This paper relates to Agenda Item 7

Title/Subject:	**Partnership Funding**
Meeting:	**Integration Joint Board**
Date:	**3 June 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of this report is to present findings and recommendations regarding Partnership funding: Integrated Care Fund, Delayed Discharge and Bridging Funds. This follows a report to the Integration Joint Board on 4 February 2014, which made the following recommendations:

a) authorise the Chief Officer, in discussion with the IJB Chair and Vice-chair and Chief Executives, to agree interim funding of up to 6 months beyond 31 March 2016 where funding ends at that date within the existing available resources

b) remit the Chief Officer to complete a full evaluation and review of each project and to report back in detail with recommendations to the IJB meeting on 3 June 2016

c) remit the Chief Officer, in conjunction with the Falkirk Joint Management Group (JMG), to review local governance arrangements for the administration of the partnership funding; and

d) remit the Chief Officer, in conjunction with the Falkirk JMG, to bring forward to the June 2016 Board meeting a detailed Partnership Spending Plan for 2016/17 that will support the implementation of the Strategic Plan priorities.

2. RECOMMENDATIONS

The Integration Joint Board is asked to:

2.1. note the current financial position detailed in section 4,

2.2. note the approval of interim funding of up to 6 months by the Chief Officer, in discussion with the IJB Chair and Vice-chair and Chief Executives, for projects with an end date of 30 March 2016,

2.3. approve the draft Integrated Care Fund, End of Year report for submission to the Scottish Government, provided as Appendix 3,

2.4. note the findings of the review of partnership funding and remit the Chief Officer to take forward specific recommendations arising, namely:

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

2.5. approve the revised governance and monitoring arrangements described in section 8 of this report and remit the Chief Officer to implement these with immediate effect,

2.6. approve allocation of partnership funds, for initiatives with an end date of, or before, 30 September 2016 as presented in Appendix 6,

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

3. BACKGROUND

Integrated Care Fund

3.1. In September 2013, the Scottish Government announced additional resources of £100m to Health and Social Care Partnerships in 2015/2016 through the Integrated Care Fund (ICF). The purpose of the allocation is to support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen approaches to tackling inequalities. In March 2015, the Scottish Government announced an additional £200m to be shared between partnerships during the period 2016-2018. Falkirk HSC's allocation of ICF is £2.88m per annum, over the three years, 2015-2018.

3.2. Partnerships were asked to submit an Integrated Care Plan to the Scottish Government in December 2014, providing evidence based proposals setting out local principles and investment priorities, proposed allocations against the priorities and implementation and governance arrangements. The Plan outlined that ICF will be used to support a focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity is common in adults under 65, as well as in older people. A narrative regarding the local investment priorities and the national and local principles are provided in Appendix 1 of this report.

Bridging Fund

3.3. ICF is intended to build on the Reshaping Care for Older People (RCOP) Change Fund, which ran from 2011-2015.To enable Partnership areas to continue and build on initiatives established through the RCOP Change Fund, permission was granted for unallocated resource to be carried forward to be used to transition a limited number of relevant RCOP initiatives to ICF. The criteria for this being that any continuing initiatives must contribute towards the integration of health and social care, are scalable to include the adult population, as opposed to older people, and align with ICF priorities. The amount of bridging resource carried forward was £1.639m.

3.4. The introduction of the ICF builds on the achievements of the RCOP programme in Falkirk by extending provision in areas including:

- The implementation of the Joint Commissioning Plan for older people.
- The redesign and roll out of intermediate care pathway to support hospital discharge and prevention of admission.
- The development and implementation of technology enhanced provision to support care pathways through telecare and telehealth.
- Enhanced community based support focussing on early intervention and prevention and avoiding escalation of condition.

Delayed Discharge Fund

3.5. In January 2014, the Scottish Government allocated an additional £100m over three years to Partnerships via NHS Boards, aimed at preventing delays in discharge and preventing admissions to hospital and attendances at A&E. The intended cumulative effect was to reduce pressure across the system and to support health boards and local authorities to deliver good quality care and support for people at home or in a homely setting. Delayed Discharge funds must be targeted on initiatives which support achievement of the government target. Falkirk Partnership's allocation for the three years 2015-2018 is £0.864m per annum.

3.6. In addition, the Scottish Government had provided non-recurring funding to the Falkirk Partnership in 2014/2015 and there was a small carry forward of £33k into 2015/2016 financial year. Therefore, the total available Delayed Discharge (DD) resource during 2015/2016 was £0.897m.

3.7. Although the ICF and Delayed Discharge (DD) fund have defined parameters of use, the collective resource has the potential to enable transformational change and improvement to service provision across the whole system. Therefore, to allow the impact of the total resource contribution to be evaluated, a consistent approach to governance, monitoring and reporting will be applied across all funding partnership funds.

4. FINANCIAL OVERVIEW

2015/16 Expenditure

4.1 Total Expenditure against Partnership Funding Streams totalled £3.676m in 2015 /2016 and is detailed in Table 1, below.

	2015/16 Funds Available	2015/16 Expenditure	Variance
	£'000	£'000	£'000
Bridging Resource	1,639	1,448	191
Delayed Discharge	897	867	30
Integrated Care Fund	2,880	1,236	1,644
Transistional Funding	126	126	0
TOTALS	**5,542**	**3,676**	**1,866**

Table 1

4.2 This reflects expenditure being £647k less than was projected in the report to the Integration Joint Board on 4 December 2015.

4.3 The movement is largely a matter of timing of projects and expenditure and some projects spending less than previously anticipated. It is imperative to consider these as part of a three year investment programme to support the priorities of the Strategic Plan.

4.4 The main areas of movement between the December 2015 projections and the outturn related to:

Bridging Resource

- An underspend on Social Work Capacity Team as a result of inability to fill posts;
- Unspent resource allocated for Share Lives Project not taken forward; and
- An overestimate of costs relating to Support for Carers at Hospital Discharge.

Delayed Discharge

- Less than anticipated expenditure levels relating to the Rapid Access Frailty Clinic and Discharge Hub.

Integrated Care Fund

- Less than anticipated expenditure on Closer to Home;
- The Alcohol Related Brain Disorder (ARBD) project not yet having commenced;
- The Data Analyst post not being appointed to in 2015/16;
- No spend in 2015/16 relating to Stakeholder Engagement (this will now occur in 2016/17); and
- Small underspends within other projects.

2016/17 and 2017/18 Resources Available

4.5 Taking into account 2015/16 expenditure Table 2 below reflects the total resources available to the partnership over 2016/17 and 2017/18

	Carried Forward from 2015/16	2016/17 Allocation	2017/18 Allocation	TOTALS
	£'000	£'000	£'000	£'000
Bridging Resource	191	-	-	**191**
Delayed Discharges	30	864	864	**1,758**
Integrated Care Fund	1,644	2,880	2,880	**7,404**
TOTALS	**1,866**	**3,744**	**3,744**	**9,354**

Table 2

Comparison of Projected Expenditure and Resources Available 2016/17 and 2017/18

4.6 Based on the content and issues describes in this report the currently projected expenditure levels for 2016/17 and 2017/18 are detailed in Table 3, below. This table assumes the Bridging and Integrated Care Fund Resources carried forward from 2015/16 are utilised evenly over 2016/17 and 2017/18.

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

Table 3

4.7 Table 3 illustrates the resources available to commit in 2016/17 and 2017/18 to support the delivery of the priorities in the Strategic Plan.

4.8 It should be noted that there is unallocated Delayed Discharge funding for 2016/17 of £378k. In 2015/16 Delayed Discharge funding was made available to contribute to costs of Care Home Places and Ward 5 at Falkirk Community Hospital which has not been included in 2016/17 projections. It is suggested that proposals are brought forward to the August board on the utilisation of this funding. Future commitments against Delayed Discharge funding requires to be aligned to Strategic Plan priorities and achievement of national Delayed Discharge targets.

4.9 The Board will also wish to ensure that commitments against funding available reflect the need to maintain recurrent financial balance and ensure that projects achieve outcomes required.

5. APPROVAL OF INTERIM FUNDING

5.1. In line with recommendation a) presented to the Integration Joint Board on 4 February 2016, on 17th March, 22 projects were presented by the Chief Officer to the IJB Chair and Vice-chair and Chief Executives, with recommendations regarding interim funding of up to 6 months beyond 31 March 2016, for projects where funding ended at that date, within the existing available resources.

5.2. Approval was given for twenty of the twenty-two projects reviewed, to continue for a period of six months, from 1 April 2016 to 30 September 2016. One project has reached a natural conclusion and therefore stopped and one project was suspended due to recruitment issues that prohibited progress.

5.3. Project leads were asked to submit a confirmation of award form, stating that the funding would be used within the defined period of time and award was subject to submission of quarterly monitoring returns. Where required, these projects have now submitted proposals for on-going funding, details of which are included in section 9.

6. REVIEW OF PARTNERSHIP FUNDED PROJECTS

6.1. In relation to recommendation b), which was to 'remit the Chief Officer to complete a full evaluation and review of each project and to report back in detail with recommendations to the IJB meeting on 3 June 2016', an evaluation has now taken place of overall performance and progress during 2015/2016.

6.2. The Integrated Care Plan submitted to the Scottish Government in December 2014, described local investment priorities for the allocation of ICF. The investment priorities take into consideration whole system pathways for people with multiple conditions and therefore are relevant in the review and evaluation of both ICF and DD investment. In summary, investment areas are:

- **Avoiding Unplanned Admission**
  Anticipatory and responsive integrated pathways, for people who are frail, have complex or multiple conditions, with an emphasis on intermediate care, that enable people to remain in their own home, or in a homely setting for longer.

- **Health and Wellbeing in Communities**
  Locality based investment tackling inequality and geographical need, with a focus on keeping people healthy, early diagnosis and preventing decline through development of sustainable local capacity and support networks.

- **Carers**
  Provision of a range of support for people who provide unpaid care to ensure that they are confident and able to fulfil their caring responsibility whilst also maintaining their own health and well being.

- **Infrastructure**
  Investment enabling specific improvement or re-design of services of systems, that will underpin and support integrated pathways and short-term investment to help facilitate the development of Partnership infrastructure which adds value to capacity and the ability to deliver effective and integrated services, in the longer-term.

6.3 During 2015/2016, partnership funding supported a total of 43 initiatives, of which seven were supported by DD funds. Figure 1 provides initiatives funded, grouped by priority investment area. Initiatives supported by DD funds are grouped within the heading of Avoiding Unplanned Admission on the basis of the benefit to service users of timely discharge in terms minimising the trajectory to care home admission.

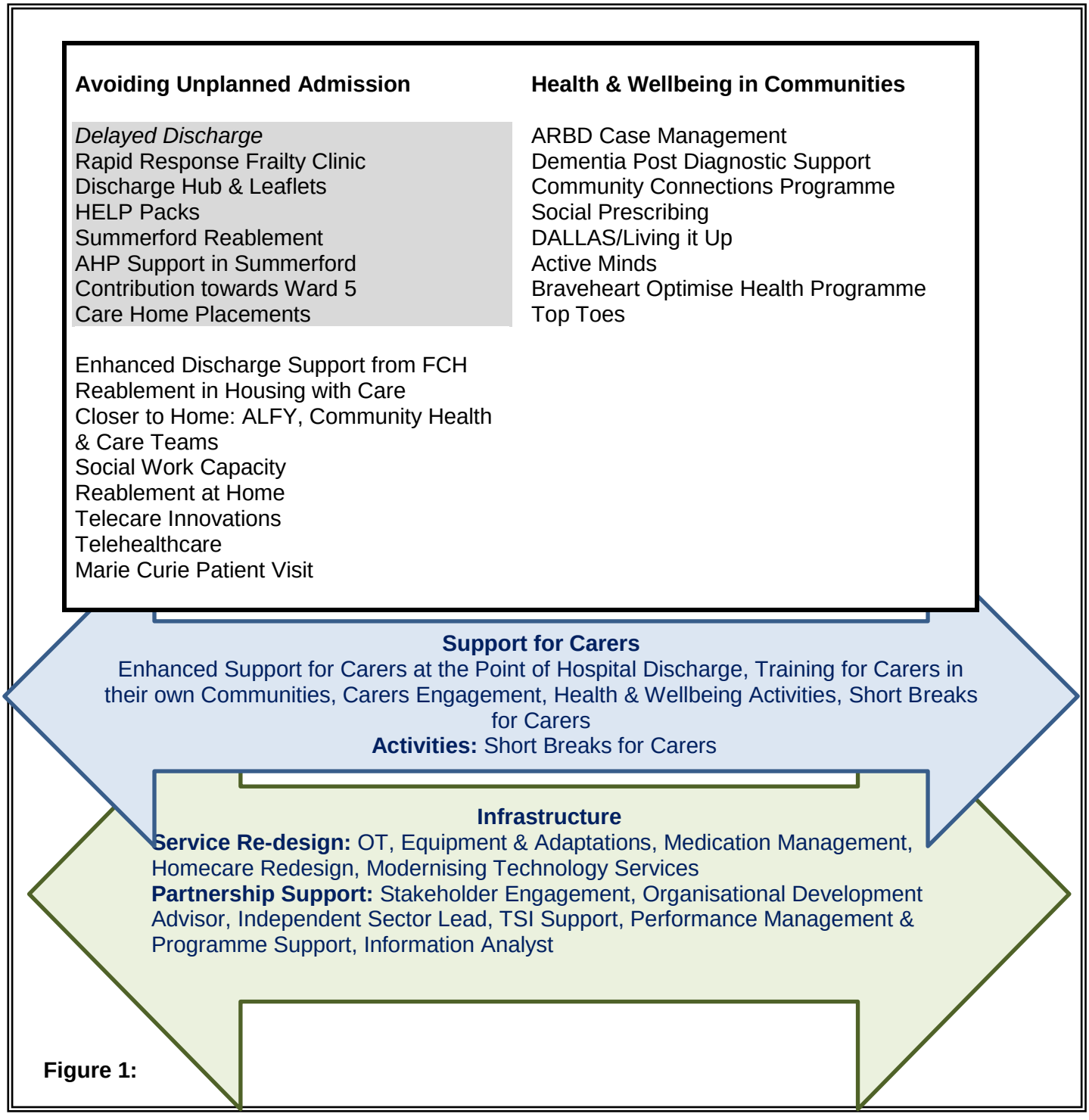
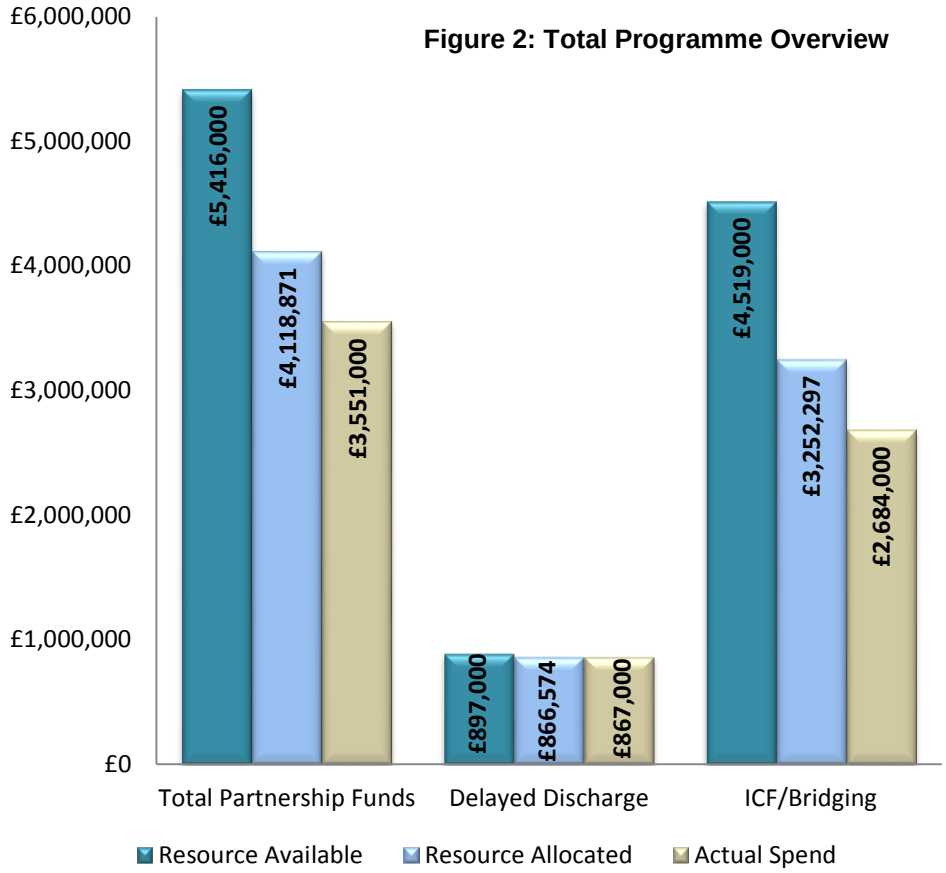


Figure 1:

6.4. As described within section 4 of this report, the total partnership funds available during 2015/2016 were £5.416m. This figure includes DD, ICF and Bridging Funds. As noted in 3.3 of the report, the Bridging fund comprises unspent resource from the RCOP Change Fund. It was agreed that Bridging be used to extend initiatives that contribute to ICF programme principles and priorities, including provision of direct support for Carers. As such ICF and bridging have been grouped to illustrate the collective spend and impact. Figure 2 provides an overview for 2015/2016 of total partnership funds, the approved allocation of partnership funds by DD and ICF/Bridging and the total spend by DD and ICF/Bridging.



