Clinical and Care Strategy 2021 - 2031

Version 3

June 2021

Executive Summary

NHS Shetland's Clinical and Care Strategy sets out how we will shape services that continue to provide high quality care to our population over the next 10 years.

This strategy document is the culmination of a series of engagement events and discussions with our staff, people who access care and support and the wider Shetland community during 2020/2021. It also incorporates information drawn from feedback, complaints and workshops over recent years as well as learning from the Covid-19 Pandemic.

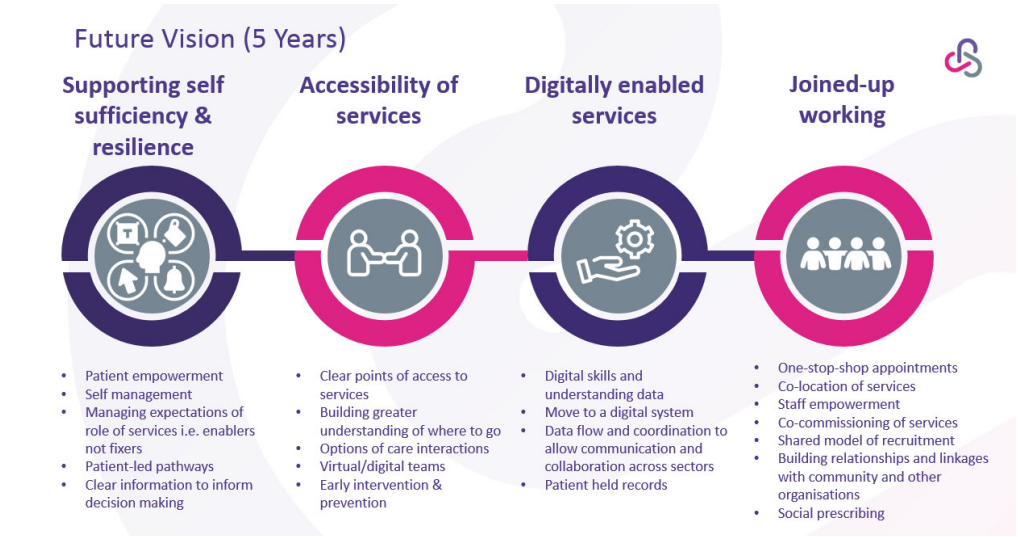
Our strategic aims are:

- 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 new technologies to improve access, promote person-centred care and reduce inefficiencies

Our strategic priorities, based on what we have learnt from the engagement activities:

- We will work more closely with our communities
- We will place more emphasis on preventative approaches
- We will continue to prioritise joined up working and reduce duplication
- We will use digital solutions, where they are appropriate to improve access and bring care closer to home
- We will develop new roles and models for training to support our generalist workforce

A chart to show our future vison for health and care over the next 5 years



We hope you find the strategy inclusive and useful. Thank you to everyone who has participated in the process.

Kathleen Carolan
Director of Nursing & Acute Services

Dr Kirsty Brightwell
Medical Director

Introduction

NHS Shetland's Clinical and Care Strategy sets out how we will shape services that continue to provide high quality care to our population over the next 10 years.

This strategy document is the culmination of a series of engagement events and discussions with our staff, people who access care and support and the wider Shetland community during 2020/2021.

It also incorporates information drawn from feedback, complaints and workshops over recent years as well as learning from the Covid-19 Pandemic.

Our 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; and
- Making best use of new technologies to improve access, promote person-centred care and reduce inefficiencies.

Healthcare is continually evolving, and our services need to adapt to be able to offer the outcomes that the people of Shetland deserve. With advances in public health and medicine, people are living longer with diseases that used to radically reduce their life expectancy such as diabetes, heart disease and cancer. Remaining well with a long-term condition requires services to support people over their lifetime as opposed to irregular, infrequent visits to the GP surgery or hospital for short, acute illnesses.

People living in poverty have shorter life expectancies and spend more of that time unwell. We need to improve access and tailor our care to people in their context to meet their needs. This requires us to work with people to understand what will support them.

The strategy highlights areas that will change to meet the aims described above. Integrated working in Primary Care and the Community already means close team working. Expanding the range and access to services in the community will strengthen people's ability to take control of their health, increase confidence and choice, all of which are important to mental wellbeing. Supportive, connected communities will work alongside the health service to maximise everyone's potential. With the addition of new digital technologies, individuals will be able to lead this care, maximising their potential to remain well and reducing their risk of admission to hospital.

Services for children are another example of where integration is working and building on this foundation will be more supportive and proactive. Closer working with education, voluntary services, social care and the NHS will anticipate changing needs and provide easy access to the right support at the right time.

Mental Health like physical health encompasses a wide range of conditions and opportunities. Access to services and support will be widened with the NHS team providing support and expertise from within this network. This will include access to specialists on the mainland such as for eating disorders and acute psychiatric emergencies with the aim of reducing the need for prolonged hospital stays. These

community supports will be aligned to the principles of enabling individuals to maximise potential and support them in their communities. Streamlining access to the right service and clinician is important to avoid unnecessary delays and people having to repeat their story to multiple clinicians. Technology will enable safe and efficient sharing of information, focusing appointments and travel where they are required to add value to the person's experience.

A new role for specialist and tertiary services to support the delivery of healthcare in communities will also be facilitated by technology. Advances in technology will also mean bespoke assessments and early interventions, reducing the need to stay in hospital and increasing access to these services for more of the population. Innovation will also increase the range of specialist services available in Shetland and access to training and skills maintenance for our clinicians.

Our strategy requires the NHS to continually listen and adapt services to take account of what the population is experiencing. We will build on our previous engagement work to encourage a new relationship with the population.

We recognise that providing heath and care and working in partnership with organisations and individuals is complex and interlinked. In order to try and make sense of the feedback in response to developing this strategy, we have organised the strategy into a number of sections which are shown in the following pages.

We have focussed on building into these sections the feedback we received, and to do that we have included examples of services and support that are available now and those we expect to deliver in the future. We have also used direct quotes in places to illustrate key points.

We have deliberately kept this document 'short' in order to make sure it is accessible. However, the volume of materials that have been generated through the strategy review process are significant and we do not want to lose sight of all of this work. So to accompany the strategy document, we have also developed a library of documents including presentations and detailed feedback reports that can also be accessed via the following web link:
https://www.shb.scot.nhs.uk/board/clinicalstrategy/index.asp

In the following section we have set out the approach we took in developing the strategy.

How we developed the strategy

We were supported to develop the engagement process for the strategy by an academic partner, the Digital Health & Care Innovation Centre (DHI)[1] which is affiliated to the Glasgow School of Art and the University of Strathclyde.

DHI helped to design and host events and an engagement survey. The output of these events along with discussions via our Clinical Pathways Group, have been used to shape the content of the strategy.

[1] https://www.dhi-scotland.com/

Focus group sessions were also offered to enable people to provide detailed feedback. Nine focus groups were organised and 23 people participated in the discussions from a range of different professional backgrounds including healthcare, community care, third sector and community development.

In addition to this, between September 2020 and March 2021, we hosted three workshops in order to bring together colleagues across a wide range of organisations in Shetland that contribute to providing health and care support. The workshops[2] were open to the public and people from across Shetland, as well as Shetlanders based in other countries, participated in the workshop discussions. Over 200 people attended one or more of the three workshop events, which we consider to be good evidence of how important people considered being part of the process of developing the strategy was to them, particularly as we were managing and living with the pressures of winter and the pandemic at the time.

The charts shown below summarise the key findings from each of the workshops and the emerging themes have been used to describe 'what' and 'how' we need to change the way we provide health and care to deliver our aims.

Figure 1 – A diagram to show the method used to develop the engagement approach and gather information to inform the content of the Clinical and Care Strategy

[2] The workshops and other engagement activities were publicised widely using social media and with assistance from the local media.

Figure 2 – Topics identified as priorities by the participants in Workshop 1

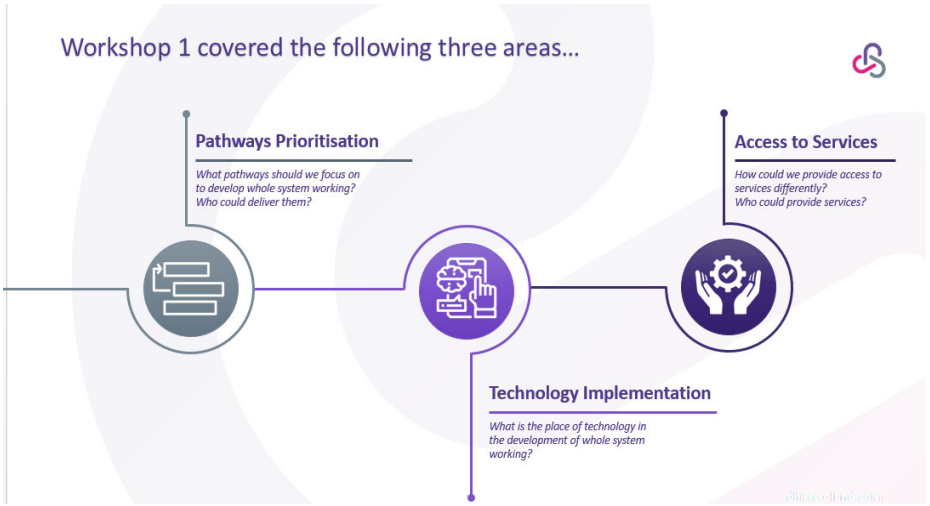
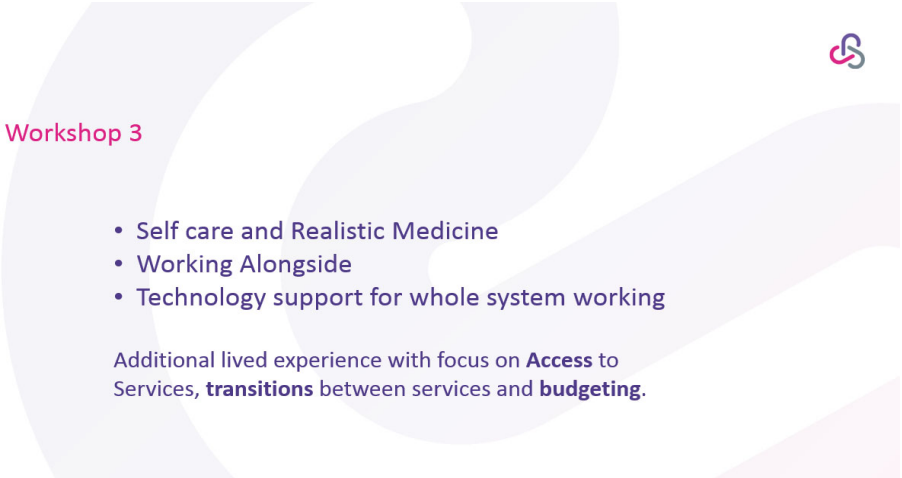


Figure 3 – Themes discussion by participants in Workshop 2

Figure 4 – Themes presented at workshop 3 (national and international perspectives)



What we need to change

Our aim in the development of the strategy was to genuinely listen to people to hear 'what really matters' to the Shetland community. The things that we need to change about the way we provide support through health and care services has been driven by the feedback.

