This paper relates to Agenda Item 10

Title/Subject:	**Draft Integrated Care Fund Mid-Year Report to Scottish Government**
Meeting:	**Integration Joint Board**
Date:	**04 December 2015**
Submitted By:	**Interim Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of the report is to advise the Falkirk Integration Joint Board of the Scottish Government request for a mid-year progress report on the Integrated Care Fund and to seek approval for the attached draft report to be formally submitted.

2. RECOMMENDATION

The Falkirk Integration Joint Board is asked to:

2.1 consider the Draft Integrated Care Fund Mid-Year Report for submission to the Scottish Government.

3. BACKGROUND

3.1 The Scottish Government requested partnerships provide a mid-year report on the progress made to date by those projects allocated funding from the Integrated Care Fund in 2015/2016 and how this has supported achievement against the national Health and Wellbeing outcomes. The attached draft Integrated Care Fund Mid-Year Report has been submitted to the Scottish Government to meet Scottish Government reporting deadlines.

4. Summary of ICF Funding

4.1 The Scottish Government has allocated additional resources of £100m to Health and Social Care Partnerships in 2015-16 through the Integrated Care Fund (ICF). The Cabinet Secretary for Health, Wellbeing and Sport announced on 19 March 2015 that an additional £200m will be shared between health and social care partnerships during the period between 2016/18.

4.2 The first tranche of Integrated Care Fund monies of £100m were included in NHS Board's baseline funding allocation letters for 2015-16.

4.3 The allocation to the Falkirk Partnership was £2.88m, of which £2.04m has been allocated to date. Of this allocation spend to date is £290k, with a predicted further spend of £1.55m.

4.4 The agreed process identified by the then Transitional Board was a commissioned intervention allocation approach not a bidding approach. Notional proportions of ICF budget was allocated against each priority area. At the time of approval the ICF Spend Plan confirmation of one-year funding, only was allocated to new projects or to 31 March 2016 for existing projects.

4.5 Following the process above, the approval process has contributed to a delay in some of the new projects commencing. However it is anticipated that the first monitoring review with the project leads due early January 2016, will provide further information to the IJB to support decision making processes for 2016/17 funding.

4.6 It is intended that the ICF Monitoring Group will submit a report for the February IJB Meeting with recommendations on the current funded projects and their progress in meeting outcomes.

5. CONCLUSION

5.1 Based on the information provided the conclusion is that the Integration Joint Board considers the Draft Integrated Care Fund Mid-Year report and agrees final submission to SG.

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Approved for Submission by: Tracey McKigen, Interim Chief Officer

Author – Catriona Cockburn, Service Manager, Falkirk Council and James Cassidy, Service Manager, NHS Forth Valley

Date: 23 November 2015

List of Background Papers: Copy of Draft Integrated Care Fund Mid-Year Report.

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16 **ANNEX B**

Integrated Care Fund – 2015/16 – Mid-Year Financial Summary Falkirk Partnership – 2.88 £m ICF Allocation for 2015/2016

	Allocation for 2015/16	Spend - April to September 2015	Forecast Spend – October to End March 2015	Projected Over/Underspends
Telecare Innovations – MECs Night Services and Fall Management	163,500	21,670	162,100	1,400
Homecare Redesign	214,000	105,520	214,000	0
Living it Up (DALLAS)	9,200	0	2,400	6,800
Enhanced Support for FCH Developing The Rehab Support	108,300	34,204	84,604	23,696
Modernising Technology In Care Services (Real Time Monitoring)	67,800	10,200	67,800	0
Alzheimer's Scotland PDS Link Workers	76,000	19,266	77,333	-1,333
Alzheimer's Scotland - Community Connections	10,600	0	10,600	0
Marie Curie Patient Visit Services	31,200	0	19,000	12,200
Braveheart Optimise Health and Wellbeing Service	13,400	3,350	13,400	0
Health and Wellbeing Activities Programme (Carers)	6,000	115	6,000	0
Support Break for Carers	29,200	834	29,200	0

