INTEGRATED CARE FUND UPDATE

Aim

1.1 The aim of this report is to provide IJB members with an update on the partnership's Integrated Care Fund (ICF) Programme and further detail on those projects approved to date in terms of their cost commitments and targeted outcomes.

Background

2.1 Integrated Care Funding was first allocated to the shadow partnership in 2015/16. The ICF commenced on the 1st April 2015 with the award of £2.13m per annum (2.13% of £100m p.a.), a total allocation of **£6.39m** over the 3 years of the programme. During this year, a number of projects were approved by the partnership through the governance structure in place at that time. Of the £2.13m allocated for 2015/16, **£224k** was spent by the partnership in 2015/16 and a further **£132k** to date in 2016/17, a combined total of **£356k** over the life of the programme to date. Analysis of the spend to date on those projects approved by the IJB is detailed in **Appendix 1**. Each project has also been classified as a partnership priority, non-priority or enabler, based on they degree that they are deemed to support the delivery of new, improved pathways of care or the implementation of a locality model for health and social care services.

Current Position

3.1 Overall, 19 projects, projected to cost **£2.401m** have been commissioned as part of the ICF programme to date. In summary, these are:

Table 1 – Summary of 3-Year Resource Requirements of ICF Projects approved by Steering Group to date

1	Programme delivery	£	219,563
2	Community Capacity Building	£	400,000
3	Independent Sector representation	£	93,960
4	Transport Hub	£	139,000
5	Mental Health Integration	£	38,000
6	My Home Life	£	71,340
7	Community Ward delivery(18mth pm, pso)	£	53,655
8	Health Care & Co-ordination (18mth pm, pso	£	53,655
9	Delivery of the Autism Strategy	£	99,386
10	BAES Relocation	£	241,000
11	Delivery of the ARBD pathway	£	102,052
12	Health Improvement (phase 1) and extension	£	38,000
13	Stress & Distress Training	£	166,000
14	Transitions	£	65,200
15	Delivery of the Localities Plan 18 mths)	£	300,000
16	Locality Managers x 1 locality for 1 year	£	65,818
17	H&SC Coordination x 1 locality for one year	£	49,238

18	Community Led Support	£	90,000
19	The Matching Unit	£	115,000
		£	**2,400,867**

3.2 This represents further Steering Group-approved spend of **£620k** since the last report to the IJB in June and the board is now asked to ratify the five further projects to which this further direction of funding relates and an increase in the allocation to two of the existing projects based on the ICF Steering Group / EMT review of updated briefs.

Update

3.3 Five projects have been approved by the ICF Steering group since the last IJB report. These are:

1 - The Development of Localities Plans

The redesign of services to meet needs within each locality (£300k).

Scottish Borders Council and NHS Borders have committed to developing an infrastructure to support planning and delivery at a locality level, as outlined in Scottish Government legislation.

Building on the existing work by SBC to devolve services to localities supported by a Locality Planning Group, it has been recognised that by using the opportunities afforded by the health and social care strategic plan and the potential for joining up delivery arrangements locally, a truly integrated locality approach can be taken forward. The intent is to translate the national health and wellbeing outcomes into local targets based on need.

So far in Borders we have:-

- Established a localities planning group to be a focus for change linking the existing initiatives, the integrated care funded projects e.g. health and care coordination and the virtual ward and the emerging strategic plan priorities.
- Collated and mapped information on a locality basis relating to local demographics and needs.
- Reviewed previous locality management initiatives to build on what works.
- Set up local working groups responsible for the development of locality plans.
- Developed proposals for the implementation of co-located, locality based multidisciplinary teams.
- Given a focus to localities in the strategic planning consultation, seeking views from GPs, the third sector, the independent sector and local communities, helping us shape future arrangements.

Through Locality Co-ordinators leading the development and delivery of locality plans this project will bring about the redesign of services in each locality to meet the needs of the local population and local communities. This will result in better integration, communication and coordination of services and easier access to local services for service users, their families and GP's. This will also make recommendations to the Localities Group on future planning arrangements.