6.5 Underspend in allocation relates to projects that have been approved, but have then experienced delays in recruitment or have issues with staff retention. It should be noted that given the notable scale of this issue, governance arrangements are described in 8.14 of this report.

6.6 The Integrated Care Plan, submitted to the Scottish Government in December 2014, provided an indicative allocation of ICF funds for each priority investment area. Figure 3 provides an overview of the proportional split of indicative allocation by priority heading. Figure 4 highlights the proportions of actual spend of ICF/Bridging during 2015/2016, against each priority heading. It is notable that the proportion of spend does not align with the indicative proposals within the Integrated Care Plan, with a significant underinvestment in Health and Wellbeing in Communities.

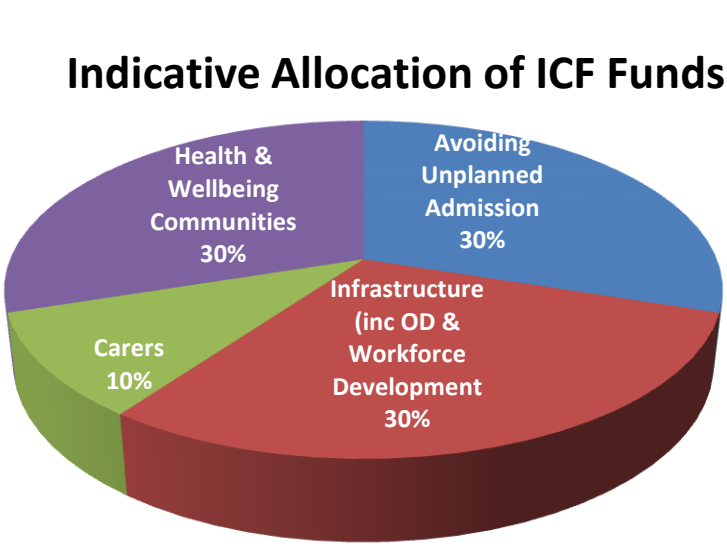


Figure 3

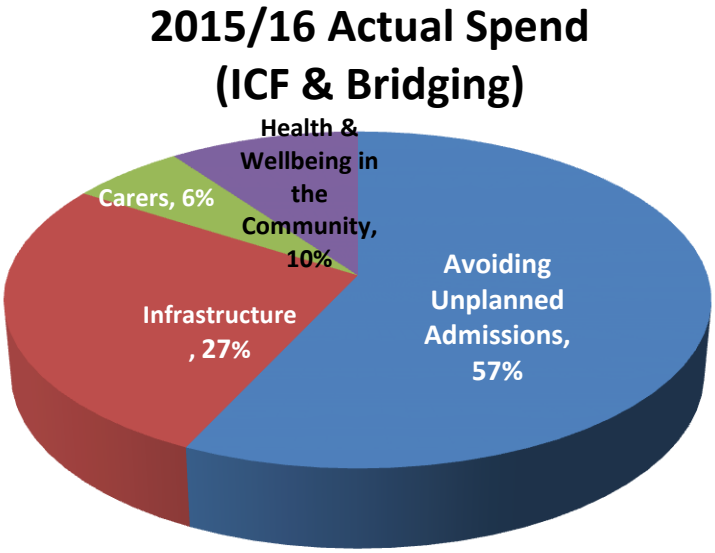


Figure 4

6.7 When the ICF/Bridging spend is combined with the DD spent, it is further evident that the highest level of investment during 2015/2016, supported pathways around hospital admission and discharge. Figure 5 shows the overall proportional investment of partnership funding during 2015/2016, against priority investment heading.

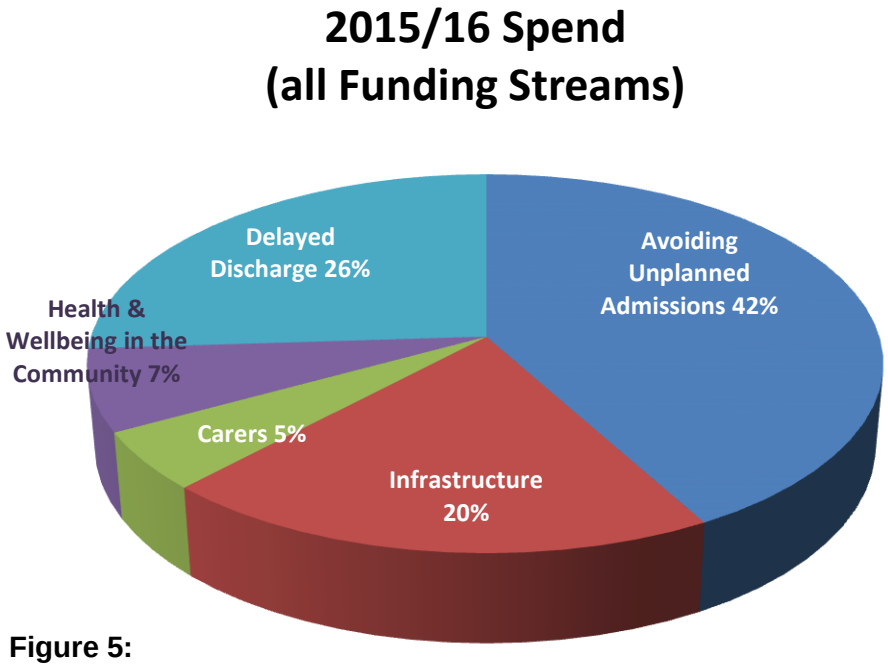


Figure 5:

6.8 Although Bridging funds have been used to support initiatives carried forward from the RCOP Programme, and therefore have some bearing on the proportional allocation of funds during 2015/2016, the intention of the RCOP Change Fund is consistent with ICF in terms of developing support pathways for people with multiple conditions and frailty, with a focus on provision of care and support within communities. The investment profile of the RCOP Change Fund was similar in that

the highest proportion of investment related to avoidance of hospital admission through transitional care and reablement.

6.9 Following formal incorporation and launch of Health and Social Care Partnerships in April 2016, the Scottish Government has specified that ICF must be used to support local HSCP outcomes, which in turn link to the nine National Health and Wellbeing outcomes. In addition, there remains a requirement that ICF is used in line with programme principles developed by the Scottish Government, as set out within Appendix 1. This stipulation has been used to provide a consistent framework for assessment of ICF/Bridging and also DD funds. Appendix 2 provides a concise analysis of performance across all partnership funds.

6.10 The Scottish Government require an annual report in relation to ICF investment. The timescale for submission of the report was the end of May 2016, however to provide opportunity for IJB approval a short extension has been requested. The template provided to all Partnerships has been populated with detailed performance information regarding each initiative and is provided as Appendix 3 of this report. The IJB are requested to approve the information contained, for submission to the Scottish Government.

6.11 Information regarding the use of Bridging funds is contained within Appendix 4 as there is not a requirement to report this to the Scottish Government. In addition, the Scottish Government have not issued a request for formal reporting regarding the use of DD funds and therefore a supplementary table has been provided at Appendix 5.

7 SUMMARY AND RECOMMENDATIONS BY INVESTMENT AREA

Avoiding Unplanned Admission

7.1 A total of sixteen initiatives have been supported within this area during 2015/2016, amounting to an allocation of £2.755m and spend of £2.226m. Two areas of investment totalling £0.472m (Contribution to Ward 5 and Care Home Placement) are noted as one-off contributions and a further two, (Social Work Capacity and Discharge Hub) provide an assessment and co-ordination function.

7.2 The remaining twelve initiatives form part of the intermediate care umbrella. Although individual initiative progress is being measured and short term service user outcomes are positive, there is a lack of overall strategy connecting this area with notable differences in referral pathway, assessment process, practice and risk tolerance, meaning that overall impact is difficult to assess. Long term service user outcomes should also be tracked (e.g. 6 months after exit from service) as a further means of assessing service impact and the ability to generate cost benefit analysis.

7.3 It is recommended that focussed work takes place to fully map existing provision and connectivity in relation to intermediate care, with a particular focus on the frailty model and reablement pathways. This work should build on on-going developments in relation to Single Shared Assessment and Single Point of

Contact. The purpose of this work would be to allow for a strategic approach to be taken to service re-design and future targeting of partnership funding to achieve leverage and improved outcomes for service users, based on re-shaping or developing current initiatives.

Health and Wellbeing in Communities

7.4 Eight initiatives have been supported within the investment heading Health and Wellbeing in Communities, during 2015/2016, with a total investment of £0.467m. One initiative has successfully become self-sufficient during the period, by becoming a social enterprise (TopToes). Six initiatives are based within the third sector and two within statutory services (ARBD Case Management Model & DALLAS Living it Up). It should be noted that following delays in recruitment, ARBD Case Management and Active Minds have only recently commenced, therefore progress to date is limited.

7.5 The integration of health and social care must harness approaches to joint working between third and statutory sectors. Although there are areas of good practice of collaboration, for example links established between FDAMH's Social Prescribing project and GPs, Central Carers Centre working closely with the ReACH team in Falkirk Community Hospital, there is little evidence to demonstrate that that this approach has been more widely adopted.

7.6 The ability to maintain service provided via initiatives relies on third sector organisations being truly integrated within service provision, becoming a component part of the total system through the strategic commissioning process. It is not sufficient to recommend that initiatives are sustained by third sector organisations, without first reviewing commissioning and procurement arrangements. This will require joint consideration of current Service Level/Joint Working Agreements that are in place whether supported by NHS Forth Valley and Falkirk Council, to ensure that longer-term service can be incorporated.

7.7 In order to further develop linked pathways for service users, ensuring that targeting inequality and early intervention and prevention becomes an integral component of the whole system, it is recommended that future partnership funds be directed towards community based supports that enable people to remain healthy and self-manage within their own community. The investment must support capacity and service delivery in line with ICF principles and with clear strategy for long-term sustainability.

Carers

7.8 Partnership funding has supported six initiatives that provide direct support for carers, all of which are provided by Central Carers Centre. In 2015/2016 the total allocation was £145,722. Four of the initiatives provide support through dedicated workers, two provide short breaks and health and wellbeing activities. The outcomes for carers as a result of support are very good, however, in order to assess the collective impact of all initiatives, all six individual projects now report within a single monitoring structure.

7.9 In relation to mainstreaming initiatives, it is recommended that the Social Care (Self-Directed Support)(Scotland) Act 2013 and the introduction of the Carers (Scotland) Act 2016 be considered, with regard to statutory responsibility and mechanisms for delivery and the commissioning of services to support carers.

Infrastructure

7.10 Investment in infrastructure has supported both short-term investment in service development, for example the review of medication management practice and process, to inform future provision, and also to support the development of the Partnership, for example through data analysis that helps focus service provision or engagement with stakeholder to support locality planning.

7.11 Scottish Government guidance is very clear that partnership funding should not be used to support mainstream functions within partnerships, therefore future investment requires close scrutiny to ensure that the function is not already a core partnership responsibility. It should however be noted that there is an ability to pump-prime certain activity.

8 GOVERNANCE, ACCOUNTABILITY & MONITORING

8.1 Recommendation c) was to 'remit the Chief Officer, in conjunction with the Falkirk Joint Management Group (JMG), to review local governance arrangements for the administration of the partnership funding'.

Accountability and Decision Making

8.2 Until now, there have been separate commissioning and review processes in place for ICF and DD funds. Decision making authority for all resource has been with the IJB and recommendations for both funds have been developed in conjunction with the Joint Management Group (JMG). However, ICF initiatives have been assessed and monitored by an ICF Monitoring group, comprising of NHS and Council representatives, whilst DD funds have been assessed and monitoring by the Delayed Discharge Steering Group. To enable a whole systems approach, it is proposed that processes are brought into alignment.

8.3 In line with the Public Bodies (Joint Working)(Scotland) Act 2015, a Strategic Planning Group was formed with responsibility for the development of the HSCP's Strategic Plan on behalf of the IJB. This group has a prescribed membership of NHS, Council, and Third and Independent sector representatives, including staff, carer and Housing representation.

8.4 The Strategic Planning Group has an on-going role in monitoring of the Partnership's progress towards strategic outcomes and priorities. On this basis, it is proposed that a sub-group be formed, and remitted to work with the Chief Officer and Chief Finance Officer to assess and monitor partnership funding. Recommendations made by the sub-group will then be presented to the Strategic Planning Group.

8.5 The Strategic Planning Group has no delegated authority to take decisions. Although the Chief Finance Officer, in conjunction with the Chief Officer will be accountable for the overall administration and financial governance of ICF and DD funds, they do not have delegated authority to approve funding. All recommendations for decision regarding partnership funding will therefore be presented to the IJB. Figure 6 provides an overview of the decision making structure.

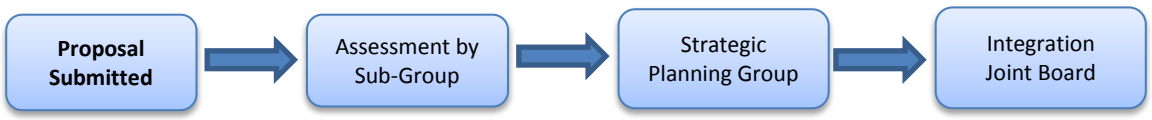


Figure 6

8.6 It is proposed that an update regarding partnership funding is provided to the IJB bi-annually, by request, by exception or where decision is required.

