THIS PAPER RELATES TO ITEM 09

ON THE AGENDA

CLACKMANNANSHIRE COUNCIL

Report to Housing, Health & Care Committee

Date of Meeting: 28 January 2016

Subject: Integrated Care Fund Plan 2015/16 Progress Report

Report by: Head of Social Services

1.0 Purpose

1.1. This report informs the Housing, Health and Care Committee that the Integrated Care Fund Plan (ICP) for 2015/16 is being implemented and that the Clackmannanshire & Stirling Health & Social Care Partnership have completed and returned the 'Integrated Care Fund – Mid Year Reporting Template for 2015/16' to the Scottish Government. A copy of the Clackmannanshire & Stirling report to the Scottish Government is appended to this report.

1.2. This report also informs Committee that an approval process is being developed for the allocation of 2016/17 ICF resource via the Reshaping Care Strategy Group (RCSG), the Joint Management Team (JMT), and the Integration Joint Board (IJB). This process will align existing ICP services and the finalised Health & Social Care Integration Strategic Plan priorities by the end of the 15/16 financial year.

2.0 Recommendations

The Committee agrees:-

2.1. To note the following:

2.1.1. That the Scottish Government created a successor to the Reshaping Care for Older People's Change Fund called the Integrated Care Fund (ICF). This fund commenced on the 1st April 2015 and is intended to support the rollout of Health and Social Care Integration.

2.1.2. That on the 6th October 2015 the Scottish Government requested that an Integrated Care Fund – Mid Year Reporting Template for 2015/16 was completed and returned by 6th November 2015. A copy of the letter from the Scottish Government requesting the ICF Mid-year Report is appended to this report (Appendix 1).

2.1.3. That the Clackmannanshire & Stirling Health & Social Care Partnership have completed and returned the Integrated Care Fund – Mid Year Reporting Template for 2015/16 to the Scottish Government. A copy of

the Clackmannanshire & Stirling report to the Scottish Government is appended to this report (Appendix 2).

2.1.4. That it is expected that a further report on the 2015/16 ICF will be requested by the Scottish Government for submission in early May 2016. The Clackmannanshire & Stirling response will be compiled following the receipt of reports from services supported through the ICF at the end of April 2016. An update on progress including a copy of the report submitted to the Scottish Government will be provided to the Stirling Council Social Care & Health Committee at the 25th August 2016 meeting.

2.1.5. That an approval process is being developed for the allocation of 16/17 ICF resource via the Reshaping Care Strategy Group (RCSG), the Joint Management Team (JMT), and the Integration Joint Board (IJB). This process will align existing ICP services and the finalised Health & Social Care Integration Strategic Plan priorities by the end of the 15/16 financial year.

3.0 Considerations

3.1. In July 2014, the Scottish Government wrote to Health and Social Care Partnerships to announce the allocation of additional resources for 2015/16 to support the delivery of the National Health and Wellbeing outcomes for Health and Social Care Integration. In December 2014 the Clackmannanshire and Stirling Partnership submitted its Integrated Care Fund Plan (ICP) to Scottish Government. The Integrated Care Fund (ICF) supports investment in integrated services for all adults. The 2015/16 allocation for the Clackmannanshire & Stirling Partnership area is £2.48million. (Clackmannanshire £0.96m and Stirling £1.52million).

3.2. The Scottish Government ICF guidance sets out a number of key messages that reinforces and builds on the successes of the Reshaping Care for Older People's (RCOP) Change Fund programme. It is recognised that the full ambitions of the RCOP 10 year programme have yet to be fulfilled and that partnerships require to continue to make progress within the context of the new integrated arrangements for adult services from 1st April 2015. This work is led by the Integration Joint Board (IJB) and supported by the development of the Strategic Plan by April 2016.

3.3. In line with Scottish Government Guidance, the Integrated Care Plan (ICP) for Clackmannanshire and Stirling focuses on the following priorities:

a) Reducing health inequalities.

b) Tackling the challenges associated with multiple and chronic illnesses for adults and older people.

c) Focus on multi-morbidity and the correlation with mental health physical health problems and deprivation.

d) Transformational activity focused on prevention and preventative spend to redesign and redirect activity from complex and high cost service models.

e) Working with the third sector and the independent sector as key partners in the delivery of care.

f) Ensuring that personal outcomes for individuals and carers are at the centre of the plan.

3.4 The introduction of the ICF also builds on the achievements of the Reshaping Care for Older Peoples' programme for Clackmannanshire and Stirling these include:

a) The implementation of a Joint Commissioning plan for older people.

b) The redesign and roll out of intermediate care and enablement services to support hospital discharge and prevention of admission.

c) The implementation of winter planning arrangements including, telecare & additional support for delayed discharge.

d) The redesign of Health and Social Care pathways to ensure they are consistent with transformation programmes namely Clackmannanshire Councils Making Clackmannanshire Better (MCB) Stirling Council Priority Based Budgeting (PBB) and NHS Forth Valley Clinical Service Review.

