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

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

<table>
<tr><td>Direction: Primary Care</td><td>Direction to: NHSS</td><td>Overall Budget allocated by IJB for Direction:
£6,263,883</td></tr>
<tr><td>Reference Number:
1.11</td><td rowspan="2">Relevant Function(s):
• Primary Care</td><td rowspan="2">Review Date:
March 2025</td></tr>
<tr><td>IJB Report(s) Reference Number:
CC-17-24</td></tr>
<tr><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 1.11 (IJB Report Ref. CC-30-23-F)</td></tr>
<tr><td colspan="3">Purpose of Direction</td></tr>
<tr><td colspan="3">Provision of the Primary Care Service which currently comprises the following:

• 10 Health Centres in Shetland providing GP services together with 5 non-doctor islands which are staffed by community nurses and receive GP services from a local health centre.
  ○ Of the 10 GP practices 9 are currently salaried to NHS Shetland (all staff are employed by NHS Shetland). The other one is an independent practice which means they contract with NHS Shetland to provide core GP services funded through a national contract.
• Provide Ophthalmic Services with two providers based in Lerwick.
• To ensure support, training and governance in medicine use and administration in community care settings.
• To support a multidisciplinary approach within GP Practices providing pharmaceutical input.</td></tr>
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Accountability and Governance
NHS Shetland is accountable for the delivery of the primary care services commissioned by the IJB.

Overarching Directions to Function(s)

- Provision of the Primary Care Services
- Provide Ophthalmic Services

Directions	**Outcomes and key actions**	**Performance Monitoring and Indicators**	**Challenges & Opportunities – inc. Risks and Finance**
Provide Primary Care services across the life course for the population of Shetland.	• Develop appropriate models of care for Shetland to suit the local context, within funding available. • Stabilise and enhance the Primary Care Workforce. • Embed efficient and effective ways of working. • Collaborate effectively with other partners across the Health and Social Care system. • Much of this work is embedded within the Network Enabled Care workstream in the Shifting the Balance of Care programme.	Measured by meeting outcomes, performance indicators and by feedback.	Risks: • Finance • Workforce capacity for improvement work • Unable to deliver programme

	Scottish Government long term outcomes for Primary care: • we are more informed and empowered when using primary care • our primary care services better contribute to improving population health • our experience of primary care is enhanced • our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care • our primary care infrastructure – physical and digital – is improved • primary care better addresses health inequalities		
Primary Care teams support people to have improved health and wellbeing, and contribute to a number of outcomes measured locally and nationally and used by the HSCP to plan improvements.	Locally the short to medium term outcomes we hope to achieve are: • Fewer people requiring primary care services as they are supported to	Some ways we monitor our services include • Patient experience, Health and Care Experience survey,	Maintenance and review of buildings is linked to the work of Estates within NHS Shetland

	self-manage and access other appropriate services within their communities and online • When they do require services, they are supported and enabled to understand the different services, and ways of accessing them, and are able to see the right person, at the right time, in the right place • We will aim to provide planned continuity of care for long term conditions; there will be a variety of different ways of accessing unplanned care. • People are able to access a wide range of preventative support, within their communities, including social prescribing; support will be available remotely as well as in person. • We will have multi-disciplinary teams in place, including strong links into third and voluntary sector. • People with complex needs are supported to	gathered nationally, covering: ○ The GP Practice ○ Treatment of advice from the GP Practice ○ Out of Hours healthcare ○ Care, support and help with everyday living ○ Caring responsibilities • Core suite of Integration Indicators (those not informed by Health and Care Experience survey above) ○ NI-11 Premature mortality rate ○ NI-12 Emergency admission rate ○ NI-14 Emergency readmissions to hospital within 28 days of discharge ○ NI-15 Proportion of last 6 months of life spent at home or in a community setting	

	live well, for as long as possible • We have reviewed our physical resources (estate) to ensure that it is fit for purpose • We will have IT systems that support integrated, flexible and adaptive patient-led models • We will have incorporated Realistic Medicine and Care principles into our service, reducing unnecessary or ineffective treatment, and working collaboratively with service users, enabling them to become the experts on their own health and wellbeing. • We will value our staff and their health and wellbeing, and support training and growth. • We will have highly trained staff, able to meet the needs of an elderly population. People will be supported to die well, at home or in a homely setting.	**Note these are not a direct measure of Primary Care services, but are an indicator of how well the health and care system is working together to meet the needs of the population**	

	Support Shetland population to use breadth of services available appropriately, including digital support, NHS Inform and other community services Implementation of Learning Disability Health Checks locally. • Form working group to support implementation • Collate data to understand demand/requirements – cross checking health and care services data for true picture (including appropriate data sharing assurance) Explore feasible models for delivery, including Nurse-led.		

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)
PJR0028	House of Care
PJR0031	Future Care Planning (ACPs and ECPs)
PJR0049	Community Link Workers