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

ISSUED UNDER SECTION 26(1) OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

<table>
<tr>
<td>Direction: Community Nursing including Intermediate Care</td>
<td>Direction to: SIC and NHSS</td>
<td>Overall Budget allocated by IJB for Direction: £4,110,040
Community Nursing £3,627,388
Intermediate Care £482,652</td>
</tr>
<tr>
<td>Reference Number:
1.5</td>
<td rowspan="2">Relevant Function(s):
Community Nursing Services
• District Nursing
• General Practice Nursing
• Advanced Practice
• Non-doctor Island Nursing
• Specialist Nurses
• Intermediate Care Team</td>
<td rowspan="2">Review Date:
March 2025</td>
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<tr>
<td>IJB Report(s) Reference Number:
CC-17-24</td>
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<td>Date Direction issued/authorised by IJB:
1 May 2024</td>
<td>Date Direction takes effect: 1 April 2024</td>
<td>Does the Direction supersede, amend or revoke an existing Direction? If yes, include reference number of existing Direction:
Supersedes Direction 1.5 (IJB Report Ref. CC-23-23-F)</td>
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<tr>
<td colspan="3">Purpose of Direction</td>
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<td colspan="3">The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting. Community Nursing staff also provide support and teaching to informal or family carers to enable them to care effectively for their relative, whilst also addressing any care and support needs the individual carer might have themselves.

All of the component services within the Community Nursing service work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.</td>
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The Vaccine Transformation Programme and NHS Shetland Travel Health Service is provided by the vaccination team within Public Health, with clinical professional oversight via Chief Nurse Community, while this service does require resource from Community Nursing workforce to deliver vaccines, there is management resource consideration in this clinical oversight.

Whilst the District Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16 years and are housebound, all of the services within Community Nursing will endeavour to meet the needs of any individual across the lifespan from birth to death, within the community setting who have a nursing and/or health need.

There is a national move towards more specialist nursing roles and related service redesign across the Health and Social Care System. These changes are related to a recognition of nursing expertise, Shifting the Balance of Care, and a response to recruitment challenges within the medical workforce. To effectively implement these changes means a growth in capacity and expertise of the nursing service, to off-set pressure in other areas by providing services in a more effective sustainable way. The impacts on related services are not fully reflected within this Direction but are an important consideration for decision making.

Accountability and Governance

NHS Shetland is accountable for the delivery of the services within Community Nursing, which have been commissioned by the Integration Joint Board (IJB).

Overarching Directions to Function(s)

- **District Nursing** - community based nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.
- **Practice Nursing** – at all 8 Board provided general practices;
- **Advanced Nurse Practitioners** – Advanced Nurse Practitioner posts based in Primary Care;
- **Non-Doctor Island Nursing** – nurses resident on the small outer islands of Fair Isle and Foula;
- **Non-Doctor Island Healthcare Support Worker model** – HCSW support for health needs and care provision with Fetlar, Skerries and Bressay
- **Intermediate Care Team** – multi-disciplinary, partnership team focussed on provision of re-ablement programmes, additional support to increase independence on discharge home from hospital and provision of additional support at home to prevent unnecessary admission to hospital or care home.

Note: Continence services are now delivered from within the District Nursing team

Directions	Outcomes and key actions	Performance Monitoring and Indicators	Challenges & Opportunities – inc. Risks and Finance
Provide high quality care and support for all adults within the community who have a nursing or re-enablement need	People are seen by the most appropriate person, at the right time, as close to home as possible in a way that meets their needs and supports them to remain independent. • Complete evaluation of ANP OOHs cover • Develop working model for DN role in Care Home health provision • Embed District Nursing model - shift cover till 5pm and on call thereafter, supporting development DNs	Reported in Annual Report from Core Suite (Shetland/Scotland): NI-1 Percentage of adults able to look after their health very well or quite well NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible NI-4 Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated. NI-14 Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges).	Recruitment Finance Workforce capacity for improvement work £60,000 savings associated with Network Enabled Care
Plan, develop and implement the nursing contribution of the Primary Care Improvement Plan, particularly in relation to: • Development of Community Treatment and Care centres (CTAC) • Urgent Care services	Contribute to the delivery of local priorities that support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way.	KPI – Percentage of Band 6 & Band 7 Community Nursing staff who possess a Specialist Practitioner Qualification, Advanced Clinical Assessment skills and a Non-Medical Prescribing Qualification	

