Portsmouth CITY COUNCIL

NOTICE OF MEETING

CABINET MEMBER FOR HEALTH, WELLBEING & SOCIAL CARE

TUESDAY, 19 MARCH 2019 AT 10.30 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to: Jane Di Dino, 023 9283 4060
Email: Democratic@portsmouthcc.gov.uk

If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Membership

Cabinet Member for Heatlh, Wellbeing & Social Care
Councillor Matthew Winnington (Cabinet Member)

Group Spokespersons
Councillor George Fielding
Councillor Luke Stubbs

(NB This agenda should be retained for future reference with the minutes of this meeting).

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Deputations by members of the public may be made on any item where a decision is going to be taken. The request should be made in writing to the contact officer (above) by 12 noon of the working day before the meeting, and must include the purpose of the deputation (for example, for or against the recommendations). Email requests are accepted.

A G E N D A

1 Apologies for Absence

2 Declarations of Members' Interests

3 Adult Social Care Conference December 2018 (For information only)
(Pages 3 - 22)

Purpose

To summarise the key outputs and messages from the Adult Social Care

Conference held in December 2018.

Recommendation:

That the Cabinet Member note the report.

4 Update on the Winter pressure funding for 2018/19 (For information only) (Pages 23 - 48)

Purpose

To provide the Cabinet Member with an update on the winter pressure funding for 2018/19.

Recommendation:

That the Cabinet Member note the report.

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THIS ITEM IS FOR INFORMATION ONLY
(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Subject:	Adult Social Care Conference December 2018
Date of meeting:	19th March 2019
Report by:	Chief of Health & Care Portsmouth
Wards affected:	All

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1. Requested by Councillor Matthew Winnington.

2. Purpose

2.1. The purpose of this report is to summarise the key outputs and messages from the Adult Social Care Conference held in December 2018.

3. Introduction

3.1. Adult Social Care (ASC) is an increasingly high profile area of local authority business. There is an acknowledgement at a national level that social care is under increasing pressure for a variety of reasons including an increasing demand to support people with more complex needs in their own homes. The conference aim was to introduce the workshop attendees to the adult social care agenda, hold workshop sessions to create ideas for improving adult social care in the city, gain understanding as to the most popular ideas and agree how to move forward in partnership.

3.2 An introduction to the day was made by Cllr Matthew Winnington, Cabinet Member for Health, Wellbeing & Social Care Workshop participants were introduced to the adult social care strategy by Director, Adult Social Care. Workshop themes were then set out as workforce, personalisation, market development and technology.

3.3 Each theme was considered by two tables of participants made up of representatives from the voluntary, statutory and private sectors, with the following statements and questions:

3.3.1 Workforce:
The social care workforce needs to ensure that it is equipped to deliver safe and high quality services in the future
How does the workforce give choice and control to people, whilst also ensuring they are safe from harm?
What would a future Health & Care workforce look like in the future?

3.3.2 Personalisation:
People will have real choice and control of their care. Information about services will be available to all regardless of whether or not they fund their own care.
How do we get staff and organisations to recognise individuals as experts?
What are the key features of a really personalised service?

3.3.3 Market Development:
Developing outcome focused services / opportunities for people; working in partnership with individuals and organisations to have vibrant and varied options for care and support.
How do we stimulate the market to develop and provide new options for people?
What is needed to move away from traditional service delivery and expectations?

3.3.4 Technology:
Technology has the ability to really transform people's lives
How do we make the best use of all available technology to support people to manage their care and support needs?

4. Conference Output

4.1. The full output from the day is contained in the document at Appendix 1, with the ideas that gained the greatest support on the day indicated by the number of voting stickers they received (represented in the word document by coloured dots).

4.2. Summary of Output

Workforce:
Value the workforce
Career Pathways
Create a single workforce for the city
Flexible commissioning
Develop a shared culture - we are in this together
Walk in each other's shoes

Personalisation:
Cross-boundary funding e.g. Portsmouth City £1 - prevents "us" from recognising individuals as experts
Training - better facilitators - use the service user
Culture change for individuals as well as organisations and their staff
Service user-led co-production
Should we even contract and tender?
Approach by asking what person can do not what they can't do. What help are they currently getting

Market Development:
To have creative entrepreneurial priorities - need to create an environment where these people flourish.
Need accessible tendering process
Publish care pathways → The Hive
Contracting, commissioning, assessing and reviewing → collaborative approach → person's voice (case studies)
Create an environment:

- To try things
- To allow somethings to fail
- Trust
- Take joint, measured risk

Be agile, flexible (commissioned processes are still too long and arduous)

Technology:
Asking across the city - what is the problem we are trying to address together? (Partnerships)
Technology collaborative - group who focus on this / understand the need
Choose right tech partner to develop our offer and ensure best use of available technology
Don't limit offer - fit the solution to the person, not person to the solution

A video of the day was produced and the reactions of a number of attendees are captured

Cllr Winnington closed the conference and thanked participants for attending and their work. An accompanying video to the day is in preparation and will be made available on the PCC website.

……
Signed by (Director)

Appendices
Appendix 1 - ASC Conference Write Up

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
None	

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Appendix 1: Adult Social Care Conference Write Up

Workforce (Table 1)

The social care workforce needs to ensure that it is equipped to deliver safe and high quality services in the future

How does the workforce give choice and control to people, whilst also ensuring they are safe from harm?

Value the workforce ●●

Career Pathways ●●●●●

Create a single workforce for the city ●●●●

We want primary care as part of our workforce

Can we have a city wide strategy? ●

We need a local offer for adults ●

Care Campaigns - support and train

Promote positive risk takig

Flexible commissioning ●●●●

Sharing good ideas and lessons learned

We need an informed workforce ●●

Mix up the training

Break down barriers across the workforce - collaborative ●●

Lose the hierarchy

Talk more

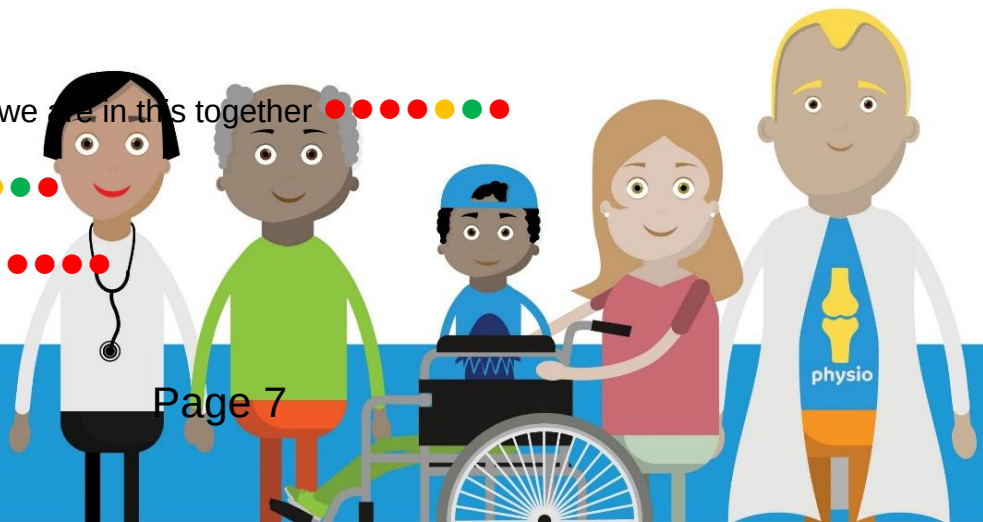
More flexibility to work together ●●●

Encourage creativity

Develop a shared culture - we are in this together ●●●●●●●

Strength based approach ●●●

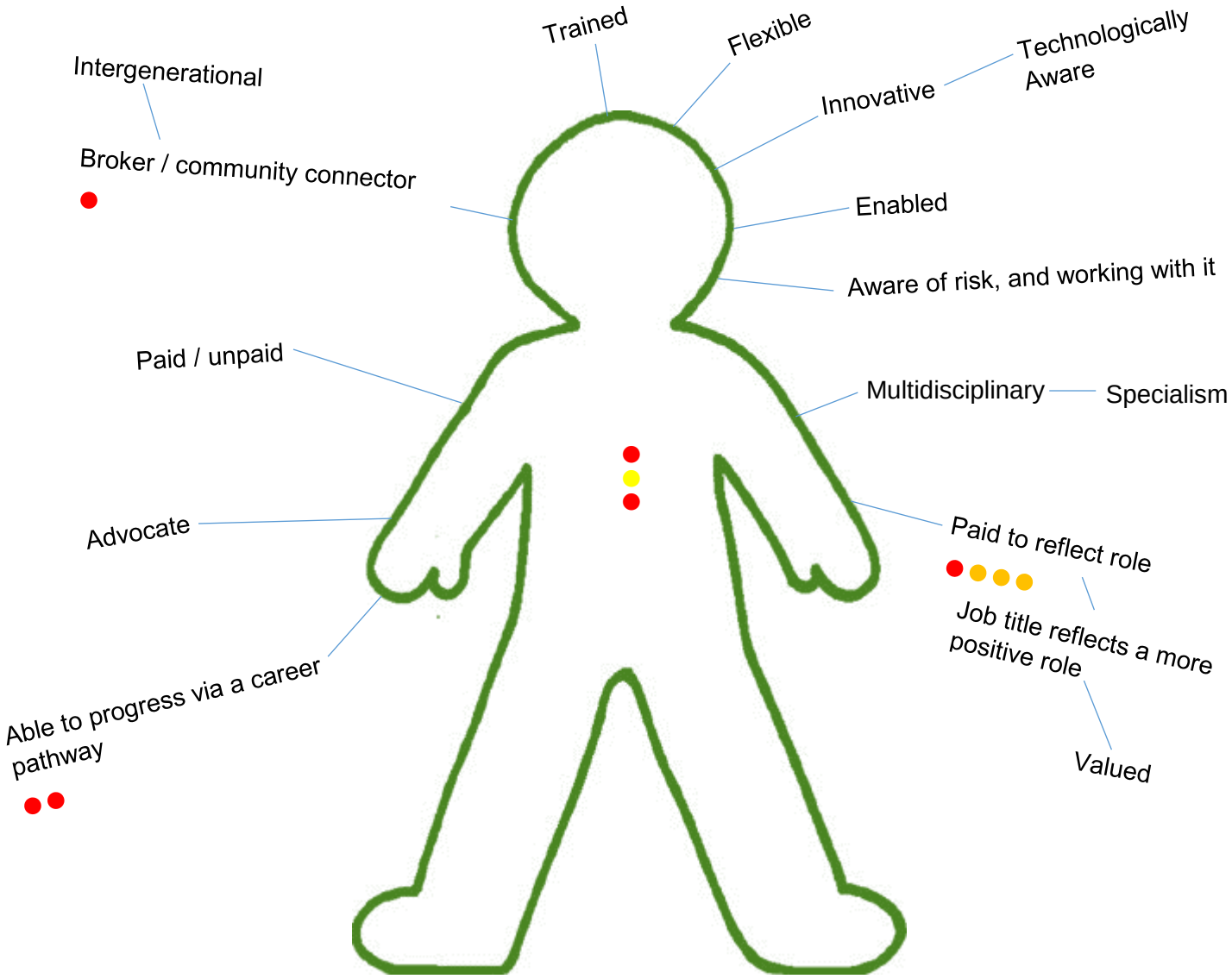
Walk in each other's shoes ●●●●



Workforce (Table 2)

The social care workforce needs to ensure that it is equipped to deliver safe and high quality services in the future

What would a future Health and Care workforce look like?



