Appendix 2 – Integrated Care Fund Projects Approved to Date

Project	Objectives	Benefits Realised (ROI)		Progress	Sustainability	Funding
		Contribution to National Health and Wellbeing Outcomes	Contribution to Local Strategic Objectives			
ICF Project Delivery April 2015 - March 2016	To allocate the Integrated Care Fund in line with the ICF Plan 2015-18	• Providing support to all ICF projects in order to assist them in the delivery of their outcomes. • The team therefore contributes to all National Health and wellbeing outcomes and Local Strategic Objectives.		13 Projects are in progress and 3 are being supported to produce project briefs for appraisal. The governance structure is under review and the projects are under scrutiny for their performance and alignment the Strategic Plan. A resource has been secured to assist the projects with their monitoring and evaluation.	One off cost for the term of the ICF Funding. No ongoing costs.	£219,563
Independent Sector Representation April 2015 – March 2018	The provision of Independent Sector advice to the programme.	Outcome 4 • Training/educating care providers • Providing tools to assist delivery • Working with the service users	Objective 2 • Training/educating care providers • Providing tools to assist them in prevention and early interventions • Assisting providers in delivery of new models of care • Working with partners in gaining trust	Progress has been made in 3 key areas – the review of care assistants training needs, the setup of a second rapid reaction team from a care home and the development of the My Home Life Project.	One off cost for the term of the ICF Funding. No ongoing costs.	£93,960
Transport Hub	Putting in place a co-ordinated, sustainable	Outcome 1 • Simplification of	Objective 9 • Providing a more	Improvements have been	The project will be part of a bigger review of	£139,000

April 2015-March 2017	approach to community transport provision.	accessing transport to health services • Greater levels of support for users	efficient service with better utilisation of vehicles • Reduced duplication of journeys • Better coordination with planned facilities discharge.	reported around ease of use, appropriate transport provision, better vehicle utilisation, greater partnership working, improvement of the skill of the volunteer base and respite provision for carers. In the first year the transport hub has facilitated 482 journeys by using 56 volunteers. In June the Transport Hub received an award for the Accessibility project of the year.	transport provision in the Borders with a primary aim of being sustainable.	
Health Improvement, Self-Management Phase 1 September 2015 – June 2016	To improve shared management of LTCs amongst older people (Phase One). The new proposal (Phase Two) extends the basic concept to include all adults with Long Term Conditions (LTC's), including those with multiple conditions, so learning from	Outcome 1 & 2 • Promoting shared management of existing conditions • Helping to bridge the gap between community and acute care • Development of knowledge, skills, pathways and processes	Objective 2 by • Equipping practitioners to build health improving measures into their assessments • Integrated anticipatory, treatment and recovery/re-ablement care	Phase 1 of this project is underway and showing improvement in service with 49% of people questioned rating the service as good and 50% rating the service as Excellent. This project has also evidenced a 10% improvement in wellbeing scores across the project.	The project will end with no ongoing costs as all the changes will have become business as usual.	£19,000 (for the extension to phase 1.)

	experience and maximising the use of short-term funding.	• Supporting and enabling carers to look after their health	plans • Supporting people to live well with their conditions			
Transitions August 2015 – May 2018	This project will focus upon young people who have a diagnosed learning disability between the ages of 14 and 21 who are moving towards and are progressing through the transition from children's to adult services across Health, Social Care, Children's Services and Education.	Outcome 3 • Ensuring people receive the correct information at the right time • Giving timely collaborative assessment and support plans	Objective 7 • Creating a clear transitions pathway, accessible to all partners including young people and their carers.	Planning is underway for the delivery of this project, which should commence fully in June 2016. Recruitment is underway (interviews took place on 23rd June).	The project would specify that recommendations must be achieved within the existing resources across services. This may mean disinvestment in one area and re investment in another. More efficient and effective pathways for the customer would also have a positive impact upon staffing resources	£65,200
Borders Community Capacity Building September 2015 – May 2018	To develop a series of community support projects to bring together services and to support further development and growth of local services and activities.	• Outcome 1 Encouraging people to engage and participate in activities • Improving their mental and physical wellbeing • Reducing isolation	Objective 1 • Encouraging and supporting communities to create and run their own services.	BCCB have reported an increase in the number of people, from different communities, becoming engaged in physical activities and being more active in their communities. They are also reporting an improvement in their participants physical and mental wellbeing.	Projects initiated by this Team during the term of the ICF funding should be self-sustaining by 2018.	£400,000
Mental Health Integration –	The transition from a dedicated social work team to having social	Outcome 9 • Integrating social work into the	Objective 5 • Providing support to admin staff and	This project is now complete and has reported improvement in the service	One off cost to implement a new integrated model of	£37,500

