Renfrewshire Council

Item 4

To: Social Work, Health and Well-Being Policy Board

On: 19 January 2016

Report by: Chief Officer, Renfrewshire HSCP

Heading: Integrated Care Fund 2015/2016: Mid Year Report to Scottish Government

1 Summary

This report presents for information the Mid Year Report on the Integrated Care Fund (ICF) submitted to the Scottish Government by the Renfrewshire Health and Social Care Partnership (HSCP). The report is attached at Appendix One.

2 Recommendation

2.1 The Board is asked to note the report and the contents of Appendix One.

3 Background

The Integrated Care Fund 2015/2016

3.1 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.

3.2 At its meeting of January 2015 the Board noted the ICF Plan submitted to the Scottish Government in December 2014.

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 three years and the 2015/2016 allocation to Renfrewshire is £3.49m

The Integrated Care Fund planning process, Renfrewshire

3.7 In preparing the Integrated Care Fund Plan for Renfrewshire, the Partners considered the lessons learned from the implementation of the Four Year Change Fund Programme (Reshaping Care for Older People) which ended 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 ICF 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 Integrated Care Fund Plan has been developed taking full cognizance 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 technology-enabled care and the European projects, SmartCare and United4Health.

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 community capacity-building work. 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.

The draft Integrated Care Fund Plan for Renfrewshire

3.16 The Integrated Care Fund Plan 2015/2016 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)

2. The delivery of a community capacity building plan, engaging a wide range of stakeholders in its development and delivery, with third sector organisations leading on a number of the work areas

The Mid Year Report

The Mid Year Report attached at Appendix One has been agreed by the Partners and submitted to the Scottish Government.

The Board may wish to note in particular:

The Partnership is pleased with progress and has drawn the Ministerial Strategic Group's attention to two major developments and one proposed adjustment to the existing ICF budget plan:

- Proposed review of Home Care resource plan
- Implementation of strategic programme of community capacity-building Infrastructure Investment Projects
- Proposed enhancement of resources for Integration and Localities partnership-building

As the report at Annex B part (i) shows, some slippage is expected in the 2015/2016 budget as a result of:

a) The anticipated need to realign the ICF home care budgets in the near future;
b) The need to step up action on recruiting into posts as a result of additional ICF funding being made available in key pressure areas; and
c) The need to match resources to the pace of development in integration and localities development in Renfrewshire

Significant interest is being raised in the third and community sectors around the implementation of the four infrastructure investment projects and it is anticipated that interest in engagement activities in local communities will rise significantly over the next 12 – 18 months as these projects roll out.

Implications of the Report

1. **Financial**

The Integrated Care Fund allocation to Renfrewshire is £3.49m

2. **HR and organisational development**

None

3. **Community Planning**

Community Care, Health and Well-being:
The Integrated Care Fund Plan was 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. Some elements of work is led by third sector organisations or partnerships.

4. **Legal Implications**

None

5. **Property/Assets**

None

6. **Information Technology**

None

7. **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

8. **Health and Safety**

None

9. **Procurement**

None

10. Risk

None

11. 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
Renfrewshire ICF Plan December 2014

Renfrewshire
Health & Social Care Partnership

INTEGRATED CARE FUND
2015/2016
MID YEAR REPORT
To
MINISTERIAL STRATEGIC GROUP ON HEALTH AND COMMUNITY CARE

9 November 2015

1 Introduction

The Renfrewshire Health and Social Care Partnership is pleased to submit its Mid Year report on progress with the Integrated Care Fund (ICF) programme 2015/2016.

2 Summary Report

2.1 The HSCP and its partners have proceeded with its ICF Plan as approved by the Scottish Government in February 2015, with some proposed amendments arising from early reviews of progress and responses to partners engaging in the Integration and Localities development process.

2.2 The Partnership is rolling out the service developments initiated under the previous Change Fund project to all adult care groups, with adjustments where appropriate to ensure a close fit with ICF outcomes, priorities and criteria.