Pan Forth Valley Initiatives

8.7 Where initiatives are proposed to operate across Forth Valley, leads will be required to submit a single proposal form containing information about the impact of the initiative as a whole, and also by Partnership area. Initial assessment will be made following individual Partnership area processes. Chief Officers will then lead collective discussion regarding the outcome of individual assessment. Final recommendation will then be made to the IJB within each area. The process is illustrated within Figure 7 below.

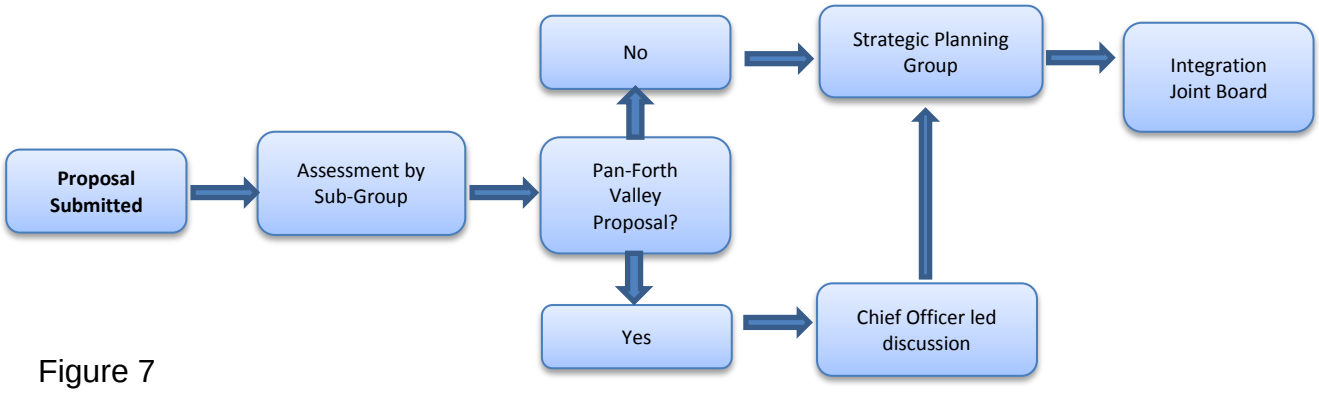


Figure 7

Commissioning and Monitoring

8.8 An amended commissioning and monitoring framework has been developed following the principles of the RE-AIM planning and evaluation framework. The RE-AIM framework allows the planning and evaluation of interventions to follow a single process, which is then aggregated to provide information about the overall impact and success of the initiative. This can be applied to both individual initiatives and the partnership funding programme.

8.9 The five core elements of the framework are:

Reach – Target group, geography and scalability.
Effectiveness – Outcomes set and impact
Adoption – Uptake of the intervention across agencies and settings
Implementation – Impact of delivery on service users, their carers and families
Maintenance – The sustainability of the intervention

8.10 The roll out of this process will be incremental. The framework has been used in the assessment of proposals where initiative end dates are 30 September or before. The outcome and recommendations are presented within section 9 of this report. It should be noted that at the time of assessment the proposed extended role of the Strategic Planning group was not in place therefore the assessment process was undertaken by the existing ICF Monitoring Group.

8.11 Although the Scottish Government now require Partnerships to report partnership funding annually, it is proposed that locally, initiatives will be monitored quarterly. Payment will be linked to submission of monitoring information. This process will be applied consistently across initiatives being delivered within statutory, third and independent sectors, with compliance being a condition of funding. This process follows the principles of Following the Public Pound, and will enable increased transparency regarding the use of partnership funds.

8.12 During 2015/2016, six projects allocated funding were then delayed or unable to progress. Reasons included issues regarding recruitment and change of initiative lead. It is proposed that a further condition of award is notification of any delay in progress/commencement. Where possible, relevant recruitment documentation should be progressed and in place as part of the development of future proposals. This will ensure that at the point that funding is awarded, that recruitment can be progressed immediately.

8.13 Failure to comply with monitoring requirements or to progress initiatives within 3 months of award will result in escalation to Chief Officer. On-going failure to comply with monitoring requirements or failure to progress initiative within 6 months will result in escalation to IJB and possible withdrawal of award.

9. INVESTMENT PLAN 2016/17 and 2017/18

9.1 Recommendation d) was to ‘remit the Chief Officer, in conjunction with the Falkirk JMG, to bring forward to the June 2016 Board meeting a detailed Partnership Spending Plan for 2016/17 that will support the implementation of the Strategic Plan priorities’

9.2 With regard to initiatives with an end date of 30 September, the revised proposal process has been implemented and funding recommendations are presented in Appendix 6 of this report.

9.3 As noted in section 4, based on funding assumptions of continued funding for the existing initiatives, there is a projected balance of partnership funding of £1.516m in 2016/17 and £1.586m in 2017/18.

9.4 The Chief Officer is currently leading a series of logic modelling discussions, which will further inform Partnership priorities in line with the outcomes of the Strategic Plan. This discussion is also helpful in being able to identify future areas of investment.

9.5 Future investment must be developed in the context of the Strategic Plan and the priorities emerging within the Local Delivery and Recovery Plans. This will require a rebalance of fund allocation towards integrated early intervention and prevention within community settings.

9.6 It is proposed that commissioning discussion now be taken forward, with a view to presenting proposals for further investment to the IJB in August 2016. Areas identified for potential further commissioning include:

- Development regarding assessment process to ensure consistency across the partnership and a focus on reablement,
- Accelerated development of locality based planning and provision,
- Community based grants to support and pump-prime the sustainable development of small, community led initiatives,
- Progression of asset mapping work previously undertaken to develop a centralised source of reliable information for use by service users, their carers and families, but also by practitioners.
- Further direct support for carers, through integrated provision.

10. CONCLUSIONS

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

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

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

Consultation
The review process has been undertaken in consultation with initiative leads. Individual initiatives are required to consult and engage with stakeholders in the development and implementation of all services. During the preparation of future

commissioning proposals, consultation is an expectation and condition of partnership funding.

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

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Approved for Submission by: Patricia Cassidy, Chief Officer

Author – Lesley MacArthur, Integrated Care Fund Co-ordinator
Date: 18 May 2016

List of Background Papers: The papers that may be referred to within the report or previous papers on the same or related subjects.

- Integrated Care Plan December 2014
- IJB Papers regarding Partnership Funding: 5 February 2016 & 4 December 2015
- Scottish Government Correspondence in relation to Year 1 ICF Reporting requirements: March 2016

Appendix 1

Falkirk Partnership Integrated Care Plan:

Integrated Care Fund Local Investment Priorities

The funding will support our partnership to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity is common in adults under 65, as well as in older people.

We will continue to build on strategic planning and operational work taking place and reflect on the lessons learned from this work and ongoing reviews.

Taking into account all the information previously noted in the plan, the partnership's investment priorities for the Integrated Care Fund are:

- **Avoiding Unplanned Admission**
  for example, build on anticipatory care planning; build on intermediate care bed capacity; build on emergency respite capacity provision; enhance co-ordination of the discharge process via enhanced multi-agency working and information sharing; develop care home capacity for those people with complex and challenging care needs; improving care pathways and navigation through the system.

- **Health and Wellbeing in Communities**
  for example, develop a localities approach and extend asset based approaches, in particular linking service user feedback with service provision; social prescribing; develop local capacity and infrastructure for example thematic groups e.g lunch/stroke clubs, community transport, drug and alcohol services; focus resource within geographical areas of high inequality (e.g. patients with complex care needs in areas of high inequality have higher level access to holistic/supported service via a case manager connected to GP service). When focussing on inequalities, we will consider those geographical areas where greater proportions of the population experience inequality and projects which will focus on prevention and mitigation of inequalities. We will also take into account priorities indentified through Falkirk Council's Poverty strategy 'Towards a Fairer Falkirk'. It is recognised that ICF investment will be used to provide opportunities for further longer-term outcomes to be delivered, given this is a one year fund.

- **Carers**
  for example, ensure the partnership continues to support the needs of carers, through the provision of direct carer support services such as short breaks/respite especially where the carer and the cared-for person both benefit, carer training, the provision of information and advice and emotional support to improve carers' health and well-being. It is expected that indirect support to carers, that takes into account carer's needs and influences the delivery of the project, are reflected across all investment priorities, augmenting the proposed allocation for this priority area.

- **Infrastructure, including OD and Workforce Development**
  for example, OD and Workforce Development - ensure that staff across all sectors have skills which allow new methods of working e.g. re-ablement;

continue to improve joint working and communication across all partners. Information and e-health programme – access to shared ICT systems for certain staff groups; information and performance management; telecare and telehealth technology. Business development support - audit current service provision across sectors with a view to developing a complete view of current provision and build on this; ensure partners management structures are able to assess impact and risk in service re-design/investment/dis-investment; improve referral processes between statutory and third sector.

Scottish Government Principles

The Scottish Government set six principles that should underpin the use of the Integrated Care Fund. These are as follows:

- **Co-production** – the use of the Fund must be developed in partnership, primarily between health, social care, housing, third sector, independent sector, people who use support and services and unpaid carers. It should take an inclusive and collaborative local approach that seeks out and **fully supports the participation of the full range of stakeholders, particularly the third sector,** in the assessment of priorities and delivery of innovative ways to deliver better outcomes;
- **Sustainability** – the Fund needs to lead to change that can be evidenced as making a difference that is **sustainable and can be embedded through mainstream integrated funding sources** in the future;
- **Locality** – the locality aspects must include input from professionals, staff, users and carers and the public. Partnerships should develop **plans with the people who best know the needs and wishes of the local population.** Such a bottom-up approach should maximise the contribution of local assets including the third sector, volunteers and existing community networks. Partners will be expected to weight the use of their funding to areas of greatest need;
- **Leverage** – the funding represents around 1% of the total spend on adult health and social care so must be able to support, unlock and improve the use of the total resource envelope;
- **Involvement** – Partnerships should take a co-production, co-operative, participatory approach, ensuring the **rights of people who use support and services and unpaid carers are central to the design and delivery of new ways of working**; and
- **Outcomes** – partnerships will be expected to **link the use of the funds to the delivery of integrated health and wellbeing outcomes for adult health and social care**.

Local Principles

Local Principles were also established. Investment:

- Will enable transformation in the delivery of core services, across all sectors;
- Is based on unmet need and the views of stakeholders;
- Transforms something which is lasting and sustainable, within defined timescale, with clear milestones;

- Directly correlates with one or more local priority and clearly helps deliver vision, outcomes and principles;
- Set out how the intervention will be delivered, monitored and evaluated;
- Is focussed on, or leads to prevention, anticipatory care and early intervention;
- Is not reliant on employing staff; and
- Demonstrates how efficiencies can be delivered.

Project Name	Lead Agency	Project Allocation 2015/16	Total Spend 2015/16	Approved End Date	Alignment to Strategic Plan	Allignment with ICF Principles	Target Age	Support for Carers	Performance	Comment
Avoiding Unplanned Admission										
Closer to Home - ALFY	NHS	£103,500	£32,799	Nov-16			OP	DIRECT	?	New initiative
Closer to Home - Additional Care & Support	Falkirk Council	£229,200	£94,214	Nov-16			OP	INDIRECT	?	New initiative
Closer to Home - Enhanced Community Health Team	NHS	£346,500	£63,860	Nov-16			OP	INDIRECT	?	New initiative
Social Work Capacity	Falkirk Council	£42,962	£42,962	Suspended			OP	INDIRECT	?	Suspended
Enhanced Discharge Support from FCH	NHS	£125,751	£103,876	Sep-16			OP	DIRECT	✔	
Reablement in Housing with Care	Falkirk Council	£326,896	£326,896	Sep-16			OP	DIRECT	✔	
Reablement at Home	Falkirk Council	£234,459	£234,459	Sep-16			OP	DIRECT	✔	
Telecare Innovations - Night Service & Falls Co-ordinator	Falkirk Council	£258,164	£239,601	Sep-16			OP	DIRECT	?	Further review
OT, Equipment & Adaptations Redesign	Falkirk Council	£67,000	£0	Sep-16				INDIRECT	✘	Now recruiting
Marie Curie Patient Visit Service	Marie Curie	£46,517	£34,712	Sep-16			OP	DIRECT	✔	
Telehealth Care	Falkirk Council	£220,997	£220,997	Sep-16				DIRECT	✔	
TOTAL		**£2,001,946**	**£1,394,376**							
Avoiding Unplanned Admission: Delayed Discharge										
Rapid Response Frailty Clinic	NHS	£173,499	£173,499	Mar-16			OP	DIRECT	?	Further review
Discharge Hub	NHS	£94,439	£94,439	Mar-16			OP	INDIRECT	✔	
HELP Packs	CVS Falkirk & District	£26,866	£26,866	Sep-16			OP	DIRECT	?	Further review
Summerford Beds Cost to Council	Falkirk Council	£47,800	£47,800	Mar-16			OP	INDIRECT	?	Further review
AHP Support to Summerford	NHS	£51,970	£51,970	Mar-16			OP	INDIRECT	?	Further review
Care home placements	Falkirk Council	£236,000	£236,000	Mar-16			OP		●	
Contribution to FHC Ward 5	NHS	£236,000	£236,000	Mar-16			OP		●	
TOTAL		**£866,574**	**£866,574**							
Health & Wellbeing in Communities										
ARBD Case Management Model	Forth Valley ADP	£75,000	£0	May-17				INDIRECT	✘	Now recruiting
Post Diagnostic Support	Alzheimers Scotland	£95,333	£95,333	Sep-16			OP	DIRECT	?	
Community Connections Programme	Alzheimers Scotland	£10,600	£10,360	Sep-16			OP	DIRECT	✔	
Active Minds - FCT	Falkirk Community Trust	£40,800	£6,840	Feb-17					?	New initiative
Braveheart Optimise Health Programme	Braveheart	£20,067	£20,067	Sep-16					?	
Top Toes	CVS Falkirk & District	£43,067	£43,067	Ended			OP	INDIRECT	●	
Social Prescribing	FDAMH	£100,000	£53,848	Sep-16				INDIRECT	✔	
Dallas / Living it Up	NHS	£15,950	£9,150	Sep-16			OP	INDIRECT	✔	
TOTAL		**£400,817**	**£238,665**							
Direct Support for Carers										
Carers Support Planning	Central Carers Centre	£30,237	£30,237	Sep-16				DIRECT	✔	
Enhanced Support for Carers at Point of Hospital Dicharge	Central Carers Centre	£5,688	£5,688	Sep-16				DIRECT	✔	
Traiining for Carers in their Own Community	Central Carers Centre	£35,484	£35,484	Sep-16				DIRECT	✔	
Carers Engagement	Central Carers Centre	£39,113	£39,113	Sep-16				DIRECT	✔	
Health & Wellbeing Activities	Central Carers Centre	£6,000	£6,000	Sep-16				DIRECT	✔	
Short Breaks for Carers	Central Carers Centre	£29,200	£29,200	Sep-16				DIRECT	✔	
TOTAL		**£145,722**	**£145,722**							
Infrastructure										
Medication Management	Falkirk Council	£20,000	£12,500	Sep-16					✔	
OD Advisor	NHS	£50,839	£50,455	Sep-16					?	Post vacant
Homecare Redesign	Falkirk Council	£214,000	£214,000	Ended			OP	INDIRECT	●	
Modernising Technology in Care Services (RTM)	Falkirk Council	£111,499	£111,499	Sep-16			OP	INDIRECT	✔	
Stakeholder Engagement Officer	Falkirk Council	£53,930	£13,930	Sep-16				DIRECT	✘	Not commenced
TSI Support	CVS Falkirk & District	£75,000	£75,000	Sep-16				INDIRECT	✔	
Independent Sector Lead	Scottish Care	£33,300	£16,600	Sep-16				INDIRECT	✔	
Senior Information Analyst	ISD	£48,700	£0	Sep-16					?	SLA being developed
Integrated Care Fund Coordinator	Falkirk Council	£55,000	£0	Sep-16					✔	
Performance Management & Programme Support	Falkirk Council	£41,544	£41,544	Sep-16					✔	
Infrastructure		£0	£133,964	Sep-16					●	
TOTAL		**£703,812**	**£669,492**							
		£4,118,871	**£3,314,829**							