Findings from the community engagement survey

A survey was made available electronically and as a paper document with a freepost address for ease of return, so that people could offer their views and experiences on local health and care services to inform the new strategy.

Over 200 people completed the survey which was open for eight weeks during January and February 2021. In addition to this, we received feedback from young people who organised group discussions to tell us what is important to them.

A summary of the findings is shown below and the feedback, along with contributions from the workshops has been used to develop the emerging themes for the strategy which are shown on the following page. There is remarkable consistency between the themes identified in the workshops with the individual feedback received from people who have personal experience of accessing health and care services across Shetland.

- People want to see improved and easier access to services;
- More support to maintain a healthy lifestyle;
- More support to be independent and stay in their own homes;
- Better continuity in services (and between services) e.g. between GP and hospital or hospital and specialist services; and
- Young people want to be supported to thrive e.g. access to recreational facilities, support with mental health and wellbeing, access the culture of Shetland (music, social events) and a career.

Figure 5 A chart to show the combined themes from the engagement activities e.g. engagement survey feedback

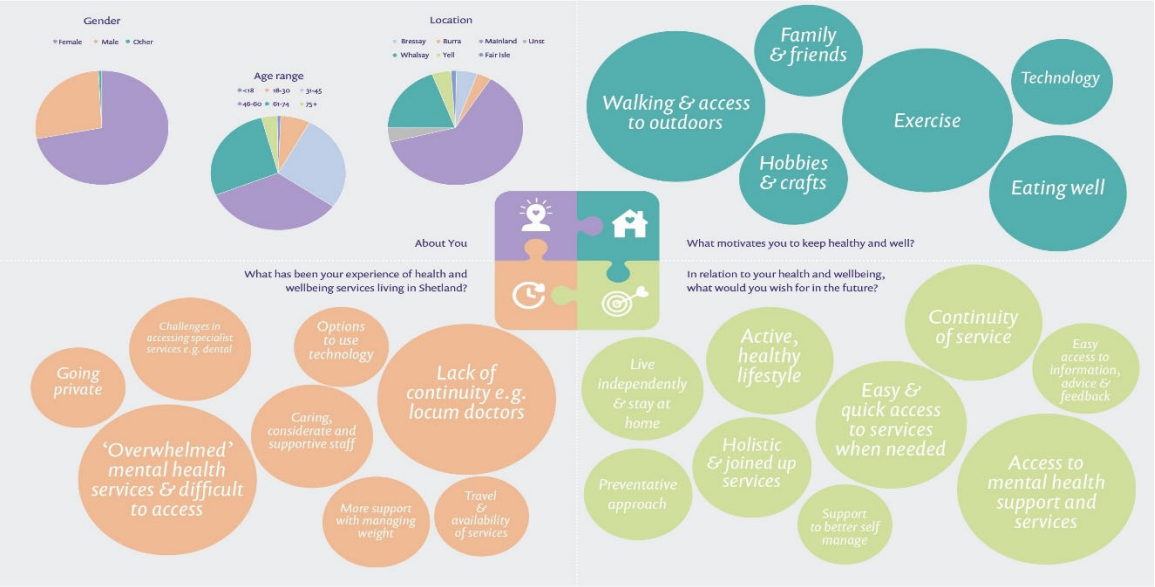
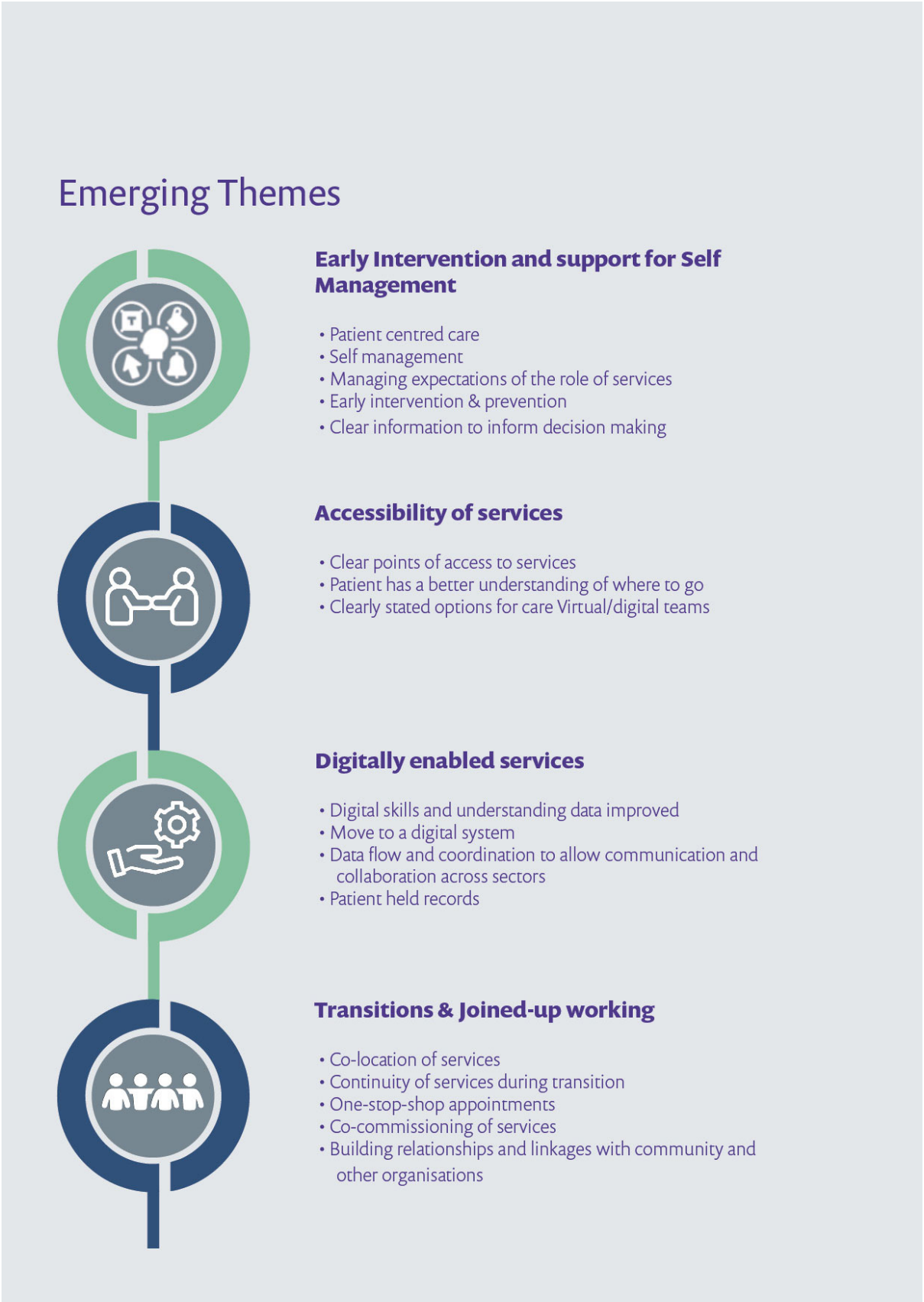


Figure 6 ***Spotlight*** *Gowri Saravanan, Multiple Sclerosis (MS) Clinical Nurse Specialist. Gowri has helped to raise the profile of remote and rural MS services by showcasing the work that she has undertaken during the pandemic to adapt the service to continue to support people with MS using technology instead of face to face consultations*

Figure 7 – A diagram to show the emerging themes from the engagement activities September 2020 to March 2021



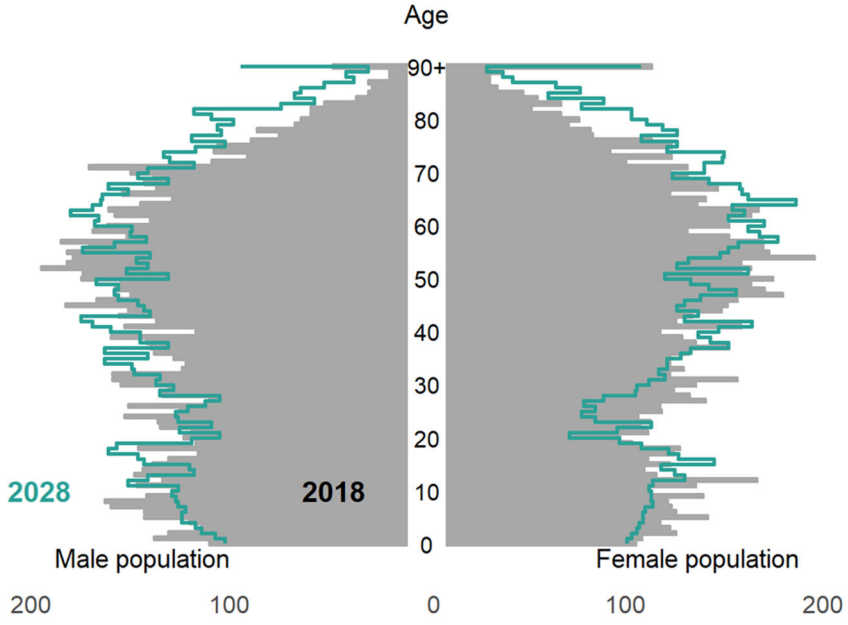
Why we need to change

Demographic changes

The current population in Shetland is about 23,000. As has been the case for many years, people are living longer and therefore the older population is increasing. The chart below shows that the estimated numbers of people in the older age groups is tending to increase between 2018 and 2028, whilst the numbers in the younger age groups is tending to decrease. As well as living longer, there are other factors that influence demography including the number of children born and people moving in and out of Shetland to live and work. This is turn is influenced by the opportunities, economics, community and environment in Shetland, and the experiences and aspirations of individuals and their families.

There are many illnesses that become increasingly common with older age, most types of cancer for example and degenerative conditions by their nature tend to get worse with age. This means that the older the population, then the more health and care needs it tends to have. This is exacerbated because there will be fewer younger people to meet those health and care needs.

Figure 8 A chart to show the predicted population age 2018-2028 in Shetland



Changing patterns of illness and disability

The pattern of illness experienced by the Scottish population has changed significantly, from acute life-threatening illnesses towards long-term conditions and disability. For example previously a heart attack or a road traffic accident may have killed someone immediately, but now with advances in treatment, people survive these events. They can however leave individuals with many years of ill health or disability. This, combined with the increase in certain conditions associated with older age, and changes in lifestyle can lead to people spending many years of their life in poor health and requiring input from health and care services.

Although in Shetland we enjoy relatively long lives compared with most of the rest of Scotland, this is not the same as having a long healthy life. The most recent life expectancy and healthy life expectancy figures for Shetland show that a baby boy can expect to live for 69 years in good health, and 80 years altogether, which suggests 11 years in poor health. A baby girl can expect to live 83 years, of which just 62 years will be 'healthy', i.e. implying 21 years in poor health, or 25% of their lifetime.

This change in patterns of ill health is reflected in the causes of death that we see most commonly in Shetland.

