NHS Shetland

NHS Shetland Annual Review 2020

Briefing material

		Page
1	**Pre-Covid Performance 2019/20**	
1.1	Financial balance and efficiency savings	2
1.2	Performance	5
1.3	Adult Mental Health Service	6
1.4	Workforce	8
2	**Covid-19 Initial Response to July 2020**	**10**
3	**Forward Look**	**16**
Annex 1	**Area Clinical Forum comments**	**19**
Annex 2	**Area Partnership Forum comments**	**21**

Section One: Pre Covid-19 Performance 2019-20

NHS Shetland submitted its draft Annual Operational Plan to the Board in June 2019 following dialogue with the Scottish Government. It was published in August 2019 at: https://www.shb.scot.nhs.uk/board/meetings/2019/0621/20190621-19-20-27.pdf. This set out the strategic overview and key performance targets to achieve for health and care in Shetland, with a focus on financial sustainability.

1.1 Financial balance and efficiency savings

Main Achievements in 2019-20

- Revenue under spend only £41k, equivalent to 0.1% under spend against core funding.
- Out-turn revenue position was contingent upon £1,200k in additional funding for Primary Care that brought NHS Shetland funding for Primary Care in line with NHS Orkney.
- Capital expenditure £979k, resulting in an under spend of only £6k (0.6%) on CRL.
- Delivered in year efficiency savings of £3,480k, with £820k on a recurrent basis.

Utilisation of Funds and Shifting the Balance of Care

NHS Shetland continues to work to with the IJB to shift the balance of care locally as illustrated by the relative shift in share of resources that has increased expenditure in community services by 2.66% over the last five years.

	Acute	Community	Support Services
2014-15	43.66%	40.36%	15.98%
2019-20	42.60%	43.02%	14.38%
Movement	-1.06%	2.66%	-1.60%

Direct expenditure on General Medical Services at 10.0% accounts for the majority of 16.3% spent locally with what are traditionally services delivered via Primary Care Contractors. However in Shetland both General Medical Services and General Dental Services, although a mixed economy of providers, are primarily delivered through a directly managed salaried service.

Patient Travel costs represent a larger share of expenditure than for most Boards. However work is ongoing, as part of the patient-centred agenda, to reduce off island outpatient appointments. In Shetland the patient travel share of overall expenditure has fallen from 5.4% in 2014-15 to 3.5% in 2019-20. In 2019-20 tele-health clinics prevented 970 off-island appointments. There are 40 Near Me clinics.

Main Challenges

Financial Planning

The two principle financial challenges that NHS Shetland's long-term financial sustainability is contingent upon are:

- Sustainable staffing models that are resilient to the challenges of remote and rural

healthcare; and

- Delivery of recurring efficiency savings to address the inherent public sector funding gap that challenges the NHS to strive for best use of resources.

Sustainable staffing models – recruitment and retention

Primary Care: NHS Shetland is now fully responsible for the delivery of GP Primary Care services in 8 out of our 10 GP practices / health centres, including the three smaller island practices. Recruitment to GP Practices, especially for the single handed practices that have to provide a 24/7 service in our remote areas, remains challenging. Removing the reliance on locum staff in providing primary care services is a key priority to support the provision of quality services, including continuity of care, as well as reducing the significant costs associated with the current model. GPs recruited via the GP Joy scheme have helped to provide essential cover in filling gaps in vacant substantive posts during 2019-20 (see page 8).

NHS Shetland's total expenditure per head on primary medical care is broadly in line with both NHS Western Isles and NHS Orkney. However our primary care allocation is significantly lower than the other two remote Island Health Boards, causing a gap which the £1,200k received in both 2018-19 and 2019-20 has helped bridge. Longer term recurrent funding to address this gap is an on-going discussion point.

Mental Health: The Board made a decision in June 2014 to invest in the Mental Health Consultant Psychiatric workforce and increased this staffing establishment to 2.0 wte. The initial recruitment in 2015 provided additional staff, however since 2017-18 sustaining substantive appointments to these posts has not been possible.

Gilbert Bain Hospital: The acute consultant model at the Gilbert Bain Hospital had been relatively stable at 3.0wte Consultant General Surgeons (with additional annual leave and weekend cover), 4.0wte Consultant Physicians and 4.0wte Consultant Anaesthetists. However since 2017/18 neither the Consultant Physicians nor Consultant Anaesthetists have had all their posts filled substantively. The move to a more focused specialisation in training models for Junior Doctors to become consultants has reduced the availability of those with a relevant 'generalist' skill set.

