Integration and Better Care Plan

Portsmouth City 2017 - 2019

Executive Summary

This report sets out Portsmouth's Better Care vision for the next two years, 2017-19, it discusses the strategies and plans that are proposed to achieve this vision by changing the way Portsmouth offers services across the whole spectrum of health and care.

The integration and better care plan builds upon the Portsmouth blueprint, health and care Portsmouth transformation plan, Portsmouth clinical commissioning group operating plan and the original five year better care plan.

Hampshire and Isle of Wight health and care systems have come together in partnership to develop a sustainability and transformational plan which sets out the strategic aims and objectives across the county. It has been agreed that the vision of the STP needs to deliver at local level in order to meet the needs of the local population. The multi-layered planning approach enables system partners to focus on the delivery of the commitments through either locally delivered systems or with wider systems partners where it makes sense to do.

The sustainability and transformational plan sets out the financial challenge for the Hampshire and Isle of Wight health economy. For Portsmouth and South East Hampshire a financial challenge of £80 million has been defined. Delivery of this new model of care will take place through interconnecting transformation work streams; multispecialty community provider development, adult social care transformation and the Portsmouth and South East Hampshire urgent care programme.

Portsmouth recognises that there is a need to radically re-think the way the current services operate and a new model of care delivery and way of working is required in order to achieve the vision.

This plan will be achieved in a number of ways including; bringing together some existing services, providing other services at scale, embracing technology, delivering care in the community where appropriate. At the core of this is ensuring separate agencies, multi-disciplinary teams operate as a single team to support patients and users of service needs.

To date the better care fund has had an impact in a number of areas including; the development of a new community independence service, the co-location of the three locality teams, the successful implementation and extension of the original acute visiting service pilot. For 2017/19 the focus of the Better Care Fund plan will be on; early intervention and self-care, admission avoidance, effective discharge and co-ordinated care. The plan aims to bring city services together through interconnected work streams to enable effective delivery of the new models of care ambition through an integrated approach to commissioning and delivery across health and social care.

A robust programme management and governance approach has supported the delivery of the Better Care programme from the outset; the same approach will continue to be used for 2017/19. The programme of work is overseen by the Partnership Management Group.

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1.0 Introduction / Foreword

This paper sets out the Portsmouth City Better Care Plan submission for 2017/19. It draws from the Portsmouth Blueprint; Health and Care Portsmouth Transformation Plan, Portsmouth Clinical Commissioning Groups (CCG's) Operating Plan and the original five year Better Care Plan, submitted in September 2014. This outlines in detail the vision and case for change underpinning the Portsmouth Better Care Fund (BCF) delivery strategy, integrating services and admission avoidance at the core through the close working of Health and Care partners in the City.

The Portsmouth and South East Hampshire (PSEH) CCGs Operating Plan 2017/19 sets out the PSEH CCGs contribution to the delivery of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Plan (STP). The PSEH CCGs Operating Plan has been deliberately aligned with the HIOW STP both from a presentational perspective as well as from a programme perspective. This should enable a clear read-across between the Operating Plan and the STP and provide alignment demonstrating how the Operating Plan will directly support the HIOW STP and the financial reset.

A high level summary of the programmes and enabling programmes along with 2017/18 and 2018/19 expectations from local PSEH delivery are set out in the embedded document below:

Final Joint PSEH CCGs Operating Plan.

2.0 Portsmouth's Vision and Approach for Health and Social Care Integration

Over the next five years, with all health and care partners in the City, including Portsmouth City Council (PCC), we propose to change the way we offer services across the whole spectrum of health and care. To achieve this will mean bringing together some existing services, providing other services at scale, embracing technology, ensuring that people only go to hospital to receive care that can only be done in an acute setting and that social and health care needs are met in the community wherever possible. This ambition is set out in the Portsmouth Blueprint and the underpinning Portsmouth Health and Care Transformation programme.

Instead of working as separate agencies, multi-agency/multi-disciplinary professionals will operate as a single team to support patients and users of service's needs. For patients and users of services, this will mean that they only tell their story once, with professionals coordinating and wrapping services around the patients and users of services rather than people seeking out all the support they require from different agencies. Single care records and introduction of a shared information system - System One, will enable this and lead to referral free zones between professionals for a seamless service to be the experience of residents of the city.

A key element of the Blueprint is the need to radically transform the way we commissioning care to support the integration of front line services and delivery of more person centred care approaches. As an Integrated Personal Commissioning (IPC) demonstrator site we are committed to developing a completely different approach to planning and commissioning health, community, social care and other services, with the adoption of evidence-based approaches to delivering personalisation at scale.

IPC is characterised by five key shifts in current models of care (figure 1). Together these will drive improved outcomes for people, the system and the tax payer. Delivery of this will be central to how we commission services to deliver the Blueprint and we will measure ourselves against them.

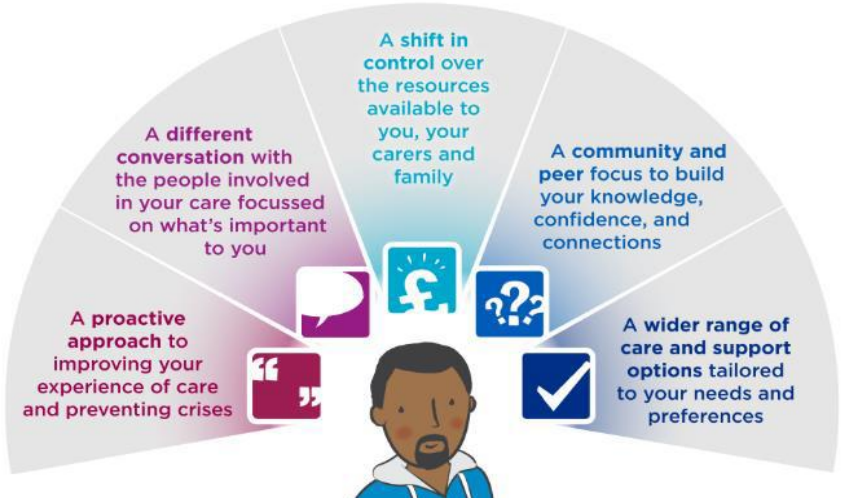


Figure 1 - IPC 5 Key Shifts

3.0 Background and Context to the Plan

The Blueprint for Health and Care in Portsmouth (HCP) is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together. The blueprint has an overarching goal *where everyone is supported to live healthy, safe and independent lives by health and social care services that are joined up around the needs of individuals and are provided in the right place at the right time.*

The blueprint sets out a vision for the delivery of health and care services in the city that will be less fragmented and better able to support people to stay well and remain independent, through the delivery of seven key commitments. The delivery of the blueprint is integral to improving the long term health of the population. The Portsmouth Better Care Plan has always been a fundamental element underpinning delivery of the blueprint.

There is a great deal of work underway in all organisations and services, as business as usual, in order to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint. This landscape is increasingly complex as work also develops across a wider PSEH around an Accountable Care System (ACS), as well as responding to the county-wide STP footprint. Portsmouth also has strong similarities with Southampton City and continues to develop partnership working and increasing links with Southampton via the public health agenda.

3.1 Health and Care System Tiers of Planning

3.1.1 Hampshire and Isle of Wight Sustainability and Transformation Plan

Health and care systems across HIOW have come together in partnership to develop a STP, setting out the strategic aims and objectives for transformation across the county. The key aims and objectives of the Portsmouth blueprint are reflected within this wider system plan. There is a shared desire to build a strong primary and community care service which will be the foundation for the delivery of the Portsmouth blueprint.

It has been agreed that delivery of the STP needs to take place at local level, within local delivery systems. The City of Portsmouth forms part of PSEH delivery system. Health and care partners in PSEH have come together to form an ACS.

3.1.2 Accountable Care System

The aims and objectives and key work programmes to deliver the Blueprint are reflected in the ACS plans. The PSEH ACS has been developed as an added value vehicle for delivering the New Models of Care set out in the NHS 5 year forward view and the programmes outlined in the STP at a local level. The ACS aims to address the behaviours and capacity issues that exist within the Portsmouth system that are causing progress to be slowed or stalled. The ACS will focus on flattening and reducing demand by concentrating on rapid acceleration of programmes that are focused on improvement for patients. It is viewed this in turn will rapidly accelerate and refocus key project to scale up and ensure sustainability by driving out non-value adding costs in the system by aligning quality,

innovation, productivity and prevention (QIPP) and cost improvement programme (CIP) schemes to remove costs equitably.