Workforce (Table 2)

The social care workforce needs to ensure that it is equipped to deliver safe and high quality services in the future

What would a future Health and Care workforce look like?

Paid ●

Voluntary but trained and supervised

Innovative

Would start with strength, asset based conversations (neighbours, family, society, interests) or a one to one volunteer? Shared interest ●●●

Intergenerational work - nursery in care home ●●

Training for volunteers who are all different (uniting them to develop training for paid staff) e.g. Minstead

Using e-communication and diaries to manage volunteers / help 'carers' e.g. Minstead ●

Able to have conversations about risk helping individuals to manage own risk ●

Need bank for volunteers and for paid care staff in the city

Given value as carers, trained and paid adequately to attract a younger workforce

Easier access to jobs / work experience for young people. Sell the role better - apprentices etc.

Personalisation (Table 3)

People will have real choice and control of their care. Information about services will be available to all regardless of whether or not they fund their own care.

How do we get staff and organisations to recognise individuals as experts?

Cross-boundary funding e.g. Portsmouth City £1 - prevents "us" from recognising individuals as experts 🔴🔴🔴🔴🟠🟡🟢

Personalisation (Table 3)

People will have real choice and control of their care. Information about services will be available to all regardless of whether or not they fund their own care.

How do we get staff and organisations to recognise individuals as experts?

Training - better facilitators - use the service user 🔴🟡🟡

Culture change required 🔴🟢

Service user-led co-production 🟡🟢🟢

Focus groups

Personalisation (Table 3)

People will have real choice and control of their care. Information about services will be available to all regardless of whether or not they fund their own care.

How do we get staff and organisations to recognise individuals as experts?

Needs to be "all" individuals, not just expert groups ●●●

Empower / create a culture for new generation of service users / individuals who believe they are "expert" and in control ●●

Culture change for individuals as well as organisations and their staff

●●●●●●●●●●●●

Personalisation (Table 3)

People will have real choice and control of their care. Information about services will be available to all regardless of whether or not they fund their own care.

How do we get staff and organisations to recognise individuals as experts?

Should we even contract and tender?

Need agile and flexible ways of working

Population based balanced against indiviudal

Personalisation (Table 4)

People will have real choice and control of their care

Information about services will be available to all regardless of whether or not they fund their own care

What are the key features of a really personalised service?

What the person needs Outcomes Goal Person is the expert	TRUST LISTENING Do not worry about taking risks	Really have real choice and control over what I need / want	What matters to the person then actually do what matters!
Res & Nursing Ensure person has access to what support they need i.e. dentist, doctor	What professionals say may not be what the person really wants. i.e. very poorly, do take dog or child for visit	Flexible responsive openness	Signposting - point in the right direction
Ensure information regarding resources is readily available	Advertise resource in the community	Educate staff about useful resources	Approach by asking what person can do not what they can't do. What help are they currently getting

Personalisation (Table 4)

People will have real choice and control of their care

Information about services will be available to all regardless of whether or not they fund their own care

What are the key features of a really personalised service?

Enabling the person to have what's important to that person	Expert Ask people what they want	Listening and trust Good communication	It's not what we think they need
Able to respond	How we meet these needs is very important E.g. time for toileting	Choice and control at an early stage	A choice of services to choose from - a varied market
Flexibility	People's lives don't happen 9 - 5	Openness to diversity	Approach by asking what person can do not what they can't do. What help are they currently getting
Access to good information	Front line staff also need to be well informed	Doesn't have to be expensive	Prevention aspect is very important

Market Development (Table 5)

Developing outcome focused services/opportunities for people; working in partnership with individuals and organisations to have vibrant and varied options for care and support

How do we stimulate the market to develop and provide new options for people?

Market:

- What formal and informal support and services are there to support people achieve their outcomes
- Prevention

Conditions

Market Development (Table 5)

Developing outcome focused services/opportunities for people; working in partnership with individuals and organisations to have vibrant and varied options for care and support

How do we stimulate the market to develop and provide new options for people?

Conditions for development ●

To have creative entrepreneurial priorities - need to create an environment where these people flourish. ●●●●●●●●●

Need accessible tendering process ●●

Value the right things about organisations ●●

Be clear what you want in terms of contracts ●●

Move away from block contracts ●

Intelligent customers SW / DPs ●

Buy good stuff and don't invest in bad stuff

Commissioning support for DPs

Partnership with providers

Market Development (Table 5)

Developing outcome focused services/opportunities for people; working in partnership with individuals and organisations to have vibrant and varied options for care and support

How do we stimulate the market to develop and provide new options for people?

Gap analysis

Learning from what works

Services around GP

Market Development (Table 5)

Developing outcome focused services/opportunities for people; working in partnership with individuals and organisations to have vibrant and varied options for care and support

How do we stimulate the market to develop and provide new options for people?

Publish care pathways → The Hive

Befriending services

Closer working relationships

Getting to know providers

Contracting, commissioning, assessing and reviewing → collaborative approach → person's voice (case studies)

Outcome

Better balance of trust

Market Development (Table 6)

Developing outcome focused services/opportunities for people; working in partnership with individuals and organisations to have vibrant and varied options for care and support

What is needed to move away from traditional service delivery and expectations?

1. Stop counting beans ●

2. Effective communication - "deaf ears" ●
    - We need to inspire people
    - Viral marketing
    - Personal experiences / recommendation
    - Word of mouth
    - Simple messages ●
    - Generationally sensitive messaging
    - Communicate positive outcomes (things have worked)

3. Create an environment: ●●●●●●●●●●●●●●●●
    - To try things
    - To allow somethings to fail
    - Trust
    - Take joint, measured risk
    - Be agile, flexible (commissioned processes are still too long and arduous)

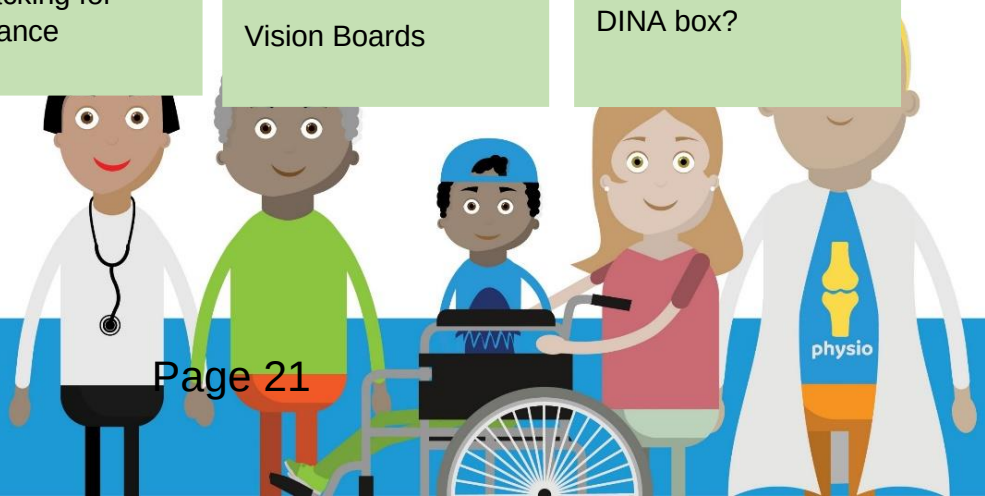
4. Overcoming tribalism
    - Collaboration e.g. Project Bridge ●

Technology (Table 7)

Technology has the ability to really transform people's lives

How do we make the best use of all available technology to support people to manage their care and support needs?

- Asking across the city - what is the problem we are trying to address together? (Partnerships) ●●●
- Knowledge gap for all staff, citizens
- Community Champions - upskilling staff
- Learning together about what is out there across health and care
- Linked tech to the right people at the right time ●
- One provider? But need to be personalised
- Get the intelligence together to identify the care offers
- Technology collaborative - group who focus on this / understand need - uni? ●●●●●●●●
- Understand the demand - commission what is common, but with some personalised options too
- Systems that should work for all systems
- Apps for phones re: anxiety management ●
- Pro Loco picture aids for stroke survivors
- I need an email address of professional who are involved in your care (health and social care) ●
- Centrikey or Key Safe Access
- Technology fair?
- Using schools and unis to help create tech solutions ●
- Technology for staff lone working e.g. alarms
- Animatronic dogs (re: loneliness) ●●
- Laptops, Skype to relieve loneliness
- Need for tech support - not just give out device
- Apps to keep family connected to their families (mobile phones) ●
- Digital screen set up with care plan to show 'what next'
- CCTV re: reassurance
- GPS tracking for reassurance
- Vision Boards
- DINA box?
- Join up with HCC to do schools and public health messages by text



Technology (Table 8)

Technology has the ability to really transform people's lives

How do we make the best use of all available technology to support people to manage their care and support needs?

1. Google Homes:
    - Can this improve emergency response time
    - Can this increase self task management
2. Skype Calls:
    - Better communication between service and the person
    - Manage risk
3. Establish our delivery mechanism ●
    - 1 team
    - In ASC, Housing, autonomous?
    - Mechanism for collaboration and sharing
4. Provision of iPads for people with apps, communications, etc. and information to underpin
5. Ensure providers have access to SystmOne, bedview, etc.
6. Choose right tech partner to develop our offer and ensure best use of available technology ●●●●●●●●●●
    - Future proofing
    - Interoperability
7. Making sure everyone is talking about technology.