Partnership working with other NHS Boards

Extensive work is underway to manage our relationship and patient pathways with NHS Grampian for "off island" activity, including the transfer of resources back to Shetland for the repatriation of services where this is clinically safe. We continue to work with NHS Grampian via the obligate network to maximise on island provision and avoid the centralisation of services on the mainland where this is not clinically required. This also assists in the reduction in off island travel, with funding diverted to provide resources for sustainable on island services. Although not included as part of the Board's formal CO_2 target, this will also reduce the carbon footprint of patient journeys.

We are continuing to roll out Near Me out-patient e-technology with NHS Grampian and other North of Scotland partners to make efficient use of e-technology to reduce patient travel as part of redesign projects. We are also working with the Golden Jubilee National Hospital in respect of orthopaedic pathways to minimise patient travel through the use of video conference out-patients supported on island by our Physiotherapy team. In 2019-20 these efforts managed to reduce the cost of patient travel off island by £320k as part of our local programme for delivering efficiency savings.

Public Sector Efficiency Savings Challenge

NHS Shetland's five year financial plan recognises the Scottish Government target of 3% efficiency savings for the Public Sector and the Health and Social Care medium term financial framework. Over the next five years £7.3m in recurring efficiency savings will be required to achieve financial balance.

A new Project Management Office to co-ordinate our work on redesigning services and pathways in partnership with the local IJB and NHS partners is being established in 2020.

Capital programmes including the Board's progress in maintaining estate

The 10 year Capital Plan aids our strategic direction, however not all schemes can be funded from within the specific Board allocation.

The Ambulatory Care project funded by £1.3m additional capital funding investment from Scottish Government has been agreed with a completion date in 2021-22.

NHS Shetland's only hospital, the Gilbert Bain, opened in 1961. During 2019-20 the Board agreed a strategic assessment review be undertaken for future provision of services.

The CT Scanner originally funded by public donations and installed in 2007 will require replacement early in 2021.

The Scan Shetland Can MRI Scanner Appeal campaign that aims, via public donation, to fund an MRI Scanner in Shetland will reach its funding target in 2020 following recent funding pledges.

1.2 Performance

Performance information for 2019-20 can be found in the Board's Annual Operating Plan previously submitted to the Scottish Government. Key issues identified concerned achieving access and treatment time targets for planned care, and improving waiting times for adult mental health psychological therapies.

Access targets

Whilst we continue to perform well against national waiting times access targets for outpatient services and the treatment time guarantee (TTG), some of the key challenges in the delivery of planned care services for NHS Shetland are associated with the intra-Board/regional capacity to deliver shared care pathways.

We have seen a mismatch in the demand for some services and the capacity available to deliver 'visiting services' for a variety of reasons but include as significant factors an increase in the referral rates for all specialities, along with challenges in recruiting key clinicians. This means that a number of the shared services with NHS Grampian are not performing consistently within the national waiting times targets. We have developed a recovery plan to ensure that we address short term (non-recurrent) access issues as well as using the Scottish Access Collaborative methodology to understand the opportunities to redesign pathways taking a whole systems approach. We expect some of these issues to continue into 2020-21 whilst we look for mutual aid from other Health Boards in the region and intend to use independent providers to manage the gaps in the service.

Psychological Therapy Service Waits: Psychological Therapy Service waits were a particular concern in 2019-20 (see broader Adult Mental Health briefing section, page 6).

Reducing 'generalist' skill set

We have also seen the impact of the shift towards increasing clinical sub specialisation on service sustainability where the historical model was that clinicians with 'generalist' skills supported remote and rural services - this is no longer possible and so we are starting to explore alternative models such as increasing access through telemedicine and telecare approaches.

1.3 Adult Mental Health Service

In 2019-20 there were two main issues within the adult mental health service which required addressing:

1) Waiting times for the Psychological Therapy Service (PTS); and
2) Financial risk of the current medical workforce provision prior to the response phase of the Covid-19 pandemic.

1. PTS Access: In September 2020 12.5% (1 out of 8) was seen within the 18 week target. There are currently 135 patients on the waiting list with 37 patients waiting for more than 104 weeks and the longest wait is 173 weeks. This has been highlighted in the Board's Quality Report. In 2019-20 there had been some improvement in waiting times in Q2 and Q3 but this was quickly undone by the pandemic. A recovery plan was initiated in August 2020 as part of the Board's Remobilisation Plan. This incorporated a better skill mix within the team, including the use of Occupational Therapists and additional therapists, and better hiving off of low level interventions from the waiting list. A new Consultant Psychologist arrives within the next month and they have been briefed on their role within the recovery plan to lead this work.