3.2.3 Multi-layered Planning Approach

This multi-layered planning approach (figure 2) enables system partners in the city to focus the delivery of the commitments through either local delivery or with wider system partners where it makes sense to do so and whereby incoming together maximum gains can be achieved. We are working on the principles across the wider system that transformation must be based on local needs and where possible delivered locally. However, effective partnership working across PSEH and allows us to work together in areas of commonality and shared aims to ensure alignment and ability to operate on a wider footprint to achieve efficiencies from a truly 'do it once' approach where it makes sense to do so.

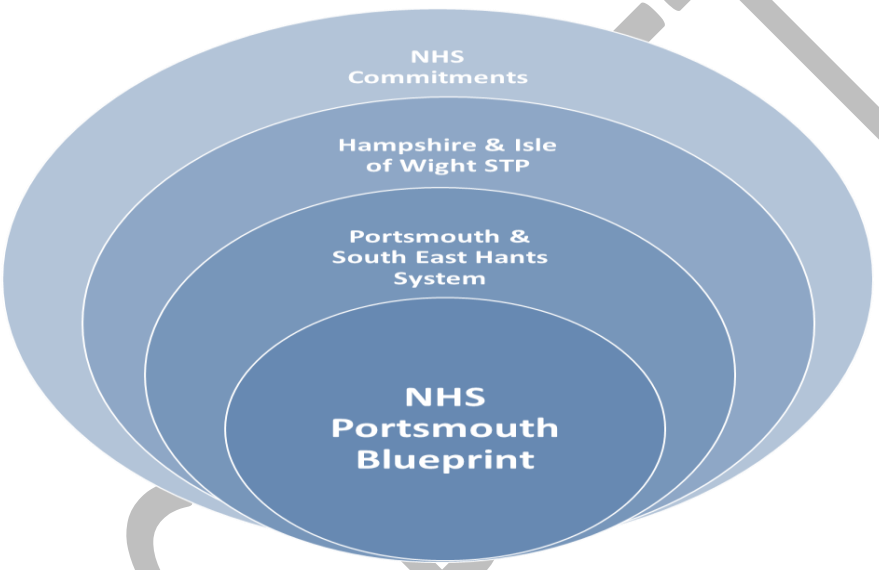


Figure 2 - How the plans fit together

3.2 The Financial Challenge

It is important that the city is able to articulate how the local transformational programme is supporting sustainability in the longer term and addressing the financial challenges of the wider system. The HIOW STP sets out the financial challenge for the HIOW health economy. Within this, more detailed analysis has been undertaken for each of the local delivery systems and alignment to individual organisations.

For PSEH there is a financial challenge of £80 million, which by working together through the ACS, the system needs to meet. Key to the delivery of this is the development of new methods of contracting and the agreed aligned incentive contract between Portsmouth Hospitals NHS Trust (PHT) and the three local CCGs, (NHS Portsmouth CCG, NHS South Eastern Hampshire CCG and NHS Fareham and Gosport CCG). This new contract model moves the system away from the traditional activity based contracting approach of payment by results (PBR), whereby the hospital is paid on an activity basis to payment for an agreed expected level of activity. This method means the CCGs and hospital can work more effectively together to reduce costs and manage demand for services.

For the local authority, adult social care (ASC) is an increasingly high profile area of local authority business. There is acknowledgement at national level that social care is under increasing pressure, for a variety of reasons, including increasing demand; and that the quality of the social care system is critical to ensuring the health services remain viable in the medium to long term.

The Department for Communities and Local Government produced a pre-budget report in March 2017 highlighting some of the national drivers of demand and cost, in particular:

- Demographic changes - the King's Fund report that the number of people in their 80s and 90s has increased by almost a third in the last 10 years; and is set to double in the next 20 years.
- Care Act 2014 - reformed and modernised social care law, and whilst the sector was broadly enthusiastic about the changes introduced, there were concerns about potential increases in demand for services, leading to higher costs.
- National Living Wage (NLW) - In July 2015, the Government announced the National Living Wage for those aged 25 and over. While the NLW gave care workers, amongst whom recruitment and retention is a significant issue, a needed increase in pay, it did add to the funding pressures on councils.
- Deprivation of Liberty safeguards - A Supreme Court judgement in March 2014 changed the definition of "deprivation of liberty" under the Mental Capacity Act 2005, resulting in more people who have been deprived of their liberty for treatment, care or protection from harm coming forward for council safeguarding assessments.

The cumulative effect of these high-level pressures on Portsmouth means that at the beginning of the financial year 2017/18 there is an underlying budget deficit of £1.158m per annum, with a forecast future savings requirement in the next two years of £1.848m to be achieved, and projected demographic pressure of £1.3m in the next two years. However, there are also funding opportunities to support transformational change.

4.0 Impact of the Better Care Fund to Date

The schemes and high level delivery milestones for 2016/17 were:

Scheme	Progress to Date	Still to Do
Scheme 1 Integrated locality teams	Co-location of the three locality teams Roll-out of GP led virtual ward and single list approach across the City	Single assessment and referral pathways implementation Health and care community teams under single line management.
Scheme 2 Living Well	Review and evaluation of year one of Living Well	Integrate the social prescribing community services to reduce duplication across the city. Create a single point of access and triage process to ensure individuals are seen by the most appropriate team/individual.
Scheme 3 Community reablement	Developed new Community Independence Service, which located OTs within locality teams. New VCS discharge support services operational	Full mobilisation of new discharge to assess pathways and implementation of single team approach to discharge. Develop Community Reablement to be more of a Community Rapid Response Service. Embed VCS discharge Support Service more within IDS.
Scheme 4 Implement and deliver enhanced support models in to residential care homes	Developed services business case as part of MCP. Just about to go live.	Operationalise and monitor initial roll out. Roll out across City.
Scheme 5 Early Intervention and Prevention	Trialled services and have now either mainstreamed or decommissioned.	Scheme closed.
Scheme 6 Acute Visiting Service	Successfully implemented an extension to the original AVS pilot, increasing capacity in the service during Monday mornings and expanding the service to cover	Pilot the incorporation of the AVS into an integrated primary care service delivering urgent home visiting capabilities 24/7.

	afternoon visiting. Review of expanded pilot period undertaken and agreement obtained to commission on a recurrent basis.	

5.0 New Models of Care

Fundamental to the Blueprint is the development of a new model of strengthened primary and community based care that will deliver sustainable primary care, improve access and help people stay well and independent. Care will be delivered as close to the person's home as possible and use of acute services where there is a true need to do so. Pathways will be redesigned along the following key principles:

