AGENDA ITEM
17

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Partnership Funding**
Meeting:	**Integration Joint Board**
Date:	**5 October 2018**
Submitted By:	**Chief Finance Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1. The purpose of this report is to provide the Integration Joint Board (IJB) with information and recommendations regarding Partnership Funding proposals and to provide an update on Strategic Commissioning work being progressed, in line with the approved Partnership Funding Investment Plan.

2. RECOMMENDATION

The IJB is invited to:

2.1. approve the recommendations proposed by the Partnership Funding Group and endorsed by the Strategic Planning Group, presented in Appendix 1

2.2. note initiatives supported via Leadership Group fund, as specified in 4.6, which have been assessed via the due governance process

2.3. note the progress made regarding Strategic Commissioning work and that further reports will be presented to the Board.

3. BACKGROUND

3.1. In April 2018, the IJB approved a three year Partnership Funding investment plan for the period 2018 – 2021. The Plan provided an overview of established initiatives, areas for disinvestment and areas of proposed future commissioning. Although the IJB approved the proposed areas of future commissioning, it was noted that progression was subject to the approved Partnership Funding governance process.

3.2. Continued funding of established initiatives was approved subject to standard conditions, which state: *'The award is conditional on provision of quarterly monitoring information that evidences progress towards project outcomes. It should be noted that where change occurs during the funding period that results in funding being stopped, a notice period of no less than 3 months notice can be issued. This could arise, for example, where an initiative no longer aligns with Partnership priorities or where there is a persistent deficit in performance.'*

Falkirk Council NHS Forth Valley

4. PARTNERSHIP FUNDING RECOMMENDATIONS

4.1. Five initiatives, received funding awards for a single year, with an added condition that further information was presented back to the IJB in September 2018. All five initiatives are delivered across Forth Valley and are also funded by Clackmannanshire & Stirling Partnership. The additional conditions of award relating to each of the initiatives were based on recommendations made by the Partnership Funding Group (PFG) and Strategic Planning Group (SPG) during the process of reviewing performance and developing the investment plan. To ensure consistency of approach, requests for information were made in conjunction with Clackmannanshire & Stirling Partnership.

4.2. Table 1 below summarises the additional funding conditions issued to the five initiatives in addition to the conditions noted at section 3.2. Each lead was required to submit additional information in the form of a proposal, for consideration by the PFG, by 31 July 2018.

Initiative	Additional Condition of Award
Enhanced Community Team (Closer to Home)	Review of structure and costings in context of the 'Closer to Home' model
ALFY (Closer to Home)	Proposed service delivery based on single point pilot and in context of the 'Closer to Home' model
Night Nursing (Closer to Home)	Clarity of contribution of service in context of the 'Closer to Home' model
Rapid Access Frailty Clinic	Service delivery model in line with Frailty Collaborative
Alcohol Related Brain Injury Service	Options regarding service structure and broader delivery model

Table 1

4.3. To ensure that PFG were able to fully scrutinise proposals and make informed recommendations, a consistent approach to appraisal was applied as follows:

- Performance information, evaluation documents and relevant contextual information was provided to the PFG for each initiative, including previous reviews or changes.
- All proposals were scored using a consistent framework, which includes Best Value considerations as well as how the initiative supports outcomes for people and the Strategic Plan.
- The three proposals identified as 'Closer to Home' were appraised individually in terms of performance, and collectively in terms of the contribution made towards an enhanced model of provision.
- Clackmannanshire & Stirling Partnership have a parallel scrutiny process. There has been ongoing collaboration between Fund Co-ordinators and Chief Finance Officers to ensure consistency in approach.

- In the event of different decisions being taken by the Partnerships, discussion will take place regarding the viability of the initiative being progressed at a local level. It is important that the IJB makes funding decisions based on local need and demand.
- An assessment was also undertaken in relation to the overall sense of impact on service users and carers and other services and also potential redesign options.
- Where the service provided by a Forth Valley wide initiative, funded on a set apportioned basis disproportionately benefits one Partnership at the detriment of the other, consideration has been given to alternative costing models. This is subject to ongoing review.
- Equality and Poverty Impact Assessments will be undertaken by project leads in relation to potential service change.