FDAMH Social Prescribing Service	100,000	0	100,000	0
OD Workforce Development Post (OD Advisor)	40,000	25,308	51,614	-11,614
Stakeholder Engagement And Participation	40,000	0	0	40,000
Active Minds: A Physical Activity and Wellbeing Programme For Falkirk	40,800	0	40,800	0
Forth Valley Case Management Service – For People With	75,000	0	75,000	0
Medication Management Project	20,000	0	20,000	0
OT, Equipment and Adaptations Redesign	67,000	0	67,000	0
Data Analyst	48,700	0	16,250	32,450
ICF Co-ordinator	55,000	0	17,600	37,400
Performance Management And Programme Support	36,500	15,510	36,500	0
Integration Partner : Independent Sector	33,300	16,650	33,300	0
TSI Support	75,000	37,500	75,000	0
Closer to Home- ALFY	103,500	0	51,750	51,750
Closer to Home- Enhanced Community Team	346,500	0	173,250	173,250
Closer to Home-Additional Care and Support Costs	229,200	0	114,600	114,600
Total ICF spend to date- 2015/16	**2,039,700**	**290,127**	**1,559,101**	**480,599**

1	The Transitional Board approved the Integrated Care Plan at its meeting on 9th January 2015 with further detail of the programme being presented to the Transitional Board at meetings on 5th June, 4th September 2015 and 2nd October 2015.
2	The partnership are considering the Integrated Care Plan for 2015/2016 as an investment programme which will be subject to ongoing monitoring, scrutiny and review particularly in light of the development and approval of the partnership's strategic plan. Meeting planned for 23/11/2015 to reinforce ICF monitoring process which will support project leads in reporting progress towards ICF Outcomes.
3	Given the above the partnership does not consider the financial summary to represent an underspend, but rather a timing of expenditure issue across the 1 year investment programme. NHS Forth Valley will manage the difference in timing of expenditure compared to timing of allocation through its financial management regime. The partnership anticipate, particularly in light of a very challenging financial environment, that this approach will assist with sustainability of the programme.

Integrated Care Fund – 2015/16 – Progress towards ICF Outcomes

WORK STREAM ACTIVITY OR PROJECT	OUTCOMES FOR 2015/16	PROGRESS TOWARDS OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE
Telecare Innovations – MECS Night Services and Fall Management	• Join together Telehealthcare projects across Falkirk (specifically medication reminder devices and the Housing Technology project.) • Increase the number of people who are prevented from being admitted to hospital/care home as a result of the falls bundles work.	• Implementation Officer now in post. • Continue to analyse the impact of the service and its effectiveness. Resources are being used to evaluate the demand and report on trends and base business.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