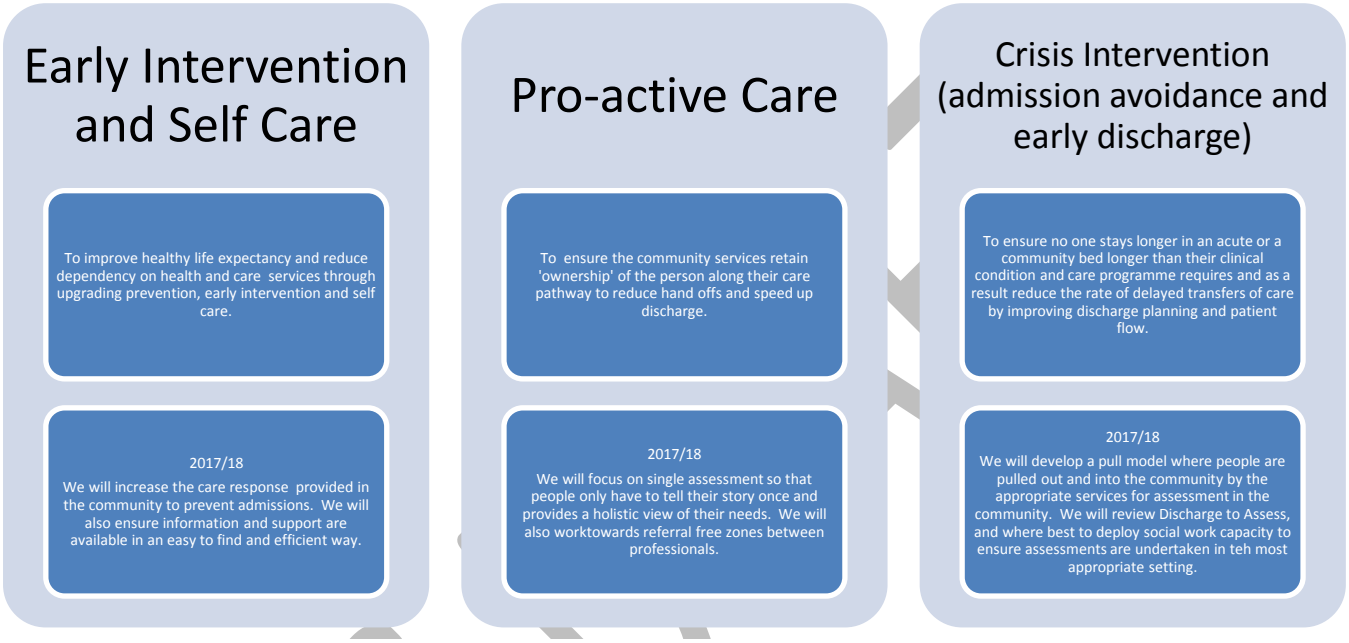


Figure 3 - New Models of Care Principles

Early intervention and self-care- early help and support, living well, social prescribe etc. Self-Care to manage long term conditions - assistive tech, demand management.

Pro-active care - planned proactive care management, primary care in community, etc. enabling effective primary care at scale, involving the extended primary care tem to better support people to remain healthy and independent. Moving from community services being co-located and where teams work together to a position where true integration exists, where there is cross over in the persons care management so that we have referral free zones for professionals alongside a single assessment document so that the person truly only tells their story once.

Crisis intervention - Avoiding admissions through providing effective urgent care in the community - Working with the acute to ensure the IDS is an efficient and effective service including whether social work could be single lead by either Portsmouth or Hampshire and whether it needs to remain in the hospital at all. Implementing all aspects of D2A fully so patients are not assessed to D2A and instead receive a truly proportional check before discharging for assessment in the community. - preventing admission to acute by developing community support team / wrap around service that will enable a more effective community response.

5.1 Strategic Aims and Objectives

The provision of a co-ordinated health and care response to effectively and safely manage people's health & social care needs in the community in order to support people to stay in their own home and maintain their independence for as long as possible, has been a long held ambition of health and care partners in the city. By doing this, the aim is to improve quality of care provided, enable people to stay in their homes longer, reduce acute admissions and length of time spent in hospital, as well as reducing the cost of long term care. Our belief is that this will create a more sustainable health and care system.

There has been significant investment into community service in the city over the years and most of the elements of core provision and skills to achieve this vision already exist. However, existing services do not function well enough together to provide the rapid and wrap around support necessary to truly enable people's needs safely manged in their home to prevent hospital admissions.

There is a need to radically re-think the way current services operate and a new model of care delivery and way of working is required in order to achieve the objective outlined above, improve outcomes and reduce the current pressure on the acute system for Portsmouth patients.

Delivery of this new model of care will take place through interconnecting transformation work-streams as part of Health and Care Portsmouth and within the ACS. These are:

- Multispecialty community provider (MCP) development
- ASC transformation
- The PSEH Urgent Care Programme.

5.1.1 Creation of an Multispecialty Community Provider as Delivery Vehicle

A key element of the City transformation is the formation of a MCP arrangement for primary and community services as the overarching delivery vehicle of the Portsmouth Blueprint / New Model of Care.

PCCG has established a partnership agreement with existing providers, Solent NHS Trust and Portsmouth Primary Care Alliance, in effect a virtual MCP approach. A joint programme board has been established and a number of priority schemes have been identified and are being worked on, which focus on three core foundations;

- Sustainable and extended primary care
- Integrated out of hospital primary and community care teams
- Prevention and wellbeing - Demand management

PCC ASC and children's social care services are also involved in the programme and represented on the programme board.

The local MCP work fits into the ACS New Models of Care work stream and CCGs are working to align timescales and approaches. There are a number of joint work streams including long term condition (LTC) hubs and GP out of hour's service developments.

A number of enabling work-streams also in place including optimising use of System-One and a commercial work stream between the two providers looking at partnership working arrangements, shared infrastructure and possible future organisational form models (CCG not involved in this).

The key projects being undertaken are as follows:

Foundation	Project	Current progress	Expected impact
Sustainable primary care	Same day access and triage; including MSK triage	A new way of working has been piloted in 2 large practices. A toolkit is now being developed to support roll-out to other practices Part of this included telephone triage to MSK services. - This is now being extended to all practices	Improved access to primary care. Better use of extended primary care teams
	24/7 seamless primary care delivery	Single procurement approach for integrated primary care delivery encompassing; GP improved access, Acute visiting service, GP Out of Hours. An interim direct award procurement is planned for these services to enable testing and development of an integrated delivery approach as part of 'virtual MCP'. Longer term will be included as part of full MCP procurement. New service model will take effect from June 2018, when current OOH contract ends. AVS is already well established. GP improved access services underway, Saturday service established and evenings will begin from Sept	Reduced hand-offs between key primary care services, improved access to primary care across the 24/7 period. Reduced ED attendances and conveyances. AVS - has already seen reduction in conveyances and improved patient satisfaction.
Integrated out of hospital primary and community care teams	Enhanced care home team	New way of working with a dedicated care home team, building on and integrated ways of working with existing nursing team which has been extended to include physios, OTs and pharmacy. - Being rolled out across 5 homes with most conveyances. New primary care model being piloted as part of this and rolled out within 2 additional homes	Improved pro-active care management of frail, vulnerable patients; improved quality within and support to the homes. Reduced ambulance conveyances and emergency admissions

	Rapid response services	Review existing rapid response services within the City and improve integrated working eg PRRT and AVS. Working closely with social care as part of their new way of working and improved access approach	Reduced ED attendances and emergency admissions
Prevention and wellbeing - demand management	ACS prevention and well-being project	Working as part of the HIOW STP, the ACS NMC work programme is enabling local delivery of key priority areas such as 'Stop Before the OP' and introduction of 'My COPD'	Improvement in lifestyle factors such as reduction in smoking, drinking and weight management to reduce risk of illness and /or development of 'lifestyle' based conditions.
	LTC hubs	The ACS NMC work stream is looking to develop a new hub based model of care for diabetes, heart failure and respiratory services. Currently developing the model and inclusion criteria.	Improved management of LTC patients

The long term commissioning intention is to procure a partially integrated MCP contract within two years. The CCG is working on the outcome framework and specification for this. A stakeholder engagement plan is in place, which will involve market and public engagement. Ongoing engagement with GPs is also underway.

5.1.2 Adult Social Care Strategy and Approach to iBCF

ASC is an increasingly high profile area of local authority business. There is acknowledgement at both national and local level that social care is under increasing pressure for a number of reasons. In the recent past a number of measures have been introduced to try and address these issues, including;

- BCF
- Social Care Precept
- The ASC support grant

The cumulative effect of these high level changes in Portsmouth has resulted in an estimated £4.6m savings to be found over the next three years to 2019/20. This relates to budget savings required to contribute to the Council's overall corporate saving requirements of £3.8m and the demographic cost pressures of £0.8m.

It is recognised that there are opportunities to create savings through additional 'one-off' funding opportunities;

- Grant for ASC as announced in the 2017 Spring Budget of £7m, available on a reducing basis over the next three years
- Social Care Precept may generate an estimated additional £2.1m in 2018/19 and 2019/20 and will be on going
- A number of 'one-off' savings amounting to £0.7m that have been identified in 2017/18.

This funding leave 'one-off' funding of £8.5m, taking into account the identified demographic pressures and the likely cost pressures funded from the ASC precept, to be used to invest in the transformational change of ASC services. The £8.5m will not only be used to deliver the ongoing saving requirement but also to prepare the service to be able to make further savings beyond 2019/20 as the austerity period continues. It is acknowledged that funding will be released when there is good fit with the blueprint principles national conditions of grant usage and a demonstration of the capacity to sustain or enable further transformational change.

In order for Portsmouth to achieve the purpose of *'helping people live the life they want to live, in the way they want to live it*' by 2020, ASC will need to be;

- Delivering individual services to people
- Working in a way that recognised the strengths that people have
- Working efficiently and responsively
- Financially stable and sustainable.

