Renfrewshire Council

Item 11

To: Social Work, Health and Well-being Board

On: 13 January 2015

Report by: Director of Social Work

Heading: The Introduction of Integrated Care Fund 2015/2016

1 Summary

This report presents a draft Integrated Care Fund Plan for adult services in Renfrewshire which has been submitted in draft to the Scottish Government pending approval by the new Integrated Authority in April 2015.

Attached at appendix 1 is the Scottish Government guidance on the Integrated Care Fund and at appendices 2 and 3 are the draft projects and the outline community capacity building plan recommended for inclusion in the Renfrewshire Integrated Care Fund Plan.

2 Recommendations

2.1 It is recommended that the Board homologate the decision to submit the Integrated Care Fund Plan for Renfrewshire, in draft, to the Scottish Government by its deadline date of 12 December 2014.

3 Background

The Integrated Care Fund 2015/2016

3.1 The new Integrated Health and Social Care Authority will be established in April 2015, integrating health and social care services for adults.

3.2 The Scottish Government has allocated £100m across Scotland in 2015/2016, the Integrated Care Fund, to support investment in integrated services for adults with a focus on prevention, early intervention and support for people with complex and multiple conditions.

3.3 The Scottish Government is keen to support the shift towards prevention and reducing future demand on services and envisages the Integrated Care Fund activity demonstrating a high degree of partnership working with the Third Sector in local communities.

3.4 The Integrated Care Fund has been committed for one year, 2015/2016, and the allocation to Renfrewshire is £3.49m

3.5 Scottish Government guidance on the Integrated Care Fund is attached (Appendix 1).

3.6 The Renfrewshire Partnership's draft plan for the use of the Integrated Care Fund had to be lodged with the Scottish Government by 12 December 2014.

The Integrated Care Fund planning process, Renfrewshire

3.7 In preparing this draft Integrated Care Fund Plan for Renfrewshire, the Partners have considered the lessons learned from the implementation of the Four Year Change Fund Programme (Reshaping Care for Older People) which will end in March 2015.

3.8 The Partnership has noted and acted upon lessons learned from the processes involved in implementing and monitoring the delivery of a complex programme of change. Key approaches have been to develop and change working practices in:

- Person-centred health and care service provision and patients' and carers' pathways
- Capacity building at key pathways and interfaces between Acute, Community Health and Social Care services
- Multi-agency work, particularly in relation to planning and developing preventative services and to area-based planning with community-based partners

3.9 The Partnership's draft plan was founded on the evidence produced through the joint commissioning process and the findings of consultation and planning events with a range of stakeholders.

Strategic Priorities

3.10 The draft Integrated Care Fund Plan has been developed taking full cognisance of local work on the delivery of national outcomes and action plans.

3.11 Of particular note in terms of supporting people with multi-morbidities are the linkages between Change Fund, supported technology-enabled care and the European projects, SmartCare and United4Health.

3.12 The Partnership is actively participating in United4Health and SmartCare European projects. These three-year projects commenced in March 2013

and are jointly funded by the European Commission and the Scottish Government. These projects are part of the Digital Health and Care Innovation Partnership (DHCIP) which promotes technology initiatives to support people with disabilities and/or health conditions in their own homes and communities. Match funding is provided by the Partnership through the Change Fund and will carry forward to the Integration Fund.

3.13 The list of projects recommended for inclusion in the Integrated Care Fund Plan 2015/2016 is attached at Appendix 2.

Community Capacity Building and the Integrated Care Fund Plan

3.14 Community capacity-building is a common and strong theme emerging from consultations and planning sessions and the outputs from these sessions, along with earlier findings of consultation and joint planning events, underpin the draft community capacity-building plan attached at appendix 3. It has been noted that the key elements of capacity-building are common across all adult care groups, being strongly oriented towards preventative action on health and on supporting people with multi-morbidities in the community.

3.15 Most recently, the draft capacity-building plan was considered at a meeting of the third sector-led Community Health and Well-being event on 6 November 2014 where it was agreed to recommend the plan as the basis for further joint development sessions in the first quarter of 2015.

The draft Integrated Care Fund Plan for Renfrewshire

3.16 The draft Integrated Care Fund Plan attached has two main themes:

1. The roll-out of successful rehabilitation, reablement and technology-enabled models of service to all adult care groups, building on the successful application of such models through the four year Change Fund Programme (Reshaping Care for Older People) (see appendix 2)

2. The delivery of a community capacity building plan, engaging a wide range of stakeholders in its development and delivery, with a view to third sector organisations or partnerships leading on a number of the work areas (see appendix 3)

Implications of the Report

Financial

The Integrated Care Fund allocation to Renfrewshire is £3.49m and all projects will be delivered within this envelope.