    Considering at assessment and at reviews

    Don't limit offer - fit the solution to the person, not person to the solution ●●●●●●●●●●

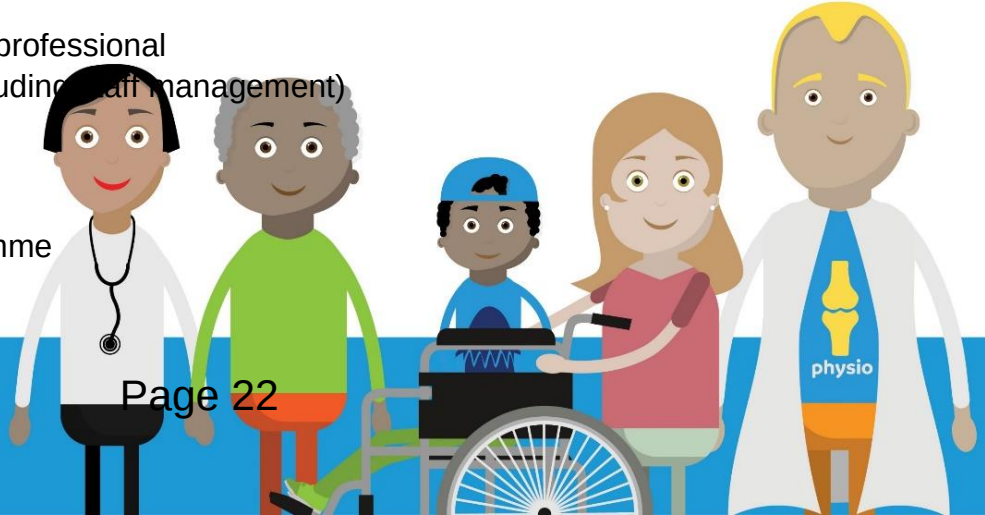
    Establish technology enabled champions to lead awareness ●●

    Ensure technology offer is council wide but also part of system level discussions

    Diagnosis of current system capability = what do our providers need? ●

    Identify 'quick wins' to generate interest. ●●

    - Practitioner / professional
    - Provider (including staff management)
    - Primary care
    - Hospital
    - Carers
    - MCP Programme



Title of Meeting:	Cabinet Member for Health, Wellbeing & Social Care Decision Meeting
Date:	19 March 2019
Subject:	Update on the Winter pressure funding for 2018/19
Report by:	Head of Business Management and Partnerships, Adult Services

1. Executive Summary

1.1 The number of patients at Portsmouth Hospital's Trust (PHT) who have been declared medically fit for discharge, but who are still in hospital, had, before the 2018 Winter Pressure Funded schemes commissioned (detailed within appendix 2), fluctuated between 200 - 250 patients (at its peak) across the Portsmouth and Southeast Hampshire health and care system. This was leading to the increase of the risk of clinical harm to patients and had a long term impact on the reablement potential of people, which in turn reduced the ability of Adult Social Care (ASC) to reduce the on-going cost of care.

1.2 Table 1 (appendix 1) provides a snapshot of the number of medically fit patients waitng to leave the acute hospital, the QA, and how many bed days were being lost for both Portsmouth and Hampshire. Table 2 (appendix 1) shows the present situation as the system now considers what is required to deliver greater performance heading into Spring 19.

1.3 These tables are only a snapshot in time. The additional tables (appendix 1) show the change in variation achieved through the winter funding that was provided. Unfortunately the data does not demonstrate a consistent reduction in the numbers of patients medically fit to leave the hospital. However, table 5 (appendix 1) shows an increase in demand for Adult Services during this period of time with the number of patients becoming medically fit increasing. This demonstrates that the funding allowed for sustained performance levels in the face of increasing demand but did fail to meet the anticipated targets the funding was predicated upon.

2 Background

2.1 Funding was sought to temporarily increase capacity within the Portsmouth Rehabilitation and Reablement Team along with extra domiciliary care capacity to deliver a further 23 care spaces within their service. This included additional social workers and therapy staff. The part year (Sept to March '19) investment requirement was £1,373,952 (Table 7) and included sustaining existing additional capacity that was already in place plus new

additional capacity being requested for winter 2018. The PCC funding element was £599,977.

3. Delivery

3.1 Key performance measures were put in place and monitored weekly. Adult Services assured itself that the additional care capacity the funding was to provide was delivered and utilised. However, there has been no overall sustained improvement seen in the QA Hospital Bed Occupancy level, which means there are people waiting within the QA to receive community support to leave, which continues to have an impact on the hospitals ability to manage its demand. This is a mixture of Adult Services and other organisations responsibilities.

3.2 However, rather than considering the winter funding as failing to address the bed gap in the QA hospital, it has enabled the Council to meet an increase in demand to support people to return and remain at home that we would not have otherwise have been able to manage whilst continuing to reduce residential and nursing placements.

3.3 The health and care system for Portsmouth and Southeast Hampshire are now being asked to put forward proposals for continuing to sustain current levels of performance and to achieve a greater reduction in numbers of medically fit patients remaining in the QA hospital as we move into the Spring 19. This will form the basis of a separate report and proposal to be considered at a later time.

4. Appendices

Appendix 1 - Winter 2018 supporting tables.

Appendix 2 - Re-ablement and Home First 201 Proposal

Background list of documents:

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	

Title of Paper:	iBCF / BCF D2A Investment Update Post Winter 2018/19
Date:	06th February 2019
Subject:	Appendix 1: Tables
Report by:	Head of Business Management and Partnerships, Adult Services

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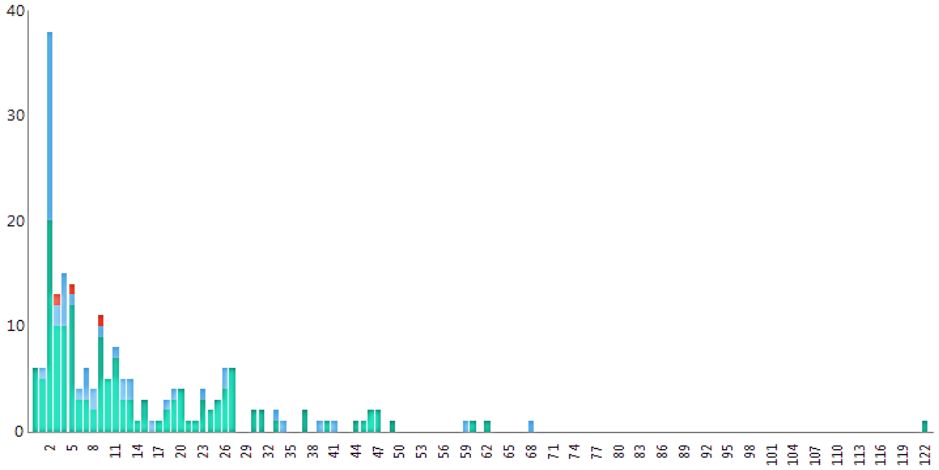
Table 1

Length of Delay since MFFD for Sun 05 Aug 2018

Current number of days since patient marked as MFFD

Date	HANTS		PORTS		OOA		Total	
	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost
Sun 05 Aug	150	2100	51	583	3	17	204	2700



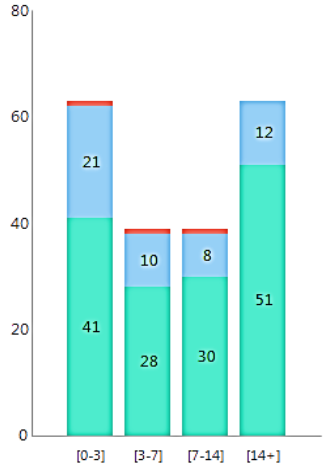
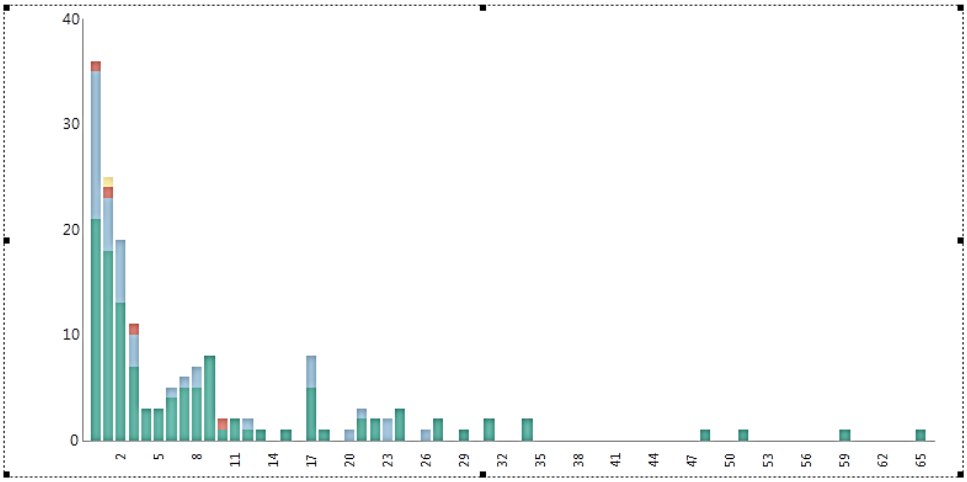


Table 2

Length of Delay since MFFD for Thu 07 Feb 2019

Current number of days since patient marked as MFFD

Date	HANTS		PORTS		OOA		No Location		Total	
	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost
Thu 07 Feb	117	1032	41	231	4	14	1	1	163	1278



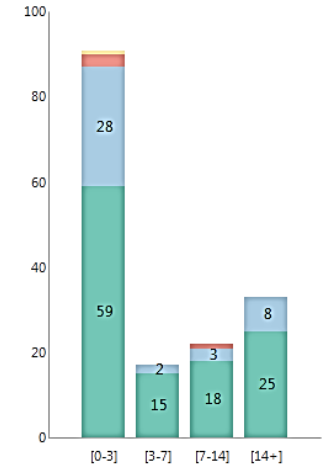


Table 3

Portsmouth Patients medically fit for discharge occupying an acute bed

The SPC graph displays the count of Portsmouth patients medically fit for discharge occupying an acute bed.