2. Mental Health Management Team: An Internal Audit Report made several recommendations regarding the structure and functioning of the Mental Health Management Team. There are also some relationship issues in the team that need to be addressed. The Board has committed to supporting this work to be undertaken in a timely manner. An external facilitator (Affina OD) has been engaged in this regard. It is hoped that with a better functioning team, there will be better outcomes for patients.

There were also two audits undertaken in the last year which have focussed the management team on two recovery plans to address the PTS waiting list and to review the MH management team structure and functionality. These challenges still exist but with some service reconfiguration over the last 6 months in response to Covid-19, this may have aligned the Service to make the necessary changes to address these risks.

Learning from Covid-19

Initially during the pandemic there was an increase in patients coming into the acute setting in crisis. Due to the nature and location of presentation, it meant that consideration had to be given to admitting patients into hospital. An OOHs model using CPNs was implemented to act as a first port of call to try and keep patients safely in the community and out of the acute setting. This was deemed to be a success and now we are looking at adapting the model to support the change in urgent care with an outcome that the CPN provides more of an early intervention role. In order to bridge the interface between acute and community to ensure patients are moved to most appropriate place for their continued care, the Board has support the implementation of a psychiatric liaison nurse post.

Regional Work

There is an acknowledgement that the Island Health Boards have challenges sustaining a quality and high performing Mental Health service. In particular OOHs Consultant input has been difficult to sustain with rosters often being fragile and continued only by the use of high cost locums. Discussions have been initiated across the region to ascertain if there is an economy of effort in resourcing the OOHs tasking across Island Boards. We would hope the less demanding on-call commitment (currently 1:2) coupled with a new OOHs CPN model, would help make the workforce more sustainable moving forward.

Specific actions have been taken as follows:

a. A recovery plan has been formulated for PTS waiting times;
b. A recovery plan has been formulated to review and reconfigure the MH management team which commences mid October 2020;
c. In response to Covid, a Liaison Psychiatric Nurse post has been implemented to provide an interface between the community and acute sectors to ensure patients have access to the correct professional in the correct setting;
d. In response to Covid, a CPN roster was implemented to provide OOHs cover to decrease the footfall in the acute setting and to maintain as many patients as possible in the community safely; this model is being sustained as a new way of working;
e. Discussions have been initiated to scope if there is a regional solution to some of the workforce issues including OOHS cconsultant cover and rotational working.

1.4 Workforce

Main Achievements in 2019-20

1. We remained the Board with the lowest absence rate for territorial boards in Scotland, with an annual absence rate of 3.82% (below the Scottish average of 5.44% and below the Heat target of 4%). The Board's long term absence rate was 2.09% and short term sickness absence was 1.72%, both below the Scottish average.
2. We have had some success in offering rotational consultant posts, where there is a commitment to spend an agreed number of weeks to work in Shetland across the year, with CPD supported to maintain development in an alternative Board in Scotland. This enables the individual the freedom to work oversees on voluntary projects and maintain a UK base. Sufficient interest will be required to maintain and develop this model of working.
3. The GP Joy programme funded by Primary Care Division in Scottish Government has enabled NHS Shetland (on behalf of the Scottish Rural Medical Collaborative) to trial a new and innovative recruitment process with the aim of recruiting GPs to work in GP practices, initially across the Islands and NHS Highland, and in January 2020 to recruit Scotland wide. All of the GPs are on employed contracts with NHS Shetland, working between 8-18 weeks per annum. Various practices in different geographical areas for Shetland have been supported. In 2019-20 this has equated to 73 weeks of GP time as opposed to more expensive locum usage (with an estimated cost reduction of £132k).
    - Wave 1 Highlands & Islands Joy group (original group)
      19 current GP members Jul 2019 – March 20. In the first 9 months of the project there was a total of 99 weeks of GP cover over 20 different practices spread across the four Health Boards, including practices such as Port Appin, Wick, Aultbea, Gairloch, and South Uist and the Shetland practices of Walls, Unst, Scalloway, Brae and Whalsay.
    - Wave 2 The GP Support group (Scotland wide)
      We recruited 30 GPs to this group in February 2020 with placements in Stornoway, Scalloway, Thurso, Tobermory and Brechin.
4. Four poster submissions for the 2019 NHS Event from a variety of directorates (including for the first time a submission from the Estates and Facilities Team).
5. The delivery of a Leadership Matters Week with a programme of activities with a leadership theme ranging from workshops, Q&A sessions, debates, stories and wellbeing sessions. This was an open and free event for all Shetland residents.
6. The first coaching cohort was delivered in June 2019 with nine staff in attendance, from facilities to senior team members. These staff have been developed to act as influencers and support the Ask, not Tell model to empower staff/managers in every day conversations.
7. Twelve staff members from Health and Care were put forward to attend a local Leadership Development Programme to explore their own leadership potential and ambition in readiness for application of Senior Management positions – this is being delivered virtually. Team members are all also participating in a coaching qualification.
8. 63% of staff across Health and Care completed the iMatter questionnaire with 78 as the Employee Engagement Index.

