Integration Joint Board 21.09.17
Agenda Item: 7.3
Purpose: For Assurance

Strategic Plan: Implementation Progress Report

	Key Deliverables	Performance Indicators	Lead	IJB Report	RAG Status	Previous Status
1	We will put in place locality planning and service arrangements to support more responsive local services	Five locality plans will be developed, updated and agreed by LPGs and IJB annually % overall satisfaction rate, based on annual survey of LPGs	Chief Officer	December 2017		
	Activity Report: All Locality Planning Groups are now meeting regularly. All have community or third sector representatives as chairs, as well as a senior management presence, and are beginning to focus on core business. We are in the process of developing locality plans, with development days beginning to be scheduled. However, there are challenges in some areas. The Stornoway group has struggled for numbers and tensions have emerged in other groups between community and IJB representatives.					
2	Multi-disciplinary teams will deliver holistic, well-coordinated care, which builds on the natural capacities in people's lives	Locality managers in place to oversee multi-disciplinary teams % improvement in percentage of staff who say they would recommend their workplace as a good place to work	Head of Locality Services	Update Reports, as required		
	Activity Report: Locality service management arrangements are in development, with an interim appointment in the Uists leading the way in terms of a locality manager with responsibilities across community nursing and social care. Work is underway with HR and Trades Union colleagues to create permanent locality managers within the establishment. A workforce consultation has recently concluded and work will now commence in analysing responses.					
3	We will implement the Scottish Patient Safety Programme within primary care and as part of that we will review the use of higher risk medications and address polypharmacy	A pharmacist review of at least 95% of patients who have polypharmacy (repeat medications from multiple drug groups). A pharmacist review (either of notes or in person) with potential safety issues highlighted to prescriber in at least 95% of patients who are taking high risk medications.	Associate Medical Director	Update Reports, as required		
	Activity Report: This work is being led by the primary care pharmacist, with oversight by the Associate Medical Director. Some reporting issues emerging which are being considered by the Associated Medical Director.					
4	We will continue to strengthen our adult protection protocols through case conferences, data collection and use, and service planning.	Training Plan milestones achieved within reporting period % of case files audited	Head of Partnership services	Update Reports		
	Activity Report: Work is ongoing with the Adult Protection Committee to continually strengthen and improve our adult protection protocols. Significant case reviews held					

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5	People with assessed social care needs will be supported to use personal budgets to access care and support from a diverse range of providers to maximise the choice and control they have over their lives.	Equivalency model implemented for all new clients % of new service users who are provided with a personal budget	Head of Partnership services	March 2018		
	Activity Report: This is a longer term ambition. Technical work is underway, with a view to having systems in place by March 2018. Ongoing dialogue with the third sector to maintain market mix. Quality Improvement post in development.					
6	We will develop a strategy and service model that supports people who have dementia to live at home for as long as possible. This will include the delivery of post diagnostic support that will support people who have received a diagnosis of dementia.	Dementia strategy developed and agreed by March 2017 % of people diagnosed with dementia accessing Post Diagnostic Support	Ass. Dir. Mental Health and Learning Disabilities	June 2017		
	Activity Report: Dementia nurse consultant in post and plans in place to create post-diagnostic capacity. The dementia strategy is now in final draft, and will align to the main reforms being progressed as part of the redesign of mental health services.					
7	We will encourage rehabilitation and recovery of personal independence by developing an intensive reablement service	Intensive reablement service developed by March 2017 % of service users undertaking intensive reablement showing an improvement in level of independence	Head of Partnership services	September 2017		
	Activity Report: Plans for the development of a new Intermediate Care service have now been fully developed, and we antiicpate this will be operational by November 2017. The team will combine OT, physiotherapy, and care input and will be based at the Dun Berisay flats in Stornoway. Further work is required to develop reablement capacity across all localities.					
8	We will develop an intermediate care service to prevent hospital admission and support discharge within our care hubs	Bed-based step-up and step down care developed % of service-users showing an improvement in level of independence	Head of Locality services	September 2017		
	Activity Report: Plans for the development of a new Intermediate Care service have now been fully developed, and we antiicpate this will be operational by November 2017. The team will combine OT, physiotherapy, and care input and will be based at the Dun Berisay flats in Stornoway. Further work is required to develop reablement capacity across all localities. See investment report.					

