DIRECTION FROM THE SHETLAND ISLANDS INTEGRATION JOINT BOARD ("IJB")

ISSUED UNDER SECTION 26(1) OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

<table>
<tr>
<td>Direction:
Community Nursing including Intermediate Care</td>
<td>Direction to:
• Shetland Islands Council (SIC)
• NHS Shetland (NHSS)</td>
<td>Overall Budget allocated by IJB for Direction:
£4,934,400
• Community Nursing £4,229,275
• Intermediate Care £705,125</td>
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<tr>
<td>Reference Number:
1.5

IJB Report(s) Reference Number:
CC-10-26</td>
<td>Relevant Function(s):
Community Nursing Services
• District/Community Nursing
• General Practice Nursing/CTAC services
• Advanced Practice: Primary Care/OOH/Outreach/Custody Healthcare
• Non-doctor Island Nursing/HCSW
• Specialist Nurses/Respiratory
• Intermediate Care Team
• H@H/Focus on Frailty</td>
<td>Review Date:
March 2027</td>
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<tr>
<td>Date Direction issued/authorised by IJB:
18 March 2026</td>
<td>Date Direction takes effect:
1 April 2026</td>
<td>Does the Direction supersede, amend or revoke an existing Direction? If yes, include reference number of existing Direction:
Supersedes Direction 1.5 (IJB Report Ref. CC-24-25-F)</td>
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Purpose of Direction

The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting. Community Nursing staff also provide support and teaching for patients, families and carers to enable them to care effectively for their relative, whilst also addressing any care and support needs the individual carer might have themselves.
All of the component services within the Community Nursing service work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.

Advanced Nurse Practitioners supports Primary care, OOH/Custody Healthcare, Outreach Services, Respiratory services and Hospital at Home services (H@H) including new Focus on Frailty MDT expansion.

The Vaccine Transformation Programme and NHS Shetland Travel Health Service is provided by the vaccination team within Public Health, with clinical professional oversight via Chief Nurse Community, while this service does require resource from Community Nursing (DN Teams and GPN Teams) workforce to deliver vaccines, there is management resource consideration in this clinical oversight.

Whilst the District Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16 years and are housebound, all of the services within Community Nursing will endeavour to meet the needs of any individual across the lifespan from birth to death, within the community setting who have a nursing and/or health need.

There is a national move towards more specialist nursing roles and related service redesign across the Health and Social Care System. These changes are related to a recognition of nursing expertise, Shifting the Balance of Care, and a response to recruitment challenges within the medical workforce. To effectively implement these changes means a growth in capacity and expertise of the nursing service, to off-set pressure in other areas by providing services in a more effective sustainable way. The impacts on related services are not fully reflected within this Direction but are an important consideration for decision making.

Accountability and Governance

NHS Shetland is accountable for the delivery of the services within Community Nursing, which have been commissioned by the Integration Joint Board (IJB).

Overarching Directions to Function(s)

- **District Nursing** - community based nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.
- **Practice Nursing** – at all 9 Board provided general practices
- **Advanced Nurse Practitioners** – Advanced Nurse Practitioner posts based in Primary Care/OOH/Custody Healthcare/Outreach

- **Non-Doctor Island Nursing** – nurses resident on the small outer islands of Fair Isle and Foula (Foula post currently vacant)
- **Non-Doctor Island Healthcare Support Worker model** – HCSW support for health needs and care provision with Fetlar, Skerries and Bressay
- **Intermediate Care Team** – multi-disciplinary, partnership team focussed on provision of re-ablement programmes, additional support to increase independence on discharge home from hospital and provision of additional support at home to prevent unnecessary admission to hospital or care home.
- **CTAC services**:
- **Hospital @ Home with MDT recent expansion** to Focus on Frailty – delivering hospital level care to patients in their own home or care home. To support MDT frailty work

Note: Continence services are now delivered from within the District Nursing team

Relevant Links

- HSCP Joint Strategic Plan

Directions	**Outcomes and key actions**	**Performance Monitoring and Indicators**	**Challenges & Opportunities – inc. Risks and Finance**
Provide high quality care and support for all adults within the community who have a nursing or re-enablement need	People are seen by the most appropriate person, at the right time, as close to home as possible in a way that meets their needs and supports them to remain independent. • Complete evaluation of ANP OOHs cover • Develop working model for DN role in Care Home health provision • Embed District Nursing model - shift cover till 5pm and on call thereafter, supporting development DNs	Reported in Annual Report from Core Suite (Shetland/Scotland): NI-1 Percentage of adults able to look after their health very well or quite well NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible NI-4 Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated. NI-14 Emergency readmissions to hospital within	Recruitment Finance Workforce capacity for improvement work Supports shifting balance of care

