REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 26 November 2015

BY: Chief Officer

SUBJECT: Integrated Care Fund

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1 PURPOSE

1.1 This report provides an update on activity aligned to the Integrated Care Fund and a summary of the mid year review submission to Scottish Government.

Any member wishing additional information should contact the author of the report in advance of the meeting.

2 RECOMMENDATIONS

2.1 The Integration Joint Board is recommended to:

i. support the Integrated Care Fund spend and its intentions.

ii. note the detail of the 6 month review.

iii. agree the recommendations for evaluation and governance.

3. BACKGROUND

3.1 Scottish Government introduced as prioritised spend from 2015/16 an Integrated Care Fund of £300 million nationally over three years. The fund for East Lothian is £1.76 million annually and has been available from April 2015. As reported to the shadow board on April 2nd, Scottish Government approved East Lothian's draft submission on March 3rd 2015.

3.2 The Integrated Care Fund offers an opportunity to consolidate proven effective practice and to extend scope to improve care for people with multimorbidities across adults and older people as per national guidance.

3.3 Locally the extensive learning and evaluation activity undertaken as part of RCOP / Change Fund was utilised to inform the ICF submission. As a result existing proposals from Change Fund have been continued with some modification. Equally new areas of focus emerging from the Joint Strategic Needs Assessment for the Strategic Plan and the evidence base for addressing unscheduled care activity were prioritised as new spend.

3.4 The priority areas identified for ICF support to drive change centre on three key themes:

3.4.1 Prevention and early intervention:

- GP cluster / LINK teams focusing initially on Musselburgh and the West locality (including additional capacity for wellbeing connectors, volunteering and mental health support)
- Increased carer identification, assessment and support
- Risk stratification
- Post diagnostic dementia support
- Transport (improving access to care)

3.4.2 Care closer to home: Additional staffing to enhance the whole system ELSIE programme to deliver a 24/7 service for adults, enhanced end of life care, dementia and cognitive impairment support in addition to locality working.

3.4.3 Workforce development, including independent sector development and primary care strategy development

3.5 The spend to date and projected FYE spend for each workstream is outlined in Annex A. Whilst no underspend is forecast there is the potential for some financial slippage within year given the timing of announcements and the need to plan and recruit to services. NHS Lothian currently holds and disburses ICF allocations on behalf of Partnerships .It is proposed that should there be any slippage, a further report is brought to the IJB.

3.6 Appendix B also outlines the alignment of ICF to the Strategic Plan and its performance and outcomes framework. Outcomes can be delivered through a complex series of interventions and many of the specific measures within the performance matrix cannot be directly attributable to ICF funded interventions – particularly those services focusing on prevention and early intervention. It is proposed, therefore, that the service evaluation and reporting mechanisms developed and adopted over 4 years for Change Fund and cited as exemplar by Scottish Government, continue for ICF.

3.7 It is proposed that appropriate governance for the Integrated Care Fund for 2016/17 and beyond, including monitoring, review, and regular reporting, is through the IJB. Supporting developmental and

background work will be carried out through the strategic planning framework, specifically the Strategic Planning Programme Board and the Strategic Planning Group.

4 POLICY IMPLICATIONS

4.1 None

5 EQUALITIES IMPLICATIONS

5.1 There are no equalities issues arising from any decisions made on this report

6 RESOURCE IMPLICATIONS

6.1 There are no immediate resource implications other than annual disbursement of the £1.76 million Integrated Care Fund.

6.2 However, one of the key aims of the RCOP programme is to identify areas of disinvestment in order to support reinvestment of resources in community services and supports. Whilst Audit Scotland highlighted a "lack of evidence of progress in shifting resources" across Scotland, the IJB should note the need to focus on bed based activity locally in order to rapidly accelerate progress in this area.