2.3 The Partnership is pleased with progress and would draw the Ministerial Strategic Group's attention to two major developments and one proposed adjustment to the existing ICF budget plan:

- Proposed review of Home Care resource plan
- Implementation of strategic programme of community capacity-building Infrastructure Investment Projects
- Proposed enhancement of resources for Integration and Localities partnership-building

3 Proposed review of Home Care resource plan

3.1 The ICF budget is monitored and analysed at a monthly financial monitoring officer group led by the Chief Finance Officer.

3.2 The Partnership is currently undertaking a review of Home Care processes. The findings of this review may lead to proposals to realign the ICF budget allocations within the overall £1.52million ICF allocation to Home Care service development. This would not result in a change to the overall planned allocation of ICF to the development of Home Care services but may result in recommendations to realign budget headings in pursuit of the continuing transformational change to home care for adults and to ensure close realignment with ICF outcomes, priorities and criteria.

3.3 Justification for the proposed review and realignment of the ICF's home care budgets may be reflected in the current reporting of underspend in some home care budget lines.

3.4 Proposals for realignment, should they emerge, will be considered by the Partnership's ICF Sub Group as part of its budget planning process for 2016/2017 and finalised by the HSCP's Integrated Joint Board before submission to the Scottish Government.

4. Implementation of strategic programme of community capacity-building Infrastructure Investment Projects

4.1 The 2015/2016 Integrated Care Fund plan included an outline of the community capacity building plan being developed.

4.2 A third sector steering group (community capacity building) has been established and four infrastructure investment projects were approved by the HSCP ICF Sub Group in August 2015. These projects are now in their set-up phase. The partners will agree a strategic evaluation framework in January 2016 following the set-up phase and will engage a range of stakeholders in the process.

4.3 These infrastructure investment projects are being developed as pilots in different localities in Renfrewshire, with each project being led by a third sector partner.

Community Health Champions Programme - recruiting, training and supporting local people in their communities to become community health champions, supporting local health and well-being activity and developing links between communities and local health and care services (partnership initiative being led by third sector health and well being organisation)
GP Social Prescribing – a pilot setting up a Social Prescribing scheme in a number of GP practices to link patients with non-medical supports in their own communities (partnership initiative being led by third sector mental health organisation)
Lifestyle management programme - support for people with long term conditions, setting up a pilot to test referrals from GPs, the Social Prescribing Scheme and other health and care providers into a structured self-management course embedded in local community supports (partnership initiative to be led by the Thistle Foundation)
Housing and Health Information Access Points – piloting the delivery of easy access points of information for people about health and well being and health-related housing issues in local communities in points with a lot of public footfall (Partnership initiative being led by Linstone Housing Association)

4.4 It is anticipated that the monitoring and evaluation of the impact of these Infrastructure Investment projects will include measures of impact on individuals' self-management of mental health and well being.

5 Proposed enhancement of resources for Integration and Localities partnership-building

5.1 The original ICF plan submitted to the Scottish Government in February 2015 included resources for "Localities and Care and Repair service". This project was originally described as "localities and care and repair" but, on review, the Sub Group agreed to recommend to the HSCP that the primary focus of this workstream be partnership-focused relationship-building in the new localities being developed in the Renfrewshire HSCP.

Current developments being supported are:

- GP support for engagement in localities planning
- Business Admin support for Localities and Integration

5.2 The HSCP's input to the Care and Repair service will be considered as part of a wider consideration of the development of the aids and adaptations services in partnership with the Council's Housing service.

6. Outcomes monitoring

6.1 The Partnership monitors regularly the delivery of the ICF projects in pursuit of Integrated Care Outcomes on an operational basis through the Senior Management Monitoring group, which meets monthly, and the Interim Integrated Care Fund Sub Group, which meets on a 6 weekly cycle, in partnership with the Third Sector Steering Group (Community Capacity-building).

6.2 The strategic Community Capacity-building outcomes will be monitored through a strategic evaluation framework, the design of which is currently underway and which is expected to go live in early 2016 (see fig 1 below). The Framework will be developed using a Contribution Analysis model.