For men, they are:

- Ischaemic heart disease (19.6%)
- Lung cancer (7.5%)
- Chronic lower respiratory tract disease (5.6%)
- Dementia and Alzheimers (4.7%)
- Prostate cancer (3.7%)

For women they are:

- Dementia and Alzheimers Disease (13.6%)
- Ischaemic heart disease (10.0%)
- Breast cancer (5.5%)
- Cerebrovascular disease (5.5%)
- Chronic lower respiratory tract disease (4.5%)

If we look at the conditions that cause the most years of ill health or disability (as measured by 'disability adjusted life years', which combines years of life lost with years spent living with disability), then these are the leading causes in Scotland:

- Cancer
- Mental and substance use disorders
- Cardiovascular disease
- Neurological disorders
- Musculoskeletal diseases

Many (not all) of these illnesses can be prevented, delayed or treated more effectively if identified early. Where conditions cannot be prevented, effective management can make huge differences to individual wellbeing and outcomes, potentially slowing down if not reversing deterioration.

The health of the population and persisting inequalities in health

There are a huge number of factors that impact on the health of the population. Access to health and care services is just one. There are many individual factors such as genetics, lifestyle, behaviour and personal circumstances that can determine health experience and outcomes. These are influenced by interacting underlying factors including physical environment and housing; wealth (or poverty); social support, networks and community; education and employment. The modes of transport that people use are influenced by their income. Evidence shows that

people in lower income households are more likely to take the bus, while people in higher income households are more likely to drive or take the train. The situation is more complex for people on low incomes living in rural areas. People in rural areas drive more frequently than those in urban areas (Transport Scotland, 2019). The issue of 'forced' car ownership has been identified in both rural and urban areas, but is particularly pronounced in rural areas where lack of public transport means that people can be forced into running a car even if it puts real pressures on their budget.[3]

We know that childhood experiences can have huge influences on future health, with adverse childhood events increasing the risk of physical illness in later life. Although we know that Shetland is considered as relatively affluent and a 'good place' to live, this is not the experience of everyone in our community.

- 5.3% of children in Shetland are living in low income families.
- 11% of households in Shetland receive support with housing costs.
- 53% of households in Shetland spend over 10% of their income on energy bills.
- During 2019-2020, the Shetland foodbank distributed 1368 food parcels, including 308 for children.
- The cost of living in Shetland is 20-60% higher than the UK average.

The lists of disease and conditions above that most commonly cause death and disability include a number that we know have specific risk factors. Smoking is still a major risk factor for lung (respiratory) conditions, heart disease and cancers. Obesity, alcohol and lack of physical exercise all contribute. But we know that on a population level people are more likely to have these risk factors if they are living in more deprived circumstances than other people. It is not just the fact that they may be more likely to have these risk factors, socio-economic disadvantage is a risk factor itself.

Early years and childhood experience is now recognised as having a huge impact on adult life, including health outcomes. 'Adverse Childhood Experiences' (ACEs) are not just about direct physical, psychological or sexual abuse of children. They include abuse circumstances such as parental separation, a household member being imprisoned, domestic violence, drug or alcohol abuse or people experiencing mental illness within the child's household. Research has shown that adults who reported four or more 'ACES' were far more likely to be obese, have cardiovascular disease, have a limiting long term condition and have worse mental wellbeing.

Furthermore, even if we have the very best health and social care services, people who are more advantaged or affluent are far more able to access them than people who are more disadvantaged. There are a huge range of factors that influence access: transport, getting time off work, childcare, caring responsibilities, IT access (hardware and skills), communication needs, confidence in accessing services (and feeling deserving of the service), flexibility of services, past experience of services, or beliefs about health and healthcare.

[3] Poverty and Inequality Commission (2019) https://povertyinequality.scot/wp-content/uploads/2019/06/Transport-and-Poverty-in-Scotland-Report-of-the-Poverty-and-Inequality-Commission.pdf

Sustaining and growing our workforce

Acknowledging that there will be considerable challenges to delivering services with growing pressures within the workforce due to the outlined demographics, a comprehensive workforce plan and workforce development plan will support the Clinical and Care Strategy. Priorities will include youth employment, refocusing the age profile, staff experience measures to drive succession planning along with recruitment and retention, working to influence education providers to develop actions to sustain the nursing and medical, AHP, pharmacy and health care scientists' workforce and building capacity with digital resources within Shetland.

A key aim of the revised approach is to ensure that there is closer alignment of workforce planning, operational service developments and financial planning processes and to take forward how planning procedures can be applied in a consistent way to support the integration of health and social care services.

The initial focus of workforce planning is on recovery from the Pandemic. A three year workforce plan is required for 2022-25 when the impact of Covid-19 and longer term implications on services will be more fully understood. This plan will reflect and complement the Clinical and Care Strategy. It will also support implementation of the Health and Care (Staffing) (Scotland) Act 2019.

Key risks in respect of workforce planning include:

- The need to support small, fragile services;
- Challenges in the supply of skilled staff (local unemployment remains low, therefore competition for local skilled resource is high and there is competition across the public sector for the same people); and
- Challenges in accessing training in a remote and rural setting (e.g. more limited opportunities to undertake undergraduate and post graduate programmes via distance learning and blended learning, but this is changing).

Key priorities for role development and workforce planning include:

- Continuing to extend initiatives such as modern apprenticeship opportunities and flexible contractual arrangements to widen access to professions in health and care;
- Continuing to look at ways in which we can support staff to maintain their skills as generalists e.g. increasing investment in learning placements with other health boards to enable staff to develop new skills, maintain skills and be part of a wider professional network; and
- Looking at opportunities to develop alliances with other health and care partners, including other health boards and partnerships to strengthen fragile services e.g. working more closely with the third sector to provide blended services and/or other health boards so that we can share recruitment strategies and posts.

Figure 9 A case study to describe novel and flexible working patterns for doctors that are currently being tested and evaluated

Workforce Case Study

Rediscover the Joy of General Practice is a programme developed by the Scottish Rural Medicine Collaborative aimed at offering novel and flexible working patterns that suit GPs and their teams, at the different stages of their careers and family lives. 'GP Joy' is aimed at providing choice for GPs who may wish to combine urban living and working, with time spent in remote and rural parts of Scotland. The GP Joy recruitment team is based at NHS Shetland and there has been considerable success in matching GPs with placements in very remote Practices across Shetland. This has helped to sustain medical services in the North Isles in particular, where recruitment was challenging.

We have since developed a similar approach for other medical roles, with rotational posts for Consultants working in various settings including emergency medicine and obstetrics and gynaecology. More novel approaches to role development and recruitment, combining working in Shetland with other interests is a new approach and one that we will develop across the professions to help ensure we have the right multi-disciplinary teams for the current and ongoing delivery of services.

A need to reduce waste, harm and variation in treatment: values based healthcare

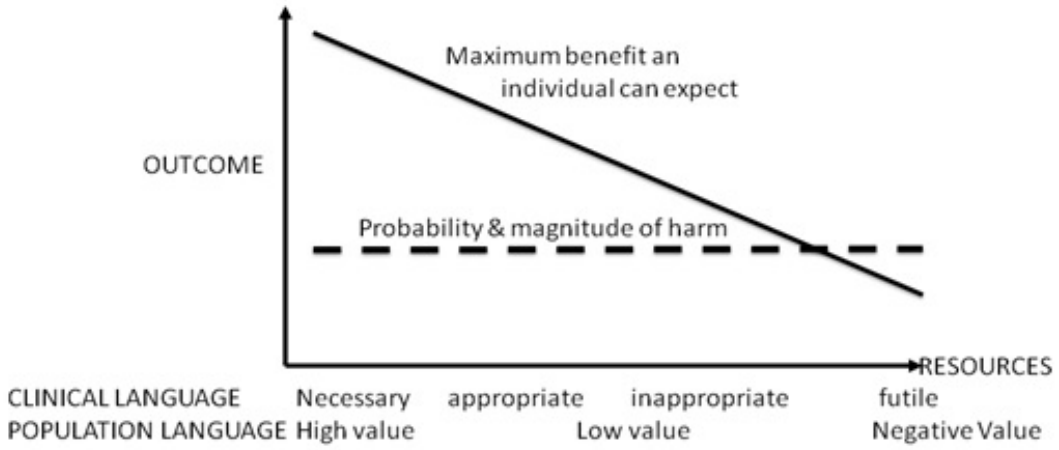
One of the fundamental principles of a healthcare system must be to avoid harming our patients, our staff and our population. Clearly in a publically funded health and care system with finite resources, reducing waste must be also be a key objective of this Clinical and Care Strategy. Unintentional harm and waste can be caused by both overuse and underuse of resources, and by unwarranted variation in care.

'Unwarranted variations' in healthcare describe differences in resource allocation, resource use or outcomes in health that are not explained by patient preference or by their individual circumstances or by their specific illness or conditions. Recognising unwarranted variation is of vital importance because it allows the identification of:

- Underuse of higher value interventions – i.e. under-treatment
- Overuse of lower value interventions
- Overuse of interventions which may result in increasing harm

It will also inform discussion on how to shift resources to areas which provide the greatest value.

Figure 10 A chart to show how high value or necessary interventions provide most benefit and reduce harm



Many interventions have a risk of harm. This chart shows how high value, or necessary interventions provide the most benefit, which outweighs any harms. But as the intervention becomes lower value, or more inappropriate, then the maximum benefit reduces until it is outweighed by risk of harm, whilst at the same time using increasing resources.

A 'value based healthcare' approach aims to deliver excellent and consistent health outcomes that matter to patients and their families and make best use of available resources – by reducing waste, harm and unwarranted healthcare.

"Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person."

Demand for health and care services is increasing and we have to make the best use of the resources we have to ensure the best possible care for both individual patients and the population as a whole. We already focus on services and interventions being effective, cost effective, high quality and safe but to be high value, they need to be delivered to the 'right' patients at the 'right' time. This means reducing unwarranted variation and waste and therefore reducing harm.

There are three types of value that need to be address within a universal health and care system to achieve the highest value and best outcomes for patients and the population. This is referred to as 'Triple Value' health care.

- Personal value is about improving outcomes that matter to the individual.
- Population value is about allocating resources across a health and social care system to maximise the health and wellbeing of the whole population covered by the system.
- Technical value is about how well the allocated resources are used to achieve valid outcomes for all the people in need within the population, and is about equity as well as good outcomes.

Reducing waste, harm and unwarranted variation, and the concept of value based healthcare are part of a broad approach to healthcare called Realistic Medicine, discussed later in this document.

How we need to change

The need to embrace early intervention and community led support

Key statistics about this service
Community Led Support is a philosophy – or a way of working – that does not lend itself to 'counting' in the traditional sense associated with Health and Care Services but there is evidence that this approach has a real and meaningful impact on people's overall health and wellbeing.

Strategic objectives and guiding principles
To make sure that "citizens are seen by the right person, at the right time and in the right place".

Community Led Support seeks to change the culture and practice of community health and social work delivery so that it becomes more clearly values-driven, community focused in achieving outcomes, empowering of staff and in a true partnership with local people.

