Agenda Item
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Agenda Item: 8

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Partnership Funding Report**
Meeting:	**Integration Joint Board**
Date:	**6 September 2019**
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:

- an overview of recommendations made by the Partnership Funding Group (PFG) and Strategic Planning Group (SPG)
- a proposed spending strategy for the Dementia Innovation Fund; and
- an update on the implementation of strategic commissioning and proposed Partnership principles.

2. RECOMMENDATION

The IJB is asked to:

2.1. approve recommendations relating to applications for Partnership Funding, set out within Appendix 1

2.2. approve recommendations arising from the review of initiatives currently supported by Partnership Funds, within Appendix 2

2.3. note that a review of Partnership Funding governance, including the role of the PFG has been progressed and the outcome will be presented at a future IJB

2.4. approve the spending strategy and governance arrangements for the Dementia Innovation Fund, set out within section 5 and Appendix 3

2.5. note progress regarding strategic commissioning in section 6, in line with the implementation of the integrated structure and localities

3. FUNDING PROPOSALS

3.1. The PFG considered 3 proposals for Partnership Funds on 31 July 2019. Recommendations made by the PFG were endorsed by the SPG on 9 August 2019. Details of the applications and funding recommendations are detailed within Appendix 1 and are summarised below:

Proposal	Recommendation
Falkirk Community Trust	Delay decision
Tackling Inequalities & Improving Outcomes	Defer
Refurbishment of Denny YMCA	Approve with conditions

3.2. An overview of the Partnership Funding financial position is provided within the Chief Finance Officer's report. All recommendations relating to new proposals are affordable within the overall resource available and are in line with priorities of the Strategic Plan 2019/2022.

3.3. The Board is asked to approve the three proposals at 3.1.

4. REVIEW OF CURRENT INITIATIVES

4.1. Between 29 May 2019 and 24 June 2019, a series of PFG assessment sessions have been held with initiative leads. Leads were invited to present information about project progress against outcomes and transformational change achieved during the funded period. The sessions were to enable an opportunity for peer review, consideration of further opportunities for collaboration, and to identify any duplication and areas of improvement.

4.2. As part of the assessment process, the recommendations were presented and endorsed by the SPG on the 9 August 2019. Recommendations are presented within Appendix 2 and are summarised below:

Initiative	Recommendation
Closer to Home: ECT (FV)	* Review structure to align with localities
Closer to Home: Night Nursing (FV)	* Review all overnight provision
Overnight MECS	* Review all overnight provision
Technology Enabled Care	* Review in line with development of TEC strategy
Summerford	Continue
Rapid Access Frailty Clinic (FV)	* Proposal required re revised model
Discharge Hub (FV)	Progress appraisal to refocus investment to deliver the Home First vision
Enhanced Discharge FCT	Progress appraisal to refocus investment to deliver the Home First vision

Initiative	Recommendation
AHP Capacity	* Assess capacity requirements
FDAMH Services	Develop single monitoring framework
Mental Health & Wellbeing in Forth Valley College	Confirm funding ends 30/06/20
Post Diagnostic Support & Community Connections	Monitor impact on PDS within FV service
Living Right to the End	Continue
Support for Carers	Review total package of funding
Pharmacy	* Amend positioning of pilot from FCT
Alcohol Related Brain Injury (FV)	* Review with Clacks/Stirling on submission of a full progress report
Social Inclusion Project	Continue

4.3. Recommendations marked with an asterisk (*) in the above table indicate that further information or a review has been requested by 30 October 2019. Details of the information requested for each initiative is provided within Appendix 2. In the event that further information is not provided by this date and/or where any earlier requests for information have been outstanding for longer than 6 months, this will be escalated to the Chief Officer. Progress will be reported to a future IJB.

4.4. The Board is asked to approve the review recommendations set out at 4.2.

4.5. The Partnership Funding report presented to the IJB in April 2019, noted that recommendations regarding a review of the Partnership Funding governance process and role of the PFG would be provided in September 2019. Due to the complexity and time commitment required to undertake the PFG assessment session, the review has been progressed, but not finalised. Recommendations arising from the conclusion of this work will be presented at a future IJB.

5. DEMENTIA INNOVATION FUND

5.1. In 2017, the Scottish Government launched Scotland's National Dementia Strategy 2017 - 2020. The vision is of:

'A Scotland where people with dementia and those who care for them have access to timely, skilled and well-coordinated support from diagnosis to end of life which helps achieve the outcomes that matter to them'.

5.2. This is Scotland's third National Dementia Strategy. It builds on progress over the last ten years in transforming services and improving outcomes for people with dementia, their families and carers. Setting out 21 new commitments, the strategy provides a framework for further action to ensure the realisation of the shared vision. Representatives from both IJB Partnership areas have been working together to develop a local Dementia Strategy.

5.3. During 2018/ 2019, work progressed to develop an integrated dementia team, supporting Forth Valley. This resource includes the NHS Dementia Outreach Team (DOT), Alzheimer Scotland Post Diagnostic Support (PDS) and Adult Social Work support, which is aligned to each Partnership area. The team are now co-located in Airth surgery. With the stability and service infrastructure that the integrated team will provide to formal provision, the Partnership is now well placed to identify and evidence how best to allocate resource within localities.

5.4. In April 2019, Falkirk IJB approved that partners, services users, their carers and families work together to co-produce a community based dementia model and funding strategy. This work sits within the context of the development of the local Dementia Strategy and has been led by a Falkirk focussed Dementia Innovation Fund Group. It was also noted that the spending strategy would align with the review of day services.

5.5. Clackmannanshire & Stirling Partnership has also undertaken local area development work. Their key focus is to establish and promote a Dementia Friendly Stirling. A non-recurring challenge fund will also be made available to support activities.

5.6. Although the local Dementia Strategy is still under development, clear themes and areas of focus have been identified. The Dementia Innovation Fund Group has considered the themes in the context of the service need and perceived gaps within the Falkirk area. The group recommend that resources are allocated against 4 themes, which have been presented to and endorsed by the HSCP Leadership Group and SPG. The themes are:

1. Community Assets

People living with dementia should have the opportunity to live well and maintain a role in the community. To achieve this, it is important that community contacts are developed and maintained. This may take many forms and include projects which support neighbourhood efforts to maximise accessibility, provide refreshments at lunch groups or meetings, or support local excursions or interest groups.

2. Technology Enabled Care (TEC)

Preventing unnecessary hospital admission, maintaining people at home and supporting carers, can be assisted with the effective use of technology across health and social care services. The fund provides an opportunity to explore and test TEC solutions to support people at home and to inform larger scale roll-out or purchases on behalf of the

Partnership. The fund could also be used to test innovative solutions and concepts in specific areas of challenge, for example, respite care or housing.

3. Education and Awareness Raising

It is known and understood by professionals working in the field that early detection and intervention improves outcomes for people with dementia. However in Falkirk, around 50% of people receiving a diagnosis are coming forward at a much later stage in their illness. Education and awareness raising would help tackle this by supporting people to identify symptoms and signs at an earlier stage.

Similarly with a growing population of people with dementia, people working in a variety of roles in, for example, local government are becoming increasingly likely to encounter people with dementia who have unique needs. Education and awareness raising for staff involved in town planning, decision making at strategic levels and those with a public facing role would position Falkirk to make the town a Dementia-Friendly place to live and work, whilst reducing the challenges that people with dementia and their families face.

4. Respite

Carer support is essential and many carers express the need to have access to breaks from their caring role. Traditionally respite has been considered as people with an illness going to stay in a specified location where care is provided. However, this does not meet the needs of everyone and leaves a number of carers, for whom this doesn't suit, without support for breaks. The fund provides the opportunity for testing innovative and varied methods of providing respite.

5.7. The following table provides an indicative apportionment of £200k of the £300k funds for each theme and also a brief summary of proposed areas of investment and decision making. It should be noted that the allocation per theme is indicative to enable effective financial management and monitoring. Actual allocations may change during the course of the programme. The balance of the funds will be allocated in line with the finalised local dementia strategy and to extend successful pilots. This will be based on evaluation of outcomes achieved per theme.

