Scottish Borders
Health and Social Care
PARTNERSHIP

INTEGRATED CARE FUND UPDATE – DECEMBER 2016

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 as well as seek IJB ratification of three projects.

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 **£318k** to date in 2016/17, a combined total of **£542k** over the life of the programme to date. Analysis of the spend to date on those projects approved by the IJB is detailed in **Table 1**.

Current Position

3.1 Overall, 25 projects, projected to cost **£3,682m** have been approved as part of the ICF programme to date. In summary, these are:

Table 1 – Summary of 3-Year Resource Requirements of ICF Projects

Approved Projects		
1. Community Capacity Building	£	400,000
2. Independent Sector representation	£	93,960
3. Transport Hub	£	139,000
4. Mental Health Integration	£	38,000
5. My Home Life	£	71,340
6. Community Ward delivery(18mth pm, pso)	£	-
7. Health Care & Co-ordination (18mth pm, pso	£	-
8. Delivery of the Autism Strategy	£	99,386
9. BAES Relocation	£	241,000
10. Delivery of the ARBD pathway	£	102,052
11. Health Improvement (*phase 1*) and extension	£	38,000
12. Stress & Distress Training	£	166,000
13. Transitions	£	65,200
14. Delivery of the Localities Plan 18 mths	£	259,500
15. Locality Managers x 1 locality for 1 year	£	65,818
16. H&SC Coordination x 1 locality for one year	£	49,238

17. Community Led Support	£	90,000
18. The Matching Unit	£	115,000
19. Programme Delivery Team	£	469,626
	£	**2,503,120**

For IJB Approval		
20. RAD	£	140,000
21. Transitional Care Facility	£	941,600
22. Pharmacy Input	£	97,000
	£	**1,178,600**

Total	**£**	**3,681,720**

3.2 This represents further approved spend of **£1,178,600** since the last report to the IJB in August and the board is now asked to ratify the three further projects.

3.3 The projects that are already approved are constantly under review and scrutiny to ensure that they continue to deliver outcomes in line with the strategic plan. A programme support team is in place to support the delivery of all approved projects. The intention is to review the role of the team to enable it to continue to support the work of the ICF but also more broadly support the work regarding Integration.

3.4 Work is underway with the approved projects to ensure that their outcome monitoring is robust.

3.5 The Executive Management Team (EMT) recently reviewed all approved and pending ICF projects. EMT recommends that the Integrated Care Fund is now closed to future bids for funding and that all projects in development are placed on hold. This would leave the remaining £2.7m of the fund available for key priority areas including dementia and improving care pathways.

Update

4.1 Three projects have been approved through the ICF governance process since the last IJB report. These are:

1 – Rapid Assessment and Discharge Team (RAD)

To ensure that all patients who are frail, elderly and/or complex in functional and social care needs presenting as an emergency at the front door of the hospital (Emergency Department, Acute Assessment Unit) and who do not have a medical need for admission will be reviewed and wherever possible discharged home (£140k)

The service will provide 6-day/week rapid assessment and discharge service for patients who are frail, elderly and require functional and social care needs assessment. It will provide a consistent and robust screening and assessment process for appropriate patients and will discharge all patients who do not require admission.

- All patients will receive next-day follow-up phone call or check to prevent readmission

- The service will be fully sustainable, with 52-week cover and rotation of staff across AHP services
- The service will work to the following standards;
    - Access to RAD will be 0800-1800 Monday-Friday and 0830-1400 on Sunday
    - No patient who does not require admission is admitted due to a lack of access to appropriate therapist review
    - No patient should wait longer than 2 hours for review when service is operational and no more than 48 hours when service is not operational
    - All patents identified as able to return home through RAD assessment should be discharged home the same day
    - Readmission rates for patients discharged by AD should be 5% or less

The service to date has demonstrated the following outcomes;

- Most referrals reviewed within 2 hours
- A consistent 45% same-day discharge rate for patients referred to RAD
- An average 3 discharges per day of patients seen by RAD
- RAD is considered an integral part of the multidisciplinary front door assessment team, as per guidance from Society for Acute Medicine

There are three further expected outcomes:

