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: Primary Care</td><td>Direction to: NHSS</td><td>Overall Budget allocated by IJB for Direction:
£ 5,769,527</td></tr>
<tr><td>Reference Number:
1.11</td><td rowspan="2">Relevant Function(s):
Primary Care</td><td rowspan="2">Review Date:

March 2024</td></tr>
<tr><td>IJB Report(s) Reference Number:
CC-30-23</td></tr>
<tr><td>Date Direction issued/authorised by IJB:
29 June 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 DIR002.11/09.03.22/CC-07-22-F</td></tr>
<tr><td colspan="3">Purpose of Direction</td></tr>
<tr><td colspan="3">Provision of the Primary Care Service which currently comprises the following:

• 10 Health Centres in Shetland providing GP services together with 5 non-doctor islands which are staffed by community nurses and receive GP services from a local health centre.
  ○ Of the 10 GP practices 8 are currently salaried to NHS Shetland (all staff are employed by NHS Shetland). The other two are independent practices which means they contract with NHS Shetland to provide core GP services funded through a national contract.
• Provide Ophthalmic Services with two providers based in Lerwick.
• To ensure support, training and governance in medicine use and administration in community care settings.
• To support a multidisciplinary approach within GP Practices providing pharmaceutical input.</td></tr>
<tr><td colspan="3">Accountability and Governance</td></tr>
<tr><td colspan="3">NHS Shetland is accountable for the delivery of the primary care services commissioned by the IJB</td></tr>
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Overarching Directions to Function(s)	
Directions:	**Performance / Objective(s):**
Provide Primary Care services across the life course for the population of Shetland. Develop appropriate models of care for Shetland to suit the local context, within funding available. Stabilise and enhance the Primary Care Workforce. Embed efficient and effective ways of working. Collaborate effectively with other partners across the Health and Social Care system. Much of this work is embedded within the Network Enabled Care workstream in the Shifting the Balance of Care programme.	Scottish Government long term outcomes for Primary care: • we are more informed and empowered when using primary care • our primary care services better contribute to improving population health • our experience of primary care is enhanced • our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care • our primary care infrastructure – physical and digital – is improved • primary care better addresses health inequalities

Locally the short to medium term outcomes we hope to achieve are:
 	
• Fewer people requiring primary care services as they are supported to self-manage and access other appropriate services within their communities and online
• When they do require services, they are supported and enabled to understand the different services, and ways of accessing them, and are able to see the right person, at the right time, in the right place
• We will aim to provide planned continuity of care for long term conditions; there will be a variety of different ways of accessing unplanned care.
• People are able to access a wide range of preventative support, within their communities, including social prescribing; support will be available remotely as well as in person.
	Primary Care teams support people to have improved health and wellbeing, and contribute to a number of outcomes measured locally and nationally and used by the HSCP to plan improvements. Some ways we monitor our services include:
	
	• Patient experience, Health and Care Experience survey, gathered nationally, covering:
	  ○ The GP Practice
	  ○ Treatment of advice from the GP Practice
	  ○ Out of Hours healthcare
	  ○ Care, support and help with everyday living
	  ○ Caring responsibilities

• We will have multi-disciplinary teams in place, including strong links into third and voluntary sector.
• People with complex needs are supported to live well, for as long as possible
• We have reviewed our physical resources (estate?) to ensure that it is fit for purpose
• We will have IT systems that support integrated, flexible and adaptive patient-led models
• We will have incorporated Realistic Medicine and Care principles into our service, reducing unnecessary or ineffective treatment, and working collaboratively with service users, enabling them to become the experts on their own health and wellbeing.
• We will value our staff and their health and wellbeing, and support training and growth.
• We will have highly trained staff, able to meet the needs of an elderly population.
• People will be supported to die well, at home or in a homely setting.
	• Core suite of Integration Indicators (those not informed by Health and Care Experience survey above)
	  ○ NI-11 Premature mortality rate
	  ○ NI-12 Emergency admission rate
	  ○ NI-14 Emergency readmissions to hospital within 28 days of discharge
	  ○ NI-15 Proportion of last 6 months of life spent at home or in a community setting
	Note these are not a direct measure of Primary Care services, but are an indicator of how well the health and care system is working together to meet the needs of the population
	
	IN DEVELOPMENT – note the Primary Care and Information teams are working together to develop a meaningful and collectable dataset to measure, understand and inform improvement around Primary Care activity