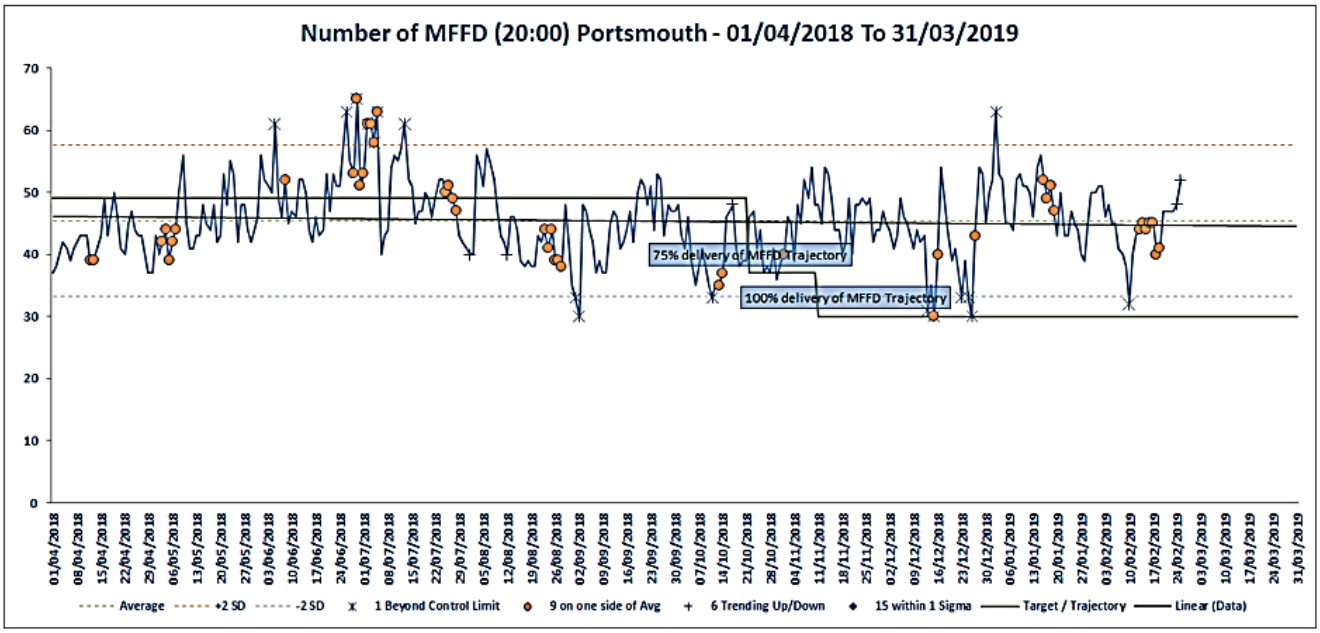


Table 4

Number of days lost post MFFD for Portsmouth patients

The SPC chart displays the number of days lost for Portsmouth patient's post being deemed MFFD. There is currently no target. Lower is better.

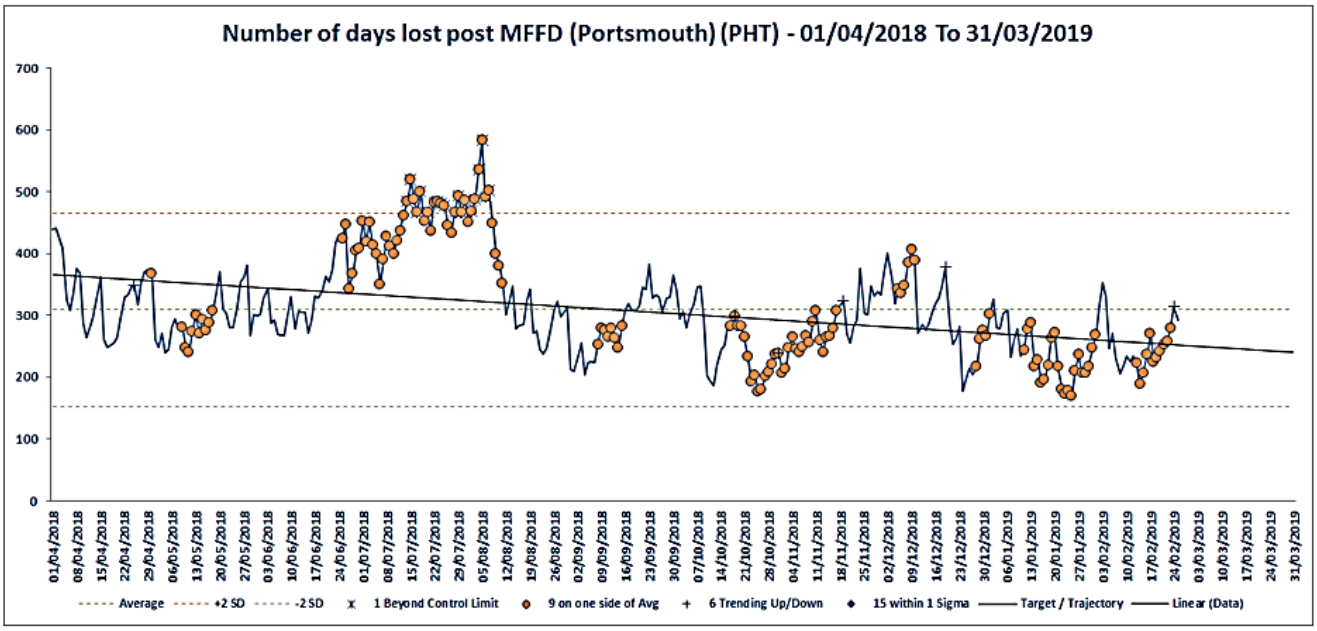


Table 5

MFFD Additions to list (rolling 7 day average)

The SPC graph displays the count of MFFD additions to the list averaged across 7 days.

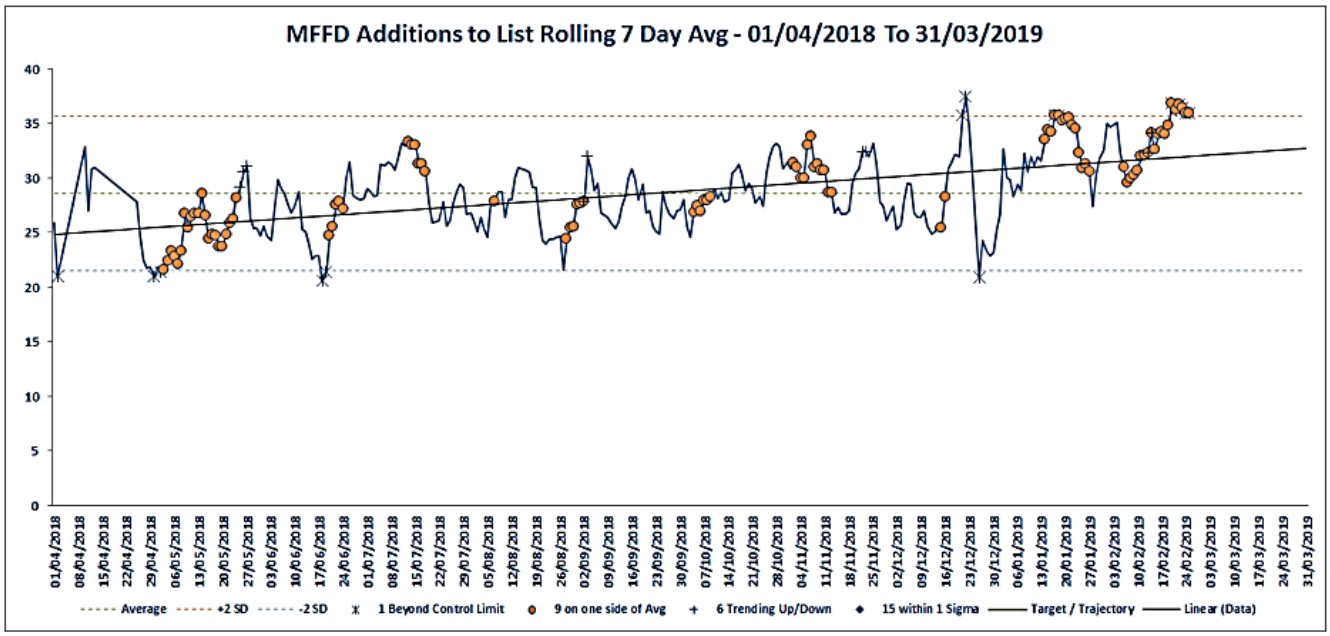


Table 6

Requirement category	PwC requirement	Impact on beds	Proposal
Pathway 1: Sustain current provision **[AginCare]**	N/A	N/A	• **350-450 care hours p.w.** through AginCare • **MFFD / Blue Team** • **Social care assessment** capacity in QA
Pathway 1: Additional provision	**19 beds**	**19 beds**	• **606 care hours p.w.** (TDS x 2, 45 min sessions) • **2.1 WTE OT/PT**
Pathway 2	**0 beds**	**0 beds**	• **0 beds**
Pathway 3	**4 beds**	**4 beds**	• **4 care home beds** delivered through transformation at Jubilee House (opportunity associated with EoL patients)
Total	**23 beds**	**23 beds**	

Table 7

Key: Yellow = Sustain, Clear = Additional

Scheme	Initial Proposal	PCC	CCG	GAP	Updated Proposal
Sustain 350 care hours p.w. through AginCare	385,749	385,749			385,749
Sustain MFFD/blue team [1]	179,133		179,133		179,133
Sustain social care assessment capacity in QA	53,333	53,333			53,333
Agincare (PCC 24 hour live in)	244,352				
Additional 606 care hours p.w. (TDS x 2, 45 min sessions)	432,250			432,250	432,250
4 care home beds delivered through transformation at Jubilee House	n/a				
PRRT to Support Agincare (Additional 2.1 WTE OT/PT to support pathway 1)	160,895	160,895			160,895
CHC Nurse B6	40,925		40,925		40,925
System Requirement for Investment - D2A Education	121,667		121,667		121,667
Sub-total	**1,618,304**	**599,977**	**341,725**	**432,250**	**1,373,952**

Notes:

1 £179k represents 7 months of MFFD to Solent (as PCC covered 5 months and total FY value £307k only)

*>> Not clear how many hours this will provide: potentially 314 hours per week (220 working days * 9.9 people * 7.5 hours a day / 12 months * 9 = 12,251 hours in 9 months / 39 weeks = 314 hours per week)* ***tbc***

2 £315k is balancing item: £494k - £179k = £315k.

>> Not clear how many hours the missing £ funding would provide: ***potentially 386 hours*** *(£315k / £494k * 606 hours = 386 hours gap)*

>> Not clear how many of the 606 hours remain unfulfilled: ***potentially 292 hours gap*** *(If Solent provide 314* ***tbc****, 606 - 314 = 292)*

Glossary:

MFFD = Medically Fit for Discharge from Portsmouth Hospital's Trust.

