AGENDA ITEM

9

Agenda Item: 9

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Partnership Funding**
Meeting:	**Integration Joint Board**
Date:	**4 August 2017**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

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

- Funding recommendations relating to proposals reviewed in accordance with the agreed Partnership Funding governance process, detailed within Appendix 1.
- Further information regarding Advice Line for You (ALFY) and Braveheart Optimise Health Programme, as requested during the IJB's meeting on 16 June 2017.

2. RECOMMENDATIONS

The Integration Joint Board is asked to:

2.1 approve allocations of Partnership Funding, as presented in Appendix 1; and

2.2 note additional information relating to ALFY and Braveheart Optimise Health Programme.

3. BACKGROUND

3.1 During 2016/2017, Integrated Care and Delayed Discharge Funds have been allocated and monitored within a single governance framework and collectively referred to as Partnership Funding.

3.2 In June 2017, the IJB were presented with a financial position to the end of the financial year 2016/2017. The information presented is shown in table 1 below. Monitoring returns are currently being gathered for quarter 1 (April – June) of 2017/2018 and therefore an updated financial position will be presented to the IJB in October 2017, along with the bi-annual performance report.

	2016/17			2017/18		
	Resource available	**Actual Expenditure**	**Available to commit**	**Resource available**	**Current Projected Expenditure**	**Available to commit**
	£'000	£'000	£'000	£'000	£'000	£'000
Integrated Care Fund and Bridging	3,863	2,461	1,402	3,798	3,372	426
Delayed Discharge Fund	894	877	17	864	509	355
TOTALS	**4,757**	**3,338**	**1,419**	**4,662**	**3,881**	**781**

Table 1: Overview of financial position at 31 March 2017

4. PARTNERSHIP FUNDING INVESTMENT

4.1 The Partnership Funding Group have considered one new proposal for funding during this period, which was submitted by Strathcarron Hospice. The value of the request was £73,442 for a period of 18 months. In recognition of the strategic commissioning work recently commenced, the Partnership Funding Group recommend an award of £49,962 for 12 months. This recommendation has been endorsed by the Strategic Planning Group. Details of the proposal are provided within Appendix 1.

4.2 With regard to work relating to strategic commissioning, agreed by the IJB in March 2017, a working group Chaired by the Chief Finance Officer, has now been established. Initial work being undertaken will:

- Finalise the detailed overview of provision relating to health and/or social care within the third sector, currently resourced by Falkirk Council and/or NHS Forth Valley.
- Establish links with expert groups, initially focussing on mental health and support for carers.
- Gather national learning through discussion with strategic commissioning leads within iHub.
- Engage with third sector partners in the strategic commissioning process and to communicate local position. Engagement will include a series of strategic commissioning events, the first of which is scheduled to take place on 22 August 2017.

4.3 The schedule of work relating to strategic commissioning presented to, and approved by the IJB in March 2017, is ambitious. Progress against the initial timescale will be monitored and reported to the IJB on an on-going basis.

5. REQUEST FOR FURTHER INFORMATION

5.1 Following the presentation of the bi-annual Partnership Funding performance report to the IJB in June, requests were made for further information regarding

the implementation of the revised ALFY model and also the Braveheart Optimise Health programme.

Advice Line for You (ALFY)

5.2 ALFY forms part of the Forth Valley wide Closer to Home initiative. ALFY was established in 2015 as a dedicated, public facing advice line, operating on a 24/7 basis. The purpose of ALFY was to provide a first point of contact for people over the age of 65, at risk of hospital admission or with a long-term condition. ALFY is intended to provide advice, support and re-assurance, connect people to health and care services, including direct access to day and night nursing, referrals to ReACH, social work services and signposting to third sector organisations.