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9	We will transform our mental health provision to deliver an integrated community model which is empowering to users and supports people to remain in control of their own lives	Vision, strategy and implementation plan agreed % of service users accessing service showing an improvement in overall well-being	Ass. Dir. Mental Health and Learning Disabilities	Updates as required		
	Activity ReportA preferred option was selected by the NHS Board and IJB in December and full costings were provided in February. Consultation and engagement with LPGs has since been undertaken. Five workstreams are meeting to drive forward with the redesign work.					
10	We will support our general practices to collaborate, develop multi-professional teams and influence local service arrangements	100% of GP practices actively participate in cluster arrangements 100% of GP practices actively participate in Locality Planning Meetings	Associate Medical Director	Update Reports		
	Activity Report: The Scottish Government has asked all partnerships to roll-out new cluster arrangements, whereby each practice nominates a Quality Lead to engage engage in active quality improvement work. We are in the process of developing our Cluster, which will be led by the Associate Medical Director. In addition, we have been encouraging GP practices to participate in the locality planning meetings, and thus far engagement has been comprehensive.					
11	To reduce unnecessary clinical interventions and personalise the care experience, we will work with health and social care professionals to increase our use of Anticipatory Care Plans	Local ACP template agreed and disseminated for use by March 2017 % of Palliative patients with ACP whose wishes met at End of Life	Associate Medical Director	Update Reports		
	Activity Report: The IJB Lead Nurse has chaired a series of meetings about how to develop ACP templates that are technology enabled and can be used across professional groups, focusing on people with long term conditions and palliative care. Work is ongoing.					
12	We will diversify our existing residential estate to create additional capacity in Extra Care Housing and specialist nursing care and will work with partners to ensure our existing housing stock is maintained and adapted to a standard which supports people at home for as long as possible	Service design proposals developed for IJB consideration Proportion of care services graded 'good' (4) or better in Care Inspectorate inspection	Head of Partnership Services	September 2017		
	Activity Report: The main focus of reform has been on the redesign of the Lewis residential estate. A programme board has been established. A paper is being taken to the Sept. IJB.					

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13	We will work with communities and the third sector to support community ventures which tackle social isolation, including, where appropriate, supporting community transport	Implementation of Social Prescribing Service as part of new strategy on Tackling Social Isolation No. Referrals to Social Prescribing service who are experiencing social isolation/loneliness. No. Participants in Social Prescribing service with improvements in social isolation/loneliness (via appropriate measurement scales)	Chief Officer	December 2017	Starts 2017	
	Activity Report: The Head of Public Health Intelligence is leading this workstream and has worked with stakeholders to agree a pilot Social Prescribing scheme in Uists, focusing on clients with social isolation/loneliness issues affecting their health. A Social Navigator post supported by Advocacy Western Isles is in place to coordinate and receive referrals via this scheme funded from the EU Remoage programme. The scheme Guidelines have been produced and currently finalising the promotional material for launching the service to begin receiving referrals in January 2017. It is envisaged that this Social Prescribing service will link into other synergous EU projects which are either at planning or developmental stage. In terms of **Western Isles Social Isolation Strategy Development,** Social Prescribing and ICT social support are two strands to tackling social isolation/loneliness and a wider strategy tackling Social Isolation/Loneliness in Western Isles communities is to be written to inform coordinated action across range of initiatives and agencies as well as identifying gaps. This wil lbe done collaboratively with third sector and community groups					
14	We will support our Alcohol and Drug Partnership to deliver on its strategic commissioning role to support the recovery of people dependent on alcohol, by focusing on prevention and educational services	ADP delivers alcohol and drugs awareness sessions, supports health behaviour change and provides Alcohol Brief Interventions Rate of alcohol related A&E attendances per 1,000 population	Chief Officer	Update Reports		
	Activity Report: The ADP has continued to work with alcohol and drug service providers and geographical subgroups on the way forward with ROSC implementation, service development and the commissioning of services in the near future.					
15	We will support people with long-term conditions to self-manage through the provision of advice and clinical support. Specifically, we will develop personal technology/systems that allow patients to monitor their vital statistics.	Roll-out of Florence service across different conditions, age groups & localities % service user who feel empowered	Associate Medical Director	Update Reports		
	Activity Report: 130+ local people have used Flo since Sept 2015. Work is being advanced under the e-health programme board to develop a strategic approach to the effective use of technology as a means of improving person-centred care. Flo expanding into Maternity, MS, Podiatry, Health Promotion (includes public and staff engagement) & Orthopaedic surgery. Continuous Glucose Monitoring; Diagnostic VC testing and evaluation (PCCP cross over); Primary care Digital Services -TEC enablement through infrastructure and capacity					

