NHS SHETLAND: 2022/23 ANNUAL DELIVERY PLAN

This 2022/23 Annual Delivery Plan narrative provides an overview of actions to deliver the following priorities, as defined by the Scottish Government:

- Staff wellbeing;
- Recruitment and retention of our health and social care workforce;
- Recovery and protection of planned care;
- Urgent and unscheduled care;
- Supporting and improving social care;
- Sustainability and value.

This delivery plan is underpinned by the following NHS Shetland Board objectives, the Clinical and Care Strategy ambitions and the Health and Care Partnership strategic aims:

NHS Shetland Board Objectives

- To continue to improve and protect the health of the people of Shetland
- To provide quality, effective, and safe services, delivered in the most appropriate setting for the patient
- To redesign services where appropriate, in partnership, to ensure a modern sustainable local health service
- To provide best value for resources and deliver financial balance
- To ensure sufficient organisational capacity and resilience

NHS Shetland Clinical and Care Strategy aims

- Integration of services around the needs of local communities
- Making sure the care provided in our NHS is the right care for an individual, that it works, and that it is sustainable
- Making best use of innovative technologies to improve access, promote person-centred care and reduce inefficiencies

Shetland Health and Care Partnership Strategic Commissioning Plan (March 2022).

The vision of this plan is that that by 2025 everyone will be supported in their community to live longer, healthier lives and we will have reduced health inequalities.

- To prevent poor health and wellbeing and intervene at an early stage to prevent worsening outcomes
- To reduce the avoidable and unfair differences in health and wellbeing across social groups and between different population groups
- To demonstrate best value in the services that we provide and the ways in which we work

- To shift the balance of care towards people being supported within and by their communities
- To meaningfully involve communities in how we design and develop service and to be accountable to their feedback.

Overview

Shetland faces the same challenges as elsewhere is Scotland, including:

- Demographic changes - increasing numbers of elderly people with increasingly complex conditions and a decreasing working age population
- Increasing numbers of clients in Adult Services with increasing length of time over their life course
- Increased people with complex life and social issues which can lead to crisis management
- Increasing frailty
- People in Shetland do not want to live in institutional settings; they want to remain in their communities surrounded by people who know them best.
- Recruitment and retention issues
- Funding from all sources likely to decrease in next 5 years
- Strategic driver to Shift the Balance of Care

However, there are also some unique challenges faced by NHS Shetland, which are different to mainland Boards. For example:

- We have to be able to provide immediate and ongoing care – including life or limb treatment/surgery
- 197 major cases treated by the local General Surgeons on average each year – 50% are emergency cases
- We must be able to stabilise critically ill patients – our experience during the pandemic was that patients required stabilisation for 24 hours+ before transfer (level 3 care)
- On-site diagnostic testing is essential - Labs, Echo, Medical Imaging in being able to offer level 2-3 care in Shetland
- The cost of the care model in Shetland per head of the population is significantly higher than elsewhere in Scotland

The request from government is to recover from COVID and renew; the ongoing impact of the pandemic means that we are also being asked to stabilize and begin to implement improvement actions to make sure that we are able to cope with future waves of COVID and anticipated winter pressures. While doing this, we cannot lose sight of the fact that the only

way we can build a sustainable health and care system for the future is by reducing or eliminating those conditions which we know it is possible to prevent, and by tackling the circumstances which cause poor health and increase vulnerability. The Board and Health and Social Care Partnership will continue to prioritise preventative work, with their community planning partners, to reduce the burden of preventable poor health in Shetland. We have already seen increased demand for mental health services, cardiac and diabetic services since COVID; all these conditions are, to varying extents, preventable or responsive to early intervention.

1. Staff wellbeing

As highlighted in the NHS Recovery Plan and Remobilisation Planning guidance, our staff need to be at the heart of plans for recovery and transformation. We recognise how essential it is that staff get the support, rest, and recuperation that they need.

To support this ambition, we have put in place psychological support for staff, established a staff support group, and a phone line that provides Psychological first aid, and onward referral for support if required. Our Confidential Listeners service has been re-established, and we are rolling out Trauma Risk Management training and support for staff. In addition, we have a fund available that staff or staff teams are able to bid from in order to support their wellbeing. We will continue to monitor and evaluate our interventions and be innovative in our approaches to ensure that we are reaching the staff who are in most need.

This work is being developed in conjunction with the Area Partnership Forum, Area Clinical Forum, Employee Director, and our Workforce Wellbeing Champion, and is led and monitored through the Staff Governance Committee of the Board.