The underpinning principle is to build on the assets that are found in the community and mobilise individuals, associations, and institutions to come together to realise and develop their strengths. The identified assets from an individual are matched with people or groups who have an interest in or need for those strengths by using what is already in place in each the community. This approach sees health and care solutions being developed with communities and often out with the formal health and care settings.

The guiding principles are:

- Co-production brings people and organisations together around a shared vision
- There has to be a culture based on trust and empowerment
- There is a focus on communities and each will be different
- People are treated as equals, their strengths and gifts built on
- Bureaucracy is the absolute minimum it has to be
- People get good advice and information that helps avoid crises
- The system is responsive, proportionate and delivers good outcomes

How we will focus on early intervention
This approach encourages those people who require a relatively low level of support to identify and manage their own support needs.

Ways in which we will improve access
Providing advice and support and, where appropriate, redirecting people to the most appropriate community service, will help to improve access. The services may be statutory services or those run by community or non-statutory organisations.

Ways in which we will work in a more integrated way
By working together, with individuals and communities, we will support an approach where 'no door is the wrong door'. People will be well informed about the services on offer and the choices they have over accessing these.

Ways in which we will use technology to provide more person centred care
This way of working is underpinned by close relationships and face-to-face interactions and while technology may assist with supporting the arrangements it is not a primary consideration.

Figure 11 A Case Study – an example of community led support for young people with lifelong care needs

Shetland Community Connections

Shetland Community Connections is a local charity with a vision for a person to have the freedom to be ordinary. They embrace the principle of using a person's assets to build on their strengths and where they can contribute and be a part of their own community. They encourage individuals to explore what a good life looks like for them, what is working well, what resources they have around them and if they are needing a bit of extra support they support people to get this.

As a result of the safety measures required to deal with Covid-19, some of the more traditional service models were not available to our young people with lifelong care needs, when moving on from a school setting. For some of our young people, job or training opportunities available to others may not be suitable for them and it can be an anxious time for them and their families. Working with Shetland Community Connections, one young person was able to find a work placement in the community which suited their interests and skills. The family said, "things have actually worked out for the best and I am delighted with the package that we have put together. … [name] is so sociable, the package really complements that".

Opportunities for increasing support for self-management and monitoring

Key statistics about this service
Improvements in health care have resulted in greater numbers of people living with multiple chronic conditions for longer periods of time. With this change, chronic illness is now a major focus of health care.

Many prevalent chronic conditions, such as heart disease, diabetes, and arthritis, though unique in their own attributes and demands, share common challenges associated with their management. These include dealing with symptoms and disability; monitoring physical indicators; managing complex medication regimens; maintaining proper levels of nutrition, diet, and exercise; adjusting to the psychological and social demands, including difficult lifestyle adjustments; and engaging in effective interactions with health care providers.

Strategic objectives and guiding principles
Self-care and self-management are terms used for how we work with people. It is about recognising that people have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. It is also about enabling individuals to live with their long term conditions, ensuring that they maximise their positive health and well-being outcomes. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their

own health. They may do this independently or in partnership with the healthcare system.

We will work with people to help them to better understand when they can look after themselves, when a pharmacist can help, and when to get advice from a GP or another health or care professional.

Self-care is the practice of consciously doing things that preserve or improve people's mental or physical health. It is about supporting people to make positive choices to look after their own health and wellbeing. This covers both mental and physical health. Self-care has a number of benefits, such as improving physical health, reducing stress and anxiety, boosting self-esteem, protecting mental health and having better relationships.

How we will focus on early intervention
An early intervention approach can, in some cases, avoid ill health or accidents. This might be in the areas of, for example, a positive approach to diet, nutrition and exercise, maintaining a healthy weight, avoiding excessive alcohol or drug use, avoiding smoking, staying connected to other people and preventing falls.

Ways in which we will improve access
Self-care is an approach which is available to the whole population, as well as supporting people to manage their long term conditions. It is one of the underpinning principles of the Realistic Medicine approach, which encourages all health and care workers to find out what matters most to people so that support can be designed to best fit people's needs and situation. The work can be supported by a range of partners, often through social and community connections out with formal health and care settings.

Ways in which we will work in a more integrated way
By definition, self-care and self-management puts the person receiving health and social care at the centre of decisions made about their care and encourages a multi-disciplinary approach to meeting their needs in a holistic way.

Ways in which we will use technology to provide more person centred care
This approach is best supported by good conversations, often using motivational interviewing techniques, but technology is already helping many people to manage their own health on a day-to-day basis, such as online information and advice, lifestyle apps and wearables, and online symptom checkers.

We work to support people to stay well in their own home. There are a number of self-help technology systems to help people to do that, such as automatic pill dispensers, reminder clocks or personal alarms.

Figure 12 A Case Study – patients using technology to monitor their symptoms, share data and access advice remotely

Using technology to self-monitor COVID 19 symptoms

During 2020-21, in response to the pandemic, NHS Shetland purchased 50 pulse oximeters, for patients who had been diagnosed with Covid-19. Those patients were then able to self-monitor their oxygen saturation levels. They had regular follow up calls with the COVID assessment centre who checked on their levels and gave advice. This meant that people could be monitored at home, which helped to reduce their anxiety, and medical assistance could be provided if their levels dropped.

Figure 13 A Case Study – examples of ways in which people will use technology to support self-care in the future

Using technology to support behaviour and lifestyle changes

Many health apps and wearables relate to healthy living, including fitness, lifestyle, stress, diet and nutrition. There is emerging evidence that these apps can have a positive impact on diet monitoring, physical activity, adherence to medication and management of long-term conditions. By using behaviour-change techniques such as promoting goal setting, reviewing progress and feeding back on performance, these apps have the potential to improve individuals' daily choices and lifestyle decisions, encouraging healthier living in the wider population.

The need for realistic medicine

"By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine."

Realistic medicine is the Scottish approach to tackling some of the major challenges in healthcare provision in the 21st century. It was first launched in the Chief Medical Officer for Scotland's Annual Report for 2014-15[4]. This posed the following questions:

- How can we further reduce the burden and harm that patients experience from over-investigation and overtreatment?
- How can we reduce unwarranted variation in clinical practice to achieve optimal outcomes for patients?
- How can we ensure value for public money and prevent waste?
- How can people (as patients) and professionals combine their expertise to share clinical decisions that focus on outcomes that matter to individuals?
- How can we work to improve further the patient - doctor relationship?
- How can we better identify and manage clinical risk?
- How can all doctors release their creativity and become innovators, improving outcomes for people they provide care for?

These are not new themes, and there are many initiatives and programmes aiming to tackle the same issues in different nations. Realistic medicine aims to bring together these themes into one approach that underpins our approach to delivering healthcare now and into the future. There are six key areas, but these are underpinned by and linked to broader concepts.

[4] https://www.gov.scot/publications/chief-medical-officers-annual-report-2014-15/

Shared decision making Personalised approach to care Reducing harm and waste Reducing unnecessary variation in outcomes and practice Managing risk better Improvement and Innovation	Valuing & supporting our workforce Creating a sustainable workforce Compassionate leadership Engaging with patients Culture of Stewardship Value based healthcare Green & sustainable healthcare

There are a wide range of tools, resources and training that can support health and care providers, staff, patients and the population working together to achieve a sustainable service that produces the best possible outcomes for patients and the population within our finite resources.

Much of the realistic medicine approach relates to changing culture and attitudes of both those who work in health and care, and the patients, service users and wider community. However there are specific initiatives that are focusing specifically on one or more of the themes above. For example national projects include a Citizen's Jury on Shared Decision Making; the development of a Scottish Atlas of Variation; and the 'five key questions' to support shared decision making. There are national training resources on shared decision making and a Value Improvement Fund, which has funded two local projects: Diabetes Pathways and Tele-pharmacy: Utilising Pharmacy Skills.

In addition to this, we have included the principles of realistic care and realistic medicine into our Palliative and End of Life Care Strategy[5]. The focus of the strategy is to offer person-centred holistic anticipatory care planning, supporting choice and control to the individual, their family and carers, engaging in timely, open and honest conversations that focus on quality of life outcomes.

Realistic medicine and realistic care – five key questions

- Is this test, treatment or procedure really needed?
- What are the benefits and what are the downsides?
- What are the possible side-effects?
- Are there simpler or safer options?
- What would happen if I did nothing?

[5] https://www.shb.scot.nhs.uk/board/meetings/2019/1210/20191210-19_20_58.pdf

Changes in the range of possible medical treatments

This summary has been developed to share some of the available evidence around the use of technologies to inform longer-term thinking about the role of digital technology and medical innovations.[6]

Strategic objectives and guiding principles
Person-centred care
Optimising outcomes
Prevention

How we will focus on early intervention

Genomics and personalised medicine: advances in technology are enabling the identification of an individual's genetic code which means we can start to predict the likelihood of developing conditions such as diabetes or heart disease. This could allow a tailored approach to prevention, the choice of medications (as we all have individual differences in how we respond to some drugs) and even gene therapy to reduce these risks.

There are potential problems with such an approach in terms of people's ability to understand the risk and act on the information. People may become anxious knowing that there is a possibility of developing a disease even if the chances are not high. There is also the possibility that the information might be used by insurance companies or employers, thereby creating inequities. People considered higher risk may find that they are "uninsurable" or that fees are too high for them, creating more inequalities.

Gene therapy is starting to be possible for a small number of conditions but the cost is currently restrictive, so it is not widely available. With time the cost is likely to fall. The ability to prevent or cure diseases and reduce suffering brings hope but there is a pressing need to explore the legal and ethical aspects of these advances.

Wearable technology: the possibility of monitoring all sorts of measurements such as our body temperature and blood pressure, and to interpret these measures in terms of health, brings the ability to spot where people might benefit from intervention at an early stage. The evidence for these technologies is at an early stage and there is the potential that the measurements themselves cause more anxiety as people are continually reminded of their blood sugar levels or blood pressure and become fixated. Cheap and accessible monitoring could reduce the need for hospital appointments and admissions for observation for people with sleep problems and where epilepsy or diabetes is difficult to control.

Use of **Artificial Intelligence** in diagnosis and decision-making: by making better use of the data that exists in medical records and from individuals, computer programs can prompt people to the relevant information and analyse several pieces of information without the need to trawl through notes. Computers are able to "read" images and data, increasing the potential to pick up changes at an early stage and

[6] https://www.kingsfund.org.uk/publications/future-digital-technology-health-social-care

find abnormal heart rhythms in a fraction of the time taken by a human with less risk of error.

In the operating theatre, **robotic** machines are assisting surgeons to increase the precision of operations. This requires a change to training of surgeons and a new skill set. This approach could minimise the effect of the operation, reducing recovery time and therefore time spent in hospital. It is also possible that the range of people that could benefit from surgery would increase as previously “inoperable” lesions become possible with robot-assisted surgery.

Ways in which we will improve access
Clinicians will need to help people to navigate and decide what will give them the best potential outcome given what is important to them. Risk is a difficult concept – the possibility that something may happen in the future makes for difficult decision making. The role and training of health care professionals will need to change to support the different needs of the population. People will require more information and time to explore meaning and how this fits into their lives. The ability to then tailor support for people through technology and with resources in their community should mean fewer but longer appointments with the NHS.