3.5 The ICP was developed by a wide partnership of people across a broad range of organisations. The partnership approach has been assisted by having close links to, and subsequent scrutiny by, the Reshaping Care Strategy Group (RCSG). The RCSG has a formal role within the Community Planning structures in both Clackmannanshire and Stirling.

3.6 RCSG recommendations relating to the ICP are received by the Joint Management Team (JMT) and the JMT in turn makes further recommendations to the Integration Joint Board (IJB).

4.0 Sustainability Implications

4.1. Following consideration of the sustainability implications of this report no relevant issues have been identified.

5.0 Resource Implications

5.1. Following consideration of the resource implications of this report no relevant issues have been identified.

6.0 Exempt Reports

6.1. Is this report exempt? Yes ☐ (please detail the reasons for exemption below) No ☑

7.0 Declarations

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities** (Please double click on the check box ☑)

The area has a positive image and attracts people and businesses	☐
Our communities are more cohesive and inclusive	☐
People are better skilled, trained and ready for learning and employment	☐
Our communities are safer	☐
Vulnerable people and families are supported	☑
Substance misuse and its effects are reduced	☐
Health is improving and health inequalities are reducing	☑
The environment is protected and enhanced for all	☐
The Council is effective, efficient and recognised for excellence	☐

(2) **Council Policies** (Please detail)

8.0 Equalities Impact

8.1 Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations?

Yes ☐ No ☐

It was determined that an Equality Impact Assessment was not required as this paper provides information for the Committee to note rather than asking the Committee to approve a proposal.

9.0 Legality

9.1 It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes ☐

10.0 Appendices

10.1 Please list any appendices attached to this report. If there are no appendices, please state "none".

Appendix 1 – Scottish Government Letter, INTEGRATED CARE FUND – MID YEAR REPORTING 2015/16.

Appendix 2 – Completed Clackmannanshire & Stirling Integrated Care Fund – Mid Year Reporting Template 2015/16 returned to the Scottish Government.

11.0 Background Papers

11.1 Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)

Yes ☐ (please list the documents below) No ☑

Author(s)

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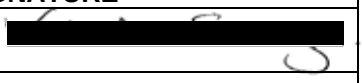
Approved by

NAME	DESIGNATION	SIGNATURE
Val de Souza	Head of Social Services	
Elaine McPherson	Chief Executive	Signed: E McPherson

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The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014
XX COMMONWEALTH GAMES SCOTLAND

To Chief Officers, Integration Joint Boards
Lead Officer of The Highland Partnership
Copy to - Local Authority, Chief Executives
NHS Chief Executives

Our ref: ICF/MYR
6 October 2015

Dear Chief Officers

INTEGRATED CARE FUND – MID YEAR REPORTING 2015/16

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

The first tranche of Integrated Care Fund monies of £100m were included in NHS Board's baseline funding allocation letters for 2015-16. The allocations to local health and social care partnerships were based on a composite of the following two distributions on a 1:1 ratio:

- The NHS National Resource Allocation Committee (NRAC) distributions for adults in the Acute, Care of the Elderly, Mental Health and Learning Difficulties, and Community care programmes;
- Local Authority Grant Aided Expenditure (GAE) distributions for People aged 16+ derived using a population weighted composite indicator based on a number of factors.

Individual allocations to each health and social care partnership are profiled at Annex A and it is expected that all Integrated Care Fund resources should be used in 2015/16.

As you will be aware, ICF resources are to be used by health and social care partnerships to support investment in integrated services for all adults and should be used to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen local approaches to tackling inequalities.

As stated in the Integrated Care Fund guidance which was issued to health and social care partnerships on 7 July 2014; it is important that the approaches for the use and monitoring of Integrated Care Fund resources are built in to and sustained through the longer term strategic commissioning approach. In addition, one of the conditions attached to the

Integrated Care Fund was that all partnerships in receipt of funding are required to monitor their own performance and must submit two progress reports at six monthly intervals to the Ministerial Strategic Group on Health and Community Care.

With this in mind, Annex B provides a template for partnerships to use when reporting progress. The template asks for information in relation to the following areas;

- Spend to date in 2015/16 against the activities identified within partnership's ICF plans (submitted January 2015);
- Progress towards achieving the outcomes outlined in partnerships ICF plans and how this has been measured;
- ***For those partnerships that were in the process of developing robust monitoring arrangements when their Integrated Care Fun plan was submitted. We now expect details of their locally agreed outcomes to be finalised and reported on,***
- Where partnerships are not making progress towards achieving the outcomes outlined in their ICF plans information on what action is being taken to address this should be included; and finally
- Partnerships should include, information into the broader impact that ICF resources have had in;
    - Establishing links with wider Community Planning Activity;
    - Progress made in linking ICF activity with wider strategic commissioning activity;
    - How ICF funding has strengthened localities including input from Third Sector, Carers and Service Users;
    - What evidence (if any) is available to the partnership that ICF investments are sustainable; and
    - Where applicable - what impact the ICF has had on implementing the National Action Plan for Multi-Morbidity

You will also wish to note that discussions with Stakeholders on the shape and content of guidance for future years of the Integrated Care Fund will begin shortly and it is envisaged that this will be issued to partnerships by the end of 2015.