Recruitment challenge

- We have had some difficult to fill posts that attracted no candidates or were not appointed to which resulted in repeat advertising campaigns or a change in approach to fill vacancies. Substantive medical staffing remains a concern, but the posts also included specialist nurses, laboratory scientists and psychological therapists. Fixed term posts can be particularly difficult to fill as appointment to a post requires relocation to Shetland.

Section 2: Covid-19 Initial Response to July 2020

NHS Shetland staff rose well to the challenge of preparing services to respond to the Covid-19 Pandemic. Elective services were stood down early and considerable work was undertaken across the acute sector to create appropriate pathways and environments for the care of both suspected Covid and non-Covid patients.

At the end of July 2020, there were 54 positive cases of Covid-19 in Shetland. One additional person tested positive via a private test; this did not appear in our figures as it came through a non-NHS route.

Shetland Pandemic Response Team

The Shetland Pandemic Response Team was activated on Monday 9th March 2020. The role of the Pandemic Response Team is to co-ordinate arrangements for the treatment of patients suffering from COVID-19 and the prevention of further spread. Initially this group met on a daily basis to ensure a clear process for moving actions forward and resolving issues at a senior operational level. Issues which could not be resolved at this meeting were escalated to the (Gold Command) Executive Management Team. As the pandemic progressed the group moved to meeting three times per week, then once per week, and was stood down at the end of July 2020.

Governance

Alongside the rapid establishment of a Gold, Silver and Bronze command structure, Shetland NHS Board considered and approved a temporary revised approach to corporate governance at its Board meeting on 3rd April 2020: https://www.shb.scot.nhs.uk/board/meetings/2020/covid/20200403-Boardpack.pdf. This meant Board meetings were not held in public, the frequency of meetings moved from every other month to fortnightly, and the governance committees of the Board were temporarily stood down. The meeting cycle reverted to business as normal in mid-July.

Epidemiology

The Public Health Team was first notified of possible Covid-19 cases in Shetland on 6th March 2020.

By July 2020, the figures for Shetland stood at:

- 54 confirmed cases out of 1264 tests undertaken.
- 7 deaths
- 31 women, 23 men

Labs and testing

In accordance with the current Public Health Scotland and Scottish Government guidance and local risk assessments, these are the groups who are currently tested for Covid-19:

- Patients admitted to hospital who meet the case definition for suspected Covid-19, on admission.
- Patients 70+ admitted to hospital (regardless of symptoms) on admission and, if negative, repeated every 4 days until discharged or positive.
- Any patient in hospital who develops a new cough or fever.
- Clearance samples for patients who have tested positive for Covid-19 being discharged to a home setting where someone is shielding.

- Patients discharged from hospital to a care home who have tested positive for Covid-19: they must have two negative clearance swabs (24 hours apart) before discharge.
- All other patients discharged to a care home (one test within 48 hours before discharge).

Locally we have undertaken a range of additional testing for public health purposes, in order to preserve our green and red pathways and also for people who we consider to be at risk.

Any remaining testing capacity has been used to support keyworkers returning to work with highest priority given to health and social care staff, as set out in the Scottish Government prioritisation matrix. This includes:

- Symptomatic keyworkers from NHS, SIC, emergency services and lifeline transport services who are currently self-isolating for 7 days.
- Symptomatic household contacts of asymptomatic keyworkers from the groups above, who are currently self-isolating for 14 days.

All other keyworkers as set out in the Scottish Government Keyworker Prioritisation Matrix have been tested through the UK Government Keyworker Testing Programme – a satellite scheme for Shetland.

This programme is done by a self-swab at home, with tests processed at the Lighthouse Laboratories in Glasgow and therefore will continue irrespective of local testing capacity.

Surveillance Testing
There is an enhanced epidemiological surveillance programme that is managed nationally through Health Protection Scotland, independent of NHS Shetland Covid-19 testing. This involves testing a sample of patients who receive telephone advice from NHS 24 through the Highland Hub and a sample who were seen at the Covid-19 Assessment Centre (CAC). This testing is purely for surveillance and not for clinical reasons. People should not be referred for surveillance testing.