This project has a high impact across all of the Local Strategic Objectives and all of the National Health and Wellbeing Outcomes. The key outcome being outcome 4 "Health and social care services are centred on helping to maintain or improve the quality of life for the people that use those services" by providing the relevant services within the individuals locality. The key local strategic objective for this project is objective 5 "Deliver services with an integrated care model". This will be achieved by the creation of integrated teams within each locality.

This project has requested £300k over 18 months.

2 - Locality Management

Pilot Scheme: Overall management and strategic development of Adult Health and Social Care services within one locality for one year (£66k).

Scottish Borders Council and NHS Borders have committed to developing an infrastructure to support planning and delivery at a locality level, as outlined in Scottish Government legislation.

The Locality Manager will be responsible for the overall management and strategic development of Adult Health and Social Care services within each locality. They will direct, lead and be accountable for the effective management and delivery of high quality, cost effective clinical and non-clinical services within the Locality. They will manage multi-disciplinary staff from health and social care including Community Hospitals, community nursing, a range of adult social work services, care staff, local commissioners, health centres and a range of other professional disciplines and services.

They will establish effective partnership working across all agencies within the Locality (including the Third and Independent sector), facilitate integrated working with the District General Hospital, ensure effective joint working with other Local Authority departments and encourage and support the involvement of independent contractors in the delivery of the integrated services. The locality manager will also lead the engagement and involvement of local communities and service users and carers in the design and delivery of services. This will be aligned with the model for GP clusters.

This project supports the delivery of a localities approach across the Health & Social Care Partnership to enable the implementation of locality plans linked to the key outcomes for integration.

This project will contribute to a number of the local strategic objectives and national health and wellbeing outcomes. The key outcome being outcome 4 "Health and social care services are centred on helping to maintain or improve the quality of life for the people that use those services" by providing the relevant integrated services within each locality.

The key local strategic objective of this project is objective 5 "Deliver services with an integrated care model". This will be achieved by the creation of integrated teams co-located within each locality/community.

This project has requested £66k for a one year pilot in one locality.

3 - Health and Social Care Coordination

Pilot scheme: The Introduction of a Health and Social Care Coordination approach through an integrated team, within one locality for one year (£49k).

Currently referral pathways have separate routes for each service/profession, level of need/urgency, and some are unnecessarily complex and some are unsupported by information technology.

This project will develop the role of a Duty Co-ordinator who will streamline and control a new referral process and screening functions at a local level providing a single local point of access for health and social care services, similar to the Torbay model. The Torbay model has been identified as the best practice model with regards to integrated health and social care teams.

The Health and Care Co-ordinator role will facilitate liaison between newly developed integrated teams. It will also provide the main point of contact for GPs, patients and carers at a local level and will take on the initial assessment function to provide small packages of care to prevent crisis. If a patient's needs change, where a nurse would previously have had to make a referral to the local social work office for a social work assessment; under the new system, the co-ordinator would introduce changes based on the assessment of the nurse.

The project will also provide a link with the discharge coordination function in the acute hospital settings to help facilitate supported hospital discharges. The project will improve the overall outcomes for people within the locality who are frequently exposed to health and social care systems.

This project maps strongly to the majority of the local strategic objectives and the national health and wellbeing outcomes. The strongest impact being against outcome 7 "People using health and social care services are safe from harm" by streamlining services, providing a single point of access and providing small packages of care to prevent crisis.

This project maps to local strategic objective 5 "to deliver services with an integrated model". This is by the creation of integrated teams at a local level.

This project has requested £49k to test in one locality for one year.

4 - Community Led Support

To transform arrangements for access to Social Work staff and ensure more efficient use of staff and resources (£90k for 18 months).

The Social Care (Self-Directed Support) (Scotland) Act aims to ensure that care and support is delivered in ways that support choice and control over one's own life and which respect the person's right to participate in society.