If you have any questions regarding the reporting arrangements outlined above please contact me on 0131 244 3588 or via e-mail brian.nisbet@gov.scot.

In the meantime I would be grateful if you would submit your returns to the IRC@gov.scot mailbox **by Friday 6 November** outlining progress that your partnership has made thus far with Integrated Care Fund Resource.

Yours sincerely

Brian Nisbet

Annex A

NHS Board	Partnership	£m
Ayrshire & Arran	*East Ayrshire*	2.47
	North Ayrshire	2.89
	South Ayrshire	2.34
		7.70
Borders	*Scottish Borders*	**2.13**
Dumfries & Galloway	*Dumfries & Galloway*	**3.04**
Fife	*Fife*	**6.73**
Forth Valley	*Clackmannanshire*	0.96
	Falkirk	2.88
	Stirling	1.52
		5.36
Grampian	*Aberdeen City*	3.75
	Aberdeenshire	3.78
	Moray	1.59
		9.12
Greater Glasgow & Clyde	*West Dunbartonshire*	1.99
	East Dunbartonshire	1.70
	East Renfrewshire	1.43
	Glasgow City	13.29
	Inverclyde	1.76
	Renfrewshire	3.49
		23.66
Highland	*Argyll & Bute*	1.84
	Highland	4.31
		6.15
Lanarkshire	*North Lanarkshire*	6.51
	South Lanarkshire	6.04
		12.55
Lothian	*East Lothian*	1.76
	Edinburgh, City of	8.19
	Midlothian	1.44
	West Lothian	2.85
		14.24
Orkney	*Orkney Islands*	**0.41**
Shetland	*Shetland Islands*	**0.41**
Tayside	*Angus*	2.13
	Dundee City	3.10
	Perth & Kinross	2.63
		7.86
Western Isles	*Eilean Siar*	**0.64**
Scotland		**100.00**

ANNEX B

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund – 2015/16 – Mid-Year Financial Summary

(Insert Partnership Name) – (Insert Total ICF allocation for 2015/16)

	Allocation for 2015/16	Spend - April to September 2015	Forecast Spend – October to End March 2015	Projected Over/Underspends
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
[Insert workstream/project)		[Insert spend to date]		
Total ICF spend to date-2015/16				

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

WORK STREAM ACTIVITY OR PROJECT	OUTCOMES FOR 2015/16	PROGRESS TOWARDS OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE

ANNEX B

INTEGRATED CARE FUND – MID 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?	
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	
How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users	
What evidence (if any) is available to the partnership that ICF investments are sustainable	
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity	

INTEGRATED CARE FUND – MID 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 IRC@gov.scot

ANNEX B

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund – 2015/16 – Mid-Year Financial Summary

Clackmannanshire & Stirling Partnership – Total ICF allocation for 2015/16: £0.96m+£1.52 = £2.48million

	Allocation for 2015/16	Spend - April to September 2015	Forecast Spend – October to End March 2016	Total Forecast Spend 2015/16
1.1 Test and Deliver action to ensure a responsive 24/7 Health & Social Care Model	£700,000	£48,333	£272,145	£320,478
1.2 Develop and Extend intermediate care model to all adults – particularly implement a dementia intermediate care pathway	£508,254	£186,000	£333,084	£519,084
1.3 Embedding a range of person centred anticipatory and prevention planning – across areas of poverty and high multimorbidity	£284,980	£74,569	£104,363	£178,932
2.1 Extending Community Based Supports	£203,125	£52,831	£87,812	£140,643
2.2. Direct Support to Carers	£174,747	£87,374	£87,374	£174,748
2.3 Communications, Navigation/Way Finding	£76,756	£0	£23,667	£23,667
2.4 Targeted Resource to Support Lifestyle Change	£20,000	£5,000	£10,000	£15,000
3.1 Enablers for Transformational Change	£484,001	£99,865	£232,837	£332,701
Total ICF spend to date- 2015/16	**£2,451,863**	**£553,972**	**£1,151,282**	**£1,705,254**

Notes:

1) The Transitional IJB approved the Integrated Care Plan at its meeting of 13th May 2015 with further detail of the programme being presented to the Transitional IJB Briefing session on 28th August 2015.
2) The partnership are considering the Integrated Care Plan as year 1 of a 3 year investment programme which will be subject to ongoing monitoring, scrutiny and review particularly in light of the development and approval of the partnership's strategic plan.
3) Given the above the partnership does not consider the above to represent an underspend, but rather a timing of expenditure issue across the 3 year investment programme. NHS Forth Valley will manage the difference in timing of expenditure compared to timing of allocation through its financial management regime. The partnership anticipate, particularly in light of a very challenging financial environment, that this approach will assist with sustainability of the programme.

