This paper relates to Agenda Item 8

Title/Subject:	**Partnership Funding**
Meeting:	**Integration Joint Board**
Date:	**5 August 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of this report is to provide an update regarding progress towards recommendations approved by the Integration Joint Board on 3 June 2016, in relation to Partnership Funding; Integrated Care and Delayed Discharge Funds.

1.2 On 3 June 2016 the IJB approved the following recommendations with a requirement for further action:

a) note the findings of the review of partnership funding and remit the Chief Officer to take forward specific recommendations arising, namely:
- Develop a strategic approach to intermediate care pathways, including frailty and reablement;
- Review partnership arrangements for commissioning services to Third Sector organisations, including consideration of Health and Social Care Partnership responsibilities in relation to the Carers Act (2016)

b) approve the revised governance and monitoring arrangements and remit the Chief Officer to implement these with immediate effect,

c) remit the Chief Officer to initiate commissioning discussions with a view to presentation of further commissioning proposals to the IJB in August 2016.

2. RECOMMENDATIONS

The Integration Joint Board is asked to:

2.1 Remit the Leadership Group to progress development of a framework for commissioning Third Sector Organisations in the context of the Partnership governance framework,

2.2 Note that the development of strategic approach to intermediate care pathways, including frailty and reablement, will be progressed in conjunction with the formation of a whole systems approach, as outlined in the Chief Officer report on this agenda.

2.3 Note that the approved governance and monitoring structure is now in place and that further performance monitoring information will be presented in December 2016,

2.4 Approve allocations of Partnership Funding, as presented in Appendix 1, based on these services being embedded within the new whole systems approach and pathway.

2.5 Remit the Chief Officer to continue commissioning discussions and to disseminate information regarding partnership funding to facilitate innovative approaches and ensure equity of access.

3. BACKGROUND

3.1 In June, the IJB approved that Delayed Discharge and Integrated Care Funds be allocated and monitored using a single governance process. The intention being that the Partnership would be able to more effectively target investment toward greatest need, understand the total impact of investment and to avoid duplication.

3.2 The IJB was also presented with a financial overview of partnership funding, providing a 2015/2016 year end position. This information is presented in Table 1, below. This table assumes the Bridging and Integrated Care Fund Resources carried forward from 2015/16 are utilised evenly over 2016/17 and 2017/18.

Table 1: Partnership funding 2015/2016 year end position

	2016/17			2017/18		
	Resource available £'000	Current Projected Expenditure £'000	Available to commit £'000	Resource available £'000	Current Projected Expenditure £'000	Available to commit £'000
Integrated Care Fund and Bridging	3,798	2,660	1,138	3,798	2,553	1,245
Delayed Discharges	894	516	378	864	523	341
TOTALS	4,692	3,176	1,516	4,662	3,076	1,586

4. PARTNERSHIP FUNDING REVIEW

4.1 In relation to the findings of the review of partnership funding presented to the IJB in June, the Chief Officer was remitted to:

- Develop a strategic approach to intermediate care pathways, including frailty and reablement;
- Review Partnership arrangements for commissioning services to Third Sector organisations, including consideration of Health and Social Care Partnership responsibilities in relation to the Carers Act (2016)

Strategic approach to Intermediate Care Pathways

4.2 The adoption of a strategic approach to intermediate care will contribute to the development of a whole system approach outlined within the papers relating to agenda item 4, and dovetails with a number of strands of work currently taking place on a Forth Valley and Partnership level. This work includes:

- High Resource Users and Occupied Bed Days, which will include evaluation of the closer to home model,
- Critical review and action planning in relation to Delayed Discharge (as referenced in Agenda item 11),
- Review of the current Forth Valley Falls Strategy,
- Reablement workshops that will consider the evidence on what is currently working well and how provision can be further developed in conjunction with the frailty pathway,
- On-going developments relating to Single Point of Contact and Single Shared Assessment.