Acute Services

Guidance on PPE usage in the Hospital was developed. We are continuing to follow the **Resuscitation Council UK guidelines for PPE during CPR**.

A Consultant Microbiologist/Infection Control Consultant was appointed in March 2020 and continues to support us.

Surge capacity – We added in 11 additional beds to Ronas Ward, taking the total beds available for respiratory illness to 44-45. We also had plans to create 12 more beds, but this wasn't ultimately required. Modelling data had suggested this level of bed capacity would meet the demand during the peak of the pandemic.

SAS – There were initial challenges in identifying appropriate transfer pathways for Covid/non Covid patients and testing patients before transfer. Two patients were transferred by military aircraft before an Epi-pod solution was found.

Community Services

Within Primary Care, a COVID Assessment Centre was quickly established, AHP services were stood down with redeployment of staff to support other areas, and the General Practice Nursing workforce was stood down in order to increase the nursing compliment within District Nursing. These changes were in line with the National Clinical Guidance for Nursing and Allied Health Professions.

The Community Assessment Hub for people with Covid-19-like symptoms who were in need of clinical assessment was established on 23rd March 2020. The centre was staffed from 0800-1800, with two clinicians then on call from 1800-2200, with A&E covering overnight. Numbers coming into the centre were fairly low. Staffing the centre impacted on daytime Primary Care provision and the model has since been stood down.

Throughout this period we had no delayed discharges in Shetland. District nursing and community psychiatric nursing moved to a 24/7 model across mainland Shetland. Shielding letters were sent to around 800 extremely vulnerable residents in Shetland to advise them of support available to them in order to prevent them from coming into contact with coronavirus, by minimising all interaction between them and others. The majority of these people were in the community as opposed to residential care.

ICT and Information

The ICT team worked incredibly hard on a number of fronts:

- Supporting the increase in capacity in respiratory beds in the hospital
- Supporting the extended role out of Near Me technology
- Facilitating staff in working from home and requiring remote access
- Building laptops and ongoing maintenance
- Ongoing reporting of information to government as required.

Supplies and PPE

Initially there were significant issues around availability of appropriate Personal Protective Equipment, but these were resolved fairly quickly after the establishment of a PPE Hub for NHS and Health and Social Care.

Early recognition of the supply chain challenges for services locally led to the development of a single supply point for PPE for all NHS, Local Authority carers and unpaid carers resulting in a consistent supply of PPE available to all sectors throughout the time period.

A Shetland Scrubs campaign was launched where the local community made scrubs for health and care workers and this was hugely helpful.

Workforce Response to Covid-19

- The Health, Safety and Wellbeing Committee met regularly to ensure the right processes were in place to support and protect staff and patients.
- Generic example risk assessments were issued and specific area Health and Safety risk assessments carried out. Occupational Health Risk Assessments, including Covid-19 testing, fitness for work, self-care for staff patients, as well as flow charts describing the process were produced and disseminated.
- The percentage of staff absent varied over the period, from around 20% at its height. This was a combination of annual leave, staff isolating because they

themselves had symptoms of Covid-19, staff isolating because family members had symptoms of Covid-19, and other types of sick-leave or parental leave.

- A redeployment service was established with the aim of redeploying staff safely and effectively as services were stepped down and organisational hot spots became evident. Eighty-four individuals were deployed to support a range of work strands across the organisation. This involved setting up a new system which could record demand and capacity, induction requirements and risk assessments required.
- A dedicated team of redeployed staff was developed to support Face Fit Testing – supply chain issues have meant different styles of masks needed to be used so front line staff have needed testing with multiple masks. The team carried out over 1000 face fit tests during February to May.
- An increasing number of staff were enabled to work from home. This was encouraged where possible, in line with the guidance on social distancing. Guidance and risk assessments were disseminated to help support staff working from home.
- Management of day-by-day basis staff absence reporting enabled us to see trends, support organisational messaging and focus redeployment of staff into roles required by the organisation.
- A telephone support line was set up, prior to the national line being up and running, to provide a confidential supportive resource. Fourteen volunteer staff have been trained to provide this with support by the Samaritans.
- A staff Wellbeing Area was set up in the Hospital Sanctuary where any member of health and care staff can go if they need a safe space.
- Staff working across Shetland have been asked what they would like to see in their area(s) with the provision of requirements to be funded via the Endowments Committee (Captain Tom Moore's Just Giving campaign).
- TRiM is a trauma-focussed peer support system designed to help people who have experienced a traumatic, or potentially traumatic event. The use of this tool is being rolled out for staff.

Ethics committee

An ethics committee sub group was established to link in with NHS Grampian's committee as required (for example, on shared patient pathways).