April 2015 – October 2015 **Project now complete**	work functions such as care management and assessment and use of IT software such as Frameworki embedded within the integrated teams.	community • Reduce duplication • Ensuring referrals are managed effectively	team managers • Ensuring effective and efficient delivery of social work services within an integrated model.	provided to patients, working relationships and communications. It has also reported a reduction in duplication of work. A final project evaluation evidencing this improvement is currently being developed.	service delivery.	
My Home Life January 2016 – February 2017	A fourteen month programme of leadership support and training to help improve quality of life in care homes.	Outcome 4 • Educating and providing tools to assist care homes in delivery of service improvements • Ensuring that staff are trained to the same level of competency. Developing care homes to provide different models of care	Objective 3 • Providing different models of care supporting the discharge agenda and prevention of admission to hospitals	This project is underway and delivering training to care home Managers. A full evaluation against their identified outcomes will be undertaken in January 2017.	One off project – no ongoing costs.	£71,340
Delivery of the Autism Strategy April 2016 – August 2018	Delivery of all of the work streams within the Borders Autism Strategy.	Outcome 3 • Improving awareness and understanding of the needs of those with autism	Objective 2 • Improving awareness and understanding of the needs of those with autism • Ensuring that those with autism receive the right support at the	A project initiation document has been produced and the project delivery planned. Recruitment is currently underway.	One off cost to deliver the Autism Strategy.	£99,386

			earliest opportunity			
Delivery of Stress and Distress Training July 2015 – April 2018	Stress & Distress Training provides training in an individualised, formulation driven approach to understanding and intervening in stress and distressed behaviours in people with dementia.	Outcome 8 • Providing training to over 700 staff • Improve the experience, care, treatment and outcomes for people with dementia, their families and carers	Objective 3 • Reducing the likelihood of situations becoming exacerbated and resulting in residential or hospital care	Work has been undertaken to train stress and distress trainers and plan the training sessions. 16 staff have attended the 2 day training and 20 have completed the bite size training.	The potential for release of resources is a key task for the project group seeking sustainable support from internal/external funders. The evidence is that within prescribing alone it is expected that a £47k saving will be realised year on year.	£166,000
Implementation of the ARBD pathway April 2016 – August 2018	Delivery of the actions identified in the 2013 ADP needs assessment.	Outcome 2 • Assessing and improving pathways of care for those with ARBD • Reducing the need for out of area placements in residential care	Objective 4 • Assessing and improving pathways of care for those with ARBD • Reducing the need for out of area placements in residential care	A project initiation document has been produced and the project delivery planned. Recruitment is currently underway.	The resource currently being used to fund residential places could be released and used differently in order to support improved coordination in the community.	£102,052
Borders Ability Equipment Store (BAES) Relocation February 2016 – December	Relocation of the Borders Ability Equipment store to a purpose built location.	Outcome 2 • Efficiently providing individuals with the correct equipment to enable them to have care in the	Objective 4 - as outcome 2.	This project requested an additional £141,000 when tenders were recieved which were over budget. This was approved in July 2016. The project is currently in the process of accepting a tender.	One off cost.	£100,000 £141,000 Total £241,000

2016		home setting.				
Community Ward Pilot Programme Management and Support	Programme Management and Support to develop, plan and deliver alternative proposal to replace Community Ward pilot	• The outcomes and objectives of this work package will be determined when the development of the alternative options is complete		Project Support Officer in post.	One off project – no ongoing costs.	£54,000
Health and Care Coordination Programme Management and Support	Programme Management and Support to develop, plan and deliver Health and Care Coordination project	• This workpackage is an enabler to delivery of the outcome and objective detailed below in relation to the wider Health & Social Care Coordination project		Project Support Officer in post.	One off project – no ongoing costs.	£54,000
Delivery of the Localities Plan April 2016 – October 2017	Development of locality plans. The redesign services to meet needs. Make recommendations to the localities group. Link to GP services, the third and Independent sector.	Outcome 4 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model	Objective 5 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model.	This project is in the initial stage of developing the project brief, PID and work plans.	One off cost.	£300,000 for 18 months
Health & Social Care Coordination September 2016- August	Introduction of a Health and Social Care Coordination approach through integrating teams within one locality to test the change and consider scaling up across the	Outcome 7 • Providing one point of access for health and social care services • More streamlined service • More efficient	Objective 5 • Improving access to health and social care services • Improving referral and waiting times • Reducing	This project was approved in July 2016.	One off cost, for a 1 year test.	£49,238