HR and organisational development

None

Community Planning

Community Care, Health and Well-being:
The draft Integrated Care Fund Plan has been developed in consultation with Community Planning Partners and with community-based stakeholders who will continue to be involved in the development and delivery of the Plan. It is anticipated that some elements of work will be led by third sector organisations or partnerships.

Property/Assets

None

Information Technology

None

Equality and Human Rights

Integral to the draft Integrated Care Fund Plan is assessment of the impact on health inequalities of action taken on prevention and supporting people with multi-morbidities; impact on equality issues is a key criterion for assessment proposed developments under the Integrated Care Fund Plan

Health and Safety

None

Procurement

Risk

Privacy Impact

None

List of Background Papers

10 Year Joint Commissioning Plan for Older People's Plan
Board Report on the Joint Commissioning Plan process

Author: Teresa Lavery, Project Manager, Change Fund (Reshaping Care for Older People), 0141 618 7049.

Appendix 1 to board report ICF

INTEGRATED CARE FUND

Guidance for Local Partnerships

1. The Scottish Government announced that additional resources of £100m will be made available to health and social care partnerships in 2015-16 to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen our approach to tackling inequalities.

2. The £100m resource builds upon the Reshaping Care of Older People (RCOP) Change Fund (which will continue as planned until April 2015). The new Integrated Care Fund will be accessible to local partnerships to support investment in integrated services for all adults. Funding will support partnerships to focus on prevention, early intervention and care and support for people with complex and multiple conditions, particularly in those areas where multi-morbidity is common in adults under 65, as well as in older people.

3. This paper provides guidance to local partnerships on how the fund should be used. **It is not intended to create additional bureaucratic burden on local partnerships so Integrated Care Plans should be developed within the current strategic commissioning process. However, it is important to be able to account for the spend of this resource and to measure the performance improvements achieved by it.**

Background

4. The RCOP Change Fund has been a powerful lever to support the third sector, NHS, local authority, housing and independent sectors to work more effectively together and to share ownership of local change plans and delivery. The governance arrangements and improvement support for Change Plans have accelerated a change in attitudes, cultures and behaviours and have resulted in a greater focus on preventative and anticipatory care.

5. We recognise that the full ambitions of the RCOP ten year programme of reforms have yet to be fulfilled. As evidenced by the recent Audit Scotland report,[1] we have not yet been able to achieve a shift in resources away from institutional care. It is also true to say that there is scope to make further progress on the duty in the Public Bodies (Joint Working) (Scotland) Act 2014 to include key stakeholders, particularly the third sector, within the decision making processes to take advantage of their advice, experience and delivery. It is important, therefore, that partnerships continue to make progress with Reshaping Care for Older People within the context of emerging integrated health and social care arrangements and this more equal and co-productive form of partnership working. Strategic Commissioning will be critical to achieving this. As part of the Reshaping Care for

[1] http://www.audit-scotland.gov.uk/docs/central/2014/nr_140206_reshaping_care.pdf

Older People Programme, Evaluation Support Scotland was commissioned to facilitate 'A Stitch in Time'. This programme supported the third sector in Lothian to collect and present evidence to explain, measure and prove how the third sector (i) prevents avoidable future use of health and social care services; and (ii) how it optimises older people's independence and well-being.

6. The Public Bodies (Joint Working) (Scotland) Act[2] speaks to a more ambitious agenda that needs to be more squarely focused on the alleviation of health inequalities. The Route Map to the 2020 Vision for Health and Social Care[3] identifies prevention and preventative spend as a priority to improve care for people with multi-morbidities. We need now to move to a more targeted but transformational redesign focused on the complex and high cost service models that are in many cases not delivering the outcomes that people need, especially in less affluent areas. The principles and learning from "A Stich in Time" programme are equally applicable to working with adults with co-morbidity / multi-morbidity through the Integrated Care Fund. Further information and support for partnerships to understand the contribution of the third sector can be found on Evaluation Support Scotland's website at http://www.evaluationsupportscotland.org.uk/how-can-we-help/shared-learning-programmes/

7. It is therefore important that the Integrated Care Fund should be used to test and drive a wider set of innovative and preventative approaches in order to reduce future demand, support adults with multi-morbidity and address issues around the inverse care law, where people who most need care are least likely to receive it. Given that the funding is available for one year, it is important that these approaches are built in to and sustained through the longer term strategic commissioning approach.