4.4. It is worth noting that none of the five initiatives provided all of the information requested as part of (or fully complied with) the additional funding conditions. The PFG and SPG therefore considered the submissions based on the information received by each of the five initiatives. A summary of the outcomes from this scrutiny is contained within Appendix 1.

4.5. In relation to Forth Valley wide initiatives, the Board are asked to approve the recommendations set out within Appendix 1, namely:

- ECT: The 'Closer to Home' model is terms of providing support at home or in a community setting remains a key Partnership priority. The CFD Delivery Group provides a business case setting out aims and functions of CFD, to both Partnership Leadership Groups. Recommendations will then be made through the agreed governance arrangements to the IJB. The proposal received outlines the ECT service, aligned to the development of a Forth Valley Community Front Door (CFD) model. Whilst acknowledging that the ECT service should continue, further clarification is required regarding the strategic direction of 'Closer to Home' in line with the development of localities.
- ALFY: The service is provided notice that funds supporting the current delivery model will cease at 31 March 2019. It was agreed that learning points from ALFY should be embedded within future contact point service models, however it is not recommended that provision continues as a stand alone service. Any future proposal for support should align with 'Closer to Home' and locality development and will be subject to the Partnership Funding Governance process.
- Night Nursing: Overnight provision was noted as critical in terms of end of life care and avoiding admission. It is recommended that the extension of service hours currently supported via ICF should move towards the additional funded capacity being mainstreamed. Work to explore this should be progressed.
- RAFC: Provision of appropriate care and support for frail patients is a key Partnership priority. However, evaluation of the RAFC highlights that a clinic based model only reaches a small proportion of the possible service user population. It is recommended that the clinic operates on a reduced basis and

that work is undertaken with Community Services to establish provision within community setting rather than acute hospital based, on a phased basis.

- ARBI: Recognising that ARBI is a strategic priority for the HSCP and Community Planning Partnership, it is proposed that funding is ring-fenced to work with this patient group. It is proposed that a view be taken from the Alcohol and Drugs Partnership regarding the evidence base for the proposed model and link with other agencies, prior to the funding being released.

4.6. Three further proposals were also considered by the PFG and SPG, for which all recommendations are included within Appendix 1. The Board are asked to approve funding to:

- An extension to Strathcarron's, 'Living Right Up to the End: Communities Supporting People with Advanced Long Term Conditions'.
- A new proposal from Falkirk Council to take forward Community Development work, on behalf of the HSCP.
- A proposals setting out the enhanced intermediate care service being delivered within Summerford House, including areas of development and changes to the integrated staffing structure supported by Partnership Funds (approved in March 2018, subject to proposals regarding delivery).

4.7. The Leadership Group, in conjunction with the Chair and Vice Chair, have recently approved funding to three initiatives from the Leadership Group Fund. Full details are provided within the Chief Finance Officer's report. Initiatives are:

- Set up costs for locality based Independence Clinics, including an extension to the current ADL Smartcare package, adding a Clinic module and linking with the existing self-assessment function
- Locality based Occupational Therapists to support the embedding of a reablement approach, which is described within 5.5. of this report
- Additional LIST Analyst capacity, to provide bespoke specialist support across the Partnership.

5. STRATEGIC COMMISSIONING UPDATE

5.1. The principles of Strategic Commissioning are incrementally being rolled out across the Partnership. This will ensure that all service delivery is based on a cycle of planning, embedded review and continuous service improvement. Engagement with partners, service users and wider communities is critical within this model. Figure 1, below provides an overview of the Commissioning Cycle.