Delivery of care close to home using drone technology enables delivery of equipment and treatments, reducing the need for people to travel. In our island context this would support us to deliver more care locally and use resources more effectively on direct care. The need to visit a health care building will be for defined purposes, freeing up time and resource for ongoing support to be provided in a more person-centred way.

Local teams will have multiple roles:

- in support of a wider range of remote, specialist input able to support early discharge home.
- to build community confidence to provide early support to those in crisis.
- to build education and resource to maintain wellbeing and health.

Reducing the length of stay in hospital will continue the drive to more community based care. This means that there is a potential to provide more care to more people. In the event of another pandemic this increases the bed capacity from 50 in the current hospital to thousands through the use of technology enabled care.

Ways in which we will work in a more integrated way
A team-based approach will be used recognising the skills and competencies of a variety of individuals working together to support individuals.

Ways in which we will use technology to provide more person centred care
Robot Assisted Surgery will be more commonplace to increase the precision of surgery, increasing the potential and reducing hospital stays.

Improved virtual consulting, incorporating the ability to examine patients using digital equipment.

Opportunities from the increasing availability of digital and technology enabled care

The table below describes some of the ideas that were offered during the engagement activities on the ways in which we could utilise technology to support and enhance health and care in Shetland. In particular, they look to address some of the barriers that currently exist.

Figure 14 – Examples of ways in which we will use technology to support future care, taken from the workshop discussions

Using Technology to Support Health and Care – Ideas for the Future

- People being in control of their own data
- Joined up working between health boards
- Use of devices for assessment, for example self-monitoring for diabetes or COPD
- Learning from the pandemic, offering virtual consultations as a standard way of accessing advice, support and care. Widening patient choice on how they can access services
- Developing a health information portal, bringing together information including medical, other services and schools (to reduce duplication and repetition)
- The key is thinking about technology to bring people together, join up services, to enhance interaction and improve coordination of care

We also need to ensure that as technology becomes a growing part of how we support health and care services, we also need to think about how we prepare and train staff to incorporate digital skills into everyday practice. We also need to ensure that staff can access technology to support learning.

Remote and rural challenges to high quality healthcare and international solutions

One of the opportunities for NHS Shetland and the Health and Social Care Partnership (H&SCP) is to learn from the experience of international health and care systems and how they have addressed challenges in the delivery of care in remote and rural settings. It is recognised in the National Clinical Strategy for Scotland (2016)[7] that 20% of people in Scotland live in geographically remote places and there are unique challenges in ensuring the sustainable provision of health and care to people living in rural Scotland.

In acknowledging that remote and rural healthcare is by its nature high variation and low volume, we need to ensure that we develop clinical pathways that are safe and there is a robust clinical governance framework in place to enable clinicians to access advice, decision support and opportunities for training. The National Clinical Strategy for Scotland recommends that for highly specialist care e.g. some types of rare cancers, planning for these services should be undertaken at a regional or a

[7] https://www.gov.scot/publications/national-clinical-strategy-scotland/

national level and the procedures carried out in specialist centres to preserve the high standard of specialist skills in the surgical team and multidisciplinary teams, maximising the best outcomes for patients.

The majority of services though can and should be delivered locally. Digital health and technology have the potential to offer solutions that can strengthen health and care systems by bringing specialist services to rural communities. These solutions include remote consultation with a health professional, remote monitoring and self-management, the sharing of patient information, remote decision making support between local practitioners and specialists and training opportunities e.g. simulations.

Some healthcare providers, for example Intermountain Healthcare[8] in Utah have built hub and spoke models of care to provide a range of services with varying degrees of complexity and setting e.g. ranging from services offering patient advice to support self-management, through to clinical pathways to provide decision support to clinical teams providing critical care in remote settings. The technology infrastructure at Intermountain Healthcare enables multi-disciplinary teams to use tele-health and tele-care to bring together 41,000 care givers including hospital teams and care at home teams, working together in an integrated system. This approach is a sophisticated example of the clinical networks described in the National Clinical Strategy for Scotland (2016), where specialist teams provide support to peers who may be based in a small community hospital, clinic or a person's home, or they could be working in a large teaching hospital.

Notwithstanding the need to offer highly specialised treatments in specialist centres of excellence, this example is important because it demonstrates that high quality standards of care can be achieved consistently in a range of settings, which are comparable with those that you would expect to see in a specialist service[9].
The role that digital health can play has come under the spotlight during the pandemic. The use of digital tools such as contact tracing apps to monitor outbreaks and online consultations to help keep health professionals and patients safe while providing continued care are some of the ways that the potential of digital health has been harnessed. These digital methods of delivering health care are here and will very likely stay.

Recent examples of digital health solutions being used successfully in remote and rural areas include:

- the treatment and monitoring of chronic disease in the USA[10]
- improving access to specialist health services in rural Australia [11]
- tele-paediatric burns service provided in Queensland Australia[12]

[8] https://intermountainhealthcare.org/

[9] https://www.kingsfund.org.uk/publications/reforming-nhs-within/case-study-2-intermountain-healthcare

[10] Graves et al, 2013 https://link.springer.com/article/10.1186/1471-2458-13-16

[11] Moffatt & Eley, 2010 A*ustralian Health Review* 34(3) 276-281 https://doi.org/10.1071/AH09794

[12] Kimble & Smith 2004
https://www.academia.edu/12678191/A_review_of_three_years_experience_using_email_and_videoconferencing_for_the_delivery_of_post_acute_burns_care_to_children_in_Queensland

In a recent report based on international surveys of 60 chief executive officers of mid to large-sized healthcare companies in 2019, the consultancy company McKinsey highlighted a number of examples where healthcare providers are partnering to create new access in rural markets that benefit the local patients and local hospitals by extending services. This included virtual specialist care offered by an academic medical centre to rural areas.[13]

In 2019 a symposium on digital health organised by WHO/Europe showcased how governments and organisations can use health technologies to reduce inequities and improve health and well-being. In Kyrgyzstan for example, a safe delivery app provides midwives with guidance to deal with different birth scenarios – including some that may require an emergency response. The app itself, in use in more than 40 countries, was developed by the Maternity Foundation in Denmark.

In Finland, a patient-oriented digital health-care service known as Health Village was set up by different university hospitals. The online platform enables people to plan and manage their own care using simple medical devices to send readings to health professionals. It allows for a more streamlined approach to health care that takes into account the lives of patients who may struggle to find time to attend routine appointments[14].

These examples represent just a few of the recent innovations in technology used to enhance remote and rural care, making services more sustainable and person centred.

Figure 15 ***Spotlight*** *Senior Nurse Carol Colligan, who leads our air ambulance nurse escort team supporting a patient travelling to the mainland for specialist care*

[13] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/virtual-health-a-look-at-the-next-frontier-of-care-delivery#

[14] https://www.euro.who.int/en/health-topics/Health-systems/digital-health/news/news/2020/9/digital-health-transforming-and-extending-the-delivery-of-health-services

Primary Healthcare

Primary Healthcare

The budget for Primary Healthcare is approximately £4M. There are 10 GP Practices in Shetland, ranging in size from 600 patients to 8700 patients. Of these, four single-handed GP practices provide their own Out of Hours (OOH) cover - Unst, Yell, Hillswick and Whalsay. The other practices on the Shetland mainland provide OOH cover through initial contact with NHS24 and a visiting clinician will then undertake house visits where required.

Levenwick, Walls, Yell, Whalsay and Lerwick provide cover respectively to the non-doctor islands of Fair Isle, Foula, Fetlar, Skerries and Bressay. The largest practice in Lerwick is a multi-clinician practice, with a mix of GPs, Advanced Nurse Practitioners, and a First Contact Musculoskeletal (MSK) Physiotherapist. It is anticipated that a further First Contact MSK physio will be employed during 2021/22, to extend the coverage of this role to the other practices across Shetland.

Two practices in Shetland have introduced the AskmyGP service (see below), which enables patients to send queries even when the practice is closed, reducing access times and increasing patient choice. A further two practices are scheduled to introduce the service in 2021/22. Practices are also in the process of extending an online process for ordering repeat medication, allowing this to be ordered 24/7.

On average, GP Practices provide approximately 6000 appointments per month, providing a range of services including GP and ANP appointments, Practice Nurse and Healthcare Assistant appointments (which includes cervical screening, childhood immunisations, dressings, blood tests and long-term condition reviews), and of course the First Contact MSK Physiotherapist. Appointments are provided through a blend of face to face, telephone, email (through AskmyGP) and using technology such as Near Me.

There are additional visiting services available within Primary Healthcare, including the Citizens Advice Bureau, which provide a service to all health centres, so that patients can access this service without having to travel to Lerwick.

Strategic objectives and guiding principles

Our overall strategic objective is to develop a unified primary care service. Investment in community based services and strengthening primary care are two key elements of making the ‘whole system’ approach work by keeping activity out of the acute and hospital sector. We recognise that this shift in emphasis may put pressure on community resources, including GPs. There is a need to make sure that we make the best possible use of GP time and resources and get better at further developing a team approach to meet people’s needs. These teams will be multi-disciplinary and can include any health care professionals appropriate to meet health and needs, such as social care staff, nursing staff, allied health professionals, pharmacists, health improvement practitioners, therapists, third sector support, etc.

We will be supporting more people – and more frailer people - to remain living at home for as long as possible. People with care needs living in the community will have even higher levels of support needs than at present.

The main aim is to support people with health and social care problems to stay in their own communities, help them to learn to manage their conditions and, whenever possible, reduce the chances of them having to be admitted to hospital. This will mean that some services traditionally supplied in hospitals will be provided in community settings.

The teams can be physically located in one place and work out of any of the health and care buildings, in people's own homes, or be 'virtual' in nature and supported by technology to take place through video conferencing, telephone or other technology enabled solutions.

It might mean that people do not necessarily need to see a GP first to arrange health and care needs; people might see, for example, a nurse or a pharmacist or a physiotherapist. This might mean that staff have to travel and move around a bit more. It might mean that service users have to wait a little while longer, so that there are enough people to see to make it an efficient use of staff time. It might mean that we have to share scarce resources throughout Shetland to make better use of all our staff resources and skills.

We are working towards service models which deliver:

- A single point of access for queries.
- A 'No door is the wrong door' approach.
- Support for self-care and self-management, enabling people to make choices about their care.
- Better access to the right person.
- Fair and equitable distribution of staff and resources, to match the need in each area.
- Appropriate use of technology, avoiding the need for unnecessary travel.
- Maximising wider community based skills and resources.

How we will focus on early intervention

Primary Care services will support a whole system approach, embracing the concept of Community Led Support and sign-posting to services and arrangements out with health and care, where it is appropriate to do so. Whilst the principles of 'social prescribing' (that is, referrals to other community resources) are supported, there is a recognition that this is best done informally and by encouraging people to access those services directly on their own volition, through good information, advice, education and networks.