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**
People have access to the **right care**, from the **right person** in the **right place**, at the **right time.**					
Access to the right care to support their health and wellbeing, including a shift towards prevention and early intervention.	Roll out of House of Care programme for people with Long Term Conditions. Currently embedded in Scalloway and underway in Lerwick and Levenwick GP Practices.	All GP practices have completed training in House of Care by end May 2023 House of Care running in all areas by end 23/24	Finance (2) Workforce capacity for improvement work (6) Unable to deliver programme (7)		PC-2324-1 StBoC Best Value Prevention/Early Intervention Tackling Inequalities Engagement
	Contribute to Urgent and Unscheduled Care programme to support scoping of viable local delivery models that will enhance equity of service across Shetland. This includes Custody Healthcare.	Develop feasible service models as input into Urgent Care redesign work.	System/professional acceptance of change (3) Finance (2) Workforce capacity for improvement work (6)		PC-2324-2 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
		Ongoing			
	Review current access patterns and need by locality, to be included as part of Joint Strategic Needs Assessment led by Public Health to help inform future service planning and delivery.	Contribute to JSNA by PH by end 23/24	Workforce capacity for improvement work (6)		PC-2324-3 Tackling Inequalities Best Value
	Improve access to Sexual Health services in Shetland – see Community Nursing Direction for detail of collaborative work between Primary Care and ANP wsi Public Health. **Note this is one part of this workstream – see Hospital Based Services Direction and Public Health Sexual Health Strategy**	Support work of ANP wsi PH aiming to improve access to sexual health services against national standards. End 23/24	System/professional acceptance of change (3) Workforce capacity for improvement work (6)		PC-2324-4 Tackling Inequalities Best Value Prevention/Early Intervention
	Supporting access: share learning from Health Improvement/Scottish Government collaborative projects around access to Primary Care for people using BSL, communication support for services supporting people with Learning Disabilities.	Share learning and practices to plan improvement as required when complete. 23/24	System/professional acceptance of change (3) Workforce capacity for improvement work (6)		PC-2324-5 Tackling Inequalities

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
	Implementation of Learning Disability Health Checks locally. • Form working group to support implementation • Collate data to understand demand/requirements – cross checking health and care services data for true picture (including appropriate data sharing assurance) • Explore feasible models for delivery, including Nurse-led • Understand wider requirements, including environment, to make service accessible to people with LD	Data gathering end Q2 23/24 Implementation at scale allowed by staffing and capacity, with clear understanding of requirement for full effective programme 23/24	System/professional acceptance of change (3) Finance (2) Workforce capacity for improvement work (6) Unable to deliver service (7)		PC-2324-6 Tackling Inequalities Prevention/Early Intervention Engagement
	Support Shetland population to use breadth of services available appropriately, including digital support, NHS Inform and other community services, e.g. Pharmacy First	Support development and delivery of local comms strategy Q2 23/24	Workforce capacity for improvement work (6) Community/Patient acceptance of change (4)		PC-2324-7 StBoC Best Value Engagement
People are able to access the right person to support their needs	Review needs as above to inform Workforce Plan for Network Enabled Care.	Network Enabled Care workforce Plan end 23/24	Workforce capacity for improvement work (6)		PC-2324-8 StBoC Best Value 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
					Tackling Inequalities
	Improve sustainability of GP services to support continuity of care. Including through use of GP Joy, exploring alternative contracting arrangements, and effective Network Enabled Care.	Decreased locum use in 23/24	Recruitment (1) Finance (2) Workforce capacity for improvement work (6)		PC-2324-9 Best Value
	Continue to increase ANP and other nursing input within GP practices, redistributing roles and responsibilities appropriately for best use of resource.	Continue tests of change in line with Network Enabled Care, ongoing 23/24	Recruitment (1) System/professional acceptance of change (3)		PC-2324-10 StBoC Best Value
	Embed First Contact Practitioner (FCP) Physiotherapy model across current GP Practices –Lerwick, Brae, Levenwick and Scalloway. Complete evaluation of FCP service to understand impact on wider Physiotherapy and Primary Care activity (this is a Physiotherapy led piece of work)	Completion of evaluation 23/24	Workforce Capacity (6)	Shifting finance hospital – community with shift in patients	PC-2324-11 StBoC Best Value
	Work with Community Mental Health Team to scope and understand best options for MH support embedded in Primary Care – including digital,	Mental Health support embedded in workforce plan	Recruitment (1) Finance (2) Workforce capacity for improvement work (6)		PC-2324-12 StBoC