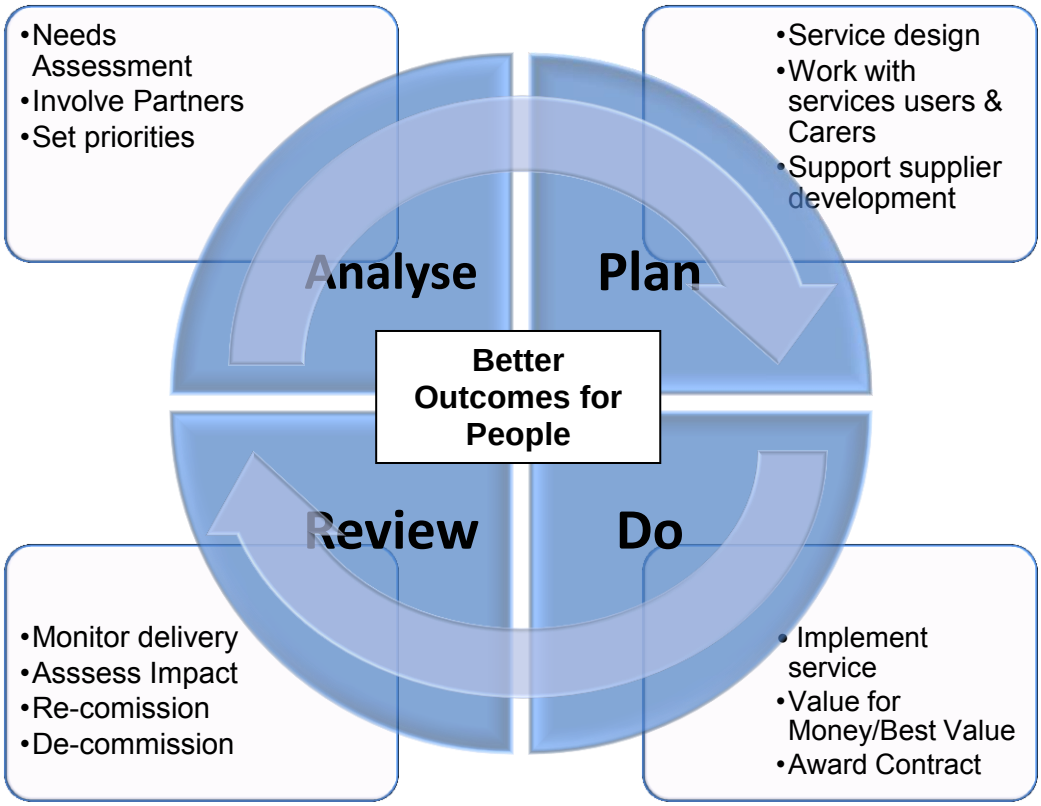

Figure 1: Commissioning Cycle

5.2. There are currently five key areas of focus relating to strategic commissioning. These areas are driven by high demand, legislation and most importantly, the desire to deliver better outcomes. The areas also align with the Partnership Funding Investment Plan. The local strategic commissioning process has been informed through a multi-agency Strategic Commissioning Steering Group and input from Third Sector Partners via an early engagement event in August 2017. The current areas of focus are:

- Community Based Mental Health
- Dementia Services
- Reablement Services
- Support for Carers
- Community Development and Link Work.

5.3. **Community Based Mental Health**

5.3.1. The commissioning work for community based mental health services is intended to ensure appropriate pathways are in place which will enable people experiencing mental health related illness to be supported within communities. The publication of the Scottish Government's Mental Health Strategy (2017-2027) in March 2017, the priority status allocated to Mental Health within local strategy such as the Community Planning Partnership's Single Outcome Agreement (SOLD) and the requirement for Integration Authorities to discharge duties in line with local,

regularly reviewed Strategic Plans, mean that the development of a commissioning plan specific to community based Mental Health Services is timely and critical.

5.3.2. A working group was established, including service leads from Social Work, Psychological, Psychiatric, Older People and Substance Misuse Services. Early meetings of the group focussed on a review of current commissioning arrangements, identifying areas of improvement in terms of process. An exercise was undertaken to gather information about existing service provision, including internal provision, service funded by the NHS Forth Valley and/or Falkirk Council and independent provision. The group has also reviewed interventions employed, the consistency of performance information and data available from services and communication across services as a network.

5.3.3. Links with GPs and other colleagues within Primary Care are in place and an engagement session was held on 30 August. A wider Mental Health and Wellbeing Strategic Commission Event was also held on 4 September. The purpose of both sessions was to offer partners who provide, or work with mental health services with an opportunity to be involved in planning future services. The output of both sessions is currently being reviewed and will be used to inform the commissioning plan. It is intended that service provision will be in place, aligned with an approved Mental Health Commissioning Plan by April 2019. The strategic resource includes Primary Care Transformation Funding and Partnership Funding, which augment core capacity.