7 BACKGROUND PAPERS

7.1 Integrated Care Fund Submission December 2014.

7.2 Scottish Government Integrated Care Fund guidelines and Multimorbidity advice note.

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DATE	11th November 2015

ANNEX A

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund – 2015/16 – Mid-Year Financial Summary

East Lothian Health and Social Care Partnership – £1.76 million

	Allocation for 2015/16	**Spend - April to September 2015**	**Forecast Spend – October to End March 2015**	**Projected Over/Underspends**
Care Closer to Home workstream:	**£1,048,378**	**£647,499**	**£400,879**	Nil
East Lothian Service for Integrated Care of the Elderly (ELSIE) expansion to support: 24/7 service development across 2 localities Enhanced end of life care Enhanced dedicated dementia / cognitive impairment support Enhanced specialist care home liaison support Enhanced discharge to assess support	£800,000 N.B Total allocation to this workstream includes continuation of Change Fund for £248,378: SW Discharge (£79,000) ECS support (£69,850) Response and rehabilitation team (£99,528)	£399,121 £79,000 £69,850 £99,528	£400,879	

	Allocation for 2015/16	Spend - April to September 2015	Forecast Spend – October to End March 2015	Projected Over/Underspends
Prevention and early intervention workstream:	**£568,622**	**£463,622**	**£105,000**	Nil
GP Cluster / Links worker service	£145,698	£145,698		
Post diagnostic dementia support	£68,000	£48,000	£20,000	
Mental health support / improved access to psychological therapy in primary care	£60,000		£60,000	
Carer identification and assessment	£25,000		£25,000	
Risk stratification and anticipatory care planning	£25,000	£25,000		
Integrated falls pathways	£25,601	£25,601		
Telehealthcare spread and support	£80,000	£80,000		
	N.B Total allocation to this workstream includes continuation of Change Fund as:			
	Carers Short Breaks service and discharge support for carers	£64,500		

	Access to health transport scheme Day centre development	£53,408 £21,415		
	Allocation for 2015/16	**Spend - April to September 2015**	**Forecast Spend – October to End March 2015**	**Projected Over/Underspends**
Workforce development: Independent sector workforce development through ELIS: improved access to learning and quality standards. Primary care development strategy	**£143,000** £95,000 £48,000	**£62,250** £47,500 £14,750	**£80,750** £47,500 £33,250	Nil
Total ICF spend to date-2015/16		**£1,173,371**	**£586,629**	**Nil**

Integrated Care Fund – 2015/16 – Progress towards ICF Outcomes

NB: The ICF submission in December 2014 proposed a performance / outcomes framework based on a measure of % of 65+ year olds living at home. This has since been adopted by the Integration Joint Board with a stretch target of 98% over the next ten years, measured on a locality basis.

Sub measures within the original performance framework included:

Unscheduled admission rates by locality
Cost of unscheduled admissions by locality
Delayed discharge rates
Bed days lost to delayed discharge
Readmission rates by locality
Length of stay <48 hours
% >65s in hospital
% > 65s receiving >10 hours homecare
Variation in access rates to primary care

This initial ICF performance framework has since been enhanced in line with the Strategic Plan and will be embedded in the wider performance management framework of the IJB as outlined below.

WORK STREAM ACTIVITY OR PROJECT	OUTCOMES FOR 2015/16	PROGRESS TOWARDS OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE
Care Closer to Home workstream	Links to East Lothian Strategic Objectives (See Appendix 1) C: To reduce unscheduled care: We want to reduce unnecessary demand for services including hospital care. D: To provide care closer to home: We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can. E: To deliver services within an integrated care model: We recognise the need to make people's journey through all our services smoother and more efficient. F: To enable people to have more choice and control: We recognise the importance of person centred and outcomes focused care planning. Links to National Health and Wellbeing Outcomes (See Appendix 1) *1,2,3,4,5,6,7,8,9* Links to East Lothian Strategic Plan Model of Care (See Appendix 1), *b, c, d, e*	Baselines for all performance metrics aligned to this workstream have now been established. These will be embedded in the wider performance management framework of the IJB.	http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey http://www.healthcareexperienceresults.org/ http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/ http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/ http://www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/ http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/Analytical-Outputs/Standard-Outputs/	**N/A**