Ways in which we will improve access

- Opportunities for self-referral services are available and will be more widely publicised.
- The work of Community Pharmacies in providing diagnostic and treatment services for a range of conditions will be promoted and encouraged, to avoid people viewing the health centres as their point of access for more minor health needs.

- The Covid-19 Pandemic has presented new opportunities for adapting access to services with repatriation of services to Shetland, or access to mainland based specialist services using video conferencing and other tools, supported by local experts and health practitioners in Shetland. This approach will be developed for certain care pathways, as appropriate, with the added benefit of avoiding unnecessary travel.

Ways in which we will work in a more integrated way

- We intend to move towards more patient led pathways, using the 'House of Care' model for long term conditions[15]. This is a person-centred, coordinated model of care which enables people to make informed decisions that are right for them, and empowers them to self-care for their long term conditions in partnership with health and care professionals. This supports a move away from the 'episodic' nature of current care models.
- We intend to better join up the patient experience from primary care to secondary care, enabling primary care practitioners to be more involved from referral through to treatment.
- There is an opportunity to further develop collaborative and effective discharge planning, so that care plans are co-produced with the people involved at the centre and with all partner agencies involved in that person's continuing care.

Ways in which we will use technology to provide more person centred care

- There is an identified need to better join up our digital information systems, with our service users and across all health and care services, with personal data security and appropriate access to information at its core.
- The ability to make appointments through booking apps is available for some services and can be more widely used and promoted.
- During Covid-19, Lerwick Health Centre rolled out an online service (Ask My GP), where the GP picks up the patient request - usually in 24 hrs - and responds. The opportunity to roll this out to all settings would allow people to access a GP at a time that suits them, if they have a simple query. In turn, this will free up GP time to deal with patients who need face to face appointments.

However, it will always be necessary to operate a mixed model of access and advice, due to limitations on usage which may be caused by technology literacy and connectivity barriers.

[15] https://www.alliance-scotland.org.uk/health-and-social-care-integration/house-of-care/

Figure 16 A Case study of current best practice in primary healthcare

Podiatry musculoskeletal pathways deliver savings and earlier access to appropriate treatments

NHS Shetland does not have an orthopaedic service on the islands, meaning anyone requiring this service has to travel to the mainland, which is costly and time consuming for the Health Board and the patient. As Allied Health Professionals, Podiatrists assess, diagnose, treat and rehabilitate autonomously and independently of supervision. Podiatrists have fully utilised these skills to develop local musculoskeletal (MSK) pathways, which are leading to improved outcomes for patients.

All orthopaedic referrals from primary care in NHS Shetland are now triaged by MSK specialist Podiatrists. The podiatrist fully assesses the person before deciding which intervention would be most appropriate for their needs. The lead MSK Podiatrist also heads up a foot and ankle video conferencing service with the consultant orthopaedic surgeon at the Golden Jubilee Hospital in Glasgow. Patients attend a clinic in Shetland with the Podiatrist and Physiotherapist and are linked directly with the surgeon in Glasgow. Should the patient be deemed inappropriate for surgical intervention, or would prefer not to have surgery, this allows the multi-disciplinary team to discuss treatment options and the podiatrist to offer alternative treatments.

Figure 17 A Case Study setting out the future for primary healthcare and the House of Care approach

Implementing the House of Care model in all our health centres

This way of working has been created out of a need to change the way we support people with long term conditions so that it is more personalised and integrated. This aims to:

- Develop a ‘birds eye’ view of the total care and support needs of an individual;
- Reduce the focus on single conditions only, where a person may have several long term conditions;
- Pay more attention to the mental health and wellbeing of people with ‘physical’ health problems;
- Take more of a whole system approach with social care or other services important to people with long term conditions (e.g. transport, employment, benefits, housing);
- Enable patients to access and use their own health records and ensure that health professionals can access them between settings;
- Identify vulnerable people who might then be given extra help to avoid hospital admission or deterioration/complications of their condition(s); and
- Stop treating people as passive recipients of care rather than encouraging self-care and recognising the person as the expert on how his/her condition affects their life.

Adult Mental Health

Strategic objectives and guiding principles

The Scottish Government's Mental Health Strategy gave a commitment to,
"prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems".

This will mean working to improve:
- Prevention and early intervention;
- Access to treatment, and joined up accessible services;
- The physical wellbeing of people with mental health problems; and
- Rights, information use, and planning.

Local priorities are:
- Ensuring people can access information to maintain their own mental health;
- Promoting resilience and mental health promotion to prevent mental illness and distress;
- Early recognition and treatment of mental illness and disorder;
- Providing person centred care which can only be achieved through well integrated services focusing on an individual's needs including their carer(s) and families;
- Ensuring service users are at the centre of care and treatment;
- Effective engagement of families and carers to support care and treatment; and
- Embedding recovery approaches within services.

Recently, in response to the emergency Covid-19 Pandemic, the Scottish Government convened a short-life working group which reported on Mental Health in Primary Care.

The Group agreed some principles to underpin service delivery, including:
- All parts of the system should enable support and care that is person centred, looking to access the most appropriate information, intervention and support in partnership with the individual through shared decision making;
- Trauma Informed Practice will be the norm;
- Wherever a person is in touch with the system they will be listened to and helped to reach the most appropriate place for them - there is no wrong door;
- Digital approaches to self and supported management of distress and mental health conditions will be an integral part of the service with the caveat that those who are digitally excluded need to be engaged positively in different ways; and
- Evidence based psychological therapies need to be offered, with appropriate supervision and stepping up seamlessly to secondary care mental health services where appropriate.

How we will focus on early intervention
We will campaign for positive mental health to be as widely accepted and talked about as is physical health. We will appropriately challenge stigma and stereotypes and take an open and inclusive approach to addressing the mental wellbeing of everyone in our community.

Training in workplaces and schools will encourage people to be more confident in dealing with lower level mental health issues, where community resources and services can be beneficial.

Ways in which we will improve access
Through consultation, participants highlighted that there are challenges in accessing specialist services. People considered that mental health services in particular were 'overwhelmed' or 'stretched', with limited opportunity for outreach services.

There is therefore a need to build a greater understanding of where to go for the right support, using a range of advice, information and education. This work will include clear explanations on the role of the specialist Mental Health Services, which deal predominantly with diagnosed mental health conditions. It will explain the role of primary care services and community support as well as information on how people can individually look after their own mental health and wellbeing.

Ways in which we will work in a more integrated way
Team working is important in mental health support and treatment, using the 'House of Care' philosophy to wrap services around the needs of individuals to manage their long term health needs and respond to episodes of crisis, if they arise.

Ways in which we will use technology to provide more person centred care
Whilst face to face support will often be the only appropriate method of providing treatment and care, there are a range of accredited online resources and advice packs to support people to look after their own mental wellbeing, either as an individual, in a group setting, or with the guidance of a practitioner.

The Covid-19 Pandemic has opened up opportunities for exploring support, advice and counselling through video or telephone appointments, which improves access overall and can avoid the need for unnecessary travel. This has suited some of our service users.

The Community Mental Health Team has access to a wider range of digital therapies for individuals which includes:

- Beating the Blues - for stress, low mood, anxiety and depression. It consists of eight modules and helps patients learn basic CBT techniques.
- SilverCloud (unsupported programme) - for stress, resilience, Covid-19, and sleep difficulties.
- SilverCloud (supported programme) - for anxiety and depression related to Covid-19, health anxiety, social anxiety, chronic pain, lung conditions, rheumatoid arthritis, diabetes and coronary heart disease. In this programme, patients are allocated to a psychological therapist who will review their progress twice only. The first review takes place five weeks after sign up to the programme and the second review takes place five weeks after the programme has ended. Patients can receive IT support if needed.
- IESO - this is a newly available online treatment option that offers patients Cognitive Behavioural Therapy (CBT) via live, one-to-one written communication. The patient and nominated therapist meet in a secure, online, virtual therapy room. The patient can choose to have appointments at a time that suits them and treatment is enhanced through the offline messaging system that occurs between sessions.

Figure 18 Case Study – an example of a model for mental health in primary care, taken from the Scottish Government learning from the Covid-19 Pandemic

Proposed model for mental health in primary care

Within an area … there should be a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing problems. The multi-agency team may include occupational therapists, mental health nurses, psychologists, enhanced practitioners, link workers as well as others such as those providing financial advice, exercise coaches, family support and peer networks.

The team would provide timely support and treatment for people in that setting with the GP providing clinical leadership and expert general medical advice where needed. Where more specialist input is required, the resources of Community Mental Health Team or other appropriate secondary care Mental Health service would be accessed and work in partnership with the Primary Care team where appropriate (e.g. shared care around medication).

That team would provide assessment and support to the individual to access appropriate levels of advice, community engagement treatment or care.

The team would work closely with and / or be part of the wider community team in that area, engaging with the wider assets of the community, health and social work staff and with other agencies as appropriate.

Systems should allow patients to be directed to an appointment with the appropriate members of the MDT based on self-directed care, including self-referral. A critical part of this approach will be a local communications strategy to inform local populations about how they can access services.

Figure 19 ***Spotlight*** *Occupational Health Nurse Sam Wylie receiving the first Covid-19 vaccination given in Shetland. Pictured with Nurse Vaccinator Margaret Cooper in December 2020*

Children and Babies

Key statistics about this service

Children make up 17% of the total population in Shetland and around 200 babies are born each year[16]. Children's services are provided across primary, secondary and tertiary care. The greatest healthcare input to children and babies by far is via primary healthcare teams and universal services provided by GPs, midwives, health visitors, occupational therapists, physiotherapists, speech and language therapists and school nurses, with a focus on health and wellness in early years to prevent illness in later life. There is close working with schools, children's services in the Council and the third sector, via the Shetland Children's Partnership (SCP)[17] where we are working collectively to develop more person centred approaches which focus on early intervention and reducing health inequalities.

The Gilbert Bain Hospital is an Island Rural General Hospital which includes a Children's Outpatients Department that hosts both local and visiting services. As part of the regional children's managed clinical networks (MCNs), we access a range of specialist services including: paediatric orthopaedics; the child development unit; paediatricians specialising in child protection; child and adolescent mental health (CAMHS) and paediatricians who provide in reach clinics from the Royal Aberdeen Children's Hospital (RACH).

In addition to this, local clinicians see and treat babies and children in an emergency via the Emergency Department (ED).[18] Support for clinical decision making is available via the RACH and the thresholds for admission are based on both clinical priorities and other external factors such as weather and access to retrieval. Following assessment in ED, a small number of children (8%) who have been carefully selected for care in either the acute medical or surgical wards are admitted to the Gilbert Bain Hospital for ongoing treatment and observation. The length of stay for a child on average is less than 24 hours and if a longer admission is required they are transferred to the RACH. Our approach is to provide personalised care for children whilst in hospital, recognising that we could not sustain an inpatient unit for children in our setting.

Strategic objectives and guiding principles

Our clinicians are in the main, trained in adult healthcare and have developed additional competencies so that they can support children who need acute care in Shetland, making decisions on whether a child is able to be cared for locally or needs specialist input from RACH.