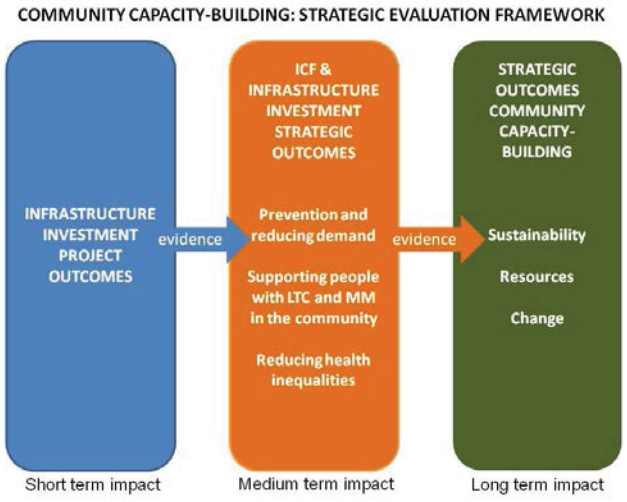

fig 1

7. Proposed Action on Potential Slippage

7.1 As the report at Annex B part (i) shows, some slippage is expected in the 2015/2016 budget as a result of:

a) The anticipated need to realign the home care budgets as a result of a major service review as described above;
b) The need to step up action on recruiting into posts as a result of additional ICF funding being made available in key pressure areas; and
c) The need to match resources to the pace of development in integration and localities development in Renfrewshire

7.2 Significant interest is being raised in the third and community sectors around the implementation of the four infrastructure investment projects and it is anticipated that interest in engagement activities in local communities will rise significantly over the next 12 – 18 months as these projects roll out.

7.3 The HSCP's IJB considers is prudent to hold over some of the capacity-building resources until a period in 2016/2017 when the four infrastructure projects begin to bear fruit and stimulate interest in engagement and the need for seed corn funding for a range of third sector-led, community-based activities.

7.4 It is proposed, therefore, that a portion of the ICF community capacity-building funds be carried forward into the next financial year to be allocated, with the agreement of the stakeholders, as part of the process of localities development, community capacity building and the development of local networks.

8. Closing remarks

8.1 The IJB would welcome the thoughts of the Ministerial Strategic Group on the Renfrewshire HSCP's progress to date and its plans for future development.

Renfrewshire HSCP ICF 2015/2016 annex B (i)

WORKSTREAM	allocation 2015/2016	spend April to Sept 2015	forecast spend Oct to end March 2016	projected over/underspend
home care	£ 1,512,441.00	£ 432,895.00	£ 640,875.00	£ 438,671.00
Mental Health Officers - Adults With Incapacity	£ 171,565.00	£ 56,502.00	£ 98,987.00	£ 16,076.00
Rehab and Enablement	£ 974,000.00	£ 453,000.00	£ 321,000.00	£ 200,000.00
hospital-based services	£ 322,480.00	£ 175,415.50	£ 147,064.50	£ -
care homes service development	£ 74,694.00	£ 7,150.00	£ 67,544.00	£ -
housing and housing-linked supports	£ 56,000.00		£ 35,500.00	£ 20,500.00
carers respite	£ 70,000.00	£ 14,119.00	£ 55,881.00	£ -
community support and capacity-building	£ 522,500.00	£ 85,105.00	£ 287,395.00	£ 150,000.00
localities and integration partnership development	£ 380,000.00	£ -	£ 322,936.00	£ 57,064.00
enablers	£ 56,238.00	£ 22,560.00	£ 26,056.00	£ 7,622.00
total	£ 4,139,918.00	£ 1,246,746.50	£ 2,003,238.50	£ 889,933.00