5.4. **Dementia**

5.4.1. Although support for people with Dementia has been considered as part of the mental health commissioning process, there has also been specific commissioning work on service improvement. The Scottish Government published Scotland's third Dementia Strategy in June 2017. This strategy underlines the importance of timely, accessible and person-centred care for people with dementia to enable them to achieve their personal goals. The strategy estimates that by 2020 there will be approximately 20,000 new cases of dementia each year in Scotland.

5.4.2. During 2017/18, considerable work had taken place to develop and improve services. Key priorities and areas of improvement were identified via a multi-agency engagement event, including services users and carers. Through further analysis of performance information, mapping exercises and the engagement process, it was recognised that whilst current support for dementia is effective, service demand outweighs current provision and there is a need for improved joined up working between agencies.

5.4.3. Following approval from both Partnership areas, an enhanced, multi-agency dementia team, incorporating current Post Diagnostic Support (PDS), the Dementia Outreach Team (DOT) (which currently provides short term crisis support), dedicated Social Work capacity and supervision from a Consultant Psychiatrist, is currently being developed. The team is supported by Primary Care Transformation Funds and Partnership Funding, to augment core delivery capacity.

5.4.4. The co-located team will ensure that a resource is available to support the shared assessment process and information sharing, therefore improving support for people with dementia and their carers. The already improved governance structure, will enable delegated authority within the locality structures as well as strategic oversight. The enhanced team will be piloted from October 2018. The team will be based in Stirling Community Hospital and will operate on a Forth Valley wide basis. A strong link to localities will be maintained, via work with Community Care teams.

5.5. **Reablement**

5.5.1. The Reablement Leadership Group (RLG) continues to oversee the rollout of reablement services across the Falkirk area. Progress is based on the Reablement Pathway developed in 2017/2018 and approved by the Leadership Team. The work of the group links to the following areas:

- Delivery of the Discharge to Assess model via the Reablement Project Team
- Embedding a reablement ethos and services within localities
- Admission prevention: Closer to Home
- Step Up, Step Down: Intermediate Care
- Early Intervention and Prevention: Living Well Falkirk & Independence Clinics
- Promotion of reablement within communities
- Workforce Training and Support across the Partnership

5.5.2. Future development work will focus on the testing and implementation of Independence Clinics. With improvements now in place within statutory provision, we are also now well positioned to progress commissioning work with external organisations. This work will focus on enhanced supports within communities to promote independence and reduce loneliness and isolation. This work aligns with the Partnership Funding Investment Plan.

5.5.3. The RLG reports to the Leadership Group. A significant component of the roll out of reablement across the Partnership is supported by Partnership Funds to help facilitate service redesign and also to support early delivery. It is anticipated that demonstration of improved outcomes and cost efficiencies as a result of earlier intervention will support longer term sustainability.

5.6. **Support for Carers**

5.6.1. Similar to the process undertaken by the Mental Health group, the Carers Strategic Commissioning Group initially gathered information about existing provision for carers as well as national and local data about service need and demand. This information has formed an important baseline against which to assess the impact of the implementation of the Carers Act (Scotland), which came into force on 1 April 2018.

5.6.2. In December 2017, the IJB agreed that support for Carers would continue during 2018/2019 at the same level and form as that provided in 2017/2018. This was to enable a robust commissioning process to be established, aligned with the complexity of requirements from the Act. This includes eligibility criteria, the waiving of fees and appropriate provision to meet the needs arising from the Adult Carer

Support Plans and (suggest insert recognised titles for these plans) carers plans developed by adults, young people and children.

5.7. **Community Development and Link Work**

5.7.1. The implementation of the new GMS contract for GPs requires the development and delivery of local Primary Care Improvement Plans (PCIP). As part their PCIP, Integration Authorities require to assess local need and develop link worker roles in every area. This is in line with the Scottish Government's manifesto commitment to deliver 250 link workers over the life of the Parliament.