8. Central to these approaches must be the shift to support the assets of individuals and communities so that they have greater control over their own lives and capacity for self-management, particularly of multiple conditions. The **third sector** has a particularly crucial role to play in supporting such an approach.

Principles

9. Through the Ministerial Strategic Group for Health and Community Care, the Scottish Government, COSLA, NHS Scotland and third and independent sector partners have agreed that six principles should underpin the use of the Fund:

- **Co-production** – the use of the Fund must be developed in partnership, primarily between health, social care, housing, third sector, independent sector, people who use support and services and unpaid carers. It should take an inclusive and collaborative local approach that seeks out and **fully supports the participation of the full range of stakeholders, particularly the third sector,** in the assessment of priorities and delivery of innovative ways to deliver better outcomes

[2] http://www.scottish.parliament.uk/parliamentarybusiness/Bills/63845.aspx
[3] Route Map to the 2020 Vision for Health and Social Care

- **Sustainability** – the Fund needs to lead to change that can be evidenced as making a difference that is **sustainable and can be embedded through mainstream integrated funding sources** in the future.

- **Locality** – the locality aspects must include input from professionals, staff, users and carers and the public. Partnerships should develop **plans with the people who best know the needs and wishes of the local population.** Such a bottom-up approach should maximise the contribution of local assets including the third sector, volunteers and existing community networks. Partners will be expected to weight the use of their funding to areas of greatest need.

- **Leverage** – the funding represents around 1% of the total spend on adult health and social care so must be able to support, unlock and improve the use of the total resource envelope. Our approach to strategic commissioning will be key to this so it is important that plans for the use of this resource are embedded in the strategic commissioning process.

- **Involvement** – Partnerships should take a co-production, co-operative, participatory approach, ensuring the **rights of people who use support and services and unpaid carers are central to the design and delivery of new ways of working** – delivering support and services based on an equal and reciprocal person centred relationship between providers, users, families and communities. These relationships should be evidenced within each partnership's plans.

- **Outcomes** – partnerships will be expected to **link the use of the funds to the delivery of integrated health and wellbeing outcomes for adult health and social care** which will be the responsibility of the new Integration Joint Boards or lead agencies following enactment of the legislation for integration.

Integrated Care Fund - Plans

10. As we enter into the 2014/15 shadow year for health and social care integration, health and social care partnerships will already be developing strategic commissioning plans for adults. The Joint Improvement Team issued practical advice on joint strategic commissioning[4] in February 2014 and this guidance should be read in conjunction with that advice note. Effective use of the Integrated Care Fund will only be achieved by adopting the principles of strategic commissioning.

What should be the focus of Integrated Care Plans?

11. Integrated Care Plans should focus on tackling the challenges associated with multiple and chronic illnesses for both adults and older people. Over two million people in Scotland have long term conditions and they are the principal driver for both chronic and urgent care and support. Multi-morbidity (two or more conditions) is the norm in Scottish patients over 50 and the prevalence is rising. Although

[4] http://www.jitscotland.org.uk/news-and-events/newsletters/?id=154

multi-morbidity is particularly common in older people, most people affected are under 65, particularly in deprived areas where the most common co-morbidity is a mental health problem. The combination of physical and mental health conditions has a strong association with health inequalities and negative outcomes for individuals and families.

12. The focus on multi-morbidity is intimately tied to wider work undertaken in respect of inequalities and deprivation. The current evidence suggests[5] that deprivation influences not just the amount but also the type of multi-morbidity that people experience. A greater mix of mental and physical problems is seen as deprivation increases, which means increased clinical complexity and the need for holistic person centred care.

13. The Integrated Care Fund should therefore be used to test and deliver a matrix of supports and interventions to improve health and wellbeing outcomes through, for example: deepening our focus on improving personal outcomes, supporting health literacy and adopting a co-production approach; using technology to enable greater choice and control; and adopting an assets-based societal model to improve population health and wellbeing. Plans should build on learning from Reshaping Care for Older People and extend the reach of successful approaches to the priority actions for partnerships set out in the National Action Plan for Multi-morbidity, which will be published shortly.

14. The use of the Integrated Care Fund should include strands that will lead to reduced demand for emergency hospital activity and emergency admissions. Investment in existing institutional bed capacity such as long stay beds, should <u>not</u> form part of the plans for the use of the Integrated Care Fund.