4.3 It should be noted that the range of work being undertaken goes beyond the scope of partnership funded initiatives to include mainstream service provision. As noted in the Partnership Funding report on 3 June, the intention is to allow for a strategic approach to be taken to service re-design and future targeting of partnership funding to achieve leverage and improved outcomes for service users, based on re-shaping or developing current initiatives.

4.4 Where services are supported by partnership funds and operate pan Forth valley, combined review will be undertaken with Clackmannanshire and Stirling HSCP. It is proposed that the outcome of this work is presented to the IJB in December 2016.

Partnership arrangements for commissioning services to the Third Sector

4.5 Initial scoping work has commenced in relation to the review of arrangements for commissioning Third Sector organisations. To enable alignment with Partnership governance arrangements, it is proposed that this work be remitted to the Leadership Group. To allow sufficient time for consultation with partners, the outcome will be presented to the IJB in December 2016.

4.6 The review will include consideration of current governance and scrutiny in place for in-scope services commissioned by NHS Forth Valley or Falkirk Council without a tendering arrangement, therefore falling within the criteria of ‘Following the Public Pound’. The output of the review will be a governance framework which will allow the IJB to allocate resource to arms-length and external organisations and thereafter scrutinise efficiency and performance in line with the Local Delivery Plan.

5. GOVERNANCE AND MONITORING ARRANGEMENTS

5.1 Approved governance and monitoring arrangements for partnership funds have now been implemented. The IJB will be presented with a 6 monthly performance overview in December 2016.

5.2 In line with the Strategic Planning Group's on-going role in monitoring the Partnership's progress towards strategic outcomes and priorities, a sub-group has now been formed, remitted to work with the Chief Officer and Chief Finance Officer to assess and monitor partnership funding. Recommendations made by the sub-group will be presented to the Strategic Planning Group and then to the IJB. It should be noted that as the Partnership Funding Group is in early stages of formation, therefore funding recommendations made within this report have been assessed by the existing monitoring group.

5.4 On 5 July 2016, the Scottish Government issued further guidance to Chief Officers regarding the use of the ICF. Given that arrangements for integration are now live across Scotland, as per the Public Bodies (Joint Working) (Scotland) Act 2014, the Scottish Government are keen to ensure that planning and reporting arrangements for the ICF are congruent with the broader requirements on Health and Social Care Partnerships that relate to strategic commissioning and annual reporting. On this basis, Partnerships are no longer required to produce a separate plan and retrospective report on use of the ICF. Instead, planned use of the ICF must be set out in Partnership's strategic commissioning plan and accompanying annual financial statement, and reported upon retrospectively via the Partnership's annual performance report and to the IJB.

6. FORWARD INVESTMENT

6.1 During the course of the last 2 months, discussion has commenced across the Partnership in relation to forward investment of partnership funding. Commissioning has been progressed where specific, evidence based need has been identified through the strategic planning process, for example:

- a gap in provision to a particular client group of geographical area, highlighted via the Strategic Needs Assessment, logic modelling process or locality profiles,
- gaps or inefficiency within a pathway of care, which may be developed or improved through service re-design,
- system or process issues that may be improved through short term investment, leading to better outcomes for service users.

6.2 Initial funding recommendations are included within Appendix 1 of this report. Investment recommendations amount to a total of £460,631. Based on these recommendations, the projected available partnership funding resource is highlighted in table 2, below.

Table 2: Partnership funding position August 2016

	2016/17			2017/18		
	Resource available	Current Projected Expenditure	Available to commit	Resource available	Current Projected Expenditure	Available to commit
	£'000	£'000	£'000	£'000	£'000	£'000
Integrated Care Fund and Bridging	3,798	2,700	1,098	3,798	2,484	1,314
Delayed Discharges	894	516	378	864	523	341
TOTALS	4,692	3,216	1,476	4,662	3,007	1,655

After taking account of the proposed commitments against these funding streams contained within the finance report the projected available partnership funding is highlighted in table 3, below.