Key									
	SP Alignment (proportion out of **5** outcomes)	ICF Alignment (proportion out of **6** principles)	OP Predominantly Older People	DIRECT Direct support	INDIRECT Indirect Support	✔ On target / Performing	? Action Required/Further Review	✘ No current performance	● Ended

INTEGRATED CARE FUND – END YEAR REPORTING TEMPLATE 2015/16 **Appendix 3**
FOR APPROVAL

Integrated Care Fund – 2015/16 – End-Year Financial Summary
Falkirk Partnership

Initiative Name	Allocation for 2015/16	Total Year Spend	Over/Underspends
Closer to Home - Additional Care & Support	£229,200	£94,214	£134,986
Closer to Home – Enhanced Community Health Team	£346,500	£63,860	£282,640
Enhanced Discharge Support from FCH	£108,300	£86,425	£21,875
Closer to Home – ALFY	£103,500	£32,799	£70,701
Homecare Redesign	£214,000	£214,000	£0
Telecare Innovations – Night Service & Falls Co-ordinator	£163,500	£144,937	£18,563
ARBD Case Management Model	£75,000	£0	£75,000
Medication Management	£20,000	£12,500	£7,500
Modernising Technology in Care Services (RTM)	£67,800	£67,800	£0
Post Diagnostic Support	£76,000	£76,000	£0
Community Connections Programme	£10,600	£10,360	£240
Active Minds – FCT	£40,800	£6,840	£33,960
Braveheart Optimise Health Programme	£13,400	£13,400	£0
Marie Curie Patient Visit Service	£31,200	£19,395	£11,805
Social Prescribing	£100,000	£53,848	£46,152
Health & Wellbeing Activities	£6,000	£6,000	£0
Short Breaks for Carers	£29,200	£29,200	£0
Dallas / Living it Up	£9,200	£2,400	£6,800
Stakeholder Engagement Officer	£40,000	£0	£40,000
OD Advisor	£40,000	£39,616	£384
Senior Information Analyst	£48,700	£0	£48,700
Integrated Care Fund Coordinator	£55,000	£0	£55,000
TSI Support	£75,000	£75,000	£0
Independent Sector Lead	£33,300	£16,600	£16,700
Performance Management & Programme Support	£36,500	£36,500	£0
OT Equipment & Adaptations Redesign	£67,000	£0	£67,000

Infrastructure	0	£133,964	-£133,964
Balance of Funding	£840,300	£0	£840,300
Total ICF spend – 2015/16	**£2,880,000**	**£1,235,6587**	**£1,644,342**

Integrated Care Fund – 2015/16 – Achievement of ICF Outcomes

ICF Themes: Service re-design, Prevention, Early Intervention, Care & Support
Funding Breakdown: Please provide a breakdown of the funding for each activity or project i.e. health board, local authority, third sector organisation, independent sector organisation

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE	THEME(S)	FUNDING BREAKDOWN (Based on Spend)
Closer to Home – Enhanced Community Health Team	24/7 service in place supporting: Patient with diagnosis, Rapid assessment following fall, Discharge facilitation. Service now developing to include pre-diagnosis support. Outcomes focus being rolled out across staff and ACP in place.	By week **(FV)**: • 244 referral received • 172 classed as urgent • Referral source (141 GP, 10 ALFY,2 frailty clinic) • No. of contacts within duration of support (1-4 103 highest) • Discharge numbers and reason (46 admitted to acute, 64 no longer need care) • Support provided	Further review of project to take place in context of Intermediate Pathway/Reablement/ Frailty model	Service re-design, Prevention, Care & Support	ICF £63,860 Health £63,860
Closer to Home – Additional Care & Support	Provision of additional capacity to allow additional reablement at home to be provided to support Closer to Home project. Aim is that social care officer to take an active role in asses of care at home provision shift package from standard 4 visits to outcomes focussed approach	1 Social care Officer recruited	Further review of project to take place in context of Intermediate Pathway/Reablement/ Frailty model	Service re-design, Prevention, Care & Support	ICF £94,214 Falkirk Council £94,214
Closer to Home – ALFY	24 hour manned help line in place. Service users, their carers and families have access to reassurance, advice and referral as required. The helpline is manned by band 5 and 6 nurses. Publicity targeting +65 & Professionals has been undertaken.	From the ALFY/ Your Plan Monitoring: • Number of Calls: average daily call rate - 4.2 calls (April 2016) • Number of Calls per month and % in priority target group: Group A 34.8%; Group B 56.5%; not in target group 8.7% (March 2016)	Further review of project to take place in context of Intermediate Pathway/Reablement/ Frailty model	Prevention, Early Intervention, Care & Support	ICF £32,799 Health £32,799

		• Breakdown of calls by day and time: weekday in-hours 70; weekday OOH28; weekend in-hours 19; weekend OOH 8 (April 2016) • Breakdown of calls by caller: 27% Patient; 30% Relative; 20% Spouse; GP 7% (between 01/12/2015-30/04/2016) • Breakdown of calls received by locality: Clacks CHP 20; Falkirk CHP 58; Non-FV 4; Stirling CHP 43 (April 2016) • Breakdown of call outcome: Over 40% Advice/Reassurance Outcome (April 2016) • Time taken to deal with calls by outcome: 60.03 hrs Outcome – NHS24 signposted; 8.80 hrs Enhanced Team; 7.72 hrs Community Nurse; 7.53 hrs ReACH; JLES – Equipment Support 7.18 hrs (April 2016) • Cumulative total of Your Plans received: 317 (March 2016 YTD) • Number of website hits by month: increased from under 200 in April 2015 to over 400 in March 2016.			
Homecare Redesign	Home Care Service has been redesigned to include new working practice and better partnerships with ReACH and RVS.A team Manager and 4 Home Care Managers were recruited through the project and have now been mainstreamed. A reablement ethos is now embedded within practice. Service Users involved in service redesign. Service users inform their care package through outcomes focussed personal plans now in place.	• Increased communication and enhanced joint working between those discharging patients and those arranging packages of care. • Increased access to care packages out with core business hours. • Enhanced outcome planning for individuals and their families. • Reduction in hospital bed days. • Reduction in hospital re-admissions following discharge. • Access to temporary care packages when normal channels are not able to	Project now complete	Service re-design	ICF £214,000 Falkirk Council: £214,000

		source the care required. • Enhanced access to and availability of rehab at home to service users • Supported service user journey from hospital to home. • Training all in house and external provider care staff on reablement enhancing their skills and promoting independence at home by attending, understanding and putting into practice training on reablement at home in general.			
Enhanced Discharge Support from FCH	Supports transition from acute setting. Person centred rehabilitation is provided to maximise functional independence and facilitate timely and safe discharge home. Service users and carers are more confident in their ability to self-manage and functional outcomes are improved. Service has been extended to 3 out of 5 wards within FCH with assessment taking place within 3 days of admission and rehabilitation plans being developed by AHP in conjunction with service user and Rehab Support Workers. Links are in place with community services to ensure on-going support following discharge.	• Significant increase in AHP activity throughout the year from 558 to 913 AHP contacts. • Focussed rehabilitation & discharge planning from the point of admission: ○ 1/1/16 - 31/3/16: 181 New patients assessed in Units 1,2, & 3 of FCH Inpatients. ○ 1/1/16 - 31/3/16: 44 Home assessment Visits - 2 therapists are required to attend Home Visits with RSW assisting AHP staff. • Functional Outcome Measures are being completed on admission and discharge - This has not been fully completed during the period but will be evidenced at the next reporting period. • Improved patient outcomes - This has not been fully completed during the period but will be evidenced at the next reporting period. • Falls prevention - RSW provided 90 patients with falls prevention advice over the 3 month period. • OTAGO - patients participate in OTAGO exercises with RSW as appropriate following assessment by	Further review of project to take place in context of Intermediate Pathway/Reablement/ Frailty model	Service re-design, Care & Support	ICF £86,425 Health £86,425

		AHP staff. • More timely assessment by Physiotherapist/Occupational Therapist – Assessments within 24 hours. • Training and education to develop the RSW role and allow a more appropriate skill mix and allocation of tasks - competency based training, evidence of skill mix & task allocation can be found by use of the handover sheet. • Efficient Structure to the daily routine for both patients and staff - RSW Timetable. • Increased level of rehabilitation- 1/1/16 - 31/3/16: AHP Contacts total 2774; RSW Contacts total 2400 • Increased engagement with 3rd sector – detailed data on this is held by the Carers Support Service. There have been 10 direct AHP referrals for the period.			
Telecare Innovations - Night Service & Falls Co-ordinator	MECs overnight care service continues to enable people to remain at home by providing overnight support e.g. turning, hydration, reassurance to allow carers to continue their caring responsibility during the day and reduce hospital admission. Service now extended to support uninjured fallers not known to MECS to support community nursing. Falls Co-ordinator progressing work on Falls Bundles to provide pathway for uninjured fallers through assessment and referral. 6-8 weeks support provided.	We opened our overnight care service on 28th November 2014. Since then we have had 99 individual service users using the service, some of those have had to re-refer for additional service so the numbers do not reflect the number of visits or the number of service users who are repeat clients.	Further review of project to take place in context of Intermediate Pathway/Reablement/ Frailty model	Service re-design, Prevention, Care & Support	ICF £144,937 Falkirk Council £144,937
Medication	Defined scoping exercise to understand current medication issues	Milestones within project plan. Final report including recommendations.		Service re-	ICF £12,500

Management	and identify best practice and therefore approach to management and administration of medication. Engagement with wide range of stakeholders underway. Project findings will inform service design and standards, including use of technology to support self-management.			design, Early Intervention	Falkirk Council £12,500
Modernising Technology in Care Services (RTM)	Development and Implementation of a real time monitoring system within care at home, across Falkirk area resulting in a more efficient management system, whilst also positively impacting on care received by service users. System will be fully rolled out by Sep 2016. Further system development has significant potential benefit for wider services.	Phased implementation plan - milestones and timescales recorded. Service user feedback and evaluation.		Service re-design	ICF £67,800 Falkirk Council £67,800
Post Diagnostic Support	190 people diagnosed with dementia have been supported by PDS Link workers to access timely, relevant and responsive information to enable them and their carers and families to be better informed and equipped to manage their condition. Personal Support Plans being in place at the end of 1 year support allow people with dementia to have control, confidence and information to allow them to self-manage. Community links and peer support are in place and access to statutory service is phased in at a time and pace that is acceptable.	• Referral rates (01/01/16-31/03/16) 61 referrals (although 3 of these declined). • Current waiting list 88 (expect to remain constant as referral rate for the year was 234 and our staff capacity remains at 150). • Number of people accessing 1 to 1 support • Courses – ran one course during quarter, with 10 attendees & positive feedback. • Peer support: build peer support networks for both carers and people with dementia at all stages. • Feedback from Service users, their carers and families.	An 8 pillar pathway is currently being developed for those at moderate/later stages of dementia. A triage process is also planned to help identify appropriate pathway.	Early Intervention, Care & Support	ICF £76,000 Third Sector – Alzheimer's Scotland £76,000
Community Connections Programme	People with dementia have access to a range of peer support groups which allow them to gather information	• Garden Club- meets twice weekly for 2 hrs. There is regular group of 6 people who attend each week		Prevention, Early Intervention,	ICF £10,360 Third Sector –

	about their condition, network with people who are experiencing similar issues thereby developing self-management and enhancing independence for longer. People with a diagnosis of dementia are introduced to services and supports in a way that is acceptable and at a pace that suits them.	(Women's group Monday & Gents' Thursday). During the winter months the focus is more on crafts however the actual activity is secondary to providing an opportunity for people to relax and chat with peers and be able to participate at their level. (Attendance Jan 86%, Feb 75%, Mar 86%) • Supper Club - couples' two course meal once a month. (5 couples regularly attend) - £7.50 contribution (per couple) towards the cost of the meal. • Evaluations reflected the importance of being able to go out socially as a couple and the value of being with others with similar issues. • Football Reminiscence - Three groups a month (also started a cricket group). People (mostly men) make their own way to and from the group • Baristas Dementia Café-Weekly – continues to be well attended & recent evaluation explored why people attend and the impact it had on them. Unsurprisingly peer support was a significant factor along with an opportunity to share their own experiences and share tips, as well as people feeling relaxed and supported in the environment. • Walking Group - Ten pin bowling - meets weekly & promotes wellbeing through activity such as walking or in inclement weather to go indoors for a game of Ten pin bowling.		Care & Support	Alzheimer's Scotland £10,360
Active Minds – FCT	People with mental health issues have access to supported physical activity programme. Co-ordinator recently appointed. Project will develop and test programmes for	Info to be gathered: Number of referrals, programmes developed. Mental Health outcomes evaluation tools will be used. Service user feedback and case studies.	Project started March 2016 and therefore limited reporting to date.	Prevention, Early Intervention,	ICF £6,840 Falkirk Community

	people with mental health issues, develop a co-ordinated referral pathway and thereafter tailored activity programme. Upskill all frontline staff in Mental Health Awareness and First Aid. Physical activity staff are qualified to level 4 standard in MH programming.			Care & Support	Trust £6,840
Braveheart Optimise Health Programme	Preventative programme developed to promote health lifestyle choices delivered to targeted groups where need is identified e.g. homeless, people in criminal justice system, overweight people. Volunteers trained as health mentors and walking guides to support project delivery.	• Number of people taking part in health & wellbeing sessions (184) • People with increased understanding of healthier lifestyle (184) • People encouraged to take up community based walking (184) • People received volunteer training (7)	Project looking to identify funding from external sources. Consider different target groups. Assess impact through follow-up and review of participants.	Prevention, Early Intervention	ICF £13,400 Third Sector – Braveheart £13,400
Marie Curie Patient Visit Service	3 Marie Curie Nurses, based within OOT in FVRH provide palliative care focussing on patient and carer to support choice to be able to die at home. The service is based within the Out of Hours team in Forth Valley Royal. As the out of hours team build preventative pathways with community nursing, care homes and A&E, the Marie Curie service is able to support and complement the core team to meet the additional demands of patients with a palliative care need. The service complements Strathcarron Services and Homecare with qualified RNs able to make evening and weekend short visits at short notice. Patient and family feedback has appreciated this partnership working. The service is match funded with Marie Curie charitable income.	• Number of people supported: 83 Patients YTD 2015/16 (as at Dec) • Number of visits: 548 YTD 2015/16 (as at Dec) • Age 60-90: 85% YTD 2015/16 (as at Dec) • Health inequalities: 50% patients seen YTD have been in IMD Quintiles 1 & 2 (most deprived) • 95% of patients support by the service died in their preferred place of choice. (YTD as at Dec 2015) • The service achieved a 96% satisfaction rating from carers (YTD as at Dec 2015) • Training days, national data re cost benefit analysis compared to local.	Discussion on-going regarding mainstreaming service	Care & Support	ICF £19,395 Third Sector – Marie Curie £19,395