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

WORK STREAM ACTIVITY OR PROJECT	OUTCOMES FOR 2015/16	PROGRESS TOWARDS OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE
1.1 Test and Deliver action to ensure a responsive 24/7 Health & Social Care Model	***More people supported to live independently at home Through a time of crisis / increasing vulnerability / acute illness*** The commissioning of "Responsive" Assessment and Care services particularly focussing on ability to deliver appropriate service at times of urgency out-with normal weekday hours and at weekends. This particularly focuses on prevention of hospitalisation, social crisis or escalation to long term care and requires: Sufficient Capacity of Rapid Access Community Care services to provide a safe, prevention based, alternatives to hospital admission. ○ Dedicated capacity for 7 day Rehabilitation / Reablement Assessment /urgent intervention and increasing capacity Community Nursing	**Measuring Impact:** • Hospital Admissions appropriately avoided • Hospital bed days saved through reducing delay in discharge • Service user testimony of support through a period of "crisis" / "acute vulnerability/ illness" • Demonstration of personal Outcomes regarding independent living of care input pre and post episode of care. • Resource use per Care episode **Demonstrating Reach:** • capacity for 5 additional full care packages or equivalent home care visits(for an average of 5 days) • Improved direct referral pathway from Primary Care to Rapid Response care team. • Improved competence and augmented care training for Support Workers employed to provide home care visits. • Opportunities to access	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service changes, and to • Demonstrate the reach achieved by service changes (more output focussed). This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15.  RCSG Role & Remit 20July15.pptx First service based ICF reporting is scheduled for Jan '16. NHS Forth Valley recruitment is now underway.

	○ Enabling Services to respond quickly and appropriately to urgent need To achieve this outcome we will: • Provide additional capacity of Rapid Response Community Care for adults • Relax criteria on duration of rapid response care from 72hrs to circa 5 days • Provide a 7 day dedicated urgent AHP response: OT and Physio • Provide a 7 day dedicated urgent enhanced nursing response • Provide enhanced overnight support • Support and co-produce the development of the frailty / enhanced care at home model • Resource Leadership/ time to develop a resilient co-ordinated Community Response model	telecare to enhace enablement. • 1 additional Nurse, OT & Physio 8-10 hours over 7 days offers total new capacity for 4-6 assessments and circa 15 follow up visits per day. • Per night -1 additional carer,1 support worker, 1 nurse will enable continuation of winter model of doubling night nursing and will enhance MECs capacity and role by 1/3)) . • Continue with rapid access frailty clinic & support alternative to hospital admission for 10 care at home users (capacity incl in above)	within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	
1.2 Develop and Extend intermediate care model to all adults – particularly implement a dementia	***Shift the balance of care to enable more adults to remain in their own homes as independently as possible.*** Refining and Extending	**Measuring Impact:** To achieve this we will measure Numbers • (%) of people living at home • Numbers of recipients of reablement & outcome in terms of level of home care required after enablement	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group

intermediate care pathway	Intermediate care models for adults with physical disabilities, Dementia, Learning Disabilities and Mental Health. To achieve this outcome we will: • Extend the enablement approach to a greater proportion of service users including Implementing recommendations of "Keys to Life" for service users with a learning disability • Include relevant groups of existing service users within the enablement approach • Provide additional intensive care at home packages as an alternative to residential care • Integrate Reablement and Rehabilitation services • Develop and transition to the Stirling care village integrated model including early implementation of intermediate care model for individuals with dementia in Allan Lodge? • Outline the Scope out the options for a similar model in Clackmannanshire • Increase hospital SW	• We will seek service user feedback on services and engagement in design of services • % reduction in personal care following enablement /short stay assessment • % home care clients receiving personal care • % of people aged 65+ with intensive needs (plus 10 hours) receiving care at home • Delays due to social work assessment in SCH • Delayed discharges >2wks • Change in Number / rate of individuals in long term care **Demonstrating Reach:** Spread of reablement to under 65's including adults with physical and learning disability • Evidence of integrated Rehab at home and reablement services in Stirling / Clacks and Rural. • Increase range of adults receiving reablement • Integrate Occupational therapy roles across health and social care • Estimated 15 short stay care episodes generated by first 5 additional Short stay beds in Allan Lodge over first year. • SW Assessment Capacity for	(Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service changes, and to • Demonstrate the reach achieved by service changes (more output focussed). This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/	has been in place since July '15. First service based ICF reporting is scheduled for Jan '16. NHS Forth Valley recruitment is now underway. Some update information provided proactively by Adult Provisions Service Manager: Additional capacity within Allan Lodge (Internal Intermediate Care Facility in Stirling) to provide 5 beds for old age psychiatry model of intermediate care – capacity has reached 3 available beds with an expectation of rising to 4 beds by mid-November 2015.