<u>How should Integrated Care Plans be developed?</u>

15. It will be for local partnerships to decide how best to develop their Plan for the use of their share of the £100m. The Integration Joint Board, through the interim Chief Officer, or Chief Executive in a lead agency, should take responsibility to work with all partners to develop the Plan. The Plan should clearly outline the role of the **non-statutory partners** and should describe the level of support to carers. Plans should be agreed and signed off by representatives from the NHS, local authority, the third sector, and independent sectors.

<u>When should the plans be completed?</u>

16. In order to commence full implementation of Plans from 1 April 2015, and therefore be able to utilise the full resource over that financial year, partnerships should aim to have Plans signed off by December 2014.

[5] BMJ 2012;344:e4152

What details should the plans cover?

17. Plans should adopt and support delivery of the aim for 2020 that all adults with multiple conditions are supported to live well and experience seamless care from the right person when they need it and, where possible, where they want it.

18. Partnerships are asked to develop Plans which describe:

- the activities that will support the delivery of integrated health and wellbeing outcomes for adult health and social care – and the contribution to wider work designed to tackle health inequalities within Community Planning Partnerships;
- the extent to which activity will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning;
- relationships with localities, including how input from the third sector, users and carers will be achieved. Such a bottom-up approach should maximise the contribution of local assets including volunteers and existing community networks.
- the long term sustainability of investments and the extent to which the use of the fund will leverage resources from elsewhere.
- how resources will be focused on the areas of greatest need.
- how the principles of co-production will be embedded in the design and delivery of new ways of working.
- progress in implementing priority actions for partnerships as described in the forthcoming National Action Plan for Multi-morbidity.
- how it will enable the partnership to produce a progress report based on the above for local publication in autumn 2016.

How should the Plans be used?

19. The Plans are primarily intended to drive service innovation, development, and improvement, and to communicate priorities. The Integrated Care Plan should therefore be published by each partnership. Partnerships will wish to monitor their own performance and will be expected to **submit two progress reports at six monthly intervals to the Ministerial Strategic Group on Health and Community Care. A template based on the bullet points in paragraph 18 will be used for these reports so partnerships should develop plans that will allow for progress and performance to be measured.**

20. In addition, Joint Improvement Team will coordinate support from national partners through the Improvement Network collaboration, support shared learning across Scotland and provide or broker support for local improvement.

How will the £100m be distributed?

21. The allocations to Health Boards will use 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. (For more information on the methodology contact Brian Slater)

22. The individual allocations to each partnership is profiled at Annex A.

Will the Integrated Care Fund continue after 2016?

23. A £100m Integrated Care Fund has been identified for 2015-16. The availability of resources after 2016 will depend on the progress made and the outcome of the next Comprehensive Spending Review. However, as stated in paragraph 7, and echoed in the principles in paragraph 9, the change must be sustainable and maintained within the strategic commissioning plans.

Can the Fund be used to support previous Older People's Change Fund activity?

24. The Integrated Care Fund builds on the RCOP Change Fund and should not simply be used to support existing initiatives previously funded through their RCOP Change Fund. Guidance on the 2014/15 Change Fund clearly stated that partners should be planning for **the range of activities that will or will not be sustained after 2015, through their Strategic Commissioning Plans**. Kathleen Bessos' letter of 10 April 2014 refers.

25. At the same time, it is recognised there may be some applicable programmes and support that currently focus on older people, and are equally transferable to adults with multi-morbidity at a younger age. There will be some limited scope to extend such interventions to the under 65 population.

Contact

26. For further information please contact the following:

Queries regarding the development of plans should be directed to Kelly Martin:
Tel: 0131 244 3744 e-mail: Kelly.Martin@scotland.gsi.gov.uk

Queries regarding improvement and support requirements should be directed to David Heaney: Tel: (0131) 244 5317 e-mail: david.heaney@scotland.gsi.gov.uk

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 Plan Template

PARTNERSHIP DETAILS

Partnership name:	
Contact name(s): See note 1	
Contact telephone	
Email:	
Date of Completion:	

The plan meets the six principles described on pages 2 and 3 (Please tick √):

Co-production		Leverage	
Sustainability		Involvement	
Locality		Outcomes	

Please describe how the plan will deliver the key points outlined in paragraph 18:

The content of this template has been agreed as accurate by:

……

(name) for the Shadow Joint Board, or for a lead agency,

…….. or ……

(name) for the NHS Board (name) for the Council

…… ……

(name) for the third sector (name) for the independent sector

When completed and signed, please return to:

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2ER, St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

Kelly.Martin@Scotland.gsi.gov.uk

Templates should be returned by **12th December 2014**.

