NHS Shetland

Meeting:	NHS Shetland Board
Meeting date:	25 June 2026
Title:	Primary Care Strategy 2026-2031
Agenda reference:	Board Paper 2026/27/14
Responsible Executive/Non-Executive:	Jo Robinson
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1. Purpose

This is presented to the Board/Committee for:

- Decision

This report relates to:

- Annual Operating Plan
- NHS Board / Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person-centred

2. Report summary

2.1. Situation

The Primary Care Strategy 2026–2031 represents a significant step in stabilising and redesigning Primary Care services in Shetland over the next five years. The Board is asked to approve the Primary Care Strategy 2026–2031, noting that it provides a clear and aligned strategic direction for Primary Care services in Shetland, supports delivery of the Strategic Delivery Plan and Clinical and Care Strategy, and establishes a realistic and structured approach to improving access, quality, sustainability and population health outcomes over the next five years.

The strategy has been considered widely across both the NHS and HSCP throughout its development. As part of the approval process a draft has been considered at Hospital Management Team; Community Health and Social Care Strategy Group; IJB Strategic Planning Group; Executive Management Team; Joint Governance Group and Clinical Governance Committee.

2.2. Background

Primary Care in Shetland plays a central role in supporting the health and wellbeing of local communities and is a critical component of the wider health and social care system. While Primary Care services currently provide good outcomes and are valued by many patients, this is not consistently experienced across all communities, with variation in access, experience and outcomes remaining evident.

Over recent years, the Primary Care model has evolved in response to significant operational pressures, including workforce challenges, increasing demand, and the complexities associated with delivering services across remote and rural island settings. These adaptations have enabled services to be maintained; however, they have often been reactive in nature and, when implemented in isolation, have contributed to variation, fragility and increasing organisational pressure.

At the same time, the nature of healthcare demand is changing. Shetland's population is ageing, with increasing prevalence of frailty, long-term conditions and multimorbidity, alongside the need to support children, families and working-age adults with complex and evolving needs. These pressures require a shift towards more proactive, coordinated and population-based models of care, rather than a system primarily designed to respond to immediate need.

The development of the Primary Care Strategy responds directly to these challenges and has been informed by a broad and inclusive evidence base. This includes population health intelligence, local service data, staff and patient engagement, and alignment with wider system strategies, including the NHS Shetland Strategic Delivery Plan and Clinical and Care Strategy. These strategies set out a clear ambition to improve access to care, shift care closer to home, strengthen prevention and population health approaches, and ensure the long-term sustainability of services.

The Strategy therefore provides a five-year framework to stabilise and redesign Primary Care services in Shetland, with the aim of delivering high-quality, sustainable and person-

centred care that is equitable across communities and responsive to the needs of the population.

2.3. Assessment

The Primary Care Strategy presents a clear and credible response to the challenges facing the Shetland health and care system and aligns strongly with the Board's strategic direction. It reflects a shift from a predominantly reactive model of service delivery to a more planned, coordinated and system-wide approach, designed to deliver improved outcomes for patients while addressing underlying risks to sustainability.

A key strength of the Strategy is the clarity of its proposed model. The move towards a networked Primary Care system, supported by multidisciplinary teams and standardised processes, is intended to reduce unwarranted variation, improve resilience and provide a more consistent experience for patients across Shetland while sustaining local delivery. This approach recognises the realities of workforce availability and geography, while maintaining the importance of local relationships and community-based care.

The Strategy also demonstrates strong alignment with the NHS Shetland Strategic Delivery Plan and the Clinical and Care Strategy, particularly in its focus on improving access, strengthening prevention, shifting care closer to home and supporting population health. As such, Primary Care is positioned as a core delivery mechanism for achieving the Board's wider ambitions of providing excellent services, creating a sustainable organisation and supporting the building blocks of healthy communities.

In terms of impact, the Strategy sets out clear intended outcomes, including improvements in access, patient experience, continuity of care, population health outcomes and workforce stability. It also acknowledges the financial and operational context within which services must be delivered, and the need to make best use of available resources.

The proposed delivery approach is pragmatic and phased, with implementation through a structured programme and shorter-term action plans. This allows for flexibility and adaptation as the Strategy is implemented in a changing environment, while maintaining a clear line of sight to the overall strategic intent.

However, the Strategy also carries a number of inherent risks that will require ongoing Board oversight. Workforce sustainability remains the most significant risk, alongside the potential for variation in implementation across sites, pressures during transition, and dependency on wider system change to deliver the intended benefits. These risks are recognised within the Strategy and will need to be actively managed through governance, monitoring and prioritisation.

Overall, the Strategy is considered to provide a strong and necessary framework for the future of Primary Care in Shetland. It offers a coherent and evidence-based approach to addressing current challenges while supporting delivery of the Board's strategic priorities. Subject to effective implementation and ongoing oversight, it is expected to improve the quality, equity and sustainability of Primary Care services over the medium term.

2.3.1. Quality / patient care

Overall, the Strategy is expected to have a positive impact on quality of care. By improving access, strengthening continuity for those with complex needs, and supporting more proactive management of long-term conditions, it aims to improve both patient outcomes and experience. There is also a clear focus on improving the consistency and coordination of care across the system.

However, as with any significant service change, there are risks during transition. These will require careful monitoring to ensure that quality and safety are maintained as new models of care are implemented.

2.3.2. Workforce

The Strategy has a strong and positive focus on workforce sustainability, recognising that this is fundamental to both service stability and quality of care. The move towards more resilient, networked teams and clearer, standardised ways of working is expected to improve both staff experience and service delivery.

At the same time, workforce challenges remain a key risk, particularly in relation to recruitment, retention and the pressures associated with implementing change – these are recognised as national challenges for some professions, and remote, rural, island challenges for recruitment generally – local teams are involved in work seeking to mitigate these challenges.

2.3.3. Financial

The Strategy supports the organisation's ambition to deliver services within available resources by promoting more efficient and sustainable models of care. Reducing reliance on temporary staffing, improving processes and making better use of available resources are all expected to contribute to improved financial sustainability

2.3.4. Risk assessment/management

The Strategy identifies a number of key risks, including workforce fragility, variation in service delivery, and limitations in digital infrastructure and data. These are well understood and directly addressed through the proposed model of a more standardised, networked and data-informed system. The use of phased action plans and programme governance provides an appropriate mechanism for managing these risks over time.

2.3.5. Equality and Diversity, including health inequalities

A central ambition of the Strategy is to reduce inequalities in access, experience and outcomes across Shetland. This is reflected in both the design principles and the proposed approaches to service delivery, including prioritising those with the greatest need and strengthening links with wider system partners.

An Integrated Impact Assessment has been drafted early in the process and is under review by the team. This will be published alongside the strategy. Completion of the impact assessment process prompted development of the "personas" from engagement activity and local data, to support a measured planning approach mindful of unintended

negative impacts related particularly to the Equality Impact Assessment, Fairer Scotland Duty and Human Rights and Children's Rights considerations.

Possible and probable impacts, and reasonable mitigations for these will form a key part of the resultant action plans for implementation of change aligned to the strategy – changes within these will have their own full impact assessment wherever indicated.

2.3.6. Other impacts

The Strategy is expected to strengthen integration across Primary Care, Community Health and wider system partners, and between these partners and Secondary Care services, as our population needs change and develop these relationships will be essential for delivering high quality, person-centred care. The strategy also supports wider system reform aligned to NHS Shetland's Strategic Delivery Plan and Clinical and Care Strategy, and the national Service Renewal Framework and Population Health Framework.

2.3.7. Communication, involvement, engagement and consultation

The Strategy has been developed through extensive engagement with staff, patients and communities, using a range of methods including surveys, workshops and targeted discussions. This engagement has shaped both the identification of challenges and the proposed solutions, and will continue to inform implementation.

2.3.8. Route to the meeting

The Strategy has been developed through the Primary Care Redesign Programme, with input from clinical, operational and strategic leadership, and in alignment with wider organisational and system planning processes.

The strategy has been considered at CHSC Strategic Meeting; Hospital Management Team; IJB Strategic Planning Group; Executive Management Team and Joint Governance Group.

2.4. Recommendation

- **Decision**

The Board is asked to approve the Primary Care Strategy 2026–2031.

3. List of appendices

The following appendices are included with this report:

Appendix 1 Primary Care Strategy 2026-2031

NHS Shetland Primary Care Strategy 2026-2031

NHS Shetland

1 CONTENTS

1 FOREWORD

Foreword

Primary Care matters to every person and every community in Shetland.

It supports people across the whole life course. It is there for children, young people and families; for adults balancing health, work and caring responsibilities; for older people living with frailty or long-term conditions; and for people approaching the end of life.