	assessment capacity • Develop a transitional integration plan for Stirling Care Village • Develop an Intermediate Care Strategy	12-14 additional cases at any one time • SC Allocation with next working day • Assess NHS long stay clients in SCH • Education on AWI legislation to increase proactivity around POA	Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	
1.3 Embedding a range of person centred anticipatory and prevention planning – across areas of poverty and high multimorbidity	***More people supported to live well and independently at home.*** Embedding a range of person centred anticipatory and prevention planning approaches across all community services whilst focussing specialist ACP resource to areas of poverty and high multimorbidity with more awareness of the under 65yrs population and those with mental health problems. To achieve this outcome we will: Keep Well Primary Prevention • Support Individuals experiencing inequalities through primary prevention programme targeting health inequalities (Keep Well). Anticipatory Care Planning Adults Frailty / Multimorbidity • Scale up ACP through targeted	**Measuring Impact:** • Referral rates into lifestyle services, core NHS services (as above) and 3rd sector agencies e.g. weight management support, mental health services. • These models have all identified a range of measures including • health and wellbeing outcome measures, • Achievement of personal outcomes • Number of Key Information Summaries (KIS) completed • acute hospital admissions rates from target localities / GP practices • Level of Hospital admissions from care homes • Referrals, post implementation of nutrition champions, for Nutritional and Fluid **Demonstrating Reach:**	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service changes, and to • Demonstrate the reach achieved by service changes (more output focussed). This approach is one that has been developed over a number of	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15. First service based ICF reporting is scheduled for Jan '16. NHS Forth Valley recruitment is now underway.

	support to Individuals with multimorbidities, at risk of hospital admission or recently discharged from hospital to remain well and living at home. • Proactively support needs of carers of same individuals • Share learning and embed Primary Prevention and ACP approaches in mainstream services Nutritional Support: Prevention Models • Deliver nutritional support to more individuals in care homes and support more adults with complex care needs • Support Service users with nutritional support needs identified through the ACP/frailty/ 24/7 pathway Deliver more Food First Training to care providers, Care Homes, Carers ***Area Wide Model Implementation in conjunction with Falkirk Plan*** Alcohol Related Brain Damage To achieve this outcome we will:	Keep Well • 200 more clients referred into Keep Well health assessments from these practices. • 20% more referrals into core services (weight management, stop smoking etc.) ACP • Building on the pre-existing change funded baseline of more than 200 people to support to a further 600 individuals and carers in year. Nutritional Awareness Training and Support • 4 frailty "set up" training sessions & ongoing implementation of nutritional screening support to 100 paid home carers (care at home) • Nutrition Champion in every Care Home, including intermediate care, supported Individual Treatment and Support • High level input complex hospital discharges -20 • Frail Older People at Home – 80 medium level • Intermediate Care Beds – 20 low level **Measuring Impact:** • Quality of Life (e.g. with quality of life and satisfaction	cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	

	• Development of a nurse-led case management service that will offer a community based, assertive outreach model of care for adults with ARBD / Korsakoff Syndrome and their carers.	questionnaire) • Occupational Therapy functional assessments, where possible • Saved bed days from acute wards (scope tbc by test of change) **Demonstrating Reach:** • Expected referrals: 100 in first year from across Forth Valley. • 12 training sessions provided in first year. • Assessment of carer need completed by end first year.		
2.1 Extending Community Based Supports	***More people supported to live well and independently at home through or following a time of crisis / increased vulnerability / acute illness / dementia diagnosis.*** The commissioning of services that support people to improve or maintain their physical and social health and independence while returning to or remaining within their own homes and communities for longer. This includes third sector provided services that: compliment and extend the reablement journey using local volunteer support; community based dementia support services;	**Measuring Impact:** • Total number of referrals into third sector provided services • Total number of third sector provided services delivered • Total number of appropriate discharges from third sector provided services • Hospital admissions/re-admissions appropriately avoided • Progress towards service users' independence related personal outcomes e.g. to go shopping, catch the bus, attend other community groups. • Service user testimony • Total number of groups applying for a small grant and total number of grants awarded. **Demonstrating Reach:** • Support up to 200 new 'step down' referrals per year from reablement/rehabilitation/ReAC	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service changes, and to • Demonstrate the reach achieved by service changes (more output	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15. First service based ICF reporting is scheduled for Jan '16. Some services are at an early stage of development and delivery. Alzheimer Scotland have decided not to progress with the additional WTE Post

	and small grant funding for purely voluntary community groups that promote ongoing independence and social connection . To achieve this outcome we will: • Extend the enablement approach to include 6 weeks of third sector provided volunteer support following discharge from reablement/rehabilitation/ReACH and ACP teams – step down support. • Extend the enablement approach to include 6 weeks of third sector provided volunteer support following self/family/GP referral – step up support. This will include a focus on those experiencing inequalities and multiple/long term conditions. • Provide a rolling year long programme of post-diagnostic dementia support for those with a new diagnosis. • Continue to deliver the community connections programmes of dementia specific events and activities including: football reminiscence; walking group; musical memories; and dementia café.	H and ACP teams across Clackmannanshire & Stirling. • Support up to 200 new 'step up' referrals per year from self/family/GP's across Clackmannanshire & Stirling. • Support 100 new post diagnoses dementia families during the next year with one year of post-diagnostic dementia support (with up to an extra 10 families receiving 'light touch' support) across a range of venues in Clackmannanshire & Stirling. • Provide up to 1200 service user / carer places at Community Connections events over the year. • Provide 6 Cognitive Stimulation Therapy Groups during the year, each group running for 1 hour per week over 14 weeks, with a maximum of 8 service users. • Provide 6 CST Maintenance Groups during the year, each group running for 1 hour per week over 6weeks, with a maximum of 8 service users. • At least 60 small grants of up to £400 made to local groups. (detail still tbc)	focussed). This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	Diagnostic Dementia Link Worker role in addition to their previous level of service. The reason for not progressing with the additional role was based on an unwillingness to accept a one year funding commitment as the basis for forming a new post.