The Community Led Support model provides a real opportunity to embed the Statutory Principles outlined in the Act of participation, involvement and

collaboration by providing a direct link between communities and health and social work practice.

The National Development Team for inclusion have developed a Community Led Support model which aims to remodel initial access to Social Work Services by developing a Community Hub model, in local community settings.
These are manned by the local community/volunteers who meet and greet customers with Voluntary Organisations supporting delivery. These will provide signposting to local services and advise on self-directed support.
Customers will also have the option of a pre-booked slot with a Social Worker/or other professional but drop-ins can also be organised. Recording needs to be minimal and a full needs assessment is only undertaken if required at a later time.

The model also provides a focus for the locality planning groups to deliver change at a tangible, local level.

This will result in a change of culture, creating a different conversation at each stage of the process. Conversations will focus on prevention and will promote aspiration and independence. The process will be more efficient, timely, proportionate and light touch and pathways will be simple, efficient and effective.

The project will increase customer satisfaction and increase staff morale and motivation. The focus will be on prevention, access to social care will be improved and there will be reduced waiting times for service users and carers. Demand and expectations will be managed effectively and there will be significant savings on health and social care budgets.
This project maps strongly to the majority of local strategic objectives. The key objective being objective 1 “Make services more accessible and develop our communities” by providing easily accessible drop in social care sessions and services to promote self-directed support in local communities. The key national health and wellbeing outcome that this project supports is outcome 1 “People are able to look after and improve their own health and wellbeing and live longer”. This will be delivered by the provision of self-directed support within the community.

This project is requesting £90k over 18 months.

5 - Matching Unit

The creation of a small central administrative team “Matching/Brokerage Unit”, to match clients, assessed by care managers as needing care at home services (£115k for 1 year).

A significant part of care managers time is taken up in trying to find external provision for clients (i.e.) rather than having full focus on assessment, managers are also spending time identifying and securing a service for clients. The creation of a small central administrative team (i.e.) Matching/Brokerage Unit, to match clients, assessed by care managers as needing care at home services will improve the productivity of the Care Managers and the quality of communication with customers.

The Matching Unit will perform a critical role in ensuring that the client needs are met quickly and efficiently by a Care at Home provider and that there is a handover period to ensure the new provider is fully aware of the care requirements of the

individual client. The focus for the Matching Unit will initially be Care at Home, however the remit of the Matching Unit could be developed over time to cover other services such as respite, day services, placement in care home, befriending and volunteering.

This project will –

- Reduce the time that care home managers spend trying to identify and secure provision for clients.
- Give a borders wide overview and resource.
- Provide a more consistent and effective approach to securing provision.
- Increase the amount of successful matching, which will have an impact on readmissions.
- Reduce long term home care hours required per client.

This project will impact on a number of the local strategic objectives, the key objective being objective 7 "We will further optimise efficiency and effectiveness" and outcome 9 "Resources are used effectively and efficiently in the provision of health and social care services" by creating a central matching unit, which will streamline the matching process.

This project is requesting £115k for the creation of a three person matching unit for six months focusing on care at home matching, and then increasing this to a five person unit for the remaining six months. If the six month evaluation shows capacity the five person team will extend their remit beyond care at home matching. If successful, the function will be mainstreamed and a permanent and sustainable source of funding put in place for this service.

3.4 Each of the approved projects is outlined in in **Appendix 2** to this report where further detail of their planned timeframes, aims and objectives, progress in their delivery to date and funding requirement is provided.

