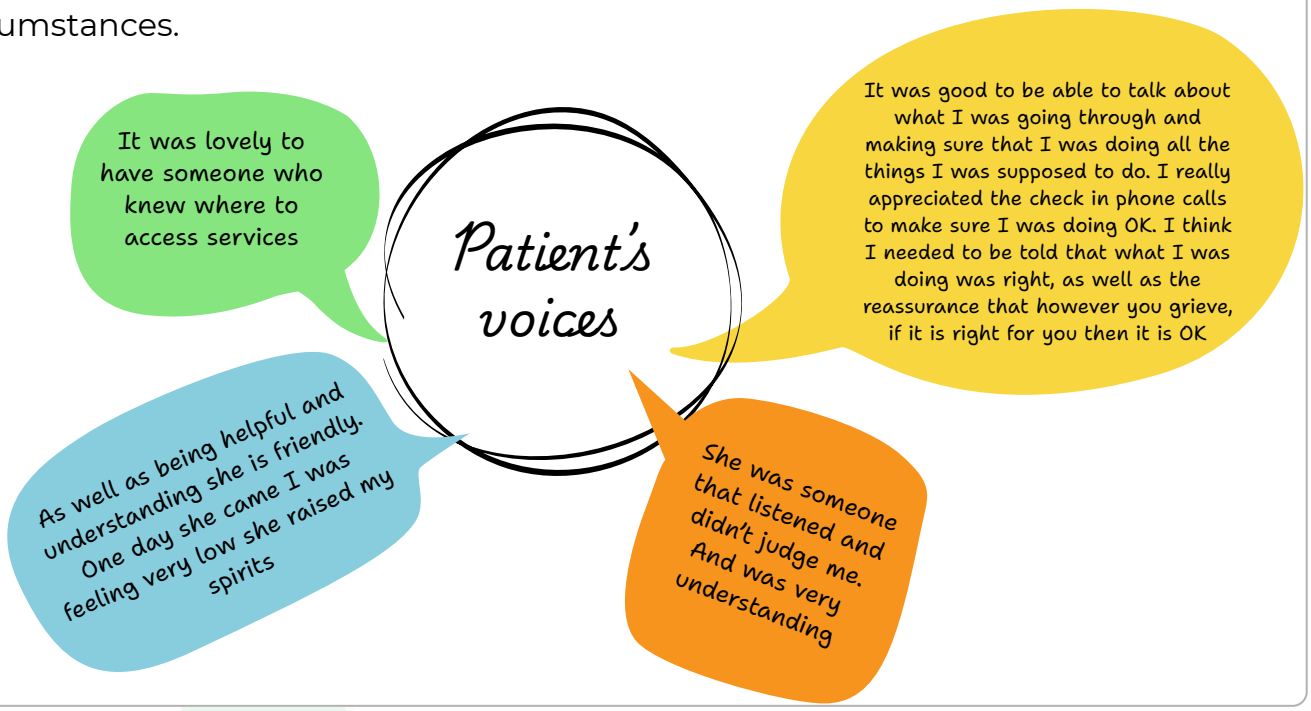
# Community Link Worker

## Reflections from CLW

Over the course of the CLW role, I have come across a variety of different people with many different issues. These range from addiction, loneliness, poor mental health, worry about medical conditions, bereavement, housing, finances and much more. Some individuals needed one appointment and others have needed longer input to get them to a place where they want to be.

More often than not, an individual can be referred in for one concern and there are lots more things that need addressed once we have had the strengths-based conversation. One example is a referral for someone who wanted support with social connections – on having a conversation we worked out that they also needed support with controlling their alcohol intake, they had debt worries and they were concerned they might have a fall.
From this I was able to link them up with SMRS for support with reducing their alcohol intake, and a volunteering opportunity to meet their social needs, which they are really enjoying. I also referred them onto the citizen's advice for support with their debt, linked them up with the OTAGO classes to improve their balance and sourced a walking stick for them. They weren't previously aware what support was available for them in their local area and were delighted to find out about the Living Well Hub and the Recovery Hub.

I have found over the past two and a half years that listening without judgement is very powerful. I am comfortable with not having to always fill silence. This gives people time to work things out for themselves while having someone to advise and support with finding the right solutions for their own individual circumstances.



# Healthier Futures: Diabetes Framework

In 2018, the Scottish Government released the "A Healthier Future: type 2 diabetes prevention, early detection and intervention: framework" which aims to provide equitable access to effective weight management services across Scotland, focusing particularly on the prevention and early intervention of type 2 diabetes.

The framework is designed to ensure quality provision and equal access, especially for those vulnerable to health inequalities. It outlines specific actions and milestones for health boards to achieve consistency across regions.

### Framework at a glance


### Framework milestones

- Impact assess all programmes
- Gap analysis of healthy weight services
- Pathways of support for:
  - Pre-diabetes
  - Gestational diabetes
  - Type 2 diabetes remission via Counterweight Plus
  - Adult weight management
    - Tier 2 - Lifestyle interventions
    - Tier 3 - Specialist interventions
- Recording of interventions in Turas Weight Management dataset

The Health Improvement Team have been working in partnership with the Dietetics and Maternity Departments, alongside wider partners, to establish services and pathways which align with national standards and meet the needs of our local communities.

## Summary of work in 2023-2025

Tier 3 Weight Management (Dietetics Department): The Tier 3 specialist weight management service is delivered by the Dietetics Team. During 2023/24 these programmes were on hold and in 2024/25, the Healthier Together group programme was implemented.

The following Health Improvement workstreams are delivered under the framework and described in this report:

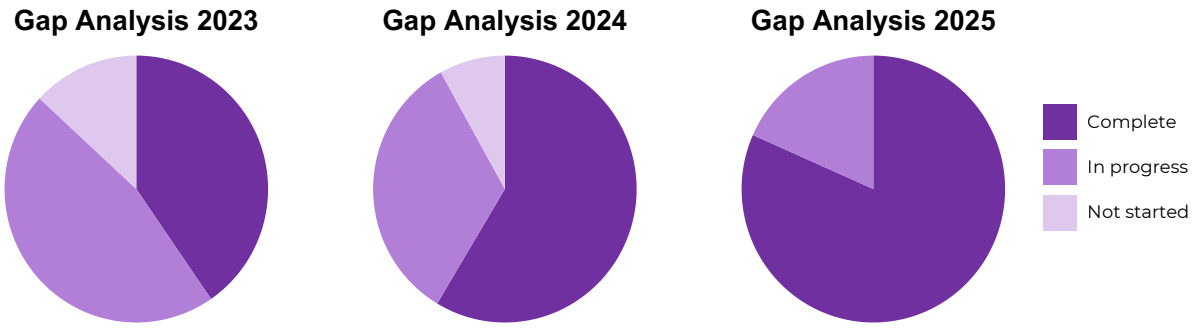
- Adult healthy weight gap analysis
- Type 2 diabetes remission via Counterweight Plus
- Type 2 diabetes prevention and education
- Tier 2 weight management - Get Started Programme

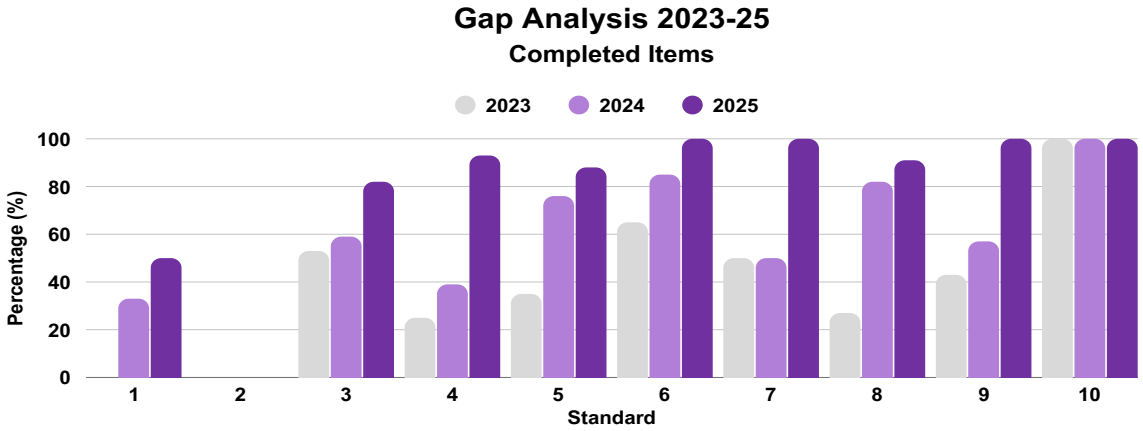
# Adult Healthy Weight: Gap Analysis

## Summary of Work 2023 - 2025

Fern Jamieson, Health Improvement Advisor, leads on the adult weight management gap analysis which was completed in February 2024 and February 2025.

Between 2023 and 2025, there has been significant improvements towards meeting the adult healthy weight standards with overall completion increasing from 40% to 80%. Key remaining actions include Health Inequalities Impact Assessment, updating local Adult Healthy Weight Pathway documentation and increasing awareness of local Adult Healthy Weight Services.




### Adult Healthy Weight Standards

**1.** Designing services to meet the needs of local populations
**2.** Equipment and environment considerations
**3.** Referral pathways and criteria
**4.** Triage and assessment
**5.** Intervention design and core components
**6.** Treatment duration, length of consultation and frequency of contact
**7.** Weight management/intervention goals
**8.** Staff: knowledge, skills and training
**9.** Monitoring, evaluation and reporting
**10.** Sharing learning and good practice

# Type 2 Diabetes Prevention: Pre-diabetes Brief Interventions

We are working to reduce the prevalence of **Type 2 Diabetes** in Shetland by identifying individuals who are at risk of developing Type 2 Diabetes and providing early intervention for those at high risk.

**Pre-diabetes** is a term used to describe when a person's blood sugar levels are higher than normal but not high enough for a diagnosis of type 2 diabetes. Without intervention, they would be at high risk of developing type 2 diabetes in the future.

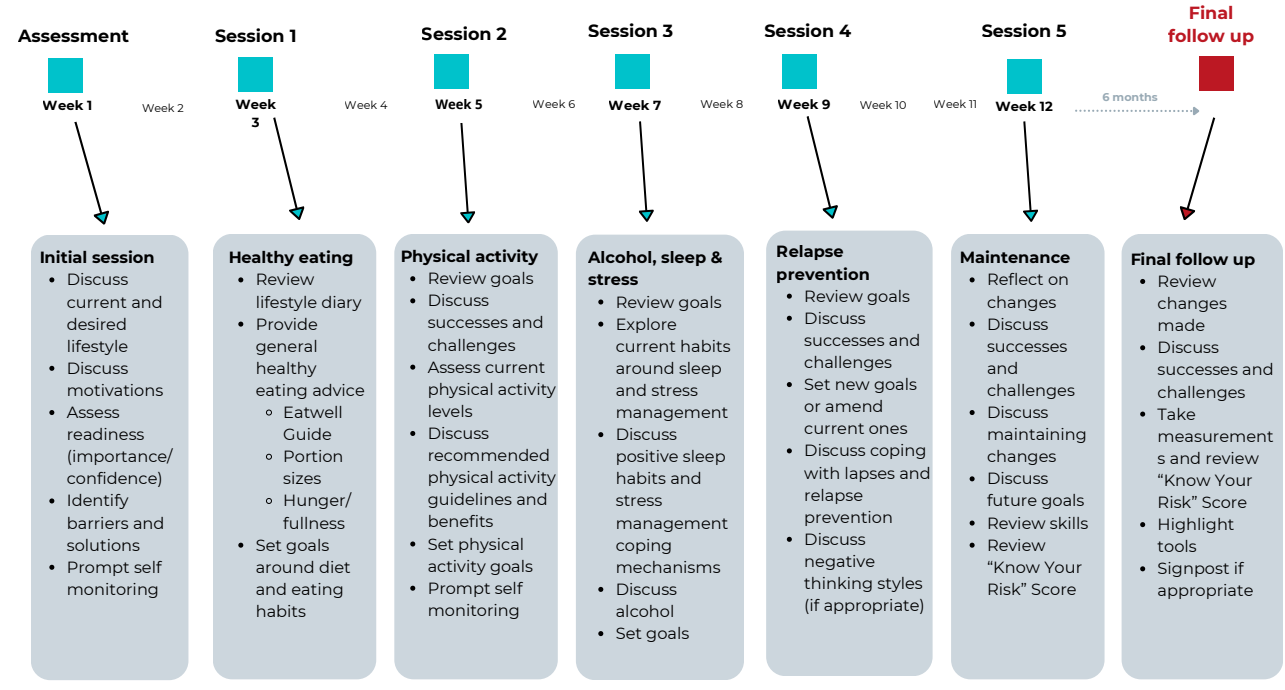
## What we have done

- Embedded the Diabetes UK "Know Your Risk" tool into our weight management service screenings and review appointments, and recording this data on EMIS.
- Encouraging and supporting colleagues working in primary care to use this tool during routine appointments to identify and raise a conversation with patients who may be at risk.
- All HIP practitioners are trained in diabetes prevention as a core competency and are specialists in health behaviour change. We offer Pre-diabetes Brief Interventions (PDBI) on a 1:1 basis for those requiring further support to make lifestyle changes to reduce their risk.

The Pre-diabetes Brief Intervention (PDBI) structure, resources and training were developed by Krissi Sandison, Health Improvement Practitioner in 2021. The PDBI involves 6 structured sessions with topics around diabetes prevention, from eating habits and physical activity to sleep and stress. The appointments are typically delivered fortnightly for 12 weeks with a follow up after 6 months of the intervention.  Numbers referred for PDBI have been low over 23-25.

**Next steps are to improve awareness of the support available with key services such as primary care, and to improve the referral system for all pre-diabetes with access to education (Control IT) as first line support and 1:1 support where necessary.**

### Brief intervention timeline overview



## Type 2 Diabetes Education: Control IT

Structured education is a vital element of Type 2 Diabetes (T2DM) care, supporting individuals to understand their condition and adopt sustainable lifestyle changes. Up until 2019, T2DM structured education in Shetland was delivered through the Conversation Maps programme. This one-day group course was suspended due to staffing pressures in Dietetic department and the Covid-19 pandemic.

Since 2021, newly diagnosed patients have received one-to-one education from the Specialist Weight Management Dietitian, within the Health Improvement Team, while planning for a new group programme progressed.