It is often the first place people turn when they are worried, unwell, managing a long-term condition, seeking advice, supporting someone else, or trying to understand what help is available.

This strategy sets out how Primary Care in Shetland will develop over the next five years. It comes at a time of pressure, but also at a time when there is much to build from.

Primary Care teams across Shetland have kept services delivering through workforce pressure, geography, changing need and rising complexity. They have adapted, tested new ways of working, supported each other and continued to provide care close to people's homes. That work should be recognised and valued.

The strategy starts from a practical point, of the current model in part relying on reactive adaptation, goodwill, short-term fixes and local workarounds. That has helped sustain services, but it is not enough for the future.

People's needs are changing, and with that the same number of people can need a different level and type of care over time. More people are living with long-term conditions, frailty, medicines complexity, mental wellbeing needs, caring responsibilities and social pressures. Children, young people and families also need timely support and early help that can prevent future ill health.

Primary Care is central to how people experience health and care, but it cannot work alone. People's needs often cross service boundaries. When services work well together, care feels clear, safe and joined up. When they do not, people may have to repeat their story, chase decisions, manage uncertainty, or carry too much of the burden of coordinating their own care.

This strategy is centred on people's outcomes and experiences. It supports NHS Shetland's commitment to excellent services, the building blocks of health, and a sustainable organisation. It also reflects the national direction for more care in communities, stronger prevention, better use of digital tools, and clearer planning around population need.

The direction set out here is clear. Primary Care in Shetland will work as a joined up Shetland-wide Primary Care system, delivered through local health centre teams.

This does not mean one single practice, one single building, or the loss of local identity. Local health centre teams remain central. The aim is to make sure every community benefits from the best learning across Shetland, while protecting the local relationships and community knowledge that make Primary Care so important.

Change will continue over the life of this strategy as it has in the work before it. Need, workforce, technology, policy and public expectations will all change. For change to succeed, teams need time, support, practical help, testing, learning, information, staff involvement and patient insight.

Change in this strategies context will be done with and through our local teams.

Together, we can build a Primary Care system that is fair, adaptable, sustainable and connected, and that helps people in Shetland live well for longer.

2 EXECUTIVE SUMMARY

Primary Care in Shetland has strong foundations, but the current model cannot continue unchanged.

Most people value their local health centre and many report good experiences of care. This is not universal and there are persistent, unfair differences in access and outcomes across our communities. Most of these differences in outcomes are driven by circumstances outside the control of Primary Care, but we can work differently to mitigate their impacts. Staff across Shetland have worked hard to maintain services through workforce pressure, geography, changing need and rising complexity. this is not universal and there are persistent, unfair differences in access and outcomes across our communities. Most of these differences in outcomes are driven by circumstances outside the control of Primary Care, but we can work differently to mitigate their impacts.

Workforce fragility, rural and island geography, with a dispersed population, and reactive operating models are driving risks to sustainability.

Shetland's population size has remained fairly stable, but the needs within that population have changed. More people are living with long-term conditions, frailty, medicines complexity, mental wellbeing needs, caring responsibilities and social pressures. Children, young people and families also need timely support and early help that can prevent future ill health.

List size alone does not tell us enough about the service people need. The same number of people can need a different level and type of care over time.

This strategy sets a clear direction for the next five years to deliver effective access to high quality, sustainable and person-centred care as close to home as possible. We will

achieve this by strengthening multidisciplinary teams (MDTs), standardising core business processes, improving digital and data flows, scaling up preventative and long-term conditions care, and establishing a stronger Shetland-wide way of working

– meaning practices working together across Shetland to make our services more robust and sustainable. Success will be measured through improvements in access, [maintain/improve population health outcomes – these are already fairly good, need more targeted measure], patient experience, continuity for complex care, workforce resilience and financial sustainability.

The work aligns with national NHS reform ambitions [add links/overview if appropriate Operational Improvement Plan, Population Health Framework, Service Renewal Framework and sub-national planning), within the context of Shetland's unique remote and island situation and operating model.

The strategy is built around four ambitions.

Ambition	What this means
Fair	People receive support based on need, risk and ability to benefit, with reduced unwarranted variation across Shetland
Adaptable	Services can respond to changing need, workforce, technology, policy and public expectations
Sustainable	Services are safe and workable within available workforce, finance, estate, digital and community resources
Connected	People experience care that feels joined up across Primary Care and partner services

The case for change is shaped by eight connected pressures:

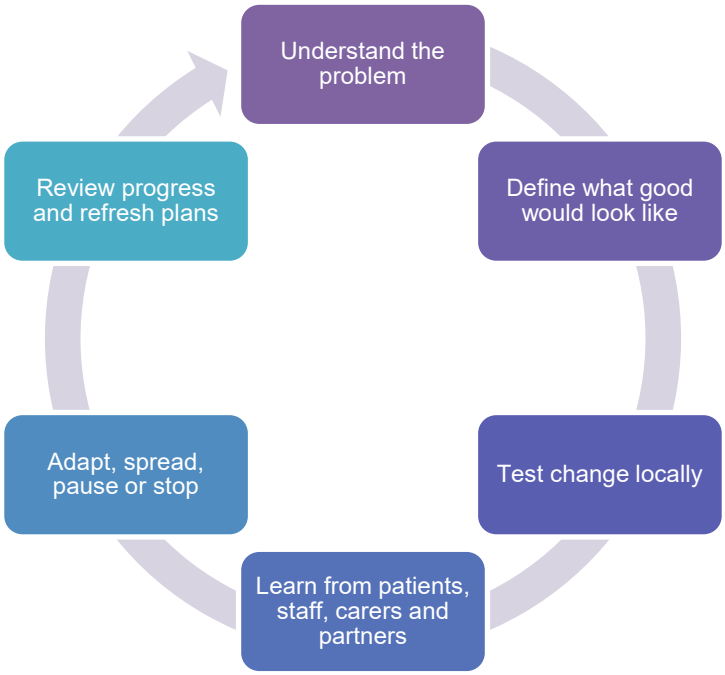
Pressure	Why it matters
Changing need	People's needs are becoming more complex, even where population size is stable
Workforce	Historic workforce models are becoming harder to sustain
Access and experience	People's experience can vary across Shetland
Same-day pressure	Same-day care matters, and requires balanced against other longer-term needs
Planned care	Urgent demand can crowd out longer term, preventative and proactive care and follow-up
Processes and interfaces	At risk processes and between team handovers create avoidable work, delay, risk and frustration

Digital and information	Digital tools and information are not yet doing enough to support care, planning and improvement
Change support	Change needs support, time, testing, learning and involvement

The strategy will be delivered through five connected priorities:

1. Fair access, clear navigation and good communication.
2. Continuity, planned care and proactive support.
3. Workforce, roles and core processes.
4. Digital, data and information flow.
5. Prevention, inequalities and community support.

The strategy will be delivered through shorter 1 to 2 year delivery plans. These plans will set out actions, sequencing, risks, measures, support required and decisions needed.



Progress will be measured through a developing Primary Care scorecard that will be both locally focused and nationally aligned. This will bring together service information, patient and carer experience, staff experience, quality and safety information, workforce information and learning from local improvement work.

The scorecard will measure more than activity. More appointments, contacts or reviews do not automatically mean better care. We will work to understand whether people are receiving the right support, at the right time, with the right outcome and experience.

Measuring Domain	What we need to understand
Access, navigation and communication	Can people get the right response, understand the route, and know what happens next?
Continuity, planned care and proactive support	Are people with greater need getting planned review, follow-up and continuity where it matters?
Quality, safety and experience	Are services safe, fair and experienced positively by patients, carers and staff?
Workforce, roles and core processes	Are teams supported, roles clear, and key workflows safer and more consistent?
Digital, data and information flow	Are tools and information helping teams plan, communicate and act earlier?
Connected care across services	Are interfaces clearer, safer and less burdensome for people and staff?
Prevention, inequalities and community support	Are services identifying risk earlier and reducing barriers for people most likely to face poorer outcomes?

By 2031, Primary Care in Shetland should be easier to understand and navigate; urgent, routine, planned and proactive care should be in better balance; people with complex needs should have better continuity and coordination; planned care should be more reliable; staff should have clearer roles and stronger support; digital tools and information should help teams act earlier; links with other services should be safer; unwarranted variation should be better understood and reducing; and patients and carers should feel more listened to, informed and involved with; **and people will have better outcomes ahead of them.**

3 National and Local Context

Primary Care in Shetland is developing during a period of major change across health and social care in Scotland.