2. Recruitment and retention of our health and social care workforce

Inability to attract and retain staffing is one of our biggest risks. Detailed workforce information is provided within the Shetland Health and Social Care Workforce Plan, with some key points noted below:

We plan to look at models that have been successful in other settings to see whether they can be replicated, for example, changes in shift times, skill mix, appropriate task allocation, sharing of generic staff across different settings, sharing of responsibilities, shared leadership opportunities and development of Team Leaders. We will continue to explore alternative staffing models and build on skill mix within practices to work towards 'Right Person, Right Place, Right Time.'

International recruitment has not been hugely successful for Shetland or other remote, rural and island settings. Consideration is being given to development of a regional 'hub' approach to international recruitment, with NHS Grampian leading.

We will work with our community planning partners to tackle shortages in accommodation which are impacting on our ability to recruit staff from south.

3. Recovery and protection of planned care

The concept of 'Right place, right practitioner, right time' is an entire system priority which runs throughout every element of our planning.

Our plans to support the recovery and protection of planned care include:

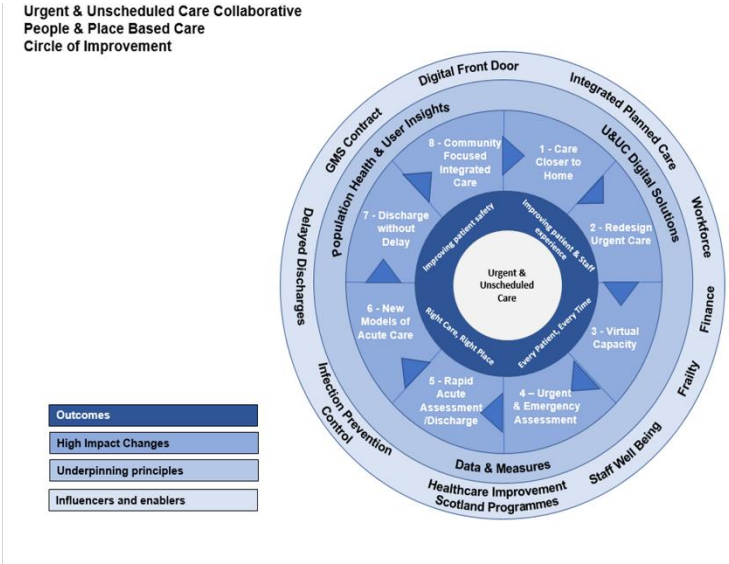
- Providing safe and effective cancer care and pathways for patients
- Maximising capacity for elective care - HEAT Map
- Reviewing cross boundary flow of patients to identify if alternatives to referral to specialist care can be identified. A focus on working regionally and maximising care provided in Shetland
- Providing safe and effective care for children, including CAMHS redesign
- Emphasis on delivering improvements in women's health in line with the national strategy

During 2022-23 we will be:

- Increasing ambulatory care capacity – new Day Case/Elective Ambulatory Care Unit opens in Autumn 2022
- Building new models/team to support CAMHS/Neurodevelopmental pathways
- Investing in diagnostic services – new sonography suite, cardiac CT pathways, DEXA scanner, access to MRI
- Investing in maternity services and women's health, including a new bereavement suite and PMB pathway
- Continue to redesign pathways – maximise opportunities to repatriate services and focus on areas where we can offer telehealth and ambulatory care options
- Accelerating work to develop intra Board services/solutions e.g., diagnostics pathways, national treatment centres (resulting in cost avoidance in patient travel, care closer to home, more resilient models etc)

4. Stabilising and improving urgent and unscheduled care

We know that urgent and unscheduled care services are under significant pressure, nationally, leading to delays for people in seeking access to unplanned care. We have recently undertaken and submitted an urgent and unscheduled care self-assessment in order to provide ourselves with more clarity on the key actions required in this area. This is based on the Circle of Improvement model below:



Multi-disciplinary models for urgent care will be expanded to ensure sustainability. This will include increasing nurse-led triage into Same Day Emergency Care (SDEC) and nurse-led pathways. Work will be undertaken to ensure that people most at need within the community are aware of national urgent care systems (e.g., NHS24) and are able to use them effectively and appropriately. We will also further develop the 'Near Me' (Attend Anywhere) model to improve patient accessibility and experience.

We will enhance the multi-disciplinary team (MDT) to deliver Right Place, Right Time with a focus on building community strengths. We will develop a Frailty MCN (Managed Clinical Network) in order to reduce the numbers of elderly people admitted to hospital due to frailty.