Communications

- Staff worked hard to develop and maintain a flow of information throughout the pandemic. Regular opportunities have been taken to communicate with the public, including Facebook Live sessions with the Chief Executive, BBC radio Shetland phone-ins with the Medical Director and Public Health and the development of a microsite solely focused on Covid-19.
- One particular public communication was to remind people who are particularly unwell not to ignore symptoms but to ask for help. A highlight was the release of a new version of a Right Said Fred tune 'I'm too sexy for my scrubs' with the video featuring health and social care staff wearing a variety of scrubs.

Integration of community health and social care – whole system working through the pandemic

Integration has largely served Shetland well through the Covid-19 pandemic. The close knit nature of our teams meant that we were able to respond quickly to need as it arose. The pandemic brought about even closer working between the acute and community sectors with a particular outcome being the reduction of delayed discharges to zero for the majority of the pandemic period and the release of resources to support community areas where required.

It was notable that the initial focus of the pandemic response was on acute services, but in Shetland it was quickly identified that the bulk of the response was going to be in the community, and not only in the health arena. The need for a distinct model of PPE distribution in Shetland led to a proposal for a hub to be set up to serve NHS and community needs, and this worked well in responding to the needs of communities whose need for PPE hadn't been identified initially. Critically this included supplying PPE to personal assistants for Self-Directed Support Packages, and to informal or unpaid carers identified through our Caring for People Team, to enable them to do their work safely. If this hadn't been possible, a further burden of care would have fallen to the local authority, as well as potentially removing some of the close network of support that vulnerable people rely on.

Initial communications with regard to the NHS contribution to assurance in care homes made little reference to existing roles of Chief Social Work Officer, IJB Chief Officers, as well as the responsibility of local authorities to provide care. Our mature and respectful relationships between the Director of Nursing, Director of Public Health, Chief Social Work Officer, IJB Chief Officer and Medical Director meant that we were able to navigate these potential difficulties and quickly identify how we could work collaboratively to produce an assurance framework that would suit all the respective needs of the parties. Trust and mutual respect were key to these successes. There were some issues around understanding of partnership working in small communities e.g. our Care for People team was asked to follow up all GP calls to people who were shielding with a further call from a local authority perspective. In Shetland our Primary Care lead and Social Work leads had been meeting on a daily basis with shielding conversations high on their agenda, so were confident that there was no need to duplicate calls.

We note the importance of communication across boundaries. We implemented daily huddles across mental health, social care, social work and primary care, including weekends, to make sure we had the right resource in the right place at the right time. This was particularly effective in responding to an increase in mental health presentations to A&E from people previously unknown to mental health services. Close working between the Scottish Ambulance Service, mental health and social work services to agree responses to individual cases enabled early intervention and resolution.

The use of technology, e.g. Microsoft Teams, has meant that staff have been able to work closely together including remotely. There remain issues with connectivity in some areas of Shetland and accessibility of organisations systems, e.g. if NHS Microsoft Teams site is used to host a meeting, local authority staff cannot necessarily access all aspects, including contact lists unless given an additional log in. This can result in inefficient use of time. The need for specific data sharing agreements can serve to inhibit productivity.

Finally, we have had ongoing concerns about the profile of adults with disabilities and particularly those with learning disability and autistic spectrum disorders in the government's roadmap – but are pleased to see that these are now being responded to.

Section 3: Forward Look

A Mobilisation Plan was submitted to the government on Monday 25th May, to cover the period to end July 2020. This included the process of building red and green pathways for all clinical specialities, maintaining the capacity for any Covid-19 surge, and the increase in elective care. Within community settings, we continue to provide support for care home safety and primary care, maintenance of some of the positive changes in working practices (e.g. use of Near Me) that have been made, the reintroduction of screening programmes and planning for flu immunisation.

The Board's subsequent Remobilisation Plan (focussed on the public health agenda, safety, delivery and financial sustainability as the core pillars of the remobilisation process) was published in October 2020 at:
https://www.shb.scot.nhs.uk/board/meetings/2020/1006/20201006-20_21_37.pdf

In addition to the Remobilisation Plan, Section 1 provides details of some of the actions being taken to address residual areas of concern moving forwards (e.g. with regard to partner Board capacity, recruitment concerns and PTS waits).

Moving forwards and wider impact

We are starting to plan for the recovery/renewal phase of the epidemic; this includes the standing up of paused services. We are very conscious of some of the well-received new ways of working that have developed over the past couple of months and the need to maintain or build on these. Examples would be the use of Ask My GP/Near Me which has been universally welcomed by patients, clinicians and administrative staff at Lerwick Heath Centre, and the willingness of staff to go where they are most needed and work flexibly in different roles.