Theme	Indicative Allocation	Investment Summary	Governance
Community Assets	£50,000	Innovation Fund to support small scale community activity	Small Grants Programme with Terms & Conditions, reported collectively to Leadership Group
TEC	£90,000	Pilot 'Just Roaming' within a Glenbrae supported housing	Leadership Group approval in line with spending strategy

Theme	Indicative Allocation	Investment Summary	Governance
		and establish tests of change for introduction of further TEC	
Education/ Awareness Raising	£20,000	Additional 17.5 hours Dementia Advisor, Alzheimer Scotland	Leadership Group approval in line with spending strategy
Respite	£40,000	Provision of flexible, ad-hoc respite opportunities accessible by both people with dementia and their carers – either together or alone. Test befriending model	Leadership Group approval in line with spending strategy

5.8. Further information regarding the proposed allocation against each theme is provided within Appendix 3 of this report.

5.9. In relation to governance, it is proposed that following IJB agreement of the spending plan, the IJB delegate authority to the Leadership Group to approve funding aligned to the proposed themes.

5.10. With regard to the governance and monitoring of awards made via the small grants scheme, as any single payment will be less than £5,000, the terms and conditions in place for Falkirk Council's community grant scheme will be adopted. This includes a requirement for applicants to sign a funding declaration at the point of application and to submit an end of award report. The procurement team have confirmed Contract Standing Orders would not apply to this type of fund and therefore the proposed framework is appropriate. The impact of the overall grants programme will be reported collectively.

5.11. In relation to financial and performance monitoring, it is proposed that the Dementia Innovation Fund Group continue to have operational responsibility for the fund. Monitoring information will be provided to the Leadership Group on a 6 monthly basis and performance to the IJB will be reported by exception or by request. The SPG will also be provided regular updates.

5.12. The Dementia Innovation Fund Group is in the process of developing an evaluation framework for each investment theme.

6. STRATEGIC COMMISSIONING UPDATE

6.1. In April 2017, the IJB agreed that the Partnership would develop and embed a strategic commissioning approach across services. Strategic commissioning is the main process for understanding, planning and delivering better health and wellbeing outcomes. Although, strategic commissioning is embodied in legislation and public policy, it is nationally recognised that the process can be challenging and that a substantial amount of work is needed to deliver this process effectively. The approach must also be agile and responsive to the implementation of the local integrated structure and development of locality based provision.

6.2. Well planned strategic commissioning offers the opportunity to increase the value and financial sustainability of care by making the most effective use of available resources and the most efficient and consistent delivery. This ensures that the balance of resource is spent where it achieves the most, and focuses on prevention and early intervention. The process is a continual cycle, as opposed to a single means to and end.

6.3. The Strategic Plan 2019 - 2022 provides a framework of priorities and outcomes, which are underpinned by the Strategic Needs Assessment. This in turn, provides a basis for local strategic commissioning. During 2018 - 2019, a range of work has been progressed incrementally, by theme. Key areas of focus to date have been:

- Support for Unpaid Carers
- Mental Health
- Dementia
- Day services
- Partnership Funding.

6.4. In order to apply strategic commissioning to the key areas highlighted above, multi-agency working groups have been formed, for each theme. These groups have ensured an appropriate skill mix and expertise is available for each area of work. With the introduction of the integrated structure and development of localities, the groups and reporting structure now requires review and to be refocused.

6.5. The accumulation of learning from early work is informing the development of commissioning principles. The intention is that these principles will be used to underpin future work and to inform the terms of reference of any future thematic commissioning. Proposed principles will be presented to the IJB on completion.

6.6. To date, the strategic commissioning approach has largely been applied to establishing internal services and provision via external providers within the Third Sector. Work is being progressed to ensure a more strategic and outcomes focused approach is adopted with Independent Sector providers.

For example, the Board will recall previous reports to the IJB regarding the Care at Home tender, which embraced a strategic commissioning approach. The Market Facilitation Plan, which is currently being refreshed, will provide clarity about Partnership's approach going forward.

7. CONCLUSION

7.1. This report provides the IJB with recommendations made by the PFG and SPG regarding Partnership Funding, as set out within Appendix 1. Recommendations arising from the review of current initiatives are provided within Appendix 2.

7.2. The Dementia Innovation Fund Group, which includes representatives from health, social work and third sector have collectively developed a funding strategy which describes the proposed allocation of the £300k fund. The fund will be used to support activities within four themes, which support the vision of the national Dementia Strategy and the development of the local Dementia Strategy. Details are provided within Appendix 3.

7.3. Strategic commissioning continues to be incrementally implemented across services. Approaches have been developed to be agile in terms of the introduction of the integrated structure and development of localities. Existing thematic groups and reporting structures now require revision. Commissioning principles are currently being developed and will be presented to the IJB in due course.

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.

The value of the Dementia Innovation Fund is £300k. For all investment, appraisal will be undertaken to understand future sustainability in terms of potential ongoing cost and also costs avoided as a result of adopting new practice.

The Dementia Innovation Fund Group will continue to meet and co-ordinate the monitoring of the fund.

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

The Dementia Innovation Fund spending plan aligns with strategic priority and outcomes, in particular Self- Management, Experience and Stronger Resilient Communities.

Legal & Risk Implications
Where a recommendation is being made that will result in service change and therefore impact of service 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.

The development of the funding strategy has been progressed through a consultative process, which has included representatives from health, local authority and third sector.

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: 27 August 2019

Appendix 1

Strategic Planning Group and Partnership Funding Group Project Summary and Recommendations

Project Name & Lead Agency	Amount and Term Requested	Project Summary	Strategic Alignment	Recommendation	Justification/Condition
RESUBMISSION Tackling Inequalities & Improving Outcomes (TIIO) Criminal Justice/ Signpost	19/20 £108,336 & 20/21 £132,174	The Tackling Inequalities & Improving Outcomes Project aims to reduce health inequalities and improve the health and wellbeing of people in the criminal justice system by identifying and addressing the health-related factors that impede their access to, and ability to engage in, volunteering, training, further learning and employment. Many people in contact with our criminal justice services have multiple barriers to accessing and participating in employment. The barriers include poor physical health, mental health issues, substance misuse and poor access to health services appropriate to their needs. Almost every health problem, social issue and economic disadvantage is over-represented in the people who make up the criminal justice cohort. This Project aims to positively target those with a history of offending to afford them an opportunity for support. The Project will actively work with them in order to address the identified health inequalities and therefore improve their health and wellbeing outcomes. Funding is requested to continue a 1 year pilot funded by Scottish Govt. for a Co-ordinator, Admin & 2 Health Care Assistants. This is a contribution towards TIIO, which also includes Keep Well Nursing resource, funded by Criminal Justice. Project intended to support 120 people in 19/20 and 150 in 20/21.	Aligns with Health Inequalities priority within HSCP Strategic Plan 2019-2022.	Defer	Further information is not yet available in response to previous recommendation: *'Whilst the PFG acknowledged that there is a need to support this client group, it is recommended that decision regarding supporting this model is deferred until September '19 to include consideration of:* • *The outcome of the ADP service review.* • *Distribution of Action 15 funds, which may include a CPN within Community Justice.'* No further recommendation was made.
Denny YMCA YMCA	19/20 £25,000	Request for £25k towards £73k total capital costs. Denny YMCA own a community hall within Bridge Crescent, Denny. Denny YMCA intends to refurbish the local hall to provide a range of community based projects	Aligns with Localities and Health Inequalities priority within HSCP Strategic Plan 2019-2022, SOLD Plan and	Approve	Approve subject to completion of Committee becoming incorporated.