National reform is focused on improving access, prevention, supporting more care closer to home where this is safe and appropriate, planning services around population need, making better use of digital tools, and improving how services work together around people.

These themes are set out through the NHS Scotland Operational Improvement Plan, Scotland's Population Health Framework, the Health and Social Care Service Renewal Framework, and the developing Primary Care and Community Health Route Map.

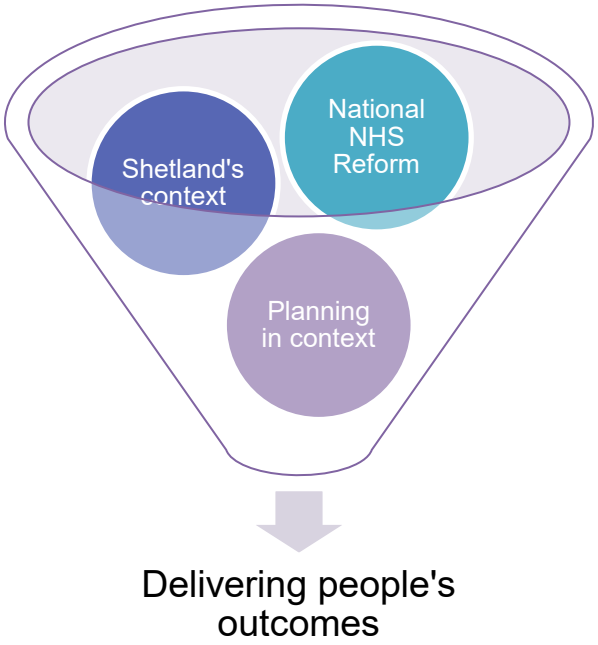
The direction is clear nationally, and health and care services will need to, over time, move towards earlier support, stronger prevention, better planned community care, clearer access, improved digital and information flow, and care designed around people and outcomes.

For Shetland, this national direction confirms that Primary Care and community-based services will play a bigger role in the future health and care system. It also supports the

need to make better use of local teams, shared learning, digital tools, population planning and prevention.

However, national policy does not always describe the practical realities of delivering care across remote, rural and island communities. Shetland will still require a local way of working that fits its geography, workforce, communities and service arrangements – a point learned in the 2024 to 2026 Primary Care Phased Investment Programme work.

3.1 SHETLAND'S RESPONSE IN THIS CONTEXT



Primary Care in Shetland plays a critical role in supporting the health and wellbeing of our communities, supporting people and families across the whole life course from birth to death.

Primary Care in Shetland operates differently from most other areas of Scotland. The current model of delivery across ten sites has evolved over the past two decades away from independent or contracted practices to consist of almost entirely 'Board-run' Practices (known as "2c practices", the alternative being independent or contracted practices). There are currently eight 2c practices across 9 sites, and 1 contracted practice (Hillswick). These changes have come about as staffing and maintaining a contractor practice has become unviable – similar challenges are seen in other remote, rural, island areas. This change means staff across all 2c practices are employed by NHS Shetland, rather than by their individual practices. For some teams this has allowed greater stability and resilience as they have developed to provide services across practices.

This brings responsibilities and opportunities. NHS Shetland has a more direct role in supporting practice teams, planning services, managing workforce risk, improving core processes and sharing learning across sites.

This model of working means Primary Care in Shetland is more closely integrated with whole system planning, the Health and Social Care Partnership (HSCP) is more tightly integrated with NHS working, and local arrangements often move ahead of national expectations.

The model has evolved to respond to immediate pressures and challenges, staffing shortages, viability of commissioned services, increasing demand, and the challenges of delivering care across remote and rural settings. While this adaptive approach has enabled services to remain functional and has generally supported good access and outcomes for patients, it has also resulted in variation, fragility, and a system that is increasingly difficult to sustain. To meet the needs of the population now and in the future, we must shift from reactive, incremental adjustments toward a planned, whole system approach to community health services.

Primary Care also has a direct role in the wider local system, including Acute and Specialist Services. Sharing roles across planned care, maintaining good same-day access, support for complexity, anticipatory care and discharge follow-up can reduce avoidable attendance, admission and re-attendance.

This reflects the increasing need for supported shifts of care from acute and specialist partner services into Primary Care with support. Care should move closer to home when the move is safe, supported and better for people.

Shetland also depends on strong regional and specialist networks. Local generalist care needs clear routes into specialist advice, diagnostics and treatment, including links with mainland services. Digital tools, telehealth, Near Me, shared information and planned pathways can help, and they need to support clinical decision-making and avoid adding unnecessary complexity.

While national policy informs the direction of travel, it does not always reflect the realities of remote, rural and island care. This strategy is therefore designed to respond directly to Shetland's context: solutions that are locally led, nationally aligned, and deliverable within our health and care system.

3.2 Primary Care in Shetland

Primary Care in Shetland is delivered across a small but complex island system.

Almost everyone in Shetland is registered with a local health centre. Most people in Shetland report good health outcomes and good access to their local practice (HACE, population health survey, Shetland LE and HLE), but this is not the case for everyone.

There remain unfair differences in access, experience, and outcomes across communities. Some of these differences reflect longstanding challenges in service capacity and workforce availability, which vary significantly by location. Others stem from broader inequalities in our communities that health services alone cannot resolve. While

we cannot undo these inequalities of outcome, we can design services that lessen their impact, particularly for individuals and families with the greatest need.

Shetland's population has remained relatively stable in size, but the needs within the population have changed.

List size alone does not tell us enough about the service people need. Two communities may have similar numbers of people but different levels of need, depending on age, long-term conditions, including frailty, and mental health, transport, housing, medicines burden, digital access, caring responsibilities and social support.

Much of our future health need will be driven by older age and long-term conditions, and Shetland's population has aged more rapidly than the Scottish average.

More people are living with multiple long-term conditions. More people are living for longer with frailty, medicines complexity and changing independence. More people need support that is planned, coordinated and proactive, not only care that responds when something has already gone wrong.

At the same time, children, young people and families need support that is timely, accessible and appropriate to their stage of life. Working-age adults may be balancing health needs with employment, caring responsibilities, financial pressure and mental wellbeing. People of all ages may struggle to advocate for themselves, use digital routes, travel to appointments, or know what support is available.

The way primary care is currently planned and delivered makes it difficult to consistently meet the needs of our population. A number of changes and solutions have been implemented over recent years to respond to a challenging delivery environment and workforce availability challenges. Some of these have included service redesign and have reshaped our services, while others have been a crisis response and are less sustainable in the longer term. While these solutions have kept services running, when done in isolation they can also create instability, variation, pressure on staff and managers, and financial strain on finite resource.

A Primary Care system for Shetland must therefore support the whole life course and the differences across it.

What is Primary Care?
Primary Care is the part of the health and care system people usually contact first when they need advice, assessment, treatment, review or support.

In Shetland, people often experience Primary Care through their local health centre and the teams working in and around it. Almost everyone in Shetland is registered with a health centre. This gives Primary Care an important relationship with most of the population, across the whole life course.

Primary Care is not one profession or one type of appointment. It is a broad set of clinical and non-clinical functions that help people get the right support, at the right time, in the right way.

For this strategy, Primary Care means the functions delivered in and around Shetland's health centres, or delivered by teams normally based there and across the community.

This includes urgent care, routine care, planned review, prevention, long-term condition care, medicines work, care planning, navigation, administration, records, results, referrals, coding, digital tools and information flow.

It also includes the work that makes safe care possible before, during and after an appointment. This includes reception, care navigation, appointment booking, recall, results handling, referrals, communication, practice management, information quality and day-to-day service flow.

3.3 WHY WE TOOK THIS APPROACH

NHS Shetland wants to develop a strategy that is ambitious but realistic for our context, and that builds on the wealth of experience and wisdom in our system. We drew on a wide range of evidence including population health intelligence, national policy direction, local service data, staff and patient engagement, and learning from the Primary Care Phased Investment Programme.

To have a clearer, holistic sense of our population and communities we looked across multiple sources including the Healthy Shetland Population Health Survey (2021), Shetland Partnership community profiles, Health and Care Experience data, available census data, service feedback, needs assessments, the NHS Shetland Strategic Delivery Plan, the Clinical and Care Strategy, and the Health and Social Care Strategic Plan, as well as national sources of feedback and population data. From this evidence base we identified nine key areas that the strategy development process needed to address:

Priorities and vision	Patient access and pathways	Physical estate
Workforce development	Collaboration and integration	Integrating practice functions
Digital and data	Health inequalities	Managing workforce sustainability risks

These themes reflect the recurring challenges faced across the system, as well as the opportunities to design a more consistent, equitable and resilient model. The strategy draws together what we already know, what our staff and patients have told us, and what the evidence shows us about what will make the biggest difference over the next five years.

