Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 28 JUNE 2023 AT 10.00 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL, PORTSMOUTH

Telephone enquiries to Anna Martyn Tel 023 9283 4870
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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Public health guidance for staff and the public due to Winter coughs, colds and viruses, including Covid-19

- Following the government announcement 'Living with Covid-19' made on 21 February 2022 and the end of universal free testing from 1 April 2022, attendees are no longer required to undertake any asymptomatic/ lateral flow test within 48 hours of the meeting; however, we still encourage attendees to follow the public health precautions we have followed over the last two years to protect themselves and others including vaccination and taking a lateral flow test should they wish.
- We strongly recommend that attendees should be double vaccinated and have received any boosters they are eligible for.
- If unwell we encourage you not to attend the meeting but to stay at home. Updated government guidance from 1 April 2022 advises people with a respiratory infection, a high temperature and who feel unwell, to stay at home and avoid contact with other people, until they feel well enough to resume normal activities and they no longer have a high temperature. From 1 April 2022, anyone with a positive Covid-19 test result is still being advised to follow this guidance for five days, which is the period when you are most infectious.
- We encourage all attendees to wear a face covering while moving around crowded areas of the Guildhall.
- Although not a legal requirement, attendees are strongly encouraged to keep a social distance and take opportunities to prevent the spread of infection by following the 'hands, face, space' and 'catch it, kill it, bin it' advice that protects us from coughs, colds and winter viruses, including Covid-19.
- Hand sanitiser is provided at the entrance and throughout the Guildhall. All attendees are encouraged to make use of hand sanitiser on entry to the Guildhall.
- Those not participating in the meeting and wish to view proceedings are encouraged to do so remotely via the livestream link.

Health and Wellbeing Board Members
Councillors Lewis Gosling, Graham Heaney, Suzy Horton, Steve Pitt and Matthew Winnington (Joint Chair)

Dr Linda Collie (Joint Chair), Helen Atkinson, Roger Batterbury, Sarah Beattie, Andy Biddle, Sarah Daly, Penny Emerit, Prof Anita Franklin, David Goosey, James Hill, Maggie MacIsaac, Paul Markham, Kirsty Ranford, Lorna Reavley, Paul Riddell, Dianne Sherlock, Alasdair Snell, David Williams and Jo York

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

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

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 interest**

3. **Minutes of previous meeting held on 15 February 2023** (Pages 5 - 12)

   RECOMMENDED that the minutes of the meeting held on 15 February 2023 be approved as a correct record.

4. **Integrated Care Board - Joint Forward Plan** (Pages 13 - 52)

   To update the committee on the requirements for the Integrated Care Board to publish a Joint Forward plan (JFP) by June 2023.

   RECOMMENDED that the Health & Wellbeing Board
   1. **Receive the report and support the approach to the development of the Joint Forward Plan.**
   2. **Note the work in progress to develop the Joint Forward Plan.**

5. **Health & Care Portsmouth Project Fusion update** (Pages 53 - 58)

   To provide a progress update on Project Fusion.

6. **Better Care Fund update** (Pages 59 - 132)

   To update the Health and Wellbeing Board on the Better Care Fund Returns for 2022/23 and 2023-25.

RECOMMENDED that the Health & Wellbeing Board

1. The Health and Wellbeing Board is requested to ratify the submitted Better Care Fund End of Year Return 2022/23 v1.3.
2. The Health and Wellbeing Board is requested to approve the draft Better Care Fund Narrative before submission to national NHS England Better Care Fund Team on 28 June 2023.
3. The Health and Wellbeing Board is requested to approve the draft Better Care Fund Planning Template 2023/25 before submission to national NHS England Better Care Fund Team on 28 June 2023.

7. Pharmaceutical Needs Assessment (Pages 133 - 140)

To set out the responses to the statutory consultation on the draft PNA (revised, 2023) and to set out options for the HWB to consider in response.

Recommended that the Health & Wellbeing Board:

1. Considers the consultation responses in section 4 and appendix A;
2. Decides which of the options (A and B) set out in section 5.1 and 5.2 to pursue with option B being recommended;
3. if option B is chosen, decide whether to agree the proposal regarding Supplementary Statements set out in section 5.4.

8. Community Safety Plan 2022-23 - Progress report (Pages 141 - 154)

1. To update members of the Board on the progress towards addressing the priorities in the Community Safety Plan 2021-22 and;
2. Subject to the findings of the annual community safety analysis, that will identify any new or emerging priorities in November 2023, to recommend the current priorities are rolled forward.
3. To note that the findings from the strategic assessment (SA) 2023-24, due in November 2024, will be used to develop a new community safety plan for Portsmouth, alongside other related plans as explained below.

9. Developing a Violence Against Women and Girls Strategy (Pages 155 - 174)

To update the Health and Wellbeing Board (HWB) on work to review existing plans in respect of Violence Against Women and Girls (VAWG) and request that the HWB approve the development of a VAWG Strategy, building upon work to date, focusing on strengthening existing arrangements, closing gaps, and maximising impact.

Recommended that members of the Health and Wellbeing Board approve the development of a city-wide VAWG Strategy.

10. Health & Wellbeing Strategy - Housing priority

Report to follow

11. Stroke Recovery Service (Pages 175 - 180)

To provide an update on the decision to withdraw from recommissioning the Stroke Information and Support Service, commonly known as the Stroke Recovery Service.

12. Dates of meetings for 2024

To confirm the dates of future meetings (all Wednesdays at 10 am) as 6 March, 26 June, 25 September and 27 November 2024.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

Whilst every effort is made to webcast this meeting, should technical or other difficulties occur, the meeting will continue without being webcast via the Council's website.