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Homecare Redesign	• Additional capacity of four extra managers to the team to help manage the overall impact of the introduction of the new real time monitoring system and support redesign of service. • Extension of Team Manager development time.	• Staff restructuring in progress • Recruitment of staff to redesigned service ongoing.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Living It Up (DALLAS)	• Continue the Project Manager post to the end of March 2016. • This work will continue the service development opportunities and embedding Living it up in to service delivery.	• Due to staff turnover post advertised with Interviews scheduled for 23/11/2015.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Enhanced Support for Falkirk Community Hospital- Developing the Rehab Support Worker (RSW)	• The RSW are involved in the provision of cognitive rehabilitation with patients as appropriate. • RSW shadowed the Occupational Therapist (OT) during treatment sessions to increase knowledge and understanding of cognitive problems. They are now confident in carrying out a basic cognitive assessment (AMT10)	• Ongoing training and education from the OT. • Leading cognitive therapy sessions as advised by the OT. • Continue to carry out AMT 10 assessments.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Modernising Technology In Care Services (Real Time Monitoring)	• Continue rolling out and fine-tuning the configuration of the system. • Progress the ongoing work required to achieve a go live date. • Agree a go live date for the system. • Implement the go live date. • Review the initial roll out and plan in future go live dates for other areas.	• Arrange how the system will be maintained and supported long term • Monitor and report on benefits and efficiencies from use of the system • Continue setting up user accounts, training staff, rolling out aspects of the system • Look at future development of the system (including how external care providers could be brought on).	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Alzheimer's Scotland PDS Link Workers	• The person with dementia, their family and carer will: 1. benefit from timely, relevant and responsive Information & advice from the point of diagnosis and throughout the duration of the illness. 2. be better informed and equipped with skills to manage the challenges of living with dementia 3. have legal and financial arrangements in place for the future 4. be in a position to take control, now and in the future, of services to support them to live at home as independently as possible 5. build on existing support networks 6. maintain community links & build peer support networks for both carers and people with dementia at all stages 7. benefit from sharing experiences, tips and coping strategies 8. statutory supports will be phased in at a pace and time that is acceptable to both the person with dementia and their carer 9. carers will feel confident and well supported in their caring role 10. finish the one year support with a Personal Support Plan in place. • Monitor referral rates to assess capacity of team	• Continue to deliver the 5 pillar Post Diagnostic Support model for those in the earlier stages of Dementia and support those in the moderate stages to access appropriate support • Continue to offer information courses throughout the year- 3 to be offered per year • 1-1 support to be offered to people post diagnosis, working though the 5 pillar model • Promote access to community links and Drop in Cafes. • Liaise with the CMHT, continue to record and submit HEAT data	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Alzheimer's Scotland - Community Connections Programme	Links to local priorities: • Service users and family/carers meet in familiar local settings. • Increase of walking and other activities which keeps people in good mental & physical health • People, who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. • Co-production involves service users, carers and family members, volunteers and NHS Forth Valley.	Continue maintaining the three groups: • Garden Club • Walking Group • Football Reminiscence	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Marie Curie Patient Visit Services	• Continue to deliver an end of life service for patients at home • Design and agree a long term operating model for the service. • Develop further partnerships with all providers of a palliative care as part of wider discussions on patient pathways. • Identify the benefits of delivering within a local clinical coordination of Marie Curie care or continue as part of FV Out of Hours Nursing Team.	Continue to provide support to patients and their carers during end of life care	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Braveheart - Optimise Health and Wellbeing Service	Links to local priorities • Provision of a person centred approach to support adults with Long Term conditions • Provide an opportunity to enable people to self-manage their condition • Support the achievement of National Health and Wellbeing Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.	• The service recruits, trains and manages volunteers to become Health Mentors who deliver self-management activities with adults at risk of developing long term health conditions.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Health and Wellbeing Activities Programme (Carers)	• To provide opportunities for carers to participate in a range of activities designed to improve their health and wellbeing such as: singing, walking, pampering, relaxation, alternative therapies, healthy eating and fitness. Links to local priorities ▪ Carers: direct carer support services ▪ Health and Wellbeing in Communities: develop local capacity and infrastructure; focus resource within geographical areas of high inequality.	• The Carers Centre uses outcome focused measures to record and report on the services provided to individual carers	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Support Break for Carers	• Promote and administer a carers' break fund that will provide grants of up to £300 to allow around 80 carers to have a personalised short break which will help carers continue to provide care, helping reduce isolation, providing a better quality of life and maintaining carers' health and wellbeing. Links to local priorities ▪ Carers: direct carer support services such as short breaks/respite especially where the carers and the cared-for person both benefit	• The Carers Centre uses outcome focused measures to record and report on the services provided to individual carers.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