Project Name & Lead Agency	Amount and Term Requested	Project Summary	Strategic Alignment	Recommendation	Justification/Condition
		within an area of high levels of multiple deprivation. The Hall will provide a community led base for: • Dignified approach to food insecurity • Opportunities to combat social isolation and loneliness, • Digital inclusion • Interest groups, including informal Day Care The various projects located within the hall will also create volunteering opportunities for local people and communities of interest. The building can also provide a base for the Community Led Support initiative within Denny, and provide an additional resource for HSCP CLD workers. The HSCP CLD worker will work alongside the local community to co investigate community infrastructure in terms of assets. This work will contribute to reducing health and wider social inequalities. The hall will provide a community resource for this to progress going forward. It will also provide a community resource for non statutory services to access either for service delivery or to facilitate community events.	Fairer Falkirk Strategy.		This request is for a capital investment of £25k towards building renovation costs of £73k. Until now Partnership Funds have been used for revenue costs only. The building is owned by the YMCA and run by a volunteer committee. The committee are currently being supported by CLD and Corporate Policy Officer to redesign the current offer. The vision is to develop a community hub, led and run by community. Key driver for committee is improved health and wellbeing outcomes through sustainable community led provision. The committee is part of a consortium of 9 local organisations, who are working together to provide a co-ordinated response. The PFG were clear that the purpose of this investment is to achieve longterm health and wellbeing outcomes, as opposed to just investment in a building.

Appendix 1

Project Name & Lead Agency	Amount and Term Requested	Project Summary	Strategic Alignment	Recommendation	Justification/Condition
Physical Activity in Care Homes Falkirk Community Trust	19/20 £17,650 & 20/21 £31,650	Falkirk Community Trust would like to bring physical activity into the community and specifically care homes, within the Falkirk area. There are clubs and facilities to support the local community be physically active however at present customers have to come into our facilities. FCT would like to bring physical activity into care homes to both patients and employees. Evidence based exercise practice will improve the strength & balance of care home residents, involving OTAGO exercises, chair Yoga and coordination activities. Care home staff can be involved with the patient's activities and can even be trained by our teams, to take these going forward. To support care home employees overall health and well-being, we can offer any of the following: mini health checks, Blood pressure, body fat, awareness sessions and discounted corporate membership, into FCT clubs.		Postpone decision	The PFG acknowledged that there is currently a nationally supported initiative to create a sustainable change in culture and practice within care homes to enable staff to consider their own health and wellbeing, as well as residents. CAPA is supported by the Care Inspectorate and is available to all care homes in the Falkirk area for a further 10 months. The PFG would like to revisit the proposal once clear about the outcome of the evaluation of CAPA in the Falkirk area, proposing a more light touch model whereby a support might be formed for care homes around regular check-ins and on-going support re CAPA implementation. The group also highlighted that they would like to focus funds towards prevention and earlier intervention i.e. people who are experiencing decline but have significant reablement potential through activity etc. They would

Appendix 1

Project Name & Lead Agency	Amount and Term Requested	Project Summary	Strategic Alignment	Recommendation	Justification/Condition
					welcome proposals that broadened access to FCT services thereby having a more broad ranging positive impact on a greater number of people. Particularly older and younger people who have not previously participated.

Falkirk
Health and Social Care
Partnership

Partnership Funding

Review Sessions Report

Lesley MacArthur Partnership Funding Coordinator

23 July 2019

Partnership Funding Review Sessions 2019

1. Introduction

1.1. Falkirk HSCP operate a Partnership Funding programme providing a critical opportunity for partners to establish, transform and deliver integrated services, in line with local priorities and also to test and drive innovation. The fund draws together 2 previously ringfenced allocations from the Scottish Government; Integrated Care Fund and Delayed Discharge Fund. During 2018/19, the programme has been reviewed to ensure that the structure and allocation of Partnership Funds is agile and able to support both transformation and emerging improvement need within the Partnership.

1.2. Partnership Funding is grouped into two strands; the main programme and the Leadership Fund. During 2018/19, £5.51m has been available through the main programme and a further £1.6m via the Leadership Fund. The Partnership Funding Group, which is a sub-group of the Strategic Planning Group, make recommendations to the IJB regarding allocation of funds from the main programme. Leadership Funding is allocated by the Falkirk HSCP Leadership Team, with approval via the Chief Officer in consultation with the Chair and Vice Chair of the IJB.

2. Background

2.1. Between 29 May and 24 June 2019, a series of Partnership Funding Group (PFG) assessment sessions were held with initiative leads. Leads were invited to present information as follows:

- Brief overview of service/project, including intended outcomes;
- Key performance information for 2018/19;
- Challenges or learning that have resulted in changes during the life of the project; and
- The accumulative impact of the initiative on transformation within the whole system.

2.2. Each of the sessions were structured to enable the PFG to ask the leads questions following presentations. There was also an opportunity for peer review, consideration of further opportunities for collaboration, and to identify any duplication and areas of improvement. At the end of each session PFG were allocated time to discuss their conclusions and make recommendations.

2.3. As part of the assessment process, the recommendations were presented to the Strategic Planning Group (SPG) on the 9 August 2019. These are summarised below:

Initiative	Recommendation
Closer to Home: ECT (FV)	Review structure to align with localities
Closer to Home: Night Nursing (FV)	Review all overnight provision
Overnight MECS	Review all overnight provision
Technology Enabled Care	Review in line with development of TEC strategy
Summerford	Continue
Rapid Access Frailty Clinic (FV)	Proposal required re revised model
Discharge Hub (FV)	Progress Appraisal to refocus investment to deliver the Homefirst vision
Enhanced Discharge FCT	Progress Appraisal to refocus investment to deliver the Homefirst vision
AHP Capacity	Assess capacity requirements
FDAMH Services	Develop single monitoring framework
Mental Health & Wellbeing in Forth Valley College	Confirm funding ends 30/06/20
Post Diagnostic Support & Community Connections	Monitor impact on PDS within FV service
Living Right to the End	Continue
Support for Carers	Review total package of funding
Pharmacy	Amend positioning of pilot from FCT
Alcohol Related Brain Injury (FV)	Review with Clacks/Stirling on submission of full progress report
Social Inclusion Project	Continue

2.4. It should be noted that detailed assessment has yet to be undertaken for initiatives that support the infrastructure of the HSCP.

3. PFG Assessment Session 1

3.1. The first PFG assessment session was held on 29 May 2019. The focus of the session was on initiatives supported to avoid unnecessary hospital admission and to ensure timeous and effective discharge. Attendees are shown within the below table:

Attendee	Remit	Initiative
Diane Sharp	Lead	Closer to Home: ECT
Margaret Ferguson	Lead	Closer to Home: Night Nursing
Pauline Waddle	Lead	Night MECS Service
		Technology Enabled Care
Nikki Harvey	Lead	Summerford
Graham Haldane	Lead	Summerford
Lynda Bennie	Lead	Rapid Access Frailty Clinic

Attendee	Remit	Initiative
Deirdre Gallie	Lead	Discharge Hub
Viv McCaig	Lead	Enhanced Discharge from FCH
Heather Fraser	Lead	AHP Capacity
Amanda Templeman	Chair PFG	
Suzanne Thomson	PFG	
Marlyn Gardner	PFG	
Irene McKie	PFG	
Allyson Black	PFG	
Julia Potter	PFG	
Claire Bernard	PFG	
Margaret McGowan	PFG	
Lesley MacArthur	PFG	

3.2. Falkirk HSCP, as detailed within the Reablement & Bed Based Intermediate Care update presented to the IJB on 7 June 2019, remain committed to embedding a recovery, recuperation and reablement approach that enables people to remain at home or to return home quickly where hospital admission is required.

3.3. There are currently significant areas of strategic work, which are intended to move the Partnership towards this commitment. These includes:

- Getting Forth Right (Unscheduled Care Board)
- Promoting Independence (IPC)
- Primary Care Improvement Plan

3.4. Partnership Funds are intended to support transformation and therefore provide an opportunity for the Partnership to direct resource towards supporting and enabling change within priority areas. In order to do this, it must be recognised that changes in the direction of investment may be part of the transformation process. For example, avoiding discharges in delay remains a priority, however Partnership Funds may be more effectively testing alternative services to support discharge or targeting avoidance of admission.