In 2023, NHS Shetland adopted Control IT, a nationally recognised, Level 3 structured education programme developed by NHS Ayrshire & Arran.

Control IT is a two-hour session suitable for people with both Pre-Diabetes and Type 2 Diabetes. It can be delivered online or face-to-face and covers:

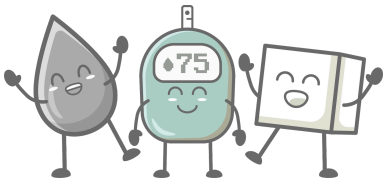
- Know IT – understanding effects of high blood glucose
- Eat IT – healthy eating and impact on blood glucose
- Move IT – benefits of activity and barriers
- Plan IT – setting SMART goals
- Live IT – accessing resources and support

## Activity 23-24

**Session Delivery**

Sessions delivered by the Specialist Weight Management Dietitian, supported by the Dietetic Assistant Practitioner.

- 2022/23: One online session delivered.
- 2023/24: Two online sessions delivered.
- All evaluated positively by attendees.




**Barriers and Actions**

Early delivery faced low referral rates and poor uptake. Impact of Covid on primary care, dietetic waiting lists, lack of awareness that diet and lifestyle are integral to T2DM care, and confusion about referral processes were all identified as causes.

**Actions**:

- pathway meetings, engagement with GPNs and GP Clusters, direct patient mailing, and patient feedback.

**Other barriers:**

- Many patients declined sessions, citing reasons such as managing well independently, preference for one-to-one sessions, lack of confidence with IT, or inability to attend during working hours.

**Response**:

- Offered one-to-one sessions where appropriate.
- Planned future face-to-face delivery and potential out-of-hours provision.

## Activity 24-25

**Session Delivery**

- Expanded to include face-to-face sessions at the Isleburgh Centre, alongside online options.
- Pre-Diabetes included: Control IT now offered to both Pre-Diabetes and T2DM patients, often as mixed groups, which has worked well.
- 1:1 Pre-Diabetes Brief Interventions offered where group delivery was unsuitable

**Referrals and Uptake**

- Referrals: 44 (37 T2DM; 7 Pre-Diabetes).
- Enrolled: 27 for Control IT (24 T2DM; 3 Pre-Diabetes), plus 5 for 1:1 support.
- Attended:
  - Online: 7 across two sessions.
  - Face-to-face: 6 at one session.
  - Total attendance: 13



**Attendance rates:**

- 65% of newly diagnosed referred (estimate).
- 61% of those referred enrolled.
- 48% of enrolled attended.
- 30% of referred attended.

Sessions planned for January 2025 were cancelled due to staff illness, with rescheduled sessions seeing limited attendance.

**Integration with Weight Management Pathway**

- Recognising the close relationship between weight and diabetes risk, NHS Shetland aligned the weight management and diabetes education pathways.

- Single Point of Referral developed (launch early 2025/26):
  - Sci-Gateway for primary care referrals.
  - MS Forms for self-referrals and other professionals.

Patients are reminded throughout the pathway that they can access both weight management and education support.

## Next Steps 25-26

- Launch of single point of referral expected to streamline access and increase uptake.
- Further engagement with primary care to embed education discussions at diagnosis and reviews.
- Dietetic Assistant Practitioner to begin delivering sessions, supported initially by the Dietitian, with the aim of independent delivery.
- Continued review of patient feedback, including demand for out-of-hours sessions.
- Consideration of an additional multi-session programme to provide more in-depth support for those requiring extended education

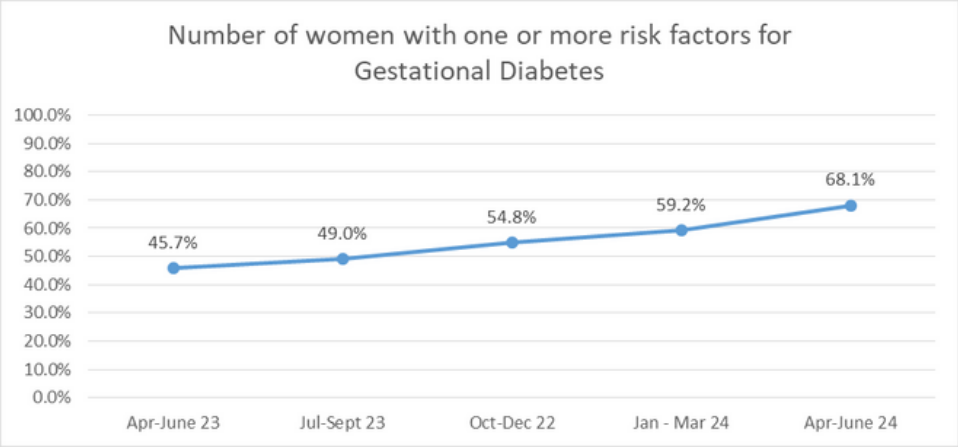
# Diabetes Framework: Gestational Diabetes

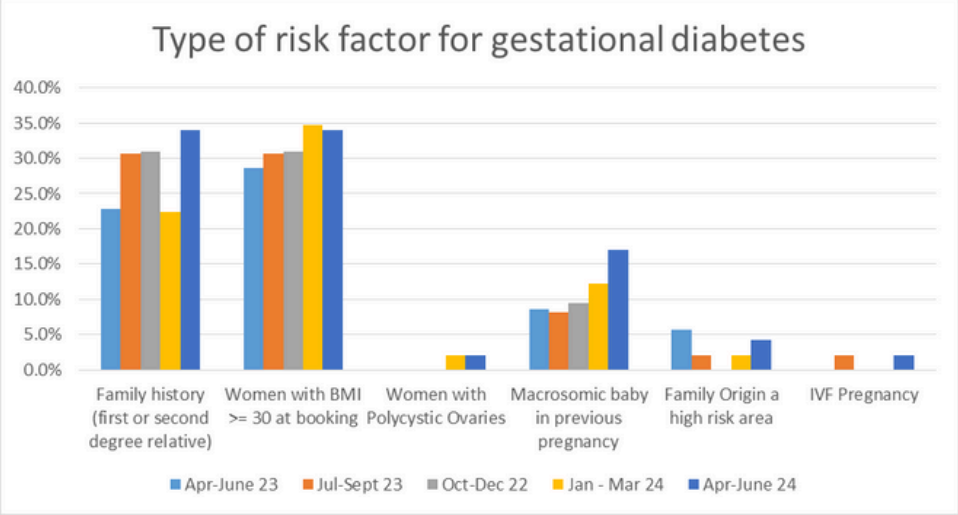
This work is delivered by the Maternity Department with support, as appropriate, from Health Improvement Team as set out in the national standards and of diabetes prevention and early detection.

**Summary of work in 2023-2025**

In 2023/24, people with gestational diabetes were referred to the Dietetics Team for one-to-one support over 1-2 appointments with a dietitian. Due to small patient numbers, group education for people with gestational diabetes is not feasible. Therefore in 2024/25, patients receive support through the NHS Grampian gestational diabetes education sessions which are delivered in groups online. People with gestational diabetes are supported continuously by their midwife and healthcare support workers in the Maternity Department.

The graphs below are taken from locally developed 'Maternity Lifestyle Reports' which are generated quarterly by Senior Public Health Analyst, Fiona Hall, from the Maternity Badgernet system. Please note that data may be incomplete at time of generation, and therefore any figures must be treated with caution. These lifestyle reports inform an important part of our development and recording of gestational diabetes monitoring and planning with Maternity and Dietetics teams.



# Type 2 diabetes remission Programme 2023 - 2025

**This programme supports people in Shetland to achieve remission through structured weight management.**

As part of the Scottish Government's Type 2 Diabetes Framework, Lisa Truefitt, Specialist Weight Management Dietitian delivers the Counterweight Plus Programme for NHS Shetland, supporting people with Type 2 Diabetes to achieve remission through rapid and significant weight loss.

Remission is defined as HbA1c <48 (6.5%) for at least three months without glucose-lowering medication. This approach is grounded in evidence from the DiRECT Trial, which demonstrated high success rates for remission through structured weight management.

The programme has been available in Shetland since 2021, offering patients personalised, dietitian-led care, access to remote appointments, and locally tailored support.

## Programme Delivery

- **Eligibility**: Patients are referred or self-refer following education sessions, subject to BMI, age, HbA1c, and time since diagnosis criteria.
- **Structure**: 12–24 months, with frequent appointments initially, tapering to 2–3 monthly in year two.
- **Support**: Patients receive remote consultations, meal replacement provision, home monitoring kits, and GP oversight.
- **Format:** To date, all patients have opted for video-based appointments, citing flexibility and convenience.

## Activity and Outcomes in 2023/24

**Cohort Results**

- The first full cohort (2021–22 intake) completed the programme this year, with outcomes and patient evaluations showing favourable remission rates, consistent with DiRECT trial results (fuller reporting to follow).

**Recruitment and Retention**

- 2022/23: Recruitment was limited due to late funding confirmation. Of four patients referred, two commenced and both withdrew within six months.
- 2023/24: Nine patients opted in, six started, three remain active, and four discontinued within six months.

While recruitment has been modest and dropout rates remain a challenge, patient evaluations are highly positive, reinforcing the value of continued programme delivery.

## Service Development and Innovations

NHS Shetland is Leading the Way!

- **Psychology Clinical Supervision:**
  - Joint pilot with Counterweight, providing structured supervision sessions since September 2023.
  - Attended by Health Improvement Practitioners, Dietitians, and Assistant Practitioners.
  - Evaluations show improved confidence, transferable behaviour-change skills, and enhanced patient support.

- **Transition to Digital:**
  - NHS Shetland became the first Scottish health board to approve and implement the Counterweight App, replacing paper resources.

**Ongoing Improvement Work**

- Developed new referral pathways into remission services.
- Promoted programme at Primary Care Cluster Meetings and public events.
- Worked with Counterweight to improve communications, reporting, and patient processes.
- Contributed to the national development of a digital remission pathway, ensuring rural/Island needs are considered.
- Strengthened partnership with Shetland Recreational Trust, enabling free gym and activity access for patients for four months.
- Continued clinical supervision links with NHS Forth Valley Specialist Dietitians.

## Future Plans 2024/25 and Beyond

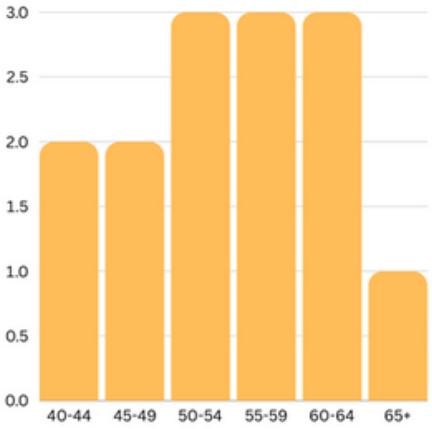
- **Boost Recruitment** – Launch redesigned Weight Management Service with a single point of triage and improved self-referral routes.
- **Offer Greater Choice** – Broaden the suite of weight management options, ensuring patients can access interventions that best suit them, reducing dropout rates.
- **Pilot Inclusion of Pre-Diabetes Patients** – Supporting earlier intervention and maximising resource use.
- **Sustain Digital Innovation** – Continue to refine patient record-keeping and digital pathways, aligning with national initiatives.

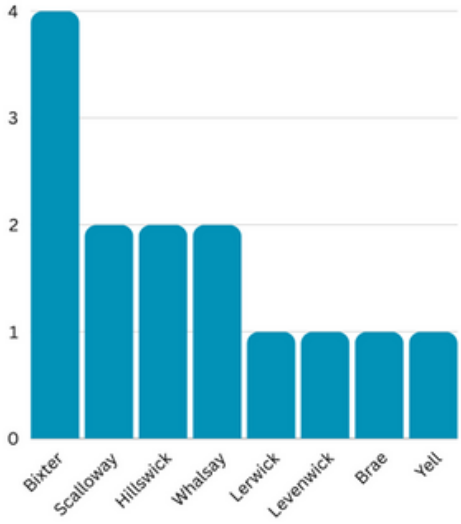
Despite challenges in recruitment and retention, the NHS Shetland Type 2 Diabetes Remission Programme continues to deliver clinically meaningful outcomes for patients and contributes to national innovation in diabetes care.
The service has positioned itself as a leader in piloting digital tools and psychological supervision approaches, ensuring patients receive not only medical but also behavioural support on their remission journey.

# Type 2 Diabetes Remission Programme 2023 - 2025 Data

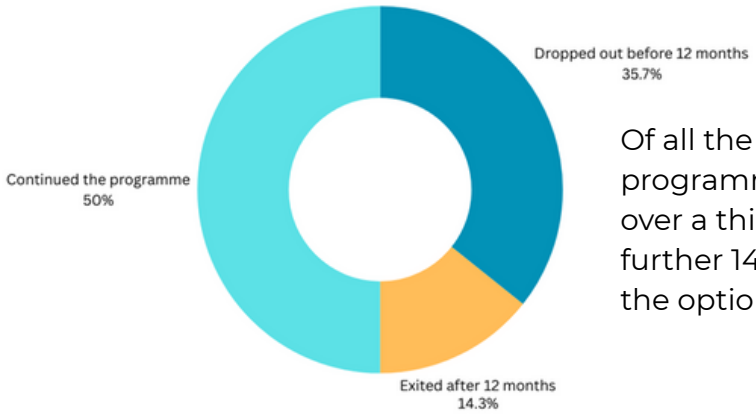

There were 14 participants in the initial cohort, of which 7 were male and 7 were female.

Eligibility criteria states that participants must be aged between 18 and 65 years. Within the initial cohort ages ranged from 41 years to 65 years, with the mean age being 54 years. (Median age was 56 years)




Participants came from a range of areas within the Shetland Islands with patients from all but one GP practice taking part in the programme. The majority of patients were registered with Bixter Health Centre and there were no patients from Unst Health Centre.




Of all the participants who started the programme, 50% completed it. However, over a third dropped out before 12 months. A further 14% exited the programme during the optional 12-24 months' stage.

Of all the participants who started the programme, 50% completed it. At the end of the Total Diet Replacement (TDR) phase, 86% of participants were still actively taking part. This participation rate continued until 12 months where 64% of participants were still active.