Table 3: Partnership funding position August 2016 post Falkirk Community Hospital Ward 5 and Locality Project Manager commitments

	2016/17			2017/18		
	Resource available	Current Projected Expenditure	Available to commit	Resource available	Current Projected Expenditure	Available to commit
	£'000	£'000	£'000	£'000	£'000	£'000
Integrated Care Fund and Bridging	3,798	2,736	1,062	3,798	2,549	1,249
Delayed Discharges	894	894	0	864	523	341
TOTALS	4,692	3,630	1,062	4,662	3,072	1,590

6.3 Discussion currently underway in relation to further investment includes:

- Development of a Community based grants programme to support and pump-prime the sustainable development of small, community led initiatives. This programme would be delivered to support the West Locality Pilot and in conjunction with Falkirk Community Planning Partnership,
- Resource to support the development and implementation of the West Locality Pilot,
- Progression of asset mapping work previously undertaken to develop a centralised source of reliable information for use by service users, their carers and families, but also by practitioners, and
- Exploration of opportunities to enhance partnership working with Forth Valley College, particularly in relation to health promotion, carers and mental health.

6.4 Where specific initiatives are commissioned, a business case will be developed in line with the RE-AIM planning and evaluation framework. Proposals will be assessed by the Partnership Funding Group and recommendations will be made to the IJB.

6.5 To date, information about the partnership funding application process and criteria has not been widely disseminated. With the introduction of new partnership funding governance arrangements, it is proposed that information is now more broadly disseminated across the Partnership. The purpose being to explore further opportunities to enabling innovative approaches to achieving better outcomes through the provision of integrated services, with a particular emphasis on prevention and tackling inequalities.

6.6 Information regarding partnership funds will be disseminated via partner websites and local networks and will be open to all sectors. In the first instance, it is suggested that the total amount of £0.25m ICF be ring-fenced for allocation through this means, over the remaining life of the programme. Proposals will be assessed using standard assessment process, with a significant emphasis on whole system impact and sustainability or exit strategy.

7. CONCLUSIONS

Resource Implications
There are no additional resource implications over and above those reported within the body of the report.

Impact on IJB Outcomes and Priorities
Partnership investment aligns and contributes directly towards local outcomes.

Legal & Risk Implications
No legal issues have been identified. Risk implications relate to individual initiative performance and compliance with Scottish Government requirements regarding use of partnership funds. The governance and monitoring process presented for approval address any potential risk.

Consultation
Individual initiatives are required to consult and engage with stakeholders in the development and implementation of all services. During the preparation of future commissioning proposals, consultation is an expectation and condition of partnership funding.

Equalities Assessment
Allocations of partnership funding directly contribute towards and align with the Strategic Plan and full Equalities and Poverty Impact Assessment has been completed for the Plan. Further EPIA will be undertaken for areas of disinvestment.

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Approved for Submission by: Patricia Cassidy, Chief Officer

Author – Lesley MacArthur, Integrated Care Fund Co-ordinator
Date: 29 July 2016

List of Background Papers:

- Integrated Care Plan December 2014
- IJB Papers regarding Partnership Funding:
  3 June 2016
  5 February 2016
  4 December 2015

Funding Proposals: Recommendations – All funded services and posts are required to integrate within the Change Programme and be an integral part of the cohesive whole system approach

Project Name & Lead Agency	Amount Requested	Term Requested	Fund Source	Project Summary	Recommended Funding	Justification/Condition
Avoiding Unplanned Admission						
Closer to Home: Enhanced Community Team NHS Forth Valley	£120,120	4 months (1 Dec 16– 31 Mar 17)	Integrated Care Fund	**Closer to Home is an enhancement of current services that provide community nursing, therapy services, community psychiatric nursing and care at home. It provides an urgent and coordinated response from these services at a time of escalating need or 'crisis'. Closer to Home comprises 3 elements; Enhanced Health Team, Enhanced care at Home and AFLFY. The project commenced in November 2015.** **Closer to Home aims to support individuals to remain more resilient at home by providing a seven day service, at home. Anticipated outcomes:** • **A reduction in avoidable ED attendances** • **A reduction in avoidable emergency hospital admissions and readmissions** • **A more coordinated health and social care response to patient's need particularly during times of crisis** • **More access to carer support during the day and overnight** • **A better experience and quality of life for patients at home, improving resilience, reducing reliance on managed care sector by maximising use of their own assets** • **More involvement of carers and support for carers at times of escalating need** The **E**nhanced Community Team provides the following 7 days a week: 1. Assessment Unwell Patient – where a diagnosis has already been undertaken but the patient has additional needs or is deteriorating / at risk of admission. 2. Rapid Assessment e.g. un-injured faller – implementation of agreed falls pathways. 3. Discharge facilitation. An interim model is currently in place whereby NHS Forth Valley have appointed additional Health Care Assistants to support people home following discharge from hospital and also to prevent hospital admission when care at home is assessed as a need. Health Care Assistants are deployed for an interim period until such time as care packages are established through the Care at Home Team.	£120,120 4 months (1 Dec 16– 31 Mar 17) Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. No additional financial impact on projection.	On-going funding will enable continuity of service during review period and ability to make incremental change based on findings and where required. This service is delivered pan Forth Valley, therefore review will be undertaken with Clacks/Stirling Partnership. The outcome of the review will be reported to the IJB in December.
Closer to Home: Enhanced Care at Home Team Falkirk Council	£79,456	4 months (1 Dec 16– 31 Mar 17)	Integrated Care Fund	Enhanced Care at Home is intended to: 1. Provide supported access to home care services for people ready for discharge from hospital by increasing Social care Officer and Re-hab Carer capacity within 24/7 Home Care Team. 2. Enable a reablement ethos into home care practice. This requires care staff to understand the need to adopt a 'hands-off' approach to supporting people. The project has recruited one of three Social Care Officers. Recruitment of the remaining team Social Care Officers, Re-hab Carers and a Training Officer has not been successful. This has been due to the temporary nature of the posts and grading. As a result of this, the budget drawn down by the project has been less than anticipated. As stated within the Enhanced Community Team Narrative, as an interim measure, NHS Forth Valley have appointed additional Health Care Assistants to support people home following discharge from hospital and also to prevent hospital admission when care at home is assessed as a need. Health Care Assistants are deployed for an interim period until such time as care packages are established through the Care at Home Team.	£79,456 4 months (1 Dec 16– 31 Mar 17) Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. No additional financial impact on projection	On-going funding will enable continuity of service during review period and ability to make incremental change based on findings and where required. This service is delivered pan Forth Valley, therefore review will be undertaken with Clacks/Stirling Partnership. The outcome of the review will be reported to the IJB in December.