Workstream Projects

home care

further development of reablement

reablement rapid response

extra care home care staff

dementia and palliative care

telecare and telehealth

Mental Health Officers - Adults With Incapacity

MHO posts - increasing capacity to meet demand

Rehab and Enablement (RES)

staff

equipment

carers respite (older people)

home-based respite service

Community Support and Capacity-building

ROAR older people's social and well being clubs

Food Train shopping service for older people

Alzheimer's Scotland community connections

Capacity Building

housing and health support (3rd sector)

multi morbidities innovation

community capacity building

enablers

project manager post

info and networking support (third sector)

hospital-based services
IN Reach Nurses (RES employees)

additional AHP staff to Acute, orthopaedics, stroke
outreach and unscheduled care service
out of hours physio and OT at RAH
community geriatrician

care homes service development
increase CPN input to care homes
Scottish Care Development Officer support
GP input into palliative care

housing and housing-linked supports
handyperson service (committed to March 2016)
options advice (older people) (committed to end March 16)

localities and integration partnership building

GP engagement
business and admin support
Adults with Incapacity - Financial Welfare Assistant (2015/2016)

WORKSTREAMS AND PROJECTS, INTEGRATED CARE FUND 2015/2016

RENFREWSHIRE

Work Streams	ICF Outcomes and Approaches to Service Development 2015/16	Progress towards outcomes	Sources of data used to monitor progress	Action taken in relation to under-performance
Home care Comprising: • Further development of reablement • Reablement rapid response • Extra care home care staff • Dementia and palliative care • Technology-enabled care	outcomes: reducing future demand; supporting people with multi-morbidities service dev: personalised service; asset-based service model; increasing use of technology-enabled care	Despite demand for services continuing in an upwards direction as a result of demographics, the Partnership has managed to sustain the improvements made during the last 5 years in terms of reducing delayed discharge from hospital to extremely low levels (excluding AWI cases) through the provision of a flexible and responsive home care service, supported by technology enabled care approaches. Bed Days Lost due to delayed discharge in August 2015 totalled 284 of which 217 were due to AWI issues. The reablement rapid response service works closely with the hospital- based discharge services and the "front door" developments at the RAH designed to divert cases to appropriate services in the community wherever possible, reducing avoidable admissions and maintaining performance in low levels of delayed discharge. A major review of the Home Care service is currently underway and will inform future development of the reablement service. The ICF is supporting the home care services to develop and deliver support for people with dementia to live at home for longer, helping reduce or defer demand on care home placements. This has been primarily through the provision of extra care homes, the upskillling of staff to deliver care for people with dementia and a comprehensive technology enabled care programme.	Monthly performance reports to Senior Managers' monitoring group with data from the EDISON and SWIFT information management systems	Meeting monthly, the Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways. A major review of the Home Care service planning is currently underway. This may result in recommendations on the realignment of budgets within global "home Care" ICF budget to take account of developments in service in the last 5 years; demand continues to climb but the impact of Change action under the Change Fund is likely to require a shift of resources from some budget areas to others to maintain direction of travel in reducing future demand and supporting people with multi-morbidities in the community and in further developing personalised services across all adult care groups.