[16] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths

[17] Shetland Children's Plan 2021- 2024

[18] In 2019, 1515 children attended ED, 128 children had an unplanned admission to the Gilbert Bain Hospital, 36 children were transferred to RACH and 50 children had a planned surgical procedure in Shetland

Sustaining paediatric skills is challenging and can only be achieved through hub and spoke models of care, with shared learning and understanding of the pathways of care.

Children who have very complex health needs are supported by local, multi-disciplinary teams as well as specialist services on mainland Scotland. Wherever possible, we have developed in reach clinics and use telehealth to reduce travel, but there is still a need for some children and their families to access specialist services in Aberdeen, Edinburgh or Glasgow and this has an impact on the whole family.

The CAMHS team works closely with specialist services based in the North of Scotland as well as with the local Child Health team. Whilst access to CAMHS services is good in Shetland, we have a clear focus on building and developing the clinical model for CAMHS in line with the national Mental Health Strategy[19] and the role that the team will play in helping to develop services for young people who do not need specialist care, but need support to maintain their emotional wellbeing and resilience.

A recent review of neuro-developmental services across the North of Scotland has shown that there is significant variation in the way in which neuro-developmental pathways are organised and the resources available in Health Boards to provide these services. This is also an identified gap in Shetland and the SCP has commissioned a service of the way in which we assess, treat and support children who have a neuro-developmental condition such as autism spectrum disorder (ASD).

How we will focus on early intervention
We want to focus on early intervention and support in order to give children the best start in life. To do this, we will put more emphasis on supporting healthcare professionals to promote wellbeing and health improvement and know where to signpost families for support e.g. maternal health, perinatal health and child centred, family led approaches.

Ways in which we will work in a more integrated way
We want to sustain the current level of care that we provide to children in Shetland and to do this, we need to ensure our healthcare professionals are well trained and have access to ongoing professional development and expert opinions. We know that there are already good networks in place across local services and with those based out with Shetland. We would like to develop opportunities for additional collaborative working between clinical teams in Shetland and with teams in specialist paediatric settings. This could include more formal arrangements for training, clinical supervision, virtual wards, hub and spoke models of care.

Ways in which we will improve access
We want to reduce health inequalities and reduce the impact of geographical remoteness. We recognise there is a need for clearer pathways to support children with complex health needs over their lifetime. Feedback from parents tells us that there is duplication and it can be difficult to navigate through the different layers of services e.g. GP, Child Health Team, multiple teams in children's hospitals etc. We need to look at how we can provide better care co-ordination for children with

19 https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/pages/2/

complex health needs to offer a more personalised approach, which reduces duplication and bureaucracy across organisational boundaries.

Ways in which we will use technology to provide more person centred care
We want to improve access to services, recognising that technology has a role to play in reducing unnecessary travel for children. This in turn impacts on their learning, their lives and the financial costs to families. We will look at ways of building on the tele-health systems so that more children can access health professionals from home, school or local hubs to reduce travel where it is safe to do so.

"When your child is poorly or sick or has a long-term condition, there's a lot of joy that can go as you're spending your life in a medical situation."

Figure 20 Example of a future service development to offer early action to support young people with a neuro-developmental condition

Developing a multi-agency neuro-developmental assessment team

Children and young people who have a developmental delay or disability (e.g. a learning disability, autism or foetal alcohol syndrome) will be assessed by a neuro-developmental team who will agree as a multi-disciplinary team how best to organise assessments to reduce duplication and the amount of time it takes to reach a diagnosis.
Services will work more closely with children, young people and their families to identify when support is needed during and after assessment / diagnosis and through the full course of the child's early years into adulthood.
Children and families will be fully included in the decision making process to determine what support they need and the planning for support into adulthood will start in early teenage years so the transition from school into adult services, the workplace and supported living, if needed, is well planned and well organised.

Island Rural General Hospital

Key statistics about this service

The Gilbert Bain Hospital is an Island Rural General Hospital which is 224 sea miles away from the nearest specialist hospital in Aberdeen. There are times during the year when the weather prevents travel and in combination with our geographical remoteness, this means that we have to be able to provide comprehensive emergency care for people in Shetland. The extent to which we need to provide 24/7 emergency care, including obstetrics is greater than some Rural General Hospitals on mainland Scotland, because we do not have an option to transfer patients by land to a specialist centre. Therefore we need to be able to safely maintain patient care, including critical care for up to 24 hours.

The hospital includes an emergency department (ED), ambulatory care areas (elective and emergency), two wards organised around medical and surgical pathways, two high dependency beds, two theatres, a renal unit, maternity unit, a chemotherapy unit, an outpatient department and a full range of clinical support services i.e. medical imaging, laboratory services, other diagnostic services, clinical pharmacy and allied health professionals.

Our ongoing aim is to be able to deliver safe and effective care as close to home as possible. Over the last 10 years we have developed a wide range of new roles and clinical pathways to support more people to access care locally. This has led to the repatriation of services in subspecialties including oral surgery, ophthalmology, ENT (Ear, Nose and Throat), gynaecology and cancer care. In 2019-20 we reduced the number of new off island outpatient appointments by 2% and return appointments by 13%[20].

Over the last decade we have increased investment in community based services and developed new ways of delivering care that means less people need to go into hospital and if they do, their length of stay will be shorter. In the last two years we have seen a 38% reduction in the number of occupied emergency medical bed days (standardised rate per 1000 population) and in the last six years, we have seen a reduction in medical ward occupancy of 8.1%. In the same time frame we have increased day surgical activity by 24%[21]. The number of people delayed in hospital who are medically fit for discharge is also low.

This has changed the shape and size of both emergency and planned care services at the Gilbert Bain Hospital with a greater emphasis on how we can provide rapid and safe ambulatory care as an alternative to an inpatient admission. The Gilbert Bain Hospital site has been an incredibly adaptable and flexible space, with various additions since it was built in 1961. This has been particularly evident during the pandemic where new facilities have had to be developed such as the Respiratory Care Unit (RCU) the Same Day Emergency Care Unit (SDEC).

[20] Data taken from NHS Scotland Discovery platform
[21] Data taken from the NHS Shetland Annual Operating Plan 2020-21

However, there are limitations in our scope to adapt the hospital site further, to keep pace with the changing clinical models of care over the next 5-10 years and beyond[22].

The development of new ways of working in many cases has included the use of technology to enable access to specialists on the mainland, without the need for healthcare professionals or patients to travel. Over 2000 consultations per year have been undertaken using tele-health in the hospital setting, ranging from phone calls through to complex multi-disciplinary team meetings and clinical assessments using the Near Me video consultation platform.

Our healthcare team is made up of generalist health professionals e.g. doctors, nurses, midwives, scientists, pharmacists and therapists. A critical factor in our ability to sustain emergency care, planned care and diagnostic services is the emphasis we place on undergraduate and postgraduate training and education. Maintaining and developing our status as a teaching hospital is vital in attracting new healthcare professionals to Shetland and being able to support opportunities to work in a remote and rural setting. It is also important to be able to offer access routes into professions that enable training to take place in Shetland – again the role of technology is critical in being able to offer remote learning and clinical supervision, as well as close working with other NHS organisations and academic partners.

Another essential factor is the need to develop clear clinical pathways between primary, secondary and tertiary care services. There are opportunities to look at how best to deliver urgent care and older people's care in different ways e.g. through highly integrated teams that do not sit in silos in primary or secondary care but work together in a range of settings with a broader range of partners, including the third sector. Agreeing the balance of care that can be safely delivered in an Island Rural General Hospital, with the support of a managed clinical network including specialist hospitals, is an important part aspect in planning the future of the Gilbert Bain Hospital.

Ways in which we will improve access

We want to widen access for patients to increase efficiency and offer a more person centred approach. To do this, we will look at options to offer more 'one stop' clinics and pathways to reduce the amount of time patients spend waiting for tests and travelling to appointments. We also want to reduce the amount of time patients need to spend in hospital by increasing our capacity to provide ambulatory care.

Ways in which we will use technology to provide more person centred care

We want to reduce health inequalities linked to geographical remoteness. To do this, we will continue to look at ways in which we can use technology to enable access to specialist services on mainland Scotland and / or the remote outer isles of Shetland, as an alternative to patient travel. We will also continue to look at ways in which we can safely develop a wider range of services in Shetland, whether they are hospital based or in the community to improve access and health outcomes.

[22] North Regional Property Asset Management Plan, 2018-2028 https://www.shb.scot.nhs.uk/board/foi/2019/01/2019-043a.pdf

How we will focus on early intervention

We want to support people to manage their own health and health conditions. To support this aim, we will continue to invest in education and technology that allows people to be in control of their own health needs. This includes more emphasis on secondary prevention, reablement and rehabilitation to support people with long term conditions.

Ways in which we will work in a more integrated way

We also want to look at ways in which we can develop more integrated services. This includes shared models of care between primary healthcare, secondary care and specialist centres so we can deliver care as close to home and in people's homes. We need to develop clear future models of service delivery which include regional partners to ensure that we can maximise the safe delivery of clinical services in Shetland. This may also need to include more hub and spoke models of care, shared multi-professional teams and shared training and clinical supervision.

Figure 21 Case Study describing current best practice using technology to support patients at home, in hospital and to access specialists in Aberdeen

Using technology to support shared care in ophthalmology

We have developed a specialist eye clinic for people who need regular injections to reduce the impact of age related macular degeneration. This service was initially delivered by Consultant Ophthalmologists, but now we have a blended team of doctors and nurses providing this treatment. Again, this is a good example of shared decision making between local practitioners and specialists in Aberdeen, using technology to share CT scans to make decisions about when treatment is required. This has significantly reduced the number of people who need to travel to access specialist ophthalmic care.

Using technology to support people with a hearing impairment

Remote support is available for hearing aid adjustment in people's homes.

Figure 22 Case Study describing future models of care, which are easier and less invasive for patients

Using technology to support shared care to identify and / or monitor bowel conditions including cancer

Pill cam: a camera in a pill that takes a picture of your bowel, avoiding the need for a colonoscopy in hospital.

Access to MRI scans: from 2023 onwards clinicians will be able to refer patients for MRI scans in Shetland, reducing travel and increasing access to early cancer treatment.

Tertiary Care and Specialist Services

Key statistics about this service

We spend around £8.4M each year on specialist services provided by NHS Grampian and a further £350,000 on treatments for patients elsewhere in Scotland or the UK.

Strategic objectives and guiding principles

These services are traditionally provided in a hospital by referral from Primary Care with people needing to travel. Referrals put people through steps in a process which can result in delays and risks them getting missed accidentally or ending up in the wrong place in the healthcare system. Although letters about people's health with advice and opinion have moved from paper to electronic forms, the step wise approach to patient care including communication can result in unnecessary waits. "Patient" means one who waits.

NHS Shetland cannot provide all the services that some individuals require. Some of this care requires highly specialised clinicians who would not be able to maintain their skills if they worked here; some requires equipment and services to support this and it would not make economic sense to have these in Shetland; and some requires both. Access to these services can be in an emergency, for example removal of blood clots from the heart or brain blood vessels (thrombectomy). For others the need is urgent but can be better planned, for example cancer surgery. Some care is routine, including follow-ups and monitoring conditions with the potential to get worse over several years.