At the end of the Total Diet Replacement (TDR) phase weight loss (compared to baseline weight) ranged from 10kg to 21.9kg, with the mean weight loss being 16.1kg. By the end of 12-month weight loss (compared to baseline weight) ranged from 1.2kg to 18.9kg, with the mean weight loss being 11.4kg.

# Type 2 Diabetes Remission Programme 2023 - 2025 Data - Patient Experiences

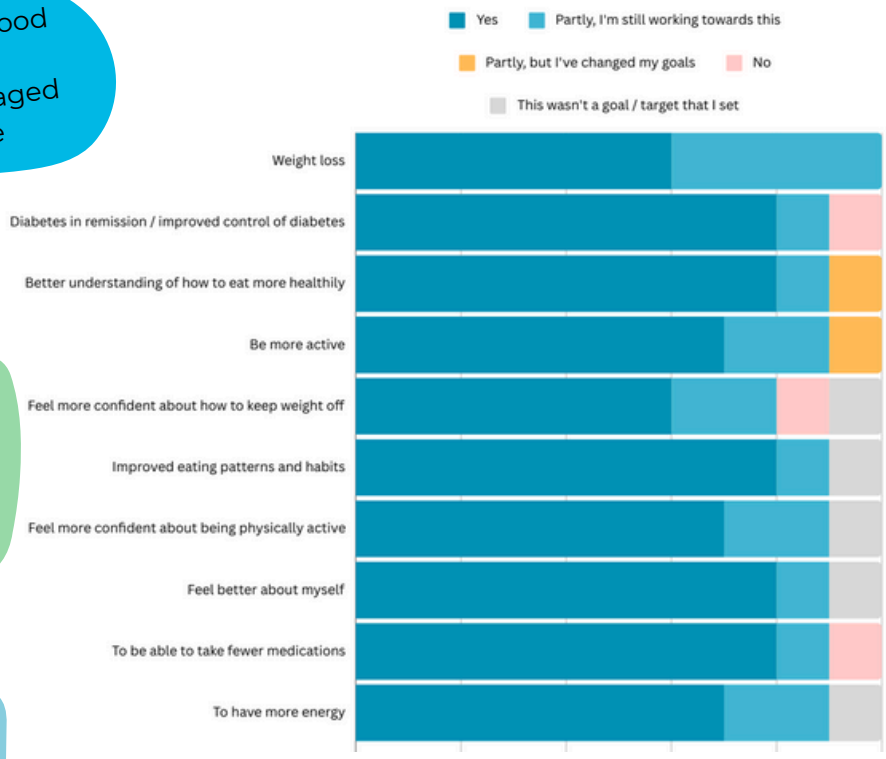
When asked if they had been able to achieve the outcomes they had wanted, the majority of participants reported that they had. This was especially true in relation to diabetes being in remission/improved control of diabetes, having a better understanding of how to eat more healthily, improved eating patterns and habits, feeling better about themselves and being able to take fewer medications.
A number of participants stated that they had partly achieved the outcomes they had wanted and were either still working towards them or had changed their goals. Very few participants reported that they had not achieved the outcomes they wanted.

Really good and encouraged me

Really good and couldn't have done it without her

I cannot honestly believe how lucky I was to be chosen for this programme and want to thank you for the change and hope it has given to me....

Right balance of supportive and an intuitive understanding




90% of participants rated their experience of the support they received from the dietitian as excellent and gave it 5 out of 5 stars.

Participants were asked on a scale of 1 to 10 how likely they would be to recommend the programme to other people with Type 2 Diabetes. Overall likelihood to recommend ranged from 7 to 10, with the majority of participants reporting that they were 'Extremely likely' to recommend the programme to others. Participants gave mostly positive feedback, noting improvements in diet, mental health, and physical wellbeing. They valued the right level of support and practical tools that helped them take control and make positive choices.

# Physical Activity Brief Interventions

The World Health Organisation lists **physical inactivity** as one of the five key modifiable behaviours which increase the risk of five major non-communicable diseases (NCDs), along with tobacco use, unhealthy diet, air pollution and the harmful use of alcohol. In 2023, 63% of adults in Scotland met the guidelines for moderate or vigorous physical activity (MVPA), with only around three in ten adults meeting both MVPA guidelines and muscle strengthening recommendations (29%). (Scottish Health Survey, 2023)

Evidence shows that well-informed conversations and person-centred approaches taken by healthcare professionals are effective for encouraging people to be more active. There is particularly strong evidence for providing brief advice and for signposting or referring patients to physical activity opportunities within the community.

The National Physical Activity Pathway (NPAP) is an evidence-based intervention a healthcare professional can take to encourage individuals to be more active. It provides a set of steps to have an informed discussion about physical activity and to signpost or refer people to the right service for them.

## What we have done 2023-25

- Embedded Scot-PASQ (The Scottish Physical Activity Screening Questionnaire) into our weight management service screenings and review appointments, with an additional focus on screening muscle strength-based exercise.

- Provided training to all HI practitioners in physical activity brief interventions (in 2024). We offer physical activity brief interventions on a 1:1 basis for those requiring further support to break down barriers and build up physical activity habits.

- A practitioner guidance toolkit was developed to support the delivery of physical activity brief advice and interventions, ensuring staff have the necessary skills and confidence to provide consistent, high-quality care for patients.

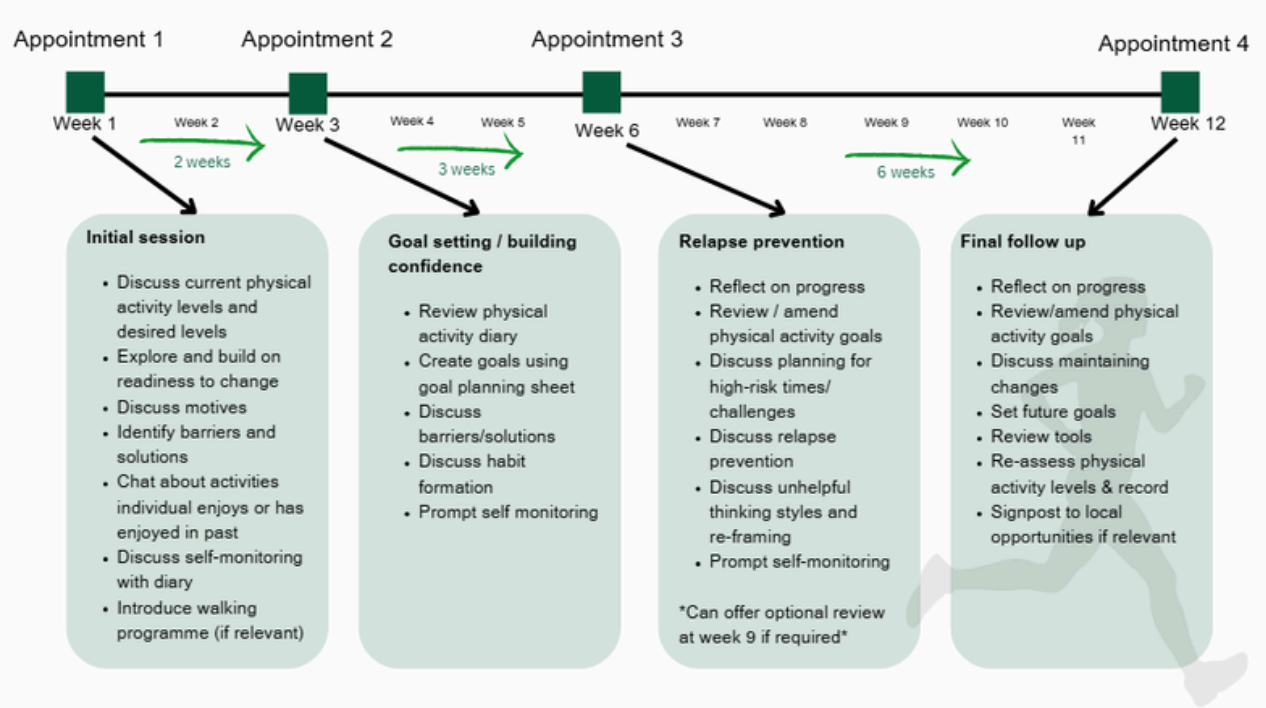
- Improved the way physical activity levels are recorded in primary care by updating the template on EMIS with the addition of muscle strengthening exercise screening and revamped the layout for clarity. The template has also been embedded into the new ‘House of Care’ template, making it easier for professionals to find and use.

# Physical Activity Brief Interventions

## What we have done 2023-25

The physical activity brief intervention resources and training were revamped by Krissi Sandison, Health Improvement Practitioner, in 2024. The PABI involves several structured sessions using health behaviour change techniques and goal setting to help build up physical activity in a way that works for the individual. The appointments are typically delivered across 12 weeks with around 3-4 sessions.

**Brief intervention timeline overview**

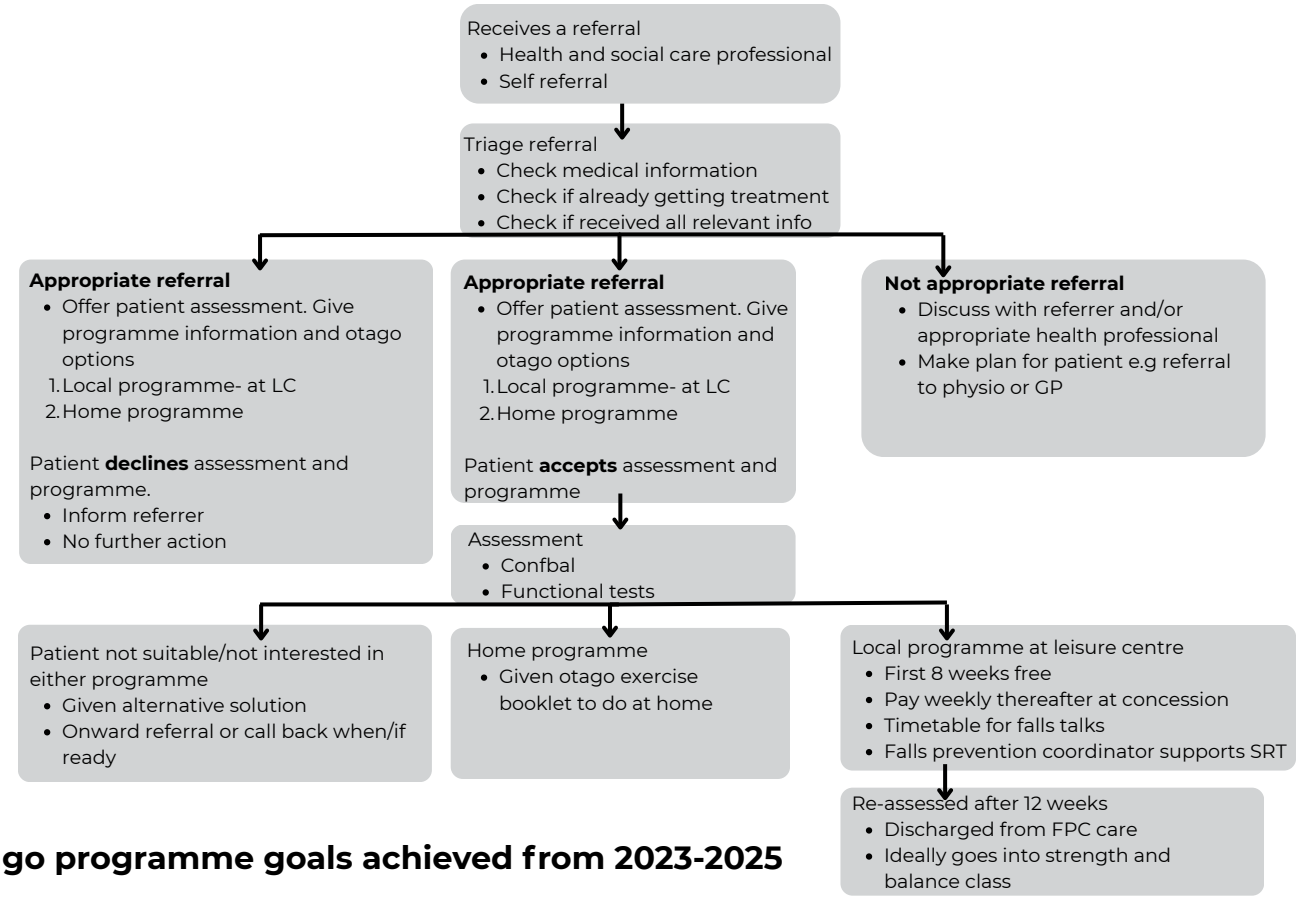



Numbers referred for PABI have been low over 23-25, which may reflect our promotion and recruitment efforts for our 'Get Started' Programme, designed to support people in becoming more active and overcoming barriers through engagement in leisure facilities.

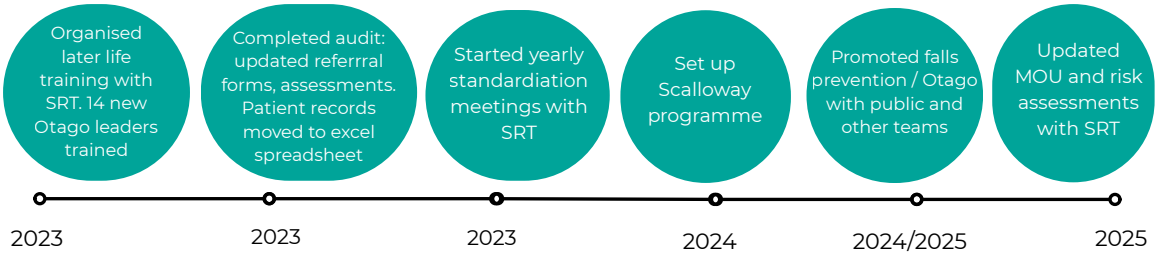
**Next steps are to improve awareness of the support available with key services such as primary care, and to improve the referral system to physical activity opportunities, with a greater focus on utilising community-based interventions.**

# Falls Prevention - Otago

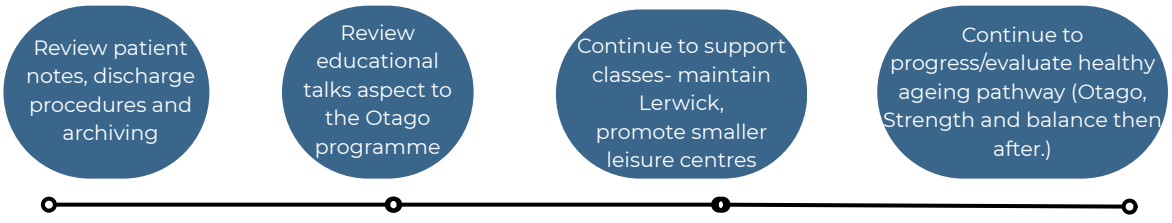
**Harm from falls and fear of falling** is still a prevalent part of the ageing community. There has been a lot of work done both nationally and locally to try reduce falls within hospital and community settings. Evidence based strategies has been at the forefront of this. Falls are multi-factorial, lack of exercise and inactivity being one of these factors. Strength and balance exercise programmes are proven to reduce falls. The Otago programme is an evidence based strength and balance exercises class run throughout Shetland. Since the Otago pilot in 2016, the Otago programme has progressed and developed. The partnership working with SRT has been key to this. This allow the falls prevention coordinator (FPC) to triage, assess each referral appropriately. See referral procedure below. In 2023/2024, SRT has developed a strength and balance class. This is for patients to progress into after Otago but can also be a pre-Otago programme too.