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Title of Paper:	iBCF / BCF D2A Investment Request
Date:	14th August 2018
Subject:	Increasing Reablement from Acute Setting on Interim Basis until Integrated Locality Teams are in Place from 1st April 2019
Report by:	Simon Nightingale - ASC Senior Business Manager

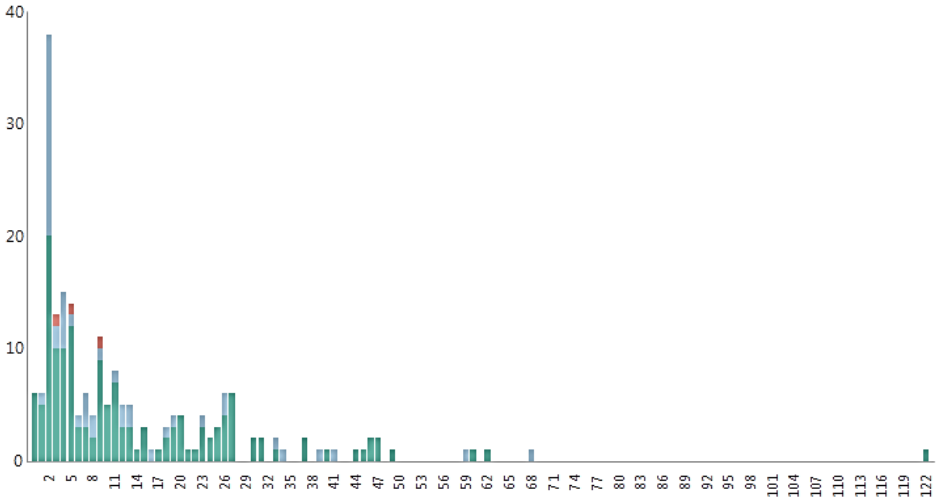
1. Executive Summary

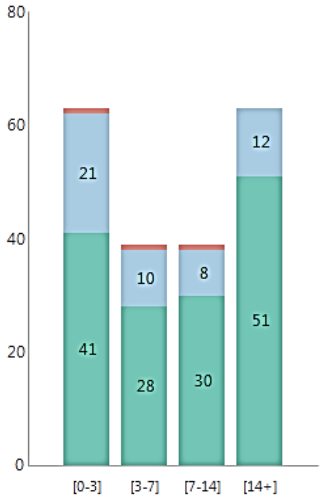
1.1 The number of patients at PHT who have been declared medically fit for discharge, but who are still in hospital – the "MFFD backlog", fluctuates between 200 - 250 patients (at its peak). There are currently over 2500 bed days being lost due to the delay in discharging people within 0 - 3 days, which is the NHS England expectation. This has the impact of increasing the risk of clinical harm to patients and has a long term impact on the reablement potential of people, which in turn reduces the ability of Adult Social Care (ASC) to manage down the on-going cost care.

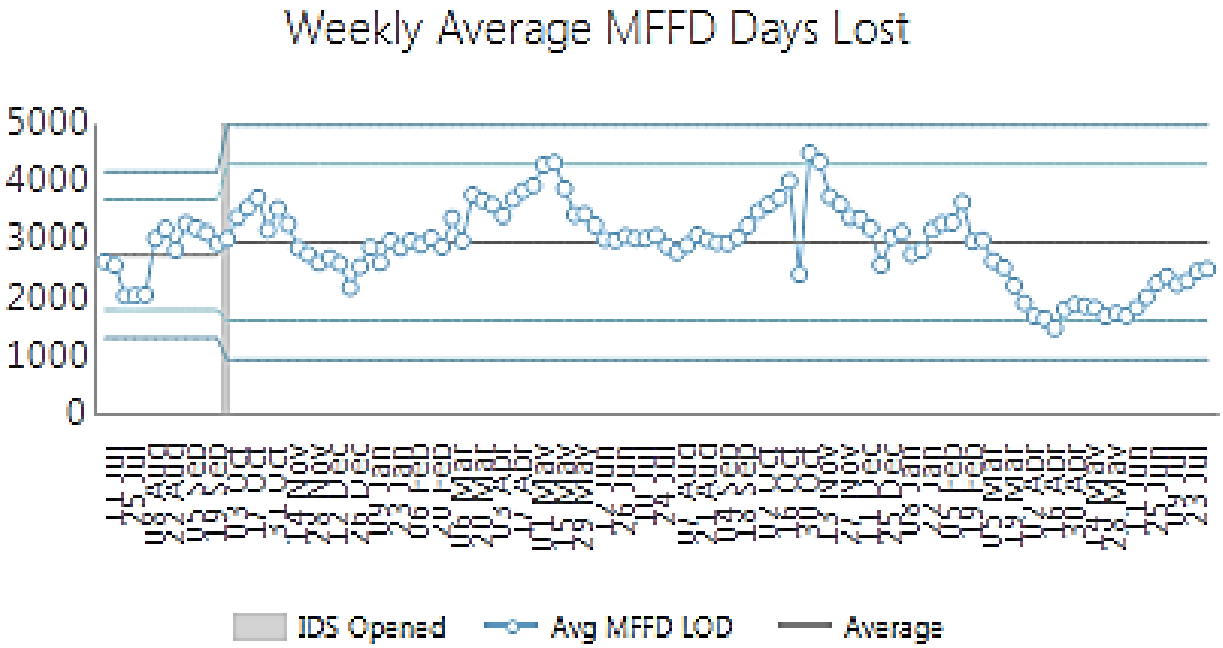
Length of Delay since MFFD for Sun 05 Aug 2018

Current number of days since patient marked as MFFD

Date	HANTS		PORTS		OOA		Total	
	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost	No. Patients	Bed Days Lost
Sun 05 Aug	150	2100	51	583	3	17	204	2700



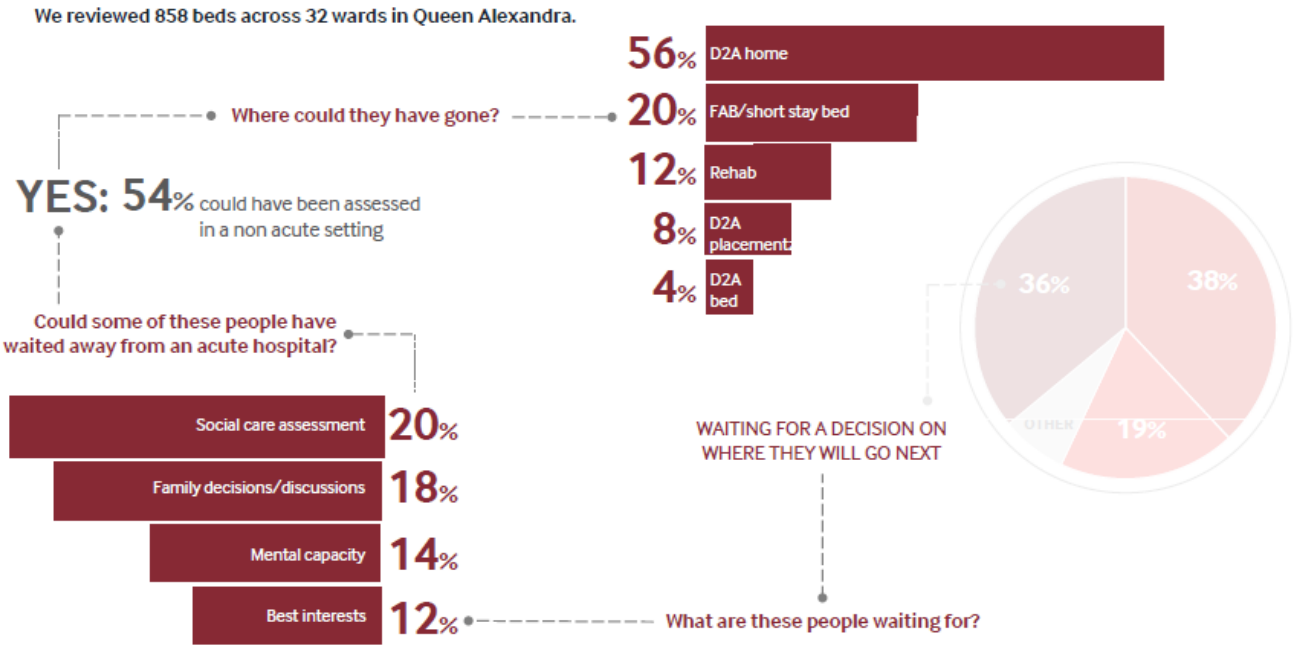




1.2 People who stay in hospital longer than necessary have poorer outcomes and experience increased rates of mortality as a result. An audit in June 2017 by PHT of 334 deaths in respiratory and medicine for older people's wards showed 8% were medically fit at some point during their stay, and 6% died in PHT whilst on an end of life fast track pathway.

1.3 This also means that there are 200 - 250 people (approx. 45 currently for Portsmouth) that not only need an improved experience in leaving the QA but also are not being supported by ASCs strategy to enable a delay to residential and nursing care and a reduction of domiciliary care package size through providing rehabilitation and re-enablement programmes of support before patients begin to deteriorate once being medically optimised and no longer needing to be in an acute care bed.

1.4 Newton Europe have worked with the health and care system in Hampshire and Portsmouth to identify the opportunities for increasing reablement for people and reducing delays to discharge:



1.5 In order to provide a social care service that meets the needs of Portsmouth residents awaiting support to leave the QA hospital, meets the Council's statutory duties within the Care Act and other relevant legislation and manage the demands of increasing needs and costs, ASC is proposing to implement an interim increase of reablement capability until our transformation work to further integrate with health in the form of integrated locality working is delivered. This supports one our ASCs key strategic shifts which is to:

1.5.1 Have a focus on 'reablement' services that aim to help people get to a level of independence, rather than 'do for' people. Ensuring that responding to people who need help is at the right time and in the right place and that we learn from experience which builds the evidence as to what works.

1.6 If ASC are able to deliver this element of ASC strategy and optimise a person's independence sooner after being in the acute then we know care costs can be reduced. This means the cost to ASC of providing care could be approx. £480k less[1] if we provide reablement opportunities once someone has been deemed as being medically fit. This is based on national research which suggests that intensive rehab/reablement intervention at the appropriate time can result in savings for ASC averaging over £1,500 annually (£29 per week) per person on the average package of care a person would require if we can discharge people in a timely manner when they no longer need the services of an acute hospital. This is based upon healthy older adults with 10 days of bed rest leading to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of aging.

