Chief Officer: Jo Robinson	
Health and Social Care Partnership: Shetland	
HSCScotland five essential elements *(please tick relevant priority):*	
Transforming the approach to improving health, wellbeing and independence	✓
Building stronger community care systems and primary care services	✓
Establishing a new focus on mental health	
Securing a sustainable acute hospital service and specialist care service	
Strengthening future partnerships to ensure a modern sustainable workforce	

Title: Post Diagnostic Support in Primary Care Project

Situation:

There was a poor take up of Post Diagnostic support in Shetland, with PDS being undertaken by a wide variety of staff with little uniformity in approach, impacting on continuity and quality of interventions. Only 31% of individuals had an Anticipatory Care Plan completed.

What action did the integration authority take:

Redesigned the Post Diagnostic Service to be coordinated through the Community Occupational Therapy Service, ensuring that the "Essential 5" bundle is fully implemented.

The bundle looks at 5 areas against which the plans are measured: the person at the centre of the plan; personal outcomes; if person has ownership of the plan; personal resilience; and that the plan is reviewed. There are 17 questions in the bundle.

In a recent audit, each of the care plans reviewed scored 15 out of 17 demonstrating a high level of focus on developing the personal outcomes of each individual. The format of the plans was developed with a consideration of the essential 5 bundle and this has been helpful in assisting the PDS Practitioner in facilitating outcome focused conversations with the clients on their caseload. The paperwork therefore reflects the wishes, strengths and experiences of the individual named in the plan.

The creation of a formal structure around the role has increased the visibility of the PDS Practitioner to the wider social care team, increasing the scope of the role and the support that the practitioner can provide. In addition, with the consent of the individual or the power of attorney, the PDS Practitioner has been routinely sharing the Anticipatory Care Plan and care plan with the local primary care and social work teams. This ensures that this crucial information about the individual's long-term wishes is being utilised appropriately.

Impact:

A recent audit provides clear evidence that the new model of PDS is providing significantly improved outcomes in recording, client support and outcome focused care planning. 97% of clients have an Anticipatory Care Plan document completed or in progress. 100% of clients have contemporaneous records on the record keeping system. The current paperwork appears to be providing sufficient guidance and direction to the outcome focused conversations that are key to the PDS intervention. It is clear that employing an identified PDS Practitioner who is supported and fully trained provides better outcomes for clients, for the clinical governance of the service and is the most effective use of available resources.

Core components of your example which should be applicable across Scotland: