This paper relates to Agenda Item 6

Title/Subject:	**Partnership Funding**
Meeting:	**Integration Joint Board**
Date:	**2 December 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of this report is to provide the Integration Joint Board with the following information in relation to Partnership Funding; Integrated Care and Delayed Discharge Funds:

- Detail regarding the development of a framework to enable the IJB to appropriately commission and thereafter scrutinise services to Third Sector organisations, compliant with 'Following the Public Pound' guidance
- Conclusions and recommendations arising from initial evaluations of specific initiatives: Closer to Home, Rapid Access Frailty Clinic and Discharge Hub, within the context of the whole system approach, detailed within Appendix 2
- A six monthly performance review of all Partnership Funded initiatives in line with mandatory Following the Public Pound requirements, along with recommendations for continuation of funding for initiatives funded until 31 March 2017, detailed within Appendix 4
- Funding recommendations for new proposals reviewed in accordance with the agreed Partnership Funding Governance process, detailed within Appendix 4.

2. RECOMMENDATIONS

The Integration Joint Board is asked to:

2.1 Note the progress of the Leadership Group in relation to a framework for commissioning Third Sector organisation in compliance to 'Following the Public Pound' and agree that the framework is presented to the IJB in February 2017.

2.2 Note the outcome of the evaluation of specific initiatives: Closer to Home, Rapid Access Frailty Clinic and the Discharge Hub, presented in Appendix 2 and note phase 2 evaluation will consider initiatives with a reablement focus.

2.3 Note the six monthly performance report for all Partnership Funded initiatives and approve continuation of funding for initiatives with a current end date of 31 March 2017, as detailed in Appendix 3.

2.4 Remit further work to be undertaken with all initiatives to ensure that performance information gathered is adequate and articulates impact.

2.5 Approve allocations of Partnership Funding for new initiatives as presented in Appendix 4.

3. BACKGROUND

3.1 The Scottish Government allocated Integrated Care (ICF) and Delayed Discharge (DD) funds to add value to existing core services. The local investment of these ring-fenced funds are intended to support the delivery of improved outcomes from health and social care integration and to prevent delays in discharge and prevent admissions to hospital and attendances at ED. Funds are allocated through a single governance process, which is intended to provide transparency of allocation and allow effective performance monitoring.

3.2 In October, the IJB was also presented with a financial overview of partnership funding, which included funding approved during that meeting. This information is presented in Table 1, below.

	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	2,966	832	3,798	2,600	1,198
Delayed Discharges	894	894	0	864	523	341
TOTALS	4,692	3,860	832	4,662	3,123	1,539

Table 1: Partnership funding position October 2016

4. FOLLOWING THE PUBLIC POUND FRAMEWORK

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 review Partnership arrangements for commissioning services to Third Sector organisations in line with Audit Scotland and the Accounts Commission, 'Following the Public Pound' guidance.

4.2 The Leadership Group have initiated work in relation to the review of arrangements for commissioning Third Sector organisations. This is being undertaken with regard to IJB governance arrangements.

4.3 The review has given consideration to the 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' (FPP). The governance framework 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.

4.4 Work to finalise the framework is on-going. It is proposed that the final framework be presented to the IJB in February 2017. During this development period, allocations currently in place will continue to be scrutinised by Falkirk Council and NHS Forth Valley in line with their individual scrutiny arrangements.

5. EVALUATION OF SPECIFIC INITIAVES IN CONTEXT OF WHOLE SYSTEMS APPROACH

5.1 The adoption of a strategic approach to intermediate care has progressed within the context of the development of a whole system approach. This approach incorporates the developments relating to Frailty and Discharge to Assess models, for which an update on progress is included within the Chief Officer's report, agenda item 4.

5.2 There are currently a number of partnership funded initiatives operating within NHS Forth Valley and Falkirk Council that fall within the investment category, 'Avoiding Unplanned Admission', that provide an ideal platform for current developments, as noted in 5.1. In June 2016, the IJB agreed that 'a strategic approach 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'.

5.3 During the past months, an initial phase of evaluations has been undertaken, with the purpose of assessing the impact of initiatives, their contribution to the whole system and to help inform recommendations regarding funding beyond March 2017. The first phase of evaluation has included Closer to Home, Rapid Access Frailty Clinic and the Discharge Hub, as these initiatives are central to an integrated approach to supporting people within a community based setting. The phase 2 evaluation will focus on initiatives providing reablement based services.

5.4 The evaluation framework has been designed in line with the RE-AIM framework, which enables formative assessment, providing feedback on initiatives as they develop and summative assessment, which helps inform funding decisions. An overview of the framework is attached as Appendix 1. In order to effectively triangulate evidence, it was intended that baseline information be drawn from initial proposals and the on-line survey that all services were asked to complete, whilst impact and outcome information has been drawn from monitoring returns and detailed discussion with leads and key stakeholders.

5.5 The evaluation process would have benefitted from, but was not dependent on, the completion of the on-line survey. To date, no responses have been submitted by the 5 initiatives evaluated. In addition, although the initiatives reviewed

operate on a Forth Valley basis, there was limited capacity within the Clackmannanshire and Stirling Partnership to participate in the evaluation process, within the timescales set by the Falkirk Partnership. The timescales were set to ensure that the IJB are able to take decisions on the significant investment allocated and to enable service development and realignment to the whole systems approach. The recommendations made have been based on the information provided by projects to date. A summary of evaluation findings and recommendations, which have been reviewed by the Partnership Funding Group (PFG), is provided within Appendix 2.

6. SIX MONTH PERFORMANCE REPORT

6.1 In line with the agreed governance framework for Partnership Funds, the IJB receive a performance reported on a 6 monthly basis. Appendix 3 of this report provides information about each initiative's performance for the period April – September 2016. Detailed performance information has been scrutinised by the PFG.

6.2 The information contained within Appendix 3 has been drawn from quarterly monitoring returns. Of particular note:

- There remains a general lack of quality information that clearly articulates the impact and outcomes of initiatives against initial proposals. At the time of the introduction of the new governance framework and monitoring structure, initiatives were asked to submit revised proposals stating performance information. This information was used to consider funding awards and was intended to be used to monitor progress, thereafter. Some initiatives are not recording information in line with performance initially described within proposals. Work will continue with initiative leads to address this issue during the current quarter.
- Initiatives are well aligned to the outcomes of the Strategic Plan and a contribution is being made toward achieving the strategic outcomes. However, limited outcomes based performance measures means that it is difficult to specifically quantify the total contribution.
- Based on actual expenditure presented in monitoring returns, there is currently a variance in actual spend from initial allocation of approximately £363k. This is largely due to:
  - Recruitment delays: ARBD, OT Alignment and Stakeholder Engagement
  - Changes in staff: Closer to Home, OD Advisor
  - Inability to recruit: Closer to Home (SW Capacity)

  It should be noted that slippage has occurred, it is anticipated that £170k expenditure will move to 2017/2018. Table 2, below shows projected expenditure for 2016/2017, including slippage and underspends for reallocation.

	Resource available	Allocation	Monitoring Returns Projected Expenditure	Variance from allocation	Cfwd 17/18 projects slippage	Resource for Re-allocation
	£'000	£'000	£'000	£'000	£'000	£'000
Integrated Care Fund and Bridging	3,863	2,896	2533	363	170	193
Delayed Discharges	894	894	894	0		0
TOTALS	4757	3790	3427	363	170	193

Table 2: Partnership Funding expenditure 2016/2017

6.3 In June 2016, it was highlighted within the Partnership Funding report that investment within the priority area 'Health & Wellbeing in Communities' was significantly lower (10%) than the level initially anticipated within the submission to the Scottish Government in December 2014 regarding ICF, which indicated a 30% allocation. During 2016/2017, there has been a shift in investment, with projected expenditure of 15% in Health and Wellbeing in Communities. This shift is likely to increase in 2017/18, when expenditure will be incurred for initiatives approved over recent months. Performance information relating to the new initiatives will be reported to the IJB in June 2017.

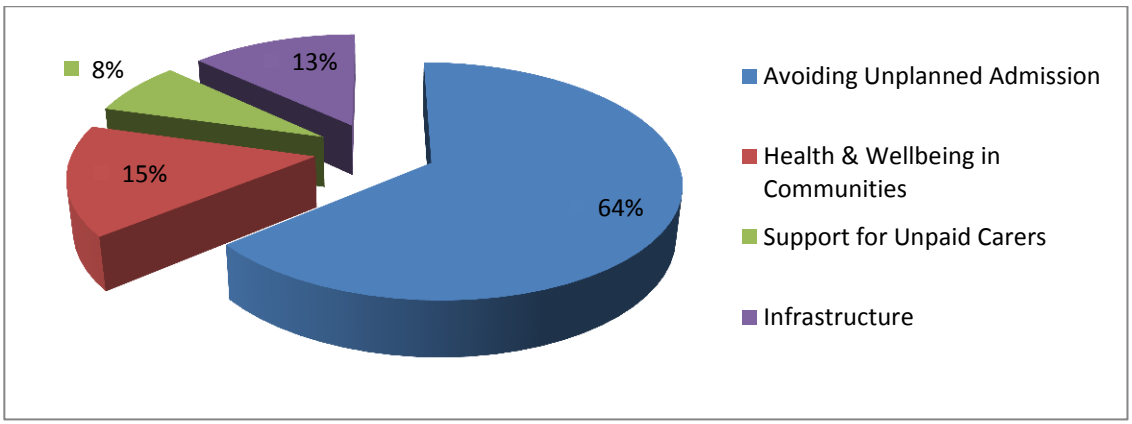

Figure 1: 2016/2017 ICF projected expenditure by investment category.

6.4 In addition, in June 2016, it was noted that investment within the priority area 'Avoiding Unplanned Admission' would be reconfigured in line with the development of a strategic approach to intermediate care and the whole systems approach, introduced by the Chief Officer in August 2016. This investment includes the development of a consistent approach to reablement, frailty and the discharge to assess model. The reconfiguration of these initiatives is on-going and will be confirmed to the IJB on completion of evaluation phase 2, which will focus on projects with a reablement focus. Recommendations for on-going funding, outlined in 7.2 of this report reflect this re-alignment.

7. PARTNERSHIP FUNDING INVESTMENT

7.1 During the past two months, the PFG has considered five new funding proposals. Recommendations made by the PFG have been endorsed by the Strategic

Planning Group and are included within Appendix 4 of this report. Investment recommendations relate to three out of the five proposals and amount to a total of £60,741.

7.2 In addition to the five new proposals, following analysis of initiative performance, highlighted within Appendix 3, the PFG also considered continuation funding for projects with a current end date of 31 March 2017. The majority of these initiatives are linked to the implementation of the whole systems approach, referenced in 5.1 of this report. Recommendation is made to continue funding during 2017/2018, to a maximum value of £1,766,296. Specific conditions relating to on-going funding are as follows:

- The Enhanced Community Team (Closer to Home) was intended to focus on provision of a community based response to avoid admission, however the ECT have also had to respond to significant discharge pressures. It is hoped that the Discharge to Assess model will alleviate pressure within the system and enable the ECT to re-focus on community based referrals. However, the Partnership needs to continue to provide a response and to direct services to meet the demands of discharge, utilising all resources at its disposal. In line with recommendations made to Clackmannanshire and Stirling IJB, funding for the Community Psychiatric Nurse will cease by 31 March 2017, as will additional resource towards Health Care Assistants.
- There is scope to reconfigure ALFY to provide a public and professional single point of contact. In order for funding to be allocated for this purpose, a business case should be developed, providing detail of the amended model, including staffing requirements. This should be submitted for assessment by the PFG by 20 December 2016, for consideration by the IJB in February 2017. This development should be taken forward in discussion with Clackmannanshire and Stirling Partnership.
- In recognition of the need for effective frailty provision, on-going funding to the Rapid Access Frailty Clinic will be subject to the submission of a business case by 1 March 2017, outlining a revised model of delivery and taking into account learning from current provision. Assurance must also be provided that Partnership Funded resource is dedicated to the provision of the initiative. This will be taken forward in discussion with Clackmannanshire and Stirling Partnership.
- Funding for reablement focussed initiatives is recommended to continue, however funding is subject to phase 2 of detailed evaluation, as outlined in 5.3.

8. 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 previously approved addresses 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 a 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: 11 November 2016

List of Background Papers:

Integrated Care Plan December 2014
IJB Papers regarding Partnership Funding:

- 7 October 2016
- 5 August 2016
- June 2016

Partnership Funding Group minute and scoring matrix

- 16 August 2016
- 14 September 2016
- 6 October 2016

Strategic Planning Group minute

- 23 August 2016
- 25 October 2016

Evaluation Framework: Overview

Since June 2016, Falkirk HSCP has been implementing RE-AIM as a methodology for Planning and Evaluation, which is based on theory of change principles. The Board received a presentation on logic modelling and RE-AIM at this time. This process was initially developed in the context of initiatives funded via Partnership Funds: Integrated Care Fund and Delayed Discharge Fund.

In relation to Falkirk HSCP Partnership Funds, a framework of proposal forms, assessment criteria and monitoring returns have been developed in line with the principles of RE-AIM. This enables formative feedback to be gathered in order to improve initiatives as they go along, not just to provide summative outcomes data – hence the emphasis on processes of implementation and adoption as well as reach and effectiveness data (i.e. outcomes). In addition, by focusing on implementation and maintenance, the framework should help to identify the ways in which successful initiatives can be rolled out more widely.

The RE-AIM framework consists of 5 key elements, as detailed in table 1.

Element	Planning	Evaluation
Reach: Participation and representativeness of the target population	Anticipated: • Target population/anticipated client group as a proportion of total target population. • Characteristic of client group. • Staff structure: Numbers/Hours • Wider links e.g. referral points.	Actual: • Service users. • Characteristic of service users. • Barriers experienced to participation. • Variance in service users compared to those initially identified. • Staff structure and any variance. • Challenges in relation to staffing. • Referral pathways and any variance.
Effectiveness: The effect of the programme and cost efficiency	Anticipated: • Fit with local Strategic Plan outcomes. • Identification of whether initiative is evidence based or innovative (and evidence source) • Initiative outcomes – individual and organisational. • Measurement of change over short, medium, long term. • Cost benefit.	Actual: • Contribution towards local Strategic Plan outcomes. • If evidence based, how does performance align with evidence and any variance. • Performance against outcomes over short, medium and long term. • Unintended individual outcomes (positive and negative). • Variance in change measured as a result of alteration to delivery. • Difference in outcomes between service users by characteristics, location. • Cost benefit and any factors affecting this.
Adoption: Uptake of the intervention	Anticipated: • Services/agencies that the initiative will work with, receive and provide	Actual: • Services/agencies engaged and any variance.

within agencies and settings	referrals. • Potential barriers. • Promotion/awareness raising for service users/staff.	• Challenges in working with other services/agencies and gaps in engagement. • Engagement with initiative that is over and above what was anticipated. • Promotion/awareness raising undertaken, impact and any variance from anticipated impact.
Implementation: The extent to which the initiative was implemented within mainstream practice	Anticipated: • Activities to be delivered. • Pilots or tests of change. • Process of tracking/monitoring change during programme. • Stakeholder involvement.	Actual: • Activities delivered. • Outcome and impact of pilots or test or change and further implementation if successful. • Consistency of delivery across area/sites. • Unintended organisational outcomes (positive and negative). • External factors that have altered delivery or performance. • Any changes that have been adopted by service/agencies in order to facilitate initiative. • Evidence of stakeholder involvement (service users, practitioner and agencies) • Any self-evaluation undertaken.
Maintenance: The extent to which the initiative and benefits can be sustained	Anticipated: • Exit Strategy. • Ability to produce lasting benefits for service users/organisations. • Availability of long-term resource/service re-design. • How initiative will be integrated into mainstream provision.	Actual: • Aspects of initiative are sustainable without on-going resource. • Progress with any service re-design.

Closer to Home

Closer to Home is an initiative that operates across Forth Valley, consisting of three elements: **Advice Line for You (ALFY), Enhanced Social Work Capacity and Enhanced Community Health Team**. All three elements of Closer to Home formally commenced in December 2015.

The purpose of Closer to Home is to provide an integrated, seamless support to enable people to be supported within their own home to both avoid admission to hospital. The initiative is targeted toward all adults, but predominantly supports those with long-term conditions and frail older people. Specific target groups are:

- Those with a +40 SPARRA score (specifically ALFY)
- Uninjured Fallers
- Unwell adults (requiring support at a time of escalating need, but without a formal diagnosis)
- People assessed as medically ready for hospital discharge

The integrated solution is intended to provide early intervention and support to enable self-management via ALFY, enhanced nursing support for service users and to support carers via the Enhanced Community Team and a responsive provision of packages of care via the 24/7 Social Work Team.
The effectiveness of the model relies on each of the three components working in an integrated way, with clear referral pathways and clarity regarding roles and responsibilities.

NB: It is noted that Closer to home has been in place for less than 1 year and therefore evaluation at this stage is intended to be formative rather than summative. An evaluation framework is currently being developed to enhance the ability to monitor and evaluate the impact and outcomes. Some information has been gathered regarding patient outcomes and linked data, however this is still an area of development.

Closer to Home

ALFY:

24/7 Advice line for all over 65s. (+40 SPARRA score specifically targeted) and issue and recording of 'Your Plan' (patient held holistic care plan)
Staff (FV) 1.49 FTE Nurses, 1.4FTE Administrator

Key Performance Information	Cost Analysis (Based on available information)	Conclusions	Recommendations
NB: Figures relate to Forth Valley **Calls received FV(April – Sept): 593** **Average calls per day: 3.3** **(1.7 Falkirk resident)** **Calls received weekday, in hours: 55%** **Proportion of calls Falkirk: 53%** **Your Plans Completed: 140** **Call Outcome:** **Community Nurse: 21%** **Reassurance: 45%** **Social Work: 7%** **NHS 24: 7%** **Third Sector: 1%** (Note calls may have more than 1 outcome) **ED/Discharge Follow-up calls (Sept): 131 call attempted, 58 answered**	Based on April – Sept performance and expenditure: £119.54 per call received, NB: Further cost benefit analysis is required. The above figure is based on call and follow-up undertaken by staff, after the call. This may vary according to the outcome of the call.	Figures provided indicate that there is limited need for a dedicated public facing 24/7 advice line. Data captured relates to call outcomes and number of Your Plans in place. Outcome based data is not currently recorded. Initial publicity resulted in a slight increase in use (peak at 9 per day), however numbers dipped when publicity stopped. It is noted that time is spent taking action following call, however this information is not currently recorded. The scope of ALFY provision has now been extended to provide follow-up calls from ED and Discharge.	Initial work has been undertaken to reconfigure ALFY into a Single Point of Contact for professional to enable referral to ECT and other services, whilst continuing to take calls from service users. In order for ALFY to be reconfigured as a single point of contact in addition to a public facing helpline, a business case, including amended staffing structure is required, in line with governance process. It is recommended that the business case be submitted by the 20 December, for assessment by the Partnership Funding Group. Recommendations regarding on-going funding will then be presented to the IJB in February 2017. This process should run in conjunction with Clackmannanshire and Stirling Partnership.

Closer to Home

Social Work Additional Care & Support

Integrate with Enhanced Community Health Team by providing responsive home care service to avoid hospital admission and facilitate discharge.

Key Performance Information	Cost Analysis (Based on available information)	Conclusions	Recommendations
NB: Figures relate to Falkirk only **Referral from ECT (Apr – Sept): 11** **Referrals to ECT (Apr – Sept): 0**	N/A	Project has not been implemented as proposed, mainly due to recruitment issues. There is little evidence of integrated working practice between Social Work 24/7 and Enhanced Community Health Team, which is critical to the Closer to Home model.	It is not recommended that further funds are allocated to the existing model/structure. An integrated response to discharge facilitation and provision of immediate packages of care is required. This should be developed with Social Work 24/7 team, Falkirk Council procurement team and local providers.

Closer to Home

Enhanced Community Health Team

Provision of a 24/7 service via enhanced core nursing and AHP staff focussing on providing short-term care (usually 7 days) for those with an escalating need and immediate needs following discharge from hospital.
Staff (FV): 1 FTE Advance Nurse Practitioner, 5.6 FTW Community Staff Nurses, 4FTE AHPs.

Key Performance Information	Cost Analysis (Based on available information)	Conclusions	Recommendations
NB: Figures relate to Falkirk only **Total referral (Apr – Sept 16): 139** **Classed as urgent: 89** **Discharge facilitation:66** **Uninjured faller:17** **Unwell adult: 93** **Avoidance of admission (Jul-Sept): 24 (67%)** **Patients admitted: (Jul-Sept): 4 (11%)**	Based on April – Sept performance and expenditure: £1,125 per patient £291,312: Estimated cost avoidance of 48 admissions avoided for 6 months. (17 days @ £357 – calculated using 15/16 direct cost per day) £134,974: Net cost avoidance after project expenditure, for 6 months. NB: Further cost benefit analysis is required regarding the cost of immediate packages of care being put in place compared to admission/on-going hospital stay.	The ECT is well embedded as a response to avoiding hospital admission. It is noted that the service has been required to respond to a higher than anticipated level of discharge support, which was not the focus of the initial model proposed. ECT has responded to a lack of immediate availability of care at home packages, through the deployment of Health Care Assistants. This has been due the SW 24/7 aspect of the project not being developed. The use of bank staff to support packages of care has been effective in the short term and provides an integrated approach from the patient point of view as both nursing and home care tasks can be undertaken. The ETC team note that is a costly approach which was not intended as a sustainable solution. It is noted that all staff recruited on a permanent basis, despite funding being short term. This encourages retention, however creates some risk in terms of long-term deployment of staff. Further development of a monitoring and evaluation framework will enable the ECT to assess impact and outcomes in the longer term.	Recommended that approach is continued, maintaining the focus on community referral and allowing the model to be further developed and embedded. The further development of monitoring information should be used to effectively assess impact. In line with recommendations to Clackmannanshire and Stirling IJB, funding for the CPN element of the ECT should end on 31 March 2017, as this component of the service has not been well used. In relation to the deployment of Health Care Assistants to provide immediate packages of care, an integrated response should be developed with Social Work 24/7 team and Falkirk Council's procurement team, in conjunction with local providers. Funding for the Health Care Assistant element should end on 31 March 2017.

Discharge Hub

The Discharge Hub was established to provide a co-ordinated response to discharge facilitation from both Forth Valley Royal and Community Hospitals, across Forth Valley. The capacity of the team has increased from 2.7FTE to @7FTE by adding an additional 4.3FTE. The additional capacity consists of 3.3FTE Band 6 nurses and 1 FTE administrator.

The service has been extended from 5 days to 7 and ensures a presence in the Acute hospital and Community hospitals. The team work with ward staff and multi-disciplinary supporting both Ageing and Health patients and those in non-Ageing and Health wards to ensure appropriate referral to Community Hospital, Short Term Assessment or Home. Packages of care and support are also co-ordinated prior to discharge, including equipment and adaptations. The approach is partly intended to release the time of medical staff, previously central to negotiating discharge.

The performance data and outcomes information gathered by the Discharge Hub is still under development. No information is provided about the outcome of patients beyond discharge.

Key Performance Information	Cost Analysis (Based on available information)	Conclusions	Recommendations
NB: All figures are FV wide **Moves from FVR to CH(May – Sep): 632 (of which 88 facilitated at weekend)** **Moves in 5 Days (May to Sep): 365** **Average wait reduced from 9 days to 5 days** **Moves to Short Term Ass (Apr-Sep): 109** **Non Ageing & Health patients reviewed: 217 (200 appropriate)** **114 moved to Community Hospital** **52 moved Home** **13 Short Term Ass.** **2 referred to Closer to Home** **19 Died**	N/A	The Discharge Hub is successfully facilitating moves from Acute and Community hospital, however it is difficult to assess impact on system or individual outcomes. This partly due to no baseline information having been collected and also a general increase in the requirement for discharge facilitation. Professional feedback from ward staff and managers has been positive in terms of the positive impact on workload. There is potential opportunity for the Discharge Hub to be further integrated with the hospital SW team and potentially to also align with the development of a Single Point of Contact. This should be considered in line with development of frailty approach, discharge to assess and Closer to Home. It may be beneficial to undertake a rapid evaluation regarding service user outcomes and long-term destinations.	Recommended that funding of Discharge Hub continues, however further integration with social work teams would be beneficial and should be considered in conjunction with Clackmannanshire and Stirling Partnership. Further work is required regarding monitoring of outcomes and impact.

Rapid Access Frailty Clinic (RAFC)

The RAFC operates on a Forth Valley wide basis and is based within Forth Valley Royal, targeting people over the age of 75 or 65 is resident within a care home, who require specialist review by a consultant geriatrician. The RAFC was initially intended to operate a 7 day service. The key purpose of the RAFC is to avoid the need for admission to hospital.

Patients are referred from primary care. The clinic intends to provide a spectrum of diagnostics, assessment and treatment plans, with the patient returning home within the same day, where possible. The clinic also liaises with community based services to ensure that on-going treatment or support is in place. Carers are involved in the assessment process as much as possible.

FV Staff: 1.5 FTE Consultant Geriatrician, 1 FTE Band 6 Nurse Assessor, 0.2 FTE Band 6 Physiotherapist, 1 FTE Band 3 Administrator

Key Performance Information	Cost Analysis (Based on available information)	Conclusions	Recommendations
NB: Figures provided are for Forth Valley **Total patients(Apr-Sep 16): 259** **Total return visits(Jul-Sep):31** **Patients admitted (Apr-Sep): 17** **Possible Clinic: 262** **Total clinics held: 119 (45%)** **70% GP practices in Falkirk refer to RAFC** **83% GP practices in Clacks/Stirling refer to RAFC**	Based on April – Sept performance and expenditure: £540.92 per patient £91,560: Estimated cost avoidance of 25% admissions avoided for 6 months (7 days geriatric assessment @£218 – calculated using 15/16 direct cost per day)	The RAFC is not currently running as initially intended. Although 1.5FTE geriatricians are funded, this increases the total geriatrician capacity within the Acute setting rather than providing a static, dedicated resource to the clinic. The costing associated with the model does not allow for clinics to be run over 7 days, as was initially stated. It is estimated that 1.5FTE geriatricians enables a total of 9 sessions per week, including admin and follow-up time. This equates to 4.5 days. Low referrals to the clinic mean that the current lower than anticipated clinic capacity does not have a negative impact on patients i.e demand does not outweigh capacity to deliver. Further promotion of the RAFC is required, in line with communication regarding general frailty provision.	Recommended that RAFC is reconfigured to work directly with the front door, in addition to provision of the clinic on an on-going basis. The amended provision should align with the development of the frailty model and the outcome of the Discharge to Assess pilot. In line with governance process, a revised business case outlining revised provision should be submitted via the Partnership Funding Group, by 1 March 2017. This timescale is to enable conclusion of the Discharge to Assess pilot. On-going funding should be considered in conjunction with Clackmannanshire and Stirling Partnership.

Project Name	Lead Agency	Start Date, if Pre-ICF/DD	Intended Contribution to Strategic Plan Priorities	Support for Carers	Performance	Comment	Current End Date	Funding Recommendations
Avoiding Unplanned Admission: ICF								
Closer to Home - ALFY	NHS			DIRECT	✗	Demand for public facing advice line low.	Mar-17	Reconfigure service, extension subject to approved Business Case.
Closer to Home - Additional Care & Support	Falkirk Council			INDIRECT	✗	Project not developed as intended and therefore not perfroming.	Mar-17	No further funding.
Closer to Home - Enhanced Community Health Team	NHS			INDIRECT	?	Performance impacted by discharge pressures. Further integrated approach required.	Mar-17	Extend to 31/3/18, excluding CPN
Enhanced Discharge Support from FCH	NHS	CF 2013		DIRECT	✓	Performing	Mar-17	Extend to 31/3/18, subject to phase 2 evaluation
Reablement in Housing with Care	Falkirk Council	CF 2012		DIRECT	✓	Performing	Mar-17	Extend to 31/3/18, subject to phase 2 evaluation
Reablement at Home	Falkirk Council	CF 2012		DIRECT	✓	Performing	Mar-17	Extend to 31/3/18, subject to phase 2 evaluation
OT, Equipment & Adaptations Redesign	Falkirk Council			INDIRECT	✗	Recruitment in progress	Sep-17	N/A
Telehealth / Telecare (combined)	Falkirk Council	CF 2012		DIRECT	✓	Performing	Mar-17	Extend to 31/3/18, subject to phase 2 evaluation
Avoiding Unplanned Admission: Delayed Discharge								
Rapid Response Frailty Clinic	NHS	CF 2014		DIRECT	?	Operating below capacity	Mar-17	Reconfiguration service, extension subject to approved Business Case.
Discharge Hub	NHS	CF 2014			✓	Performing	Mar-17	Extend to 31/3/18, subject to alignment with Discharge to Assess
HELP Packs	CVS Falkirk & District	PIF 2013		INDIRECT	✓	Ended	Ended	N/A
Summerford Reablement	Falkirk Council			DIRECT	✓	Performing	Mar-17	Extend to 31/3/18 -service reconfiguration
Care home placements	Falkirk Council			INDIRECT	✓	Ended	Ended	N/A
Contribution to FHC Ward 5	NHS				✓	Ended	Ended	N/A
Health & Wellbeing in Communities								
ARBD Case Management Model	Forth Valley ADP				✗	Recruitment in progress	May-17	Further information required regarding progress
Medication Management	Falkirk Council				✓	Ended (Final report due)	Ended	N/A
Post Diagnostic Support	Alzheimers Scotland	CF 2013		DIRECT	?	Issues will be addressed by extended PDS	Sep-17	N/A
Community Connections Programme	Alzheimers Scotland	PIF 2013		DIRECT	✓	Performing	Sep-17	N/A
Active Minds - FCT	Falkirk Community Trust				?	Impact unclear due to slow start.	Feb-17	N/A
Braveheart Optimise Health Programme	Braveheart	PIF 2013			✓	Performing	Mar-17	Funding Ends 31/3/17
Social Prescribing	FDAMH			INDIRECT	✓	Performing	Mar-18	N/A
Marie Curie Patient Visit Service	Marie Curie	CF 2013		DIRECT	✓	Ended	Ended	N/A
Dallas / Living it Up	NHS	CF 2012		INDIRECT	?	Impact unclear, but performance reporting has been reviewed and improvements being made.	Sep-17	N/A
Direct Support for Carers								
Support for Carers	Central Carers Centre	CF 2012		DIRECT	✓	Performing	Mar-18	N/A
Infrastructure								
OD Advisor	NHS			INDIRECT	?	Post vacant during period. Post holder has started during Q3.	Dec-17	N/A
Modernising Technology in Care Services (RTM)	Falkirk Council	CF 2013			✓	Performing	Ended	N/A
Stakeholder Engagement Officer	Falkirk Council	CF 2013		DIRECT	✗	Recruitment in progress	Dec-17	N/A
TSI Support	CVS Falkirk & District			INDIRECT	✓	Performing	Oct-17	N/A
Independent Sector Lead	Scottish Care			INDIRECT	?	Impact now being measured	Mar-17	Extend to 31/3/18
Senior Information Analyst	ISD				✓	Performing	May-17	N/A
Integrated Care Fund Coordinator	Falkirk Council				✓	Performing	Jun-17	N/A
Performance Management & Programme Support	Falkirk Council				✓	Performing	Mar-17	N/A

Key		INDIRECT	DIRECT	?	✗	✓
	SP Alignment (proportion out of 5 outcomes)	Indirect Support for carers	Direct support for carers	Action Required	Not performing	Performing

Partnership Funding Group Project Summary and Recommendations (Endorsed by the Strategic Planning Group 25 October 2016)

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 and Term Requested	Project Summary	Strategic Alignment	Recommended Funding	Justification/Condition
Forth Valley Sensory Centre Centre Users & Carers Health & Wellbeing Lunch Club	£15,181.95 15 months 1 Jan 2017 – 31 March 2018	**Overview:** Forth Valley Sensory Centre(FVSC) is an inclusive, accessible place where people with a visual or hearing loss, their friends, families, carers and the wider community can access services and advice from partner organisations including RNIB, Action on Hearing Loss, NHS Forth Valley and Falkirk Council. The overall objective of FVSC, is to help people who have a sensory impairment live as independently as possible. Many of those who use the Centre were not born blind or deaf and are experiencing the emotional and practical impact of sensory loss in later life. Following engagement and consultation with Centre users and carers, key themes and issues emerged such as: • Experience a contracting of their world • Low self-esteem and self-confidence to look after their health & wellbeing • Mobility issues within their home including accessibility to transport • Feeling vulnerable and unsafe in (cooking) and when leaving their own home • Barriers placed between them and their ability to participate in activities within the wider community • Lack of support or guidance for carers • Pressure of changing relationships In response to this, FVSC propose to introduce a centre user and carer health & wellbeing lunch club. This club would initially run for one day per week from 12 noon to 2:30pm, for 20-30 centre users and carers. The club would provide a dual function, offering social activity along with practical support from specialists such as occupational therapist and rehabilitation mobility training. The club will be open to people living within the Falkirk Council area. Promotion will be targeted at people who do not currently access the range of services available within FVSC and existing centre users. **Sustainability:** A key focus of the provision will be to train and develop the skills of volunteers, the intention being that they are eventually skilled and confident to run the club with minimal staff intervention over and attendance from specialist service providers. FVSC will explore funding from trust funds to enable the service to effectively continue to be developed and have a positive impact on centre users and cares. A nominal fee will also be considered, for centre users and carers. FVSC will also continue to work closely with Forth Valley College and Falkirk Carers Centre. The PFG noted that the unit costs of this provision is £8.43 per person, per session based on 30 people attending. This is slightly higher than standard lunch club, however the cost of BSL interpreters are included in this unit cost. This is also significantly less than the unit cost of day care, which can be up to £60.00 per session.	**Self Management**: The project will focus on helping people to adapt to sensory impairment and maintain or re-gain independence within their own home. **Safe:** Advice and skills will be provided to centre users and carers to enable people to manage safely within and around home. **Community Based Supports**: Support will be provided within the local area (transport provided where necessary). Volunteers will be engaged and upskilled. The initiative is in line with Scottish Govt. principles for ICF. The project has been formed based on feedback from centre users and carers and will continue to be developed with their feedback. Health and Social Work teams, Forth Valley College and Falkirk Carers Centre will be involved in the provision of support and volunteers.	£15,181.95	Partnership Funds have not previously been targeted towards sensory impairment. PFG noted that the club will provide multiple benefits to service users and their carers in terms of both practical, social and emotional support.
Peer Information Hub Outside the Box	£24,933 15 months 1 Jan 2017 – 31 March	**Overview:** This proposal seeks to address a gap that has been identified in the provision of information on housing options and related matters through peer-based face-to face contact, to private sector tenants. The Housing Contribution Statement to the Falkirk Strategic Plan highlighted the importance of specialist housing advice, particularly for older people who live in the private sector and want to remain there. A report to the Integration Joint Board (3/6/16) highlighted that funding	N/A	N/A	The PFG felt that although the proposal was interesting, there was a lack of clarity regarding evidence reach and potential impact. In addition, there was a lack of clarity regarding how the impact on housing services would be measured. The

	2018	would be explored for older people to use the tools that they developed through the Outside the Box/Making It Happen project to empower them to assist contemporaries address housing, health and support needs. The proposed service was intended to provide a source of information on matters related to housing that older people feel are relevant for them. Information would be disseminate using tools such as the Hints and Tips booklets developed by older people for older people with Outside the Box/ Making It Happen, information on the Living It Up website. In addition, older people who are peer volunteers would take information out to places where older people go and take a peer support approach to encouraging people to follow up on sources of support and practical help. The aim is to get information to older people that will enable them to understand more about their housing options, be safe and well at home, have more choice and control over their home, and so have a good life. Ultimately, it is hoped that older people will access support from Housing Services before reaching a point that their home is unsuitable due to changing support needs.			PFG felt that the proposal would have been more appropriate if submitted directly from Housing Services rather than via an external organisation. Funding is not recommended at this time. Feedback has been provided to Housing Services who are resubmitting a proposal for consideration.
Training Academy FDAMH	£53,800 16 months 1 Dec 2016 – 31 March 2018	Proposal to further develop specific strands of FDAMH's Training Academy provision, which has been established as a social enterprise to provide tailored training regarding mental health. The training academy is at fairly early stages of development and FDAMH are looking to test various ways of working, which will allow evidence to be gathered regarding outcomes. The intention being that each strand will then be self-sufficient via charging. Three strands of work were proposed: 1. Mental Health Awareness programme for 17 – 18 years olds, making the transition from High School to further or higher education, work and adult hood. 2. Introduce a programme of mental health awareness to local people who attend local groups throughout Falkirk: including groups such as Home Start who support vulnerable parents, sport clubs, older people's lunch clubs. 3. Undertake an awareness raising campaign in local workplaces to encourage local employers to start a conversation about mental health in the workplace. The PFG reviewed each strand of the proposal and initially recommended that only the schools component of the application be progressed. As part of the assessment process Falkirk Council's Children's Services were consulted to consider the contribution of the initiative and fit with existing commissioning requirements. The Head of Education Services expressed concern regarding the sustainability of the delivery within schools and inability to commission on a needs basis. Based on this feedback, the PFG recommend that funding is not awarded.	**N/A**	N/A	No funding recommended.
Post Diagnostic Advanced Support Alzheimer Scotland	£43,870 15 months 1 Jan 2017 – 31 March 2018	This proposal was deferred in October, pending the outcome of work being undertaken regarding Dementia Pathways. **Overview:** This proposal is to work with families of those referred who more advanced in their illness and are less able to self- manage. This would be a test of change which will provide clear links for people receiving a diagnosis at a stage where they are more likely to be starting to benefit more from the 8 pillar model. This project would support a worker to work closely with the Link Workers and wider multi-disciplinary team, focussing on shorter term support for around 60 people with dementia and their families throughout the year. Currently within Falkirk, anyone who receives a diagnosis of dementia and who requests and/ or is offered Post Diagnostic Support is referred to the Dementia Link Worker Service (currently funded via ICF), irrespective of what stage they are at in their illness. There is recognition that accessing community based support services is a significant challenge and whilst work continues in the development of a Dementia Pathway and a whole system redesign, this post addresses the immediate level of diagnosis of dementia and the resulting high demand for PDS. This proposal recognises that all people being diagnosed may be at different stages of the illness and have different needs as a result. Data so far known indicates that around 40% are in the moderate to	**Self Management:** Service users and carers will have better knowledge of how to cope with illness and symptom management. **Safe:** Identify individuals at risk in the community and link with appropriate support. **Autonomy & Decision Making:** Carers and families are support to make decisions that focus on maintaining or improving quality of life of person with dementia. **Community Based Supports:** Peer support for carers within community.	£43,870	This project will help alleviate demand and capacity to enable the Partnership to manage potential service change in line with the ongoing development of the dementia pathway and prepare for the implementation of the 8 pillar model. It is proposed that this project is supported on a short term basis and for no longer than until 31 March 2018.

		advanced stages of dementia and while some will still benefit from the 5 pillar model, as needs are all individual and person centred, it is also clear that some people and their families are more likely to benefit from support more akin to the 8 pillar model which is coming into effect. In discussion with professional stakeholders from health and social work there is also recognition that existing link workers may be spending time on undertaking work which is not naturally within their remit, for example addressing support packages, due to the absence of other support mechanisms at that point in time. Current waiting list in Falkirk is 138 and this post will support the ability of multi-disciplinary professionals to "triage" the service users in to the most appropriate support to meet their needs. This will be done in discussion with Link Workers and we anticipate it will increase capacity so they can concentrate more fully on those at the 5 pillar stage. Alzheimer's Scotland are also progressing discussion at government level in terms of some of the challenges which have naturally emerged as the PDS programme and diagnosis have gathered momentum and again the proposal will support those discussions to be progressed. **Sustainability:** During the assessment of this proposal, discussion took place between colleagues in Alzheimer's, Health and Social Work. It was agreed that this project provides a short term solution to support the needs of service users and carers and manage waiting lists. Work in relation to the dementia pathway is ongoing. This project help manage demand and capacity to enable the Partnership to respond to service change across the pathway and prepares for the implementation of the 8 pillar model. It is therefore proposed that this project is supported on a short term basis and no longer than until 31 March 2018. The PFG noted that there is currently 1 PDS link worker in Clackmannanshire and Stirling Partnership. Waiting lists are significantly higher.	**Service User Experience:** People at mid or late stage of their illness and their carers, will be provided with practical and emotional support which will help to prevent crisis. The initiative is in line with Scottish Govt. principles for ICF. The project has developed in conjunction with services users, carers and in consultation with colleagues within Health and Social Work.		
Community Connections - Restructure Alzheimer Scotland	£1,689 11 months 1 Dec 2016 – 31 Oct 2017	**Overview:** This proposal will allow Alzheimer's Scotland to restructure the Community Connections programme in line with service user feedback. Additional funding is requested to pay for an additional sessional worker. The current Community Connections programme is currently funded via Partnership Funds (£10,600) until October 2017. It delivers a varied programme of less structured community based support opportunities for people with dementia. This includes a twice weekly gardening group, weekly walking group, weekly Baristas café, monthly supper club and three sessions of football reminiscence. The walking group has been poorly attended for some time and therefore it is proposed that this activity is stopped and that a "Brain Gym" is commenced instead, which aims at keeping people mentally and physically fit. This new group adapts the principles of a Cognitive Stimulation Therapy maintenance group and is identified as a need by the CMHT as they have a rolling programme of CST groups with no place to refer people on to and no capacity to do this. The Brain Gym will have space for an additional 10 people and will run for 2 hours per week. The type of activities offered will focus on helping people to make new connections within the brain by offering a variety of brain training exercises and also incorporating physical exercises such as Otago and relaxation. **Sustainability:** A charge of £5 will be applied to the 'Brain Gym'. This will offset some of the costs, however ongoing funding will be required in order to continue the Community Connections Programme.	**Self Management:** Participative activities help people with dementia and their carers to maintain independence for longer. **Community Based Support:** Activities and groups are run within local communities, volunteers support groups. The restructure of the initiative is in line with Scottish Govt. principles for ICF. It is based on input from service users and CMHT.	£1,689	Funding recommended.