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

ISSUED UNDER SECTION 26(1) OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT2014

<table>
<tr><td>Direction: Community Nursing including Intermediate Care</td><td>Direction to: SIC and NHSS</td><td>Overall Budget allocated by IJB for Direction:
CN £3,239,382
ICT £478,296</td></tr>
<tr><td>Reference Number:
1.5</td><td rowspan="2">Relevant Function(s):
Community Nursing Services
• District Nursing
• General Practice Nursing
• Advanced Practice
• Non-doctor Island Nursing
• Specialist Nurses
• Intermediate Care Team</td><td rowspan="2">Review Date:

March 2024</td></tr>
<tr><td>IJB Report(s) Reference Number:

CC-23-23</td></tr>
<tr><td>Date Direction issued/authorised by IJB:
May 2023</td><td>Date Direction takes effect:
1 April 2023</td><td>Does the Direction supersede, amend or revoke an existing Direction? If yes, include reference number of existing Direction: Supersedes CC-07-22-F</td></tr>
<tr><td colspan="3">Purpose of Direction</td></tr>
<tr><td colspan="3">The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting.
These services include:

• 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 8 Board provided general practices;
• Advanced Nurse Practitioners – Advanced Nurse Practitioner posts based in Primary Care;</td></tr>
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- **Specialist Nurse - Continence Nurse Advisor** – Shetland wide service to support patients, care and nursing staff;
- **Non-Doctor Island Nursing** – nurses resident on the small outer islands of Fair Isle, Fetlar and Foula;
- **Non-Doctor Island Healthcare Support Worker model** – HCSW support for health needs and care provision with Skerries
- **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.

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 does not demand CN resource to deliver, 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.

Community Nursing staff also provide support and teaching to informal or family 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.

- 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)	
Directions:	**Performance / Objective(s):**
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. 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 (93%/90.9%) NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible (89.8%/78.8%) NI-4 Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated (69.8%/66.4%) NI-14 Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) (72/110) Under development - compilation of local data on 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: • Development of Community Treatment and Care centres (CTAC) • Urgent Care services Working collaboratively with both community and acute services to ensure appropriate skillmix, and sustainability of services.	Objective - 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 within each locality.
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.	Objectives – 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. Monitoring: 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 (thus supporting independent practice) KPI – Number of Band 5 staff to commence Graduate Diploma in Integrated Community Nursing (new programme of education)

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 maintain independence and allow people to contribute to society in a positive way. KPI – Stability of health care cover in Non-Doctor Islands (NDIs) KPI – **Under development** - OOHs ANP (Out of Hours Advanced Nurse Practitioner) model – cost/benefit analysis/evaluation of trial
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.	Objective - Evidence the delivery of high quality, timely and appropriate care and support to Shetland residents from the component parts of the Community Nursing service. 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. Under Development in 23/24 – review of frailty scoring links with ACPs, and Respiratory end of life care – linking with local MCNs for system approach.

Improvement Plan

Strategic Priorities 2022-25, and associated heading used in table:

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

Expected Outcomes	**Key Actions/ Milestones (inc dates)**	**Target (inc. dates)**	**Risks (detail in risk table below)**	**Savings/ funding (amount and source)**	**Ref. and linked priorities**
We have a skilled and appropriate **workforce** to provide high quality health care in communities, allowing for the increased demand that will arise due to demographics and StBoC	Continue to increase ANP/DN workforce. Continue to test and evaluate new models of provision for feasibility, including: • ANP OOHs cover • Network Enabled Care • NDI alternative models • DN role in urgent care pathway • DN role in Care Home health provision	Complete evaluation of ANP OOHs cover **Q1 23/24** Develop working model for DN role in Care Home health provision **Q3 23/24**	Recruitment (1) Finance (2)	**Cost/benefit analysis will form part of OOHs evaluation** **Plan for similar re: DN input where it displaces requirement for GP** £60,000 savings associated with Network Enabled Care – note plan represents shift	CN-2324-1 StBoC Best Value

Expected Outcomes	Key Actions/ Milestones (inc dates)	Target (inc. dates)	Risks (detail in risk table below)	Savings/ funding (amount and source)	Ref. and linked priorities
				in skill mix which will include increased nursing provision, and these savings will be experienced in Primary Care budget.	
Individuals with **complex care** needs are cared for either at home or in a community setting	Embed District Nursing model - shift cover till 9:30, on call thereafter, supporting development DNs into this role (see above). Build on existing connections with Care services to allow anticipation and effective response to changes in need. Build dataset to understand locality need and appropriate flexible staffing models to meet surge requirements.	Decreased residential care admissions Maintain low 28-day re-admission rates (NI-14) **Quarterly** Dataset available to support systematic staffing decisions **Q2 23/24**	Recruitment (1) Finance (2) Workforce capacity for improvement work (6)		CN-2324-2 StBoC Early Intervention Best Value