	Performance indicators will be developed in tandem with Strategic Plan monitoring but will focus on improving the following outcomes and outputs, many of which link to other programmes: • Percentage of adults supported at home who agree that they are supported to live as independently as possible. • Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. • Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. • Percentage of adults receiving any care or support who rate it as excellent or good • Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. • Percentage of carers who feel supported to continue in their caring role. • Rate of emergency admissions for adults. • Rate of emergency bed days for adults. • Readmissions to hospital within 28 days of discharge • Proportion of last 6 months of life spent at home or in community setting. • Proportion of care services graded ‘good’ (4)			

	or better in Care Inspectorate Inspections. • Percentage of adults with intensive needs receiving care at home. • Number of days people spend in hospital when they are ready to be discharged. • Percentage of people admitted from home to hospital during the year, who are discharged to a care home. • Percentage of people who are discharged from hospital within 72 hours of being ready.			
Prevention and early Intervention workstream	Links to East Lothian HSCP Strategic Objective B: To improve prevention and early intervention: We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises. Links to National Health and Wellbeing Outcomes *1, 2, 3, 4, 5, 6* Links to East Lothian Model of Care a, b, c, d	Baselines for all performance metrics aligned to this workstream have been established. These will be embedded in the wider performance management framework of the IJB.	http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey http://www.healthcareexperienceresults.org/ http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/ http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/	

	Performance indicators will be developed in tandem with Strategic Plan monitoring but will focus on improving the following outcomes and outputs, many of which link to other programmes: • Percentage of adults able to look after their health very well or quite well. • Percentage of adults supported at home who agree that they are supported to live as independently as possible. • Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. • Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. • Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. • Percentage of carers who feel supported to continue in their caring role. • Premature mortality rate. • Rate of emergency admissions for adults • Rate of emergency bed days for adults. • Readmissions to hospital within 28 days of discharge.		http://www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/ http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/Analytical-Outputs/Standard-Outputs/	

	• Proportion of last 6 months of life spent at home or in community setting. • Falls rate per 1,000 population in over 65s			
Workforce development workstream	Links to East Lothian Strategic Objective G: To further optimise efficiency and effectiveness Links to National Health and Wellbeing Outcomes 5,7,8,9 Performance indicators will be developed in detail as part of ongoing Strategy development, but will focus on improving the following outcomes and outputs, many of which link to other programmes: • Percentage of staff who say they would recommend their workplace as a good place to work.* • Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	Baselines for all performance metrics aligned to this workstream have been established. These will be embedded in the wider performance management framework of the IJB.	NHS Staff survey national report http://www.scotland.gov.uk/Publications/2014/12/8893/0 East Lothian Council Improvement Plan Public Sector Improvement Framework	**N/A**

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?	The broad aim of community planning is to improve outcomes for the people and communities across East Lothian by ensuring that public services work in a more integrated and effective way. The shared commitment of the Health and Social Care Partnership and East Lothian Partnership to reducing inequality means it is essential that these groups drive greater collaboration and the Integrated Care Fund has provided a means of focusing joint planning on shared objectives with a locality focus. By getting organisations to work together more closely, sharing resources and information to provide a better network of local support, we aim to support the creation of resilient communities across our county Through the Resilient People Partnership, the Health and Social Care Partnership has a key role within East Lothian's wider CPP and in delivering specific Single Outcome Agreement results which are consistently monitored and reported. This equally relates to one new overarching Integration Joint Board strategic measure which has been adopted by the CPP (%65+ at home) which the Integrated Care Fund has a clear focus on supporting and achieving through the "Care Closer to Home" workstream.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	East Lothian's (second draft) Strategic Plan aims to enhance the capacity of the whole system to improve health and social care outcomes, supporting communities and organisations to promote and improve health and wellbeing. In developing our planning and commissioning approach as a Partnership we have built on the positive experience of the RCOP and Change Fund programmes and worked actively and closely with our third and independent sector partners to develop both the current draft Strategic Plan and the supporting Integrated Care Fund Plan. The Integrated Care Fund proposal submitted in December 2014 was specifically aligned to the then first consultation draft Strategic Plan for East Lothian, is clearly congruent with the ambitions and objectives of the second consultation draft and is a key driver in transition.
How has ICF funding	In developing all our plans we have utilised a wide range of information to consider where we need to