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16	We will work with the third sector to increase the numbers of identified carers, offer every identified carer a carer support plan and assess their eligibility for formal support. This will tie into to the equitable provision of respite care, to ensure that carers are supported to maintain their caring role.	A system of assessment and resource allocation is developed and operational by March 2017 Average respite hrs per carer delivered	Head of Partnership Services	December 2017		
	Activity Report: The Scottish Government's implementation of the Carers Act has been subject to delay. We await statutory regulations and guidance. In the meantime, work has been taken forward with the third sector to consider imeplementation arrangements, including building third sector assessment capacity.					
17	We will continue to contribute to the Western Isles Early Years Collaborative, to ensure that our children get the best start in life. This will include the further development of early intervention and prevention strategies that will be delivered by our universal services, including health visitors and GPs.	Embed the 27-30 month assessment into practice, including a review and refresh of screening tools. % children with no concerns across all domains at 27-30 month review	Chief Officer	Update Reports		
	Activity Report: We are steadily progressing with Health Visitor training and development and are meeting our trajectories to achieve an increase in core capacity to support the implementation of the Children's and Young Persons Act 2014. Positive reinspection of children's services in the Western Isles.					
18	Where appropriate, we will reduce the variation between localities in resource use at end-of-life by supporting palliative care at home or in a homely setting	A structured multi-agency care pathway is developed for people with incurable disease % of people who die at place of residence	Chief Officer	March 2018		
	Activity Report: A short-life working group was convened to consider the development of integrated pathways of care for palliative and end-of-life care. In addition, the Western Isles will participate as a national test-site in the roll-out of the new national strategy. It is anticipated that this will run over the next financial year but has been subject to delay.					
19	Where appropriate, we will seek to reduce expenditure on the top 2% of the population who use the highest levels of resource, to ensure greater levels of healthcare equity	Implementation of delayed discharge policy and action plan No. of patients that account for upper 50% of spend	Head of Partnership Services	Sept. 2017 Annual		
	Activity Report: In the Western Isles, the majority of our High Resource Individuals are delayed discharges. It is a major operational challenge and we have been focused on the redesign of service, the development of a new operational policy, and the implementation of an action plan. The action plan has delivered positive results.					

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20	We will continue to invest in technology and improve processes to ensure that we maximise the potential of telecare, telehealth and networking with clinical and professional networks	Technology-enabled care strategy produced and agreed by March 2017 % of people with assessed need receiving technology enabled care	Associate Medical Director	2018		
	Activity Report: Initial work has started to pull together the full range of technology supports, from the Faire system through to advanced medical technology. We aim to bring core elements together into a coherent startegy that will drive future activity. However, this work requires more time.					
21	We will reduce the number of long-term placements within off-island health and social care facilities in favour of a more efficient use of local resources	No. of mainland placements reducing within the reporting period Cost of Mainland placements within reporting period	Head of Partnership Services	Update Reports		
	Activity Report: We continue to review assessment opportunities to repatriate mainland placements and avoid new placements. Significant investment in local staff is being undertaken to ensure an appropriate care package can be put in place for two individuals being repatriated.					
22	We will establish a health and social care hub in every locality area, which will deliver co-located integrated services	All locality plans consider options around use of and/or development of hubs	Chief Officer	December 2017		
	Activity Report: Recent activity has focused on the development of the outline business case for the new St Brendan's campus in Castlebay; and the redesign of the hospital and dental service in the Uists. Further work will be undertaken with LPGs over the course of 2016/17.					
23	We will develop a three year workforce plan, based on labour market intelligence, which will consider how best our partnership can compete within the local, national and international labour market	Workforce strategy developed and agreed by IJB. % of vacancies by functional area and locality unfilled within 6 months	Chief Officer	June 2016 (target met)		
	Activity Report: The IJB adopted the workforce startegy in June. Implementation plan has now been developed.					
24	We will work with our parent bodies - NHS Western Isles and Comhairle Nan Eilean Siar - to keep people healthy at work and support them through periods of transition from one model or care to another	Policy framework for staff members affected by service change % of staff & staff hrs lost to unplanned absence type by locality and absence type	Chief Officer	Update Reports		
	Activity Report: The HR Forum will be responsible for the development of protocols in support of service change and restructuring. Work on locality management is advancing, and initial conversations have been held with staff potentially affected by mental health redesign.					

25	We will work with our parent bodies - NHS Western Isles and Comhairle Nan Eilean Siar - to increase the proportion of our staff whose contract of employment provides guaranteed hours and predictable patterns of work	Homecare redesign implemented across all localities % of staff and staff hrs on variable hrs	Chief Officer	Sept 2017		
	Activity Report: Homecare redesign for Stornoway and Broadbay has been successfully implemented. Satisfaction levels from service users is high and staff have generally welcomed the change to shifts and operating arrangements. The learning will now be applied to the other localities as part of the development of locality structures.					