3.4 WHAT IS ALREADY WORKING

There is strong work to build from. Teams across Shetland have adapted to maintain care. This strategy is written with the understanding of the wealth of **what is already working** locally:

Area of work	What it shows
Supported models on non-doctor islands	Local models can be redesigned with communities to sustain safe care where traditional staffing models are no longer workable.
First Contact Physiotherapy and Community Link Worker roles	People can access different types of support closer to home when routes are clear and roles are well integrated.
Long-term condition review through nursing and healthcare support worker roles	Planned review can become more consistent when teams use skills well and use agreed checks.
Early frailty work	Primary Care can identify risk earlier and support people before crisis, admission or loss of independence.
Shetland Health Intelligence Platform	Better use of information can help teams understand risk, identify people who have not been reviewed, and target time more effectively.
Networked pharmacy support	Specialist-generalist skills can be shared across sites while maintaining links with local health centre teams and provided over distances and systems.
Shared and rotational staffing approaches	Different workforce models can improve stability where permanent cover is hard to secure.
Community Health Out of Hours models	Shared approaches across Primary Care, community nursing and local clinicians can support urgent and remote care.

3.5 IDENTIFIED DELIVERY CHALLENGES

The challenges facing Primary Care in Shetland are clear and are shared across much of the public sector. These challenges shape how we can respond and which solutions are likely to have an impact. Challenges and examples of local work to overcome them are briefly detailed below:

Workforce sustainability: We cannot reliably source the staff required to maintain historic models, particularly in small or remote practices. The need to maintain service delivery has driven a reliance on short-term solutions to fill gaps in rotas or service provision-. Some of these short-term solutions have made staffing models complicated and challenging to maintain.

Variation in access and experience: While many people can access what they need quickly and easily, this varies significantly between localities, and those who need coordinated or ongoing support may not receive consistent continuity of care.

Reliance on reactive solutions: Changes made under pressure to respond to critical challenges have kept services going but have also created inefficiencies and inconsistent ways of working across sites.

Growing and changing demand: Rising multi-morbidity, increasing frailty and an ageing population mean that without deliberate redesign, existing pressures will intensify.

Geographic complexity: Distance, dispersed populations and differing local contexts mean that models designed for mainland systems cannot be lifted and replicated here, often nationally prescribed solutions can drive more challenges and need to be implemented cautiously.

Inequalities and unmet need: Structural inequalities continue to shape health outcomes, requiring primary care to play a stronger role in prevention, early intervention and targeted support.

Digital and infrastructure gaps: Information management and flows, digital access and data quality, and consistency of approach to digital systems need to improve to support safe, efficient and equitable care.

These challenges are clearly felt and understood by staff, patients, communities and leadership, as they were clearly articulated through the strategy development process.

Much of the development work Primary Care and Community Health teams have trialled and embedded in recent years responds to these challenges. Some examples include:

Skill Mix and MDT
Delivering healthcare through a Resident Nurse model on “Non-Doctor Islands” became unsustainable when vacancies remained unfilled. Development of a supported Health Care Support Worker model in collaboration with local communities has made health and care sustainable for the local community. Development of First Contact Physiotherapy and Community Link Worker roles is helping people in some areas access what they need closer to home.

Community Health Out Of Hours
The historic GP Out of Hours (OOHs) model was increasingly challenging to staff, requiring costly locum cover to sustain the service.
The Community Nursing team, in collaboration with Primary Care and local GPs developed an OOHs model that included Advanced Nurse Practitioner cover – developing appropriate local training, mentoring and supervision to make the model safe, effective and sustainable. This model has delivered financial savings while stabilising cover.

Networked Pharmacy Team
Pharmacy work as a team of pharmacists and technicians delivering functions across different health centres as part of local health centre teams. This makes best use of their Generalist –specialist skills and ensures pharmacy support is consistent, accessible and resilient. This maintains the benefit of local multidisciplinary team working, while ensuring best use of resource and minimising impact of vacancies and leave.

GP Joy and Rotational Models
Permanent GP cover was becoming increasingly challenging to find, with persistent vacancies and gaps in service. Development of rotational contract models, and implementation of the GP Joy programme have supported more stable and consistent staffing, meaning improved continuity for patients and health centre staff, as well as financial savings and improved resilience for Primary Care in Shetland.

Managing Long Term Conditions Well
Making effective use of the skilled and consistent General Practice Nursing and Health Care Support Worker roles to implement standarised long term condition checks to improve LTC management and decrease the preventable complications people with LTCs can experience. This has also allowed us to build strong foundations for frailty work.

Visualising Data to Improve Effectiveness
Shetland Health Intelligence Platform (SHIP) – a way to visualise our patient data to make it more meaningful and help clinicians take meaningful action.
This lets us understand who has particular risk factors, who hasn’t been seen recently and how we can best target our time and resources.

4 What People Told Us

A structured programme of staff and patient engagement was undertaken throughout 2025, combining surveys, workshops, targeted discussions and meetings. This process provided a clear and compelling picture of what matters most to the people who work in, deliver, and rely on primary care services in Shetland. It has helped build a shared understanding of the challenges facing the system, highlighted opportunities for improvement, and confirmed the importance of moving toward a coordinated Shetland model of Primary Care delivery.

4.1 What we Heard at a Glance

Theme	Main message
Access	People want access to feel effective, fair, understandable and safe
Communication	People want to know what will happen next, especially when they are waiting
Continuity	People value continuity where it counts, especially when needs are complex or changing
Local teams	People value local relationships and the knowledge held by health centre teams
Staff pressure	Staff are committed, but the system is under pressure
Core processes	Staff want clearer and more consistent ways of working where this improves safety, quality and fairness
Digital access	Digital routes help some people, but cannot be the only route
Carers (Unpaid Carers)	Carers often hold important knowledge and need support when coordinating care
Whole life course	The strategy must work for children, families, working-age adults, older people, people approaching end of life, and people facing barriers to care.

4.2 Patient Engagement — Key Findings

Patients provided valuable insight into their experiences and expectations, reinforcing areas of strength while identifying opportunities for improvement:

- Patients generally report good health, positive relationships with their practice, and the ability to obtain an appointment when needed
- Continuity of care where it counts, and timeliness of appointments were the most frequently cited areas where improvements would enhance their overall experience

- Many patients are willing to wait for an appointment but want clearer communication about how long they might wait and what they should do in the meantime
- Individuals with supportive networks often turn to family or friends when they cannot be seen promptly, highlighting the need to consider those without such support
- Above all, patients want to be listened to, taken seriously and involved in decisions about their care

4.3 Staff Engagement — Key Findings

Staff consistently emphasised the essential conditions required to deliver high-quality, sustainable and person-centred care:

- **Equitable access** should be prioritised, with services organised to meet the needs of those who would benefit most
- **Information flow between services and systems** must improve to support safe, effective and coordinated care
- **Standardised business processes across Shetland** would reduce variation, improve efficiency and support resilience
- **Staff wellbeing, training and opportunities for progression** are critical to recruitment, retention and long-term sustainability
- **Continuity of care and meaningful patient engagement** are central to delivering a patient-centred service

These points matter because good Primary Care depends on more than clinical appointments. It depends on the whole system working well: booking, navigation, records, recall, results, referrals, communication, staffing, digital tools, buildings and relationships between and within teams.

4.4 How Listening has Shaped the Strategy

The development journey has had value in its own right, helping to:

- surface issues that had not been widely understood across the system,
- enable staff and patients to articulate their priorities clearly,
- strengthen connections across services and disciplines, and
- reinforce the case for designing primary care at a system level, rather than relying on site-by-site solutions.

This collaborative approach has deepened our understanding of both the common and unique challenges facing primary care in Shetland.

What we heard	How this strategy responds
People want access that feels fair and understandable.	The strategy includes a priority on fair access, clear navigation and good communication
Same-day access matters, but it is not the whole answer.	The strategy balances urgent, routine, planned and proactive care
People value continuity, especially when needs are complex	The strategy aims to prioritise continuity where it matters most
People want to know what will happen next.	The strategy supports placing stronger emphasis on communication, reassurance and safety-netting
Staff want better information flow between services	The strategy includes digital, data and information flow as a core priority
Staff want clearer and more consistent processes	The strategy supports shared standards and core processes where these improve safety, quality, access and fairness
Staff want better role clarity, training and support	The strategy includes workforce, roles and core processes as a priority
Local teams are under pressure	The strategy makes clear that change should be supported through local teams, not done to them as well as investing in them
Digital tools help some people, but not everyone	The strategy supports digital choice while maintaining non-digital access routes
Carers often know what is changing before services do	The strategy recognises carers as partners in care and includes carer feedback in measuring progress
Communities differ across Shetland	The strategy values local health centre teams while working towards a stronger Shetland-wide Primary Care system with them

5 AMBITIONS, VISION, AIMS AND OUTCOMES

5.1 HOW THE STRATEGY FITS TOGETHER

This structure gives the strategy a clear line from purpose to action. It also helps test future decisions. A proposed change should be able to show how it supports the aim, ambitions and outcomes set out in this section.