Social Prescribing (FDAMH)	3 Social Prescribers provide a holistic non-medical based service that increases people's ability to self-manage long term conditions leading to increased mental health and wellbeing. Links and referral pathways are in place between service and GPs and other agencies. People are more confident and able to cope. Reduction in referral to psychological services and GP prescribing. People are supported through informal networks to support own mental health and access information impacting on their mental health e.g. debt advice	• Clients (390) • Referral to SP (309 from GP, 81 from Immediate help service)WEMWB scale, • Client feedback forms, • Feedback from GPs re reduced need to prescribe and onward referral, • Session/courses delivered (3 Anxiety management courses with 21 participants, 551 1-1), • Info provided (817), • Referral onwards (295)	Social Prescribers operating on rotational basis due to demand.	Prevention, Early Intervention, Care & Support	ICF £53,848 Third Sector – FDAMH £53,848
Health & Wellbeing Activities (Alzheimer Scotland)	Provision of health and wellbeing activities for carers which helps sustain their caring relationship by improving their own health and wellbeing. Carers involved in the development of the programme by using solution focussed, asset based approaches to support carers to build of their own skills and knowledge to plan the type of support that they need to help them continue with their caring role.	• Number of sessions delivered (25) • Number of carers participating(127) • Carers feedback and evaluation		Prevention, Early Intervention, Care & Support	ICF £6,000 Third Sector – Central Carers £6,000
Short Breaks for Carers (Carers Centre)	Adds value to existing short breaks provision by provision of 80 carers of an adult with short breaks (includes young carers). Carers are more confident and able to cope with their caring responsibility, have improved emotional and physical wellbeing, be able to combine their caring responsibility with work, social, leisure and learning opportunities and be able to maintain good	• Number of breaks provided (43) • Carers evaluation feedback		Prevention, Early Intervention, Care & Support	ICF £29,200 Third Sector – Central Carers £29,200

	relationships with those cared for				
Dallas / Living it Up	Support Project Manager to further develop the Living it Up online platform as a means of access to information and education to promote self-management, condition management and promotion of people recognising and using their own assets. Professional able to develop specific supports e.g. videoconferencing for ReACH team, Cardiac Rehab Team 'Get Active' Programme. People gain confidence in technology as a means of additional support.	• Number of people engaged (10,000 in 3 years). • Number of people recruited to site (2000). • Additional developments.		Service re-design, Prevention, Early Intervention, Care & Support	ICF £2,400 Health £2,400
Stakeholder Engagement Officer	Development currently being undertaken to scope purpose and scope of activity. There is a need for activity however this needs to link with SP priorities and support locality planning - both of which are currently being developed.		Project requires further development prior to recruitment.	Service re-design, Prevention, Early Intervention	ICF £0 Falkirk Council No spend in 2015/2016
OD Advisor	OD Advisor has supported activities relating to staff engagement, leadership development, development of a Staff Development Framework and Participation and Engagement Strategy. Thematic/service specific OD support also provided.	Feedback from participants.	Post Vacant.	Service re-design	ICF £39,616 Health £39,616
TSI Support	The third sector assets are engaged and utilised effectively in a consistent manner via sharing information, gathering feedback through regular e-bulletin, thematic Forums, management of Community Hub at FVRH. Dedicated partnership manager to represent interests and	Number of forums, attendees, e-bulletins, notes of meetings, website content, feedback from sector		Service re-design, Prevention, Early Intervention, Care & Support	ICF £75,000 Third Sector – CVS Falkirk & District £75,000

	view of third sector in cross partnership meetings. Promote opportunities to sector.				
Independent Sector Lead	Independent Sector Lead ensures that Independent sector is engaged in strategic and operational developments within HSCI as a key partner. Development of training opportunities, links established with statutory and third sector e.g. Carers Centre.	Independent Sector Partnership Meetings: • Average attendance to date - 16.33 providers represented. • Steady increase in engagement over 2-year period from 8 providers to 28 providers. • Positive feedback required from private providers re these partnership meetings .		Service re-design, Prevention, Early Intervention, Care & Support	ICF £16,600 Independent Sector – Scottish Care £16,600
Performance Management & Programme Support	Monitor and support projects, and provide performance information to the Joint Management Group and the Integration Joint Board.	Supporting projects, assisting in the preparation of reports as required to the Integration Joint Board and Scottish Government. Collating, analysing and reporting on the performance of individual work streams.		Service re-design	ICF £36,500 Falkirk Council £36,500
ARBD Case Management Model	Development and implementation of an alternative pathway for people with ARBD which avoids admission to long-term residential care and better supports the need of the individual. Staff are better informed in being able to identify ARBD at early stages.	To be collected: CHI patient data to identify patients and follow pathway, cost saving as a result of alternative care to residential care	Progress recruitment	Service re-design, Prevention, Early Intervention	ICF £0 Health No spend in 2015/2016
Senior Information Analyst	Service level agreement being established with ISD, LIST team. The resource will support locality profiling, further analysis re high resource individuals.	Not yet started.		Service re-design	ICF £0 No spend in 2015/2016
Integrated Care Fund Coordinator	Oversee, co-ordinate and provide programme management support to ICF projects including projects utilising other partnership funding.	Overall co-ordination of ICF Plan and supporting projects, including oversight of the budget, project review and evaluation arrangements; preparation of reports as	Funding rolled forward to 2016/17 due to time	Service re-design	ICF £0 No spend in

		required to the Integration Joint Board and Scottish Government.	to recruitment.		2015/2016
OT Equipment & Adaptations Redesign	Objectives: A) Alignment of OTs; skilling of non-qualified staff and other professionals through core training; and B) Provision of clear pathways and procedures supporting assessment and interventions for individuals regardless of tenure would provide timely and person centred response to the citizens of Falkirk.	Tests of change: • Partnership group with all partners, with a shared strategy, planning processes and governance. • Performance management improvements, including budget setting and cost effectiveness. • Redesigned services with fewer hand offs (stages) and shorter end to end process. • Fast track approaches, for those in acute and community hospitals, intermediate care, short-term assessment beds and rehabilitation. • Information & advice on housing options and adaptations. • Improved approaches to communication during process, and greater choice and control.	Not yet started. Funding rolled over to 2016/17 due to recruitment issues.	Service re-design	ICF £0 No spend in 2015/2016
Infrastructure	Infrastructure				ICF £133,964 IJB Infrastructure £133,964

INTEGRATED CARE FUND – END YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund - Indicators of progress

Question	Comment
How has ICF funding allowed links to be established with wider Community Planning activity?	Links are in place between Falkirk HSCP and Falkirk Community Planning Partnership(CPP), with representatives from the HSCP being nominated onto the CPP Leadership Group. The HSCP have a responsibility in the delivery of the 4 high level priority areas and 6 outcomes described within the CPP's Strategic Outcomes and Local Delivery Plan 2016-2020 (SOLD). Falkirk HSCP's Strategic Plan is directly reflected within Outcome 5 of the SOLD Plan, '**People live full, independent and positive lives within supportive communities'.** ICF investment aligns with Falkirk HSCP outcomes and priorities. ICF contributes to wider CPP activity by supporting services which enable the development of a linked and supportive local infrastructure. ICF investment supports links between CPP partners for example, Community Care Team links with Housing Services, Braveheart with Criminal Justice, Carer's Centre with Central Scotland Fire and Police Services. In addition, a single locality planning framework is currently being developed by the CPP and HSCP. A united approach is intended to ensure that identified needs within our communities can be targeted effectively and that ICF can be directed to support this.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	Falkirk HSCP is currently undertaking a series of Logic Modelling workshops, with all partners. The purpose of the workshops is to work collectively to develop the Local Delivery Plan, which will clearly describe local priorities in relation to the outcomes of the Strategic Plan and the actions that will be required in order to meet these priorities. The process will inform the strategic commissioning process and links directly with current and future investment plans for ICF. The Logic modelling process involves the development of long, medium and short term outcomes. The Partnership's priority activities are then formed based on considering current provision against outcomes, impact and success of current delivery and evidence gathered via the Joint Strategic Needs Assessment. The process enables partners to identify gaps and initiate solution focussed discussion.
How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users?	During 2015/2016, whilst the formal locality framework has been under development, work has continued to progress within localities. Through ICF investment, Independent Sector and Third Sector Leads have worked closely with locality based organisations, to ensure inclusion and representation in strategic developments and also that local partners are able to begin to consider and develop practice and service provision in line with existing and emerging local priorities. In addition, both leads have been central to the development of the Workforce Development Plan, Participation and Engagement Plan and Market Facilitation Strategy with a key role in terms of ensuring inclusion and relevance to the Third and Independent Sectors, but also to ensure that frameworks are developed within localities to ensure implementation going forward. The Third Sector Lead facilitates the local Community Health and Care Forum, which has a wide membership of organisations who provide direct and indirect health and social care. The forum pro-actively shares information and best practice, considers and develops approaches to integrated service provision. The CHCF is also willing to be a consultative forum for the HSCP, as required. The Independent Sector Lead also facilitates a providers forum, but also attends the CHCF. At a project level, Central Carers Centre and Falkirk and District Association for Mental Health both deliver services that are

	specifically targeted to locality need. Carers Centre provides training and develops sustainable peer groups for carers, within local areas, whilst FDAMH deliver a social prescribing service within GP practices. This operates on a rotational basis, due to high demand from GPs. Future allocation of ICF further targets need within localities, based on locality profiles and locally identified need.
What evidence (if any) is available to the partnership that ICF investments are sustainable?	During 2015/2016, the Top Toes project has evolved to become a social enterprise and therefore has become self-sufficient. Homecare Redesign has concluded and the change is now being implemented within the service. Modernising Technology (Real Time Monitoring) is due to reach a conclusion in September and will continue to be rolled out through mainstream resource. In addition, the Reablement at Home project and Telecare projects are progressing to a position of sustainability through service re-design and mainstreaming. The Partnership is also reviewing services which have previously been supported through ICF, to consider and define mainstreaming in the context of provision of on-going partnership support e.g. Organisational Development.
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity?	Falkirk Partnership's ICF investment plan with consideration to the National Action Plan for Multi-Morbidly. Investment has been targeted towards adding value or accelerating developments being taken forward through mainstream provision or enhancing services through re-design. 67% of ICF investment during 2015/2016 has targeted service delivery for people who are likely to have multiple conditions, both over and under the age of 65, whilst investment in Infrastructure has focussed on in short term service design to support enhanced patient pathways or initiatives that help inform service re-design through staff and service user engagement. Anticipatory Care Planning, assessment and support for carers have been incorporated within 10 ICF funded initiatives, augmenting with mainstream service provision. Whole system pathways have been improved through integrated provision for example, AHP support within reablement in housing with care and in care at home. Technology Enabled Care has significantly developed through developments supporting self-management and independence through the Living it Up web portal and also via the Telehealth Innovations project, which provides home based supports for services users, their carers and families. The Medication Management project is examining current procedure and protocol, with a view to implementation of recommendations leading to improvement for service users. Organisational Development supports the on-going formation of a cohesive Partnership, with a Leadership structure that will support and enable innovation in practice, through a combination of evidence based improvement and scalable tests of change.

INTEGRATED CARE FUND – END YEAR REPORTING TEMPLATE 2015/16

Question	Comment
Please provide a brief narrative around how the ICF has been used in year one towards achieving the overall outcomes set out in the strategic plan.	All initiatives funded via ICF have been assessed regarding their alignment with the Strategic Plan, by taking into consideration the five local outcomes and various underpinning priorities. The majority of initiatives funded during 2015/2016 fit well with local outcomes, although it should be noted that the outcomes were developed and agreed during the same period. Based on initiatives supported during 2015/2016, there is a particularly strong alignment with 'Self-Management', 'Autonomy and Decision Making', followed by 'Safe' and 'Experience' then 'Community based Supports'. All future ICF investment will directly align with local outcomes and priorities, with a further focus on early intervention and prevention within community based settings.

INTEGRATED CARE FUND – END YEAR REPORTING TEMPLATE 2015/16

PARTNERSHIP DETAILS

Partnership name:	
Contact name(s)	
Contact Telephone	
Email	
Date Agreed	

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

…….. (name) for NHS Board

…….. (name) for Local Authority

…….. (name) for Third Sector

…….. (name) for Independent Sector

When complete and signed please return to:

Brian Nisbet
GE-18, St Andrew House,
Regent Road,
Edinburgh,
EH1 3DG

Or send via e-mail to brian.nisbet@gov.scot

FOR INFORMATION **Appendix 4**

Falkirk Partnership: Bridging Fund – 2015/16 – End-Year Financial Summary

	Allocation for 2015/16	Total Year Spend	Over/Underspends
Social Work Capacity	£42,962	£42,962	£0
Enhanced Discharge Support from FCH	£17,451	£17,451	£0
Reablement in Housing with Care	£326,896	£326,896	£0
Reablement at Home	£234,459	£234,459	£0
Telecare Innovations – Night Service & Falls Co-ordinator	£94,664	£94,664	£0
Telehealth Care	£220,997	£220,997	£0
Modernising Technology in Care Services (RTM)	£43,699	£43,699	£0
Post Diagnostic Support	£19,333	£19,333	£0
Braveheart Optimise Health Programme	£6,667	£6,667	£0
Marie Curie Patient Visit Service	£15,317	£15,317	£0
Top Toes	£43,067	£43,067	£0
Carers Support Planning	£30,237	£30,237	£0
Enhanced Support for Carers at Point of Hospital Discharge	£5,688	£5,688	£0
Training for Carers in their Own Community	£35,484	£35,484	£0
Carers Engagement	£39,113	£39,113	£0
Dallas / Living it Up	£6,750	£6,750	£0
Stakeholder Engagement Officer	£13,930	£13,930	£0
OD Advisor	£10,839	£10,839	£0
Performance Management & Programme Support	£5,044	£5,044	£0
Partnership Innovation Fund	£0	-£50,025	£50,025
Shared Lifes	£0	-£84,313	£84,313
Organisational Development	£0	-£4,875	£4,875
Completion of 14/15 Projects	£374,258	£374,258	£0
Balance of Funding	£52,145	£0	£52,145
Total Bridging Spend – 2015/16	**£1,639,000**	**£1,447,642**	**£191,358**