				Until such time as the whole Closer to Home project is reviewed and evaluated it is recommended that funding be continued until 31 March 2017, for the existing Social Care Officer and also for Health Care Assistants working within the interim model.		
Closer to Home: ALFY NHS Forth Valley	£35,880	4 months (1 Dec 16– 31 Mar 17)	Integrated Care Fund	ALFY is the third component of the Closer to Home model. The phone line continues to operate on a 24/7 basis. The service is manned by nurses. During the day, the service is provided by dedicated band 6 nurses and out of hours, the service is provided by the night nursing service. Out of hours demand on the service remains low. The service will be evaluated within the overall review of the Closer to Home model.	£35,880 4 months (1 Dec 16– 31 Mar 17) Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. No additional financial impact on projection	On-going funding will enable continuity of service during review period and ability to make incremental change based on findings and where required. This service is delivered pan Forth Valley, therefore review will be undertaken with Clacks/Stirling Partnership. The outcome of the review will be reported to the IJB in December.
Rapid Response Frailty Clinic NHS Forth Valley	£75,092	6 months (1 Oct 16 – 31 March 17)	Delayed Discharge	The Rapid Access Frailty Clinic (RAFC) is a service within an ambulatory setting in FVRH for people over 65 year old, who require specialist review by a consultant geriatrician in an ambulatory setting. Patients are normally seen within 48 hours of being referred by Primary Care and without this service would require to be admitted for assessment and treatment. A full spectrum of diagnostics, assessment and treatment plan is completed and wherever possible patients return home on the same day. The clinic liaises with community based services to ensure appropriate on-going treatment or support is in place. The aim of the service is to provide an improvement in the patients longer term outcomes and on-going care needs compared with the potentially debilitating impact of an extended admission. Review of RAFC will be undertaken in conjunction with Clack/Stirling Partnership, focusing on: • Review position of clinic in relation to A&E • Referral procedures are reviewed • Promotion of service • Wider range of practitioners are able to make referrals into service The review outcomes will be reported to the IJB in December. This process will also link with the development of a strategic approach to intermediate care pathways.	£75,092 Approve funding to 31 Mar 17 Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. No additional financial impact on projection	On-going funding will enable continuity of service during review period and ability to make incremental change based on findings and where required. This service is delivered pan Forth Valley, therefore review will be undertaken with Clacks/Stirling Partnership. The outcome of the review will be reported to the IJB in December.
Discharge Hub NHS Forth Valley	£50,513	6 months (1 Oct 16 – 31 March 17)	Delayed Discharge	Continue the enhancement to the Discharge Team which were funded from Delayed Discharge Resource 15/16 to maintain the delivery of the improvement to the service i.e. 7 day cover for discharge, support early discharge from Acute Hospital, review of Ageing and Health patients in non-Ageing and Health wards to ensure appropriate transfers to Community Hospitals, review of patients with extended length of stay over 28 days, review patients admitted with existing care packages to ensure early discharge home with care package. Future plans will link The Discharge Team to support the Frailty Model across Forth Valley Review of the Discharge Hub is underway, in conjunction with Clacks/Stirling Partnership, focussing on the assessment process in relation to the hospital based Social Work Assessment Team. This process will also link with the development of a strategic approach to intermediate care pathways.	£50,513 Approve funding to 31 Mar 17 Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. No additional financial impact on projection.	On-going funding will enable continuity of service during review period and ability to make incremental change based on findings and where required. This service is delivered pan Forth Valley, therefore review will be undertaken with Clacks/Stirling Partnership. The outcome of the review will be reported to the IJB in