PROPOSED PROJECTS INTEGRATED CARE FUND 2015/2016

RENFREWSHIRE

Projects	Activities	All Care Groups?	ICF Outcomes and Approaches to Service Development	Considerations	Recommendations
Social Work Assessment & Care at Home					
Further development of reablement	Expand and develop reablement services which allow people to live independently in own homes with no or with low levels of support required from statutory services. OTs and adult services coordinator posts.	Y	outcomes: reducing future demand; supporting people with multi-morbidities service dev: personalised services, asset-based model	The reablement model of service can be extended to meet the needs of people in all adult care groups, contributing to early intervention and support for people in the community living with multi-morbidity and long term conditions, enabling people to recover or develop life skills to maintain as much independence as possible.	recommended for inclusion in Integrated Care Fund plan 2015/2016
reablement rapid response	increase capacity to support discharge and pathways. Home care staff posts	Y	As above	As above; note the focus of this project on development of discharge pathways at the RAH	recommended for inclusion in Integrated Care Fund plan 2015/2016
extra care home care staff	home care staff posts working in extra care housing complexes, providing enhanced levels of care for older people with dementia; post holders provide standard home care but capacity is provided to allow additional time to deal with socialisation activities for older people e.g. digital therapy, group activities	Y	outcomes: supporting people with multi-morbidities service dev: personalised services; increasing use of technology	extra care home care is a means of delivering support for people with dementia and other long term conditions, contributing to support for people in the community with long term conditions and multi-morbidity	recommended for inclusion in Integrated Care Fund plan 2015/2016
dementia and palliative care	delivering care packages at home or in care homes which provide support for people with dementia or palliative care needs; ensuring staff capacity to release staff for training	Y	outcomes: reducing future demand; supporting people with multi-morbidities service dev: personalised services,	dementia and palliative skills are essential for care at home staff delivering support for people with dementia and conditions which need end-of-life care. Care at home staff are equipped to work in mult-disciplinary teams with other health and care colleagues in providing services to meet the needs of individuals and their families. This service can be rolled out to all adult care groups.	recommended for inclusion in Integrated Care Fund plan 2015/2016
telecare and telehealth	Provision of telecare safety packages and a team of installers to respond flexibly to non emergency calls. Includes Community Alarm service	Y	outcomes: reducing future demand, supporting people with multi-morbidities service dev: personalised services, increasing use of technology	this initiative is a key component and match fund for the European projects SmartCare and United4Health, projects concerned with developing digital technology to support people in the community with early intervention care options and supports for people with long	recommended for inclusion in Integrated Care Fund plan 2015/2016

				term conditions and multi-morbidity; note also proposed Renfrewshire RCOP bid for national funding	
Increased MHO capacity	Increase the number of MHOs for assessments at RAH based SW team to deal with increasing numbers of adults presenting with incapacity issues at a point when long term care decisions require to be made	Y	outcomes: reducing future demand service dev: personalised service	demand on this service has increased and is expected to increase amongst the adult population, dealing with issues of capacity and long term planning for people's care	recommended for inclusion in Integrated Care Fund plan 2015/2016
RES/DN					
RES Equipment	provision of equipment for health care at home from EQUIPU	Y	outcomes: reducing future demand, supporting people with multi-morbidities service dev: personalised services, increasing use of technology	demand on this service has increased and is expected to continue to grow as the shift in the balance of care provides more community-based care for people with long term conditions and multi-morbidity	recommended for inclusion in Integrated Care Fund plan 2015/2016
RES staffing	Rehabilitation and Enablement services to support older people at home, coming out of hospital, avoiding hospital admissions; AHP and nursing staff	Y	as above	demand on this service has increased and is expected to continue to grow as the shift in the balance of care provides more community-based care for people with long term conditions and multi-morbidity.	recommended for inclusion in Integrated Care Fund plan 2015/2016
Hospital-based services					
In Reach Nurses	district nurses in acute wards to work towards patients' discharge and post-discharge care and support	Y	outcomes: reducing future demand, supporting people with multi-morbidities service dev: personalised services,	these posts have contributed to reductions in the levels of delayed discharge from hospital and make a contribution to the Renfrewshire CSR Development programme. The posts are part of multi-disciplinary approaches to reducing levels of bed-based care by providing appropriate and sufficient care in the community for people with long term conditions and multi-morbidity; these posts function across hospital based and community services	recommended for inclusion in Integrated Care Fund plan 2015/2016
additional AHP staff to Acute, orthopaedics, stroke outreach and unscheduled care services	increased staff capacity to deliver AHP services for people preparing for hospital discharge	Y	outcomes: reducing future demand, supporting people with multi-morbidities	these posts have contributed to reductions in the levels of delayed discharge from hospital and make a contribution to the Renfrewshire CSR Development programme. The posts are part of multi-disciplinary approaches to improving patients' pathways in hospital and their safe discharge	recommended for inclusion in Integrated Care Fund plan 2015/2016
out of hours physio and OT at RAH	provision of out of hours staff		As above	these posts have contributed to	recommended for inclusion in