	• Support people with dementia by delivering a cognitive stimulation therapy programme, providing group support and helping to promote wellbeing and social interaction. • Deliver a small community grants fund for local voluntary groups that welcome new participants/members and contribute to social and physical health.			
2.2. Direct Support to Carers	***Carers are supported to live healthy and independent lives even if the person that they care for experiences periodic times of crisis / increased vulnerability / acute illness / or long term condition(s).*** To achieve this outcome we will: • To provide emotional and practical support & advice to Carers on a 1-1 basis to address a range of issues • To identify and offer support to a wide range of carers including "hidden" carers • To undertake carer assessments on behalf of Social Services in Stirling area • To work in partnership with Social Services, NHS and	**Measuring Impact:** Percentage of carers reporting improved outcomes in relation to issues they've identified, including: • % of carers reporting improved or sustained outcomes in relation to their health and wellbeing • % of carers receiving Carers Assessment reporting improved access to support • % of carers reporting improved or sustained outcomes in relation to having confidence in their caring role • % of carers reporting improved or sustained outcomes in relation to being able to retain a life outside of caring • % of carers reporting improved or sustained outcomes in relation to their economic wellbeing • % of carers reporting improved	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service changes, and to • Demonstrate the reach achieved by service changes (more output	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15. First service based ICF reporting is scheduled for Jan '16. Some update information provided proactively by Stirling Carers Centre is noted in the document embedded below:

	Voluntary Organisations including Community Anticipatory Care and Hospital Enhanced Discharge teams • To provide information and advice to carers • To establish signposting and referral services with other agencies • Production of information and advice in a range of formats e.g. leaflets, newsletter, web • To provide a meeting place and a focal point for carers • To provide support to secure respite / short breaks / information / funding • To provide rural and urban peer group support. • To provide welfare benefits advice • To advocate on behalf of carers if appropriate • To provide training sessions to Social Service, NHS and other statutory staff around carers issues • Liaison with other relevant agencies in signposting carers to services and in contributing to policy and service developments	or sustained outcomes in relation to involvement in planning and shaping services (including carers being treated as equal partners in care). • Annual cumulative figure of benefits claimed by carers (Baseline annual rates are available from carers centres) **Demonstrating Reach:** • number carers' support plans completed to national standard • number of carers worked with per year (including new/hidden carers identified) (expect approx. 1200carers/400new in Stirling and 500carers/200new in Clackmannanshire) • The number of newsletters distributed • The number of carers supported to secure respite / short breaks / funding to do so • Number of peer group support sessions delivered over the year • Number of training sessions (including 'Caring with Confidence') delivered over the year • Number of training/ information sessions delivered to other professional groups (minimum 2 per year) • No of unique Carers taking part in Stirling Carers Voice and other forums throughout the year • Evidence from each identified	focussed). This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	Integrated Care Fund – Stirling Care

		work stream on the scale to which impact on carers has been considered and monitored.		
2.3 Communications, Navigation/Way Finding	***Personal outcomes for individuals and carers are at the centre of the plan.*** ***Workforce is engaged and developed*** ***Health and social care services contribute to reducing health inequalities*** ***Needs are identified at a locality level and local service provision and redesign is tailored to the locality.*** To achieve this outcome the Community Navigator will: • Make links with GP's, CPN's, ACP Nurses and care workers to: 1) offer a navigation service where relevant public sector service users are helped to access local community services and supports; 2)increase knowledge and understanding amongst local public sector colleagues of local community based activities and services; and 3)	**Measuring Impact:** • % of service users referred to the navigator service reporting that they feel the service has helped them to build confidence and become more independent. • % of public sector staff using the navigator service that report seeing evidence that service users experience health benefits. • % of individuals and their carers reporting that they are better informed about local activities and more likely to be proactive and take control of their own health and social needs (including the management and spend of self-directive support (SDS)). • % of participating local voluntary groups that see the navigator service as beneficial to them. To achieve this Integrated Care Planning will measure: • Experience from staff, partners and users to gauge how well the system is working. A review of complaints over time may also indicate increased satisfaction with the new ways	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service changes, and to • Demonstrate the reach achieved by service changes (more output focussed). This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15. First service based ICF reporting is scheduled for Jan '16. Some services are at an early stage of development and delivery. NHS Forth Valley recruitment is now underway.