FDAMH Social Prescribing Service	Links to local priorities • Provision of a holistic and person centred approach to support people experiencing reduced mental wellbeing • Builds on continuing good practice - continuation of a service that is already in existence, offers early intervention and support, is recovery focused, ensures signposting (where necessary) to correct service, promotes partnership working and, evidence suggests, reduces the need for medication. • Uses validated evaluation tools to assess impact of intervention • Was / is an innovative approach to early intervention. Is highly regarded by the GP's who have access to the service. Reports indicate that this has been a highly effective project that merits consideration of continuation.	• We will monitor the impact of the project to support the current GP challenges in some practices across the Falkirk area • Project reports are available.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
OD Workforce Development Post (OD Advisor)	• Implement the OD/Change Management Plans across the Partnership to take forward priorities agreed through the Integration Joint Board	• Priorities agreed to make best use of available resources • Comprehensively engaging with and involving all partners. • Establishing sustainable structures and processes for joint/integrated working.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Stakeholder Engagement and Participation	• Raise awareness and increase skills regarding asset based approaches and co-production amongst staff across the Partnership, through training workshops.	• Delivered training workshops in June/July. • Scheduled annual training workshops. • Building the co-production training resources into HSCI OD.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Active Minds: A Physical Activity and Wellbeing Programme For Falkirk	• Improve health inequalities around mental health and wellbeing in the Falkirk area by decreasing levels of sedentary behaviour and physical inactivity. • This will provide a supportive physical activity pathway to cater for individuals following treatment from primary care or clinical services.	• The funding will be utilised to increase service provision, as well as support the existing Active Forth team to increase their knowledge, understanding and programming skills for customers with mental health conditions. • A key focus will be ensuring teams can actively engage with this key group. • This engagement will ensure consistent support and motivation throughout the 12 weeks, to maximise participation throughout the programme. • Upon completion of the 12 week programme there will be opportunities for re-referral or signposting into main stream activities.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Forth Valley Case Management Service – For People With ARBD	• Provide a cost effective service to ensure that individuals are not kept in hospital for too long, and do not present in crisis when this can be avoided. • Develop an integrated care pathway for ARBD. • Develop training materials and information for partner agencies • Provide comprehensive assessment including alcohol screening, cognitive screening, mental and physical health, quality of life/recovery capital. • Design holistic and person centred care packages, liaising with other disciplines where necessary. • Provide comprehensive assessment as above. • Offer a holistic rehabilitation package to each individual, including cognitive enhancement sessions and psychosocial interventions adapted for cognitive impairment. ▪ Provide support for individuals to access recovery community e.g. mutual aid, peer support etc. ▪ Provide intermediate care through in-reach to neuro-rehabilitation where appropriate ▪ Provide a model of care based on the quality principles, embedded within a recovery oriented system of care. ▪ Provide individualised care plans following comprehensive assessment. ▪ Provide alcohol free social activities to maximise opportunities to integrate, socialise, build confidence and engage with recovery-oriented activities. ▪ Provide holistic and person centred	• A steering group will be developed in order to ensure that the new service meets existing gaps, and compliments existing provision. The service developed will target those with alcohol related brain damage, i.e. those who are experiencing lasting cognitive impairment as a result of chronic alcohol use and poor nutrition. • The service will aim to provide intensive case management for those with the most complex needs and will assess where local gaps in care may exist, e.g. the provision of rehabilitation facilities. • Training and liaison with existing services will also be provided, in order to prevent deterioration of those at risk of ARBD, e.g. through consultation with health promotion and public health, and training on recognising signs and symptoms of ARBD for multiple organisations.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	.

Medication Management Project	▪ Carry out a scoping exercise across the Falkirk Council area to establish the extent and nature of problems experienced within the community regarding the management of medication for service users.	▪ Review legislative requirements, current practice as well as consider good practice in other local authority areas and work recently carried out by the Care Inspectorate and the Royal Pharmaceutical Society. ▪ Present a report highlighting the issues and potential solutions	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
OT, Equipment and Adaptations Redesign	The provision of a streamlined service, which supports: ▪ Timely discharge and prevention of admission to hospital; ▪ Supports people to live independently within their living environments and supporting health and wellbeing for both them and their carers; ▪ Establishes an appropriate integrated infrastructure, including workforce development/training to ensure the assessment and intervention processes are timely, completed with minimum numbers of professionals being involved and person centred and make best use of available joint resources. ▪ Develop the role of the Health Care Support Worker and other non-qualified staff skills sets from across the partnership to enable all people living in all tenures to have equitable access to equipment and adaptations.	• Recruitment is about to commence	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Data Analyst	▪ To support the development of the Strategic Needs Assessment and the Strategic Plan. The post holder will explore opportunities to link information from across health and social work.	▪ Recruitment discussions ongoing	▪ Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
ICF Co-ordinator	• Oversee, co-ordinate and provide programme management support to ICF projects including projects utilising other partnership funding.	• Recruitment process ongoing • There will be overall co-ordination of ICF Plan and supporting projects, including oversight of the budget, project review and evaluation arrangements; preparation of reports as required to the Integration Joint Board and Scottish Government.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