	capacity to provide AHP services at the weekend for patients preparing for hospital discharge	Y		reductions in the levels of delayed discharge from hospital and make a contribution to the Renfrewshire CSR Development programme. The posts are part of multi-disciplinary approaches to improving patients' pathways in hospital and facilitating discharge from hospital with support from RES and Care at Home services	Integrated Care Fund plan 2015/2016
community geriatrician	Geriatrician input to RES, Care Homes and liaison with AHPs; early assessment at rapid access clinics and day hospitals; complement work of Single Point of access and gerontology nurse		outcomes: reducing future demand, supporting people with multi-morbidities service dev: personalised services	this post is integral to the development of services at the interface of hospital and community health and care services, developing patient pathways, including the CSR Older People's Assessment Unit at the RAH and rapid access clinics taking referrals from GPs; the Change Fund allocation is a contribution to costs and does not meet the full costs of the post	recommended for inclusion in Integrated Care Fund plan 2015/2016
Care Homes					
increase CPN input to care homes	CPN responsible for working with clusters of care homes and be named link for care homes		outcomes: reducing future demand, supporting people with multi-morbidities service dev: asset-based model	this service has supported developments in community health and care for older people through supporting skills development and capacity-building in care home staff. The project contributes to the reduction in levels of unnecessary admissions to hospital for people living in care homes	recommended for inclusion in Integrated Care Fund plan 2015/2016
Scottish Care development worker	to engage care homes in RCOP programme		service dev: co-production	this post provides ongoing support for partnership links with care homes in the independent sector and to the development of the Renfrewshire Ten Year Joint Commissioning Plan and its implementation planning; this will be of significance in the development of new services and/or pilot projects as part of the future locality-based planning processes.	recommended for inclusion in Integrated Care Fund plan 2015/2016
GP input into palliative care	GPs working with care home staff to support ACP and palliative care		outcomes: reducing future demand, supporting people with multi-morbidities service dev: personalised services; increasing use of technology, co-production	this project contributes to the further development of Anticipatory Care Planning (the subject of current CSR activity in Renfrewshire) and to the work of the McMillan palliative care team; note that this is match-funded by	recommended for inclusion in Integrated Care Fund plan 2015/2016

				MacMillan	
Housing Support					
handyperson services	doing house maintenance and repair tasks for older people	Y	outcomes: reducing future demand service dev: asset-based model	While the evaluation of this project demonstrates good performance and high levels of satisfaction amongst service users, it is not possible to recommend full year funding from the one - year Integrated Care Fund to maintain this service. The Integrated Care Fund guidance requires funding to be allocated to short term investments in innovation or pilot development work and/or as leverage for income generation from other sources. it may be that the Integrated Care Fund could be a source of seedcorn money to contribute to a funding package for a new model of delivery designed to enhance the sustainability of the service. The Sub Group recommends that the Change Fund Project Manager and Engage Renfrewshire facilitate discussions between this project and other potential partners to consider future development options	Funding committed to 1 Nov 2015 future option of support from ICF to business plan regarding adapting model of service to enhance long term sustainability of the service – will require approval of proposed business plan
Carers' Support					
home based respite service	short respite breaks for carers of older people - "free breaks for carers".	Y	outcomes: reducing future demand, supporting people with multi-morbidities service dev: personalised services, co-production, asset-based model	The evaluation of this service indicates good performance and high levels of satisfaction from service users. Demand on the service is increasing. It is anticipated that this service will be reviewed as part of a wider review of respite services scheduled for 2015/16. The Sub Group recommends continued funding for this service in 2015/2016 pending the outcome of the wider review of respite services, on the grounds that it	recommended for inclusion in Integrated Care Fund plan 2015/2016