	to establish referral pathways. • Make contact with individuals and their carers following referral, to link them with local services. • Work with residents, community groups, service providers and statutory partners to identify local assets, including volunteers and existing community networks. • Publicise the HSCI small grant fund. To achieve this outcome Living it Up will: • work to promote volunteer opportunities with 3rd sector interfaces and voluntary organisations, and promote educational opportunities • Signpost to relevant services/ products/ interests, produce 'how to guides and work with libraries to enhance their service To achieve this outcome Integrated Care Planning will: • help people access the services they need when they need them from health promotion and education to end of life care and everything in between. • identify people with specific	of working. • Service user experience. **Demonstrating Reach:** • Number of individuals referred to the Community Navigator that engage with the navigator. • Number of individuals who make contact with a local group or service following the Community Navigator intervention. • Number of individuals who feel the contact made was of benefit to them. • Number of community events held. • Distribution of leaflets. • Number of public sector workforce personnel the Community Navigator makes links with. • Number of public sector personnel who go on to make referrals. • Total number of referrals made. • Number of people who are not tech aware provided with training opportunities by Living it Up • Number of opportunities provided for remote monitoring of long term health conditions via Living it	will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	

	needs and anticipate change or react swiftly to allow individuals to remain independent at home. allow access to important information e.g.ACPs.	Up. Integrated Care Planning will: • Survey staff and users • Review pathways and systems • Use Significant Event Analysis • Review a sample of admissions of individuals supported at home • Audit access to ACPs • Review the outputs from the review of services and the upcoming WSW sessions (September and February) Conduct a review of process to make changes to pathways and strategies		
2.4 Targeted Resource to Support Lifestyle Change	***People are able to live in good health for longer*** ***Health & Social Care services contribute to reducing health inequalities*** ***Coproduction*** ***Carers are supported*** ***Personal Outcomes for Individuals are at the centre of the plan.*** To achieve these outcomes the exercise referral scheme will:	**Measuring Impact:** To achieve this we will measure • Physiological and psychological data gathered from targeted referrals. • Behaviour change in relation to physical activity as a result of brief intervention • Service user testimony highlighting impact of intervention on targeted individuals. • Referrals from Clackmannanshire Number of carers who take up the option of free access when accompanying the GP referral client that they care for.	Data used to monitor progress will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to: • Measure the level of impact on the expected outcomes of the service	Monthly reporting on implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15. First service based ICF reporting is scheduled for Jan '16. Some services are at an early stage of development and

	• Deliver an outcomes based brief exercise intervention focusing on behaviour change, targeting those who are living in one of the identified areas of need, or receiving income support, and suffering from at least one long term condition. • Expand scheme into communities of identified need, delivering consultations and programmes within such communities. • Provide free access to the scheme for those who are in the most need. • Establish referral pathway from the exercise referral scheme into other person centred community services such as Keep Well and Employability who target similar individuals from areas of need. • Expand the scope of the scheme to offer free access to the facilities for carers of GP referral patients.	**Demonstrating Reach:** • 150 service users from specified target groups. • 70% of service users classed as 'physically active' at week 12. • Active Living for Life being delivered in at least 1 additional community venue • Number of service users from deprived area. • Number of service users who are on income support or other benefits • Number of service users with co-morbidities • 250+ 1-2-1 annual exercise consultations. • Lead 2 evaluative focus groups with Exercise Referral Clients from target group. • 50 service users accessing the scheme within their own community.	changes, and to • Demonstrate the reach achieved by service changes (more output focussed). This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015. http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	delivery.
3.1 Enablers for	***Resources are used***	• Support organisational culture	Data used to monitor progress	Monthly reporting on

Transformational Change	***effectively and efficiently***
	
	Positive experiences and outcomes
	
	Engaged Workforce
	
	OD & Workforce Development
	
	Information and eHealth programme social care integration
	
	Business Development Support
	
	Flexible Fund - to be utilised in line with a submitted and agreed plan with reshaping care strategy group.
		change work, workforce development across local authority, health and third sector.
		
		• Support analytical needs for Health and Social Care Integration. This would include:
		  ○ Undertake the strategic needs assessment;
		  ○ Support Integration Joint Board to develop a performance framework;
		  ○ Create the performance framework
		  ○ Complement any resource available from LIST service
		
		• Oversee commissioning of services based on priorities identified for the Integrated Care Fund.
		
		• Support commissioned services to report on outcomes
			will be gathered by and within services and presented in periodic reports. Reports will be fed into the Reshaping Care Strategy Group, the Joint Management Team, and then to the IJB (Integration Joint Board). The expected mixture of quantitative and qualitative data will be used to:
			
			• Measure the level of impact on the expected outcomes of the service changes, and to
			
			• Demonstrate the reach achieved by service changes (more output focussed).
			
			This approach is one that has been developed over a number of cycles of improvement and reporting with the Change Fund and is clearly demonstrated within the Change Fund End of Programme Report. The Change Fund End of Programme Report will be available at the following web link from Monday 16th November 2015.
				implementation progress (development of Job Descriptions, Advertising of Posts; Staff in Post etc.) to the Clackmannanshire & Stirling Reshaping Care Strategy Group has been in place since July '15.
				