## Otago programme goals achieved from 2023-2025



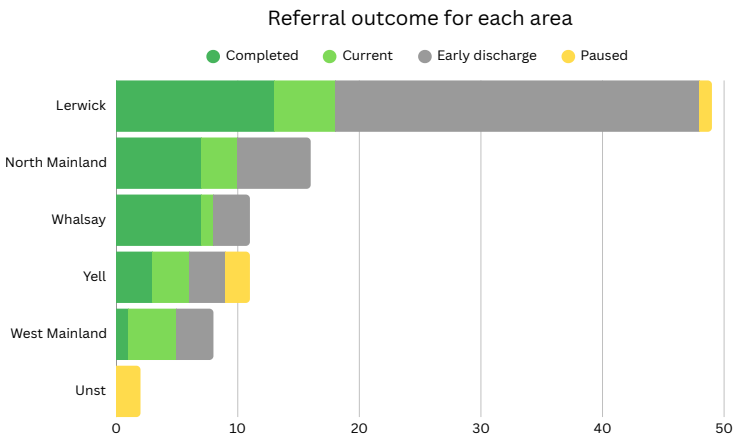

## Otago programme goals for 2025/2026



# Falls Prevention - Otago

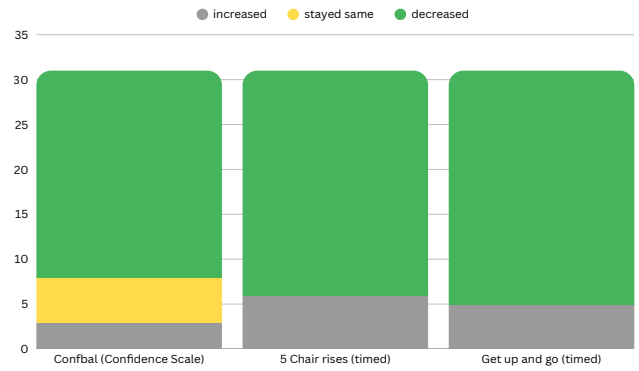
## Otago Evaluation 23-24

**97 Total referrals**
**31 Completed**
**16 Current / awaiting re-assessment**
**45 Early discharge**
**5 Paused**




### Results

These results are compiled from the pre and post Otago programme assessments in 23/24. Re-assessments are usually done around 12 weeks. The Confbal scale is a confidence scale, the higher the score the less confident they are about their balance. 23 out of 31 patients decreased their score (74%). 5 chair rises are timed, 25 out of 31 patients decreased their time (81%). Get up and go is where they get up, walk 3 metres, turn around and come back to their chair. 25 out of 31 patients decreased their time (81%).




### Challenges

A high proportion of the Otago referrals are for the Lerwick programme. This means splitting time equally between all areas is difficult. More time needs to be spent promoting and increasing the numbers into the smaller areas. There has been a high number of patients discharged early from the Otago programme. This can be from referral triage, during offering an assessment or that they have stopped attending during the 12 week programme. The Otago programme does have a high drop off rate. The barriers for this include lack of transport, health conditions, chronic pain, knee and hip operations, change of circumstance/not the right timing e.g moving house/going away to family, not interested, more appropriate for the strength and balance class or seeing another health provider e.g physiotherapy.

Don't use walking aid anymore, socially benefitted, good company, improved my confidence.

Walking better, more confident in house, can hoover and wash dishes now. Not using my stick as much.

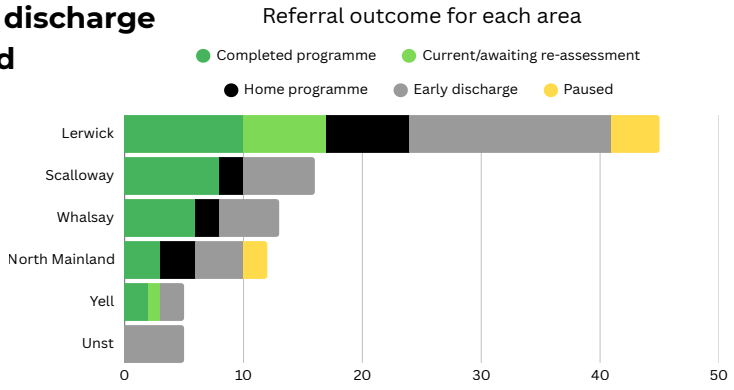
Can bend down and tie my shoes, never been able to do that. Improved my balance.

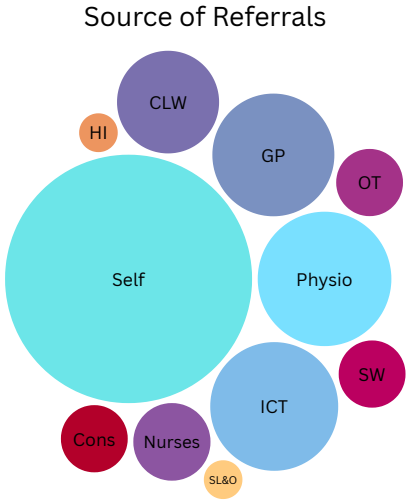
# Falls Prevention - Otago

## Otago Evaluation 24-25

In 24-25, there were similar referral numbers. The home programme numbers have been recorded so the number of early discharges have reduced compared to 23-24. There has been similar challenges carried over from 2023/2024. The barriers to completing the programme are still the same. A Scalloway programme was run this year which helped a lot with the Lerwick class waiting times. This year the sources of referrals was recorded and can be seen in a bubble chart. More work needs to be done to spread the word across different health professionals.

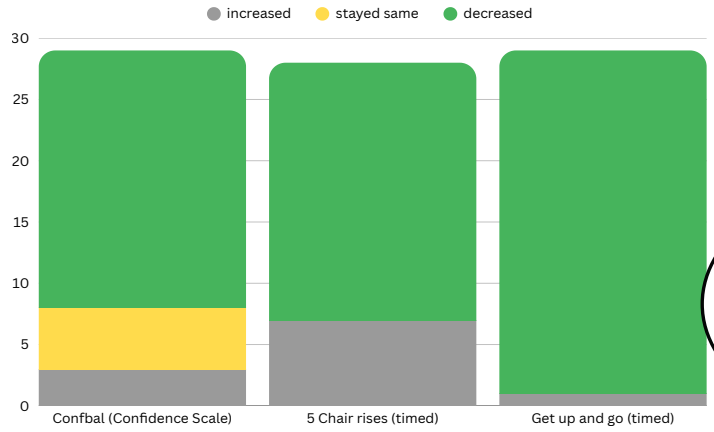
**96 Total referrals**
**29 Completed**
**8 Current/awaiting re-assessment**
**14 Home programme**
**39 Early discharge**
**6 Paused**




**Results**

These results are compiled from the pre and post Otago programme assessments in 24/25. Re-assessments are usually done around 12 weeks. The Confbal scale is a confidence scale, the higher the score the less confident they are about their balance. 21 out of 29 patients decreased their score (72%). 5 chair rises are timed, 21 out of 28 patients decreased their time (75%). Get up and go is where they get up, walk 3 metres, turn around and come back to their chair. 28 out of 29 patients decreased their time (97%).




Coming to leisure centre 3x per week with friend. Changed lifestyle. Wants to maintain. Walking up big hills better now.

Definitely got what I hoped from programme. Not fallen since class. Boosted confidence.

Do feel benefit, balance better. No more falls since attending. Feels fitter. Fine to meet up socially.

# Falls Prevention - Otago

## Case study 1

I heard about Otago from a friend. I wasn't sure at first, thought I was taking up a space from someone else but was encouraged by the FPC and continued Otago. I improved after assessments.

| Functional test | Pre Otago | Post Otago |
|---|---|---|
| Confbal scale(confidence rating) | 12 | 11 |
| 5 Chair rises | 12.98 | 11.75 |
| Up and go | 8.60 | 8.38 |
| 4 stage balance test | | Improved in all tests |

The main difference I saw was when walking the dog I was no longer out of breath when I came back. It felt easier. After completing Otago I have moved on to other exercise classes and other NHS programmes. All making a difference. Main positive has been the social side, meeting other people I wouldn't normally. Enjoyed socialising, benefitted my mental health. Want to keep as mobile and as independent as possible. Been getting positive responses from folk since starting the programmes. Benefited my health and well being. Benefitted the mental side by being sociable and meeting new people. Physically, I have more energy, I'm doing things in general better and by keeping active its keeping my joints mobile. Overall experience has been really positive. Definitely would recommend Otago, I already have.

## Case study 2

Patient had stroke, struggled with the strength in their legs. Couldn't get up from the floor. Wanted to get back to walking and improve sit to stands.

| Functional test | Pre Otago | Post Otago |
|---|---|---|
| Confbal scale (confidence rating) | 26 | 23 |
| 5 Chair rises | 17.20 ( 1 chair rise) | 4.38 ( 1 chair rise) |
| Up and go | 30.71 | 14.12 |
| 4 stage balance test | | Improved in all tests |

Patient has got so much from the programme. They couldn't complete 5 chair rises when they first came but could easily do this now. They have lost 2 stone, getting out walking, doing exercises at home, they are more aware of their feet. Determined to keep improving, still adding exercises into their routine.

# Early Years - HENRY

The Health Improvement Team deliver the HENRY '**Healthy Families: Right from the Start**' programme and workshops to support families with the tools and resources to provide a healthier, happier start in life. Topics include parenting strategies; increasing self-esteem and emotional wellbeing; changing habits; setting and achieving goals; and ideas for active play and family meals/snacks.

**8-week programme**

- Week 1: Let's get started
- Week 2: Balancing acts
- Week 3: Balancing needs & demands
- Week 4: Tuning into mealtimes
- Week 5: Time to be active
- Week 6: Eating well
- Week 7: Focus on feeling
- Week 8: Solution spotting

**1:1 Support via** the 8-week programme or workshops

**Workshops**

- Eat Well for Less
- Fussy Eating
- Healthy Teeth
- Looking After Ourselves
- Starting Solids
- Understanding Our Children's Behaviour

**HENRY - Healthy Families Programme**

The Healthy Families: Right from the Start programme is an 8-week programme delivered in groups and a one-to-one basis. One in-person group was delivered in October 2023 and an online group was delivered in partnership with NHS Western Isles in April 2024. Participants who attend at least 2 sessions are considered 'starters' and participants who attend at least 5 sessions are considered 'completers'. 11 participants started the programme, with 7 completing, a retention rate of 64%.

Participants complete a baseline and completion questionnaire as part of the programme. 5 participants completed matching baseline and completion questionnaires. Overall, participants reported improved family lifestyle scores as a result of the programme, increasing from 6/10 to 8/10.

The table below details the outcomes from the delivery of the Healthy Families: Right from the Start group programme in Shetland, covering programmes delivered from 2021/22 to 2023/24.

## Key outcomes - Improved

- Family lifestyle score
- Parenting confidence
- Parenting efficacy
- Emotional wellbeing score
- Healthy eating score
- Consumption
  - Fruit & vegetables (parents & children)
  - Water (children)
  - Energy dense snacks (children)
  - Sugary drinks (children)
- Screen time (under 18 months)

**Summary**

This section provides an overview of Healthy Families: Right from the Start group programme delivery in Shetland from 2021/22 to 2023/24.

**9** programmes delivered

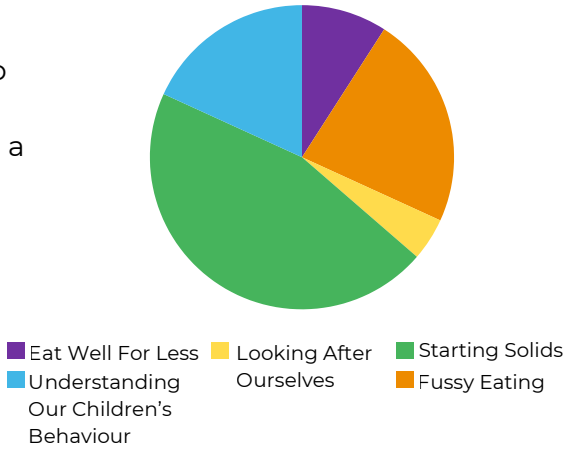
**47** parents oarticipated

**55** children reached

# Early Years - HENRY

**HENRY - Healthy Families Workshops**
Alongside the HENRY groups and 1:1 support, 20 group workshops were delivered in communities across Shetland and a further 2 workshops were delivered on a one-to-one basis.

Over 100 parents and carers attended and participant feedback was very positive with 97% of respondents reporting workshops as “great” or “good”. Participants also reported increased confidence following a workshop, with scores increasing from 6.6/10 to 8.7/10.




**Starting Solids Workshop**
The Starting Solids Workshop has been the most popular, with over 10 workshops delivered. The aim of the workshop is to increase parental confidence to introduce their baby to solid foods from the age of 6 months.