5.2 Our Ambitions

Four key overarching ambitions for our Primary Care system were clear through the development of the strategy. These are things that were important to patients, communities, teams and leadership.

We want to ensure our Primary Care system is:

Ambition	What it means	How we will test it
Fair	People receive support based on need, risk and ability to benefit. Unwarranted variation across Shetland is reduced.	Does this work for people with the greatest need and the greatest barriers, not only for people who can use the system easily?
Adaptable	Services can respond to changing need, workforce, technology, policy and expectations.	Can teams test, learn and adjust rely less on reactive responses or workarounds?
Sustainable	Services are safe and workable within available workforce, finance, estate, digital and community resources.	Does this make care more reliable without creating unsafe pressure elsewhere?
Connected	People experience care that feels joined up across Primary Care and partner services.	Does this reduce gaps, duplication, handoff risk and the burden placed on people and carers?

These ambitions give a shared direction and shape a strategy that can address today's challenges and build the foundation for a resilient, equitable primary care system for Shetland which is fit for the future.

These ambitions will guide decisions about access, workforce, digital tools, estates, service design, pathway changes, investment and shifts of care.

They also help us make trade-offs. Not every good idea can be delivered at once. Not every change will have the same impact. The ambitions provide a shared test for what should be prioritised.

5.3 VISION & AIMS

OUR VISION:

‘Everyone in Shetland can live well for longer, and easily access the support they need from us.’

OUR AIM:

- To provide easy access to high quality, sustainable and person-centred care as close to home as possible and
- To make a meaningful difference to the building blocks of good health in our communities.

Primary Care services are a critical component in the service delivery part of this work – providing easy access to high quality, sustainable and person-centred care. By implementing this strategy we hope to:

‘Provide Primary Care services that enable people across Shetland to live well, with timely access to the right support; fair outcomes across our communities; and services that respond to meet people’s needs.’

In order to achieve this vision, there are 5 key areas for improvement, these will focus resources where they are likely to have most impact, reduce the “failure demand” and duplication in our system improving outcomes and saving wasted time and intervention; and support ways of working to release time to care. The key areas are:

1. Fair access, communication, navigation and connected care
2. Workforce, roles and core ways of working
3. Continuity, planned care and proactive support
4. Digital, data and information flow
5. Prevention, inequalities and community support

Key Areas Explainer

What are 'interfaces' and why do they matter?

An interface is the point where different parts of the healthcare system meet and interact.

For example:

GP - - Hospital Outpatients

Practice Nurse - - Multidisciplinary team

At these points, information, responsibility, and care are handed over. This can be difficult if information is lost or delayed, if communication isn't clear, or there is uncertainty about expectations of who should do what. For a patient this can feel like having to repeat your story, your care not being joined up, or not getting what you need.

We know that things can go wrong in the 'space between our services', and we want to minimise this by building stronger relationships and connections.

Computer systems that do not connect to each other makes these challenges worse.

Why long term conditions (LTCs)?

Many people live with a 'long term condition', or often several, particularly as they reach middle and older age. A long term condition is a health problem that may not be cured, but can be managed or controlled with treatment and self-management – this might include medication and lifestyle management.

People who have a long term condition can experience complications, or related ill-health, if their condition is not managed well. Sometimes these complications can mean they end up needing emergency care or admission to hospital.

Managing long term conditions well, through timely reviews and appropriate intervention, is better for patients, as they avoid further ill-health and distress, and it is better for health services because they experience less 'failure demand' – when someone needs a service or intervention because their condition has not been managed well.

Why are inequalities and prevention important?

Inequalities are the avoidable and unfair differences in health, access to services, and outcomes between different people and across the population.

Some groups of people are more likely to experience inequalities, and we should organise and deliver services to try and minimize these unfair differences. A society with fewer inequalities is better for everyone.

How does having good data help us?

Having access to good data helps us understand our system, and supports us to make decisions about patient care, about how we use capacity and resources, and about how we organise our services. Having access to data can also help clinicians understand where there are challenges, and make changes for the better.

What does a networked system mean?

In Shetland, a 'networked' Primary Care model means different services and professionals being connected and working together as a coordinated team across Shetland, rather than as separate parts doing different things. This will mean we can deliver across our geography, but maintain access to specialist skills, and be resilient to changes. It also means services will be more consistent and fairer for patients – no matter where you live.

How will we know we have made a difference?

There is no clear performance framework or standard for Primary Care services, nationally. To understand whether Primary Care services are working we will devise a local performance monitoring framework based on engagement with teams and patients; we will continue to engage with national work to improve planning, commissioning and delivery of Primary Care.

Our performance monitoring framework will have to tell us about:

- Time to access, and appropriateness of this
- Means of access, and acceptability of this
- Quality of intervention, and outcomes
- Financial sustainability
- Population health outcomes across communities

We will also continue to monitor the national Health and Care Experience survey (HACE) which takes place every 2 years.

Service performance information will be used alongside patient experience to understand where changes or developments need to be focused, and information will be shared with both the IJB and NHS Board. Change work, and related evaluation information will be reviewed within the Primary Care Redesign Programme, and appropriately thereafter with management teams and governance committees.

5.4 OUTCOMES

Outcome area	What this means for Shetland Primary Care
System rebalance	Primary Care is recognised, supported and planned as a central part of the wider health and care system, with a stronger role in prevention, early intervention, planned care and care closer to home where this is safe and appropriate.
Access	People can access Primary Care in ways that are timely, sustainable and fair, with clear navigation, good communication and appropriate urgent, routine, planned and proactive care.
Coordinated, connected and person-led care	Care is organised around people's outcomes and experience, not only around service boundaries. People, carers and staff know who is involved, what will happen next and how information will flow.
Quality Primary Care	Primary Care is safe, preventative, relational and grounded in generalism and continuity where these matter most. Services reduce avoidable harm, waste, duplication and unwarranted variation.

6 STRATEGIC PRIORITIES

The strategy will be delivered through 5 connected priorities.

These priorities should not be treated as separate work programmes. Progress in one area will often depend on progress in another.

Better access depends on workforce, communication, digital tools, clear processes and good information. Better long-term condition care depends on recall systems, medicines review, continuity and time for planned care. Better prevention depends on Primary Care working with public health, community support, third sector organisations, carers and wider partners.

Connected care runs through all five priorities. People's needs often cross service boundaries. Primary Care is important, but it cannot work alone. The strategy therefore focuses on access into Primary Care, care within Primary Care, and the links between Primary Care and other services.

The five strategic priorities are:

6.1 Fair Access, Communication & Navigation

Strategic intent

People should be able to access the right support, at the right time, in the right way, with clear communication and better links between services.

Why this matters

Access is one of the issues people notice most. It affects confidence, safety, experience and trust.

Focusing on access, interfaces and service navigation is important because both staff and patients highlighted that getting into services, moving between them, and knowing what to do are key challenges. Improving this will make it easier for patients to access the right care at the right time, with clearer communication and fewer barriers, leading to a more joined-up and person-centred experience. Importantly, patients are often willing to wait, but they want to understand why, feel reassured their need has been assessed, and be given clear advice or alternatives while they wait.

Aims:

People are easily able to access what they need – this will include flexibility of where they access services; and continuity of healthcare professional when they need it - flexibility where it helps, and continuity where it counts.

People get support when they need it – often people do not need care urgently, or on the same day but our systems are arranged to make this the norm – people will be able to book ahead when that is right for their condition, and people who need to be seen more quickly will be.

People know what to expect when accessing Primary Care across Shetland – practice relationships with their communities remain strong, and standards for contacting and accessing support are high and fair across practices.

People requiring ‘shared care’ pathways feel their needs are well managed, and their team communicates well with them and each other.

Approach:

- Standardise access and triage processes across practices, balancing on-the-day and planned appointments and prioritising the highest need effectively.
- Strengthen joined-up working with secondary care, including urgent and unscheduled care and scheduled or long-term condition care with improved relationships, communication flow and information sharing.
- Build clear pathways and expectations around elements of patient care shared between Primary and Secondary Care teams – setting out to be consistent across practices, and aligned to national and subnational work reimagining the role of hospital care.
- Improve proactive continuity for people with more complex needs or presentations, using Multi-disciplinary team (MDT) approach so people get what they need early, and feel supported and listened to – We trust out clinicians to protect time for people

with more complex presentations or symptoms giving them time to work with their health professional and make plans for their support.