Performance Management and Programme Support	• Monitor and support projects, and provide performance information to the Joint Management Group and the Integration Joint Board	• Source, gather and analysis detailed statistical information to support the implementation of the ICF and DD projects using service improvement tools. • Support change and improvement in efficiency and productivity in the delivery of these projects. • This evidence will enable the IJB to assess impact and risk in service re-design/investment/dis-investment areas.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Integration Partner : Independent Sector	• Continues to improve communication and engagement with the independent sector providers for care at home and care homes in the Falkirk area.	• There are now regular meetings with the providers and officers to address a number of areas. • This has resulted in opportunities to improve skills, learning and training and consider how provider can respond creatively and responsively to changing needs. • As the post holder is employed by Scottish Care there is a strong network of learning and support that is of benefit to the partnership.	• Quarterly Monitoring Reports • Six-monthly Project Update Review Meetings • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

TSI Support	• To facilitate wider representation with the sector that will be underpinned by a framework allowing an ongoing, two way exchange of information and provide the sector the opportunity to input views, where appropriate.	• Recruitment process ongoing.	• Quarterly Monitoring Reports. • Six-monthly Project Update Review Meetings. • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	
Closer to Home- • ALFY • enhanced community team • Additional Care and Support Costs	• Building on the Bo'ness pilot, further develop a streamlined model for accessing services and supporting people to remain at home in a more effective way across the full partnership area. • Provide a single point of contact for specifically identified individuals using SPARRA data. • Adopting a model similar to Hospital at Home which will provide the most appropriate and least invasive care option.	• There are already a number of initiatives underway. This project will connect projects and services in a more cohesive way.	• Quarterly Monitoring Reports. • Six-monthly Project Update Review Meetings. • Quarterly reporting to Falkirk Joint Management Group and Falkirk Integration Joint Board.	

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16 **ANNEX B**

Integrated Care Fund - Indicators of progress

Question	Comment
How has ICF funding allowed links to be established with wider Community Planning activity?	The Falkirk Integrated Care Programme reports to the Falkirk Joint Management Group (JMG) at monthly meetings. The JMG is a key group which supports the Community Planning Partnership in Falkirk. This ensures that services and projects funded through partnership funding such as the ICF is aligned to the Single Outcome Agreement. This structure enables public and third sector organisations to play a crucial role in aligning the needs of service users and carers with the priorities of CPP partners.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	The Falkirk Integrated Care Programme has been established on the basis that a commissioning based approach is taken to directing ICF investment in contrast to the previous process in allocating RCOP money. The Falkirk Health & Social Care Partnership Draft Joint Strategic Needs Assessment and the Draft Falkirk Integrated Strategic Plan 2016/2019 being developed are currently going through governance processes which will direct future commissioning efforts and the use of ICF resources. ICF funding will be crucial to enable investment in priorities identified in the Strategic Plan. Projects have been awarded linked to service user and carer needs that have been identified. Linkages to the Draft Falkirk Integrated Strategic Plan 2016-2019 will continue to be developed with full stakeholder engagement.
How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users	The Integrated Care Programme in Falkirk has added additional capacity to localities by delivering locally based services. The ICF investment has supported the partnership, including the third and Independent sectors to develop targeted services to deliver on priorities such as inequalities within communities and offering services to service users and carers. All of these approaches help to demonstrate that strategic priorities can be progressed by targeted activity tailored to local geographies and demographics which echoes the main underlying message of the localities approach.

What evidence (if any) is available to the partnership that ICF investments are sustainable	The continued development and implementation of the ICF project Performance Framework will help to measure the sustainability of ICF investments. This will provide information to enable future investment and disinvestment decisions.
Where applicable - what progress has been made in implementing the National Action Plan for Multi- Morbidity	The Falkirk Integrated Care Programme has been developed in alignment with the National Action Plan for Multi-Morbidity

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

PARTNERSHIP DETAILS

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The content of this template has been agreed as accurate by:

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