This vision will be achieved by;

- Reshaping the social care workforce
- Changing the approach to customers
- Managing demand for services
- Continuing to integrate with health partners where it is relevant to support holistic care and continuity of care
- New model of care and support for people including through accommodation
- Developing the relationship with external partners, including providers and the voluntary and community sector (VCS).

These principles form the core of a 'blueprint for social care' in Portsmouth, this blueprint compliments the Blueprint for Health and Care, a statement of commitments to the residents of Portsmouth which sets out the range of ways in which health and care services will work together to ensure more co-ordinated , assessable and effective services in the city.

The transformational fund will be used to pump prime projects that will improve the ongoing revenue of the service. However, it is anticipated the service will be able to work itself out of the deficit as much as it can and the transformation fund can be used for service transformation and ensure long term sustainability.

It is important to note long-term sustainability in the ASC system can only be achieved by looking at how we reduce demand for the highest cost service; focus resources on areas of

greatest need; and reduce the costs of service that are necessary to support the most vulnerable.

5.1.3 PSEH Urgent Care Plan

Much has been done in the past and currently at PHT to try and address the issues of flow. There are a number of issues that the wider urgent care programme seeks to address. Although the integrated discharge service (IDS) and discharge to assess (D2A) models have been in place since September 2016 they have struggled to deliver the expected outputs for various reasons and length of stay has increased across all areas of the Trust and excess bed days have not reduced. For example:

- Other supporting systems had not been in place e.g. SAFER, BedView, electronic reporting
- Continual increase in the number of referrals to IDS – due to rising patient complexity or lack of understanding of wards of the IDS role, lack of collaborative working between the wards and IDS – patients are referred with the expectation IDS will take over the discharge completely
- Those resources in place are not maximised - inappropriate patients in pathway 2 beds because of hospital status
- The system is used to being in crisis
- Long queues in A&E are a consequence of slow admissions not the volume of activity. The work required from staff is larger with a long queue than it is with a short queue even if the total flow of patients is the same. A failure to solve the core problem is increasing costs and damaging quality.
- Instead of relentlessly focusing on the root cause of delays, there has been too much effort focusing of the problems that are demonstrably not the root cause and expending effort on initiatives that cannot possibly solve the issue.

One of the key priorities of the PSEH ACS is the improvement of the urgent care pathway. A shared plan has been developed to achieve this.

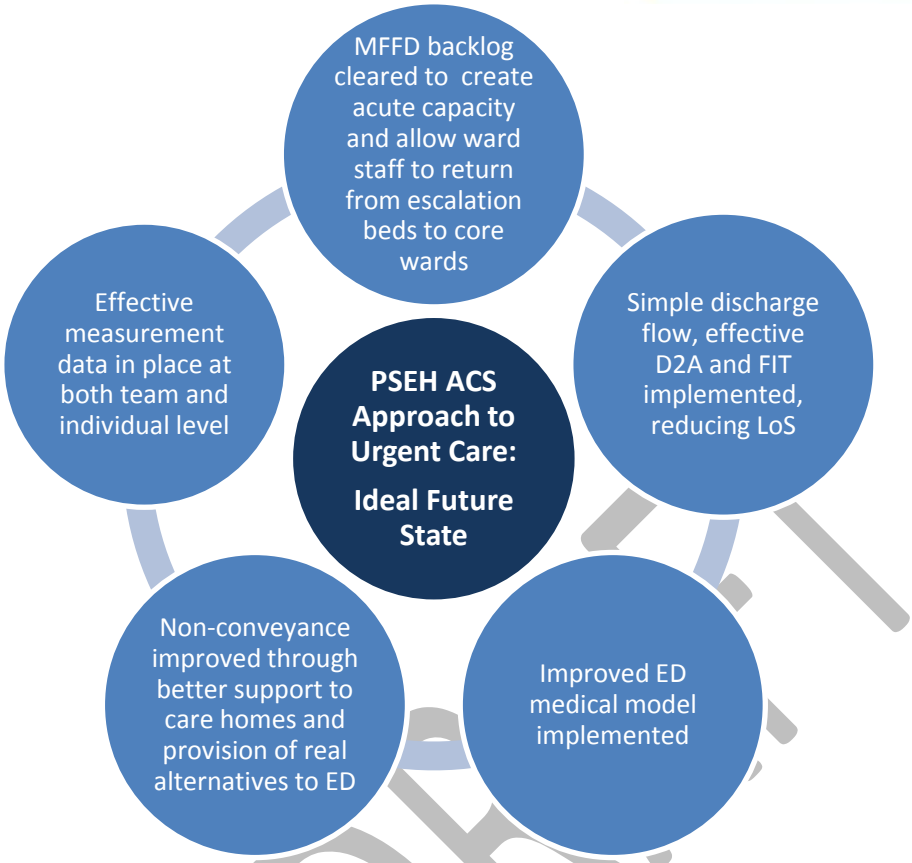


Figure 4 - PSEH Approach to Urgent Care

The above diagram demonstrates that there are several initiatives that need to be implemented to achieve the future state. On 05 April 2017, the PSHE ACS Board agreed the first 3 priorities to achieve the ideal future state:

- Clear Medically Fit For Discharge (MFFD) backlog - a one off initiative
- SAFER – simple discharge flow - requiring full implementation as 'business as usual'
- New medical model in the emergency department (ED) - requiring full implementation as 'business as usual'.

The delivery of these three programmes is crucial to achieving flow (particularly MFFD and SAFER) and quality in the emergency department. Our view is that clearance of the MFFD backlog will enable SAFER to be more successfully implemented.

System partners are clear that all three must be delivered and organisations should be held to account accordingly.

Fundamental is our ACS methodology that combines focus on the key projects using quality improvement methodology with performance measurement and analysis of variation, high quality project management and clear accountability.

In addition to the first three priority areas, there are other specific areas that will need to be addressed in time. Although these were not seen as the immediate priorities their

implementation is necessary to create the improvements required to be able to manage urgent care demand and flow effectively. Specifically these initiatives are;

- Full implementation of the frailty interface team and Integrated discharge service
- Reducing length of stay through the introduction of a dedicated Frailty Unit.
- Reduction in Care home conveyance to ED
- Reduction in Faller conveyance to ED

6.0 The Portsmouth Better Care Plan 2017/19

The Better Care Plan approach in the City brings together these interconnected work programmes to enable effective delivery of the new model of care ambition through an integrated approach to commissioning and delivery across health and social care.

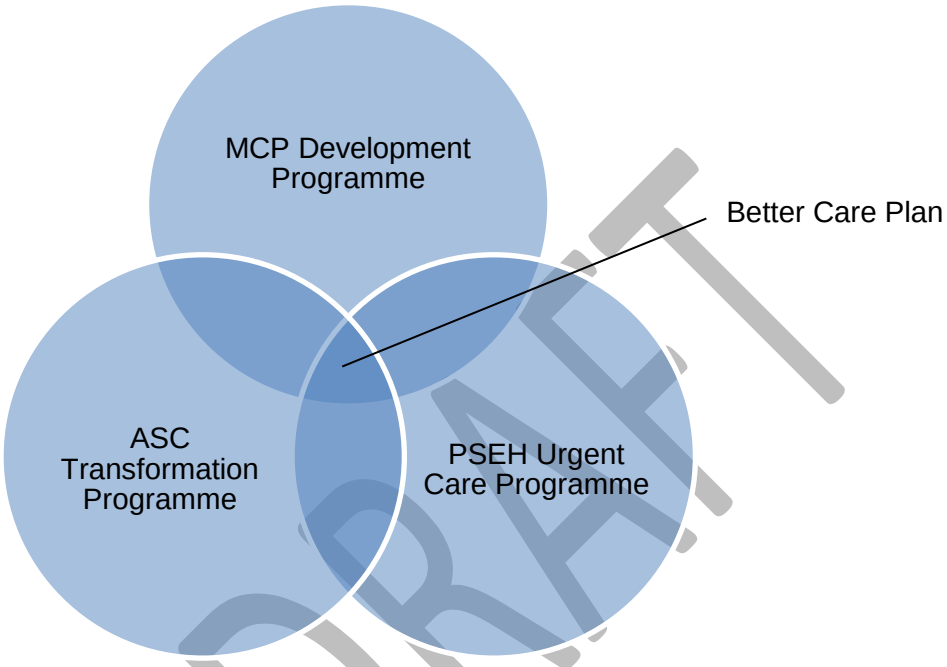


Figure 5 - Portsmouth Integrated Approach to Commissioning

For 2017-2019 the focus of the BCF plan will be on the following areas under each of the headings:

- Early intervention and self-care
- Pro-active care
- Crisis intervention (admission avoidance and early supported discharge)

6.1 Better Care Plan for Early Intervention and Self-Care

6.1.1 Non-Medical Voluntary and Community Services

It is recognised Portsmouth currently has a number of different services that exist to improve the use of non-medical voluntary and community services to promote health and wellbeing, increase independence, reduce social isolation, assist with the management of long term conditions and support mental health. Each service currently has different commissioning arrangements, outcomes and reporting measures which is creating duplication and confusion as to which services to access for both patients and referrers.