- Optimise emerging opportunities to test alternatives to urgent and unscheduled care access, including (but not limited to) GP/ANP walk-in clinic provision, closer working with hospital-based urgent care, exploring expanded MDT to include other advanced practice roles – robust evaluation of these opportunities will support developing delivery models.

Continuity where and when it counts

Continuity is one of the distinctive strengths of Primary Care. It is more than simply a preference for seeing the same person. Used well, continuity supports clinical judgement, trust, pattern recognition, safer decisions, shared decision-making and care that is fitted to the person's wider context.

Continuity has different forms. Everyone should expect good informational and management continuity: accurate records, clear plans, reliable follow-up, and safe communication between professionals and services. These are basic features of a safe Primary Care system.

Some people also need relational continuity: an ongoing therapeutic relationship with a clinician or small team who knows them, understands their history, and can recognise change over time.

Relational continuity is most valuable where care is complex, uncertain, cumulative or dependent on trust. We will aim to prioritise it where it is most likely to change care, reduce risk, reduce avoidable repeat contact, or help someone make sense of changing needs.

This will usually matter most for people living with long-term conditions, frailty, multimorbidity, medicines complexity, mental health needs, safeguarding concerns, palliative or end of life care needs, or new and uncertain symptoms that require assessment, diagnosis, planning and follow-up over time.

For more straightforward needs, timely access to the right member of the Primary Care team may be the better form of care. The aim is not to offer the same form of continuity to every person at every contact. The aim is to use continuity deliberately: clear information and reliable follow-up for everyone, and relational continuity where it counts most.

What this means

For people	For teams	For the wider system
People should know how to contact their health centre, what response to expect, and what to do while waiting. They should repeat their story less often and have clearer information when more than one service is involved.	Teams should have clearer triage processes, better advice routes, more consistent access standards and better information to support decisions.	NHS Shetland and partners need clearer shared care pathways, safer handovers, better communication routes and a shared understanding of what can safely move closer to home.

Constraints:

Access cannot be improved through appointment numbers alone. Workforce, estate, digital tools, communication systems and demand all shape what is possible.

Workforce pressure in Primary Care, community services and hospital services will affect how quickly shared pathways can improve.

Shetland's geography also means that every type of service cannot be available in every site at all times. This will need careful use of local, remote, virtual and Shetland-wide options..

How we will know progress is being made

We will look at:

- patient experience of access
- clarity of communication while waiting
- balance between same-day, routine and planned appointments
- continuity for people with more complex needs
- variation across practices
- avoidable repeat contacts
- staff experience of managing daily demand
- delays caused by unclear responsibility between services
- safety events involving handovers or communication

6.2 WORKFORCE, ROLES AND & IMPROVED WAYS OF WORKING

Strategic Intent

Primary Care teams should be stable, supported and able to work as part of a Shetland-wide system, while remaining rooted in their local communities.

Why this matters

Primary Care depends on people and the whole team. Teams highlighted challenges around recruitment, workload, and variation in how services operate, alongside the need for better shared working and communication across sites and teams. Strengthening the workforce and working more as a connected system will help make better use of skills, improve continuity and consistency of care, and reduce pressure on individual services. Streamlining and standardising processes will reduce duplication and delays, meaning patients experience smoother, more reliable care and fewer barriers when moving through services.

Aims:

Teams are more resilient and stable.

The MDT is better accessible across delivery locations for people

Processes are clear and well understood across practices, lowering decision-making load for staff, and improving management of the working day.

Teams are supported to develop capacity and capability to meet growing and changing demands.

Teams feel supported by the organisation.

Work that is avoidable and duplicative is reduced

Approach:

- Continue to improve cross-site working between teams and staff to support demand across all sites
- Making the most of our MDT resources to meet local needs, removing barriers to access that are currently in place
- Standardise SOPs (Standard Operating Procedures) across sites and optimise workflows across administrative and clinical processes to reduce variation and waste.
- Take all opportunities to invest in recruitment, induction and development to appropriately respond to “shifting the balance of care” from hospitals to community – building capacity and capability to meet needs.
- We will use workforce, service and population information to plan services around need, not only around historic staffing models.

What this means

For people	For teams	For the wider system
People should experience clearer communication, fewer delays caused by unclear internal processes, better use of the full Primary Care team, and a more consistent experience across practices.	Teams should have clearer roles, shared procedures, better induction, practical training, cross-site support, and clearer routes for raising problems and improving workflows.	NHS Shetland needs to support practices as part of one Primary Care system, with shared learning, clearer workforce planning, and better use of available skills across Shetland.

Constraints:

National priorities drive national funding opportunities and decisions, Shetland must adapt opportunities when they arise to optimise impact for Shetland.

Financial constraints are likely to continue, and change will be ongoing, this is a challenging context for teams to work in.

How we will know progress is being made

We will look at:

- vacancies and turnover
- staff experience
- sickness absence
- use of locums and temporary cover
- completion of shared SOPs
- process variation across practices
- training and induction completion
- workflow measures where available
- patient experience of consistency

6.3 Continuity, Planned Care, and Proactive Support

Strategic Intent

People with long-term, complex or changing needs should receive planned and proactive support that helps them stay well, manage risk, avoid deterioration and maintain independence.

Why this matters

Shetland's population size has remained fairly stable, but the needs within that population have changed.

Focusing on long term conditions, including frailty, is important because both staff and patient feedback highlight increasing complexity of need and the importance of continuity, prevention and person-centred care. Strengthening how we support people with long term conditions will help prevent complications, maintain independence and improve overall outcomes by intervening earlier and supporting people to manage their health. It will also reduce avoidable demand on services (failure demand) by ensuring patients get the right support first time, experience fewer repeat contacts, and move more smoothly through the system with consistent, proactive care.

Aims:

We identify and manage risk factors for long term conditions well, giving people the opportunity to minimise their risk.

We reduce failure demand within our system by managing long term conditions (LTCs), including Frailty, proactively. Including through regular long term condition checks building on House of Care implementation.

People know what to expect when they are living with a long term conditions, and manage it well with their Primary Care team so they have fewer preventable complications.

People are able to access continuity where it counts – for example where they have more complex presentations, or are managing more challenging situations.

Approach:

- Recognise this as current and future drivers of healthcare need, gather robust intelligence about need and risk in Shetland
- Use health intelligence gathered to identify risk factors for key long term conditions and make people aware of their risk, and options to modify this
- Connect people with identified risk factors with appropriate resources, support and preventative services to modify their individual risk factors
- Spread and scale approach to LTC management tested through House of Care, to other appropriate LTCs

What this means

For people	For teams	For the wider system
People should know what review or follow-up to expect, receive support before problems worsen, have clearer plans for managing long-term conditions, and experience continuity where their needs are more complex.	Teams should have reliable recall systems, better information on risk and need, time for planned care, clear roles in long-term condition management, and better use of MDT skills.	NHS Shetland needs to protect planned and proactive care within the operating model, rather than allowing urgent demand to consume all available capacity.

Constraints:

Patient and community behavior will be a considerable element in managing risk factors for a number of long term conditions; socioeconomic circumstances also play a more significant role. Health services cannot change this, but NHS Shetland will remain heavily involved in the Shetland Partnership to influence circumstances wherever possible.

Preventative support and health improving services (within and outside the NHS) are often less well resourced than other health services, and may not be as consistently available – self management opportunities and resources should be optimised, and available services should seek to proactively support those at risk, where this information is available to them.

How we will know progress is being made

We will look at

- long-term condition review coverage,
- anticipatory care completion
- follow-up for people with higher need,
- continuity measures for complex care,
- medicines review delivery,
- frailty identification and support,
- patient and carer experience of planned care,
- and avoidable escalation or repeat contacts

6.4 DIGITAL, DATA AND INFORMATION FLOW

Strategic Intent

People and teams should have the information, tools and routes they need to support safer, clearer and better coordinated care.

Why this matters

Good care depends on good information and many safety, experience and access issues can happen between services and teams. Focusing on digital, data and information flow is important because staff highlighted the need for better integrated systems, improved use of existing technology, and stronger information sharing across services.

Strengthening these foundations will support more joined-up care, enable staff to access and share the right information at the right time, and reduce duplication. For patients, this means a smoother, more coordinated experience, with fewer repeated questions and clearer communication, helping ensure care is more efficient, consistent and responsive to their needs.