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE	FUNDING BREAKDOWN
Social Work Capacity	Community Care Worker and Social Care Officer provide timeous outcomes focussed assessment, working with service users and their carers to enable community based support to be put in place to allow hospital discharge and prevention of readmission.	• No. of days from referral to assessment - not recorded as this info can be meaningless • No. days from referral /assessment to discharge - not collected but could be obtained for future • All people moving to care homes are formally reviewed at 6 weeks and six months however if issues arise some involvement lasts longer until situation stable and passed to colleagues in locality teams for on-going review. • Social Care Officer was employed for 18 months and assessed 106 service users. • 104 delayed discharges were avoided as all service users assessed once home (2 were assisted to apply for housing and delayed awaiting suitable offer)	Project Currently suspended: Full Review of Project with a view to future development.	Bridging £42,962 Falkirk Council £42,962
Enhanced Discharge Support from FCH	Supports transition from acute setting. Person centred rehabilitation is provided to maximise functional independence and facilitate timely and safe discharge home. Service users and carers are more confident in their ability to self-manage and functional outcomes are improved. Service has been extended to 3 out of 5 wards within FCH with assessment taking place within 3	• Significant increase in AHP activity throughout the year from 558 to 913 AHP contacts. • Focussed rehabilitation & discharge planning from the point of admission: o 1/1/16 - 31/3/16: 181 New patients assessed in Units 1,2, & 3 of FCH Inpatients. o 1/1/16 - 31/3/16: 44 Home assessment Visits - 2 therapists are required to attend Home Visits with RSW	Review within context of Intermediate Care Pathways/Reablement/ Frailty Model	Bridging £17,451 (ICF £86,425) Total £103,876 Health £103,876

	days of admission and rehabilitation plans being developed by AHP in conjunction with service user and Rehab Support Workers. Links are in place with community services to ensure on-going support following discharge.	assisting AHP staff. • Functional Outcome Measures are being completed on admission and discharge - This has not been fully completed during the period but will be evidenced at the next reporting period. • Improved patient outcomes - This has not been fully completed during the period but will be evidenced at the next reporting period. • Falls prevention - RSW provided 90 patients with falls prevention advice over the 3 month period. • OTAGO - patients participate in OTAGO exercises with RSW as appropriate following assessment by AHP staff. • More timely assessment by Physiotherapist/Occupational Therapist – Assessments within 24 hours. • Training and education to develop the RSW role and allow a more appropriate skill mix and allocation of tasks - competency based training, evidence of skill mix & task allocation can be found by use of the handover sheet. • Efficient Structure to the daily routine for both patients and staff - RSW Timetable. • Increased level of rehabilitation- 1/1/16 - 31/3/16: AHP Contacts total 2774; RSW Contacts total 2400 • Increased engagement with 3rd sector – detailed data on this is held by the Carers Support Service. There have been 10 direct AHP referrals for the period.		
Reablement in Housing with Care	HWCRS provides reablement from FVRH, FCH and community services in 5 beds in Tygetshaugh Court. Service users and their carers are confident in their ability to return home with increased mobility/ADL skills. Reablement plans are co-	From the HWCRS spreadsheet: • Number of people supported (76 since Jan 14) • Readmission to hospital (1) • Service user and carer feedback (qualitative data from surveys): generally very good.	Review within context of Intermediate Care Pathways/Reablement/ Frailty Model	Bridging £326,896 Falkirk Council £284,726 Health

	produced with service user and their families and regularly reviewed to ensure progress. Patients Discharged have on-going plan in place with next step in place - Rehab at Home, Care at Home, on-going OT/Physio input or no care input. Carer also referred to on-going support.	• Onward referral to 3rd Sector • Diagnosis / Referral Reason • Outcome (e.g. package of long-term care) • IoRN 2 (Start/End) • Case studies received.		£42,170
Reablement at Home	Reablement is adopted as an ethos within homecare team. Support provided to service users and carers on discharge from hospital; Care in Housing with Care, and also following referral from community. Services users are receive outcomes focussed reablement plan, which Reablement Carer follows. Services users are more confident and able to live within their own home as independently as possible. Care package following reablement is reduced/not required.	Stats from CRAH Spread sheet: • There have been no consistent seasonal increases or decreases in referral numbers during the past 7 years. • Outcomes of service users receiving the RAH/CRAH Service in 2015 – 65% of service users required no additional homecare after RAH/CRAH service. • 72% of referrals were from hospital. Qualitative data is gathered via service users questionnaires.	Review within context of Intermediate Care Pathways/Reablement/ Frailty Model	Bridging £234,459 Falkirk Council £129,606 Health £104,853
Telecare Innovations - Night Service & Falls Co-ordinator	MECs overnight care service continues to enable people to remain at home by providing overnight support e.g. turning, hydration, reassurance to allow carers to continue their caring responsibility during the day and reduce hospital admission. Service now extended to support uninjured fallers not known to MECS to support community nursing. Falls Co-ordinator progressing work on Falls Bundles to provide pathway for uninjured fallers through assessment and referral. 6-8 weeks support provided.	We opened our overnight care service on 28th November 2014. Since then we have had 99 individual service users using the service, some of those have had to re-refer for additional service so the numbers do not reflect the number of visits or the number of service users who are repeat clients.	Review within context of Intermediate Care Pathways/Reablement/ Frailty Model	Bridging £94,664 (ICF £144,937) Total £239,601 Falkirk Council £239,601

Telehealth Care	Provision of telehealth equipment to service users within their home to add value to care package and enable independent living for as long as possible.	Telecare Service Users (Q4 Jan-March 2016):
		• Older persons – 5
		• Mental health – 4
		• Dementia – 11
		• Physical disability – 3
		• Learning disability – 1
		• Substance misuse – 0
		• Child (under 16) – 0
		• Not known – 0
		• How many of the new service users benefiting from Change Funding this quarter were offered telecare:
		  ○ To prevent admission to a care home – 1
		  ○ To prevent or lessen the risk of hospital admission – 7
		  ○ To facilitate hospital discharge – 1
		  ○ To improve carer peace of mind or provide respite support – 3
		  ○ To promote/maintain independence – 8
		• Did ICF telecare assist in the prevention of any delayed discharges this quarter (Yes/No)? No
		• How many unplanned hospital admissions do you estimate were avoided this quarter due to ICF telecare? 7
		• How many hospital bed days do you estimate this saved? 2
			Review within context of Intermediate Care Pathways/Reablement/ Frailty Model	Bridging £220,997
				
				Falkirk Council £202,606
				
				Health £18,391

Modernising Technology in Care Services (RTM)	Development and Implementation of a real time monitoring system within care at home, across Falkirk area resulting in a more efficient management system, whilst also positively impacting on care received by service users. System will be fully rolled out by Sep 2016. Further system development has significant potential benefit for wider services.	Phased implementation plan - milestones and timescales recorded. Service user feedback and evaluation.		Bridging £43,699 (ICF £67,800) Falkirk Council Total £111,499

Post Diagnostic Support	190 people diagnosed with dementia have been supported by PDS Link workers to access timely, relevant and responsive information to enable them and their carers and families to be better informed and equipped to manage their condition. Personal Support Plans being in place at the end of 1 year support allow people with dementia to have control, confidence and information to allow them to self-manage. Community links and peer support are in place and access to statutory service is phased in at a time and pace that is acceptable.	• Referral rates (01/01/16-31/03/16) 61 referrals (although 3 of these declined). • Current waiting list 88 (expect to remain constant as referral rate for the year was 234 and our staff capacity remains at 150). • Number of people accessing 1 to 1 support • Courses – ran one course during quarter, with 10 attendees & positive feedback. • Peer support: build peer support networks for both carers and people with dementia at all stages. • Feedback from Service users, their carers and families.	An 8 pillar pathway is currently being developed for those at moderate/later stages of dementia. A triage process is also planned to help identify appropriate pathway.	Bridging £19,333 (ICF £76,000) Total £95,333 Third Sector – Alzheimer's Scotland £95,333
Braveheart Optimise Health Programme	Preventative programme developed to promote health lifestyle choices delivered to targeted groups where need is identified e.g. homeless, people in criminal justice system, overweight people. Volunteers trained as health mentors and walking guides to support project delivery.	• Number of people taking part in health & wellbeing sessions (184) • People with increased understanding of healthier lifestyle (184) • People encouraged to take up community based walking (184) • People received volunteer training (7)	Project looking to identify funding from external sources. Consider different target groups. Assess impact through follow-up and review of participants.	Bridging £6,667 (ICF £13,400) Total £20,067 Third Sector – Braveheart £20,067

Marie Curie Patient Visit Service	3 Marie Curie Nurses, based within OOT in FVRH provide palliative care focussing on patient and carer to support choice to be able to die at home. The service is based within the Out of Hours team in Forth Valley Royal. As the out of hours team build preventative pathways with community nursing, care homes and A&E, the Marie Curie service is able to support and complement the core team to meet the additional demands of patients with a palliative care need. The service complements Strathcarron Services and Homecare with qualified RNs able to make evening and weekend short visits at short notice. Patient and family feedback has appreciated this partnership working. The service is match funded with Marie Curie charitable income.	• Number of people supported: 83 Patients YTD 2015/16 (as at Dec) • Number of visits: 548 YTD 2015/16 (as at Dec) • Age 60-90: 85% YTD 2015/16 (as at Dec) • Health inequalities: 50% patients seen YTD have been in IMD Quintiles 1 & 2 (most deprived) • 95% of patients support by the service died in their preferred place of choice. (YTD as at Dec 2015) • The service achieved a 96% satisfaction rating from carers (YTD as at Dec 2015) • Training days, national data re cost benefit analysis compared to local.	Discussion on-going regarding mainstreaming service	Bridging £15317 (ICF £19,395) Total £34,712 Third Sector – Marie Curie £34,712
Top Toes	People over the age of 50 have access to a personal toenail cutting service. Rerrals to the service can be via statutory service or self-referral. Top Toes has become a Social Enterprise which has enabled project costs to be covered and therefore ICF funding is no longer required.	• Completed Toenail cutting appts (765 to Dec) • Active Clients (294 to Dec) • No of clients referred to podiatry service (26 at Dec) • Footcare Volunteers (6 at Dec) • Meet & Greet volunteers (5 at Dec) • Telephone Triage volunteer (1 at Dec) • Impact on falls and support for carers.	Service now self-sufficient as social enterprise	Bridging £43,067 Third Sector – Falkirk CVS £43,067
Carers Support Planning	3 Carer Support Workers are employed and have supported the development of 74 Carer Support Plans. Carers have access to locality based support and have an increased ability to manage their	• No. carers accessing Carers Centre. • New carers identified (61 Jan-Mar) • Contacts with carers (333 Jan- Mar) • No Carers Support Plans (74) • No of Support Plans reviewed (16) • Increase in Health & Wellbeing (100%)		Bridging £30,237 Third Sector – Central Carers £30,237

	caring responsibility with maintaining their own health and wellbeing. Asset based approaches are used to develop support plans. GPs, Pharmacies, Community Care Teams have information and links to Carers Centre. Partnerships are established with local organisations to support carers through referral and signposting.	• Confidence in Caring (100%) • Economic Wellbeing (80%) • Life outside caring (87%) • Relationships (100%) • Involvement (100%)		
Enhanced Support for Carers at Point of Hospital Discharge	1 Carer Support Worker, based within REACH team of Falkirk Community Hospital provides early support to carers at the point of hospital discharge. Outcomes focused approach adopted to identifying individual needs, signposting and provision of relevant information and support. Professionals are more aware of carer support resulting in network and referral pathways being developed.	• New carers identified (147) • Contacts with carers (397) • Carers receiving individual support and advice (46 Jan- Mar) • Awareness raising sessions with professionals		Bridging £5,688 Third Sector – Central Carers £5,688
Training for Carers in their Own Community	Care with Confidence programme developed and delivered across Falkirk area. Programme enables carers to feel more confident in their caring role. Programme co-produced and delivered by health, social work, Police, Fire Safety, tele-health covering a range of topics - illness specific and carer focussed. Engagement with professionals re carer identification and support	• Training sessions delivered (93) • Attendances to training sessions (534) • Number of carers (190) • Carers evaluation • New Carers whose first contact with centre through training (77 April - Dec)		Bridging £35,484 Third Sector – Central Carers £35,484
Carers Engagement	1 Carer Engagement Manager supports carers consultation and participation in local and national forums which have an impact on carers. Carers have been able to	• Carers opportunities provided and promoted (7 Jan- Mar). • Number of carers actively participating (36 Jan - Mar). • Talks provided (1 Jan - Mar)		Bridging £39,113 Third Sector – Central Carers

	actively participate in Carers Forum and one-off events, Carers views have been gathered to provide input to a range of topics e.g. housing, Carers Bill, HSCI. Engagement Manager currently Carers rep on IJB.			£39,113
Dallas / Living it Up	Support Project Manager to further develop the Living it Up online platform as a means of access to information and education to promote self-management, condition management and promotion of people recognising and using their own assets. Professional able to develop specific supports e.g. videoconferencing for ReACH team, Cardiac Rehab Team 'Get Active' Programme. People gain confidence in technology as a means of additional support.	• Number of people engaged (10,000 in 3 years). • Number of people recruited to site (2000). • Additional developments.		Bridging £6,750 (ICF £2,400) Total £9,150 Health £9,150
OD Advisor	OD Advisor has supported activities relating to staff engagement, leadership development, development of a Staff Development Framework and Participation and Engagement Strategy. Thematic/service specific OD support also provided.	Feedback from participants.	Post Vacant	Bridging £10,839 (ICF £39,616) Total £50,455 Health £50,455
Performance Management & Programme Support	Monitor and support projects, and provide performance information to the Joint Management Group and the Integration Joint Board.	Supporting projects, assisting in the preparation of reports as required to the Integration Joint Board and Scottish Government. Collating, analysing and reporting on the performance of individual work streams.		Bridging £5,044 (ICF £36,500) Total £41,544

				Falkirk Council £41,544

Delayed Discharge Fund – 2015/16 – Achievement Outcomes **Appendix 5**
FOR INFORMATION

WORK STREAM ACTIVITY OR PROJECT	ACHIEVEMENT OF OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	FUNDING BREAKDOWN
Reablement Project Extension to Summerford and additional AHP Support	Additional reablement from FVRH, FCH and community services in 5 beds in Summerford House Care Home (extending to 10 from existing 5). Service users and their carers are confident in their ability to return home with increased mobility/ADL skills. Reablement plans are co-produced with service user and their families and regularly reviewed to ensure progress. Patients Discharged have on-going plan in place with next step in place - Rehab at Home, Care at Home, on-going OT/Physio input or no care input. Carer also referred to on-going support. 6-8 weeks support provided.	• Number of people supported (37) • Readmission to hospital (1) • Service user and carer feedback • Onward referral • Incoming referral	£47,800 Falkirk Council £51,970 NHS Forth Valley
Rapid Response Frailty Clinic	1.5 consultant and band 6 nursing support in place. Rapid access frailty clinic is a service within an ambulatory setting in FVRH for people over 65 year old, who require specialist review by a consultant geriatrician in an ambulatory setting. Patients are normally seen within 48 hours of being referred by primary Care and without this service would require to be admitted for assessment and treatment. A full spectrum of diagnostics, assessment and treatment plan is completed and wherever possible return home on the same day. The clinic liaises with community based services to ensure appropriate on-going treatment or support is in place. The clinic has seen 140 patients over the period of January – March 2016 with approximately 45% living within Falkirk council. The assessment takes a holistic approach, taking into account if patients are socially isolated and/or experiencing poverty. Dementia, falls and palliative care are also considered. Forth Valley does not have a falls service. These people are picked	• Reduction in avoidable admissions through rapid access clinic assessment & treatment • Improvement in patients longer term outcomes and on-going care needs compared with debilitating impact of an (extended) admission. • Support to allow patients remain in their own homes/communities, improving patient and carer experience. • Unpaid Carers have fed back that they value the RAFC. The RAFC will contact social work on their behalf if required for additional care needs and will direct carers to the Prince's carers Trust where for further support and information. • Over 94% of patients seen at the	£173,499 NHS Forth Valley

	up by the RAFC, as a significant number of people with falls are presented at the RAFC. Throughout the assessment, patients and carers will be asked if they are coping and offered support or advice as required.	RAFC return home the same day. At Nov 15: • Patients seen (267 FV, 45% Falkirk) • Feedback from patients re their experience • Clinics provided (205 between 1 April - Nov 2015, 58.7% capacity which is 348) Admissions (28)	
Discharge Hub (Delayed Discharge Leaflets)	Discharge Team funded from Delayed Discharge Resource 15/16 to maintain the delivery of the improvement to the service i.e. 7 day cover for discharge, support early discharge from Acute Hospital, review of Ageing and Health patients in Non-Ageing and Health wards to ensure appropriate transfers to Community Hospitals, review of patients with extended length of stay over 28 days, review patients admitted with existing care packages to ensure early discharge home with care package. A review of the skill mix led to a change of staff in the team. All three Band 5's returned to their substantive posts by January 2016. Recruitment started for 2 Band 6 Discharge Co-ordinators seconded for 6 months. There was no activity or data collected from January 2016 – March 2016 as the new Discharge Co-ordinators started in April 2016. The weekend cover has allowed the team to support discharges in a number of ways, mainly to:- • Facilitate transfers /reconfigure beds in community hospitals (internal moves), allowing appropriate transfers and support capacity and flow at the weekend. • Ageing and Health Reviews in non-ageing and health wards; ageing and health screening to ensure appropriate referral to geriatricians and promote appropriate pathways. • Educate ward staff regarding options for discharge. • Close links with capacity and flow managers to support any capacity issues at weekends.	• Currently, with the support of the Discharge Coordinators, a weekly list is produced detailing all patients in FVRH with a continuous inpatient stay greater than 28 days. • Details are collected on each patient from the SCN, ward staff and patient notes. • Once a week there is a scripted meeting between Discharge Co-ordinators and Capacity and Flow Manager to discuss each patient and assess progress of current plans. • A follow up de-brief is then scheduled two days later to assess follow up actions. • An update plan is populated on each patient. The most recent data-point (19th April 2016) found that there were **39** patients in the inpatient ward areas with a continuous inpatient length of stay greater than 28 days. This shows an improvement over the winter period, from October 2016, when there were **71** patients with a CIS LOS >28 days. The initial reduction in numbers of	£94,356 + £83 leaflets NHS Forth Valley