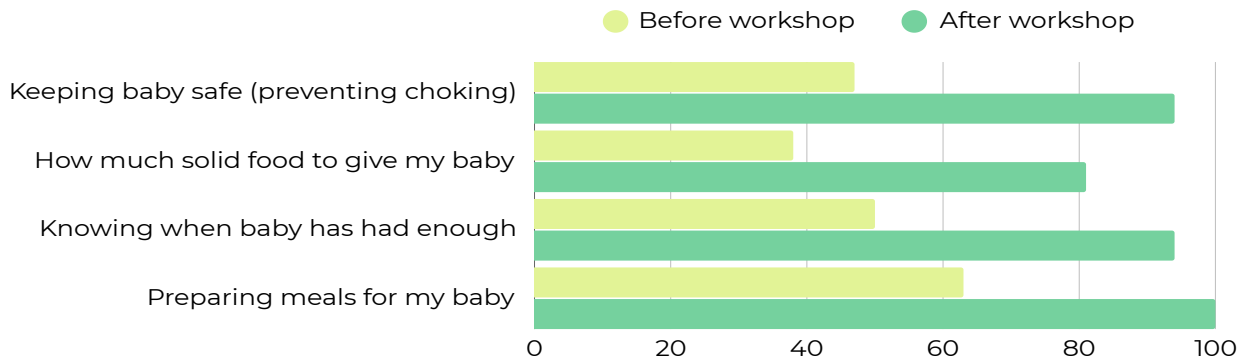
As part of the workshop parents complete a pre and post questionnaire in which they rate their confidence in the following areas:

- When to start to introduce solid foods to my baby
- Signs my baby is ready for solid foods
- Which solid foods to give my baby to start with
- How to keep my baby safe when giving them solid foods (i.e. preventing choking)
- How much solid food to give my baby
- Knowing when my baby has had enough to eat
- Giving my baby finger foods
- Encouraging my baby to try different foods
- Balancing milk and solid foods
- Preparing meals for my baby
- Making mealtimes enjoyable for my baby

**Overall confidence increased from 57% to 92% as a result of the workshop.**

Parent’s confidence increased across all areas, with significant increases seen in keeping baby safe when giving them solid foods (i.e. preventing choking); how much solid food to give; knowing when baby has had enough and preparing meals.

**Parents rating themselves as confident or very confident before and after the workshop (%)**



# Section 2

## Population Health

# Population Health Projects: Summary

## Summary snapshot

### Physical Activity

- Active Shetland Strategy is undergoing refresh with an aim to publish by the end of 2025.
- Partnership working with sub-groups has enhanced initiatives.
- Walk da Rock groups have reduced from 2023 to 2025, however walker participation has stayed fairly strong. Walk leader availability, volunteer recruitment and admin processes have impacted growth of the project.

### Alcohol Brief Interventions

- Training rolled out locally and nationally (147 trained).
- ABIs increased from 63 (2021–22) to 166 (2023–24) but dipped to 118 (2024–25).
- High proportion in priority health settings (90%+).

### Mental Health & Suicide Prevention

- Local adaptation of “Ask, Tell, Respond” training; resource revisions ongoing.
- Priority to roll out skilled-level training on self-harm and suicide prevention in 2025–26.



### Health Literacy

- Focused on improving BSL users’ access to primary care.
- Roll out and promotion of Language Line InSight Service for remote BSL interpreting.

### Workplace Health

- Launched “Mentally Healthy Workplace” training.
- Promoted e-bike pool for staff.
- Continuing to use and promote “Deskercise” resources.



### Money Worries

- Revised training to be delivered solely by HI team; aims to boost staff confidence to discuss and signpost financial concerns.

## Healthy Shetland Website Performance Overview 2024-25

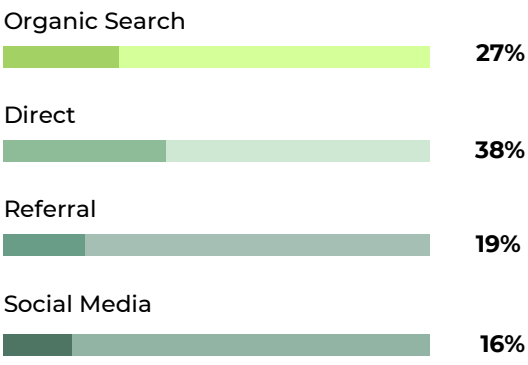
Launched in April 2023, the Healthy Shetland website improves access to health and wellbeing information while showcasing local projects and services. This infographic highlights key performance metrics and emerging trends, offering insights to help improve our online presence and user experience.

Recognising that health means different things to different people, the site offers a wide range of tailored resources. It helps people find reliable information, connect with community services, and access practical support.

From workplace wellbeing and falls prevention to our 'Get Started' programme and Quit Your Way smoking cessation services, the site provides something for everyone - whether individuals, health professionals, or organisations.

The Health Improvement Information and Resource Officer manages all updates and daily maintenance, ensuring www.healthyshetland.com remains current, relevant, and user-friendly.

### TRAFFIC SOURCES



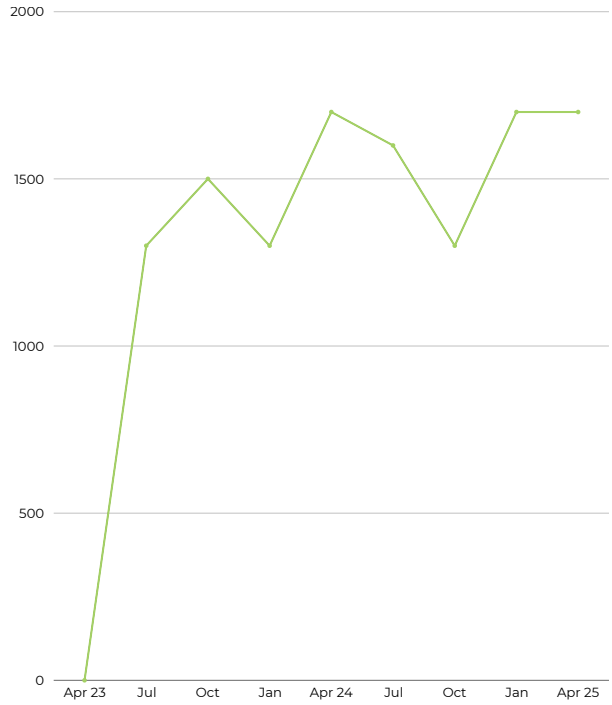

### BOUNCE RATE

(The percentage of visitors who navigate away from the site after viewing only one page.)

Bounce Rate **46.8**

A healthy bounce rate is 40% or lower, a bounce rate of 55% or higher indicates that improvements are needed to engage visitors & encourage them to explore more of the website, something which we have been working on.

### WEBSITE TRAFFIC

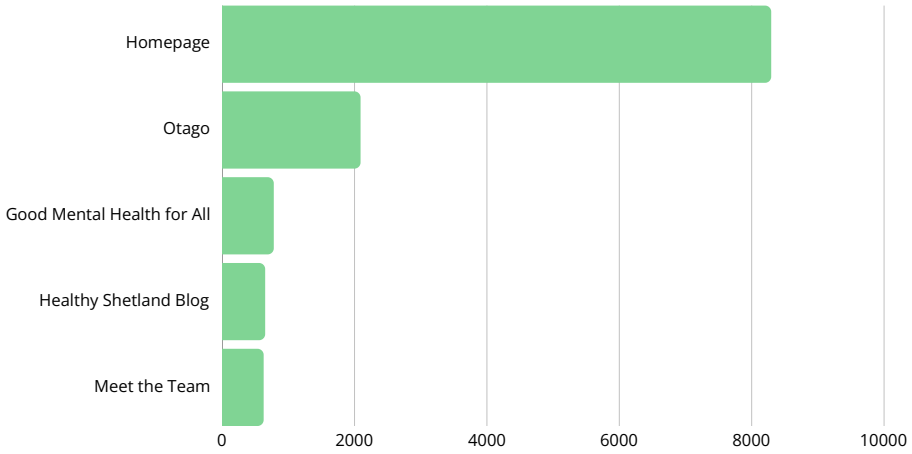



The Highest Website Traffic Value — March 2024 — **545**

## POPULAR PAGES

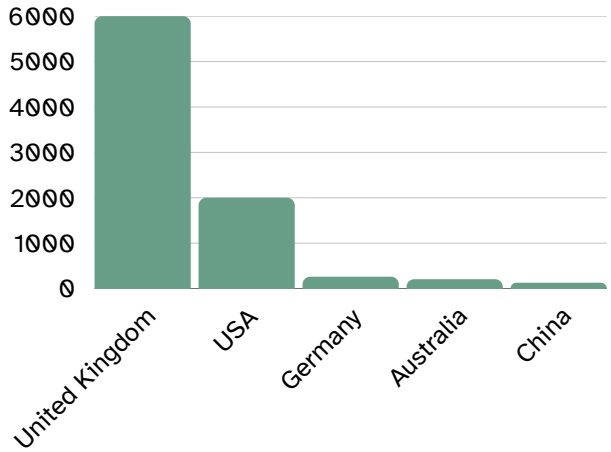
In this section, we present a detailed breakdown of our website performance over the past 2 years. Website analytics provide valuable insights into how users interact with our digital content, helping us understand what information is most sought after, how visitors navigate our site, and where improvements can be made to enhance user experience.

Earlier in the year, we took a closer look at traffic trends and which pages were getting the most attention. One area we focused on was our blog. Over the past six months, we've noticed a steady increase in views, which seems to reflect the fact that we have been posting more often and using the blog more actively to share updates and highlighting campaigns.



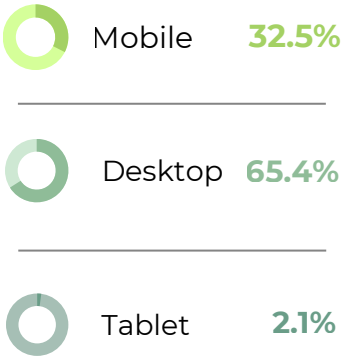

### USERS BY COUNTRY

Over the past two years, our platform reached users across multiple regions, with notable engagement from the United Kingdom and United States.




### TRAFFIC BY DEVICE

Despite mobile devices accounting for the majority of web traffic, desktop remains the preferred platform for website searches involving deeper engagement. Desktop users spend more time on site, view more pages, and show lower bounce rates—indicating more meaningful interactions.



# Healthy Shetland Social Media Report 2023-25

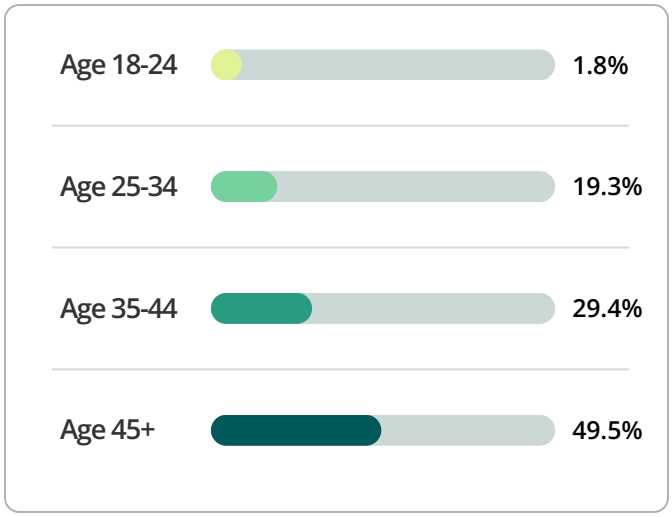
Our social media platforms continue to play a vital role in reaching and engaging our community. In the past year, our Facebook content reached over 30,400 users, while Instagram reached 5,200 users. These figures reflect strong visibility, particularly considering Shetland's population size, and demonstrate the effectiveness of our digital outreach in promoting health improvement messages across diverse age groups.

222
NEW FOLLOWERS
4K
ENGAGEMENT
30.4K
REACH

31
NEW FOLLOWERS
50
ENGAGEMENT
5.2K
REACH

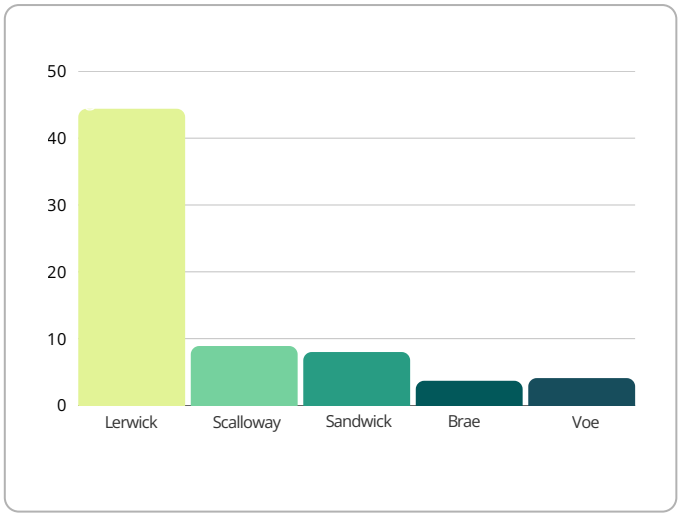
## Audience Demographics

Analysis of Facebook and Instagram insights shows our content is primarily reaching individuals aged 45 and over. To engage younger audiences (18–35), exploring new platforms (e.g. TikTok) and use more visual, local and relatable content is an aim for the coming year.

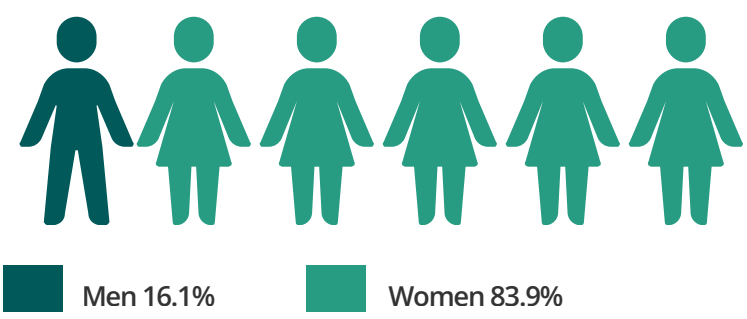



## Top 5 Areas of Engagement (%)

Over the past two years the top five areas of engagement are shown below. We continue to monitor our analytics to review the reach of our content.




## Audience Male/Female




Statistically, women are more likely to seek out health info because they're often more proactive about their health and tend to take on caring roles.
Our analytics reflects what we know nationally. To reach a wider male audience, our next steps include targeting male workplaces and getting more male input to our content.