strengthened localities including input from Third Sector, Carers and Service Users	focus and what our priorities should be, the most significant of which is our Joint Strategic Needs Assessment (JSNA). Our JSNA has provided a wide range of information on health profiles by locality**,** demographics and population projections, health care and social care provision, hospital and unscheduled care activity, variation in activity and costs and some survey information. We have also worked closely with colleagues in the third and independent sectors in order to understand and map the spread and diversity of care and service provision provided by these partners and therefore give us a more total picture of our provider landscape and understand any potential gaps. This work has allowed Integrated Care Fund spend, particularly that in the "Prevention and Early Intervention" workstream, to be specifically targeted to localities in the west of the county which exhibit significantly higher levels of multimorbidity. Examples of this include third sector Links workers being aligned with GP practices in the west locality. Equally, the RVS health transport project addresses access to care issues highlighted in remote and rural areas in the east locality. The Integrated Care Fund has also allowed East Lothian HSCP the opportunity to start developmental work with our Third Sector Interface and third sector partners in establishing a Public Social Partnership approach to joint planning, service delivery and performance monitoring which involves co-production, collaboration and consultation. Third Sector partners developed a single, unified proposal on prevention and early intervention for ICF based on a holistic service offering which is based on the JSNA and considers the needs of the East Lothian population. Service users and carers are central to the design and delivery of this model which also links into East Lothian's Single Outcome Agreement.
What evidence (if any) is available to the partnership that ICF investments are sustainable	The Integration Joint Board in East Lothian is committed to taking on the challenges of a changing health and care agenda with devolved responsibility and greater management of local budgets, making a real difference to the health and wellbeing of our local population. The potential of an integrated financial resource associated with Health and Social Care Partnerships and the acute hospital services delegated to them should drive the required policy changes more than any previous policy and presents an exciting opportunity for local communities to shape care delivery. This is the lever required to sustainably shift the balance of care and the Integrated Care Fund the key enabler which in providing bridging funding will allow East Lothian HSCP to maximise the impact of these strategies to release resource.

	Through its early performance management framework and data analysis the IJB has now developed a sound understanding of the activity / activity shifts required to ensure sustainability. Whilst undeniably challenging, this has been built into indicative directions aligned to the Strategic Plan.
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity	East Lothian's Joint Strategic Needs Assessment concentrated on understanding multimorbidity, including mental health, and where the greatest support need is across localities in East Lothian. This also analysed a wide range of health determinants and outcomes by locality and both the draft Strategic Plan and the aligned Integrated Care Fund Plan have risk prediction, multimorbidity, early intervention, and care coordination across care pathways as priority themes. This is evidenced by our early work with HRI pathways and aligned KIS, with Links workers and House of Care approach adopters in 3 general practices in high deprivation areas, and initial work on a Primary Care Development Strategy which recognises demand, access and support.

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

PARTNERSHIP DETAILS

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Appendix 1

East Lothian Health and Social Care Partnership: Outcomes Framework

National Health and Wellbeing Outcomes

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

East Lothian Health and Social Care Partnership's strategic objectives

A. To make universal services more accessible and develop our communities
   We want to improve access to our services, but equally to help people and communities to help and support themselves too.
B. To improve prevention and early intervention
   We want to shift and focus services towards the prevention of ill health, to anticipate at an early stage the need for support and to react where possible to prevent crises.
C. To reduce unscheduled care
   We want to reduce unnecessary demand for services including hospital care.
D. To provide care closer to home
   We want to deliver safe and effective care as close to home as possible, allowing people to remain in their homes and communities for as long as they can.
E. To deliver services within an integrated care model
   We recognise the need to make people’s journey through all our services smoother and more efficient.
F. To enable people to have more choice and control
   We recognise the importance of person centred and outcomes focused care planning.
G. To further optimise efficiency and effectiveness
   We want to improve the quality of our services whilst recognising and addressing the challenging financial constraints we face.

H. To reduce health inequalities

We want to reduce inequalities, break the cycle and impact of deprivation and support and protect the vulnerable in our communities.

I. To build and support partnership working

We recognise the importance of developing effective and wide ranging strategic partnerships in delivering our ambition, vision and values.

East Lothian Health and Social Care Partnership's Model of Care

a. Healthy active ageing and support for independence across the lifespan.
b. Support to live well with long term conditions.
c. Accessible and effective support at times of crisis.
d. Excellent post crisis support
e. Person centred and dignified long term care