Working collaboratively with both community and acute services to ensure appropriate skillmix, and sustainability of services.	• CTAC services available within each locality.	KPI – Number of Band 5 staff to commence Graduate Diploma in Integrated Community Nursing	
Implementation of the Transforming Nursing roles agenda to ensure that the nursing workforce within community settings can deliver on the service developments as outlined in the new GP contract.	Nursing and HCSW staff have enhanced skills and roles supporting the delivery of care by right practitioner, right place, right time for the local population thus improving continuity and timeliness of care to all Shetland residents. Nursing staff play a key role within multidisciplinary teams (MDTs) within General Practice. Recruitment and Retention of Nursing and HCSW staff is improved as they are supported to develop into new roles and access appropriate training.		
Develop new service models which are sustainable, affordable, and clinically appropriate which meet the health and care needs of Shetland residents both now and for the future.	Objective – Create sustainable, affordable, and clinically appropriate service models to support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way.	KPI – Stability of health care cover in Non-Doctor Islands (NDIs) KPI – OOHs ANP (Out of Hours Advanced Nurse Practitioner) model – cost/benefit analysis/evaluation of trial	

Implement a consistent and robust framework for measuring, assuring and reporting on the quality of nursing practice in place within Community services utilising the Excellence in Care Framework and other key quality measures.	Evidence the delivery of high quality, timely and appropriate care and support to Shetland residents from the component parts of the Community Nursing service.	KPI – percentage of District Nursing records for palliative patients with patient's preferred place of death documented in the nursing care plan KPI – Percentage of District Nursing records which evidence that the patient’s preferred place of death was met KPI - Percentage of Catheter Associated Infections identified in individuals with an indwelling urinary catheter in the community. Review of frailty scoring links with ACPs, and Respiratory end of life care – linking with local MCNs for system approach.	
Provide high quality care and support for all adults within the community who have a nursing or re-enablement need	People are seen by the most appropriate person, at the right time, as close to home as possible in a way that meets their needs and supports them to remain independent.	Reported in Annual Report from Core Suite (Shetland/Scotland): NI-1 Percentage of adults able to look after their health very well or quite well NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible NI-4 Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	

		NI-14 Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) RAG status of patients seen to better understand locality needs, patterns and use of capacity to support future planning of service models.	
Develop new service models which are sustainable, affordable, and clinically appropriate which meet the health and care needs of Shetland residents both now and for the future.	Create sustainable, affordable, and clinically appropriate service models to support the community to have improved health and wellbeing, lead healthy, active lives that maintain independence and allow people to contribute to society in a positive way.	KPI – Stability of health care cover in Non-Doctor Islands (NDIs) KPI – OOHs ANP (Out of Hours Advanced Nurse Practitioner) model – cost/benefit analysis/evaluation of trial	
Implement a consistent and robust framework for measuring, assuring and reporting on the quality of nursing practice in place within Community services utilising the Excellence in Care Framework and other key quality measures.	Evidence the delivery of high quality, timely and appropriate care and support to Shetland residents from the component parts of the Community Nursing service. • Exploring new ways of working to support people who find it hard to access services for a variety of reasons. • Evaluation of input to inform service	KPI – percentage of District Nursing records for palliative patients with patient's preferred place of death documented in the nursing care plan KPI – Percentage of District Nursing records which evidence that the patient's preferred place of death was met KPI - Percentage of Catheter Associated Infections identified in individuals with an indwelling	Workforce capacity for improvement work

	development across HSCP.	urinary catheter in the community. Frailty scoring links with ACPs, and Respiratory end of life care – linking with local MCNs for system approach.	

Shifting Balance of Care

This Direction links to the following Shifting Balance of Care work streams:

Project ref	Service/Programme
PJR0001	Primary Care - Redesign - PC Strategy
PJR0002	Primary Care - Redesign - PC Phased Investment Programme
PJR0003	Primary Care - Redesign - Westside Collaboration
PJR0004	Primary Care - Redesign - Urgent and Unscheduled Care
PJR0005	Primary Care - Redesign - Shetland Health Intelligence Platform
PJR0006	Primary Care - Redesign - Mental Health Workforce
PJR0015	Frailty Matters
PJR0016	Frailty Matters - Palliative
PJR0017	System Workforce Planning (NEW)
PJR0019	Models of Care - Accommodation/Housing (Resi)
PJR0020	Models of Care - Accommodation/Housing
PJR0028	House of Care
PJR0031	Future Care Planning (ACPs and ECPs)
PJR0036	Hospital at Home