As part of the development of the early intervention and self-care offer, services will be recommissioned to be more integrated in order to strengthen the role and facilitate increased impact and effectiveness of the support available.

It is understood the recommendations identified in the embedded report will improve the health and wellbeing of patients and reduced social isolation. These improvements can mainly be achieved through improving the use of existing resources and/or enhancing service contracts.

6.2 Better Care Plan for Pro-active Care

6.2.1 Integrated Personal Commissioning

The evidence base and local priorities to support our plan for integration comes from IPC. Our Better Care Plan is an integral part of the drive to more integrated working and a single approach to commissioning across the CCG and City Council that will underpin the STP and Operating plan. Delivery of the Better Care plan for 2017/19 will be in line with the policy framework and will continue to transform front line health and care services for adults with long term conditions through an integrated approach to service delivery to reduce unnecessary hospital and long term care admissions and facilitating early discharge.

For the final year of the IPC programme there will be a refocused delivery and programme management structure to better achieve the objectives of our IPC programme, where these are also key to the delivery of the Health and Care Portsmouth programme. This will include mainstreaming elements of the programme delivery to ensure IPC is not seen as separate but a key delivery mechanism within the HCP transformation programme and part of business as usual. This will also ensure best value for money, ensuring use of IPC resources are focused on front line service delivery transformation some of this has happened already, but the following actions need to be undertaken to support this.

For 2017-19 the IPC funding received form NHS England will be included as part of the Better Care Fund S75 agreement to enable closer alignment and acknowledge the integrated nature of this funding.

6.2.2 Integrated Locality Working

A key element of the future MCP delivery is the extended primary care team that works as a single team to support the individual and their families. This includes the integration and reduction in duplication across primary and community nursing and the interface with ASC. There are three key elements to this work:

Patient identification through effective risk stratification - this is an area that we have struggled with to date. As part of the MCP development, partners will develop and test new ways of doing this across health and social care to identify people at risk of admission and to enable more effective case management solutions to support them in their community.

Single care records and introduction of a shared information system - Achieved through the use of a single IT system. System-One, already in place for the majority of GP practices in the City and Solent NHS Trust, Adult social are services are purchasing the system and the aim is for this to be in place by April 2018. This will enable this and lead to referral free zones between professionals for a seamless service to be the experience of residents of the city.

Integrated working across health and care teams - Instead of working as separate agencies, multi-agency/multi-disciplinary professionals will operate as a single team to support patients and users of service's needs. We will continue to develop a shared assessment process, and single management structure for the locality health and care teams.

6.2.3 Carers

Delivery of effective, pro-active support to informal carers remains a key aim of the Better Care Plan within 2017-19. In this financial year we will include the ASC carers funding element within the BCF to explore even greater opportunities for pooled fund arrangements and integrated front line delivery to improve the offer for families and carers in the City.

6.2.4 Enhanced Support to Care Homes

Building upon the evidence reported in the NHS Framework for enhanced health in care homes which states one in seven people aged 85 and over is living permanently in a care homes; a future care home team model for Portsmouth has been developed collaboratively to overcome the current challenges.

The aim of the new model is to improve support to Portsmouth Care homes, educating Care Home staff and reducing conveyance to hospital, improving the quality of care for patients, and positively impacting on homes' CQC compliance. The model will provide an integrated service provision with a more focused and structured approach tailored towards prevention with a more robust response to crisis management. The enhanced health in care home model is designed to ensure that care and support is coordinated, pro-active and consistent and that interventions are offered as early as possible to meet the person's needs, preventing them from going into crisis.

The service will predominantly be delivered within the care home and will require commitment from the care home management and staff. This commitment will be encouraged through positive relationship building and empowering care home staff to have the confidence to make appropriate decisions to support their residents. This will be supported by the Solent Care Home who will help care homes to identify their training needs, undertake training and become more skilled at providing a preventative model of care to their residents.

6.2.5 Shared Lives

Shared Lives Plus recent Health Report outlines the notable ways in which Shared Lives can benefit people's health. Portsmouth CCG will support a pilot to expand the range of service users benefitting from the Shared Lives approach offered by the Portsmouth Shared Lives Scheme, building on the existing PCC Shared Lives service's expertise and infrastructure.

The pilot will provide an alternative approach for people who need supporting through a range of pre-matched shared lives options to the following cohorts;

- Short term care and support arrangements (post discharge)
- Vulnerable adults (including older people aged 65+)
- End of life care and support
- Adults with mental illness

- Step Up: Eligible Cohorts
- Vulnerable adults / older people prevention

The CCG, together with Portsmouth Shared Lives Scheme, will:

- Develop the knowledge, experience and support of (current & new) Shared Lives Carers to support individuals with health care needs
- Develop the understanding of Shared Lives throughout the CCG with local teams, organisations, members of the public and other stakeholders, that leads to an increase in the number of referrals of people with health care needs to Shared Lives
- Portsmouth CCG, working with Portsmouth Shared Lives scheme, agrees to engage with people who use Shared Lives, their families, clinicians and other relevant stakeholders, to seek their input into reviewing and (re)designing Portsmouth Shared Lives provision and to share information and learning produced from this activity with the evaluators.

The Shared Lives funding received from NHS England will be included as part of the Better Care Pooled Fund S75 agreements for 2017-19.

6.2.6 Disabled Facilities Grant

The increase to the Disabled Facilities Grant (DFG) has enabled us to continue to address a back log in adaptions within people's homes. Our ability to plan to be more innovative in deployment of the funding is therefore limited despite more flexibility in the criteria this year.

However, we are working closely with Housing colleagues to monitor demand and spend to identify opportunities for better supporting people to remain living independently at home.

Instead of using the funding differently, we are instead working with Housing to be able to better respond to requests for adaptions more quickly in support of reducing delayed transfers of care (DToC). More of a rapid response is required to reduce delays caused by waiting for adaptions.

6.3 Better Care Plan for Crisis Intervention

Building on from our 2016/17 plan, we will focus on the key areas that have the biggest chance of success to enable admission avoidance and effective discharge, reducing delayed transfers of care numbers for the city.

6.3.1 High Impact Changes

As an accountable care system, we are using the high Impact Change Model to ensure the schemes we focus on as part of our New Model of Care will be the ones that have the greatest impact on reducing delayed discharge. This is looked at within both Portsmouth and South East Hampshire and aligned to develop system priorities. Within this, the plan outlined below will enable us to address these areas within the City.

From the analysis of the high impact changes, a new care model needs to be developed to provide an effective community rapid response service to prevent emergency admission and facilitate early supported discharge; achieved through the provision of rapid assessment and triage and 'wrap care around' the individual so that their health and care needs can be safely managed within their own home or community environment. Care provision and treatment needs to be quickly stepped up and stepped down depending on the individual's condition and any stabilisation or deterioration.

This is a concept of 'wrap around care' as a front door service. Essentially a timely, (within the hour) response to people in crisis that can respond with confident, competent initial assessment, calling upon appropriate medical care where required. Such a model of care not only helps but encourages and assesses, adapting to changing circumstance by being flexible to needs increasing and decreasing.

Suggested tasks in this service are assessment and design of rehabilitation/Reablement routines/programmes; care provision, (including moving & handling) assessment of equipment needs; reactive and timely equipment delivery; prescription follow up; right sizing of ongoing support; escalation of medical need concerns based on observation and understanding what is 'normal' for a person; capacity assessment for specified decisions.