[1] The basis of this figure needs to be confirmed and validated by Financial Services

1.7 Funding is therefore being sought to temporarily increase capacity within PRRT (Portsmouth Rehab and reablement Team) to deliver a further 23 care spaces within their service which will see an additional 320 people over the next 8 months (until the Integrated Locality work has been completed) receive a reablement opportunity. Funding is requested to be sourced through the iBCF and BCF: The grant conditions for the IBCF require that:

1.7.1 Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

1.7.2 A recipient local authority must: a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption; b) work with the relevant Clinical Commissioning Group and providers to meet national condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and c) provide quarterly reports as required by the Secretary of State

1.7.3 https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf

BCF National Conditions:

1.7.4 The current agreed conditions are:

1.7.4.1 National condition one: A jointly agreed plan

1.7.4.2 National condition two: NHS contribution to social care is maintained in line with inflation

1.7.4.3 National condition three: Agreement to invest in NHS-commissioned out of hospital services

1.7.4.4 National condition four Implementation of the High Impact Change Model for Managing Transfers of Care.

1.7.5 https://www.england.nhs.uk/wp-content/uploads/2017/08/bcf-planning-requirements-faqs.pdf

1.8 The exit strategy for this time limited funding is the Integrated Locality work. Once the learning has been rolled in to our community teams (from October 2018 onwards) we will begin to realise the efficiencies within our capacity and be in a position to reduce investment in existing iBCF / BCF schemes from April 2018 once the integrated way of working is fully operational.

1.9 Therefore this proposal recommends Option 1 from the **Options Appraisal** which is to increase the opportunity for reablement early in a person's discharge pathway out of the acute setting to meet the outcomes of ASCs strategy and improve the safety of patients whilst in the QA.

1.10 The part year (Sept to March '19) investment requirement is £1,738,937 (**Summary of Costs Required from PCC and CCG**). This includes sustaining existing additional capacity plus the new additional capacity being requested for winter 2018. However, there is commitment already made from the transformation (iBCF) fund for a scheme with the intention that this will shortly be moving to the PCCG for funding. This is yet to be approved by PCCG. Therefore PCC funding element would be £774,385 if current committed funding is directed to this proposal:

Funding Reconciliation:	£
No longer need transformation funding for Blue Team (3 year investment plan)	(563,944)
Replace with costs for new activity	654,895
Replace with costs to sustain existing capacity	683,434
Potential additional cost required from BCF	**774,385**

2 Background: P&SEH System Capacity Diagnostic

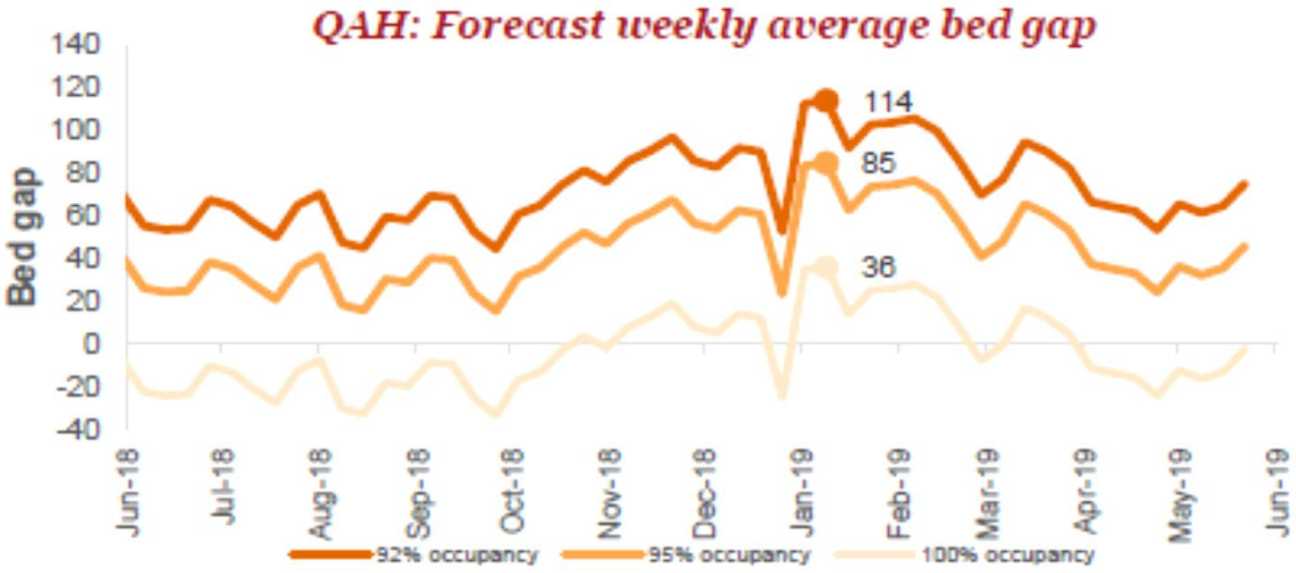
2.1 Winter 2017/18 saw the Portsmouth & South East Hampshire (P&SEH) health and care system come under extreme pressure, which manifested in a number of ways. For example, in December the number of A&E patients seen within four hours was 70% on average –at one point performance was as low as 49% at Queen Alexandra Hospital (QAH).

2.2 The national target is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The national average during this period was 85% (for all A&E types), and only two hospitals were able to hit the national target –Luton and Dunstable University Hospital and Yeovil District Hospital.

2.3 Additionally, bed occupancy at QAH averaged 97% across the winter period, well above the NHSE occupancy target of 92%. On many occasions, bed occupancy was close to, or at, 100%. Further to this there were times where half of ambulance handovers were delayed for over an hour.

2.4 Improvements have been made since winter 2017/18 on a number of key metrics related to demand and capacity across the system. For example, there has been a 27% fall in the number of patients that are medically fit for discharge (MFFD) at any one point. However, A&E 4-hour performance was 82% in May (for all A&E types), well below the England average of 90% and the target of 95%. Bed occupancy at QAH at the start of June 2018 was also high at 96%.

2.5 Despite the improvements that have been made in the system, winter 2018/19 will again be challenging for P&SEH and demand will continue to outstrip capacity. PwC forecast that there will be a peak acute bed capacity gap of 114 beds QAH in the first week of January 2019 to meet 92% bed occupancy - see below graph. Demand will also outstrip capacity for community, social care, and mental health services.



2.6 PwC modelling has shown that at no point will acute capacity be sufficient to meet 95% bed occupancy. From the start of January until March, demand for beds is expected to be in excess of 100% occupancy. Note that this is under a 'do nothing' scenario, which assumes that current measures put in place will continue to be delivered, but no further improvements will be made.

2.7 PwC analysis has identified a number of key root causes of this mismatch between capacity and demand. The report has established that the P&SEH health and care system has significantly more patients who are stranded or super-stranded than its peers. Therefore there is room for improvement with complex discharges through increasing out-of-hospital capacity and improving processes throughout the pathway.

2.8 In addition, there is a smaller opportunity associated with patient flow and effective discharge of 'simple' patients. Both PwC analysis and regional analysis conducted by NHS

Improvement (NHSI) shows that there is a clear link between bed occupancy and Emergency Department (ED) performance. Through increasing out-of-hospital capacity and through improving processes, acute beds will be freed up and consequently ED performance will be enhanced.

2.9 PwC have worked with stakeholders from across the system to develop a plan for winter 2018/19 that aims to close the capacity gap, achieve 92% bed occupancy, and achieve 90% ED 4-hour performance. This is believed to have been agreed across the system as an achievable goal, within the timeframe, and success will require full collaboration across the system and delivery at pace. The peak acute bed gap as predicted is 114 beds, however there is also a desire to convert a single ward into flexible capacity. Allowing it to be closed during summer and gradually reopened through winter. Therefore the total peak winter bed gap is 144 beds per week.

2.10 Portsmouth's proportion of the 144 beds is 23 beds with the remainder being attributed to Hampshire CC. This figure of 23 beds saved over the period relates to approximately 10 patients discharged earlier each week, each saving an average of 16 bed days in the acute hospital. If we assume that the proposal lasts a total of 8 months (from the beginning of August to the end of March), then this relates to 320 patients. Please see page 32 of the P&SEH System Capacity Diagnostic Report (**Appendices**) for further information.

2.11 Page 32 of the P&SEH System Capacity Diagnostic Report (**Appendices**) also provides detailed information regarding how the required investment for the Portsmouth Proposal has been quantified. In summary, PwC segmented the 10 patients per week into Pathways 1 (home with care), 2 (rehab or reablement) and 3 (accommodation based care). This equates to 62% on pathway 1, 19% on pathway 2 and 19% on pathway 3. These assumptions were developed based on the work carried out by Newton Europe (**Appendices**) which was similar to the capacity diagnostic work carried out by PwC. For each of these pathways, a level of daily care requirements has been assumed (see page 31 of the P&SEH System Capacity Diagnostic Report (**Appendices**)):

2.11.1 Pathway 1: 2 care hours per avoided acute/community bed day
2.11.2 Pathway 2: 1 community hospital bed day per avoided acute bed day
2.11.3 Pathway 3: 1 nursing or residential home bed day per avoided acute bed day

2.12 We also know on average how many acute bed days are avoided per patient based on PwC's long-stayer length of stay benchmarking which benchmarks patients at a HRG level - further details are on Page 83 of the P&SEH System Capacity Diagnostic Report (**Appendices**).

2.13 The daily requirement and the bed days saved translates into the care requirements (see page 33 of the P&SEH System Capacity Diagnostic Report (**Appendices**)) for Portsmouth. PwC calculated these to be 250 additional care hours per week, 0 community beds, 4 care

home beds and 53 therapy/rehab visits per week. It should be noted that this includes some inherent efficiencies assumed in other parts of the community provider sector through discharging patients earlier, which add to the care hour requirements (again see page 32 of the P&SEH System Capacity Diagnostic Report (**Appendices**)). These requirements were then converted to the requirements and investment within **Our Proposal to Increase the Opportunity for Reablement out of Hospital** based on the local operational knowledge we have.

3 Opportunities for System Improvements

3.1 PwC analysis has identified and quantified four key opportunities to focus interventions around, in order to deliver the improvements across the system:

3.1.1 90 beds to be released through improving complex discharges

This is the greatest area of opportunity in the system to help close the acute bed gap. PwC analysis of long-stay patients in comparison to peers, as well as audits conducted by Newton Europe, conclude that there is a significant opportunity to improve complex discharges (an opportunity ranging from 135 to 237 beds). Therefore a complex discharge improvement target of 90 beds is seen as achievable. The aim is to reduce the number of long-stayers at QAH by improving discharge processes and right-sizing out-of-hospital capacity. Delivering this requires maintenance of existing Agincare and Social Work support, whilst commissioning further packages of domiciliary care and community capacity.