						December.
Health and Wellbeing in Communities						
Community Connections Programme Alzheimer's Scotland	N/A	6 months (1 April – 30 Sept 17)	Integrated Care Fund	The Community Connections programme aims to increase capacity by delivering a range of opportunities for people with dementia and their carers to access and reflects one of the key objectives within Falkirk's Integrated Strategic Plan for community based support. On 3rd June, the IJB approved £10,600 for a period up 1 Oct 16 – 31 Mar 17. As an amendment, it is proposed that the project will end on 30 Sept 2017 with no further allocation of funding required for this period.	Maximum £10,600 1 Oct 16 – 30 Sept 17 £5,300 reduction financial impact on projection 17/18	Note amendment to term of funding. No further funding required.
Grangemouth Community Care Grangemouth Community Care	£14,832	1 Sept 16 – 31 Mar 18 (19 months)	**New Project** Integrated Care Fund	Since 1976, the organisation has throughout Grangemouth and beyond, supported the frail, elderly and housebound and others who are vulnerable by way of their social, economic or personal circumstances. It is run by a team of dedicated volunteers, led for the last 12 years by the current coordinator, in a voluntary capacity. It has expanded to include day care and recreational activities to members, social events, outings and information sharing. Free transport is provided to those who require it. There are 20 volunteers supporting the service, allowing elderly residents, normally isolated from social contact, to enjoy a bit of company and have a good chat with people in similar situations. Currently 60 people attend each week, may of who have complex care needs. For many it is their only chance of companionship in the week. The ageing population, which continues to grow, means an increase in the number of referrals, whether from health professionals, the local authority, the churches or by self-referral. This demand will continue to growth and the organisation cannot cope with the demand with present resources. CCG has undertaken extensive consultation with service users and worked with Make it Happen Forum. In light of the changing landscape in the provision for the care and feedback from service users, the GCC plan to reposition the organisation. GCC wish to appoint a part-time co-ordinator to assist in shaping the service delivery. The post holder will carry forward the current co-ordinator's responsibilities including forging partnerships and participating in networks to enhance opportunities for our present and future service users and developing a sustainable volunteer led model of delivery.	Maximum £14,832 1 Sept 16 – 31 Mar 18 (19 months) 16/17-£5413 17/18-£9419	Condition of Funding: An evaluation of the model is undertaken to consider the impact and benefit of an employed co-ordinator in terms of service delivery, development and sustainability, with a view to implementing model within localities.
Immediate Help Service Falkirk & District Association for Mental Health	£48,600	18 months 1 Oct 16 – 31 Mar 18	**New Project** Integrated Care Fund	Extension to the Social Prescribing Project currently operating within FDAMH to include the Immediate Help Service. FDAMH's Immediate Help Service (IHS) is funded by NHS FV until September 2016. FDAMH's 2015/16 Annual Report details service provision from April 2015 – March 2016: 660 people used the service i.e. people either telephoned FDAMH seeking advice /support or attended in person (no need for an appointment) following referral or of their own volition. Of the 660: 42% indicated that they were considering suicide: 71 were currently self-harming: 293 people had been referred by GP. There is no plan to change the service as it is currently offered. However, without further funding, it will be necessary to withdraw service provision as FDAMH does not have the capacity to continue to offer the service without a dedicated member of staff. **In June 16, the IJB approved a recommendation to review commissioning arrangements for third sector organisations with a view to developing a consistent approach across the Partnership. The intention of this work would be to ensure that services are commissioned on the basis of strategic needs assessment and broader identification of evidence based need. The new process is also intended to allow appropriate scrutiny in line with Following the Public Pound requirements. Whilst this work is progressing, it is recommended that**	£16,200 6 months 1 Oct 16 – 31 Mar 17	Condition of Funding: Funding is provided for an interim period until such time as the IJB can effectively review and commissioning services through mainstream budget. Continuation of funding will enable continuity of service.