5.7.2. A Community Link Worker (CLW) is a generalist social practitioner, generally based in a GP practice serving a socio-economically deprived community, addressing the problems and issues that the individual brings to the consultation, rather than a worker whose domain is limited to a specified range of conditions or illnesses, or one who is based elsewhere within health, social care or other services.

5.7.3. They offer non clinical support to patients, enabling them to set goals and overcome barriers, in order that they can take greater control of their health and well-being. Using 'good conversations' a CLW supports patients to identify problems and issues they are experiencing and to talk about what really matters to them. They support patients to achieve their goals by enabling them to identify and access relevant resources or services in their community. A CLW also maps local services, engaging with and developing productive relationships with these services including keeping informed of the status of existing and new services.

5.7.4. The Forth Valley Primary Care Improvement Plan Commits to "Generate a Link Worker development plan with Third sector colleagues, taking direction from national guidance, anticipating the initiation of link worker model with at least 5 practices in our most deprived areas by start of year 3". £318,000 of funding has been committed for 8.5 link worker posts across Forth Valley in year 3 (2020/21). No detail of how this service will be delivered has been proposed or agreed at this time.

5.7.5. Falkirk HSCP hosted an initial discussion around CLW in Falkirk on 7 August. This brought together a range of practitioners from health and social care, including Third Sector and Community Planning Partners. A national perspective was provided from a representative of ScotPHN on different CLW models throughout the country including learnings, themes, critical success factors and commonality among all programmes. Local learning was presented by FDAMH regarding the Social Prescribing Service currently being delivered in Falkirk.

5.7.6. The group considered potential ways of identify issues most prevalent to Falkirk in order to identify need. It was agreed that there is a wealth of information available to the HSCP and that consultation with communities was crucial, as well as using data we currently have from participation events.

5.7.7. It was noted that there is considerable potential in further development of the Community Link Work model. The success of the model will be reliant on robust

capacity within communities and Third Sector agencies to support people within their own locality. The group also agreed that the rollout of the model would require careful planning within the context of a wider community development and locality planning strategy. Work is currently being taken forward and will be reported to the IJB in due course.

6. CONCLUSIONS

6.1. This report provides IJB members with recommendations arising from additional information requests issued to five Forth Valley wide initiatives, one request for extension, one request for additional information and one new proposal. Recommendations have been scrutinised by the PFG, and endorsed by the SPG. Approval is requested as detailed within Appendix 1. Proposals align with the Partnership Funding Investment Plan 2018 – 2021 and are subject to ongoing monitoring and evaluation.

6.2. Work is being progressed to embed a strategic commissioning approach across five areas of provision. This will ensure that all service delivery is based on a cycle of planning, embedded review and continuous service improvement. Engagement with partners, service users and wider communities is critical within this model. Strategic commissioning work will continue to be developed along with the review and revision of the Partnership's Strategic Plan.

Resource Implications
There are no additional resource implications over and above those reported within the body of the report. Recommendations are made within the limitations of the current Partnership Funding programme.

Impact on IJB Outcomes and Priorities
Partnership investment aligns and contributes directly towards local outcomes. The adoption of a strategic commissioning approach to working with Third Sector organisations will further support the delivery of IJB outcomes, in the medium to long-term.

Legal & Risk Implications
No legal issues have been identified.

Where a recommendation is being made that will result in service change and therefore impact of services users, their carers or the wider community, a disinvestment impact assessment will be undertaken. Periods of notice and transition will be provided to ensure adequate time is provided to take any mitigating action required.

Consultation
Individual initiatives are required to consult and engage with stakeholders during the development and implementation of all services. This forms a condition of award for partnership funding.

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

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Approved for submission by: Patricia Cassidy, Chief Officer

Author – Lesley MacArthur, Partnership Funding Co-ordinator
Date: 20 September 2018

List of Background Papers:

IJB Papers regarding Partnership Funding
Partnership Funding Group minute and scoring matrix
Strategic Planning Group minute

Appendix 1

Integration Joint Board: Partnership Funding Proposal Summaries and Recommendations