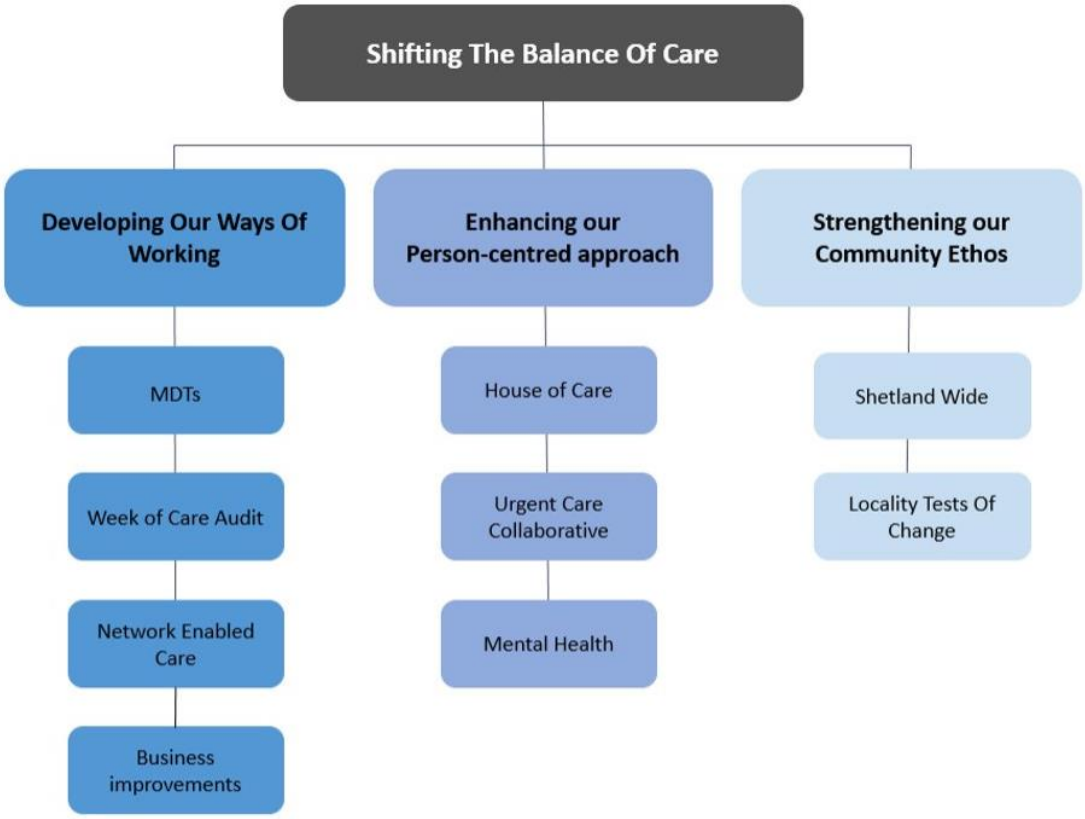
We will continue to develop the Home First approach, with the aim that people are discharged from hospital without delay, supported by nurse led discharge decision making where possible.

We will redesign Out of Hours services to create a sustainable and more affordable service. Within this we will explore different models and what these might cost. Providing additional resource to Community Nursing and Care at Home teams will facilitate an increase in 24/7 care packages in more remote areas.

These programmes of work will be underpinned by appropriate analysis of data and ongoing evaluation to ensure that the changes are effective and serve to decrease inequalities in health and access.

5. Supporting and improving social care

We have a significant programme of work in place to shift the balance of care to community support where at all possible.



Within this, we will focus on

- Better use of skill mix to ensure patients see the most appropriate professional
- Reinvigoration of remote and rural training/career pathways in health and social care
- Changing patient and staff culture from 'how can I treat you' to 'what matters to you'
- Further developing collaboration across health, social care, third sector, other stakeholders, and our communities.

Our Supported Living and Outreach services are currently at capacity; we will begin the development of a strategy for Adult Services - data map need, demand and projections, scoping change options, development of an engagement plan to base our community conversations on, and strengthen our links with housing strategy and wider strategic picture.

We will stabilise our Dementia Assessment Service and deliver on the 8-pillar model of Dementia strategy and further develop our community link worker programme and community-based initiatives.

The Substance Misuse Recovery Service continues to facilitate group work i.e., Mutual Aid Partnership (MAP), and is in the process of implementing:

- Medication Assisted Treatment Standards (including buprenorphine long-acting injection)

- Whole Family Approach
- Support for children affected by parental substance use
- Near fatal overdose pathways
- Alcohol specific death audits
- Development of an IEP service, ongoing development of the Recovery Hub and Community Network and conducting drug related death reviews.