				funding is continued via ICF, to ensure continuity of service.		
Moving Assistance – Coming Home from Hospital Outside the Box	£8,088	7 months (1 Sept 16 – 31 Mar 17)	**New Project** Integrated Care Fund	This proposal follows the paper presented to the IJB regarding the Housing Contribution Statement and has been developed in conjunction with Housing Services. Many older people find their house become less suited to their needs as they get older and especially when they have increasing health problems. The decisions about if and when to make changes to your home or to move can be difficult. The first Moving Assistance project (funded via RCOP Change Fund), developed resources to help people through these decisions and make moving home and/or making changes to their home a better experience for them. This project will further develop these resources to provide advice for people coming home from hospital. At the moment there is little readily-available information and advice about the housing aspects of coming home from hospital. This contributes to some older people and their carers: • Having less opportunity to plan ahead for their return and make the home safer • Finding themselves being asked to make quick decisions about giving up their home • Facing delays in getting home while changes are made or alternative places are found. This project will fill this gap by helping people make informed choices around going home after a hospital admission. It will: • Help people think about aspects of their home that contributed to the hospital admission or being unwell • Help them through decisions about what to do next, to be safe at home and reduce the risk of re-admissions • Help them look at options around moving home, if this is now right for them • Point them to ways to make these changes happen. There will be Tips for older people and their families, plus a resource for staff in health, social work, housing and related settings.	£8,088 7 months (1 Sept 16 – 31 Mar 17)	Approve Funding.
Infrastructure						
Modernising Technology (RTM) Falkirk Council	£22,500	6 months (01 Oct 16 – 31 Mar 17)	Integrated Care Fund	This project has seen the introduction of electronic methods of recording, monitoring and managing the delivery of home care services. The previous methods involved manual systems with little use of IT. All 9 areas to be rolled out and functioning by the end of August 2016. This is currently on target. The system however comes with many other functions e.g. service user web portal, possible use of predictive analytics for falls awareness which it is important to acknowledge, with this possible additional functionality available for evaluation for future use. In addition the original project submitted for initial Change Funding also included the possibility of using the real time monitoring system more widely across community care services e.g. its implication within community nursing services, community AHP services and community care services etc. Along with the introduction of the system to the monitoring of work contracted out to our private providers. To date, this discussion has not been progressed in detail. It also provides a web based service user system which could be looked at in regards to sharing care service information across agencies (health, social work and service users themselves) etc. with appropriate security already in place. The request for reduced additional funding is specifically to extend the time of the Implementation Officer to the 31st March 2017 in order for them to fully complete the work required within the current home care element of the project and for them to carry out an exercise in relation to the further use, benefit and best value of resources that could be made	£7,500 2 month (01 Oct 16 – 30 Nov 16) Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. Financial impact on projection 16/17- £15000 reduction . 17/18 -£46000 reduction	Project has achieved original intention regarding the implementation of Real Time Monitoring within Care at Home. An extension of 2 months will allow initial work to be undertaken and sufficient staff notice period. Further development work should be undertaken within existing staff structure, with any further proposal being considered in context of wider IT development requirements.

				of the system across both health and social care services in general.		
Partnership Funding Co-ordinator Falkirk Council	£22,650	10 months (7 Sept 16 – 30 June 17)	Integrated Care Fund	On-going implementation of systems and procedure for partnership funding, including: • Governance process • Monitoring and evaluation • Reporting requirements to Scottish Government, IJB and other relevant management groups • Forward planning and investment in line with Strategic Plan priorities and identified need Facilitate and participate in review and planning process regarding health and social care integration, with specific focus on effective use of partnership funding as a catalyst for transformation. NB: Contract awarded for 6 month however, funding was previously approved for 1 year @ £55,000, therefore the additional request is the balance to 30 June 2017 and allowing for pay increments.	£22,650 10 months (7 Sept 16 – 30 June 17) £7,550-16/17 £15,100- 17/18 Funding incorporated in table 5 of June report in accordance with the prudent accounting principal. Financial impact on projections to 31/3/18 £7550 16/17 £4712 17/18	Continue funding
Performance Management Falkirk Council	£20,300	6 months (1 Oct – 31 Mar 17)	Integrated Care Fund	Provision of performance analysis and evaluation regarding partnership funds. The role of this post has now been extended to support the development of the HSCP performance framework. Work will focus on the development of performance reporting frameworks via the Covalent system. The remit of this post will not include detailed data analysis.	£20,300 6 months (1 Oct – 31 Mar 17) Funding incorporated in table 5 of June report in accordance with the prudent accounting principal.. No additional financial impact on projection.	Continue funding on basis of broadening role within scope of current job description.
Facilitation Resource Falkirk Council	£25,000	20 months (1 Aug 16 – 31 Mar 18)	**New Project** Integrated Care Fund	This resource will enable small items of expenditure relating to development and review work requested by IJB. This includes facilitation of the logic modelling process. Expenses may include venue hire (in circumstance where no suitable venue is identified with NHS/Council facility), high quantity printing associated with workshops/seminars, participant refreshment, reimbursement of any voluntary participant costs.	£17,000 16/17 £8,000 17/18 20 months (1 Aug 16 – 31 Mar 18)	Approve Funding