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	Additional Information or IJB Condition of Funding: Exert from Award Letter April 2018	Recommendation
CLOSER TO HOME				
NHS Forth Valley Enhanced Community Team (ECT)	1 April 2018 – 31 March 2019 Funding information not provided (April 18 allocation: Falkirk £268,947, FV £537,848	The *Closer to Home* model sits as part of a broader portfolio of community health within Forth Valley. It provides care and support 24 hours a day, 7 days a week to enable people to remain at home whenever possible through the provision of timely care and support. ECT has been funded since December 2015. The team of 7 is based in Stirling and operates across Forth Valley. In 17/18 there were 504, of which 170 (34%) were from Falkirk. This proportion of admissions between areas has been consistent, however Q1 of 18/19 was balanced with 82 admissions from Falkirk and 88 from Clackmannanshire and Stirling.	Condition of funding April 18: '*Funding is based on ECT allocations during 2017/2018 and is subject to receipt of a revised proposal as described below. Review and redesign of ECT model of delivery and receipt of a fully costed proposal for ECT, including the request for additional Health Care Assistants, by no later than 31 July 2018. This should include:* • *Skill mix, structure and capacity of the ECT team* • *Description of the added value of additional HCAs* • *Confirmation of the split of funding requested from each Partnership, given the disparity of activity in the two areas over the previous 12 months* • *Confirmation of the linkages and interfaces with the wider system, including Social Care, Overnight services, GPs, Frailty pathway, Model of Neighbourhood care, ALFY; and how this contributes towards prevention of admission and avoiding delays in*	The 'Closer to Home' model is terms of providing support at home or in a community remains a key Partnership priority. The proposal received outlines the ECT service, aligned to the development of a Forth Valley Community Front Door model. Whilst acknowledging that the service should continue, further clarification and information is required: 1. Confirmation that the Forth Valley Community Front Door model has been approved by the Falkirk Partnership, in terms of fit with localities and future direction of provision. 2. It is proposed that the CFD Delivery Group provide a business case setting out aims and functions of CFD, to both Partnership Leadership Groups. Recommendations will then be made to the IJBs to provide direction to the Councils and NHS Board as appropriate. 3. Financial analysis is undertaken regarding the current funding split between partnerships, compared to activity based funding. Activity based funding to be

			discharge • *Confirmation of how the service will operate within locality structures* *<u>NB:</u> Interim funding arrangements will continue in order to cover the cost of bank HCAs until such time as a fully costed proposal is submitted and appraised.'*	considered from 1 April 2019.
NHS Forth Valley ALFY	1 April 2018 – 31 March 2019 £90,060 (Falkirk) £188,558 (FV)	The Advice Line For You (ALFY) is part of the Closer to Home model . ALFY is a 24 hour, 7 day per week telephone advice and support line which is operated by qualified nursing staff (daytime hours by ALFY team and OOHs taken by Night Nursing Team). ALFY receives calls and also makes follow-up call to people discharged from FVR. During 17/18, there were 1470 calls to and from ALFY in the Falkirk area. Calls into ALFY were 516, this equates to approx.43 calls per month or 9 calls per week. ALFY has been in place since 2015, and was redesigned in 2016/17 due low demand as an advice line. The redesign included ALFY handling District Nursing calls for 2 practices, which has been effective in releasing DN time.	Condition of funding April 18: '*Ongoing review and provision of the following information, by no later than 31 July 2018:* • *The outcome, recommendations and actions arising from the single point of contact pilot.* • *The delivery model and any proposed revision e.g. links with Dementia Team, expansion of single point of contact.* *Detail regarding links with the Enhanced Health Team.'*	Service is provided notice that funds will cease at 31 March 2019. It was agreed that there were learning points to be taken from ALFY that should be embedded within future contact point service models, however it is not recommended that provision continues as a stand alone service. Although the few people who have received a service from ALFY have shown positive outcomes, demand has remained very low, with an average of 9 incoming calls per week, despite additional promotion of the service. This has been a consistent picture of usage since the service was funded in 2015. There have been 2 redesigns of the service however there has been no significant increase in usage or evidence of impact on the whole system. The level of investment aligned to work activity was considered to be unjustifiable and not in line with best value. Evaluation information does not evidence that the impact of discharge follow up calls as being a good use of the resource.