AWI assessment – MHO capacity Comprising: • MHO staffing • Financial Welfare Assistant	outcomes: reducing future demand service dev: personalised service	Demand levels on the MHO service continues to climb as a result of demographics. The Renfrewshire Partnership continues to take a service improvement action on AWI, enhancing capacity in the MHO services, having recently created an MHO Resource worker post from one-off resources made available from Scottish Government. A post of Financial Welfare Assistant is being funded in 2015/2016 to assist families deal with AWI issues and is expected to be mainstreamed in 2016/2017. Action is being taken to facilitate and speed up connections between the various parties involved in AWI cases but, as the Scottish Government representatives acknowledge, more significant improvements in performance in dealing with AWI in Renfrewshire will rely on longer term work at a national level, taking into account legal and policy matters. The use of nursing home facilities with full NHS support for patients with AWI has helped reduce pressures on EMI beds in the RAH. Good progress is being made in working with local solicitors to facilitate the legal aspects of AWI cases.	Monthly performance reports to Senior Managers' monitoring group with EDISON and SWIFT information management systems data from the	Monthly Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways. There is no underperformance in the MHO service, but prioritisation of hospital cases does lead to delays in the private and new cases simply due to the pressure of demand and the capacity available to meet demand. The impact of the recent additional resources will be monitored by the Senior Managers' Monitoring Group and the information will contribute to future resource planning. The MHO team leader reports on progress to the group and the group takes a co-productive approach to identifying ways of enhancing the service e.g. there is now MHO/SW input to regular hospital-based multi-disciplinary case reviews.
Rehabilitation and Enablement Service (RES) and District Nursing Service Comprising: • Staff • Equipment	Outcomes: Reducing future demand; supporting people with multiple morbidities Service development: personalised services, increasing use of technology	Despite demand for services continuing in an upwards direction as a result of demographics, the Partnership has managed to sustain the improvements made during the last 5 years in terms of reducing delayed discharge from hospital to extremely low levels (excluding AWI cases) through the provision of a flexible and responsive community-based rehabilitation and enablement service that works closely with the home care service. The RES rapid response service works closely with the hospital- based discharge services and the "front door" developments at the RAH designed to divert cases to appropriate services in the community wherever possible, reducing avoidable admissions and maintaining performance in	Monthly performance reports to Senior Managers' monitoring group with data from the EDISON and SWIFT information management systems	Monthly Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways. Recent action has included reviews of the OT services and pathways to identify closer working between the former Community Health, former SW OT services and Acute services to be more person-centred and streamlined. There is also close monitoring of the physiotherapy service which is facing increasing demand as a permanent feature with limited permanent capacity to meet demand. Recent action arising from the Service Improvement

		delayed discharge.		approach has been to shift resources on a temporary basis to provide additional hours of service to address waiting list priorities.
Hospital-based services Comprising: • In Reach District Nurses on wards • AHP staff in key hospital wards • Physiotherapy and OT weekend working • Community Geriatrician	Outcomes: reducing future demand, supporting people with multi-morbidities Service development: personalisation of services	The hospital-based services supported by the Integrated Care Fund are designed to improve "front door" services at the hospital and to streamline pathways for patients, both within the hospital and between the hospital and community health and care services. Targeting the ICF on developing more flexible work patterns, out of hours services and "in reach" teams to link acute services with community services, has been further developed by the Renfrewshire Development Programme (CSR) which built on the work of the previous Change Fund. The RES In Reach nurses work closely with patients, families, ward staff and SW staff to facilitate people's discharge home from hospital. The community geriatrician makes significant contribution to the development of rapid access clinics and day hospitals, helping to avoid admissions to acute wards through closer working with GPs and the community health services. The community geriatrician has made a crucial contribution to the Renfrewshire Development Programme's Older Adults Assessment Unit at the "front door" of the Royal Alexandra Hospital. The April 2015 Status Report indicated that the **Older Adult Assessment Unit (OAAU) was delivering a** Fast track service to best care for older adults, providing access to Comprehensive Geriatric Assessment. Early results were encouraging: o Up to 6 patients per day 79% discharged directly from OAAU (29% same-day, 52% within 24hours, 66% within 72 hours) o Positive feedback from patients/carers & physicians.	Extracts from GGCNHS on performance against targets reported to the Senior Management Monitoring Group	Service Improvements at the RAH are managed by the GGCNHS Board and by hospital management. Where appropriate, the Senior Managers' monitoring group may contribute to changes in pathways or interfaces to support hospital-based improvements e.g. using the rapid response teams to support delivery of out of hours discharge service.