## Health Awareness Campaigns Summary 2023-25

The Health Improvement Team coordinates health awareness campaigns throughout the year. These campaigns are delivered through direct public engagement at a variety of local events, including those where the team are invited by partners or to promotional activities. Events include Shetland Pride, county shows, health education talks, family engagement evenings, open days and school-based initiatives. These occasions offer valuable opportunities to share health information, promote key messages, and foster community involvement in health improvement efforts.

In addition to in-person engagement, national health campaigns are promoted online through the Healthy Shetland website blog and social media platforms. We work closely with the NHS Shetland Communications Team to share consistent messages and reach as many people as possible.

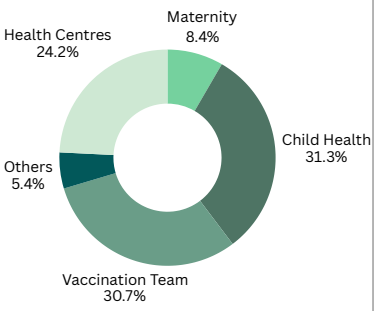
Throughout 2023-2025 we have promoted a wide array of campaigns. Each year we create a campaigns calendar which highlights national health initiatives that take place throughout the year. These include Dry January, Mental Health Awareness Week, No Smoking Day and much more. This can be found and downloaded from our website.


Photo from Health Improvement and Sexual Health Staff stall at Shetland's Pride event.

### Resources Processed

**17,805**

Resource Distribution




## Resources Available

**Leaflets & Booklets**
Topics include alcohol, smoking cessation, early years, immunisation, mental health, nutrition, money worries

**Education Packs**
Sexual Health & Contraception Kits

**Display & Pull Up Stands**
Equipment for loan such as display boards for events

**Posters**
Promotional materials for local & national campaigns

To keep up-to-date on the latest health awareness campaigns
**www.healthyshetland.com**

## Shetland Community Directory Project

The Health Improvement Team were part of the development group who worked on the creation of Shetland's Community Directory from 2023 to it's launch in April 2024. The Directory is an online resource that helps people and professionals find local services, community groups, and support across Shetland. It includes listings from youth and sports groups, community councils, halls, and services from the NHS, Council, Third Sector, and more. The Directory continues to be supported by Health Improvement, Shetland Islands Council & Voluntary Action Shetland.

To power the Directory, Shetland uses ALISS (A Local Information System for Scotland). ALISS is a national digital platform developed by the Health and Social Care Alliance Scotland and funded by the Scottish Government. ALISS enables communities to find and share information about health and wellbeing services, groups, and resources. Listings are added and maintained by individuals and organisations within the community.

Community groups are encouraged to manage their own entries via ALISS, with support from NHS Shetland's Health Improvement team, which provides training and guidance to ensure the information remains accurate, relevant, and accessible.

National Services Active in Shetland

**994**

Services Based in Shetland

**317**

To find out more:

**www.shetlandcommunitydirectory.co.uk**

# Physical Activity

## Active Shetland Strategy

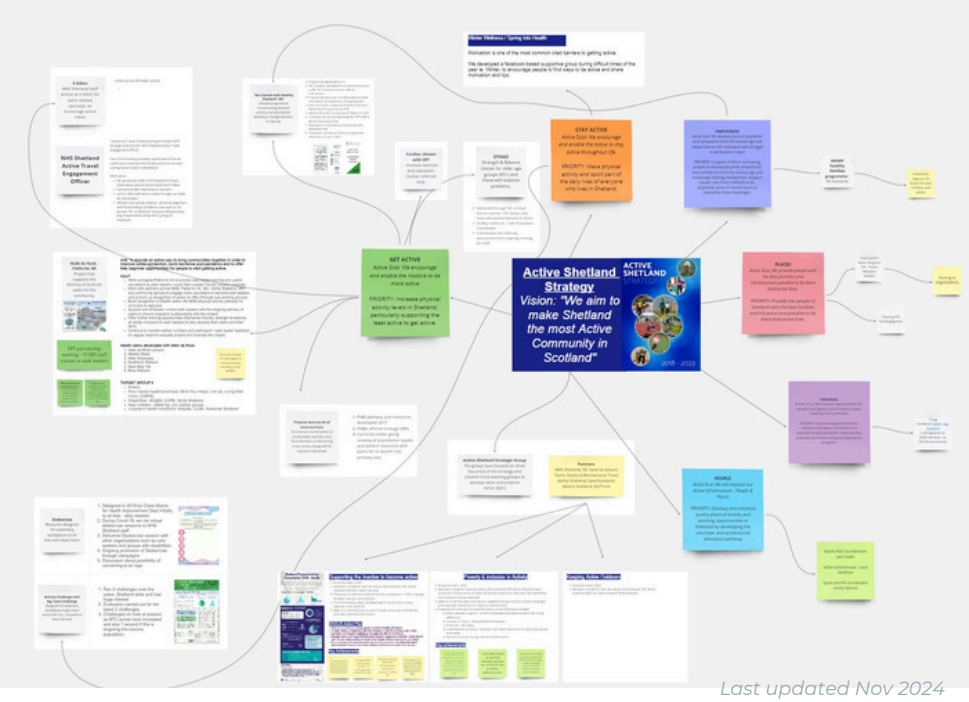
**Physical activity** is a key public health priority, as outlined in Priority 6 of Scotland's public health priorities ***"A Scotland where we eat well, have a healthy weight and are physically active".*** The Health Improvement team in Shetland is actively involved in a wide range of initiatives and projects designed to encourage more people to become physically active and stay active throughout their lives, with Health Improvement Practitioner Krissi Sandison taking a project lead focus.

Underpinning all of our physical activity work is the Active Shetland Strategy (2018-2023) which was developed by the Active Shetland Strategic Group, including local and national partners focused on sport and physical activity in Shetland. To help deliver the strategy, in 2021 three sub working groups were established with partners to provide greater focus on the agreed priorities. These working groups are now well established, and have been meeting frequently since formed.

The 3 priority areas are:

- **Supporting the inactive to become active**
- **Addressing poverty and promoting inclusion**
- **Encouraging outdoor activity.**


**Mind map of the physical activity initiatives we have been involved in**




*Last updated Nov 2024*

# Physical Activity

## 2023-2025

In 2023, the **Active Shetland Strategy** came up for renewal, and a **community conference** was held to review the work of the strategy and to gain input to future actions. The review highlighted many successes, and central to this was the development of the sub working groups and a more collaborative approach.

The **refresh of the strategy** is still ongoing and is hoped to be published by the end of 2025. We have adopted the **Scottish systems-based approach to physical activity** framework, which uses an evidence-based, outcome-focussed approach and encourages long-term, coordinated efforts across different sectors. This helps make the most of limited resources and supports physical activity at a population level. The infographic below illustrates a few of the successes achieved since the working groups were formed (2021-2025).


### 'Peerie Wanders'

In March 2025, our Peerie Wander booklets were revamped with additional input from RSPB Shetland, Shetland Amenity Trust, NatureScot and Ability Shetland. There are 9 different booklets that can be accessed online here or printed copies can be requested through Health Improvement.

# Physical Activity

## Walk da Rock Shetland

**Walk da Rock** is a project that the Health Improvement Team co-ordinate in partnership with the National Charity, **Walking Scotland** (formerly known as Paths for All). It is a local walking project that supports the development of Health Walks to be set up and delivered in communities, by **upskilling and supporting volunteers as Walk Leaders.**

The overall aim of the project is to **encourage volunteers to set up local walks** in the community and provide an opportunity for **inactive people to become more active**, working towards Walking Scotland's mission as well as our Active Shetland Strategy.

**THE IMPACT**

In 2023-2024, a small-scale evaluation was carried out.

The findings highlighted that walkers reported:

- **increased physical activity levels**
- **increased motivation and confidence**
- **more opportunities to be active in daily life.**

Further details can be found on the following pages.

**2023-2025**

**7** volunteers completed Walk Leader Training, of which:

**43%** are still active walk leaders (2025)

**3** new walking groups formed

(See more on following page)

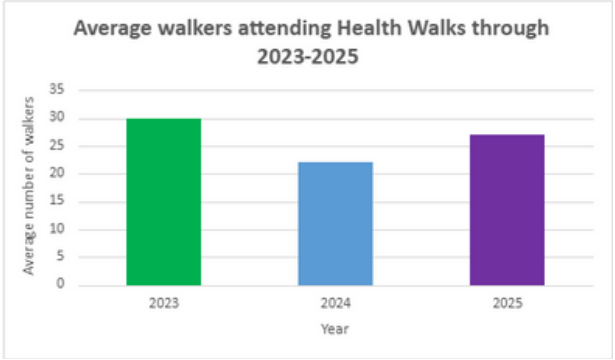
## Monitoring weekly walker numbers 2023-25

**From 2023 to 2025, participation in the Walk da Rock Project's Health Walks has experienced subtle changes.**

In 2023, three volunteers completed walk leader training. The walks drew a strong weekly turnout of around 30 participants, with seven active Health Walks running.

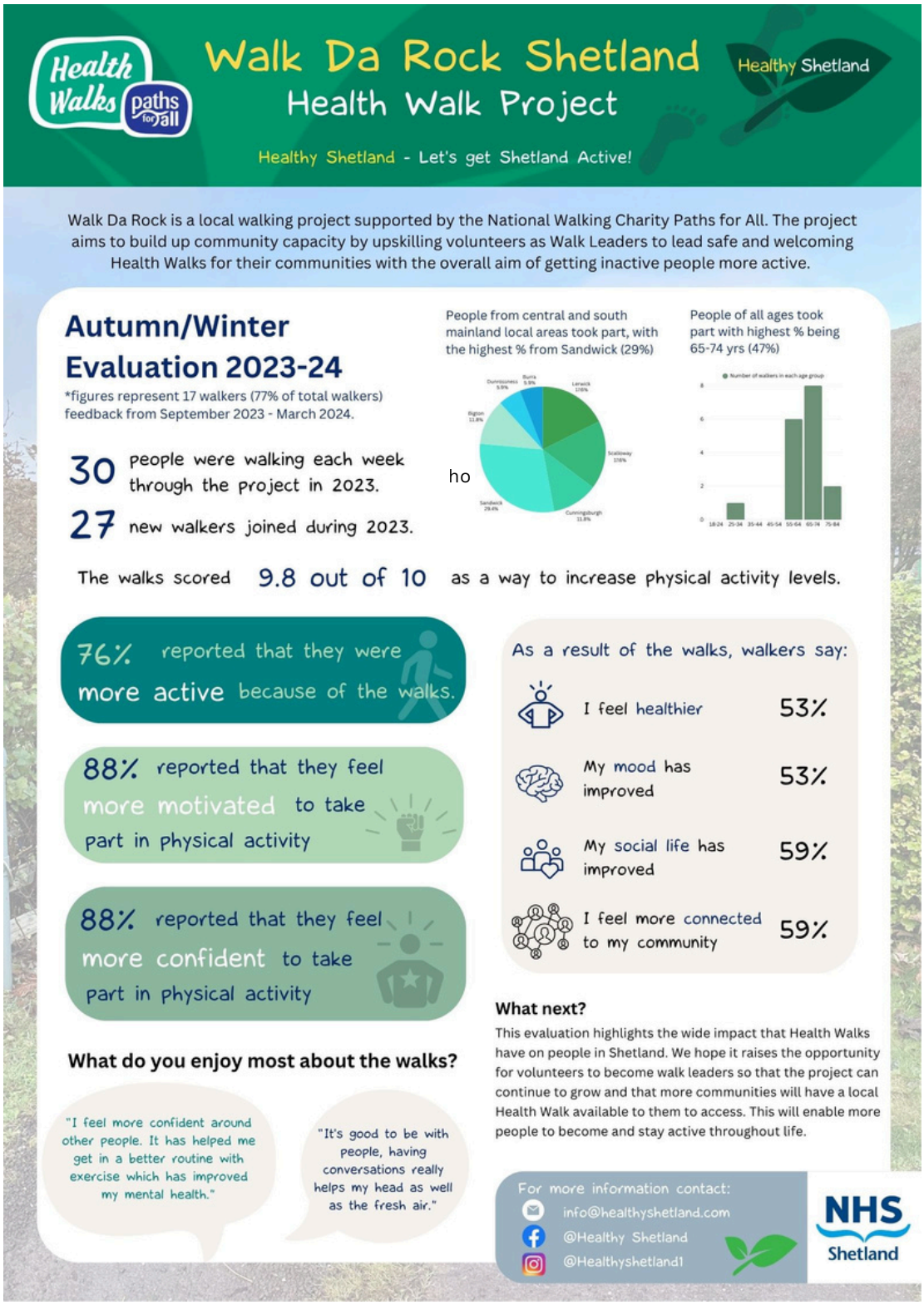
In 2024, three new volunteers completed the walk leader training. This year brought a slight dip, with average walkers dropping to around 22 per week, most likely due to some walks wrapping up or being paused with fewer volunteers available.

As of 2025, one new volunteer has completed the training. Encouragingly, we have seen a positive upswing, with numbers climbing back up to 27 walkers each week - possibly due to walks becoming more established and known in the community.



## Walk da Rock Evaluation 2023-24

In Sep 23 - March 24, a small-scale evaluation was carried out to help build a clearer picture of how the project is impacting communities. A summary of the key findings can be found in the infographic below.



## Challenges & Next Steps

Across 2024-25, one of our main challenges has been navigating how to **register and process volunteers as walk leaders** in the project. We have experienced challenges using the NHS process, particularly the lengthy admin process and paperwork involved in obtaining clearance checks. This has caused delays in getting volunteers recruited, often leading to a loss of momentum and enthusiasm for setting up community walks.

To address this, we've been exploring more appropriate approaches and have now partnered with the **Sport & Leisure team at SIC** to take on the volunteer admin process. We are currently working with them to establish a new, **more efficient and user-friendly pathway for volunteers** to register as walk leaders. We also hope this partnership working will **enhance the visibility, reach, and impact** of the project, supporting its growth and sustainability across Shetland.

Other challenges such as **limited walk leader trainers available locally** and **access to Walking Scotland's Training for Trainers (T4T) course** has impacted the number of volunteers being trained as walk leaders across the last 2 years. To address this, we plan to build capacity by training more staff in health improvement and exploring opportunities for other teams to undertake the T4T course where budget allows.