		28 days of discharge (rate per 1,000 discharges) RAG status of patients seen to better understand locality needs, patterns and use of capacity to support future planning of service models	
Plan, develop and implement the nursing contribution of the Primary Care Improvement Plan, particularly in relation to: • Continuation of Community Treatment and Care centres (CTAC) • Urgent Care services. OOH models of care, Hospital @ Home plus Focus on Frailty expansion Working collaboratively with both community and acute services to ensure appropriate skill mix, and sustainability of services.	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way. • CTAC services available To provide services within and out with registered GP Practice • H@H/Focus on Frailty - to deliver hospital level care in peoples homes/care home. • Focus on Frailty – MDT approach to patients reaching crisis, presenting to A&E (frailty at the front door) or for emergency respite. To support admission avoidance and reduce length of stay in hospital or care respite care to support	KPI – Percentage of Band 6 & Band 7 Community Nursing staff who possess a Specialist Practitioner Qualification, Advanced Clinical Assessment skills and a Non-Medical Prescribing Qualification KPI – Number of Band 5 staff to commence Graduate Diploma in Integrated Community Nursing KPI – 30 day outcome data (from discharge) KPI - Length of stay within H@H Service KPI – Number of saved bed days CTAC Long term condition monitoring data collection through SHIP	Creating a workforce for the future Career progression Development/education/training CTAC funding is now Recurring funding H@H/Focus on frailty remains fixed term funded Staffing on secondment for over 18months due to no substantive funding stream.

	people to be cared for in their own homes.		
Implementation of the Transforming Nursing roles agenda to ensure that the nursing workforce within community settings can deliver on the service developments as outlined in the new GP contract.	Nursing and HCSW staff have enhanced skills and roles supporting the delivery of care by right practitioner, right place, right time for the local population thus improving continuity and timeliness of care to all Shetland residents. Nursing staff play a key role within multidisciplinary teams (MDTs) within General Practice. Recruitment and Retention of Nursing and HCSW staff is improved as they are supported to develop into new roles and access appropriate training. Roll out of HCSW training/competencies to extend further ie medication administration via injection To introduce band 4 practitioners within community settings (GP practice/DN Teams)	To date we have 6 HCSW across the service has completed the relevant training and competency sign off to administer B12 IM 12 weekly injection. This has now been extended to include administration outwith 12 week administration (excludes loading doses) Audits undertaken and will continue to be carried out during roll out.	Provides opportunity for development/skill mix within teams
Develop new service models which are sustainable, affordable, and clinically appropriate which meet the health and care needs of Shetland residents both now and for the future.	Objective – Create sustainable, affordable, and clinically appropriate service models to support the community to have improved health and wellbeing, lead healthy, active lives that	KPI – Stability of health care cover in Non-Doctor Islands (NDIs)	Increased stability and resilience in system cost reduction over last 3 years of OOH blended ANP/GP

	maintain independence and allow people to contribute to society in a positive way. OOH/Custody GP/ANP model now BAU, increasing ANP capacity within that by end of 2026 to ensure sustainable workforce Introduction of Nurse Consultant: Respiratory to provide Clinical services across Shetland. ANP Lead providing leadership within H@H service	KPI – OOHs ANP (Out of Hours Advanced Nurse Practitioner) model – cost/benefit analysis/evaluation of trial	service redesign (approximately £250,000) Recruitment challenges Financial restraints to allow for service redesign, fixed term and uncertainty around funding allocations ie H@H, Urgent Unscheduled Care/Frailty Continuing to grow our own Nursing workforce including DNs and ANPs. Opportunities for Career progression within our Nursing workforce
Implement a consistent and robust framework for measuring, assuring and reporting on the quality of nursing practice in place within Community services utilising the Excellence in Care Framework and other key quality measures.	Evidence the delivery of high quality, timely and appropriate care and support to Shetland residents from the component parts of the Community Nursing service. • Exploring new ways of working to support people who find it hard to access services for a variety of reasons, ie Outreach ANP	KPI – percentage of District Nursing records for palliative patients with patient's preferred place of death documented in the nursing care plan KPI – Percentage of District Nursing records which evidence that the patient's preferred place of death was met KPI - Percentage of Catheter Associated Infections identified in individuals with an indwelling urinary catheter in the community	Provides reassurance around our data monitoring, but also highlights and allows for improvements where indicated. Workforce capacity for improvement work Education/Training and development within Teams around Palliative care/Digital Respect/Respiratory EOL

	Evaluation of input to inform service development across HSCP	Review of frailty scoring links with ACPs, and Respiratory end of life care – linking with local MCNs for system approach	