5.3 Following a review of the Closer to Home initiative in 2016, it was noted that the uptake of ALFY was low, with approximately 900 calls received during 2016/2017, of which 54% were from people within the Falkirk area. In December 2016, the IJB approved a recommendation that ALFY extend provision to become a first point of contact for professionals, whilst maintaining the function of a public advice line. An implementation report was provided and considered by the Partnership Funding Group in early 2017.

5.4 The revised ALFY will receive and respond to all requests for support from community health services, from both professionals and patients. The model is intended to provide a faster response, initial triage, where appropriate and to free practitioner capacity. The model will be incrementally extended to include requests for support from social work services. An initial pilot phase will take place in Clackmannanshire Community Health Centre, Clackmannan and Bo'ness Road Practices.

5.5 There has been some delay in the roll out of ALFY as a point of contact for professionals, which has been primarily due to concerns raised by Primary Care colleagues regarding the introduction of the new model. Discussion is ongoing to ensure that issues raised are addressed. With the full complement of staff commencing from the end of July 2017, the first phase will begin in August 2017. Evaluation of phase one will take place during September and October 2017.

5.6 In the meantime, progress has been made to further develop the public facing advice line:

- ALFY staff now work proactively to raise awareness of the advice line and provide initial support within the discharge lounge and two medical wards within FVRH, on a daily basis. Follow up phone calls are also now made to patients after discharge and advice given as and when required.
- The ALFY Team has now relocated to Stirling Community Hospital to allow closer links with the Anticipatory Care Plan team and the wider community services across Forth Valley.

- Data collection has now been reviewed and improved. A Service User questionnaire will be undertaken by members of the Scottish Health Council from August 2017, with the aim of providing independent data.
- ALFY has been actively promoted across the area, including recent attendance at Public Partnership Forums, radio interview and improved information leaflet, including links with BSL groups and a text service for those hard of hearing. An ALFY information leaflet is provided as Appendix 2.
- Links have been made with the Older Adults Community Mental Health Team. ALFY staff will attend the Community Psychiatric Nurse forum in each locality with a view to ALFY referring directly to the Dementia Outreach Team. The Scottish Fire and Rescue Service has shown an interest in accessing ALFY, where appropriate.

5.7 Monitoring information is currently being gathered relating to the period April – June 2017. This will be reported to the IJB within the bi-annual Partnership Funding report, with a particular focus given to any increase in service take up following recent developments to the public facing service. Information provided relating to the final quarter of 2016/2017 highlighted that of the 136 calls received within the quarter, most people were provided with clinical or general advice and reassurance, 31% were referred to District Nursing, 14% to NHS 24 and 4% to support within the Third Sector.

Braveheart Optimise Health Programme

5.8 The Braveheart Optimise Health Programme was initially funded via the Change Fund, Partnership Innovation Fund in 2013. Funding was continued through ICF due to the broader health and wellbeing benefit to adults with long-term conditions. Funding has been consistently allocated at £20,000 each year.

5.9 Braveheart introduced a weight management programme in 2015, focussing on those at tier two level obesity and weight management guidelines. In April 2016, the IJB agreed that funding would continue to enable an evaluation of the programme to be undertaken and to allow funding to be secured from alternative sources. On this basis, a funding extension of 12 months was approved in August 2016, ending September 2017. At the point of approval, it was anticipated that no further ICF funds would be sought after this period.

5.10 Interim information has been provided regarding the on-going evaluation of the programme. In summary:

- 25 people enrolled in the programmes being evaluated (2 men and 23 women).
- 14 of these were from ethnic minority groups (Rainbow Muslim Women Group), 3 from carers groups and 10 were white British.
- 25 participants attended all of the 8 sessions and completed the programme.
- 98.9% of participants rated their experience with Lose Weight with Braveheart as an excellent experience.