However it is essential to remember that the NHS and Health and Social care partnership are concerned with more than purely the delivery of health services. In our moving forward we need to be aware of the impact of Covid-19 on our community. Covid-19 has disproportionately affected people on lower incomes as a disease, and the impact on socially and economically disadvantaged people is immense.

Children

Children already living in poverty are likely to experience a greater impact of Covid-19, with potential for child poverty to become more ingrained. For already vulnerable families, the situation is likely to further compound family stress and trauma. The number of children now likely to experience poverty will increase as a result of either temporary or longer term loss of family income. This in turn will create additional demand on a range of public services including housing, childcare, rights and advice services.

Employment

As businesses are forced to close, job losses are an inevitable consequence of Covid-19. Pre Covid-19, the majority of families who were experiencing poverty had at least one adult in employment. The Institute for Fiscal Studies has identified that, in the UK, about 1 in 7 (15%) employees worked in a sector that has now fully or partially closed down. These sectors include non-food based retail, travel, personal care, domestic services and childcare. The State of the Economy Report (April 2020) suggests a 33% decrease in GDP.

Debt and Financial Resilience

The Fraser of Allander Institute estimates that only 42% of Scottish households in the bottom income decile would be able to cover 1 month of their regular income from savings[i]. This increases the risk of debt (household debt has increased in recent years in the UK and so further debt will be particularly unwelcome for many families). Households with lower income levels were more likely to report having no savings than those with higher incomes[ii].

Mobilising community assets

In responding to Covid-19, more affluent communities will be better placed to mobilise community support and resilience than poorer communities who need to focus on personal survival or need additional support to respond as a collective. In turn, the community response to recovery will happen faster in more affluent areas as people begin to rebuild the social capital and reinvest in their communities once social distancing is scaled back. In Shetland we have seen very clearly the community capacity to respond to crisis in a positive and inclusive manner; we must ensure that we build on this and ensure that people are not left behind.

(i) https://fraserofallander.org/covid/the-coronavirus-and-household-incomes-liquidity-constrained-households-in-scotland/
(ii) https://www.gov.scot/publications/scotlands-people-annual-report-results-2017-scottish-household-survey/pages/7/

Clinical Strategy

One additional area of interest may be the development of a refreshed clinical strategy and a strategic assessment for the replacement of the Gilbert Bain Hospital.

The current clinical strategy was published in 2014 and although it signals a strategic direction of travel that remains relevant, there have been numerous structural and policy updates since this strategy was produced.

The aim of this project is to produce a refreshed clinical strategy to ensure that we have a clearly articulated strategic vision for the next five years. This is a sub project, which sits within a wider programme of strategic planning and is the first phase of the capital planning process to develop a strategic assessment for the re-provision of the Gilbert Bain Hospital and other services that will make up a new health campus.

The scope of this work (phase one), is that it will include all health services that are provided by NHS Shetland and those commissioned with other partners on behalf of the population of Shetland e.g. NHS Grampian and the Shetland Integration Joint Board. A Programme Board has been established to oversee the development of the clinical strategy refresh and the strategic assessment. Two separate project teams will be instigated to lead on phase one and two, respectively. In order to undertake the refresh of the strategy, NHS Shetland will partner with the Digital Health & Care Institute (DHI) to develop the methodology. The Northern Hub Territories framework will be used to commission external consultancy for the development of the strategic assessment including a programme manager and a healthcare planner.

The timeline for the completion of the first phase is March 2021 and the second phase September 2021. Scottish Government funding has been allocated to develop the strategic assessment via the Capital Implementation Group (CIG) and the intention is to present the Strategic Assessment to CIG by September 2021 to request progression to the initial agreement stage of the capital planning process.

Annex 1: Area Clinical Forum comments

Pre Covid19 response 2019-20
In the period April 2019 to January 2020 the Area Clinical Forum met on a regular 6-8 weekly basis holding 5 meetings over this time period. A variety of areas of business were covered. These included key local service developments e.g. development of an Ambulatory Care Unit, changes to the Obstetric model, new service model for the island of Bressay as well as consideration of areas of national interest / concern, e.g. Realistic Medicine agenda, Sturrock report and the proposed Review of the Health and Social Care Partnership Integration Scheme.

In addition to matters considered at ACF meetings, the ACF Chair was honoured to be invited to represent the clinical workforce on the interview panels for both the new Chief Executive and the Medical Director. Involvement in the appointment processes for these two key posts illustrated the importance attributed to the ACF in representing the clinical workforce.