For each of these services we will work with our partner Boards to maximise what we can provide locally and reduce unnecessary journeys. This is important for patients, but also helps us to sustain the Island Rural General Hospital model of care and the skills in our workforce.

NHS Shetland will use digital solutions to enable seamless care by:

- Safe and efficient sharing of information to support informed decision making;
- Better integration of services so journeys are coordinated and minimised;
- Cooperation between teams to promote access to high quality care regardless of location;
- Delivering care as close to home as possible; and
- Innovation by default.

How we will focus on early intervention

If people are well prepared for appointments, with test results and information as to what to expect and what they might want, there are much better outcomes.
In the future you and your healthcare provider will have access to the same information about you, what the most up to date evidence shows for your health and how to access services that will provide the support or treatment. Consultations with healthcare providers will make best use of all the available information to aid better conversations which enable people to make decisions on their care that are right for them.

By reducing unnecessary steps in processes and better coordination of care, earlier consultation with the right person will be enabled to reduce unnecessary waiting times.

Ways in which we will improve access

- People will be supported to access virtual consultations as a choice. Improving the flow of information will improve coordination of care and enable on-island support of specialist advice.
- We will build on examples such as renal dialysis where local clinicians support patients in Shetland with remote expertise from specialist centres, providing the opportunity for people to benefit from the knowledge and skills of specialists without the need for long and disruptive journeys.
- Generalists can be supported by remote specialists to enhance the care delivered in Shetland. Video-calls between teams with the patient on screen will support clinicians to provide more care locally without compromising on quality. Where possible we will support more specialists to visit Shetland rather than lots of people having to travel off-island. This will increase the range of services available locally. For example, in the future visiting orthopaedic surgeons could undertake joint replacement surgery in Lerwick with suitable theatre, equipment and training for the theatre staff. To maximise the use of their time local clinicians could assess people and follow-up them up after surgery with the surgeon providing expertise by videoconferencing.

Ways in which we will work in a more integrated way

Telehealth can enable access to a wider range of services from across the country, facilitating earlier consultation with the right person. Rather than being a bolt on, services in Shetland will be part of a network of integrated care. Facilitating safe and effective communication with patients and multiple parts of the NHS will focus trips to care centres, including hospitals, on making the most of people's time.

For example, where a person is under review for heart failure, having devices at home to measure their heart rhythm and blood pressure will link directly into the specialist service, creating instant communication. Local clinicians (e.g. nurses, pharmacists and doctors) will have a baseline knowledge and be able to support patients in their own homes with easy access to specialist advice when required.

Ways in which we will use technology to provide more person centred care

The ability to hold your own health data will enable people to become experts in their own health. You will also be able to control who accesses what information, creating clarity in interactions with services.

Many groups actually found it easier to access services discreetly on a phone. Many groups can be disenfranchised by having to do things in a more interpersonal way e.g. face to face appointments. Going forward there is a societal need to separate what is seen as clinical risk management (which can also be linked to litigation) and the way interpersonal care is managed. Empowering people through access to information will create a better power balance in communication with clinicians and enable better decision making.

Figure 23 Case Study to illustrate current best practice in working between local services and specialists in Aberdeen to provide complex diagnostic tests for people with cardiac conditions

Using technology to support shared care in cardiology

Cardiology services are one of the many areas of clinical practice which are shared services delivered collaboratively by clinicians in Shetland and Aberdeen. As part of the work to reduce unnecessary travel and the number of tests that are not needed, we are developing the local cardiac physiology service to offer a wider range of complex cardiac tests in Shetland. Patients who previously had to travel to Aberdeen can now access transoesophageal echocardiography (TOE)[1] and stress echocardiography tests in Shetland. This means approximately 80 people each year will be able to access these tests more quickly and closer to home.

Figure 24 Example of future use of technology to help support local clinicians with decision making and remote access to specialists.

Using technology to support shared care and access support for decisions remotely

Bodycam for pre-hospital emergency care: using the same technology as Police officers, clinicians attending emergencies can access a team of specialists to support care remotely.

Figure 25 ***Spotlight*** *The Renal Unit team pictured with new dialysis machines installed in May 2021. The dialysis team works closely with clinicians in Aberdeen using tele-health to provide renal care to patients in Shetland, reducing the need for patients to have to travel to the mainland for treatment.*

Working Together and Next Steps

We recognise that much of what we have captured in the strategy is an over simplification of 'what' and 'how' we will redesign and deliver health and care in the future. Our ability to make the changes that are needed are impacted on by many factors, some we can influence directly and others are wider cultural, societal and political issues.

Some of the areas for change and improvement are very clear from the feedback we have gathered in the process of developing this strategy.

These key areas that we will focus on are:

- The need to **work more closely with our communities** and people who access health and care support – there is clear evidence that supporting people early has the greatest benefit and often non statutory organisations such as the third sector are often best placed to offer early interventions and are already in communities and neighbourhoods.

- The need to place **more emphasis and resources on prevention** will help people to have healthy lives (not just longer lives). We need to move away from being seen as 'fixing' health conditions to supporting and enabling people to make good choices about their life and lifestyle. This is a very complex premise, but over time we hope to see evidence of how working in partnership with people will shift everyone's thinking on the role that health and care organisations play in the wellness of people in the community. This is a central principle in the concept of realistic medicine and realistic care.

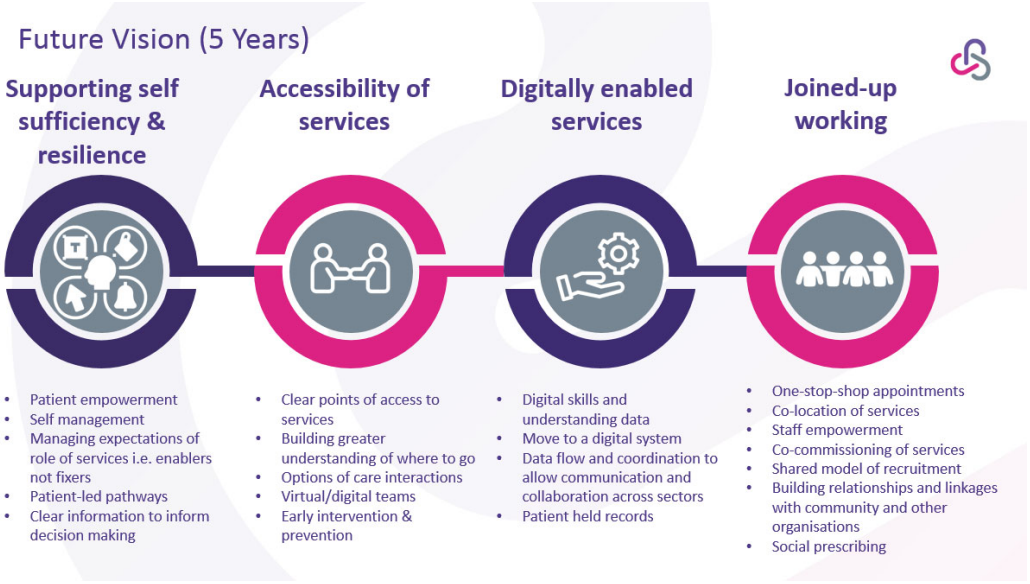
- We need to continue to **prioritise joined up working and reduce duplication**. This was a common theme described by patients and professionals – we need to think about where there are opportunities to work together more closely, stop doing things that do not add value and build relationships. This will improve access to the right type of help and support that people need.

- Use **digital solutions, where they are appropriate to improve access and bring care closer to home**. The way in which technology can support the delivery of health and care in Shetland is a strong theme. This does not mean that all services should be provided in this way and we also need to continue to consider how we address digital poverty and digital literacy in Shetland. But tele-health and tele-care access has been accelerated as a result of the pandemic and we want to continue to build on the benefits that increased access through technology have brought us.

- **Recognising that we need to develop new roles and models for training to support our generalist workforce**. Much of our strength comes from our ability to work in collaboration and we need to focus on how we can develop the networks that exist, and future networks, to support professional / clinical supervision, opportunities for skills development and working alongside specialist teams. This may mean more hub and spoke models in the future where practitioners based in Shetland are accessing advice from colleagues in

other parts of Scotland; or practitioners in Shetland are providing expertise to support patients who do not live in Shetland. Again, technology plays a significant role in this, but so too does our relationship with academic partners in schools and universities as well as our ability to work with other Health Boards to develop regional or intra-Board alliances that help to strengthen the resilience of the workforce and the delivery of care to our population.

Figure 26 A chart to show our future vison for health and care over the next five years



In terms of next steps, we will identify the priorities set out in the Clinical and Care Strategy and reflect them in the future strategic plans for NHS Shetland and the Integration Joint Board (IJB), to inform the development of the clinical and care models that are described here.

The Clinical and Care Strategy also sits within a wider programme of strategic planning and isthe first phase of the capital planning process to develop a strategic assessment for the re-provision of the Gilbert Bain Hospital which will be undertaken during 2021-22. The clinical and care models will be used to help build a ‘case for change’ that supports the need to look at our built environment as well as our clinical and care pathways.

Glossary of Terms

Ambulatory: referring to patients who are able to walk to appointments etc.

Care home: a care home is a residential home providing accommodation with personal care and / or nursing care

Care pathway: these are the guidelines for the entire process of diagnosis, treatment and aftercare for medical conditions - from the patient's first contact with the NHS to the end of their treatment

Child and Adolescent Mental Health Services (CAMHS): services provided for children and young people with emotional, behavioural and mental health needs

Clinician: a clinician is a general term used to refer to any professional who provides clinical care to a patient

Community care: this is treatment or care given to someone in their own home, a community clinic or other community setting

Elective: used to describe operations, procedures or treatments that are planned rather than carried out in an emergency

Emergency Department (ED): the ED of a hospital deals with people who need emergency treatment because of sudden illness or injury. Also called Casualty or Accident & Emergency (A&E)

Health Boards: in Scotland and Wales, the local organisation responsible for all healthcare in its area

Informatics: its broad meaning is the science of processing data. Within health and social care, it is used to refer to the processing of data on patients and clients, normally, but not exclusively through IT systems

Multi-agency: these services involve staff drawn from several organisations such as health, social services, education and voluntary groups

Neonatal: to do with new born babies, up to the age of four weeks

Primary care: the first stage of treatment when you are ill and usually provided by your GP at a Health Centre, but could also be Pharmacy, Dental or Ophthalmic care

Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to you so that the care of your condition fits your needs and situation

Secondary care is specialist care traditionally provided by hospitals in support of the primary care team. Examples are surgery, specialist medical services and mental health services

Stakeholder: a stakeholder is a person or organisation with a direct interest in a service or practice

Telemedicine / telehealth: the use of communication systems, such as television / computer screens, to help provide diagnosis and medical advice when the patient doctor are not in the same place

Tertiary care: the third and highly specialised stage of treatment, usually provided in a hospital centre which may not be local. See also primary care and secondary care

Triage: a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment, for instance in accident and emergency departments

Workforce: the term generally used within the NHS to refer to HR (human resources) issues