3.1.2 20 beds to be released through improving daily flow

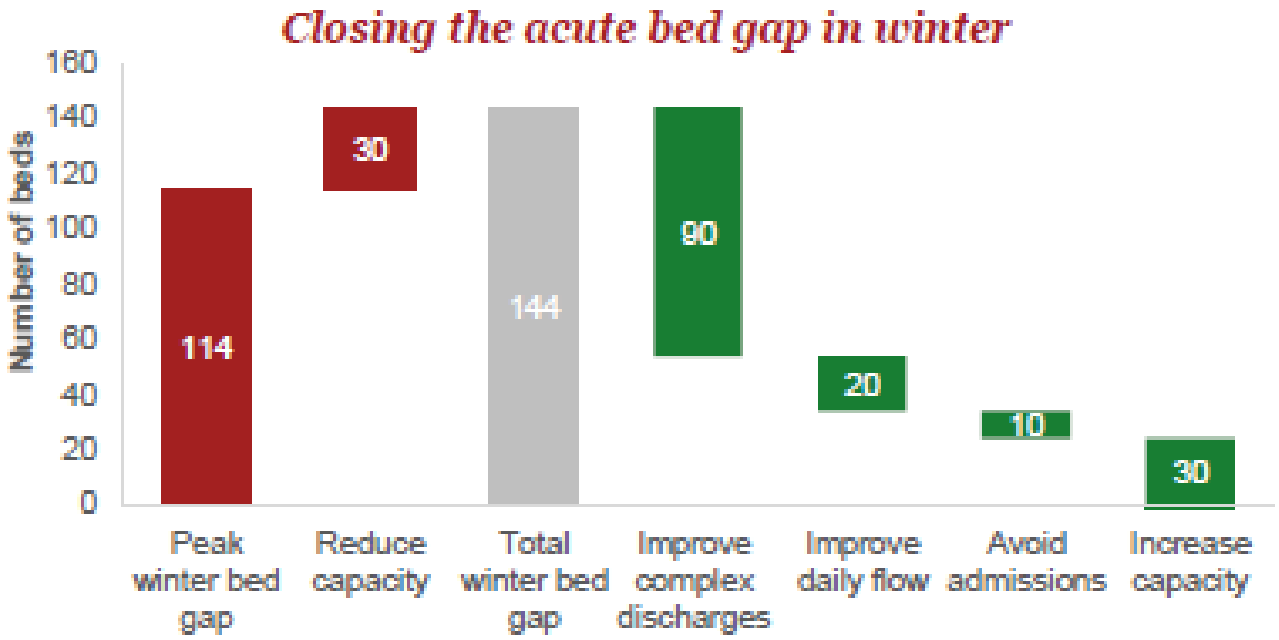
A further 20 beds could be also released by improving daily flow in the hospital to reduce the length of stay for ‘simple’ discharges, e.g. through continuing the implementation of Red2Green and SAFER.

3.1.3 10 beds to be released through avoiding admissions

10 beds could be avoided through fewer patients being admitted as an emergency through targeted interventions such as care home admission avoidance schemes.

3.1.4 30 beds to be reopened as escalation capacity through winter

During peak winter periods it has been proposed that escalation capacity will be opened so that 92% bed occupancy can still be achieved.



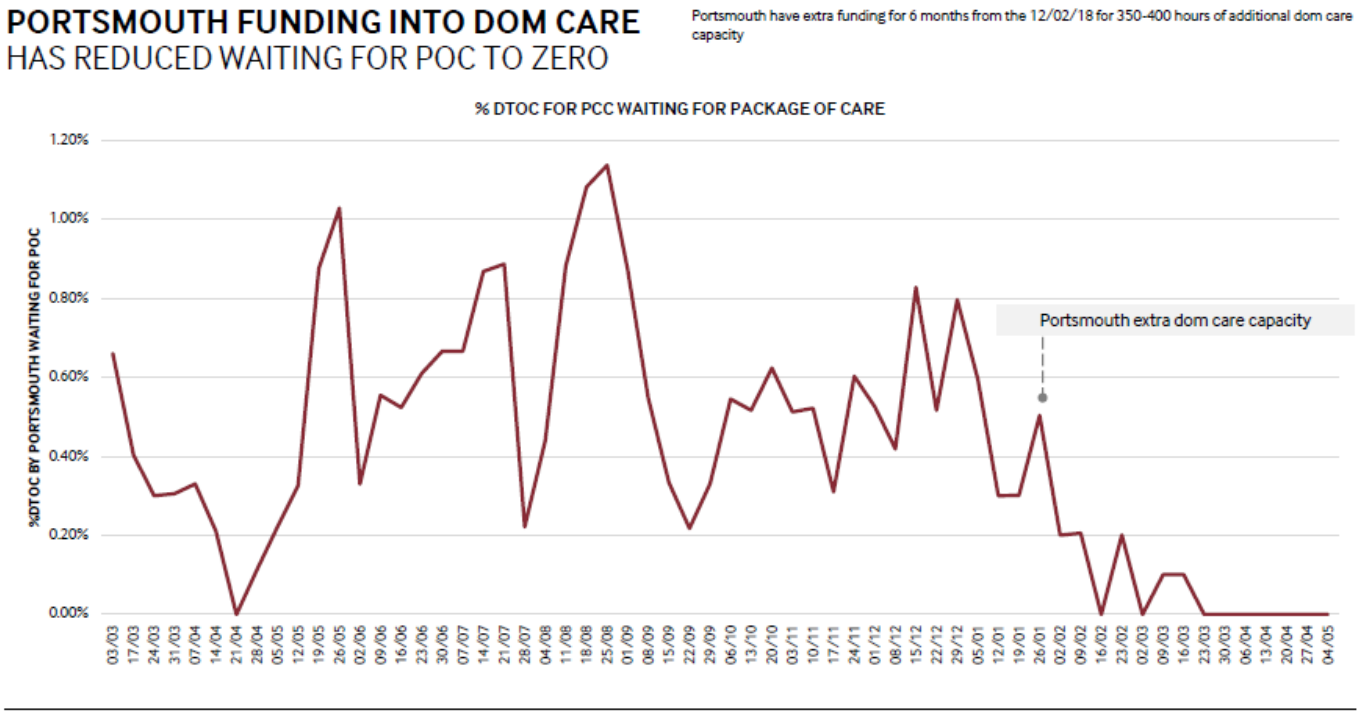
4 Our Proposal to Increase the Opportunity for Reablement out of Hospital

4.1 PWC have determined the services that patients no longer requiring acute care at QAH would have required, if they had been discharged earlier –this was done through the use of audits conducted by Newton Europe across the P&SEH system. These estimates are summarised in the table below, and have been refined further by each local sub-system (Portsmouth and Hampshire). Note that these estimates also assume a level of efficiency improvement in the community sector, as determined by bed audits which have been jointly completed.

Requirement category	PwC requirement	Impact on beds	Proposal
Pathway 1: Sustain current provision **[AginCare]**	N/A	N/A	• **350-450 care hours p.w.** through AginCare • **MFFD / Blue Team** • **Social care assessment** capacity in QA
Pathway 1: Additional provision	**19 beds**	**19 beds**	• **606 care hours p.w.** (TDS x 2, 45 min sessions) • **2.1 WTE OT/PT**
Pathway 2	**0 beds**	**0 beds**	• **0 beds**
Pathway 3	**4 beds**	**4 beds**	• **4 care home beds** delivered through transformation at Jubilee House (opportunity associated with EoL patients)
Total	**23 beds**	**23 beds**	

5 Rationale for the Portsmouth Plan

5.1 There are a number of existing schemes being funded through iBCF and BCF as well as by Solent directly linked to resolving specific blocks and barriers in the Portsmouth system linked to reducing the number of patients over 3 days being medically fit for discharge (MFFD) within the Queen Alexandra Acute Hospital (QA). Our data and feedback consistently demonstrates that the majority of these schemes are delivering much needed capacity, whilst improving outstanding outcomes for people (reduced stay in QA, able to go into re-enablement programmes sooner, return home rather than placement). For example, Solent have been funding additional domiciliary care (without confirmation of funding) which has had a dramatic result in reducing the number of people we have managed to return home without a delay:



5.2 Our solution for addressing the 2018/19 bed gap of 23 for Portsmouth is to add to this capacity in the short term whilst transforming community services through the locality intervention (integration of health and social care in the community). In addition we will need to consider repurposing some of the schemes where the evidence is not available as to their outcomes:

5.2.1 First of all sustain the existing additional capacity being provided at risk from Portsmouth City Council and Solent NHS Trust (or to continue services currently at risk from agreed funding due to end soon); and Continue with the MFFD / Blue Team funding (9.9 HCSWs) to deliver EOL pathways for CHC patients of the identified additional care hours required

5.2.2 To build upon this to go faster and deliver more capacity to reduce MFFD and meet the bed gap identified by PwC by 'pulling' patients out into community resource; and

5.2.3 Recruit capacity to enable CHC checklist and DSTs to be completed within the community once optimisation of the person's re-enablement and rehabilitation has been reached.

5.3 This proposal covers the period to March 2019 whilst the integrated localities intervention with Solent and PCC achieves the learning required to reconfigure services. This intervention will, through designing a patient pathway that reduces waste, eliminate the need for the additionality going forward and therefore funding will be not required post March 19.

5.4 The rationale for the additional capacity being that we need to cover the peak periods in demand over winter whilst transforming our locality offer to sustainably reduce long term demand for our health and care services in Portsmouth. Once roll in of the integrated localities commences, we will start to identify which schemes and resources need to be decommissioned and reallocated according to the learning.

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec 18	Jan-19	Feb-19	Mar-19
2018 Bed Gap Reduction through redesigned Rehab Community Front Door									
Enhancing CIS									
Integrated Localities Intervention									
Integrated Localities Roll in (South Pilot)									
Integrated Localities Roll in (Central & North)									
Decommissioning in line with Learning									

5.5 Sustainability in reduction of demand once the specific funding for the winter proposal comes to an end will be though the implementation of the integrated locality way of working. This is not only central to our BCF plan and Portsmouth City Health and Care Blueprint, it is also a key enabler of Portsmouth's emerging Social Care strategy in terms of the fundamental change to the front door of Adult Social Care.

5.6 There is a risk, although low at this stage, that if the integrated locality teams do not deliver the expected capacity by April 19 then the impact of this investment may not sustain the throughput into our reablement services, or put another way, not meet ASC demand. We will establish a robust set of measures and governance arrangements to monitor this proposal in-line with the roll in of the integrated locality teams.

6 The Community Front Door Service

6.1 The decision to decommission Agin Care 24/7 care has been supported and further work on the flexibility within the 606 hours will be developed within the enhanced model with Agin Care.

6.2 The Blue Team will continue to provide choice for end of life care patients who wish to receive care at home to support the system to enable patients that are deemed to be end of life for discharge from acute care to be discharged in a timely and safe manner.