- It was evident that Lose Weight with Braveheart was viewed as well-structured and provided participants with more in depth information that was easy to understand:
  "It was a great experience; the way Munira put it across has been easy to understand"
- The group setting was positively perceived by participants and they welcomed the opportunity to learn about weight management and found the practical, group based approach very useful:
  "The group make it easy for me to take the decision to change and I felt really motivated"
- 99% of participants reported that the sessions have helped them gain more confidence in managing their weight:
  "***This was a good kick start to my weight loss, after needing to lose weight for many years"***
- Some participants suggested that sessions would be enhanced with incorporated practical cooking skills and physical activities.

5.11 Recent communication with the Project Manager indicates that further sources of funds have not yet been secured and are unlikely to be in place until February 2018. To date, no formal request has been made to continue funding beyond September 2017. Confirmation has been provided to the Project Manager, that any further allocation of resource will be considered in line with the Partnership Funding governance process, with recommendations being presented to the IJB as appropriate.

6 CONCLUSIONS

6.1 This report provides IJB members with funding recommendations arising from proposals submitted and considered by the PFG, and endorsed by the SPG. Information is also provided regarding initiatives, following request from members. Performance detail regarding all initiatives will be provided to the IJB within the bi-annual Partnership Funding performance report.

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

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

Legal & Risk Implications
No legal issues have been identified.

In relation to Partnership Funding, risk implications relate to individual initiative performance and compliance with Scottish Government requirements regarding use of partnership funds. The governance and monitoring process previously approved addresses any potential risk.

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

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

Approved for submission by: Patricia Cassidy, Chief Officer

Author – Lesley MacArthur, Integrated Care Fund Co-ordinator
Date: 14 July 2017

List of Background Papers:

Integrated Care Plan December 2014
IJB Papers regarding Partnership Funding:
- 7 October 2016
- 5 December 2016
- 2 February 2017
- 30 March 2017
- 16 March 2017

Partnership Funding Group minute and scoring matrix
- 6 December 2016
- 9 January 2017
- 7 March 2017
- 18 May 2017
- 11 July 2017

Strategic Planning Group minute
- 20 January 2017
- 17 March 2017
- 12 May 2017
- 14 July 2017

Appendix 1

Strategic Planning Group: Partnership Funding Group Project Summary and Recommendations

Funding Proposals: Recommendations – All funded services and posts are required to integrate within the Change Programme and be an integral part of the cohesive whole system approach

Project Name & Lead Agency	Amount and Term Requested	Project Summary	Strategic Alignment	Recommended Funding	Justification/Condition
Living Right Up to the End – Community Support in Advanced Long Term Conditions Strathcarron Hospice	£73,442 1 Oct '17 – 31 March '19	The project intendeds to build sustainable, community capacity and resilience for end of life care, which will in turn, reduce individual dependency on health & social care services during the last year of life. Beneficiaries will include people with a wide range of Long-term conditions and their carers. Over the past year, as part of a project called 'Living Right up to the End' , Strathcarron Hospice has been engaging with people who are living with long-term conditions (LTC), to find out what is important to them as their health deteriorates. Engagement has highlighted that given the opportunity, people are willing to think about what is important to them about the end of life and they have very clear preferences. However, people: • find it difficult to find or use information that might help them to plan ahead. • find it difficult to communicate their wishes and fears with those close to them. • would prefer where possible to use lay support	**Self-Management:** People with advanced LTC and their carers are able access the right information and plan for the deteriorating health/end of life via an asset based approach (Community Circles). **Autonomy & Decision Making:** People will express preferences about their end of life care and communicate this to those important to them (family and professionals). **Safe:** People will be able to plan for the end of life but also enabled to live well and do what matters to them right up to the end. **Community Based Supports:** Capacity is increased within community and local organisations to support people right up to the end of life. **Scottish Govt. Priorities:** • Increased provision of good quality, appropriate palliative and end of life	£49,962 1 Oct '17 – 31 Sept '18	**PFG Recommendation:** Funding is recommended for an initial period of 1 year. This initiative directly supports good quality end of life care and will contribute towards people being supported within their own home, in the way that they choose. In addition, the proposed asset approach is designed to be sustainable and scalable. Conditions of funding: • Ensure single approach to ACP through links with palliative care provision. • Evaluation of the approach should be embedded from the outset. • Links be developed with existing community link working projects e.g. social prescribing, and also align with Scottish Govt. intention