2017	remaining localities.	response times	unnecessary admissions to hospital • Improving discharge from hospital Improving co-ordination of multiple services			
Locality Management September 2016- August 2017	Overall management and strategic development of Adult Health and Social Care services within one locality to test the change and consider scaling up across the remaining localities.	Outcome 4 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model	Objective 5 • Working co productively with a wide range of stakeholders to deliver a localised integrated care model.	This project was approved in July 2016.	One off cost, for a 1 year test.	£65,818
Community Led Support September 2016 – March 2018	To develop a community hub model, promoting self directed support and setting up social work drop ins.	Outcome 1 • Providing self directed support and drop in social work sessions within the community.	Objective 1 • Providing self directed support and drop in social work sessions within the community.	This project was approved in August 2016	One off cost, for 18 months.	£90,000
The Matching Unit September 2016 – September 2017	The creation of a small central administrative team "Matching/Brokerage Unit", to match clients, assessed by care managers as needing care at home services.	Outcome 9 • A Borders-wide overview of resource and capacity will be in place resulting in a consistent and more effective	Objective 7 • Care managers time is significantly reduced in trying to identify & secure provision for clients.	This project was approved in August 2016	The running cost of the matching unit will come from the efficiencies created from the more effective use of practitioner time (e.g.) increased productivity	£115,000

		approach to securing provision.			resulting in reduced requirement to either hire additional care managers or to reduce the existing number of care managers	

Appendix 3

How ICF Projects Approved to Date map to National Outcomes and Strategic Objectives

National Health and Wellbeing Outcomes:

Nine National Outcomes	
Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5	Health and social care services contribute to reducing health inequalities.
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Outcome 7	People using health and social care services are safe from harm.
Outcome 8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services.

Our Local Strategic Objectives:

1. We will make services more accessible and develop our communities.
2. We will improve prevention and early intervention.
3. We will reduce avoidable admissions to hospital.
4. We will provide care close to home.
5. We will deliver services within an integrated care model.
6. We will seek to enable people to have more choice and control.
7. We will further optimise efficiency and effectiveness.
8. We will seek to reduce health inequalities.
9. We want to improve support for Carers to keep them healthy and able to continue in their caring role.

Mapping of Projects against the Local Strategic Objectives,

Project	Objective 1 – Make services more accessible and develop our communities	Objective 2 – Improve prevention and early intervention	Objective 3 - Reduce avoidable admissions to hospital	Objective 4 – Provide Care close to home	Objective 5 – Deliver services with an integrated care model	Objective 6 - Enable people to have more choice and control	Objective 7 – Further optimise efficiency and effectiveness	Objective 8 – Reduce health inequalities	Objective 9 – Improve support for Carers to keep them healthy and able to continue their caring role
Programme Team	●	●	●	●	●	●	●	●	●
Independent Sector	★	★	★	★	●	★	■	■	■
Eildon Community Ward	★	★	★	★	★	★	★	★	★
Transport Hub	★	■	■	●	●	★	★	●	★
Transitions	★	★	★	★	★	★	●	★	★
Stress and Distress			★		★	●	●		●
My Home Life		★	★	★					★
Mental Health Integration	★	●	★	★	★	●	★	●	■
ARBD	●	★	★	★	★	★	●	★	★
Autism	●	★		●	★	★	●	★	★
Borders Community Capacity Building	★		■			●		■	●
BAES relocation	■	●	●	★	★	■	●	■	■
H&SC Coordination	★	★	★	★	★	★	★	●	●
Locality Managers	★	●	●	★	★	★	★	●	●
Locality Coordinators	★	★	★	★	★	★	★	★	★
Community Led Support	★	★	■	★	★	★	★	★	★
Matching/brokerage Unit	★	●	★	★	●	★	★	●	★

★-High Impact ● - Medium Impact ■ - Low Impact

Mapping of Projects against the National Health and Wellbeing Outcomes

Project	Outcome 1 – People are able to look after and improve their own health and wellbeing and live longer	Outcome 2- People, including those with disabilities or LTC's or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Outcome 3 – People who use health and social care services have positive experiences of those services, and have their dignity respected	Outcome 4- Health and social care services are centred on helping maintain or improve the quality of life of people who use these services	Outcome 5 – Health and social care services contribute to achieving health equalities	Outcome 6 – People who provide unpaid care are supported to look after their health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	Outcome 7 – People using health and social care services are safe from harm	Outcome 8 – People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	Outcome 9 – Resources are used effectively and efficiently in the provision of health and social care services
Programme Team	●	●	●	●	●	●	●	●	●
Independent Sector	★	★	★	★	■		★	★	★
Eildon Community Ward	★	★	★	★	★	★	★		★
Transport Hub		★	■	■		●			
Transitions	★	★	★	★	★	★	★	★	★
Stress and Distress		■	★	★			★	★	●
My Home Life	●		★	★			★	★	
Mental Health Integration	●	★	★	★	★	■	★	★	★
ARBD	●	★	★	★	★	★	★	★	●
Autism	●	★	★	★	★	★	★		●
Borders Community Capacity Building	●	■			■	■			●
BAES relocation	■	★	★	■	■	●	■	■	★
H&SC Coordination	●	★	★	★	●	★	★	★	★
Locality Managers	●	★	★	★	★	●	★	★	★
Locality Coordinators	★	★	★	★	★	★	★	★	★
Community Led Support	★	★	★	★	★	●	★	★	★
Matching/brokerage Unit	●	★	★	★	●	★	★	●	★