	• Link with Closer to Home to request packages of care starts if packages of care resourced. • Opportunity to carry out environmental visits at the weekend to allow forward planning for the week ahead to support complex/palliative discharges. • Access to short term assessment beds at the weekend as appropriate/available. • Identify patients delayed at the weekend awaiting packages of care.	patients with a CIS LOS >28 days has now allowed for some areas to focus on CIS LOS >21 days. The involvement of the Discharge Hub has been key in identifying alternative pathways, and ensuring accuracy of Community Hospital waiting lists. Further work may now be required in the escalation plans of patients who remain on the list for a continued period of time.	
HELP Packs	**Patients Remain Safe** In providing the packs eligible patients return home with fresh essential food which is readily available to them ensuring they do not have to leave their home thereby minimising the risk of falling and of dehydration/malnutrition thereby reducing the risk of the patient being re-admitted to hospital. **Independent Living** In providing the packs this supports the patient's transition home, it recognised them as an individual and puts them in control of when they would need to go to the shops. Patients can return home safe in the knowledge that there is food readily available to them and they can focus on their recovery. **Providing a Caring Role** If a patient is returning home and is to resume caring duties for a family member in providing the pack they have peace of mind that they can go home and there are essential foods readily available for both of them.	**Patients issued packs** ▪ From January to March 2016 366 packs have been issued. ▪ Feedback has been obtained from 351 patients. The breakdown of this is: ○ Falkirk 185 ○ Stirling 109 ○ Clackmannan 53 ○ Other 4 **351**	£26,866 CVS Falkirk & District
Contribution to FHC Ward 5	Provision of short term assessment from FVRH, FCH or Community. Delayed discharge is prevented and people who have reached a point of crisis at home are able to access assessment service to help determine future needs.	No Data Available	£236,000 NHS Forth Valley
Contribution to Care Home Places	Provision of support for Care Home Places.	No data Available	£236,000 Falkirk Council

Funding Proposals: Recommendations **Appendix 6**

Project Name	Lead Agency	Amount Requested	Term Requested	Project Summary	Recommended Funding	Justification/Condition
Avoiding Hospital Admission						
Social Work Capacity	Falkirk Council	£75,450	1 year	The Social Work Team based at Falkirk Community Hospital and provides an assessment and care management service in order to facilitate timeous discharge of adults from hospital. The Team receives on average 115 referrals per month and in the past year unfortunately approximately on average 28 people per month are recorded as delayed in their discharge. There are also currently 38 referrals with regard to people awaiting social work assessment. The addition of 2 new posts would result in people and their carers being assessed more timeously which would contribute to people living in good health for longer, living independently and safely within their own community and carers being offered the support they require to look after their own health and wellbeing. If more timeous assessments can be facilitated people and their carers would be seen as soon as they were clinically ready to leave hospital and potential for reablement could be maximised by this timeous intervention.	Funding not recommended at this time	The proposal relates to added capacity within SW assessment rather than service change or re-design. The service previously provided good outcomes, but should be considered within the context of intermediate care pathways before further funding is approved. Service should also be considered in relation to the role of the Discharge Hub.
Enhanced Discharge from FCH	NHS Forth Valley	£55,100	6 months (1 Oct – 31 March 17)	The funding has allowed the role of support workers within Falkirk Community Hospital to be developed. These support workers support the AHPs within community hospital and ensure the correct skill mix for the workforce delivering rehabilitation. The support workers have undergone training from Physiotherapy and Occupational therapy staff and have been working through a comprehensive competency based programme. The roles and responsibilities of the support workers ensure that all staff undertaking tasks appropriate to their level of skill and knowledge and competency. This model can be used across other areas providing rehabilitation within an Intermediate care setting.	Maximum £55,500 1 Oct 16 – 31 Mar 17	Intended change to service provision has now happened in terms of extending reablement provision. The service now augments current service delivery to provide reablement in addition to core nursing service and requires consideration within context of intermediate care pathway in order to further achieve sustainable service re-design. Project to participate in strategy development regarding intermediate care pathways.
Reablement at Home	Falkirk Council	£128,000	6 months (01 October 16 – 31 March 17)	The reablement service's key aim has always been associated with improved outcomes for service user, improvements in health related quality of life and significant decreases in subsequent social care service usage. It was set up to achieve a shift in the balance of care away from episodic care in acute settings to team based anticipatory care closer to people's homes. To promote self-care and the effective management of long term conditions in the community. Reduce avoidable admission/readmission. Develop anticipatory care. Help modernise primary and community services and assist in the education of professionals, service users, carers and providers on reablement to promote culture change. The service has been highly successful in some of the key objectives within the original proposal however there remain issues concerning the way this service has been predominantly used. Instead of being used to its best effect in preventing people from being admitted to hospital it has been used predominantly in discharging people from hospital quicker. Whilst this has proved to be highly beneficial in supporting early discharge from hospital, the promotion of a shift in the balance of care needs to be from the community end and the service would like to move on to target community referrals e.g. Gp's DN's and Community Care staff to encourage them to use the service at an early stage with service users to prevent admissions to hospital and hopefully reduce the hospital bed crisis.	Maximum £128,000 1 Oct 16 – 31 Mar 17	Intended change to service provision has now happened in terms of extending reablement provision, however further development is required to re-focus service to enable more referrals to be made from the community in addition to supporting people after hospital discharge. Project to participate in strategy development regarding intermediate care pathways.
Reablement in Housing	Falkirk Council	£260,680	1 year (1 Oct 16 – 30 Sept	Tygetshaugh reablement service is situated within a housing with care complex. Established in January 2014 it has identified accommodation for up to up to five	Maximum £128,000	Project has achieved good outcomes, but requires further scale to achieve good value for money. Discussion regarding this is ongoing.

with care			2017)	people over the age of 65 to receive reablement for a period of up to six weeks as it is recognised that some people achieve their goals quicker. The focus is on helping people accommodate illness or disability by learning or re-learning the skills for daily living through goal setting and planning care, placing the person at the centre. People using the service and their family/carer play a fundamental role in the success and reablement as an approach. The role of AHP staff initially was instrumental in training and guidance on methods of rehabilitation to the care staff and then to work collectively to agree goal setting and care planning and finally to agree a discharge plan. It was initially targeted at supporting a quicker discharge for the patient however as it has developed it has been used to prevent admission to hospital. The service is more expensive than a care home place, less expensive than a hospital place but is short term, with a percentage of people being able to return home with reduced or no care, a saving in the long term. The move from traditional homecare of "doing for" has changed to a model that supports the person in term of independence, improving confidence and wellbeing and better job satisfaction for the worker from helping the person achieve their goals and return home. A good example of joint working with Health, Housing and social care, discussions have taken place to acquire another flat, making it a more cost effective option.	1 Oct 16 – 31 Mar 17	Project to participate in strategy development regarding intermediate care pathways.
Telecare Innovations: Night Service & Falls Co-ordinator	Falkirk Council	£43,660	6 months (01 October 16 – 31 March 17)	This document proposes that the two projects in relation to Telehealthcare, that is Telehealthcare and Telehealthcare Innovations should be combined. This is as a result of discussion around the progress of these projects and the need to draw telehealthcare into one proposal. This paper is therefore drawn up on this basis. Falkirk has a long history of success as regards our progression of telehealthcare however it is recognised now that a new strategy concerning telehealthcare requires to be developed for Falkirk and that evaluation of all that has been achieved so far should now take place along with any new proposals before any further decisions are taken as regards how the future might look and how it might be funded. This of course will also require to be approved by the IJB. At present staff located within the MECS team take referral, assess for (where appropriate) and test and fit a wide variety of telehealthcare equipment. In order to maintain this on-going work and consider how we should progress telehealthcare for the future it is requested that funding be continued for this until the end of March 2017. Training on telehealthcare needs to be reviewed and progressed looking at alternative ways of delivering this. Concerning the Telehealthcare innovations project a number of posts here have now been sustained within the service. However internal resources are stretched and there remain a small number of posts for which we have been unable to identify on-going funding. These are specifically the nightshift supervisor posts. The value of these posts and the overnight service in general is clearly recognised as a positive way forward in helping to maintain people at home and out of either long term residential care or hospital and it is hoped that agreement can be reached to sustain these posts until March 2017 and throughout 2017/18 until a whole system change and permanent funding can be sourced. It is hoped that this would also be inclusive of expanding the overnight care service to move from a short term crisis intervention service to an on-going regular overnight care service to help reduce the number of care home admissions across the Falkirk area. Finally the post of Falls Co-Ordinator needs immediate review and whilst we have	Maximum £143,360 1 Oct 16 – 31 Mar 17	Telehealth and Telecare project have been combined. Both projects currently sit within the MECs service and combined review will allow for analysis of overall impact and service re-design. Overall funding requested has reduced due to mainstreaming of some staff. Telehealth – the cost of ongoing provision of equipment is high. It is suggested that options be considered regarding introducing charges as a means of contribution towards sustainability. Funding beyond March 2017 is not approved at this time. Project to participate in strategy development regarding intermediate care pathways.
Telehealth Care	Falkirk Council	£99,700	6 months (01 October 16 – 31 March 17)			

				secured funding until the end of September to review and complete any current falls work in general, it is proposed that no further funding be allocated to this post past September. It is suggested that the Falkirk Falls Implementation Group (FIG) consider the future of falls work across the Falkirk Partnership and any separate bid that they might which to make in this regard.		
Avoiding Hospital Admission: Delayed Discharge						
Rapid Response Frailty Clinic	NHS Forth Valley	£150,184	1 year (01 April 16 – 31 March 17)	The Rapid Access Frailty Clinic (RAFC) is a service within an ambulatory setting in FVRH for people over 65 year old, who require specialist review by a consultant geriatrician in an ambulatory setting. Patients are normally seen within 48 hours of being referred by Primary Care and without this service would require to be admitted for assessment and treatment. A full spectrum of diagnostics, assessment and treatment plan is completed and wherever possible patients return home on the same day. The clinic liaises with community based services to ensure appropriate on-going treatment or support is in place. The aim of the service is to provide an improvement in the patients longer term outcomes and on-going care needs compared with the potentially debilitating impact of an extended admission. The involvement of carers in the patient's assessment and on-going care has improved the quality of information available to the specialist and undoubtedly further improves safety and quality of care by • Improving timely access by Primary Care Team to Specialist Review • Reduce avoidable admissions • Reduced wait for specialist assessment with associated improvement in Quality of Care • Rapid access to 'one stop' diagnostics, AHP assessment and community rehab services The assistance of the Integrated Care Programme will be critical to keep this service running.	Approve funding to 30 Sept 16 1 April 16 – 30 Sept 16 Maximum £75,542 Defer further decision pending further discussion with leads and Clack/Stirling Partnership. Recommendations to IJB in August 16.	Forth Valley Wide Service Model of care good and services users feedback is very positive, however current available information suggests: • Low level use • Part time operation • Limitted connection with other services • Restrictive referral process Further review is required regarding: • Review position of clinic in relation to A&E • Referral procedures are reviewed • Promotion of service • Wider range of practitioners are able to make referrals into service Project to participate in strategy development regarding intermediate care pathways.
Discharge Hub	NHS Forth Valley	£106,000	1 year (01 April 16 – 31 March 17)	2 WTE Band 6s commenced 04/04/16 1 WTE Band 6 and 11.5hrs Band 6 commenced Feb 2015 Continue the enhancement to the Discharge Team which were funded from Delayed Discharge Resource 15/16 to maintain the delivery of the improvement to the service i.e. 7 day cover for discharge, support early discharge from Acute Hospital, review of Ageing and Health patients in non-Ageing and Health wards to ensure appropriate transfers to Community Hospitals, review of patients with extended length of stay over 28 days, review patients admitted with existing care packages to ensure early discharge home with care package. Future plans will link The Discharge Team to support the Frailty Model across Forth Valley	Approve funding to 30 Sept 16 1 April 16 – 30 Sept 16 Maximum £53,000 Defer further decision pending further discussion with leads and Clack/Stirling Partnership. Recommendations to IJB in August 16.	Forth Valley Wide project. Whilst this project delivers effective support for discharge, it is recommended that further review is required in relation to overall co-ordination of discharge and assessment procedures. Discussion should include links with Social Work Assessment team. Project to participate in strategy development regarding intermediate care pathways.
HELP Packs	CVS Falkirk & District	£26,866	1 year (01 April 16 – 31 March 17)	The HELP scheme started to include volunteers in the service delivery during the second half of 2015/16, and this is continuing throughout 2016/17. This enables better transition of services when the Volunteer Co-ordinator is absent and we have a Bank Worker in place, and importantly means that someone giving a pack to a patient can spend more time with them in the Discharge Lounge, as having someone to talk to has been important for many of the recipients, in their transition from hospital to home, where they are unlikely to have any company	Approve funding to 30 Sept 16 1 April 16 – 30 Sept 16 Maximum £13,433	Forth Valley wide project. Project has received good feedback from Service Users. It is open to all and therefore limited targeting to those with particular need. Evaluating the impact of provision has been difficult as the service is anonymous and therefore there is no ability to follow-up patients re outcomes.