# Alcohol

## Alcohol Brief Interventions

**Alcohol Brief Interventions (ABIs)** are short, structured conversations about alcohol consumption with an individual. Using behaviour change techniques, they aim to motivate and support the individual to think about their drinking behaviours and possible changes they could make to reduce their consumption. Sometimes this might be the first time they have discussed how much they drink with someone and may be the first step in making changes.

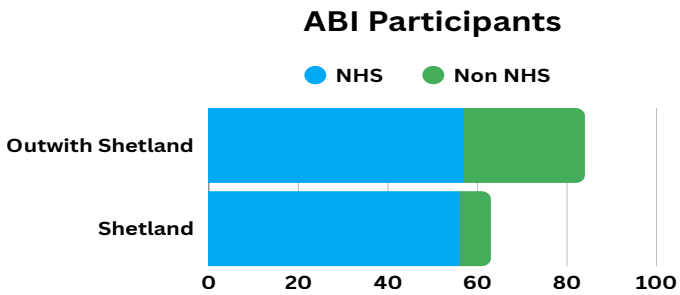
## Alcohol Brief Intervention (ABI) Training

Alcohol Brief Intervention training had not been available for several years, which contributed to a decline in the number of ABIs delivered. To address this, the original two-day in-person training was revised in 2022, and a condensed online version was developed and delivered via Microsoft Teams.

The updated training was launched in December 2022 and has been delivered regularly since. In May 2023, access to the training was extended to non-NHS Shetland participants through TURAS, resulting in uptake from across Scotland, including both NHS and non-NHS organisations.

To date, 147 individuals have completed the training. In Shetland, this includes NHS Shetland staff, Shetland Islands Council, and the Scottish Ambulance Service. Across Scotland, participants have come from 10 NHS boards and a range of organisations such as the Scottish Prison Service, local authorities, organisations that support vulnerable families and individuals, and those affected by addiction.

- 56 NHS Shetland
- 7 Shetland Non-NHS
- 57 Other NHS Boards
- 27 Outwith Shetland Non-NHS



# Alcohol

## ABI Training Feedback

I feel that the examples used for how to talk about alcohol usage were really useful and the comparison between how to start the conversation and how not to was really good as you could see the difference it made when people feel included vs spoken down to.

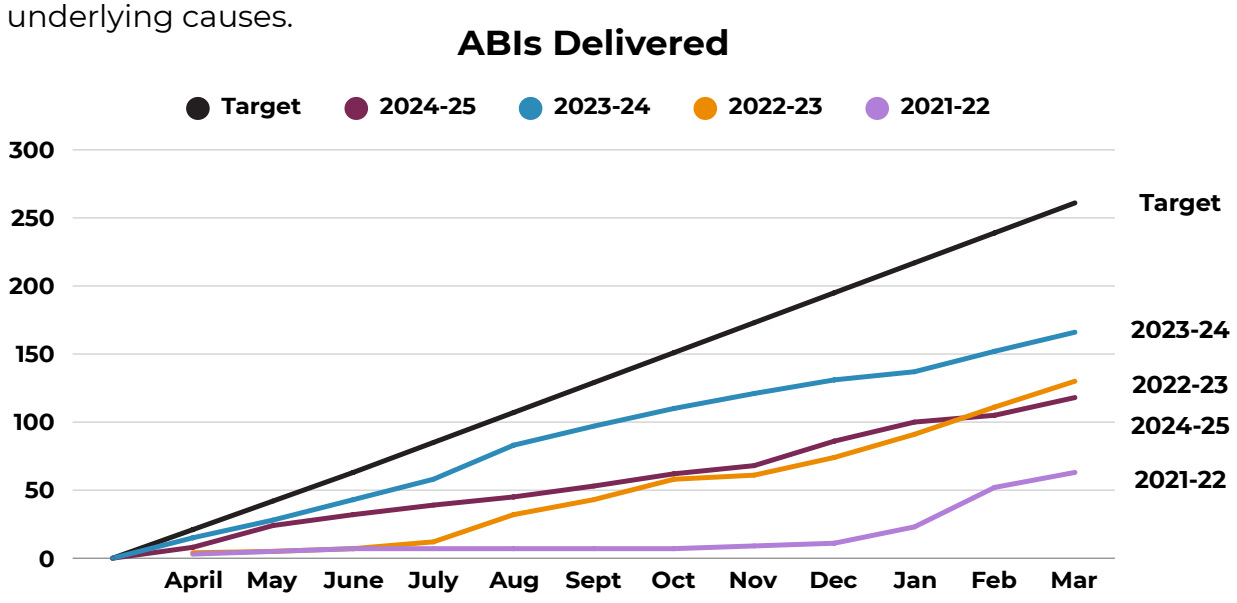
We are often called to patients with alcohol issues. The course has given me some really useful strategies to enable empathetic conversations with these patients and also provide a model of how to actively support positive changes.

Really informative session with practical advice that I feel I will be able to use in my role.

## Alcohol Brief Intervention Delivery

NHS Shetland's HEAT target for Alcohol Brief Interventions (H4) is set at 261, with 80% from Priority settings and 20% from Wider settings. Priority settings are Primary Care (inc Sexual Health clinic), A & E, Antenatal. Wider settings include Health Improvement, Podiatry, Dentistry and Social Work.

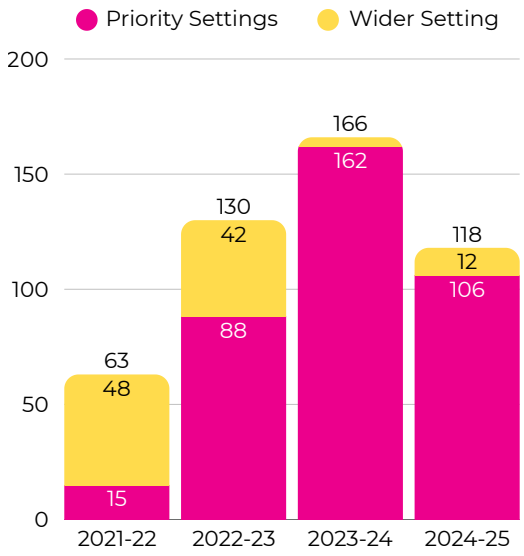
The impact of training in Shetland is evident in the rising number of Alcohol Brief Interventions (ABIs) completed. In 2023–24, the total rose to 166 - an increase of 27.8% from the previous year (130), and more than double the 2021–22 figure of 63. However, this number has since declined to 118 in 2024. It is currently unclear whether this drop reflects a reduction in ABIs delivered or a decrease in recording. This trend will continue to be closely monitored to better understand and address the underlying causes.



# Alcohol

In 2024-25, the proportion of ABIs completed in Priority settings were 89.8% and in 2023-24 they were 97.6% of the ABIs done, meaning that both years were above the 80% Priority Setting target.

This compares to 67.7% in the previous year and only 23.8% in 2021-22.




## Review of Alcohol Brief Interventions

In October 2024, Public Health Scotland published "Alcohol Brief Interventions: A Review of Strategy and Recommendations for Policy", recommending that the Scottish Government reaffirm its commitment to Alcohol Brief Interventions (ABIs).

The report recommends embedding and normalising alcohol-related conversations using a person-centred, motivational approach, without prescribing a set number of sessions. It emphasises addressing alcohol-related health inequalities and integrating these conversations into routine practice.

As of now, no further guidance has been issued. However, in November 2024, Public Health Scotland suspended national ABI data collection as part of an internal prioritisation process. Local data collection continues for reporting purposes.

## Next Steps

In 2025/26 we are developing our ABI+ brief intervention programme.
This will be aimed at individuals who are trying to make changes to their alcohol consumption and will take a person-centred approach, using behaviour change techniques to support the individual to reduce their drinking.

We will also continue to deliver ABI training and encourage staff to deliver ABIs and record both screenings and ABIs.

## What is Ask Tell?

'Ask, Tell, Respond' is a suite of training resources developed by NES and Public Health Scotland. It is designed to support the implementation of:

- Scotland's Public Health Priorities for Mental Health;
- The Mental Health and Wellbeing Strategy and Workforce Action Plan 2023
- and Scotland's Suicide Prevention Strategy – Creating Hope Together 2022-2032.

**The Ask, Tell resources will support staff across the health, social care and the wider public sector to develop the knowledge and skills needed to promote good mental health and wellbeing across the whole population and to prevent mental ill health, self-harm or suicide. It is also about improving the quality and length of life for people who experience mental ill health and addressing the inequalities people can face.**

The Mental Health Improvement Knowledge and Skills Framework (KSF) helps individuals, teams and organisations to understand the role they can play in supporting mental health improvement, and in preventing self harm and suicide.

The framework identifies the knowledge and skills required across the four levels of practice : informed, skilled, enhanced and specialist. These are based on the nature and frequency of contact staff have with people who may be at risk of, or affected by mental ill health, self-harm or suicide.
Informed and Skilled level resources have been developed and are available to use. The Enhanced and Specialist level resources are still in development.

## Local revisions and trainers

**Local implementation – our team & revisions being made**

Considering learning from previous experience, the aim is to train all Health Improvement Practitioners to deliver the Ask Tell resources. This will allow us to provide better stability in provision of training, rather than being dependent on an individual member of staff to deliver the courses.

The Health Improvement Team initially reviewed the facilitation resources in December 2024. Upon review, the team felt there were gaps in the resources and that some changes could be made to improve their quality; to include some local context and draw upon knowledge of effective resources from other contexts.

Two of the health improvement practitioners began to review the skilled level facilitation resources. Public Health Scotland then commissioned an external evaluation of their facilitation resources via Harlow Consulting. As such, we paused the local review of resources and contributed to the external evaluation.

Headline results from the external evaluation were shared in June 2025 via the National Mental Health Improvement and Suicide Prevention Facilitator Network in their Spring update newsletter. The Network also held a meeting, discussing the results and some planned updates to the facilitation resources. These updates are anticipated to be shared around the end of 2025. Locally we have decided to continue with our own review of resources in the meantime and will then take National updates into account when they are released.

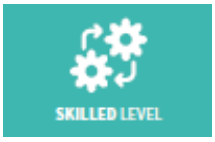
**National Network Update**

Mental Health Improvement and Suicide Prevention Facilitator Network discussed ideas for making best use of the facilitator network, including opportunities for peer support, co-delivery of training and shared learning.

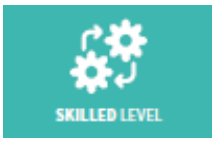
## Plans for roll out in Shetland

**The Ask Tell resources currently available to access are:**


**Informed Level e-learning:**
Ask, Tell, Respond: mental health improvement & suicide prevention
Ask Tell, Respond: Promoting children & young people's mental health and preventing self harm and suicide




**Skilled Level e-learning:**
Learning Byte 1: Promoting mental health and tackling inequalities
Learning Byte 2: Supporting people in distress & crisis
Learning Byte 3: Supporting people at risk of suicide
Learning Byte 4: Supporting people at risk of self harm
Learning Byte 5: Supporting recovery and quality of life for people living with mental ill health.




**Facilitated courses (*under development)***
Skilled Level:
Supporting people in distress & crisis
Supporting people at risk of suicide
Supporting people at risk of self harm

- We will prioritise getting the 'Skilled Level: Supporting People at Risk of Self Harm' resource finalised as a facilitated training course as there is currently no other provision for this locally. We aim to have this revised and ready to roll out by end of 2025.

- We will continue to update the facilitation resources to enable us to launch the facilitated courses in "Supporting people at risk of suicide" and "Supporting people in distress and crisis" in 2026.

# Suicide Prevention 2024-25

## Strengthening Suicide Prevention Activity

By NHS Board area, Shetland had the lowest rate of suicide in Scotland (2019-2023). However every death by suicide is a tragedy and we know that every life lost can leave devastating and long-lasting impacts on families, friends and communities.

We recognised that although many organisations, communities and individuals in Shetland want to support suicide prevention, our current approach across the Shetland System was ad hoc, with limited proactive work and coordination.

In 2024 Health Improvement Team Lead committed to be the named lead for Suicide Prevention for Shetland, linking in with national groups and aiming to strengthen suicide prevention activity locally.

Suicide prevention work encompasses a wide range of activities including activities to address social determinants of health such as poverty and debt, work to address stigma and improve people's confidence in supporting individuals at risk of suicide, activity to reduce access to means, and postvention support to people affected by suicide.

A Suicide Prevention and Response workshop was held in December 2024 to bring together key stakeholders involved with suicide prevention and response activity in Shetland. The workshop was based on a one developed by Public Health Scotland, and used a scenario developed specifically for the Shetland context.

The purpose of the workshop was to review Shetland system's preparedness for responding to suicides, improve understanding of the roles and capabilities of different stakeholders, and identify actions for improving our response.

We had an excellent level of engagement from our partners with representatives from community and voluntary sector organisations and public sector services.

## Suicide Prevention 2024-25

From the workshop, 9 recommendations for Shetland were agreed.

These ranged from work that was already underway nationally, such as the Police Scotland information sharing protocol and align this locally, to engaging with other boards to learn from any good practice. One key ambition was the development of a light-touch process for convening relevant stakeholders after a suspected suicide to share relevant information and coordinate the offer of support to those affected.

Progress on all 9 recommendations has been made to date with a new governance structure to share and collaborate in actions underway with Suicide Prevention now part of the Public Protection Committee.

### Recommendations

**Information Sharing**

- The NHS collaborates with Police Scotland to implement the information-sharing protocol in Shetland for suspected suicides. This should clearly outline who in Shetland needs to be notified about a suspected suicide and the reasons for their involvement.
- The NHS will discuss with Police Scotland the possibility of creating a low-detail information-sharing alert. This would notify community and voluntary sector organizations about suspected suicides, allowing them to prepare and allocate resources for support.
- The NHS Shetland Suicide Prevention lead will reach out to Public Health Scotland to inquire whether other regions have established protocols for sharing information regarding suicide attempts.

**Support for those affected**

- NHS Shetland Suicide Prevention lead to work with stakeholders to explore feasibility and practicalities for creating a process to rapidly establish a multiagency group to enable coordination of support after a suspected suicide.
- NHS Shetland Suicide Prevention lead to collate information about support services and materials identified during the workshop, and add these to the Healthy Shetland and Safer Shetland websites.