Care Homes Comprising: • Increase in CPN input to care homes • GP input to palliative care • Scottish Care Development Officer	Outcomes: reducing future demand; supporting people with multi-morbidities Service development: asset-based model; personalised services, co-production	The Integrated Care Fund makes a contribution to service developments in the care home services, working with care homes in the public and private sector: increasing liaison between GPs, the community geriatrician and SW services and upskilling care home staff and supporting collaborative approaches to training and development. The ICF contributes to the development of ACP in care homes and the development of palliative care skills to allow people who choose to die in their (care) homes rather than hospital. The Scottish Care post funded through the ICF contributes to the liaison between care homes and the various agencies and services in the statutory public health and care services and facilitates links with developments in the third and independent sectors. The ICF contributes to enhanced CPN input to care homes, to train and offer guidance to staff in dealing with mental health issues affecting residents. The key aim is to enable people with dementia and other mental health issues to stay in their own care homes for as long as possible, receiving appropriate care and avoiding unnecessary admissions to hospital. The innovative work initiated under the RCOP programme continues under the ICF and has proved a foundation for mainstream developments currently underway to enhance care provision in care homes, making links between hospital EMI services and care homes	Monitoring of care home developments are undertaken by SW contracts team and by HSCP operational managers working with liaison nurses and mental health staff; reports are made to the Senior Managers' Monitoring group	Monthly Senior Managers' monitoring group adopts a Service Improvement Plan approach to identified underperformance or potential difficulties in key service areas or pathways.
Housing and Housing-linked supports Comprising: • Handy person service • Options advice service Also new pilot (see below) Housing	Outcomes: reducing future demand Service development: asset-based models	The ICF currently contributes to some services delivered to older and vulnerable people under management by a third sector housing association. Lessons have been learned from the delivery of these 3 year projects, funded under the Change Fund, and future opportunities will be considered by the Interim Integrated Care Fund Sub Group at its budget planning session for 2016/2017	Service delivery projects supported by the ICF are monitored through Service Level Agreements managed by the Council on behalf of the HSCP	

and Health Community Information Hubs		and recommendations will be made to the IJB. The future development of the care and repair services (which includes the handy person service) will be considered by the HSCP as part of a wider consideration of care and repair, aids and adaptations and OT services. There is also a Housing Association-led "Housing and Health" community hubs pilot being implemented as part of the Infrastructure Investment Projects development (third sector) which seeks to provide a single point of access to information and advice within localities and to facilitate people's engagement in health and well-being activity and in locality-focused planning and decision making on health and care services.		
Carers' Support (home based respite)	Outcomes: reducing future demand; supporting people with multi-morbidities Service development: asset-based model	The service has been welcomed by older people and their carers as a means of supporting carers in their caring role.	The contract with the provider is monitored by the HSCP's SW service.	The contract manager manages the contract and liaises with the provider in relation to any service improvements required.
Community support and capacity-building: • Third sector service development: o ROAR (reaching older adults in Renfrewshire) o The Food Train o Alzheimer's Scotland Community Connections • Capacity-building: o GP Social Prescribing pilot o Community Health Champions o Housing and Health Community Information Hubs (see above) o Live Well, Stay Well (self-management programme using technology-enabled care for people with multi morbidities and long term	Outcomes: reducing future demand; addressing health inequalities; supporting people with multi-morbidities Service development: asset-based model	The four infrastructure investment pilots are currently in the set- up phase. Staff have been recruited and working relationships are being established with GP services in the pilot areas as well as with local community-based groups and organisations. It is anticipated at this early stage that key target groups will be: people with mental health issues or identified by GPs as being in danger of developing mental health problems people with a range of life issues which impact, or which will potentially impact on their physical and mental health e.g. poor housing, poor nutrition, loneliness and isolation People with multiple morbidities who may benefit significantly in terms of being able to access a range of community based supports for their self management of their conditions	Service delivery projects supported by the ICF are monitored through Service Level Agreements managed by the Council on behalf of the HSCP A third sector steering group (community capacity-building) works with the HSCP Interim Integrated Care Fund Sub Group to monitor progress in infrastructure investment projects. The Infrastructure Investment projects are currently being implemented by the third sector project leads collaboratively through a project implementation steering group.	Close self-monitoring by the project leads and by the third sector steering group, reporting to the Sub Group (6 weekly basis) with input from HSCP officers, will monitor progress. Should underperformance or difficulties be identified at an early stage, a service improvement plan will be adopted by the project leads, supported by the third sector steering group and the HSCP.