		from their own communities than work with professionals • want to focus on living rather than dying and want to contribute to and participate in their own communities. Funding requested will allow the project to work with 100 individuals and their carers, initially within the west locality area : • Recruit, train & support a community of volunteers to provide regular support to adults with advanced LTC and their carers in the final year of life. • Enable people with LTC to identify personal networks of local support and information using Community Circles model. • Enable people to engage in planning ahead for when their health deteriorates – but also to continue to live as well as they can with their illness. • Work with 10 existing community organisations to raise their awareness and skill in how to support people in the last year of life.	care. • Tests new approach to 'Community Link Working' model, focussing specific target group. **HSCP Change Priorities:** • Aligns with reablement approach and introduction of ADL Smartcare in relation to the development of asset based approaches.		to introduce Community Link Workers to all Partnership areas.

ALFY does not replace existing services.

- You should still contact 999 in an emergency or NHS 24 Telephone 111 if you need to see a GP when your surgery is closed and you cannot wait
- till it reopens.

However ALFY can give you advice or re-direct you to the service or help that you need

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Falkirk Council

NHS Forth Valley

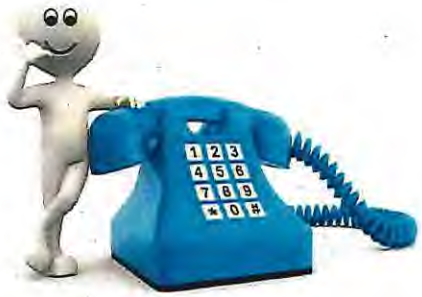
Stirling Council

Advice Line For You

ALFY

01324 567247

Are you or do you know someone over 65?
Are you or do you know someone with a long term health condition? *
Do you need help to stay at home?



Call one of our nurses for health and social care advice

24 hours a day

Helping You Remain at Home

NHS Forth Valley are working with local council partners to find new ways to support people to remain at home.

We listened to peoples experiences which told us overwhelmingly that they preferred to stay at home whenever possible. Sometimes people become anxious should a problem arise and are often unsure what to do or who to turn to.

ALFY nurse can provide :

- General advice and re-assurance.
- Arranging for a nurse to visit you day or night if necessary.
- Organising for you to receive equipment if required.
- Arranging a referral to the Community ReACH service (Rehabilitation).
- Suggest relevant voluntary organisations and other locally based services that may provide additional support.
- Follow up support telephone call after discharge from hospital and referral to the above services if required.
- If you are a hospital patient you may be introduced to an ALFY nurse prior to your discharge home.
- If you would like to know more about the ALFY service we can provide education and Information sessions for local groups in Forth Valley.

Patient Experiences

- George rose to go to the toilet during the night and cut his leg on the side of the bath. The bleeding had not stopped after 10 minutes but George knew this was not an emergency and still needed help. He phoned ALFY and spoke to the nurse who reassured him and asked a community nurse to visit that night to apply a dressing.

- Previously independent, Annie had difficulty getting around the house. She had a couple of falls where she was uninjured but concerned the next fall would incur injury. Annie phoned ALFY, spoke to the nurse who referred her to the ReACH team who visited Annie and provided her with walking aids and equipment to make her feel safer.

- Betty was discharged from hospital after breaking her arm in a fall. She found it difficult to wash and dress. She phoned ALFY and the nurse arranged for Social Work to provide a carer once a day until she was able to do it.

- *Examples of long Term health Conditions can be : Chronic Obstructive Pulmonary Disease, Diabetes, Multiple Sclerosis, Arthritis, Renal Disease etc.