				First service based ICF reporting is scheduled for Jan '16.
				
				Some services are at an early stage of development and delivery.
				
				NHS Forth Valley recruitment is now underway.

		achieved. • Support Integration Joint Board, Integrated Change Projects Evaluation, Reshaping Care Group. • Lead an agreed programme of change in partnership with operational managers • Support strategic planning • Support Third Sector and Third Sector Interfaces • Support projects during transitional year with integration, such as consultation and engagement with prescribed consultees on the strategic plan. • A fund which can be utilised to support organisational development work (culture & behaviour development) for integration across local authority, health and third sector. • Consideration of a fund which can be utilised to support	http://nhsforthvalley.com/health-services/az-of-services/reshaping-care-for-older-people/clackmannan-and-stirling/reshaping-care-change-fund/ Monitoring data is not yet available because the Integrated Care Programme for Clackmannanshire & Stirling 'went live' in June 2015 and first reporting is scheduled for Jan '16.	

		eHealth work for integration of data and systems across local authority, health and third sector to improve outcomes for people. • A fund which can be utilised to support strategic planning and commissioning work as well as performance framework for the Integration Joint Board. • Consideration of a fund which can be utilised to support workforce development work (integrated ways of working) for integration across local authority, health and third sector.		

ANNEX B

INTEGRATED CARE FUND – MID 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?	The Clackmannanshire & Stirling Integrated Care Programme reports to the Reshaping Care Strategy Group (RCSG) at monthly meetings. The RCSG is a sub group of the Community Planning Partnerships in both Clackmannanshire and Stirling (Clackmannanshire Alliance and Stirling Community Planning Partnership) which helps to ensure that all efforts are aligned to the respective Single Outcome Agreements. ICF funding has also enabled investment to be made in projects / services that are tailored to address inequalities and that enable public and third sector organisations to play a crucial role in aligning the needs of service users and the priorities of CPP partners.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	The Clackmannanshire & Stirling Integrated Care Programme has been established on the basis that a commissioning based approach is taken to directing ICF investment in contrast to the grant based approach taken to the Change Fund previously. The Joint Strategic Needs Analysis and the Draft Strategic Plan that is being developed and currently going through governance processes will direct future commissioning efforts and the use of ICF resources. ICF funding will be a crucial to enabling investment in priorities identified in the Strategic Plan in advance of the need to disinvest from other services. Social Services Planning & Commissioning colleagues have also been leading on a 'Health & Social Services Route-map in Context of Integration' to show how services are linked to each other and how priorities can be programmed. ICF funded services profiled within the Route-map help demonstrate how integrated, improvement focused, commissioning can be developed and implemented.
How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users	Localities have been strengthened as result of the Integrated Care Programme in Clackmannanshire & Stirling by showing that universal services based upon assumptions that once services start they will remain in perpetuity can be challenged. The ICF investment has helped third sector services to tailor their provision to priorities such as inequalities within communities, targeting some communities rather than all, and offering free programmes to the carers of targeted service users as well as the service users themselves.

	All of these approaches help to demonstrate that strategic priorities can be progressed by targeted activity tailored to local geographies and demographics which echoes the main underlying message of the localities approach.
What evidence (if any) is available to the partnership that ICF investments are sustainable	Too early to say given that the Clackmannanshire & Stirling ICF went live in June 2015 and first reporting is due in January '15. The development and implementation of the Integration Authority's Performance Framework following the completion of the integration process will also help to measure the sustainability of ICF investments.
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity	The Clackmannanshire & Stirling Integrated Care Programme has been developed in alignment with the National Action Plan for Multi-Morbidity including: **Care Planning and consultations help people to have control over their conditions, care and support and to achieve their personal outcomes.** Outcomes based assessments & Holistic care planning – during: NHS Forth Valley - Anticipatory Care Planning within Theme 1.3; Clackmannanshire & Stirling Council social Services - Extended Intermediate Care & Reablement supported within Theme 1.2; Royal Voluntary Service – Well and Connected (Clackmannanshire & Stirling) within Theme 2.1; and Alzheimer Scotland – Post Diagnostic Link Worker & Community Connections Programme within Theme 2.1 **Integrated care and support builds on community assets and promotes independence, wellbeing and resilience.** Self-Management information, advice and support to help people stay well, active and at work & Build enablement and generalist skills in the workforce – during: NHS Forth Valley – 'Keepwell' within Theme 1.3; Royal Voluntary Service – Well and Connected (Clackmannanshire & Stirling) within Theme 2.1; Alzheimer Scotland – Post Diagnostic Link Worker & Community Connections Programme within Theme 2.1; Local Third Sector Interfaces - Community Navigation (Simplifying Access to Community Supports) within Theme 2.3; and Active Stirling - Active Living for Life within Theme 2.4

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

PARTNERSHIP DETAILS

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..... (Val de Souza) for Local Authority

..... (Jim Gilmour - tbc) for Third Sector - Clackmannanshire

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