				The information provided did not provide clarity about the contribution made to the Closer to Home model. It has not been possible to rollout tests of change regarding District Nurse Calls or ECT calls with current resource. Alternative tests are being progressed by ECT. A proposal could be considered to support future delivery. This would be subject to the PF governance process.
NHS Forth Valley Night Nursing	1 April 2018 – 31 March 2019 £75,909 (Falkirk) £149,912 (FV)	The Night Nursing Service is a community nursing service covering NHS FV from the hours of 1630 to 0800hrs 7 nights per week. The service is intended to provide overnight care to ECT patients, however also supports palliative care patients. Work is also ongoing with SAS to support uninjured fallers. Performance information has only recently been provided in it's current form, however during Q1, 29 patients received support.	Condition of funding April 18: '*Ongoing quarterly monitoring, working with officers to strengthen performance measures.* *Clarity regarding the contribution of Night Nursing in relation to the Enhanced Care Team, within the Closer to Home model.* *Review of Night Nursing alongside social care overnight services* *Information must be provided by 31 July 2018.'*	Overnight provision was noted as critical in terms of end of life care and avoiding admission. The extension of service hours currently supported via ICF should move towards being mainstreamed. The proposal received outlines the Night Nursing service, aligned to the development of a Forth Valley Community Front Door model. Whilst acknowledging that the service should continue, further clarification and information is required: 1. Confirmation that the Forth Valley Community Front Door model has been approved by the Falkirk Partnership, in terms of fit with localities and future direction of provision. 2. Clarity is provided regarding provision of care for ETC and palliative care patients. 3. Phased approach to mainstreaming additional capacity funded.
NHS Forth Valley	1 April 2018 – 31 March 2019	The Rapid Access Frailty Clinic (RAFC) was established to provide a comprehensive geriatric assessment for patients who have	Condition of funding April 18: '*Satisfactory provision and approval of information including:*	Provision of appropriate care and support for frail patients is a key Partnership priority. However, evaluation of the RAFC highlights that

Rapid Access Frailty Clinic (RAFC)	£TBC – not exceeding current allocation £152,201	had a decline in function with the aim to prevent avoidable hospital admission which can often become lengthy. After several years of operation and attempts at promoting the service it was realised that a traditional clinic approach did not reach all those who would benefit. During 2017/18, there were an average of 36 patients per month, of which 30% were returners. This equates to 8 patients a week, of which an average of 5 were new referrals.	• *The revised delivery model, including alignment with the Frailty Collaborative.* • *Links with community based services including Enhanced Health Team.* *Financial breakdown of total costs (noting any expenditure over the approval figure will be borne by NHS Forth Valley).'*	a clinic based model only reaches a small proportion of the possible service user population. 1. Fund RAFC on 3 day per week basis. 2. Request further information regarding provision at the front door being a model supporting a wider range of people. 3. Develop service to be 'community facing' and in line with Closer to Home model 4. Service works with Community Services to establish provision within community setting rather than acute hospital based, on a phased basis.
NHS Forth Valley Alcohol Related Brain Injury (ARBI) Case Management	1 April 2018 – 31 March 2019 £75,000 (Falkirk) £150,000 (FV)	Proposal for dedicated area wide ARBI service. The ARBI service will target a particular group of people who are difficult to reach and engage. Many of this population never reach locality Substance Misuse services other than for a possible alcohol detoxification. More often than not individuals with an ARBI diagnosis present often in crisis to A & E and with significant physical health issues as a result of prolonged alcohol use. The pilot year identified the need to provide a comprehensive assessment that includes a social care assessment to provide clinical input around mental health, capacity and physical care as well as assessment and support in relation to finances, housing and functioning to remain safe at home and reduce impact on hospital bed days and A & E visits.	Condition of funding April 18: *'The structure of the service is reviewed and an options appraisal regarding models of provision is provided by 31 July 2018. The model of delivery should include service provision that is broader than a health based response and should demonstrate joint working with Partners.'*	Recognising that ARBI is a strategic priority for the HSCP and Community Planning Partnership, it is proposed that funding is ring-fenced to work with this patient group. No options appraisal was provided regarding models of provision. It is therefore proposed that a view be taken from the Alcohol and Drugs Partnership regarding the evidence base for the proposed model, prior to the funding being awarded.
Strathcarron	1 October 2018 –	Proposal to continue and increase the number and further develop the skills of	Funding is currently due to end on 30 September 2018.	Approve ongoing Funding