This service also has to follow people into A&E where admission is unavoidable. The purpose of this is to advocate for and coordinate discharge, providing clean information as to capabilities in the community and putting services rapidly into place to facilitate discharge from A&E without onward admission. Where onward admission has to occur, follow up continues to manage the shortest possible stay on the ward, including where an individual is 'outlied' as this risks changing discharge plans. This service would require access to a full range of support, utilising existing resources such as rehab flats, Victory, domiciliary care, short term residential or nursing placement, fast access therapy. For such a response to work and continue working, it must be open to community referrals with the belief that prevention is the only way to effectively manage admission and DTOC avoidance over the longer term. This service 'casts the net' as wide and low as possible in order to achieve the most effect and includes people being able to refer themselves back in to the service.

6.3.2 Key Elements of the Service Required

- Health and social care triage and assessment
- Access to medical and nursing skills
- Access to diagnostics in the community
- Ability to administer IV fluids/antibiotics in the community
- Assessment of equipment and home safety /adaptation needs
- Domiciliary care capacity
- Operate in a referral free zone – with no or low criteria
- Culture of working responsively and following the patient throughout their journey.
- Operate a 'pull' model of discharge.
- Access to a range of advice and treatment options including community beds.
- Delivery of this in the short to mid term

In order to move towards this, the culture and operational management of existing services needs to be radically changed to ensure that supporting people in their own home, avoiding an admission where safe to do so and to effectively support an individual through as short a stay in acute care as possible, by enabling timely and effective discharge is the expectation of all staff. In the short to medium term, this will require refocusing and reconfiguring a number of existing services both within and between ASC and Solent NHS Trust and developing a shared culture where what is currently thought of as 'going above and beyond' to save an admission becomes the expectation. The aim will be to empower frontline professionals, reduce handoffs and between services and professionals and operate a key worker system where the relevant support is pulled in.

The key schemes to deliver the operational transformation required to deliver this element of our New Model of Care are:

6.3.3 Establish Residential and Nursing Short Term Transition Beds

Identify potential options to create a 9 bed residential care transition unit to support people in the short term while they are waiting for either a domiciliary care package or a longer term placement. Open to both community and post-acute admissions

Identify options for short term nursing care transition beds, and / or review the CHC assessment capacity required within Jubilee House to achieve the same for those people who may require long term nursing care.

High Impact Change 4:

Home First / Discharge to assess. This will provide a short term care and reablement using step down beds to bridge the gap between hospital and home meaning that people no longer need to wait unnecessarily for assessments in hospital or for care packages to be sourced. This, in turn, will reduce delayed discharges and improve patient flow.

In addition we will review all existing community step up and step down beds to ensure they are effective in supporting this new model of care delivery. For 2017-19 the CCG's current contracts values for community health beds and ASC delivery costs of the Victory service will be included in the BCF 2 S75 agreement.

6.3.4 Refocus the Hospital Social Work Team

Within an effective discharge to assess model within the acute environment, the need for a hospital based social work assessment for all but the few most complex patients, is significantly reduced. For the majority of patients requiring ongoing community based support, a community in-reach service (MDT with VCS involvement), which is a part of the rapid response service, can work to identify the patients immediate needs post discharge; ensuring support is provided and available in their home or for a short term stay in an appropriate community bedded unit, whilst long term decisions are made.

The aim therefore will be to reduce the current team to 2-3 staff, one of whom will be based in ED and increase the involvement of the Red Cross Home from Hospital service. The rest of the team will work between the rapid response service and wider community services to support the social work assessment required for the transition into any long term care and

support needs. They will in-reach into the new and existing community bedded units, and link to the care home team and CIS service as well.

High Impact Change 3:

Multi-disciplinary / multi-agency discharge teams, including the voluntary and community sector. The refocus will lead to more coordinated discharge planning based on joint assessment and protocols and on shared and agreed responsibilities, promoting effective discharge from the acute and community beds and positive outcomes for the patients.

6.3.5 Review and Refocus PRRT

PRRT is the service which most meets the aims of the service and approach outlined above. Over time however, changes to the service and the wider health and care landscape have made it increasingly difficult for the service to meet the many and varied demands placed upon it. ASC teams need to work with Solent NHS Trust and ICS to agree a shared aim for commissioning the service based on the principles above, enabling it to become the rapid response service required.

A shared leadership, management and governance approach will be required to better support and empower the staff working within the service to meet these aims and resolve blockages as they arise. This will enable the service to work more effectively to support other community services such as AVS, community nursing, CIS, community equipment and housing services to care for people in their own home and avoid admission.

Whilst the focus must be on admission avoidance, in the short term at least the service must be able to deliver a rapid response to enable timely discharge and reduce the MFFD numbers and DTOC figures. The community based hospital in-reach team, remaining hospital social work team and VCS rehab services need to become part of this rapid response service, not separate to it, so that there is a more trusted assessment approach and confidence in the service to deliver early supported and timely discharge and pass quickly back to the wider community team as needs de-escalate, but also step-in quickly so any deterioration is quickly identified and managed to reduce unnecessary readmissions, for example, being able to provide IV fluids / antibiotics in the community.

This is a way of working that Solent NHS Trust reportedly provide in Southampton via community nursing services, but which is not replicated within the Portsmouth community nursing service. Through the BCF and the MCP partnership agreement, ASC and the CCG will work with local GPs and Solent to identify how this service can be established and tested within the City.

In addition this element of the service needs to be supplemented with housing assessment support to identify housing issues earlier in the pathway. Annex 1 describes the current and future state proposed

In order to be successful in achieving its aims, the rapid response service needs to be able to access domiciliary based personal care support that can be put in place rapidly to either supplement an existing care package or put in place a new one whilst longer term support is sourced. Failure to achieve this will clog the service and limit its effectiveness. Access to

domiciliary care support is becoming increasingly difficult within the City (as well as nationally), with capacity unable to keep pace with current demands. In the short to medium term capacity needs to be increased in the following ways:

Implement the current MFFD proposal for increasing Health Care Support Workers (HCSW) in Solent NHS Trust to enable them to manage the majority of community based EOL support, where demand for this can be clearly evidenced. Currently 4 HCSW have been recruited, it is estimated that this will release up to 150 hours of capacity which should be prioritised for CHC fast track patients to reduce delays. More work is required to evidence further need.

Review the existing reablement assistant (RA) capacity within PRRT and explore whether changes to skill mix could increase capacity within the short term.

Enhance the brokerage support / contracting options available to PRRT to enable them to more effectively source care and work more closely with one or two existing dom care agencies

Identify opportunities to expand the Agincare 24 hour short term care packages and ensure the link with PRRT to make the most of this service is understood and supported.

In the medium to long term, the following will also be required to sustain capacity

Implementation of the agreed domiciliary care procurement process which begins in August 2018.

Identify and scope the opportunity for an 'in-house' domiciliary care model, subject to financial appraisal, which could perhaps work more in partnership with the other agencies supporting recruitment and workforce development opportunities on behalf of all agencies operating within the City. PCC may be best placed to support this and offer opportunities which the existing market may struggle to implement on its own

High Impact Change 1:Early discharge planning.

High Impact Change 5:Seven day service.

High Impact Change 7:Focus on choice.

6.4 Key Next Steps

Work stream	Short term action required
Review and establish appropriate residential and nursing, transition and community bed needs and capacity in the community as a priority	Review demand and begin scoping and costing options for provision including in-house residential, HSH and Jubilee provision and EOL.
Review and refocus the hospital social work resource to create a community peripatetic service	Review existing working patterns to reduce assessment delays and focus on ED, include exploring single structure / leadership options with Hampshire. Begin discussions with staff and partners about long term aim and agree model and timeframe.

Refocus PRRT into a true Community Support / Rapid Response Service	Refocus leadership, management and governance arrangements to deliver required change. Review capability and capacity requirements, identify gaps and plan investment strategies. Delivery of IV fluids in community needs to be investigated with the ICS working with the MCP to scope how this could be achieved
Increase dom care capacity	Implement End of Life HCSW service, starting as outlined above (based on agreed levels), create single brokerage hub for the Portsmouth System (PRRT, CHC, ASC, etc.) and enable closer working between the service and dom care agencies. Cost for an in-house service and look at options.
Agree Schemes to be Funded for 2017/18	Work with Finance and commissioning to identify funded schemes continuing and needing to be commissioned to support the above. Ensure all BCF schemes have detailed RoI and include sustainability plan in terms of funding.
Review D2A to identify improvements	Set up meeting to review data. Hold session with all stakeholders to assess where we are, where we need to get to and how.
Agree use of funds to sustain ASC / enable rising demand to be met.	Previous funding needs reviewing where no transition to mainstreaming is in place. Agreement of use of funds between sustaining ASC and reducing demand through redesigning / transforming services.