Digital tools and data will not replace relationships, judgement or person-centred care. They should help teams communicate, plan, act earlier and reduce unnecessary work.

Aims:

People are able to access services in a way that works for them – this is likely to mean developing digital access while retaining traditional means of access for those who require it.

Our teams are able to access the information they need to delivery high quality services, and are safely able to share this information to support positive outcomes for their patients.

Our teams are able to access the hardware and systems they need to do their work, wherever they are based.

We make use of available technology to optimise patient outcomes, and release time to care.

We gather and analyse meaningful data about our communities, to more effectively plan services and target delivery.

We will engage in national and regional digital work where possible, so solutions reflect Shetland's Primary Care context.

Approach:

- Optimise current available systems and processes, building digital capacity and capability through this process to support future adaptation to new systems

- Support confident use of existing and new systems through access to appropriate training where available, and sharing of standardised SOPs and approaches
- Ensure consistent approaches to use of patient-facing systems to minimize confusion and frustration, and optimise engagement.
- Engage in the development, commissioning and implementation of new systems wherever possible to advocate for solutions that work for Shetland – acknowledging our Primary Care context is different to other places.
- Prioritise systems and ways of working that
    - improve patient access to services – including moving between services and settings
    - improve information flow between services and settings, recognising that digital platforms are an enabler to good care, and that collaborative, person-centred working is built on relationships and communication

What this means

For people	For teams	For the wider system
People should have clearer digital routes where these help, while still being able to use phone or face-to-face routes where needed. They should repeat their story less often and receive clearer communication.	Teams should have better access to information, clearer digital processes, suitable hardware, better data for planning, and practical support to use systems well.	NHS Shetland needs to influence digital decisions where possible, improve local use of existing tools, and make data a routine part of planning and improvement.

Constraints:

Decision making around funding and commissioning of digital products takes place almost exclusively at a national or sub-national level, influence of individual health boards on these decisions can be limited.

Resources for training and ongoing management of digital systems in a local context are limited, while this may change there will always be a need for clinical and non-clinical staff to share and demonstrate good practice to upskill colleagues.

Digital change must not widen inequalities. New digital routes should improve choice, not remove routes that some people need.

How will we know progress is being made

We will look at

- patient experience of digital and non-digital access,
- staff experience of systems,
- data quality,
- use of patient-facing systems,
- information-sharing issues,

- repeated information requests,
- delays linked to missing information,
- and the availability of useful data for planning.

PREVENTION, INEQUALITIES & COMMUNITY

Strategic Intent

Primary Care should help people stay well for longer, identify risk earlier, reduce barriers to care, and remain connected to local communities.

Why this matters

Health is shaped by more than healthcare, and people do not start from the same place.

Focusing on prevention, inequalities and community is important because staff and patient feedback highlights the need to better support people with complex needs, those less able to advocate for themselves, and to take a more proactive, person-centred approach to care. Feedback also shows both patients and staff consider their health centre teams to be an important part of their community – we want to keep this strong, local connection. Strengthening prevention will help people stay well for longer, reduce avoidable ill health and narrow inequalities. For patients, this means earlier support, stronger local connections, and care that feels more inclusive and tailored to their needs, rather than waiting until problems become more serious.

Aims:

Our Primary Care teams and services recognise that some people find it more difficult to access services and have good health outcomes, work to recognise where these differences exist in their communities and take steps to minimise the impact – including working with non-health and care services to provide more holistic meaningful support.

Our Primary Care services are trauma informed, person-centred and supportive; working within the ethos of ‘Getting it Right for Every Child’ and ‘Getting it Right for Everyone’.

While our teams are networked for resilience and stability our Primary care sites remain an important part of their communities, responding to need there, while supporting Shetland wide delivery.

Approach:

- Connect with development of next Shetland Partnership Plan – understanding this will impact many of our shared challenges as an organisation and in terms of people’s health and wellbeing.
- Work to balance the benefits of a networked approach, addressing the needs of Shetland as a whole population, and the benefits of a localised, place-based approach – recognising we need elements of both to have a viable, impactful delivery model.
- Implement known supports to access for people experiencing inequalities considering trauma informed practice, value based health and care, and stigma to accessing services
- Engage with wider system change work, including the Fairer Futures Partnership, to understand how best to achieve meaningful renewal and reform as part of the public sector.

What this means

For people	For teams	For the wider system
People should feel listened to and respected, receive support that reflects their circumstances, find it easier to access care if they face barriers, and be linked to wider support where this would help.	Teams should have better information on local need, clearer routes to wider support, stronger community links, support to use trauma-informed approaches, and practical ways to recognise carers as partners in care.	NHS Shetland and partners need to treat prevention and inequalities as shared work, not as something Primary Care can resolve alone.

Constraints

The most significant impact on inequalities and health outcomes happens out with health services – services can mitigate impact and help inform action to undo inequalities.

Work to progress system change and make a meaningful shift towards prevention is challenging and long-term – this can often be deprioritised in favour of short-term risks and solutions.

Public understanding and perception of equity and fairness may be challenging when inequalities are hidden and there is stigma around accessing support – changes to services to support those likely to have poorer outcomes, may impact access of those less likely to have poorer outcomes. There was a clear desire for this fairness across staff, leadership and patient engagement.

7 Implementing the Strategy

The strategy sets a five-year direction for Primary Care in Shetland.

Delivery will happen through shorter action plans. These will set out what will be done, who will lead, who needs to be involved, what will be tested first, what support teams need, what risks must be managed, what decisions are required, how progress will be measured, and how learning will be shared.

This allows the strategy to hold a clear long-term direction while responding to new pressures, learning and opportunities over time; and critically – changing approach where this is the right thing to do.

The successful delivery of this strategy will depend on both what we change, and how we work together to make change happen. Local teams understand their communities and the practical realities of care. Together, as the layers and elements of NHS Shetland the organisation, we will all have a role in supporting each other across and beyond these teams to support shared standards, digital tools, improvement support, governance, leadership, training and routes to share learning across Shetland.

Our method is as important as the plan.

7.1 Principles for Planning and Delivery

Taking a planning approach to delivery will help us navigate uncertainty while continuing to progress, allowing us to respond, learn and grow, in line with our strategy. To support this approach we have developed 8 principles for delivery, outlined below. These principles will guide how Primary Care services in Shetland are designed, improved and delivered over the life of this strategy.

1. Be accountable for equitable, high-quality care

We are accountable for delivering effective, safe and high-quality Primary Care services to all communities in Shetland. We will reduce unwarranted variation, improve fairness in access and outcomes, and prioritise support where need is greatest.

2. Listen to and involve people

We will listen to patients, carers, communities and staff to understand how services are experienced, and involve them in informing decisions about improvement. We will use this insight to shape services in ways that reflect real needs and experiences.

3. Validate assumptions before acting

We will not assume we understand a problem without testing and validating it. We will use evidence, local intelligence, professional experience and patient insight to understand what is happening and what is most likely to make a meaningful difference.

4. Work as unified but distributed teams

Our teams are unified in purpose, but distributed across sites and communities. We will work in ways that uses this approaches strengths, including mutual support and system resilience, while recognising the importance of local relationships and local context.

5. Collaborate across teams, services and sectors

No team or service can meet every challenge alone. We will work together across professions, roles, services and locations, sharing responsibility, skills and knowledge to improve care and manage demand effectively. We will reduce the cost, barriers and inertia that can make this challenging.

6. Make the best use of resources and focus on value

We will make the best possible use of our people and their skills, time, buildings, technology and finances. We will prioritise work that adds most value, reduce duplication and unnecessary processes, and focus on activities that improve outcomes and experience.

7. Support continuous learning and improvement

We will support each other to learn from experience, share what works, and respond to challenges together. We will learn from adverse events, improvement work and other systems, and support teams to test and adopt better ways of working.