3.5. In reviewing the above noted services, it is important to maintain an overview of the whole system. The below diagram provides an overview of initiatives currently supported by Partnership Funds.

Falkirk Health and Social Care Partnership

Services supported by PF: Avoiding Admission & Supporting Discharge

Hospital Based

Rapid Access Frailty Clinic

- Consultation & diagnosis via Geriatrician
- 3 days per week
- Care plan on day and/or referral onwards e.g. REACH, Dietitian etc.
- Linked with Frailty at Front Door

Discharge Hub (Co-ordination & Assessment)

- 7 staff (6 Discharge Co-ordinators, 3 funded by Falkirk PF)
- Facilitation of discharge
- Environmental assessments (esp. weekends)
- Education in Wards re discharge

Intermediate Care

Summerford Reablement

- 6 WTE Social Care Workers & AHPs
- +65 (some flexibility)
- 20 reablement beds
- Mainly step-down, but can take referral from community
- 6-8 week programme with on-going AHP after discharge
- Most require PoC on discharge

Enhanced Discharge from Falkirk Community Hospital

- 4 WTE Rehab Support Worker (support team of 4.1 AHP)
- All adult, but predominantly +65
- Referral from FVR
- High level of need – very frail/complex/cognitive
- Stay: days to several months
- Reablement support worker progress reablement following AHP assessment

Home Based

Closer to Home: ECT

- FV Team of 7, including nurses & HSCA
- Operating across Forth Valley
- Patients must have diagnosis
- Referral from GP & other health
- Categories: Unwell adult, uninjured faller, discharge facilitation & other (usually un clear diagnosis at point of referral)

Closer to Home: Night Nursing

- Forth Valley Team
- Supports ECT
- Palliative Care

OT Capacity in CC Teams

- 3 x OT (1 in each locality)
- Assessment and provision of reablement care
- Embedding reablement across all CC teams
- NB: In post from July 2019

AHP Capacity

- 10 FTE AHP resource – extends provision of REACH (46%)
- Supports: Summerford, ECT, RPT, Transformational Change, Community & Frailty

Technology Enabled Care (TEC)

- 3WTE (TBC)
- All adults
- No set eligibility
- Focus is to maintain safety & independence
- Equipment provided, e.g. GPS, sensors, monitors

MECS Night Service

- 4WTE Wardens and Supervisor
- All adults
- Referral from health, SW & Carers Centre
- No set timescale
- Focus: Carer support, end of life

Key

- Co-ordination & Assessment only
- Referral pathway
- Spans across locations of provision

Initiative	**Closer to Home: ECT and Night Nursing**
Lead	**Diane Sharp and Margaret Ferguson**
Area	**Forth Valley**
Current End Date	**31 March 2020**

Achievements & Issues

- Referrals to ECT within Falkirk have increased during 2018/2019, however remain lower than Clacks/Stirling by around 25%.
- In Falkirk, majority of referrals are unwell adults (avoiding admission). Supported discharge numbers are minimal in Falkirk, however can spike e.g. @15 in Nov 18, compared to @4 in Jan & Feb 19. RPT team now support discharge in Falkirk.
- The team of 7 operate over Forth Valley. This is geographically restrictive due to total area covered. Current team model too small to disaggregate to Partnership areas.
- Patients require a diagnosis before referral to ECT. Most referrals are via GPs. Social Work are not able to make referrals.
- Night Nursing: Presentation noted improved practice re supporting ECT patients.
- PF currently funds a small component of Night Nurse Service, to extend hours in early eve and am.

Opportunities

- Potential link with OPAT (Outpatients Antibiotic Therapy).
- Structural review and development. Options re local area delivery and opportunities to consider alongside the establishment of the integrated teams.
- It was noted that ANP in ECT are able to diagnose and prescribe and therefore the requirement for patients to have a diagnosis prior to referral should be reviewed.

Recommendations

The PFG noted benefit in provision of short term enhanced services within community to avoid hospital admission and alignment with HSCP vision regarding supporting people to remain at home. It was however noted that current model of ECT team is potentially curtailed in being able to integrate effectively with local mainstream services e.g. provision of reablement home care, due to the area wide approach currently taken. A review of the structure of the ECT may offer opportunity in terms of local area development of the resource. It is recommended that the ECT:

1. Consider Partnership specific delivery options, including model and resource requirement.
2. Progress discussion with RAFC/Front Door leads to consider further collaboration and integrated working practice e.g. Frailty screening in community and links with OPAT.
3. Review referral pathway re options for SW referral, with diagnosis being undertaken by ECT CPN.

Proposals regarding a Falkirk specific model should be presented by 30 October 2019, with a view to implementing a revised model of service from 1 April 2020.

Initiative	**MECS Overnight Service**
Lead	**Pauline Waddle**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- Service has extended to all adults and no time limit for provision (previously +65 and 4 weeks). This has been facilitated through capacity within existing team.
- MECS has improved working relationship with Night Nurse, with regular meetings to address specific issues.
- Information is not currently provided to demonstrate the impact of the service e.g. admissions avoided, carers able to support individual at home for longer etc.

Opportunities

- Further collaboration between Night Nursing & night MECS service over and above addressing specific issues as they arise – potential for further integrated working practice.

Recommendations

It is currently difficult to assess the impact of overnight provision in terms of reduced admissions, reduced carers stress etc. Furthermore, there is no oversight of the collective impact that the Night Nursing & MECS Overnight services have, or reporting of integrated working practice. On this basis, apart from anecdotal information, it is not possible to clearly understand the contribution made to the whole system. It is recommended that the Night Nursing and MECs Overnight services consider further joint working. Improvement is required in reporting systems to enable the collective provision of overnight care to be measured.

In addition, it is recommended that the overnight MECs service is promoted broadly across services to ensure that all are aware of provision, including there no longer being a limit to provision for 4 weeks.

Proposals regarding a Falkirk specific model should be presented by 30 October 2019, with a view to implementing a revised model of service from 1 April 2020.

Initiative	**Technology Enabled Care**
Lead	**Pauline Waddle**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- Service initially funded via Older People's Change Fund and has now received short term funding for 12 years. Supports discharge and avoidance of admission.
- Service user numbers remain consistent, with constant movement (e.g. 174 new and 127 leaving quarter 4).
- Although the service is noted as continuing to meet the needs of service users and carers, this is difficult to evidence. E.g. no information is provided regarding the proportion of people who have experienced change/improvement/extended independence etc.

Opportunities

- TEC is now cited as a priority within the HSCP Strategic Plan 2019-22. It is noted that as there is no strategy currently in place for the development or provision of TEC this is currently being progressed via TEC Steering Group.
- The service is described as developing and testing use of TEC. This knowledge should be used more effectively re planning and ongoing provision.

Recommendations

Whilst this is noted as a beneficial service, the information currently available regarding impact and longer term planning is limited. Improvement is required in measuring the impact of the service. Noting that the service has been supported via short term funds for 12 years, it is recommended that there is a wider discussion in the context of the development of the TEC strategy to consider future delivery, including options for mainstreaming. It is not currently clear how this service integrates with other provision, although clear that service user numbers demonstrate a demand for the service. It is recommended that this service be set and considered within the context of wider TEC work and strategy development is progressed.

Discussion required regarding mainstreaming options and alignment with TEC strategy to be progressed. Further information required by 30 October 2019.

Initiative	**Summerford**
Lead	**Nikki Harvey and Graham Haldane**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- Summerford received a Care Inspectorate rating of 1 in December 2018. Since then significant progress has been made to improve the service, with a recent review providing a revised rating of 3. Improvement work is ongoing. The service now provides 20 reablement places.
- Key improvements:
    - Increased knowledge about reablement within staff team
    - Increased dedicated AHP capacity
    - 6-8 week reablement service now in place
    - Internal paperwork and processes now improved
    - Falls have decreased
    - Building improvements include gym and improved use of social areas

Opportunities

- It is of note that AHP capacity has increased with Summerford since the closure of Tygetshaugh as a setting for reablement due to limited spaces at any one time for the service. The CI report highlighted areas for improvement within the service. In order to improve the whole integrated reablement service, the assumption would be that AHP provision and capacity needs should also be reviewed. Review of AHP input within the delivery model, and/or improvement was not clear from information presented.