Expected Outcomes	Key Actions/ Milestones (inc dates)	Target (inc. dates)	Risks (detail in risk table below)	Savings/ funding (amount and source)	Ref. and linked priorities
We have high quality, sustainable, well-supported **Out of Hours and Urgent Care** Services	Evaluate pilot/trial of ANP cover for GP OOHs (2x ANP cover 1-2/7 nights in place of GP, Oct-Jan) Explore feasibility of scaling up re: finance, workforce, training skills and confidence, and system wide impact Continue to build skilled ANP/DN workforce to support future model Urgent care/OOH service redesign, potential to be blended model with ANP input under Primary Care leadership, work across HSCP and Acute.	Complete evaluation of ANP OOHs cover **Q1 23/24** Develop feasible service models as input into Urgent Care redesign work. **Ongoing**	Recruitment (1) System/professional acceptance of change (3) Community/Patient acceptance of change (4) Workforce capacity for improvement work (6)	Proposed £50k saving from existing GP Out of Hours Model – note that some redistribution of funding will be needed for new services to be viable.	CN-2324-3 Best Value StBoC
Communities are more resilient and have **access** to sustainable, appropriate services to support their health and care needs, irrespective of their home location.	Embed HCSW model in Out Skerries. Including relief cover (under development/recruitment). Network Enabled Care project development (HSCP wide) Bressay community hub links effective use of resource for preventative support.	Skerries Case Study **Q1 23/24** Continue conversation with Bressay community and HSCP around use of community hub. **Q2 23/24**	System/professional acceptance of change (3) Digital access /infrastructure/ inequalities (5)	Investment funding may be required to support remodelling of services where additional Nursing input required.	CN-2324-4 StBoC, Tackling Ineq. Engagement Network Enabled Care

Expected Outcomes	Key Actions/ Milestones (inc dates)	Target (inc. dates)	Risks (detail in risk table below)	Savings/ funding (amount and source)	Ref. and linked priorities
Nursing led **service redesign** in line with Primary Care Improvement Plan, achieving: Improved patient access, enhanced patient choice, increased flexibility, sharing of workload across practices, patients able to access services closer to work/home.	Improve access to Community Treatment Assessment Centre (CTAC) Redesign of respiratory pathway as a Shetland wide service. Long term condition management with House of care model has been tested and is now for rollout to other areas. Skill mix/MDT within General Practice – continue to build ANP workforce, and explore expansion/formalisation of single-handed ANP with remote support cover to respond to vacancy pressure and staffing gaps.	CTAC pathway in place for people in Shetland-based Consultant led services Respiratory Pathway working team established Q1 23/24 Contribute to Network Enabled Care Workforce Plan Q1 23/24	Recruitment (1) System/professional acceptance of change (3) Community/Patient acceptance of change (4) Finance (2) Workforce Capacity (6)	Cost/benefit analysis of ANP cover tbc	CN-2324-5 StBoC Tackling Ineq. Best Value Engagement Network Enabled Care Primary Care Improvement Plan
Support Implementation of **Healthcare Framework for adults and older people living in care homes**: Teams across health and social care work together to provide consistently high	Local self-assessment against recommendations in framework under following 6 elements: • Nurturing Environment • Multi-disciplinary Team • Prevention (includes Infection Prevention and	Await metric aligned to framework – complete local review in collaboration with Residential teams to understand any changes required. 23/24	Finance (2) Workforce capacity for improvement work (6)	Within existing resource	CN-2324-6 Tackling Inequalities StBoC Early Intervention/ Prevention