The Area Clinical Forum had also revised its Constitution in the spring of 2019 and a selection process commenced in January 2020 to find a new Chair to take over at the end of the current Chair's term of office in May 2020. The Chair's term of office was subsequently extended to 28 February 2021.

Covid19: Initial Response (February/ March – July 2020)
The agile Board meetings that were introduced provided the opportunity to ensure that all NHS Board members were kept informed in a timely way without placing additional demands on staff who held key operational responsibilities. The briefings prepared for each meeting provided an excellent way of updating ACF members on the revised corporate governance structure in place, the local position on the pandemic and progress reports on the organisation's developing surge capacity.

An outbreak of Covid-19 was experienced within the care home sector towards the end of March. Whilst this outbreak was challenging at times for local services, and sadly saw the death of five residents, responding to the outbreak highlighted the flexibility of the local workforce and enhanced working relationships across secondary care, primary care and community care. Subsequent service reviews highlighted a number of areas of good practice and they have provided information upon which to base any future response to an outbreak within either a care home or community environment. This includes the deployment of dedicated additional staffing to support the core service in that area.

Due to the pace at which services shut down and the subsequently developed remobilisation plans, there was no formal opportunity for ACF to consider these. However, the majority of the ACF members hold key senior operational roles within the Board and were therefore aware of the changes across services and were responsible for implementing both the step down and remobilisation of services.

ACF meetings were re-established in June 2020, with this meeting being held using the Microsoft Teams meeting platform. Clinical services locally have utilised digital communications e.g. Near Me for some time. The pandemic led to a digital revolution across the organisation within both clinical and non-clinical settings. Unfortunately whilst the ACF meeting in June proceeded, we have had to cancel two further meetings due to not being able to be quorate.

Forward Look
Looking forward the following are the key priorities and challenges for the ACF:

ACF – the biggest challenge currently facing ACF is to create a sustainable Professional Advisory Structure from which new membership of the ACF can be drawn. There is an urgent need to identify a nomination for the ACF Chair position to take over the role as of the end of February 2021;

Remobilisation Plans – It is anticipated that the remobilisation plans will be considered in full at the next meeting of the ACF;

Clinical Governance Review – ACF will ensure that the multi-professional voice fully contributes to the current Clinical Governance Review;

Clinical and Care Strategy – ACF will actively seek to support and contribute to the work being undertaken to develop the Clinical and Care Strategy for Shetland for the next 5 years.

Question from ACF
What support can both the NHS Board at a local level, and the Scottish Government at a national level, provide to strengthen the position of Area Clinical Fora to enable them to continue to be the key conduit by which multi-professional advice and support is provided both to the NHS Board structure and the Integration Joint Board (IJB) structures going forward?

Edna Mary Watson
Chair, Area Clinical Forum

Annex 2

Area Partnership Forum comments

Pre Covid19 response 2019-20

There were disappointing figures from staff side recording facilities time during 19/20. We have looked at how we can improve this going forward. Suggestions include:

- Using the SSTS system to record facilities time.
- Encouraging staff side reps to record time off during work hours but also time used when preparing for meetings in their own time. The feedback from staff side reps as to why they have not recorded time is that they do work out with their normal working hours. It has been explained we need to ensure this is reflected in facilities time.
- Managers' engagement for staff side to record facilities time in SSTS.

Covid19: Initial Response (February/ March – July 2020)

There have been a lot of great examples from all areas of NHS Shetland of staff working together during this difficult period. APF would like to ensure that the review acknowledges the efforts of **ALL** NHS Shetland staff during this difficult period.

The current Covid-19 situation has brought with it challenges and we have found the use of Microsoft Teams to be beneficial to ensure APF members have been kept up to speed with pandemic-related staffing matters. There also remain other staffing issues around performance monitoring which APF has been kept abreast of.

Communication remains a challenge at times, particularly as engagement with staff who do not regularly access IT can be very difficult. Different formats have been used during this difficult period, including the establishment of a Covid-19 microsite. We need to evaluate these and continue to develop different ways to communicate.

Staff support during the pandemic from the Occupational Health and Staff Wellbeing teams has been excellent.

Forward Look

This difficult period has highlighted the need for good IT infrastructure in remote areas. APF would like to ask at this review that more investment is provided in this area to support remote and rural areas.

Question from APF

This period has also highlighted how lots of training can be delivered remotely via the use of Microsoft Teams. This has been something that APF has been requesting for a number of years. We ask at this review if NES could look at how future training can be delivered in this way for all courses.

Ian Sandilands
Chair, Area Partnership Forum