				was established as a four-year pilot due to terminate in March 2016	
Community support					
ROAR	Development of community activity hubs for older people in the community, promoting social and well being activities		<u>outcomes:</u> reducing future demand <u>service dev:</u> co-production	The evaluation of this service indicates good performance and high levels of satisfaction from service users. The Sub Group may wish to note that the service is labour-intensive and requires significant financial resources to maintain the services in their current form. The Sub Group recommends that the services funded via the Change Fund be reviewed with a view to sharpening the focus on key target groups in line with ICF criteria, with particular reference to developing sustainable services for older age groups at risk of frailty and/or long term conditions	recommended for inclusion in Integrated Care Fund plan 2015/2016, pending agreement on revised service specification to re-focus on key target groups and review models of service to support long term sustainability
The Food Train	Third sector organisation organising and supporting volunteers doing shopping for people over 65 years of age who cannot manage their own supermarket shopping		<u>outcomes</u>: reducing future demand, supporting people with multi-morbidities, addressing health inequalities <u>service dev:</u> personalised services, co-production	The evaluation of this service indicates good performance and high levels of satisfaction from service users. The Sub Group recommends that the Food Train explores opportunities for accessing external funding for 2016/17 and beyond to attract match funding for future service development	recommended for inclusion in Integrated Care Fund plan 2015/2016, subject to the Food Train identifying matching external funding to support long term sustainability of the service
community capacity building fund	Funds to support community capacity building; previous small grants for activities, including support for feasibility study Linstone Housing (consultants' report submitted), Active Communities initiative with Glasgow Caledonian (evaluation report submitted) and in 2014 support for the development of local network	Y	<u>outcomes</u>: reducing future demand, addressing health inequalities, supporting people with multi-morbidities <u>service dev</u>: personalised services, co-production, asset-based model	The Sub Group considered the report on the proposed community capacity-building action plan and its relevance to prevention, early intervention and long term conditions and multi-morbidity and the scope for recommending ICF funding on the basis of: piloting new initiatives; seedcorn funding for funding packages for initiatives; and for feasibility work on community based action on prevention, early intervention and long term conditions and multi-	recommended for inclusion in Integrated Care Fund plan 2015/2016

				morbidity The sub group recommends ringfencing a budget allocation from the Integrated Care Fund to support the delivery of the capacity-building action outlined in the draft capacity-building plan attached on the basis that capacity-building action will support development across all care groups.	
Alzheimer - Community Connections	Coordination and support for people with Alzheimer's and their families, information, advice, social activities, support for self help and peer group activities	Y	outcomes: reducing future demand service dev: personalised services, co-production, asset-based model	The evaluation of this service indicates good performance and high levels of satisfaction from service users. The Sub Group recommends that this project be the base for future service development pilots to be agreed with the local dementia strategy planning group in line with ICF guidelines	recommended for inclusion in Integrated Care Fund plan 2015/2016
Enablers					
Project Management	project manager post & admin costs: coordinating RCOP Change Fund project management and transition to Integrated Care Fund; linking Change Fund programme to Joint Commissioning work; coordinating partnership work on capacity-building and area-based planning on older people's services	Y	service dev: co-production	The Sub Group recommends that the post of project manager be continued to coordinate and support the implementation of the Integrated Care Fund and other appropriate Change management initiatives in 2015/2016.	recommended for inclusion in Integrated Care Fund plan 2015/2016