				for days at a time, until they get back to full fitness and can go out. It also enables the service to inform patients about other services they might want to access after their return home. So we are building on from just giving out food to also giving out helpful information, although the food remains the most essential part of the project.	Defer further decision pending further discussion with leads and Clack/Stirling Partnership. Recommendations to IJB in August 16.	
Summerford Reablement	Falkirk Council	£164,140	1 year (01 April 16 – 31 March 17)	Initially established through additional funding from Scottish Government the service developed was for five people, offering placements to people delayed in their discharge and requiring a period of reablement before returning home. It then increased to offer 10 placements. The service was in Summerford House a thirty bedded care home which is due for closure in 2017.18. The aim of the project which uses the reablement ethos of care to help the service user to regain their daily living skills, lost after a hospital admission or period of illness. It differs slightly from reablement in Housing with Care in that it has 24/7 care and the staff are able to administer medication if required, on admission. It also has full time night staff to support the person in overnight coping skills. Reablement includes support to self-medicate and coping skills for overnight care needs. The unit itself has two staff each shift as and the support of 0.5 AHP AHP staff Whilst the project has demonstrated that some people require slightly longer (up to eight weeks) they do return home with a reduction in care needs. Funding received for this project does not fully cover the real costs of care staff and the care home is due for closure 2017/18. In addition the accommodation is quite small and there could be difficulty for people with equipment needs as the bedrooms are small. Currently the option of developing a rehab unit within the grounds of the Community Hospital is being explored so it is unlikely this project will continue long term.	Maximum £164,140 1 April 16 - 31 March 17	Funding recommended for full year from 1 April 16- 31 March 17, however due to scheduled closer of the care home, it is suggested that this closely reviewed and funds will support transition of service to amended delivery model, when agreed. It is important that service is maintained for period while Summerford remains open to continue reablement support following hospital discharge. Project to participate in strategy development regarding intermediate care pathways.
AHP Capacity in Summerford	NHS Forth Valley	£73,022	1 year (01 April 16 – 31 March 17)	Provision of AHP support within Summerford reablement. OT and Pysio. Staff assess and monitor individuals reablement programme and provide support and training to reablement staff.	Maximum £73,022 1 April 16 - 31 March 17	Funding recommended for full year from 1 April 16- 31 March 17, however due to scheduled closer of the care home, it is suggested that this closely reviewed and funds will support transition of service to amended delivery model, when agreed. It is important that service is maintained for period while Summerford remains open to continue reablement support following hospital discharge. Project to participate in strategy development regarding intermediate care pathways.
Health and Wellbeing in the Communities						
Post Diagnostic Support	Alzheimer's Scotland	£116,000	1 year (1 Oct 16– 30 Sept 17)	We have 4 link workers (3WTE) who deliver Post Diagnostic Support to those with a new diagnosis of dementia and their family carers for a minimum of 12 months using the 5 pillar model of support, which is in line with the Scottish Governments 2020 Vision and cuts across the themes identified in Falkirk's Integrated Strategic Plan. PDS is delivered on a one to one basis and also through group information sessions with follow up support at a weekly Dementia Café. Currently everyone who requests this support is referred to the link workers irrespective of what stage they are at in their illness. However the 5 pillar model is	Maximum £116,000 1 Oct 16 – 30 Sept 17	Condition of funding: On-going development of integrated pathway with statutory service. Contribution to the development and implementation of 8 pillar model. On-going review of demand for 5 pillar model as opposed to 8, with options for service reconfiguration if required.

				aimed at people who can self-manage and many people referred are too advanced for this, requiring greater input from support services. The tightening eligibility criteria means link workers need to hold on to people for longer as there is a lengthy wait to be seen by social work. An integrated whole systems approach is required and we are we are working with Health and Social Work to develop a new pathway. This will take time to get everyone on board as there are huge pressures on social work resources. None the less once this is in place we will be able to free up Link worker time, reduce the waiting list and meet the heat target.		
Community Connections Programme	Alzheimer's Scotland	£10,600	1 year (01 Oct 16 – 31 March 17)	The Community Connections programme aims to increase capacity by delivering a range of opportunities for people with dementia and their carers to access and reflects one of the key objectives within Falkirk's Integrated Strategic Plan for community based support. These groups promote wellbeing, and opportunities for emotional and peer support, which in turn, builds resilience enabling people to live independently at home for longer. Apart from providing a way to maintain hobbies and interests and reduce isolation, these groups can act as a very gentle introduction to more formal support at a pace that suits the individual. The current programme consists of 17 groups a month Garden Club- this meets twice weekly for 2 hrs and is based at The Maples. Supper Club- Monthly Supper Club for up to 5 couples Football Reminiscence-Three groups a month Baristas Dementia Café-Weekly for 2 hours Walking Group- Ten pin bowling—weekly for 1.5 hrs	Maximum £10,600 1 Oct 16 – 31 March 17	Continue funding.
Braveheart Optimise Health Programme	Braveheart	£10,000	6 months (01 Oct 16 – 31 March 17)	The services which Braveheart provides focus on health and wellbeing outcomes to improve individual and community health and reduce health and social inequalities. As deprivation is a risk factor for the majority of chronic illnesses, Optimise has a proven track record of successfully engaging with people who have greatest difficulty in accessing health improvement. Evaluation of Optimise sessions delivered to these client groups strongly indicates that participation in the programme led participants to make positive changes to improve their health and wellbeing. ICF investment enabled Optimise to build organisational capacity and skills and develop new strong partnerships and collaborative working practices with other organisations in the Falkirk area. This has generated interest in Optimise services from groups such as local carers groups, people with dementia, people with a range of disabilities such as sensory impairment and people from ethnic minorities. Through this pilot, we plan to use these connections to further extend health and wellbeing services to help meet the increasing health challenges faced by specific target groups living in Falkirk communities.	Maximum £10,000 1 Oct 16 – 31 March 17	Project has implemented intended charge in terms of developing and delivering programme focussing on healthy lifestyle. The tested targeting of some groups has not been effective e.g. homeless, Criminal Justice. Weight management classes have been successful, however there is limited scope to scale up provision and the impact is not significant in terms of client numbers. Condition of Funding: This allocation is intended to support the project to transition into a new funding arrangement and therefore is considered to stop at 31 March 2017.
Social Prescribing	FDAMH	£100,121	1 year (01 Oct 16 – 30 Sep 17)	The SP Service supports the needs of people with reduced mental well-being who are referred to the Practitioners by their GP. This service provides an innovative approach to early intervention and recovery, providing holistic, person-centred support by means of psycho/educational work to create awareness/insights of the issues/conditions and triggers which impact on physical and emotional well-being and interpersonal relationships.	Maximum £100,121 + £50,060 1.5 years 1 Oct 16- 31 Mar 18	This project has achieved successful engagement with GPs and outcomes for clients, however is limited by available resource. There is scope for expansion however this would require further resource and sustainability of the model may be an issue without further integration within health services.

				At present Practitioners are based at two Health Centres, Stenhousemuir Health Centre and Carronbank Health Centre, Denny where they are working in partnership with approximately 24 GP's. The service is held in high regard by participating GP's and indeed other practices have contacted FDAMH requesting to be 'put on list' should the service be rolled out across the area. As a consequence of requests of this nature, it was agreed that we would endeavour to help other GP practices by withdrawing from current practices and re-locating service provision to alternative surgeries therefore: • Move from Carronbank to Camelon and reduce provision in Stenhousemuir to allow service provision in Richmond Practice in Bo'ness in July 2016. • In consultation with participating GP's, to introduce a self- referral process for clients • Provision of an in house Social Prescribing Service, taking referrals from Immediate Help Service for people in crisis who are referred via their GP's, will continue due to demand.		It would also be beneficial to gather formal feedback from GP practices that benefit from the service in relation to reduction in prescribing and GP appointments. This has previously been requested and should possibly become a condition of hosting a Social Practitioner Condition of Funding: Scoping exercise undertaken to establish demand for service, with a view to further development based on evidence gathered.
DALLAS/Living it Up	NHS Forth Valley	£12,000	1 year (01 Oct 16 – 30 Sep 17)	Living it Up Aim: "*to develop and deliver a digitally enabled, thriving community that .... support(s) better health, wellbeing and active lifestyles in Scotland. Aimed at people over the age of 50, with particular interest to carers, and people living with long term health conditions*." Up to May 2015, LiU was an award-winning innovation project funded over 3 years by Scottish Government and Innovate UK as part of the UK wide **dallas** programme. On-going funding from the ICF would continue to support the role of the Project Manager who is crucial in achieving the local outcomes which are directed nationally.	Maximum £12,000 1Oct 16 – 30 Sept 17	Forth Valley wide project Funding recommended to continue due to contribution to self-management and Technology Enabled Care. Note that this is National initiative and therefore future funding may be available from alternative sources.
Support for Carers						
Carers Support Planning	Central Carers Centre	£36,979	1 year (01 Oct 16 – 30 Sep 17)	The Carers Centre aims to ensure that carers are identified early and supported to achieve personal outcomes, care with confidence, without financial hardship, and in good health, whilst also maintaining a life outside caring. This is achieved through the provision of information, support and involvement opportunities for carers that help sustain the caring relationship, thereby enabling the people they care for to remain safely at home for longer. Funding from the Integrated Care Programme will allow the continued resourcing of: 1 full-time Service Manager (Carer Engagement); 2 full-time Carer Support Workers; 1 full-time Training Co-ordinator; and 1 part-time (WTE 0.4) Carer Support Worker who will: • raise awareness about the need to support carers and develop referral pathways • prevent re-admission to hospital by supporting carers during hospital discharge • provide individual support for carers using a 'Talking Points' framework to help them identify and achieve personal outcomes • work in partnership with other local agencies to help carers achieve positive outcomes • provide a programme of training to develop the skills and knowledge of carers and help them to look after their own health and wellbeing • give carers a voice by developing systems to involve carers in the shaping of local and national services to support carers and those they care for	Maximum £195,608 + £97,804 1.5 years 1 Oct – 31 March 18	It is recommended that funding be allocated for the remaining period of the ICF – to March 2018. Condition of Funding: The package of projects requires to be reviewed in relation to requirements regarding the Carers Act (2016), with a view to mainstreaming where possible. Therefore although longer term funding is recommended it is expected that an exit strategy be developed in conjunction with Heath and Social Care colleagues to ensure that adequate and appropriate services are in place by March 2018. This should also include tapering of funds, where possible.
Enhanced Support for Carers at Point of Hospital Discharge	Central Carers Centre	£26,137	1 year (01 Oct 16 – 30 Sep 17)			
Training for Carers in their own Community	Central Carers Centre	£30,635	1 year (01 Oct 16 – 30 Sep 17)			
Carer Engagement	Central Carers Centre	£36,264	1 year (01 Oct 16 – 30 Sep 17)			
Health & Wellbeing Activities	Central Carers Centre	£6,000	1 year (01 Oct 16 – 30 Sep 17)			
Short Breaks for Carers	Central Carers Centre	£24,000	1 year (01 Oct 16 – 30 Sep 17)			

				• support carer representation on the Integration Joint Board • represent the needs of carers at local planning groups		
Infrastructure						
Modernising Technology (RTM)	Falkirk Council	£22,500	6 months (01 Oct 16 – 31 Mar 17)	This project has seen the introduction of electronic methods of recording, monitoring and managing the delivery of home care services. The previous methods involved manual systems with little use of IT. The system is now functional and procedures in its use are now finalised in both the scheduling and monitoring aspects of the system in 2 of our 9 areas with an implementation plan for all 9 areas to be rolled out and functioning by the end of August 2016. This is currently on target. The system however comes with many other functions e.g. service user web portal, possible use of predictive analytics for falls awareness which it is important to acknowledge, with this possible additional functionality available for evaluation for future use. In addition the original project submitted for initial Change Funding also included the possibility of using the real time monitoring system more widely across community care services e.g. its implication within community nursing services, community AHP services and community care services etc. Along with the introduction of the system to the monitoring of work contracted out to our private providers. It also provides a web based service user system which could be looked at in regards to sharing care service information across agencies (health, social work and service users themselves) etc. with appropriate security already in place. This request for reduced additional funding is specifically to extend the time of the Implementation Officer to the 31st March 2017 in order for them to fully complete the work required within the current home care element of the project and for them to carry out an exercise in relation to the further use, benefit and best value of resources that could be made of the system across both health and social care services in general.	Decision deferred to August, pending further discussion	Project has achieved original intention regarding the implementation of Real Time Monitoring within Care at Home. Further discussion is required to ensure that this remains a priority area of investment, following output of logic modelling and with reference to wider work regarding Single Point of Contact and Single Shared Assessment.
Independent Sector Lead	Scottish Care	£13,750	6 months (01 Oct 16 – 31 Mar 17)	The Local Integration Lead's key aim is enabling and ensuring Independent sector involvement in the delivery of the agreed outcomes for integration and so play a lead role in service improvement and the development of exisiting and new models of care and support. The actual aims and outcomes for this coming year will be determined and agreed through consultation with key stakeholders – providers, statutory partners, Scottish Care. These will be detailed in a locally agreed workplan and will be influenced by Falkirk's strategic commissioning plan, national objectives and the objectives of providers.	Maximum £13,750 1 Oct 16 – 31 Mar 17	Condition of Funding: Workplan in developed to ensure that Independent Sector Lead is able to target support in line with IJB requirements and emerging priorities in the Local Delivery and Recovery Plans.
TSI Support	CVS Falkirk & District	£75,000	1 year (01 Oct 16 – 30 Sep 17)	The service is providing a Partnership Manager, plus Admin and Comms (part-time) resources, to ensure that the TSI carries out its role to engage the third sector in Falkirk in the Integration agenda. This activity is not funded elsewhere. During 2016/17, this programme also replaces the earlier funded activity by taking over responsibility for the Community Care & Health Forum, running the Community Information Hub in Falkirk Community Hospital, and hosting the annual International Day for Older People event in October.	Maximum £75,000 01 Oct 16 – 30 Sept 17	Condition of Funding: Workplan is developed to ensure that HSCP Partnership Manager (and support) is targeted in line with future development requirements within the third sector, IJB requirements and emerging priorities in the Local Delivery and Recovery Plans.
OD Advisor	NHS Forth Valley	£65,250	15 months (01 Oct 16 – 31 Dec 17)	The establishment of the HSCI Partnership began in 2014 and at that time it was recognised that in order to create and embed the partnership and the principles of Integration an extensive amount of organisational development and change would be required both within the first two transition years and during the first	Maximum £65,250 1 Oct 16 – 31 Dec 17	There is a clear need for OD in order to support the development of the Partnership and change management process, however this must be as a short term measure to ensure targeted work in relation to staff engagement.

				few years of Partnership establishment. At that time the Partnership invested in the appointment of a Specialist OD Advisor post whose role it was to take forward the OD and Change Work stream, supporting all aspects of the OD process and cultural transitions and the development of an Integrated Workforce Plan in support of the Partnership Strategic Plan. The Workforce Plan was supported and approved by the IJB in Feb 2016 and outlines a very extensive workload for OD & Workforce Development. It is now essential that this specialist OD support continues for the next 2 years and it is recommended that this role is extended or developed to bring further senior, more experienced OD support and capacity to the partnership.		
HR Support	NHS Forth Valley	£44,668	1 year (01 Oct 16 – 30 Sep 17)	Integral to the delivery of the Strategic Plan is the Workforce Development Strategy. The Workforce Development Strategy has been approved by the Integration Joint Boards. Current service provision is delivered in silos and this post (part-time HR Advisor) is required to ensure delivery and monitoring of the agreed workforce priorities and to support the shared workforce agenda via the Joint Staff Forum and Integrated Workforce Group. The workforce is key to delivery of the IJB's ambitions and strategic vision.	No funding recommended	Forth Valley Wide Project This function is being considered within the context of HSCP support provision and costs.
Integration care Fund Co-ordinator	Falkirk Council				Decision deferred to August, pending further discussion	
Performance Management & Performance	Falkirk Council				Decision deferred to August, pending further discussion	