- Blue Team will continue to develop enhanced pathways for EOL choice

6.3 The Blue team will be monitored with a developing set of KPI's through the CHC PMG, there will be a review on the system impact in line with the closing the GAP.

6.4 The service will be coordinated from an embedded location; enabling daily prioritisation, continuous collaboration and fluid exchange of outcome data. Service priorities will be determined by PRRT.

6.5 The principles of the service:

- PRRT will in-reach into the acute and 'pull' patients when MFFD
- High impact and needs led workforce solution
- Will deliver a reduction in MFFD numbers in the system ahead of winter and sustain at a reduced level
- Delivers the Home First principle
- Multidisciplinary solution
- Improved outcomes and well-being for people
- Optimising independent living and reducing the risk of de-compensating
- Increased independence through intensive wraparound therapies and re-enablement support services, use of assistive technologies and use of community support networks and services.
- Net system savings and efficiencies
- Blue Team will continue to develop enhanced pathways for EOL choice

7 Review and Monitoring

7.1 We already have a Project Management Group Established between NHS Solent and Portsmouth City Council that monitors the performance of PRRT and this structure would also be responsible for the oversight for delivering the additional capacity that will lead to a reduction of 23 acute beds in preparation for the winter.

7.2 In addition to the local monitoring, the Health and Care System at a local delivery level will also be monitoring the achievement of delivery and use of the resources. The measures and KPIs can be seen in the **Appendices** but as an example include the following:

7.3 The Blue team will be monitored with a developing set of KPI's through the CHC PMG, there will be a review on the system impact in line with the closing the GAP.

KPIs	Unit	Frequency	Source	Baseline	Target
600 hours per week of additional care hours in place (Additionality)	Hours	Weekly	Solent (Agincare	0	600
Additional 20 care spaces (above average baseline of 85) on PRRT caseload (Additionality)	Number of Patients	Weekly	Solent	85	105
350 hours per week of additional care hours in place (Sustaining what is already in place)	Hours	Weekly	Solent (Agincare	350	350
Bed Occupancy Jubilee House.	%	Weekly	Solent	91%	95%
Actual Number additional care hours provided	Hours	Weekly	HCC	TBC	200
Increased Number of DC across 7 days into Hampshire services.	Number of DC	Weekly	SHFT/HCC/SUS	TBC	30
Number of combined Therapy/Rehab visits per week.	Number of Contacts	Weekly	HCC/SHFT	TBC	130
Evidence of increased % of people with personalised care plans and involvment of goal setting.	%	Weekly	My well being plan/RIO	TBC	90%

8 Summary of Costs Required from PCC and CCG

8.1 The figures below highlight the existing additional capacity brought on line during 2017/18 MFFD project and winter pressures which were not stood down (in yellow). These items of spend are at risk of ending this calendar year if we cannot secure on-going funding. This is due to the financial pressure both Portsmouth organisations are under in meeting our City wide commitments. The figures also include the additional resource being requested to achieve the increase in additional reablement throughput.

8.2 Due to the pressure referred to in 8.1, we have subsequently adjusted the proposal submitted to PwC and the System. The proposal was for an investment of **£1.7m**:

8.2.1 One scheme (Agincare 24 hour £0.2m) is not recommended to continue, which along with further slippage in other schemes brings the total investment request down to **£ 1.4m**.

8.2.2 Funding sources have been proposed to cover £1.0m of this, leaving a **worst case** funding gap of **£0.4m**:

- Total PCC contribution £0.6m
- Total CCG contribution £0.4m
- Worst case gap £0.4m

8.2.3 The table below suggests using Solent to cover some of the 606 hours gap, rather than using Agincare

8.2.4 In summary, this approach requires an additional £0.16m from the ASC Transformation Fund (and a repurposing of already committed MFFD funds).

Key: Yellow = Sustain, Clear = Additional

Scheme	Initial Proposal	PCC	CCG	GAP	Updated Proposal
Sustain 350 care hours p.w. through AginCare	385,749	385,749			385,749
Sustain MFFD/blue team [1]	179,133		179,133		179,133
Sustain social care assessment capacity in QA	53,333	53,333			53,333
Agincare (PCC 24 hour live in)	244,352				
Additional 606 care hours p.w. (TDS x 2, 45 min sessions)	432,250			432,250	432,250
4 care home beds delivered through transformation at Jubilee House	n/a				
PRRT to Support Agincare (Additional 2.1 WTE OT/PT to support pathway 1)	160,895	160,895			160,895
CHC Nurse B6	40,925		40,925		40,925
System Requirement for Investment - D2A Education	121,667		121,667		121,667
Sub-total	**1,618,304**	**599,977**	**341,725**	**432,250**	**1,373,952**

Notes:

1 £179k represents 7 months of MFFD to Solent (as PCC covered 5 months and total FY value £307k only)

*>> Not clear how many hours this will provide: potentially 314 hours per week (220 working days * 9.9 people * 7.5 hours a day / 12 months * 9 = 12,251 hours in 9 months / 39 weeks = 314 hours per week)* ***tbc***

2 £315k is balancing item: £494k - £179k = £315k.

>> Not clear how many hours the missing £ funding would provide: ***potentially 386 hours*** *(£315k / £494k * 606 hours = 386 hours gap)*

>> Not clear how many of the 606 hours remain unfulfilled: ***potentially 292 hours gap*** *(If Solent provide 314* ***tbc****, 606 - 314 = 292)*

8.3 In addition to the extra reablement capacity being sought from this interim request, there are a number of existing schemes, both core and existing additionality, which are being funded through iBCF / BCF funding. The details of which can be seen within the **Appendices**. Work is on-going, under the BCF PMG, to review the impact of these

schemes and whether we decommission those not deemed to be delivering. This is also linked to the Integrated Locality Teams development as that will inevitably lead to resources being redeployed into localities or no longer needed due to efficiencies being made.

8.4 Assumptions

8.4.1 Average Fit to Leave to Leave the Acute number for Portsmouth is 45
8.4.2 The 'ask' from the System is to reduce by 15 to 30 Fit to Leave by end September 2018 and keep at that level over winter '18.
8.4.3 The focus is on 'P1' - i.e. patients that are in the 'assessment' category' as we know that this cohort makes up ~ 50% of Fit to Leave cohort and of those 65% will return home; this is the principle underpinning the D2A Improvement Programme.
8.4.4 In terms of additionality – PwC assume a QDS x1 requirement, however people with this level of need are more likely to already be with PRRT whilst those referred to ASC are more likely to have higher care requirements therefore we have based our plans on an average TDS x2 (same principle we used in EoL in 2017).
8.4.5 If we apply the same thinking to our bed base then we would expect to create efficiencies that will deliver the + 4 P2 requirement.
8.4.6 We do need to think about improvements to P3.
8.4.7 Total additionality then = 19 care spaces described as follows:

	PWC Assumptions	D2A Assumptions
Total Additionality	18	19
Care requirements per week	256 (Assumes QDS x1)	606 (Assumes TDS x2)
Therapy Requirements	12/52 therapy F2F (equivalent 0.1 wte AFC Band 5)	See table below
Provider options	18 additional care spaces PRRT (23%uplift in resource) Or 256 additional care hours and 2.1 wte PT or OT	19 additional care spaces PRRT (24%uplift in resource Or 606 additional care hours and 2.1 wte PT or OT

8.5 Additional Capacity Breakdown of the PRRT Element

PRRT Additional Support Required to Manage the Additional Agincare Capacity		Revised Budget	Current Hours	Current FTE	Current FTE
Independence Support Assistant		16,980	22		1
Occupational Therapist		7,840	7		2
Rehabilitation & Reablement Assistant (Higher Grade)		38,960	43		2
Social Worker		24,400	22		1
Physio Therapist (b5)		50,632	37.5		1
Nurse (b5)		101,263	75.0		2
Total Staffing		**240,075**	**408**		**11**
Apprenticeship Levy		**1,268**			
Total		**241,343**			

9 Options Appraisal

Option 1 -To increase reablement support to enable earlier discharge from the acute and increase throughput of reablement services.
The additional funding being requested (not sustained elements) equates to £2,831 per person per intervention. This is felt to provide the best balance of value for money (assuming £1500 saving in annual care costs) as it seeks to reable people sooner to prevent the opportunity for further deterioration whilst in hospital thereby reducing long term care costs for ASC.

Option 2 - Sustain existing level of performance
Another option is to reduce the re-enablement element of the proposal but this will not lead to savings as we would then only be providing care with no consideration of reducing the size of the care package. We could also reduce the proposal to just sustain existing schemes that seek to reable people being discharged from the QA. However, this similar to doing nothing as we know that we will see a repeat of last winter's pressures leading to patients being at risk in the QA and people in the community being at risk through reduction of ambulances whilst delaying handovers at QA. Furthermore we will not be able to re-able more people in order to support them to remain independent at home which is a fundamental part of ASCs strategy to become sustainable.

Option 3 - Relocate people awaiting discharge into a care home whilst awaiting onward assessment or service.
A third option would be to locate 23 private sector or local authority beds and transfer patients into a transitional arrangement. This is not a preferred option as this will not be expected to be in the best interests of individuals, based on our experience, as patients are reluctant to move more than once and it may do more harm than good to the person. ASC strategy is to reduce use of residential care and through our experience we know that short term placements to facilitate discharge become long term placements unless increased therapy and social work is provided to manage individual's reablement programme and support the home. We also do not have the available accessible capacity within Portsmouth to be able to deliver this option.

Option 4 - Do nothing
Finally we have the option of doing nothing. We know that by doing nothing we will see a repeat of last winter's pressures leading to patients being at risk in the QA and people in the community being at risk through reduction of ambulances whilst delaying handovers at QA. Furthermore we will not be able to re-able more people in order to support them to remain independent at home which is a fundamental part of ASCs strategy to become sustainable.

10 Appendices

Background list of documents:

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	
PwC PSEH System Chiefs Meeting Report	PSEH System Chiefs Meeting - 20180718.
PwC PSEH Urgent and Emergency Care delivery Board Report	P&SEH A&E Delivery Board - 201
PwC PSEH System Capacity Diagnostic Report	P&SEH - System Capacity Diagnostic
Newton PSEH System Capacity Diagnostic Report	Newton PSEH System Capacity Dia
Implementation Plan, Risks and Issues Log	Closing The Gap Implementation Plar
Summary of Schemes - Core, Existing Additional Capacity and Winter 2018 Additional Capacity proposal (Inc. continuation of existing schemes)	Copy of BCF Discharge support v
Balanced Score Card Measures	Copy of Balanced Scorecard Portsmou

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