Expected Outcomes	Key Actions/ Milestones (inc dates)	Target (inc. dates)	Risks (detail in risk table below)	Savings/ funding (amount and source)	Ref. and linked priorities
quality personalised care that meets the increasing complexity of needs of residents of care homes, focusing on increasing the preventative and anticipatory approach to care.	Control) • Anticipatory Care, Self Management & Early Intervention • Urgent & Emergency Care • Palliative and End of Life Care Production of HSCP improvement plan to support robust implementation of framework				
People in custody have access to appropriate health care – part of urgent care pathway.	Explore how custody healthcare fits within Urgent Care Pathway for sustainable, equitable service. (Currently provided by 1 substantive GP and ANPs and locum GPs, with gaps in cover due to capacity, training – model is not sustainable)	Clear custody health care pathway with sustainable cover. End 23/24	Finance (2) Workforce Capacity (6)	Custody Healthcare resource sits within Primary Care – to be included in discussion of pathway	CN-2324-7 Tackling Inequalities Best Value

Expected Outcomes	Key Actions/ Milestones (inc dates)	Target (inc. dates)	Risks (detail in risk table below)	Savings/ funding (amount and source)	Ref. and linked priorities
Improving access to sexual health services	Providing support to Primary Care workforce to understand barriers to providing appropriate, adequate sexual health services within the community. Support provided via advice and clinical input from specialist ANP, with view to developing robust, autonomous Primary Care pathways.	Access to sexual health services in the community as per national standards. End 23/24	System/professional acceptance of change (3) Workforce capacity for improvement work (6)	Within existing ANP resource – see Hospital Based Service for understanding of cost pressure on sexual health services.	CN-2324-8 Prevention/Early Intervention Tackling Inequalities StBoC
Improving access to healthcare services for people who experience inequalities – supporting access and implementing effective pathways – particularly links with Substance Use, Sexual Health and Mental Health initially	Targeting of existing ANP establishment to support improved access. Building links with third sector, education and wider system. Exploring new ways of working to support people who find it hard to access services for a variety of reasons. Evaluation of input to inform service development across HSCP.	Quality of service provided –report via case study. Q2 23/24 Evaluation plus recommendations for improvement end 23/24	Workforce capacity for improvement work (6)	Within existing ANP establishment	CN-2324-9 Prevention/Early Intervention Tackling Inequalities Engagement

Risks Against Improvement Plan

#	**Risk**	**Consequences**	**Control Measures**
1	Recruitment – national shortage of appropriately trained nursing staff, further risk of pressurising other areas of system by drawing on limited pool of nurses.	Difficulty staffing new or proposed models, project failure, costly locum/agency cover or service gaps leading to poorer access and outcomes for patients. System pressure continues due to staff being recruited from within system.	Maintain relationships with HE and positive recruitment practices to attract new graduates. Continue to develop “Grow-your-own” and training models to offer more attractive posts and prospects, and increase retention. Work with HR/finance/workforce development re: including training and development costs, allowances and time into posts. Actively manage risks through Health and Social Care Integrated Workforce Planning and implementation processes.
2	Finance	Unable to scale up viable models, continue with current models that result in unplanned locum spend. Impact of service improvement is seen as decreased pressure in other areas, savings/decreased cost not realised within service/Directorate.	Evaluation of change to include cost/benefit analysis of work. Prioritisation of work to illustrate what can be done within budget and what requires extra support. Work with finance, planning and Executive Managers to clarify how to shift resource where appropriate.

3	System/professional acceptance of change	Poor uptake of different service models. Lack of engagement with change process, benefits not realised.	Design and develop with teams, clinical and/or management as appropriate. Where developing skills, services and pathways embed resource within team during development where possible (e.g. Sexual Health in Primary Care). Alignment of change to strategic priorities and link improvement work across services via executive managers and programmes of work. Staff engagement through regular team meetings, involvement in change, and individual level supervision and appraisal process to understand development needs and aspirations linked to organisational priorities.
4	Community/Patient acceptance of change	Poor uptake of new services, failure to meet patient expectations, reputational risk. Poorer patient outcomes due to not accessing services.	Improve community communication, continue involvement in discussions and service development, including feedback of change.
5	Digital access /infrastructure/ inequalities	Inability to deliver sustainable, reliable remote services. Widen inequalities by change mode of access.	Work with Exec Management, and Shetland Partnership around community Resilience. Continue to offer options and understand/respond to any gaps in access.
6	Workforce capacity for improvement work	Inability to meet need due to service design and increasing demand. Poorer outcomes for patients due to need for service prioritization. Cost pressures due to delivery of inefficient or unsustainable services (NOTE these cost pressures/overspend may be realised elsewhere)	Make best use of external resource wherever available to support evaluation, data gathering etc. Clear boundaries around cover provision for other services and impacts this has on service development. Continue to develop skill mix to protect development/strategic planning time as far as possible.