Living Right Up to the End: Compassionate Neighbours	30September 2020 18/19: £22,471 19/20: £46,200 20/21: £23,747	community volunteers to support people living with long term conditions (LTC) and their carers in Falkirk West and Falkirk Central, right up to the end of life. Volunteers will: 1. Provide social, emotional and practical support to individuals and carers in a bespoke way, chosen by the person from a range of options. 2. Provide carers with an opportunity to have a short break from their caring responsibilities 3. Enable people with LTC and their carers to find and choose local assets that help them live well. 4. Build the confidence of individuals and their carers to connect with and actively participate in local opportunities. 5. Facilitate open conversations with those they support and help individuals with LTCs and their carers to be active participants in planning ahead for the latter stages of their lives, linked with ACP.	Performance from start of project in October 17 – June 18, has been good, 23 volunteers have been trained, with 29 carers receiving 820 hours of support and 46 services users receiving 1440 hours of support. Good support demonstrated for families and carers, good partnership working with other agencies to upskill staff to be able to work with EOL patients.	Condition: • Submission of ongoing quarterly monitoring information • Confirmation that support for carers includes a broader range of activity than provision of respite • Continue to demonstrate links with Anticipatory Care Planning process
Falkirk Council Stronger Communities: Community Development	1/11/18-31/03/21 18/19 £9,885 19/20 £43,687 20/21 £44,147	Partnership Funding is requested to match fund 0.5FTE Community Development resource, which will enable recruitment of 1FTE member of staff to support HSCP Community Development Work. In addition, a small resource is also requested to be used as a development fund to help initiate and support community led activity. This will be progressed using a Participatory Budgeting framework. The post holder would provide the HSCP with	Proposal closely aligns with Strategic Plan priorities regarding service provision within localities and developing capacity within communities.	Approve funding in principle and request further information. The group noted the importance of community based development, however noted that to progress work at scale and pace, further consideration should be given to the delivery model and total resource requirements. The level of investment should be reviewed and potentially increased to enable the progress of this work across all locality areas.

		expertise and capacity to be able to: • Engage in locality planning work, which is being progressed by the Community Planning Partnership (CPP) • Inform and participate in HSCP Locality Planning, from a communities perspective • Initiate community development work within West Locality, building on existing outputs from community engagement and data gathered. • Make connections in the East Locality, especially in the Community Action Planning Area of Grangemouth		In addition, clarification is required regarding the scope of the role/s as it is noted that there is a need for two different skill sets re strategy/planning and operational community work. This should be taken forward collaboratively between all relevant partners, with further information to presented to the IJB in December 2018.
Falkirk Council Summerford Intermediate Care	1/04/2018-31/03/2021	Partnership Funds will allow ongoing employment of 3 Social Care Officer and the recruitment of 3 Rehab Carers. Following recent refurbishment, capacity has been increased from the initial 5 beds to 10 beds and now up to 20 placements for intermediate care. Placements support people who have experienced a delay in their discharge and also to prevent unnecessary hospital admission. The Step up aspect of the service will be further developed over this funding period. To help support better, more person centred outcomes for individuals we will: • Trial a change to our staffing model. • Upskill existing and new staff in the reablement ethos. • Further develop our partnerships to be working in a fully integrated way. • Work with Reach to further support the	Funding was approved by the IJB in April 2018, with condition that a full proposal be provided setting out how the enhanced service will be delivered in an integrated way.	The PFG was satisfied with the information provided and recommend that funding continues in line with that proposed within the investment plan, at a maximum of: 18/19: £172,622 19/20: £176,074 20/21: £179,596 Funding is subjected to ongoing monitoring and alignment with further review of intermediate care provision within Falkirk.

		development of the service and increase of bed numbers. • Through multi disciplinary work and dynamic discharge process, individuals are discharged when they have reached their base level of functioning without unnecessary delay. • Support individuals to move on to an interim placement when it becomes clear that it would be unsafe or inappropriate for them to be discharged home with a package of care.		