**Communication**

- NHS Shetland Suicide Prevention Lead to develop a suicide prevention communications plan for Shetland. This will include arrangements for coordinating suicide prevention awareness raising activities during Mental Health Week and World Suicide Prevention day or other awareness days, and setting out how families and communities can be supported if necessary after a suspected suicide in relation to the media and social media. This is expected to include convening key stakeholders two or three times a year to discuss plans.

**Training**

- NHS Shetland Suicide Prevention Lead to identify publicly accessible e-learning and share this for publication on the Safer Shetland training page.
- NHS Shetland Suicide Prevention Lead to include collation of information and costings about training in the suicide prevention communications plan, with a view to collating this on an annual basis.
- NHS Shetland Health Improvement to include suicide prevention training in planned Health Improvement Training Brochure, and add to the Safer Shetland training calendar.

# Health Literacy

**Health literacy** is about people having the **skills, knowledge, and confidence** to **understand and use health information** to make **informed decisions** about their care. When health services are easy to understand and navigate, people are more likely to manage their health well, attend appointments, and follow treatment plans.

Improving health literacy is especially important for individuals and communities who may face extra barriers when accessing care, such as those with lower socioeconomic status, limited education, ethnic minorities, older adults, and those with disabilities or language barriers.

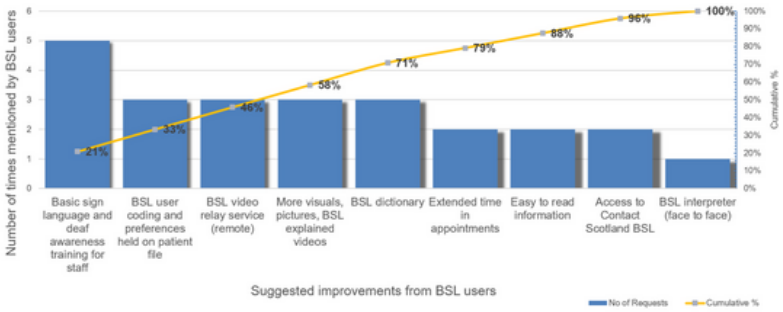
## British Sign Language (BSL)

As a result, in 2022, a dedicated working group was established to explore and improve health literacy within local communities. This group brought together members of our Health Improvement Team (Krissi Sandison, HIP), Shetland Community Connections, and received valuable support from the Person-Centred Care Team and an Improvement Advisor from the Scottish Government.

The focus of the project was to better understand how to improve access to Primary Care Services for BSL users. Using a quality improvement (QI) approach, we gathered information by supporting BSL users to map out their experiences with primary care. We engaged with 3 local BSL users using an in-person interpreter. This helped us to identify what was working well, where barriers exist, and to begin developing meaningful solutions to improve care.

### The feelings experienced by BSL users in health centres


### What would make the biggest difference?




**From the interviews the top 3 improvements that were suggested were:**

1. Sign Language and Deaf Awareness Training for staff
2. BSL user coding and preferences held on patient files (on EMIS)
3. BSL video relay service

# Health Literacy

## 2024-25

Throughout 2024–25, we engaged with health centres to identify opportunities for improvement. Unfortunately uptake has been low - likely due to the small number of BSL users currently living in Shetland - however we have had some small wins, such as:

- Development of a local health literacy support group with colleagues in NHS & SIC
- Promotion of BSL resources and support on our Healthy Shetland website
- Exploring the InSight Service via Language Line and highlighting this platform across practices.

Encouragingly, staff in one of the local practices had positive experiences using the InSight Service with Language Line during a patient consultation with a local BSL user. Building on this feedback, we're committed to supporting more staff to confidently use this platform, and make health care appointments accessible for all BSL users in Shetland.

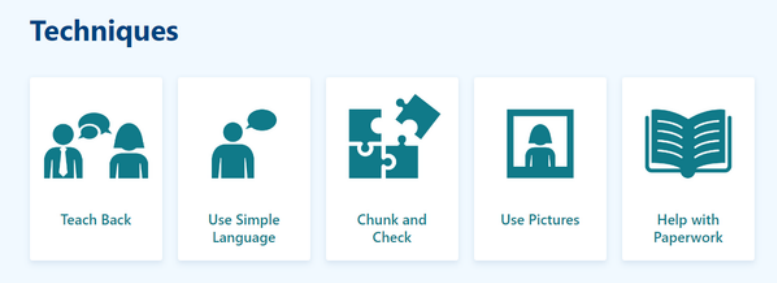
> "I felt my client was able to express himself and with the translator I was able to understand his needs and help him find access to the support that he needed. Having an interpreter resulted in a much more holistic and positive experience."

## Next steps and priorities

Krissi Sandison (HIP) and Laura Russell (HIP) are currently taking a lead focus in this topic with aims to continue working on improving accessibility in primary care, but also widening this work further into other patient groups such as those with learning disabilities.

**Top priorities include:**

- Scoping out and promoting training to NHS Shetland staff including basic deaf awareness, BSL lessons, and health literacy.
- Working alongside practice managers to streamline EMIS coding and ensure any BSL users registered have relevant notes and communication preferences on their files.
- Continuing to promote Language Line across practices and practically supporting with setting up and using effectively.



# Workplace Health

## Healthy Working Lives

Health Improvement works to support healthy, inclusive workplaces where employees can thrive physically and mentally, and support employers to build productive workplaces that protect and promote fair and healthy working practices.

**Healthy Working Lives** is part of Public Health Scotland and provides guidance, tools and training to support understanding of health risks, mental health, manage staff attendance and promote health and wellbeing, as well as how to access support services for employers and employees.

Originally Health Working Lives operated an award programme for employers, but this was paused in 2020 due to COVID-19. Since then they have been reshaping how they support employers and employees from recruitment to retirement. There has been an emphasis on fair and good working practices, providing resources to improve workplace productivity and employee health and wellbeing.

This review includes completely updating their **website**, creating **Mentally Healthy Workplace Training** aimed at managers, and developing the **Mentally Flourishing Workplace Framework**.

In February 2025 two Health Improvement staff were trained to deliver Mentally Healthy Workplace Training and the first session took place in May 2025.

## Next Steps

In 2025/26 we will continue to engage with employers, health professions and other partners to raise awareness of Healthy Working Lives. This will include:

- Promoting the **Healthy Working Lives website** and the resources contained within.
- Promote **Mentally Flourishing Workplace Framework**.
- Delivering **Mentally Healthy Workplace Training** to managers.

## Good Mental Health for All


The Good Mental Health for All Local project was completed in early 2024 and included a focus on workplaces as part of engagement.

Local evidence was gathered in four ways: community engagement; a desk review; workforce engagement and analysis of a mental health and wellbeing dataset.

The community engagement work involved asking three key questions: How do you look after your mental health? What can make looking after your mental health difficult? When times are tough, what else would help you stay mentally well?

**Groups identified as most in need of support**

- Teenagers and Young People, especially females.
- People living in the most rural areas
- Individuals living with more than one factor affecting them eg mental health issues and substance misuse.
- People who are more socioeconomically deprived

**More work is need to better understand**

- Men's Mental Health
- The needs of people who identify with a gender other than male or female
- Young people and the challenges they are facing
- Our relationships with food
- Our relationships with social media
- Other cross-over areas with mental health

**The recommended outcomes from the project were:**

- Develop an outcomes based strategy
- Identify personnel and resource to complete procedure and manage upkeep and development of dataset and dashboard.
- Identify and agree personnel/resource to build on coproduction approach
- Identify and establish leadership and governance
- Identify and agree funding and personnel to coordinate programme of work and support ongoing strategy activity.
- Identify and agree personnel/resource to progress areas for further enquiry.

## Deskercise

Often office-based staff struggle to stay active throughout the workday. To help address this, the Health Improvement team created **Deskercise** - a fun and simple 5–10 minute routine designed to get people moving using everyday office items. Deskercise was first developed in 2018 and has since been used by our team as a fun way to move more and sit less through the day. We have promoted the resource during various health campaigns through the years and also had some success with promoting with other teams.

**How it works**

- Download the Deskercise template and exercises suggestions.
- Print off the template and the exercises and cut them up and laminate them
- Pick 5 exercises for your day and stick them onto the template
- Grab a timer or use the timer on your smartphone
- Start exercising to your favourite songs by doing 30 seconds of marching followed by 30 seconds of each exercise
- Do it once through for a 5 minute workout, or twice through for a 10 minute workout.

## NHS Shetland Staff e-Bike Pool

An electric bike, or e-bike for short, is a bicycle with the addition of a motor to assist when cycling. E-bikes help us to get up hills easier, travel about faster and carry heavier loads; all while getting some exercise and having fun.

NHS Shetland has a pool of 12 e-bikes for staff to use for workplace journeys, alongside leisure and commuting for up to 3 days. These are available across different NHS sites including Health Centres and Montfield.

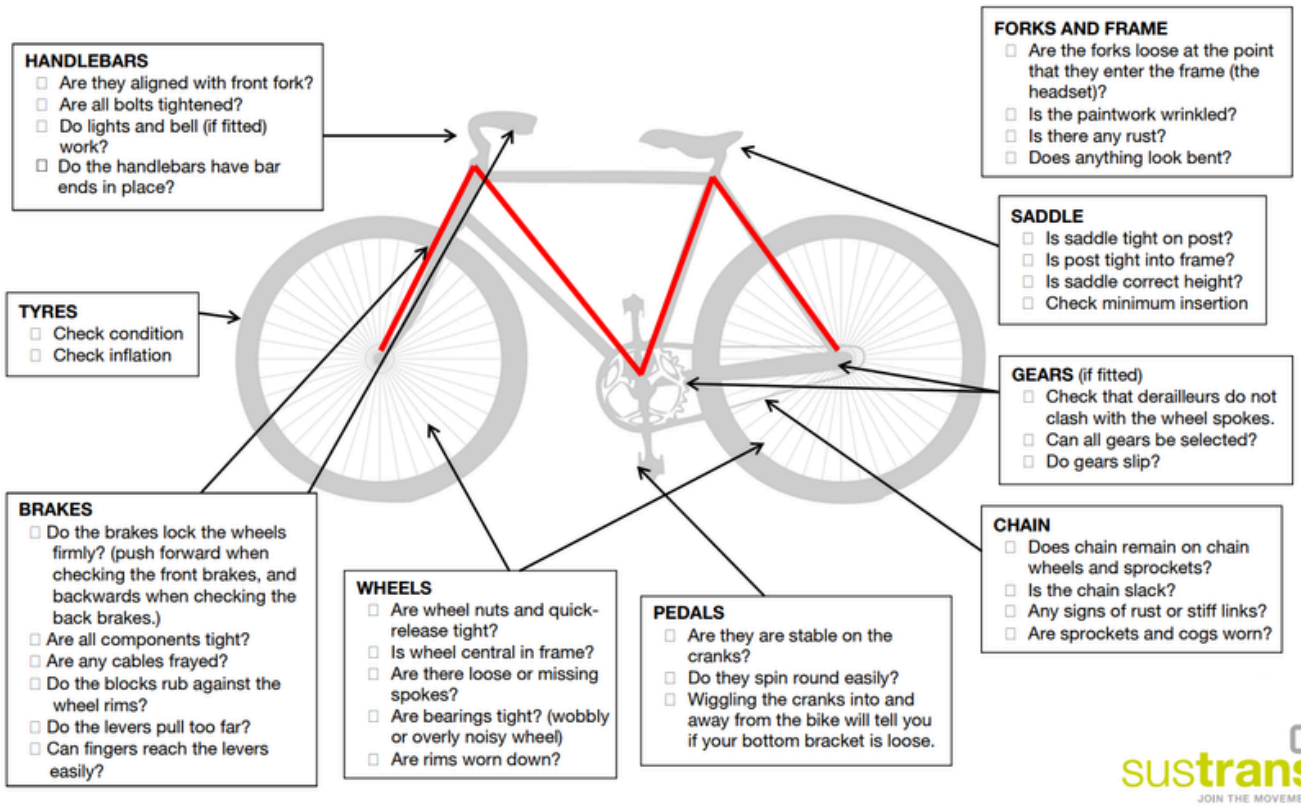
NHS Shetland staff can join the SHET - Active & Sustainable Travel MS Team to access the following documents:

1. Guidance & Safety
2. ABCD Check Postcard
3. eBikes-Getting-Started
4. Essential Cycling Skills


And register as an NHS e-bike user by completing this form.

## The M Check

Follow the strokes of the M to make sure you don't miss anything



# Money worries

## Money Worries Training

Worrying about money can have a big impact on health. With the cost of living rising, many people struggle to make ends meet but often they don't reach out for support for a number of reasons, including the fear of being stigmatised.

**Money Worries** training equips staff with the skills and confidence to raise the issue of money with individuals and give the confidence and knowledge to signpost or refer the individual to services or organisations who can help them maximise their income. By starting a conversation about money and knowing the services that can help, staff can make a huge difference to someone's life.

Previously, Health Improvement co-delivered the training with Citizens Advice Bureau and Anchor Early Action until early 2024. Due to capacity constraints, Citizens Advice Bureau were no longer able to co-deliver the training, but are happy to continue to provide information about their services to participants. Anchor Early Action ceased operation so also were unable to contribute to delivery.

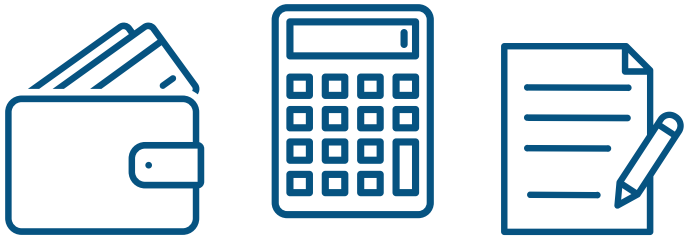
In response, a new approach to the training was taken, with the training content and structure being revised. Health Improvement will now deliver the sessions independently, with guest speakers from partner organisations invited to present and highlight their services.

The **Money Worries** course is short and informal and it's aims are:

- Increase understanding of poverty and its impact
- Increased confidence to ask about money worries
- Increase knowledge of support services for money matters

## Next Steps

The training will be rolled out to staff across NHS Shetland, Shetland Islands Council, local employers, and voluntary organisations in the coming months.



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Published September 2025