We will explore ways of working to effectively join up our Community Mental Health Team with our Community Mental Health Support services and decrease reliance on agency staff through better understanding of safe staffing, necessary skill mix, and appropriate tasks

We will review our Advanced Nurse Practitioner contribution and workload to inform service redesign and Shetland best practice for access to services, including remote GP support options to consolidate and achieve best value from available resources

We are running a test of change in dietetics this year to see whether group delivery of services is effective in terms of outcomes for patients, better use of resources and patient peer support. If effective we plan to use this model for prehab/rehab/weight management, long term condition management, pulmonary and cardiac services.

6. Sustainability and value

Financial sustainability

Our top three challenges in terms of financial sustainability are our ability to create a sustainable workforce, development of sustainable pathways, and being able to deliver more services from within our existing resources.

The primary cause of Board and Health and Care Partnership overspend is the use of locum and agency staff and a key focus this year will be to understand and implement, where possible, the actions that are required to reduce this reliance.

We know that savings can also be made in procurement and through development of more streamlined systems.

We will continue to work on a programme of pathway redesign, which over the last year has led to over 1500 care episodes being delivered in Shetland as opposed to Grampian or elsewhere and created significant financial savings. Within Community Health and Social care 71% of the recurring savings has come from prescribing efficiency savings which is a mixture of local and national initiatives.

This year we will establish a medication task group for community medicines prescribing and administration across NHS and SIC. This group will look at the implementation of recently drafted policy and procedures as well as manage learning/safe medication management in community settings.

Two of our Community Pharmacists have started Independent prescriber training which will allow them to extend the service to include Pharmacy First Plus, meaning that the public will be able to access a wider service.

A Finance and Performance Committee has been established by the Board to oversee the sustainability programmes; we also recognise that the creation and delivery of sustainable ways of working will rely on the diligent work of the Board's budget holders working with colleagues. There are also several national work streams on-going which the Board is participating in.

Population Health

In the longer term we must ensure that improving population health, especially through prevention, genuine tackling of poverty, inequalities, and climate change, is a key driver for health and social care.

We will

- Embed Realistic Medicine principles within the local health and social care system, working towards a value-based health and care system
- Engage with local partners, Public Health Scotland, and other national bodies on the aspiration for a 'World Class Public Health System' in Scotland
- Conclude the comprehensive post pandemic health needs assessment of Shetland community
- Review current local Public Health Ten Year Plan 2012 – 22 and develop new plan
- Develop a local Mental Health Strategy, involving lived experience from the outset, a Sexual Health and BBV Strategy and Joint Health Protection Plan

We will develop three core MCNs, using realistic medicine principles, further develop our health protection and vaccination teams, including training and quality improvement and re-invigorate engagement with the Community Planning Partnership with an emphasis on prevention and inequalities.

Our work will continue on Type II diabetes prevention and reversal and our community-based weight management programme. Further implementation of Alcohol Brief Interventions will aim to prevent expensive and harmful increases in alcohol consumption. We currently have an increase in requests for residential rehab which is only available off island.

We will continue to implement our Health Literacy projects in partnership with Scottish Government – three projects, improving access to primary care for people who use BSL, building capacity with the Community Learning and Development team to incorporate Health Literacy principles and tools in work within communities and strengthening communication support for service working with people with Learning Disabilities. All three projects are underway with patient and professional engagement happening to inform next steps.

Shetland's Family Wellbeing Practitioners are funded for further four years through Emotional Wellbeing and Resilience project, part of ANCHOR Early Action board – the clinical lead sits within Child Health, while funding and management is via the Shetland Islands Council.

We will continue to identify models to support early intervention and support for health young minds (Tier 1 and 2, i.e., below CAMHS threshold), which will include the upskilling of the wider workforce. As part of this programme we have financially supported third sector provision. We also need to understand the needs and demands within school settings; the school counsellor service has not reduced the load of school nursing.

Key risks across the system

- Vacancy factor across professions (long term gap in supply)
- Impact of maternity leave on acute nursing and other workforce
- Short-term funding models
- Transitioning services, remobilisation, and increased costs due to supplementary staffing
- Living with COVID and what that means for medium term planning of services (impact on pathways, staffing, and tertiary services)
- Realism and will required to create integrated services – timelines/cost benefit analysis/dis-economies of scale
- Capacity to contribute to the development of national models, for example, the National Care Service
- Elevated levels of genuine need versus patient expectations versus what we can deliver in Shetland.

The future

Although challenging, the future for health and care in Shetland is also exciting. We envisage:

- Using new technologies to enhance care and increase equity of access

- Driving sustainable models of care
- Embedding "No boundaries" for patients and staff
- Providing a flexible workforce offer that attracts and retains dynamic staffing models
- Leveraging the new GBH health and care campus to accelerate net zero
- Remote and rural as a badge of honour