conditions			Each project lead will report on performance to the Sub Group A Strategic Evaluation Framework is under development and will go "live" in January following the three month set up phase for the pilot projects. Each Infrastructure Investment pilot has an individual performance monitoring plan which is reported to the ICF Sub Group.	
Localities and Integration Partnership Development (formerly known as "Localities and Care and Repair) Note: this project was originally described as "localities and care and repair" but, on review, the Sub Group agreed to recommend to the HSCP that the focus of this workstream be partnership-building in the new localities being developed in the Renfrewshire HSCP Current developments being supported are: • GP support for engagement in localities planning • Business Admin support for Localities and Integration partnership-building	Outcomes: addressing health inequalities; reducing future demand	This support activity is still in early stages. It is, in part, responding to feedback from GPs about their interest in localities development and addressing their concerns about their capacity to release relevant staff to engage fully in planning and development activity.	Implementation of projects approved under this programme will be monitored by senior managers and/or the Sub Group as appropriate	
Enablers				
Project Management	service dev: co-production	The project manager post funded through ICF supports the ICF Sub Group, the Third Sector steering group and partners in their development planning, delivery, monitoring and strategic reporting.	The Project Manager reports to the Sub Group and to the interim heads of service (adult services and Primary and Community Health)	

ANNEX B (iii)

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund - Indicators of progress

Question	Comment
How has ICF funding allowed links to be established with wider Community Planning activity?	Engage Renfrewshire, the Third Sector Interface, is engaged both at the ICF Sub Group and the Third Sector Steering Group in the delivery of the community capacity building projects. Engage and HSCP staff report to the CPP's thematic board, Community Care, Health and Well-being, on a regular basis on progress in community capacity building on health and well being and on the progress of the Infrastructure Investment projects, helping identify potential future partnership links in locality-based activity. Previous area-based planning workshops, a joint initiatives with CPP staff, Engage, other third sector and independent sector parties and reps from the statutory services, produced information and materials which are now being used to support wider stakeholder partnership work e.g. local action research or transport, the development of the ICF infrastructure pilot, housing and health information hubs. This activity was supported by the Geographic Information System, helping the HSCP and the CPP to develop a user friendly technology to support locality-based planning.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	The Infrastructure Investment projects will be evaluated using a strategic evaluation framework, currently under development, to be launched in January 2016, which will include evaluation of the projects' impacts on long term strategic commissioning models and processes, with particular reference to preventative and support services. A member of the Council's Strategic Commissioning Team supports the third sector steering group in this work and will help coordinate the management of the Strategic Evaluation Framework over the life of the ICF Infrastructure Investment projects.
How has ICF funding strengthened localities including input from Third Sector, Carers and Service Users	Previous area-based planning workshops produced information and materials which are now being used to support wider stakeholder partnership work. The four third sector-led Infrastructure Investment pilot projects are being developed and delivered on a localities basis in a number of localities. The lessons learned will be used to help localities-based planning groups to consider the potential to roll out or adapt the pilots to suit their own local needs.

What evidence (if any) is available to the partnership that ICF investments are sustainable	Part of the strategic evaluation of the pilots will be to assess the potential for sustainability of new services developed. A positive approach has been adopted at the start by the four third sector leads of the infrastructure investment projects who were able to contribute resources other than ICF to the package of funding for the pilot projects, a recognition of the need to be more strategic in the preparation of business plans and funding packages for new service development.
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity	One of the Infrastructure Investment pilots, to be based initially in Renfrew, is focused on developing a programme of support, in partnership with GP practices, for self management for people with long term conditions and multi-morbidities, with reference to the use of technology-enabled care where possible. The other three infrastructure investment projects, focusing on Linwood and Johnstone, will also be encouraging people with multi-morbidities to engage in the community-based action on self management of conditions and of general health and well-being. There will be strong links between the Renfrew project and the Linwood and Johnstone projects.

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

PARTNERSHIP DETAILS

Partnership name:	
Contact name(s)	
Contact Telephone	
Email	
Date Agreed	

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

…….. (name) for NHS Board

…….. (name) for Local Authority

…….. (name) for Third Sector

…….. (name) for Independent Sector

When complete and signed please return to:

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