8. Use digital to improve care and experience

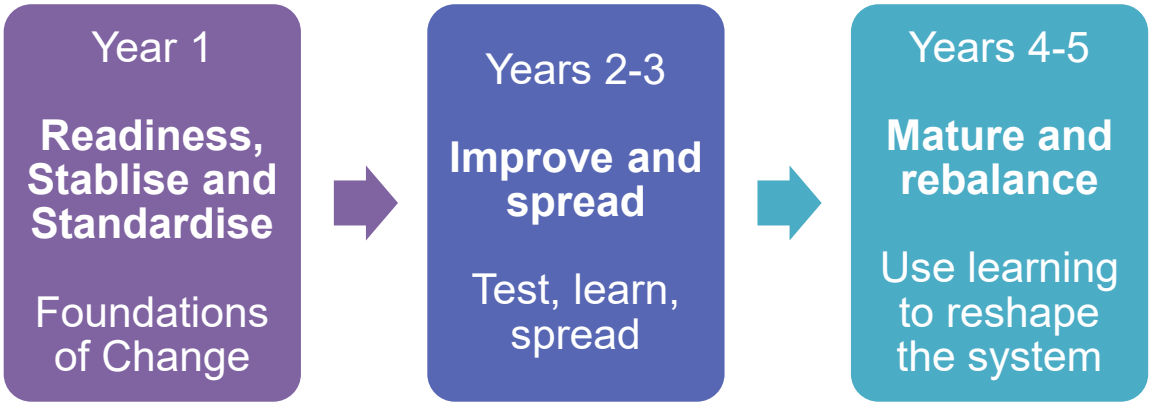
We will use digital approaches where they improve care, experience or efficiency for patients, staff and services. Digital will support better access, better information flow and reduced administrative burden, while maintaining appropriate non-digital options.

7.2 Delivery over five years

Not everything can or should happen at once.

Some work needs to happen quickly to support and stablise services and reduce avoidable pressure. Some work needs testing before it is planned for spread further across Shetland. Some work will take several years because it depends on workforce, digital systems, estates, finance, partner services and wider national reform.

The strategy will therefore be delivered through three broad horizons.



Horizon	Main focus	What this means
Year 1	Stabilise and standardise	Build the foundations for change. Develop the Shetland Primary Care model, shared access principles, governance, scorecard, workflow mapping, early improvement work and priority areas for standard processes.
Years 2 to 3	Spread and strengthen	Test, learn and spread what works. Develop access models, long-term condition review, frailty and medicines work, digital and information tools, workforce support, core processes and clearer interfaces.
Years 4 to 5	Mature and rebalance	Mature the model, reduce unwarranted variation, strengthen prevention and community support, improve outcomes and experience, and prepare for the next cycle of Primary Care development.

These horizons are not rigid stages. Some work will run across all five years. The purpose is to show the main focus of each phase and to avoid overloading teams with

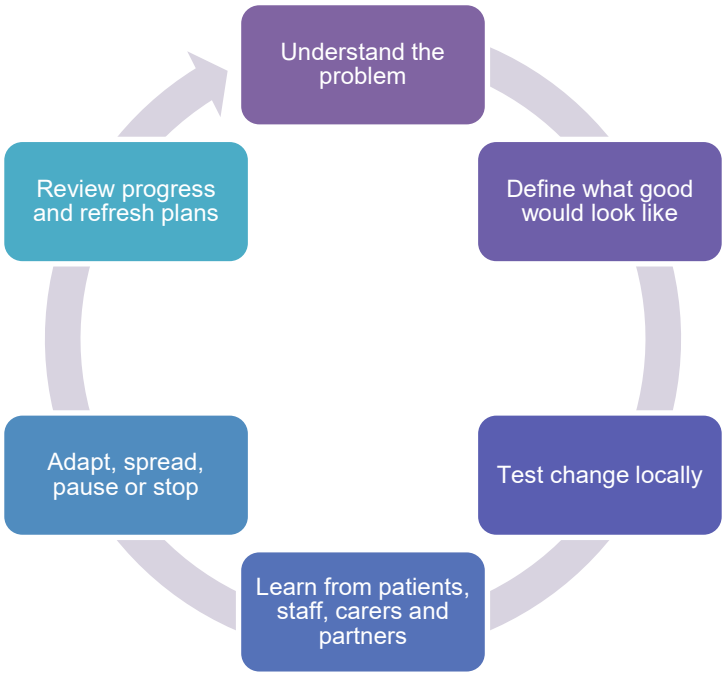
too much change at once, and to prioritise understanding the system to design the best change possible.

7.3 How change will be tested

Changes should be tested before they are spread more widely.

This is especially important where a change affects access, workforce, skill mix, digital routes, planned care, local health centre arrangements, or the way Primary Care connects with other services.

Quality improvement methodology will underpin how we approach change in Shetland for services.



Step	What this means
Understand the problem before acting	Use information, professional insight, patient experience and local knowledge before deciding what needs to change.
Define the intended improvement	Be clear about what should improve for people, carers, staff or the wider system.
Test first	Try changes on a small scale where risk, uncertainty or complexity is high.
Learn and adapt	Use staff, patient, carer and partner feedback to understand whether the change is helping.
Spread what works	Share learning across Shetland where it improves safety, quality, access or fairness.
Stop or change what does not add value	Do not continue work simply because it has started.
Keep people involved	Staff, patients, carers, communities and partner services should continue to shape delivery.

7.4 Changing Safely and Effectively

Some changes may move work:

- into Primary Care
- out of Primary Care
- between professional roles
- between sites
- into digital or remote routes

These changes need particular care, and as work progresses, there will be clarity about:

- the pathway
- clinical responsibility
- workforce impact
- supervision and escalation
- records and information flow
- patient and carer communication
- what work stops, reduces or changes elsewhere
- how the change will be reviewed

7.5 Keeping Delivery Achievable

Delivery will remain realistic about capacity.

The strategy should help teams focus and action plans will reflect this by being practical and reviewed regularly through local operational management and programme board structures where necessary.

To keep delivery practical, we will:

- focus on a small number of priorities at a time
- make support visible and available to local teams
- use information and experience together
- keep local teams involved in changes that affect them
- be honest about trade-offs required
- review risk regularly
- share learning across Shetland
- refresh delivery plans as learning, pressure and opportunities change

This approach gives the strategy enough structure to guide delivery, while keeping flexibility to learn and adapt over five years.

7.6 Structures Supporting Implementation

Primary Care sits across many parts of the system. Governance will connect operational delivery, clinical quality, patient experience, staff experience, finance, workforce, digital, estates and partnership planning.

Route	Main role
Primary Care operational management	Oversees delivery plans, workforce issues, service risks, workflow improvement, access arrangements and local team support
Clinical leadership and GP cluster	Supports clinical quality, generalist input, learning, variation review, pathway development and professional advice
Clinical governance	Provides assurance on quality, safety, risk, patient experience, clinical standards and learning from adverse events.
Health and Social Care Partnership	Links Primary Care with community health, social care, prevention, locality planning and wider partnership priorities
Integration Joint Board and NHS Board	Provide oversight, assurance and decision-making for major service, finance, workforce and system changes
Staff, patient, carer and community involvement routes	Ensure experience and staff insight continue to shape delivery.
Partner service forums	Support safer interfaces with acute & specialist services, community nursing, mental health, out of hours, NHS 24, the Scottish Ambulance Service, community pharmacy, public health and third sector partners.

7.7 MEASURING PROGRESS

Progress will be measured through a Primary Care scorecard.

The scorecard will bring together service information, patient experience, carer feedback, staff experience, quality and safety information, workforce information, finance where relevant, and learning from local improvement work.

The aim is to give teams and decision-makers useful information that supports better care. Acivity will be important to measure, but is not enough on it's own. We will work hard to understand whether people are receiving the right support, at the right time, with the right outcome and experience.

7.8 MEASUREMENT PRINCIPLES

Principle	What this means
Measure what matters	Focus on whether care is improving for people and staff
Use information and experience together	Numbers show pattern & stories explain what those patterns mean.
Look for variation	Identify where support, learning or change may be needed.
Use measures for learning and sharing	Information should help teams improve, not to rank or compete.
Keep the scorecard practical	Use a small core set of regular measures, with deeper review where needed.
Review measures over time	Measures should change as the strategy matures and better information becomes available and should be decommissioned as well as commissioned.

7.9 SCORECARD DOMAINS

The scorecard will be organised around seven domains, and this may change as further work is shared from Scottish Government on the Quality Framework for Primary Care in Scotland.

Domain	What we need to understand
Access, navigation and communication	Can people get the right response, understand the route, and know what happens next?
Continuity, planned care and proactive support	Are people with greater need getting planned review, follow-up and continuity where it matters?
Quality, safety and experience	Are services safe, fair and experienced positively by patients, carers and staff?
Workforce, roles and core processes	Are teams supported, roles clear, and key workflows safer and more consistent?
Digital, data and information flow	Are tools and information helping teams plan, communicate and act earlier?
Connected care across services	Are interfaces clearer, safer and less burdensome for people and staff?
Prevention, inequalities and community support	Are services identifying risk earlier and reducing barriers for people most likely to face poorer outcomes?

The scorecard should have two levels.

Level	Purpose
Core scorecard	A small set of measures reviewed regularly to show whether the strategy is moving in the right direction – likely to be longer term.
Deeper review	More detailed analysis where a problem, risk or variation is identified – likely to be time limited.