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
	third sector, and face-to-face support.	for Network Enabled Care, informed by Primary Care consultation data End 23/24			Tackling Inequalities
	Complete Community Link Worker pilot project in collaboration with Health Improvement.	Project evaluation by end 23/24	Workforce capacity for improvement work (6)		PC-2324-13 StBoC Best Value Engagement Tackling Inequalities
People are able to access support in the place that work best for them in a timely way	Network Enabled Care - improved patient access, enhanced patient choice, increased flexibility, sharing of workload across practices, patients able to access services closer to work/home.	Framework for delivery of NEC across Shetland developed Q1 23/24 Action plan for Phase 1 NEC in progress, to be completed by end 23/24	System/professional acceptance of change (3) Workforce capacity for improvement work (6) Community/Patient acceptance of change (4)		PC-2324-14 StBoC Tackling Ineq. Best Value 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
	Continue to improve appropriate access to remote support through digitally enhanced services, including Near Me/Attend Anywhere, DACS.	Input into local digital strategy 23/24	Digital access /infrastructure/ inequalities (5) Finance (2) Workforce capacity for improvement work (6) Community/Patient acceptance of change (4) National decision making and funding source for procured systems (8)		PC-2324-15 StBoC Tackling Ineq. Best Value

Improvement Plan Risk Register

#	Risk	Consequences	Control Measures
1	Recruitment – national shortage of appropriately trained staff, particularly GPs (Limitations of options e.g. GP Joy)	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.	Continue to work with support programmes, e.g. GP Joy. Develop sustainable service models with urgency to improve retention and protect staff. Clear communication with population to protect teams where expectations cannot be met. Work with HR/finance/workforce development re: including training and development costs, allowances and time into posts Risks are actively managed through input into Health and Social Care Workforce Plan.
2	Finance	Unable to scale up viable models, continue with current models that result in unplanned	Evaluation of change to include cost/benefit analysis of work.

		locum spend. Impact of service improvement is seen as decreased pressure in other areas, savings/decreased cost not realised within service/Directorate.	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 (often linked to 6 and inability to protect time to engage)	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 (including staff digital skills)	Limited uptake of digital options, risk of inequalities if services become “digital first”/”digital preferred”, unable to use digital systems safely and effectively, time lost of risk of poorer patient outcomes.	Input into Digital Strategy when opportunity arises. Continue to offer services in a variety of ways to support patients to access what they need. Awareness of and signposting to local income maximisation services who will support re: finance and digital inclusion (including CAB and Library)

			Continue offer support to use digital technology within Health Centres where facilities allow.
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.
7	Unable to deliver service/programme (health checks for people with LD)	People with LD experience growing health inequalities, increased spend of time and resource on treating later ill health. Poorer health, wellbeing and social outcomes for people with LD and their carers.	Use local LD Nurse Consultant expertise to improve delivery of base level services. Continue to engage in learning and support for communication (see HI projects) for people with LD. HSCP continue to improve wider support for people with LD, and look to develop/enhance LD Nursing service to support improvement.
	Unable to deliver service/programme (House of Care)	Training takes place but GP practice unable to implement programme due to capacity limitations. People with LTC do not experience systematic, planned follow up, increased incidence of complications and co-morbidity, poorer health outcomes. We do not shift to prevention/early intervention as a system, and continue costly reactive, treatment models of care.	Share learning from embedded models (Scalloway) particularly around Admin and HCSW staffing requirements. Work to understand impact of change in approach to inform potential shift in budget or finance. Prioritise implementation as far as possible to those with greatest capacity to benefit.
8	National decision making and funding source for procured systems (particularly DACS, of which AskMyGP is an example)	Pursue local option which is more costly on smaller scale, risk not being able to benefit from or link with national system in future. Await national reporting and decision and hold gap in provision in meantime. No available funding to pursue larger scale rollout funded locally.	Continue to pursue national solution for Best Value answer to service provision. Continue to understand local implementation and use DACS appropriately where possible. Cost alternatives for informed options appraisal should funding become available.

		Patients in Shetland have inequality of digital access to healthcare due to limitations in funding.	