6.5 Delivery Milestones

The key deliverables from each of the schemes expected in 2017/18 and 2018/19 are:

Work Scheme	Key Milestones 2017/18	Key Milestones 2018/19
Early Intervention and Self Help	Commissioned a new model for integrated VCS Evaluate and review the new model Improve collaborative working across different organisations	Integrated VCS model operating as business as usual
Pro-active Care	Enhanced care home team pilot completed Localities have fully integrated IPC embedded within all relevant services Domiciliary care workforce issues are identified and action plan is produced	Full enhanced care home team operating as business as usual Assistive technology embedded within all care homes Commission new model of domiciliary care subject to a financial appraisal
Crisis Intervention	Refocused PRRT into a true	Community support / rapid

	Community Support / Rapid Response Service Embed the British Red Cross Help from Hospital within the IDS Edinburgh beds fully operationalised	response team operating as per revised contract agreement

6.7 Key Schemes to be supported by the Better Care Fund.

	Scheme	Purpose
Early Intervention and Self Help	CRM	To provide a self-supporting 'information economy,' where customers reveal their requirements in return for information and advice
	VCS Response (Integration)	Reduce duplication and confusion as to which service to access for both patients and referrer. To include a TARGET-style learning programme to support the VCS
	Good Neighbours Support	Ensure that all groups within the local network are offered consistent, high quality and safe help within a range of areas. The support enables local schemes to concentrate on their core activities with confidence, and to become self-sustainable models
	Living Well	Support individuals by enhancing existing processes of care delivery so that individuals are supported to identify their own priorities/goals and to make progress toward achieving these with a resultant increase in self-reported Health and Wellbeing and a decrease in the demand on other services
	Action Portsmouth	Provide a referral pathway between GP practices in Portsmouth and appropriate not for profit / voluntary and community sector (VCS) organisations which provide community based support for patients
	Community Connectors	Provide short term support, usually about 6-8 weeks, to help individuals take the first steps to getting out and about in their community
	Salvation Army	To provide provision of a befriending service to assist vulnerable Adults, who are essentially housebound, by providing them with social contact through volunteer visitor/befrienders
	Enhanced befriending services	Provision of additional befriending services to assist with reducing feelings of isolation and loneliness, improving confidence, establishing social networks, bereavement support, practical help, feeling valued, aiding mobility, improving health, mental wellbeing and independence/autonomy
Pro-active Care	Workforce development	Carer workforce able to do the right things at the right time
	Shared lives	Enhance current shared lives carer skills to cover a number of long term health conditions
	Solent Activity Coordinator	To provide additional activities to support occupational deprivation whereby by individuals could participate in activities that they wanted to or needed to do would complement the existing therapy input at Jubilee House
	Carers	Ensure delivery of effective, pro-active support to

		informal carers
	DFG	To work with housing to be able to better respond to requests for adaptions more quickly in support of reducing delayed transfers of care
	Community Physiotherapy	To provide physiotherapy interventions to adults over the age of 18 who require domiciliary treatment within a community setting
	CIS	To maintain peoples independence in their own home
	Reablement	Increase individuals confidence and independence
	IPC	Provide a proactive approach to improving experience of care and preventing crises, a different conversation with the people involved in care, focused on what's important to the individual, a shift in control over the resources available to the individual, their carers and family and a wider range of care and support options tailored to needs and preferences
	ASC Fieldwork	To provide high quality adult social care assessments and programmes of care
	Community Nursing	To provide high quality, culturally sensitive nursing care to people in their place of residence, with the aim of preventing avoidable hospital admission and facilitating early supported discharge.
	Care Act Implementation	To implement the requirements stated in the 2014 Care Act
	Enhanced Care Home Team (inc Red Beg and Six Steps)	To ensure the provision of high-quality care within care homes and wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choice
	Breath of Life	Pulmonary rehab maintenance classes
Crisis Intervention	MFFD	Clear the bag log of Medically fit for discharge patients at PHT
	Conveyancing Reduction	Reduce the strain on SCAS and therefore release capacity/reduce response times within their services
	PRRT Rapid Response	Review and consider separating rehabilitation and reablement from the Portsmouth Rehab and Reablement team (PRRT) and develop a rapid response / community step up / Community treatment Team
	Jubilee	Support those people suffering from multiple and complex health and age related problems, which require a complex assessment and care provision
	Victory and medical cover	Provide short term rehabilitation and/or assessment to support individuals to become more independent, assess their future care need and ensure clients have medical cover while a resident at Victory
	Spinnaker	To enable patients to be assessed for ongoing

		care at their optimum capability to support the correct discharge destination by providing multi-disciplinary support including physiotherapy and occupational therapy assessment
	AVS	Enable home visits earlier in the day and to increase capacity in General Practice
	D2A (AginCare)	To ensure people who are fit for discharge are assessed and safe in their own homes
	BRC Help from Hospital	Provide a responsive service to individuals who are medically fit for discharge from acute hospital or community unit and to support these individuals to safely resettle at home and commence their reablement journey to live healthy and independent lives
	ISA	Assess packages of care post discharge from PHT and PRRT
	IDS	To provide expertise and advice in the safe and effective discharge of patients with complex discharge needs and acting as an expert to support discharge planning for the wards

7.0 Overview of Funding

In 2017-18 and 2018-19, the minimum contribution to ASC will be calculated using the figure agreed through the 2016-17 plan assurance process as a baseline, updated for each subsequent year in line with the CCG minimum contribution. This means that the minimum required contribution will rise by 1.79% in 2017-18 and 1.90% in 2018-19. Locally the minimum contributions required are £13,463 for 2017/18 and £13,718 for 2018/19.

The detailed funding arrangements for the BCF are still being worked through. The BCF pooled fund for 2017/19 has increased from £16million to £22million per annum due to the inclusion of new and additional funding streams such as;

- iBCF, which comes to the Local Authority and is required to be included in the BCF.
- Funding received from NHS England for Integrated Personalised Commissioning. has now been included to ensure more robust programme governance.
- Shared Lives Healthcare; a new pilot scheme that the City has been selected for and receives funding from NHS England to enhance the existing shared lives scheme to provide more support to people with ongoing healthcare needs.

In addition, existing CCG commissioned and PCC community service budgets have been included in the fund. These are; Spinnaker beds, Jubilee House Beds, PCC carers services, community physiotherapy and occupational therapy, have also been agreed by PMG as areas where it would be appropriate to provide greater transparency among the partners and where the planned schemes could impact on current commissioning and provision arrangements. Therefore these budgets will be included within the better care fund, similar to current arrangements for district nursing, social care fieldwork and PRRT. All areas of the plan remain as aligned funding.

As part of the BCF governance process, the PCC and CCG finance teams are members of the S75 Partnership Management Group, which will review and approve funding requirements for new and existing schemes. Any existing and new schemes requiring funding will therefore receive appropriate finance review and approval when they are at an appropriate stage in their development

8.0 Better Care Plan Programme Governance

A robust programme management and governance approach has supported delivery of Better Care from the outset. This approach will continue and for 2017/18.

8.1 Role of Partnership Management Group

The Partnership Management Group (PMG) shall oversee the S75 Agreements for the BCF and the Integrated Commissioning Service:

- provide strategic direction on the Individual Schemes;
- receive the financial and activity information;
- review the operation of these Agreements and performance manage the Individual Services;
- agree such variations to these Agreements from time to time as it thinks fit;

8.2 Delegated Authority

The PMG is authorised within the limit of delegated authority of its members (which is received through their respective organisation's own constitution and scheme of delegation).