- Reduce length of stay
- Increased discharges at the weekend by approximately 3 per day (this figure may be higher as there is currently no provision for assessment).
- Reduction in the number of older people for whom a hospital admission results in a loss of independence and a requirement for 24-hour care or nursing home placement

This project has requested £140k for 1 year. The project brief can be seen in **Appendix 1.**

2 - Transitional Care Facility

A Transitional Care Facility to provide short-term, directed support to individuals (over a maximum 6 week period) to enable them to return to their homes (£941,600)

The purpose of a Transitional Care Facility is to provide short-term, directed support to individuals (over a maximum 6 week period) to enable them to return to their homes. Without a facility such as this, the outcome for individuals may be increased dependency, increase packages of care and potentially residential care. A transitional unit of 16 beds is being created at Waverley Care Home (Galashiels), with works due to be completed by 31st December 2016 – these works will create 16 modern en-suite bedrooms, along with upgraded kitchen facilities, sluice facilities and nurse call system.

This project will provide the model of care for this facility for a fixed term of 24 months, commencing January 2017; a multi-disciplinary team, whose primary focus is to ensure that any individual admitted to the unit receives all the support required, enabling discharge to their own home within 6 weeks.

The multidisciplinary team will consist of GP cover, District nurses, AHP support, Social workers and care home staff.

In addition to the new model of care implementation, interim funding is requested for 2016/17 to fund the costs of maintaining 5 additional beds across each of 4 community hospitals until the new facility opens. This will cost approximately £2,300 per bed month. Whilst planned as part of the 2016/17 service and financial planning process, delayed implementation of the new facility and the maintaining of the additional community hospital beds to January 2017 will require non-recurring ICF allocation of an additional £410k.

This project has requested £482,100 in year 1 and £266,000 in year 2 and £193,500 in year 3 (Total £941,600). The project brief can be seen in **Appendix 2.**

3 - Pharmacy Input

The strategic and operational support of a Pharmacist and Pharmacy Technician to three ICF projects (Transitional Care Facility, Matching Unit and Enablement) within the Eildon Locality (£97k)

Through the development of joint training and guidelines with SBC it has become apparent that many of the issues for carers are around medicines and that advice from a member of pharmacy staff who understands the issues related to Care providers is necessary to reduce risk to patients and staff administering medicines.

The pressure on Social Care services is also felt by Pharmacy, the increasing elderly population on multiple medications results in more patients who require support to take their medicines and support reablement, promote independence and self-care. Many patients receive social care visits to support them with their medicines, currently there is no review of patient's medicines which may lead to a reduction in the number and/or need for visits and the length of visits due to the number of medicines.

Our frailest patients outside of the Hospital environment are looked after either in their own homes or in Care Homes yet this is the only location where patients do not receive regular pharmaceutical care input tailored to them as an individual.

The aim of this project is to demonstrate the benefits of providing Strategic and Operational support by a pharmacist and pharmacy technician into the following bids: Transitional Care facility, Matching Unit and Enablement within the Eildon locality. The project will also identify the resources needed to develop the support beyond the Eildon locality.

The project has identified the following outcomes:

- Reduced need for carer visits
- Reduced risk of medication errors
- Reduce in the use of compliance aids
- Ensure consistency of training and support to staff
- Reduce the risk of medicines related harm
- Link with GP's, GP staff, Practice nurses, Pharmacists in the community and hospital to deliver seamless care

This project is requesting £97k. The project brief can be seen in **Appendix 3.**

Summary

5.1 A total of **£3,682m** of the fund has been approved to date. It is proposed that the remainder of the fund be used to facilitate work on key priorities including dementia and improved care pathways. Work is progressing to ensure a more streamlined process for managing the fund is put in place for the future.

Recommendation

The Health & Social Care Integration Joint Board is asked to **note** the position of the Integrated Care Fund.

The Health & Social Care Integration Joint Board is asked to **support** the closing of the fund to new bids, until further planning work is undertaken.

The Health & Social Care Integration Joint Board is asked to **ratify** approval by the Executive Management Team of 3 new projects detailed in 4.1 of this report.

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

Name	Designation	Name	Designation
Elaine Torrance	Chief Officer		

Author(s)

Name	Designation	Name	Designation
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