Recommendations

Summerford has made significant progress during the past 6 months to improve and develop service. This improvement should continue and be an integrated process with AHP involvement. This should be progressed as part of the IPC improvement work.

Initiative	**Rapid Access Frailty Clinic**
Lead	**Lynda Bennie**
Area	**Forth Valley**
Current End Date	**31 March 2020**

Achievements & Issues

- The RAFC now operates 3 days per week, with an average of 40-50 patients per month.
- Clear understanding that although this service is effective for those who access it, patients are 'missed'.
- Noted that balance of resource has been transferred to support Frailty at Front Door to extend provision. Whilst this is supported in principle as an area of service development, no formal request or approval has been given via PFG/IJB governance process for this to be progressed. Previous requests have been made for clarification re costing etc for this amended model. This information has not been forthcoming.
- Although the service notes that links are in place with community partners, the focus remains on partners within wider health services as opposed to Social Work or Third Sector.
- Service appears to continue to strive for improvement and transformation in terms of move towards community based provision.

Opportunities

- With formal approval via governance process, continue to shift resource from acute based to community based provision.
- Establish links with ECT to further develop links between frailty screening, Geriatric assessment and also OPAT.

Recommendations

The PFG noted that the RAFC has made significant efforts to amend the initial model to suit the need of patients. This improvement process is ongoing. The general direction of travel is to shift resource from acute setting to community, thereby creating a more robust response to preventing people from accessing the front door or being admitted to hospital.

Formal approval is required regarding the forward plan for delivery and costings of this model. A proposal should be submitted to the PFG by 30 October 2019.

Initiative	**Discharge Hub**
Lead	**Deirdre Gallie**
Area	**Forth Valley**
Current End Date	**31 March 2020**

Achievements & Issues

- Team of 7, operating on Forth Valley basis to support discharge from FVRH. (of 6 discharge co-ordinators, 3 are funded by PF).
- High number of discharges facilitated to Community Hospital (1174 in 18/19). Non-ageing and Health Wards also supported.
- Focus of team – to co-ordinate discharge planning, provide training and advice to wards and undertake environmental assessments.
- Noted that environmental assessments are also carried out by CC teams and ReACH. Possible duplication. Leads noted that they undertake different parts of assessment, so no duplication.
- No information is collected/provided about patient outcomes. Stats collected are used to evidence reduction in delayed discharges.
- Ongoing need for service may indicate that enhanced awareness raising and training regarding discharge planning is required within wards i.e. there is no evidence of change/improvement in ward staff practice re discharge planning and communication.
- Some of the future plan points highlighted for 19/20 indicate that the service has not developed or been embedded as initially anticipated, with link to third sector, progress pathway to intermediate care and education being cited.

Opportunities

- Substantial resource invested in a co-ordinating function with no clear understanding as to why delays in discharge remain high.
- Opportunity to consider assessment process and overall OT function across DH, CC and ReACH and also role/remit of hospital SW team.
- In longer term – in line with HSCP vision for reablement and IPC work currently being progressed, following options and impact appraisal, there may be an opportunity to re-direct resource towards enhanced provision re avoiding admission.
- This is a FV service, therefore review opportunity to consider Partnership based model.

Recommendations

Whilst the PFG recognise the importance of avoiding delays to discharge and ongoing pressure regarding achieving national discharge targets, the group discussed the alignment of this investment with the HSCP vision in terms of prevention of admission/access via front door. There was a shared concern that the current model does not provide a response, patient centred approach with discharges predominantly being made to FCH. Further work is required to ensure that ward staff are initiating 'good conversations' with patients regarding discharge, from the point of admission.

Progress appraisal to refocus investment to deliver the Home First vision and link with IPC work

Initiative	**Enhanced Discharge from Falkirk Community Hospital**
Lead	**Viv McCaig**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- 4 FTE band 2 reablement carers supporting reablement over 7 days within FCT, supporting AHP after assessment and review.
- Service initially focussed on 2 wards, with purpose of embedding reablement approach across all provision.
- Provision (with current resource) now operates across all wards, including ward 5 when open. Query dilution of input/impact. Reablement approach does not appear to have been widely embedded across all staff as initially intended.
- Although evidence is provided about patient functional improvements, the initial transformation proposed does not appear to have been achieved. The service appears static in terms of ongoing improvement/development.

Opportunities

- The review of the function of Community Hospitals is ongoing. Until this has been completed, it is not possible to identify significant development opportunity for this particular resource or the model of use.

Recommendations

Whilst noting the improvement in patient functional ability, there is no evidence to suggest that this model is transformational and in line with the ongoing development of HSCP approach to supporting people at home. The PFG noted that many of the patients accessing FCH are very frail and have complex needs. Most leave FCH with significant care requirements at home or to care home. The outcome of the review of Community Hospital should be considered prior to further recommendations regarding ongoing support for this resource. In the meantime, information should be gathered regarding patient destinations following discharge from FCH.

Progress appraisal to refocus investment to deliver the Home First vision and link with IPC work

Initiative	**AHP Capacity**
Lead	**Heather Fraser**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- 10 FTE AHP resources deployed within REACH team. PF funds over 40% REACH resource and augment total REACH capacity and response.
- All referrals receive clinic triage to assess response requirement/timescale.
- Support provided in Summerford includes ongoing support at home after discharge.

Opportunities

- Review of OT functions and scope re assessment across services, including ReACH, CC, DH and FCH. Consider areas of duplication re assessment and support.
- As highlighted within Summerford note – opportunity to review provision and capacity in Summerford as overall service improvement plan.
- With regard to overall resource supported and scale of workforce, capacity tool could be used to assess resource.

Recommendations

Partnership Funding resources a significant component (over 40%) of AHP capacity within Falkirk. It is therefore reasonable to expect that this resource be deployed flexibly and to suit the priorities identified by the HSCP. During 18/19, AHP resource has been reported separately to enable the service to clearly articulate role and impact. This is an ongoing process, which requires some development to provide absolute clarity regarding integrated provision and avoidance of duplication.

An assessment of the workload and capacity of the funded resource should be undertaken, with information to be presented back to the PFG by 30 October 2019.

2. PFG Review Session 2

2.1 The second PFG assessment session was held on 11 June 2019. The focus of the session was on initiatives supported mental health and providing support towards the end of life. Attendees are shown within the below table:

Attendee	Remit	Initiative
Angela Price	Lead	FDAMH Services
Alice Smith	Lead	Mental Health & Wellbeing in FVC
Fay Godfrey	Lead	PDS and Community Connections
Susan High	Lead	Living Right to the End
Amanda Templeman	Chair PFG	
Allyson Black	PFG	
Irene McKie	PFG	
Julia Potter	PFG	
Claire Bernard	PFG	
Margaret McGowan	PFG	
Lesley MacArthur	PFG	

2.2 Mental health and wellbeing, including support for people affected by dementia, and end of life care are key priorities within Falkirk HSCP's Strategic Plan 2019-2022. During the period of the first strategic plan, 3 national strategic documents were launched by the Scottish Government that are relevant to this work. These are:

- Mental Health Strategy 2017-2027
- National Dementia Strategy 2017-2020
- Strategic Framework for Action on Palliative and End of Life Care 2015 (and subsequent Palliative and End of Life Care by Integration Authorities: Advice Note May 2018)

2.3 During 2018/19, work has been progressed to move the Partnership to a position of strategically commissioning services for mental health and wellbeing. The purpose of this work enables a whole system view of need and available resource to be taken. In addition to Partnership Funds, additional resource has been made available to support this area of work, as below:

Dementia Services	**Fund**	**Mental Health & Wellbeing Services**	**Fund**
Post Diagnostic Support		Mental Heath & Wellbeing in FVC	
Community Connections		Social Prescribing	
Social Work Capacity		Immediate Help Service	
Dementia Outreach Team		Social Spark	
Dementia Innovation Fund		Bereaved by Suicide	

Dementia Services	Fund	Mental Health & Wellbeing Services	Fund
		Primary Care Mental Health Nurses	
		Family Support for Survivors	
		Practical & Emotional for Survivors	
		Support in prison	
		Triage in A&E	
Key			
Partnership Funding			
Primary Care Improvement Plan			
NHS/FC Mainstream Budget			
Dementia Innovation Fund			
Services for Survivors			
Choose Life			
Action 15			

Initiative	**FDAMH Services**
Lead	**Angela Price**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- Service funded by PF are Social Prescribing (461 people in 18/19), Immediate Help (1,177 people in 18/19) & Social Spark (266 people in 18/19). Demand remains high across all FDAMH services. Waiting list has been introduced for the Immediate Help Service to help manage capacity, however people are still seen if they arrive at the premises.
- Numbers progressing through services are consistently high. Evaluation of impact is challenging. Both the Immediate Help Service and Social Prescribing are intended to have a direct impact on GP and prescribing, however consistent information is not available from GP practices re impact. Feedback tends to be anecdotal. It is also difficult to gather feedback from clients in terms of referrals, destinations due to the nature of the service – Immediate Help Service can be a one off intervention with no follow-up required. However, recognised evaluation tools are used to record patient's perceived outcomes in terms of changes during time of contact with service. Individual outcomes are reported as significant. It is acknowledged that measuring MH provision is a challenge across the board and not unique to FDAMH.
- Case studies and service user testaments provided highlight very good outcomes for individuals and significant benefit from service provided.
- The PFG noted that the patient journey is not linear and therefore it is hard to track services provided and outcomes achieved. FDAMH have recently purchased a new IT recording system. Staff training and system development is ongoing, however it is hoped that this will eventually reduce burden of recording against different services and allow patient journey to be tracked.
- Noted that FDAMH are currently installing CRM system, which has posed challenging, but will help recording going forward.

Opportunities

- Monitoring and patient tracking could be improved. However, this relies on GP practice and wider NHS being recorded consistently and information being made available to FDAMH.

Recommendations

It is recommended that FDAMH continue to work with NHS and other agencies both in terms of service provision and referral process. There remains an issue in terms of NHS referring to FDAMH, but not accepting referrals directly from FDAMH (or any other third sector agency). Future commissioning of the service is intended to be via strategic commissioning process, from March 2021. FDAMH have also been asked to bring the reporting of all 4 services funded, together. It is anticipated that this will provide further detail about the journey of the patient, the impact and destination after exiting the service.

Establish single reporting framework by Q2 reporting

Initiative	Mental Health & Wellbeing in Forth Valley College
Lead	Alice Smith
Area	Falkirk
Current End Date	30 June 2020

Achievements & Issues

- The service operated across 3 campus (Falkirk, Stirling & Alloa), however is only available to students resident to Falkirk Council area.
- A triage system has been introduced, which can be time consuming for the worker, however allows individual with higher needs to be identified and timeous support to be provided.
- The waiting list for service remains high (199 referrals, 84 supported – 115 waiting list). College is currently implementing the Big White Wall as a new element intended to enhance support and reduce waiting list. The impact of this is not expected to be seen until the next academic year.
- Onward referral of students to other organisations when leaving college is 50%. There is no follow-up after student has left college. Unclear whether service identifies need earlier and/or increases demand on external services.
- Throughout the period of delivery, FVC have provided case studies highlighting positive impact of the service on students, their families and the wider college community.

Opportunities

- Gathering destination data may be helpful in measuring the impact of the intervention.
- There may be opportunities to develop further referral pathways with other organisations following initial triage.
- Online support, combined with referral to NHS online resources may be beneficial for those on waiting list.
- The high waiting list remains a concern. It is however acknowledged that demand for access to the service is higher than expected which has placed pressure on the resource available in terms of the capacity to provide 1-1 support and other MH related awareness raising. The streamlining of the service plus the introduction of innovative on-line support will assist with the waiting list and provide an opportunity to test/review the effectiveness of on-line tools.

Recommendations

The PFG felt that the project has achieved its initial purpose in relation to establishing and testing an enhanced support model for improved mental health & wellbeing in FVC. It was initially anticipated that the project would be supported for 1 year and then progressed within FVC mainstream provision, through provision of evidence to senior management that the project was effective. Year 2 funding was allocated to enable continued development of the service and gathering of further evidence to support sustainability. The project was short-listed for an aware at the College Development Network, again highlighting its importance to student support.

The PFG feel that FVC has a duty of care to students to provide additional support where required, particularly where the focus is to support mental heath and wellbeing with the key driver being retention. It was noted that funding for this project is in its 3rd year and is enabling the college to implement on-line support packages and to mainstream this extended guidance role.

Although retention rates for students receiving support are good, it is difficult to measure whether this has improved as a result of the project. The high waiting list remains a concern. It is however acknowledged that a single worker has limited capacity to provide one to one support and be involved in other MH related awareness raising.
As previously reported, funding for this project will stop on 30 June 2020.

Initiative	Post Diagnostic Support & Community Connections
Lead	Fay Godfrey
Area	Falkirk
Current End Date	31 March 2021

Achievements & Issues

- PF currently funds 4 PDS Link workers, supporting 5 and 8 pillar PDS. Community Connections provides community based activities for services users and carers.
- FV Integrated Dementia team being established in Airth. This will include Social Work, Health (Dementia Outreach Team) and PDS workers. The PFG noted that whilst this was a positive move in terms of joint working that the team may find it challenging to respond to the area from where they are funded, rather than where there may be higher need or demand. This concern relates to Falkirk funding 4 PDS workers and Clacks/Stirling funding 2. Falkirk's waiting list is currently shorter than Clacks/Stirling. This may present the team with a challenge in terms of universal/equity of access.
- Noted that there remains a waiting list of 18 months from the point of discharge from PDS to ASW assessment (unless in crisis). In addition, it was noted that ASW do not accept assessments undertaken by the PDS worker and undertake a further assessment.
- Alzheimer's do not currently work with volunteers. Community Connections is resourced by sessional staff.

Opportunities

- Review of the assessment and referral process, post PDS support, with a focus on understanding any barrier to ASW accepting PDS worker assessment e.g. for referral to day care.
- There may be opportunities to develop links with TEC and also Living Well Falkirk Website Clinics to promote earlier intervention, independent living and carer support.
- Consider working with volunteers to support current staff resource, with a focus on less complex cases.

Recommendations

It is recommended that a monitoring framework is established to include impact of the integrated dementia team from the inception of its operation. The output of the team should initially be overseen by the FV Dementia Steering Group with a view to analysing the impact of the team across the area and in particular to residents within Falkirk Council area. This information should also be shared with the PFG. Discussion is required to gain a further understanding into the perceived bottlenecks within the system – particularly post PDS. Links should also be made to explore TEC and volunteer opportunities as described within opportunities.

Continue to monitor progress and improvement via monitoring returns.

Initiative	**Living Right Up to the End**
Lead	**Susan High**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- Service aligns well with end of life provision and enabling people to die at home, should they choose to do so. 5340 hours support to individuals and 3160 to carers in 2018/19.
- With relation to the 'All about me' booklet the PFG noted that there are a number of different books of this type available and also the formal ACP. Initial links have already been established. Strathcarron feel that the focus of the booklet is unique and it has been co-designed with patients and carers.
- Noted that information being provided by volunteers with a local knowledge is more effective and up to date than recording information on a database.
- The PFG noted that there are potential risks in upscaling the project and that compassionate neighbours works well at a local level, where volunteers have a good knowledge of the assets within their neighbourhood.

Opportunities

- Joint working with FDAMH e.g. options discussed regarding referring people to FDAMH's choir.