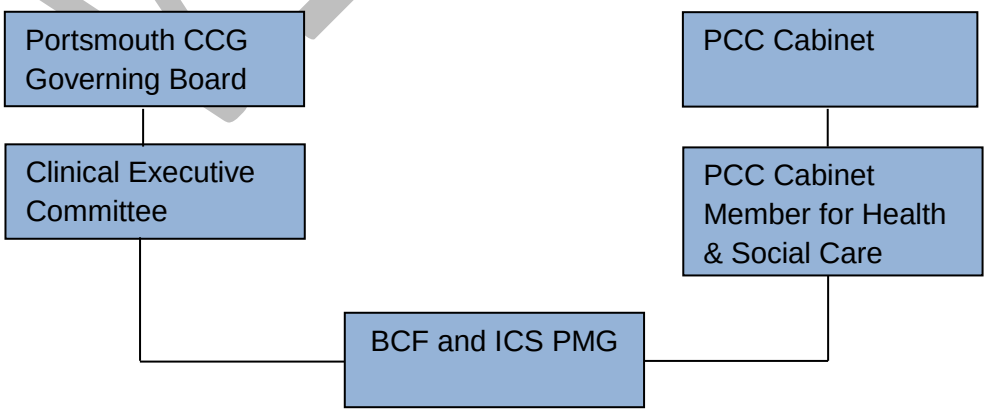
8.3 Overarching Governance Structure

The PMG shall receive reports and give direction to the BCF Delivery leads group, and relevant BCF Project Groups in relation to each Scheme.

The terms of reference for any elements of the BCF Project Groups shall be included within the Scheme Specifications, Schedule 1, where available and/or agreed through the BCF Delivery Board.

The PMG shall utilise resources from the partners including the Director of Better Care Programme for the Council and the Director of Quality and Commissioning to support the strategic delivery and lead on reporting to the Partnership Management Group.

The ICS section 75 agreement between Portsmouth City Council and Portsmouth CCG and the BCF will be actively monitored by the PMG as detailed below and reported as below:



9.0 Assessment of Risk and Risk Management Plan at Programme Level

Risk	Description	Impact	Likelihood	Risk Score
Expected outcomes	If the BCF programme does not deliver the expected outcomes as detailed in the BCF plan for 17/19, there is a risk to the residents of Portsmouth that they will experience disjointed services not fit for purpose	5	3	15
DTOC Plan	If the DTOC plan is not jointly agreed and implemented by all key stakeholders within Portsmouth, there is the risk that a reduction in both local and national targets will not be achieved and impact on hospital beds will not be reduced.	5	3	15
Duplication	There is the potential for duplication if the Better Care programme is not aligned to other programmes of work progressing in the City	4	3	12
Data sharing agreement	If there is no agreed data sharing agreements in place between the CSU, PCC and the CCG, there is the risk of data not being available. This will reduce the ability of commissioners to evaluate and commission services required to meet the demand of the residents of Portsmouth City	5	2	10
Evaluation process	If there is no evaluation process (including project measures and monitoring) in place , there is a risk that the governance of the BCF plan will not be effectively managed which will impact on funding and demonstrating the overall success	5	2	10

10.0 National Metrics

	Performance in 2016/17	Expected Performance in 2017/19
NEL admissions (Data from CSU and will support measurement of the BCF Plan)		TBC
Admissions to residential care (Data from ASC and will support measurement of the BCF the)	205	Portsmouth has seen reductions in this area in recent years, but this has slowed in 2016/17. Therefore are looking to maintain our current position for 17/19, reducing growth in NEL admissions.
TOTAL Delayed Days per day per 100,000 18+ population	9,789	A number of schemes implemented in the Portsmouth system will create recovery to all business as usual programmes to deliver sustainable improvement. The system has worked closely together to model to give a realistic reduction over the next year to deliver the target of 3.5% reduction in delayed days for the acute trust by March 2018
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	85.3%	Portsmouth is anticipating achieving 85.5% in 2017/19. A number of reablement services have now been mainstreamed and a pilot of additional services has commenced for 2017/18. A review of the PRRT service which aims to refocus should also contribute achieving the set target

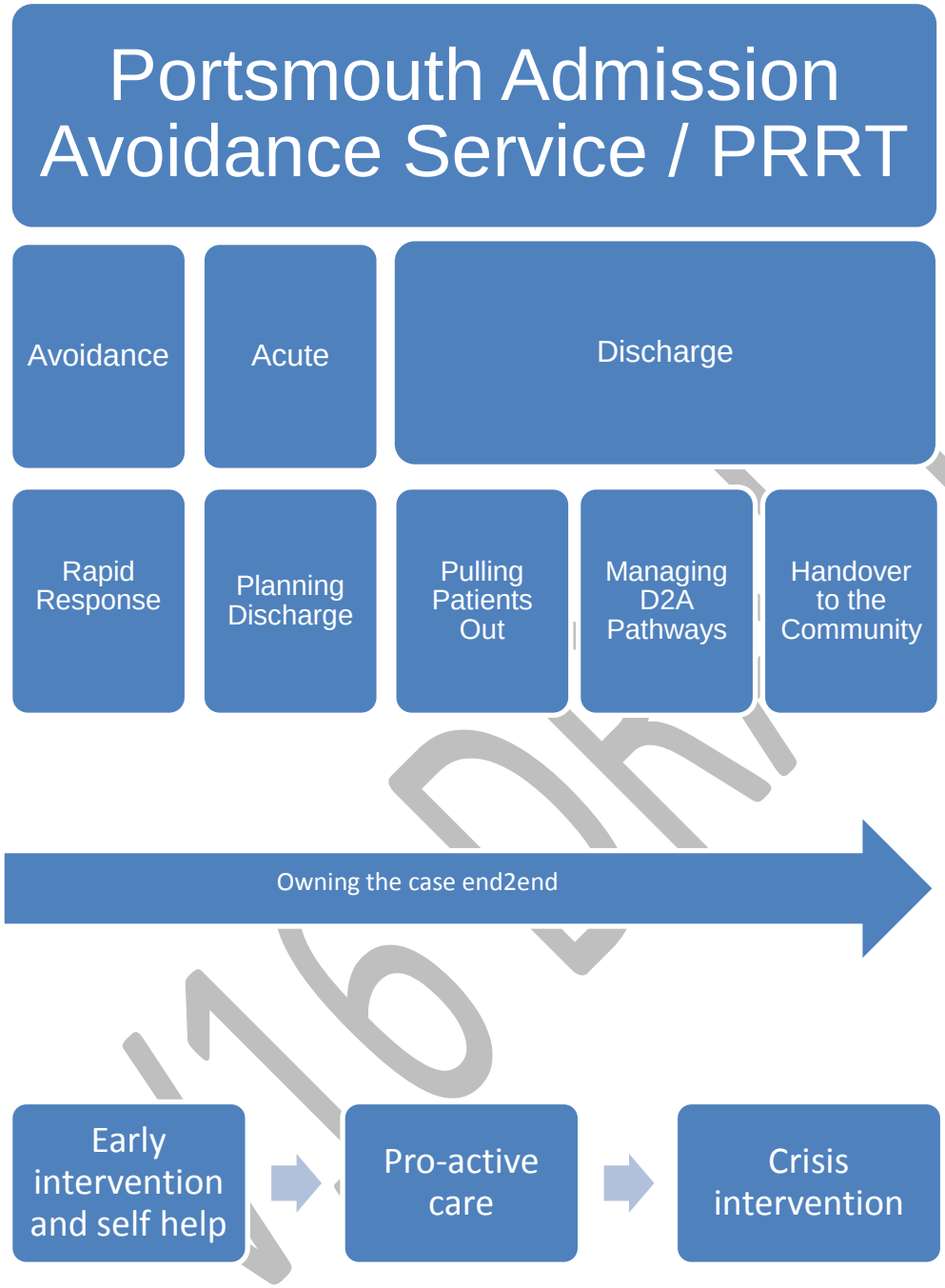
11.0 Approval and Sign Off

Signed on behalf of the NHS Portsmouth Clinical Commissioning Group	
By	Dr.
Signature	
Position	Clinical Lead Officer
Date	
Signed on behalf of the Health & Wellbeing Board	
By	
Signature	
Position	Chair Health And wellbeing Board
Date	

Portsmouth CITY COUNCIL

NHS Portsmouth Clinical Commissioning Group

Appendix A - BCF Approach



VCS

Social Prescribing, Living Well, Community Connectors, Home From Hospital

ASC Community Service

Victory / Transition Beds

Enablers: Dedicated Social Work Management, non-medical model, appropriate GP cover

Principles

- Principle purpose on rapid response to prevent admissions
- Where an admission occurs, the service maintains ownership of patient and starts planning for discharge
- On discharge, service provides whatever is needed - dom care, access to D2A pathway, etc.
- If the person is at risk of remittance, then they pick them back up to continue working with them

Enablers

- Single structure
- Trusted assessment / in-reach
- Risk appetite
- Measures / data required
- Diagnostics