Draft Integrated Care Fund Plan, Renfrewshire

Proposed projects 2015/2016

Capacity building initiative	Proposed contents	Targeted on:	Lead agency	Engagement partners	resources	considerations
Information Access pilots	a) develop local access to single points of access to information via IT, located in community spaces with high footfall, supported by local organisations and/or provision of space for volunteer activity to promote access to information about local services and activities - start with pilots in areas to be identified; b) develop a volunteer programme of people who would be able to assist older people access the IT-based information systems, either as mentors and/or "buddies" to help people learn to be comfortable accessing IT routes to information or to access community information for people on their behalf; c) roll out training to community-based organisations in using myrenfrewshire.org to promote their aims, objectives and activities and attract users of their services and new volunteers	areas and communities where evidence shows low levels of services in easy reach of residents - identifying community facilities that are well used by the public that could be used as a base for information points with support from local organisations, groups and individual volunteers e.g. Housing Association offices		all interested stakeholders in community health and well-being: possible input from GIS re accessibility of information to the public; local businesses may be willing to be engaged as info points or as sponsors of local info initiatives	planning and negotiation skills to identify and develop local info point pilots; possibly some capital required to install equipment; resources to recruit and train local volunteers - existing local community based organisations may be willing to contribute to this	Link closely with CPP development work around accessible information in local communities
Community Health Champions Programme	volunteers recruited from local communities trained as role models, mentors and local organisers; targeting "hard to reach" people in the community to engage in health and	individuals in communities who are interested in contributing to health and well being activities in their neighbourhoods and communities		all interested stakeholders in community health and well-being	resources, cash and/or in kind, to: recruit and train volunteers; provide ongoing support for volunteer	Active Communities has recommended this course of action on the basis of its on-the-ground experiences in promoting community health and well-being activities;

	well-being activities; link champions to local networks of agencies engaged in health and well being activity				engagement; facilitate access for local community volunteers to accredited training opportunities; provide a mentor(s) for local volunteers	outcomes delivered from this initiative would contribute to preventative action in promoting health and well-being and would be integral to the capacity building action within new locality-based plans, with local input to shaping and delivering services and activities
Falls Prevention in the Community – volunteer action	coordinate and publicise a calendar of learn and share events to be delivered by stakeholders in health and care in communities; include access opportunities for third sector organisations to statutory training provision; encourage and support stakeholder groups to deliver their own learn and share events or materials on issues relevant to RCOP priorities and capacity-building ; support stakeholder groups to use digital technology to share information; invite other potential partners to participate e.g. local colleges and schools	older people, particularly those who report restricting their activities due to fear of falls; people in younger age groups, to promote changes in behaviours at early stages to avoid, minimise or delay health issues arising as a result of falls in older age		intergenerational activity groups	resources to recruit and train local volunteers - existing local community based organisations may be willing to contribute to this; access to statutory training opportunities that would contribute to comprehensive falls prevention training for volunteers	this initiative has potential for major impact on health and well-being; there is a great deal of hard evidence about the detrimental impact of falls on individuals' health and well-being and on the demand on statutory services as a result of falls; improvements in falls reduction can be measured over time, particularly if initiatives are set up with baselines in place for ongoing monitoring and evaluation
Learn and share calendar 2015/2016	coordinate and publicise a calendar of learn and share events to be delivered by stakeholders in health and care in communities; include access opportunities for third sector organisations to statutory training provision; encourage and support stakeholder groups to deliver their own learn and	local community-based organisations and groups that wish to engage, or further develop their engagement, with health and care action in their communities		CPP CSR Development Projects Engage Renfrewshire	access to free or subsidised formal training places for volunteers in community-based organisations; contributions to costs of venues, publishing materials, IT technology to promote information dissemination in a variety of formats e.g. Print, DVDs, Youtube materials;resources for a	this could be a significant contribution to outcomes-focused networking, around health and care action in the community would benefit from a promotions campaign with a popular figurehead

	share events or materials on issues relevant to RCOP priorities and capacity-building ; support stakeholder groups to use digital technology to share information; invite other potential partners to participate e.g. local colleges and schools				coordinating point for the calendar to be kept up to date and be access point for information and contacts	
Transport studies	develop a comprehensive plan to address the various transport barriers that are raised in consultation and planning events, with particular reference to older people's needs; establish up to date evidence base on older people's current use of transport, uses of existing transport services used by older people and their expressed preferences for travel for various purposes (e.g. shopping, getting to services and social activities, day time travel, evening travel); test common perceptions against evidence to identify potential solutions in local areas (ref area-based planning sessions' outline development proposals)recommend pilot schemes on initiatives to address identified transport needs, based on current and accurate data	local community representative groups with an interest in promoting access to local services and facilities; local transport providers, formal and informal, to support future service planning; statutory services involved in planning and transport - provision of local research findings to support future service planning		local community councils and LACs local consumer groups local service user and carers groups	research skills local survey skills in areas targeted for research; specialist skills in e.g. Use of digital technology in research activity	can be assisted through some digital research on actual travel patterns and use of public sector and local taxi services; GIS service can assist in identifying transport routes, accessibility of various services and facilities via public transport routes etc. findings of research to be published in user-friendly formats for the public and for service users' and carers' info; evidence may assist in future discussions about planning the local dial-a-bus services