Recommendations

It is recommended that the service continues to link with District Nurse led ACPs, to ensure that people are not confused by the range of planning booklets available. In relation to the sustainability and growth of the project, it is proposed that the current small scale model is replicated within a wider range of communities as opposed to upscaling or growing a single model.

Continue to monitor progress and improvement via monitoring returns.

3. Partnership Funding Review Session 3

3.1 The final PFG assessment session was held on 24 June 2019. Attendees are shown within the below table:

Attendee	Remit	Initiative
Agnes McMillian	Lead	Services for Carers
Jean Logan	Lead	Pharmacy
Gillian Cook		Pharmacy
Frances O'Donnell	Lead	Alcohol Related Brain Injury
Heather Simpson		Alcohol Related Brain Injury
Norma Howarth	Lead	Social Inclusion Project
Claire Dempsey		Social Inclusion Project
Amanda Templeman	Chair PFG	
Suzanne Thomson	PFG	
Marlyn Gardner	PFG	
Irene McKie	PFG	
Allyson Black	PFG	
Julia Potter	PFG	
Claire Bernard	PFG	
Margaret McGowan	PFG	
Lesley MacArthur	PFG	

3.2 All initiatives reviewed during this session align with the priorities within the Strategic Plan 2019-22.

3.3 The implementation of the Cares (Scotland) Act in 2018 has significantly helped to raise the profile of unpaid carers. The Partnership has worked with Third Sector partners and Children's Services to develop Carer's Support Plans and a framework of support services. These services are supported by PF and Carer's Funding, which is allocated to Falkirk Council via the Scottish Government. Carers remain a key priority for the Partnership.

3.4 The Chief Finance Officer has consistently reported that a significant overspend within prescribing. The IJB are accountable for this deficit and therefore it is critical that the way that services are delivered are reviewed and improved. The outcome of any improvement should be better patient outcomes in addition to reduced costs. The pressure within prescribing comes at a time when there is a national shortage of pharmacists. Therefore the approach that must be taken should be innovative and agile.

3.5 Health Inequalities and Substance Use are HSCP strategic priorities. During 2019/20 a review is being undertaken about substance services and also the structure of Falkirk Drugs and Alcohol Partnership. A new contract has recently been issued to provide the majority of local services, however peripheral services remain important within overall provision.

Initiative	**Support for Carers**
Lead	**Agnes McMillian**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- Carers Centre provide a range of services via PF, core and ring-fenced carers funding. Outcomes are in line with national outcomes for carers. Projects are reported collectively. Support was provided to 850 carers in 2018/19.
- PFG noted that from the information provided, they were not able to gain an overview of the impact of the PF supported services in the context of the total service. Presentation noted that there was significant cross-over between funding stands in order to support services.
- Demand for services remains high. Implementation of Carers Act has been key challenge in terms of resourcing change – commitment/resource was underestimated by Carers Centre.

Opportunities

- PFG highlighted that discharge and engaging with hospital staff as a potential area for development.

Recommendations

It is recommended that a review is undertaken to consider the total resource provided to the Carers Centre and total service provision. It is proposed that this is taken forward by the lead monitoring officer for the carers Centre, with a completion timescale of December 2019, to enable confirmation of future funding to be in place by 31 March 2020.

Review overall funding package. To be progressed by ASW lead.

Initiative	**Pharmacy**
Lead	**Jean Logan and Gillian Cook**
Area	**Falkirk**
Current End Date	**31 March 2020**

Achievements & Issues

- Project initially funded by PF for Care at Home and PCTF for Care Home support. No information was provided re Care Home activity. It is understood that this has not yet been progressed as project has been unable to recruit full compliment of staff as per application. There is currently 2 FTE in post, working within Care at Home and FCH.
- Key challenge noted as delay in medication policy being finalised.
- Pharmacy review and support is currently being provided in Falkirk Community Hospital. The PFG queried why this was a priority area for support as clinicians visit and prescribe within CH. Provision within CH is not in line with supporting people to return home. PFG suggested that support in Summerford and/or one local care home may enable better evaluation of impact and cost reduction.
- It was noted that there are currently multiple stands of funding allocated to pharmacy services. Clarity is required re an overview of all funding. An initial meeting has already taken place regarding this.

Opportunities

- Learning from Clacks/Stirling service could be reviewed and adopted, where appropriate.
- Re-focus project on smaller test of change in intermediate care/care home.

Recommendations

Whilst this project presents opportunities to improve process and achieve significant savings in prescribing, it is clear that the challenges regarding recruitment have prevented progress as was initially intended. There is a lack of clarity regarding funding streams and it is proposed that the Chief Finance Officer takes forward this discussion with Pharmacy colleagues.

It is also recommended that the placement of the support is revisited and moved from FCH to potentially refocus on smaller tests of change within Summerford and/or another Care Home. Support within Care at Home should continue, although clarity is required about the current position of the medication policy.

Proposal regarding an amended model to be provided by 30 October 2019.

Initiative	**Alcohol Related Brain Injury**
Lead	**Frances O'Donnell and Heather Simpson**
Area	**Falkirk**
Current End Date	**31 March 2020**

Achievements & Issues

- Project has only recently established full compliment of staff. The team now includes diagnosis support from Psychology and OT capacity to support people within their own home. The team is predominantly NHS staff, however there are strong links in place with Signpost, who employ a Social Care Worker to work with the client group in community. Signpost also identify potential clients via the SIP project and refer into the ARBI service.
- There are currently 20 people within the service. This is likely to rise. It was noted that people require some stability and abstinence prior to formal diagnosis. Current patients have not yet received diagnosis. The PFG suggested that current patients reach a point were diagnosis can be considered, that the Psychology capacity could be directed to review individuals in residential care.
- The management of the service has changed since the initial pilot period. There appears to be a variance in the objectives of the new service, compared to the pilot. A key objective of the pilot service was to shift care to community rather than residential care. The focus of the current service is new referrals as opposed to those already with a diagnosis, some of who are in residential care. It was highlighted that ARBI is a treatable condition (where a person remains abstinent), therefore potentially, placement in residential care for long-term is a costly and unsatisfactory outcome for individuals. This requires further consideration and review.

Opportunities

- Building on work established in 2017, review the care packages of people with ARBI diagnosis who are currently in residential care, with a view to understanding total cost, individual outcomes and shifting support to community.
- It was noted that there was an initial expectation that the service would be sustainable through re-distribution of costs from residential care. This requires review.

Recommendations

The PFG noted that the service, in its current form, is relatively new. The Partnership Funding Co-ordinator will provide the new service manager with information re the initial service outcomes and objectives. This includes the objective to improve outcomes and reduce cost of care packages by supporting people in community rather than residential care. The number of people in residential care with ARBI is currently not known and should be explored. A revised performance framework should be established to measure the impact of the service within residential care. **Clackmannanshire & Stirling Partnership have recently requested a full report regarding the new service, which will inform their funding recommendation going forward. Liaison to continue between Fund Co-ordinators.**

Initiative	**Social Inclusion Project**
Lead	**Norma Howarth and Claire Dempsey**
Area	**Falkirk**
Current End Date	**31 March 2021**

Achievements & Issues

- The project continues to deliver good outcome for individuals 207 have accessed service in 2018/19. Demand on the service has significantly grown and outweighs capacity. The result of this may be a waiting list or less intensive support being provided.
- Staff note a significant proportion of clients have mental health issues and polydrug users. This requires close partnership working with other agencies and services.

Opportunities

- Outcomes and achievements well recorded. Could be an opportunity to share this practice with other partners.
- Within context of ADP service review and Drug Related Death work, there are significant opportunities for substance and mental health services to work closer together.

Recommendations

The PFG noted that a review of substance service provision is being progressed via the ADP. The outcome of the review will help to highlight how SIP fits with wider provision. This may include bringing forward proposals to expand the service. In this event, consideration will be required about how the service is supported on a longer-term basis through mainstream funds.

Continue to monitor progress and improvement via monitoring returns.