3.5 Supplementing the addition of these 5 new projects to the programme, 2 existing projects have been approved by the Steering Group for further funding allocations and endorsed by the Executive Management Team:

- **Borders Ability and Equipment Store (BAES)** – Following the outcome of the recent tender exercise and a robust process of due diligence over the cost of the preferred option in terms of opportunity, timescale and value for money, a further £141k is required to enable the relocation (£141k)

- **Health Improvement (phase 1)** – an extension of this project was agreed by the Steering Group for 6 months to 31st December to enable development of the community aspect of the remodelling pathways of care project and evaluation of how this project will contribute to its outcomes. (£19k)

3.6 **Appendix 3** of the report maps in detail how each particular project will deliver its contribution to both the National Health and Wellbeing Outcomes and more specifically, the partnership's local strategic objectives as outlined within its Strategic Plan.

3.7 **Appendix 4** of the report shows where the approved, recommended and pending projects sit along the care pathway.

Development Plans

4.1 Service redesign is a key priority of the Health and Social Care partnership's plans going forward and clear themes are emerging as to what models of care, delivery structures and targeted priorities are required in order to achieve the Partnership's strategic aims and local objectives. It is in funding the transformational shift to these models, structures and priorities that the enabling financial resources and in particular, the ICF, can deliver the greatest benefit.

4.2 A number of other projects within the programme therefore are currently being developed to support this this shift, at varying levels of development and approval within the fund's governance structure. In totality however, these proposals are being planned to deliver the partnership's new models of care.

This includes two projects which EMT have requested more information:

- Access to information - To improve online and offline access to information by the creation of a directory style website.
- Palliative care - To provide specialist palliative care, that patients currently receive in the Margaret Kerr Unit in patients' homes and other community settings.

Four further projects are in the process of developing briefs:

- IT integration – Putting in place an information sharing solution to enable practitioners to access full patient/client information so that they can operate in an integrated way and deliver more joined up care to the individuals along the whole care pathway.
- Transitional care – A discharge to assess model of care to be provided at Waverley Care Home.
- Remodelling pathways for older people - The development of seamless pathways for acutely ill older people requiring a hospital level of care.
- Enablement - The creation of a unified approach to mainstream the enablement approach and take a lead role on enablement activities

4.3 Following approval by the IJB, planning is underway for the implementation of the revised governance structure and the reorganisation of the associated groups/boards.

4.4 As the transformation programme develops, further reports will be brought forward to the IJB in order to ensure that a clear picture of each element of the partnership's plans is formed, in addition to an overall view, a picture that will consider not only how Integrated Care Funding is being used, but how all funding available to the partnership including its core delegated budget, large hospital budget set-aside, social care funding and change fund will support its delivery and enable future mainstreaming of the new delivery models.

Summary

5.1 As the Partnership's vision for health and social care integration develops and key themes for new models of care, delivery structures and key priorities emerge, the ICF programme continues to form in order to resource and deliver the transformation required.

5.2 To date **£2.401m** of the ICF has been approved by the Steering Group, although of this, only **£356k** has been spent to date. Work is continuing to develop further proposals that will enable transformation to new models of health and social care. As progress is made, further reports over this delivery, the required temporary (transformational) and permanent (mainstreaming) resource requirements, funding sources and expected priorities for investment and disinvestment will be made to the IJB.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the report and the progress made to date in the development of the partnership's transformation programme, in particular, those projects funded from within its Integrated Care Fund programme.

The Health & Social Care Integration Joint Board is asked to **ratify** approval by the Steering Group 5 new projects (**Table 1 Projects 15,16,17,18 & 19**) and a further increase in funding to 2 existing projects (**Table 1 Project 10 & 12**).

Policy/Strategy Implications	The programme is being developed in order to enable transformation to new models of care and achieve the partnership's objectives expressed within its Strategic Plan and national health and wellbeing outcomes
Consultation	The recommendations to the IJB have been made following consultation with a wide range of stakeholder representatives through the ICF Steering Group and Executive Management Team.
Risk Assessment	There are no risk implications associated with the proposals
Compliance with requirements on Equality and Diversity	There are no equality implications associated with the proposals
Resource/Staffing Implications	The proposals approved within the programme to date will be funded from the ICF grant allocation over its life

Approved by

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