4. Conclusion

4.1 Feedback from members of the PFG confirm that the review process followed has allowed them to gain a more rounded understanding of initiatives supported by Partnership Funds and therefore recommendations are well informed. Quarterly monitoring returns are helpful and essential in relation to ongoing performance management, however, the ability to discuss projects with leads has been invaluable.

4.2 Partnership Funding provides a critical opportunity for Falkirk HSCP to establish, transform and deliver integrated services, in line with local priorities and also to test and drive innovation. During 2018/19, the programme has been reviewed to ensure that the structure and allocation of Partnership Funds is agile and able to support both transformation and emerging improvement need within the Partnership. The programme must also continue to align with the priorities of the Strategic Plan 2019 -2022 and recognise the complex operating environment.

4.3 In addition, the development of the revised HSCP Market Facilitation Plan is intended to provide a framework of information and support for providers. It will set out principles regarding commissioning and the engagement with the market regarding how services can be developed, focussing on priority areas of delivery.

4.4 Along with the Strategic Plan, strategic change management and improvement programmes such as Getting Forth Right and Promoting Independence (IPC) provide a framework to help direct future investment. Partnership Funds are intended to be used for short-term investment. Therefore it is to be expected that when transformation has been established within specific initiatives or where there is a change in priority areas, that re-focussing of funds will occur.

4.5 As part of the application process, initiative leads are required to sign a declaration of funding that clearly states that funds are short-term. The declaration also states that disinvestment can occur when there is persistent deficit in performance or where the initiative no longer aligns with strategic priorities.

4.6 Where changes to investment are recommended, an options appraisal will be undertaken to ensure that risks are identified and mitigated.

5. Recommendations

5.1 The following table provides a summary of recommendations arising from the review process.

Initiative	Recommendation
Closer to Home: ECT (FV)	Review structure to align with localities
Closer to Home: Night Nursing (FV)	Review all overnight provision
Overnight MECS	Review all overnight provision
Technology Enabled Care	Review in line with development of Tec strategy
Summerford	Continue
Rapid Access Frailty Clinic (FV)	Proposal required re revised model
Discharge Hub (FV)	Progress Appraisal to refocus investment to deliver the Homefirst vision
Enhanced Discharge FCT	Progress Appraisal to refocus investment to deliver the Homefirst vision
AHP Capacity	Assess capacity requirements
FDAMH Services	Develop single monitoring framework
Mental Health & Wellbeing in Forth Valley College	Confirm funding ends 30/06/20
Post Diagnostic Support & Community Connections	Monitor impact on PDS within FV service
Living Right to the End	Continue
Support for Carers	Review total package of funding
Pharmacy	Amend positioning of pilot from FCT
Alcohol Related Brain Injury (FV)	Review with Clacks/Stirling on submission of full progress report
Social Inclusion Project	Continue

Appendix 3

Dementia Innovation Fund: Proposed Investment Themes

1. Community Assets: Indicative allocation £50,000

1.1. Funds will be used to support small scale community based activity, for example Dementia Café, **reminiscence** groups, interest groups or small items of equipment to help establish activities.

1.2. In order to identify funding priorities, engagement work will be progressed with services users and carers to consider any specific themes or activities that they feel that would be of particular benefit.

1.3. A challenge fund will be developed to enable community groups to apply for funds. The terms and conditions currently used for Falkirk Council's small grant scheme will be adopted for the programme. This means that groups will be required to sign a funding declaration at the point of application. Funding exclusions will be in line with the small grant scheme.

1.4. An end of award report will be requested as part of the terms and conditions. This is a short report setting out what the award has been used for. Any unused award will be returned to the fund.

1.5. Groups will be able to apply for a maximum of £5,000 per year or within any single application. The application process will be straight forward to ensure accessibility. Applications will be assessed by the Dementia Innovation Fund group with awards being reported to the Leadership Group. Monitoring of the fund will include the allocation per locality area.

1.6. In the event that funding of over £5,000 is requested, approval will be passed to the Leadership Team.

1.7. A proportion of the fund (approx. £10k), will be used to run a participatory budgeting (PB) exercise with service users and carers. This will involve proposals being assessed and voted for by service users and carers. PB can be resource and time intensive, therefore the detail of co-ordination requires further development and appraisal.

2. Education & Awareness Raising: Indicative allocation £20,000

2.1. The Dementia Advisor role is one that is well established within Alzheimer Scotland. The role can be varied with a focus on raising awareness of dementia, supporting and developing dementia friendly communities as well as providing information and advice to people and families living with dementia.

2.2. At present the current Dementia Advisor hours in Falkirk are already committed with no additional capacity to expand, however with an additional 17.5 hours a week the following key areas could be addressed.

- GP Practice liaison and links with District Nurses - to increase awareness and promote early diagnosis.
- Engage with District Nurses to promote range of community based supports that help maintain wellbeing and keep people connected to their communities.
- Awareness training in schools- work with Education Department to offer dementia awareness sessions to schools throughout Falkirk area and creating opportunities for intergenerational work with community groups and care homes.
- Promote Dementia Friendly Communities by working with businesses throughout Falkirk.
- Promote awareness of dementia to key decision makers within the local authority

3. Technology Enabled Care: Indicative allocation £90,000

3.1. **Just Roaming:** Just Roaming is a recent innovation developed by Just Checking who provide discrete movement and door sensors within people's homes to help them to live more independently. The sensors gather an overview of daily activity and provide information for care professionals to understand where support may be required. Just Roaming uses sensors to send "live" alerts to a mobile phone APP which provides information regarding individual's overnight activities. As this technology is tailored to each person, it provides accurate personalised information to assist in planning support and encourages proactive risk management. Just Roaming also provides reassurance for the person living with dementia and their carers and support can be provided as and when required. The use of this technology will not only provide a means of organising cost effective and sustainable care at night for individuals bit it will also assist in maintaining people to live at home and prevent hospital admissions.

3.2. Further options to establish tests of change will be progressed via links with national TEC advisors within Alzheimers Scotland and Scottish Government. Discussion will also be progressed with Falkirk Council's MECs service, who have developed an expertise in TEC equipment.

4. Respite: Indicative allocation £40,000

4.1. Opportunities are currently being explored to provide a more flexible approach to respite than what has been traditionally offered. It is recognised that current respite for the carers of people with dementia is limited to support worker at home, formal day care and overnight short stays. There are also a number of lunch clubs operating across the Council area, however there is often a restriction to the level of support that can be offered e.g. personal care. This

means that people who are at a more advanced stage of the conditions are not able to attend or have to be accompanied by their carer.

4.2. We would like to establish a flexible approach whereby people can access the service on an adhoc basis and during evenings and weekends. Initial discussion have progressed, as follows:

4.2.1. **Falkirk Community Trust**: FCT currently offer free access to facilities for carers who are accompanying a cared for person. The focus of this provision is the cared for person e.g. provision of any assistance, exercise advice etc. The carer is generally required to stay with the cared for person, depending on level of need. We are considering option about how carers could be provided with support in relation to their own health and wellbeing needs, whilst also supporting the cared for person.

4.2.2. **Town Break:** Town Break currently operates within the Stirling area. A range of services are provided by 8 staff and 50 volunteers for people with mild to moderate dementia, and their carers. Services include Day Clubs, Friendship Group, Befriending and Cognitive Stimulation Therapy. Options are being considered about how the service model can be delivered within Falkirk.

4.2.3. **Alzheimer's Scotland and Joint Dementia Initiative**: Options are being explored about the introduction of a voucher scheme, which would give carers access to day care services on an informal, adhoc basis. The perceived benefit of this type of provision would offer flexibility to carers in line their individual need and also allow people to slowly be introduced to day care without a formal arrangement in place with scheduled weekly places.

4.3. The challenge in introducing this model is the administration of the scheme and also the capacity of the day care services to accommodate additional service users. Appropriate notice would be required to allow services to ensure an appropriate staff compliment. The Carers Centre has also been involved in discussion and could potentially provide co-ordination of the pilot/programme. In the longer term, if the pilot was successful, sessions would be funded via the direct budget allocated to the carer via a Carers Support Plan and eligibility criteria.