Agenda Item 3

MINUTES OF THE MEETING of the Health and Wellbeing Board on Wednesday, 15 February 2023 at 10.00 am in the Guildhall, Portsmouth

Present

Councillor Matthew Winnington (Joint Chair, in the Chair)

Councillor Yinka Adeniran
Councillor Lewis Gosling
Councillor Suzy Horton
Councillor Gerald Vernon-Jackson

Councillor Scott Payter-Harris (deputation)

Andy Biddle, Director of Adult Care, PCC
Helen Atkinson, Director of Public Health, PCC
Roger Batterbury, Healthwatch Portsmouth
Simon Cooper, Health & Care Portsmouth
Hayden Ginns, Commissioning & Partnerships, Education
David Goosey, Portsmouth Safeguarding Adults Board
Paul Markham, Hampshire Constabulary
Councillor Terry Norton, in capacity as Deputy Police & Crime Commissioner
Kirsty Ranford, City of Portsmouth College
Lorna Reavley, The Hive
Dianne Sherlock, Age UK
David Williams, Chief Executive, PCC
Jo York, Health & Care Portsmouth

Officers present
Matt Gummerson, Alan Knobel, Charlie Pericleous, Mike Stoneman, Andrea Wright

1. Chair's introduction and apologies for absence (AI 1)

Councillor Winnington, Cabinet Member for Health, Wellbeing & Social Care, opened the meeting. All present introduced themselves.

Apologies for absence were received from Councillor Brian Madgwick, Dr Linda Collie, Clinical Lead/ Clinical Executive (GP) Health & Care Portsmouth, Hampshire and Isle of Wight Integrated Care Board, Sarah Beattie (National Probation Service), Sarah Daly (Portsmouth City Council, represented by Hayden Ginns), Penny Emerit (Portsmouth Hospitals University Trust), Professor Anita Franklin (University of Portsmouth), James Hill (Portsmouth City Council), Kelly Nash (Portsmouth City Council), Paul Riddell (Hampshire Fire & Rescue Service) and Suzannah Rosenberg (Solent NHS Trust).

2. Declarations of Interests (AI 2)

There were no declarations of interest.

3. Minutes of previous meeting - 23 November 2022 (AI 3)

RESOLVED that the minutes of the Health and Wellbeing Board held on 23 November 2023 be approved as a correct record.

4. Portsmouth Safeguarding Adults Board (PSAB) update

David Goosey, PSAB Independent Chair, introduced the annual 2021-2022 report, explaining that in the light of the Covid pandemic it was more practical to place the voice of service users, especially those who are not usually heard, at the heart of the PSAB's work on the strategy. There was a focus this year on homelessness and alcohol and drugs misuse; key training had been delivered to several PSAB member organisations. Two Safeguarding Adults Reviews were published which showed it was still critical to champion service users' voices. Mr Goosey hoped to report on much more significant progress next year. Funding would be very helpful. He sought the HWB's continued support and scrutiny and asked them to hold the PSAB to account.

Dianne Sherlock commended the report's honesty and transparency; it was an emotional read. Mr Goosey said the PSAB's safeguarding work included individuals, groups and organisations like Age UK, who held an enormous amount of information about people, butt was here still much work to be done.

Andy Biddle agreed it was important to have a level of accountability and scrutiny for strategic bodies. A safeguarding peer review in 2021-2022 was carried out in a spirit of inquiry but had said funding was an issue in Portsmouth so it was struggling in terms of the resources that can be allocated compared with other PSABs, which limited what could be achieved. David Williams supported Mr Goosey's determination to ensure voices of lived experience are heard, which was an important challenge for everyone. Jo York noted that although Portsmouth prided itself on partnership working the case studies in the report showed the outcome could be "horrendous" when it did not work. She asked if organisations were working with frontline teams to understand professional curiosity. Mr Goosey said the PSAB was keen to work with frontline practitioners and also at different levels in the system, including leadership. The integration of services in Portsmouth is a promising set of activities but it had the slight downside of privileging cohesion of agencies over other voices. Partnership working was sometimes discordant and generates conflict but sometimes conflict was a "best friend."

Councillor Norton explained the police emphasised the 18 to 24 age group as it was a key developmental stage when young people transitioned from school to adulthood. Habits such as drug taking were a particular threat at this stage. He asked how other organisations treated that stage and what could be done to share good practice. Mr Goosey agreed it was a key stage; last year the PSAB had developed a new transition policy for young people, which other areas had requested. Some young people, for example, those with significant disabilities, were served well whereas others that society did not regard the same way, such as those with problems with school or the police, not so well. There was sometimes a lack of wraparound support when people approached 18 so attitudes may have to change and resources shifted.

The Chair thanked Mr Goosey and his team for the report. Safeguarding was everyone's business so if someone had concerns they needed to act on them. All 42 Portsmouth councillors had a responsibility to take the lead in their communities though it had sometimes been a struggle to encourage them to complete safeguarding training. The HWB's member organisations could all do their part. He also noted that the transition stage arises consistently.

RESOLVED that the Health and Wellbeing Board note the content of the annual report.

5. Preventing Violent Extremism Strategy

Charlie Pericleous, Prevent Co-ordinator, introduced the report and said officers were seeking external funding as the EU Interreg Orpheus funding had ended in December 2022. Andy Biddle noted Prevent was fundamental to keeping the city safe. Officers were discussing how to get more permanent funding. He was not entirely sure what the independent review would result in but officers were looking to see if they could use existing internal resources. There were residual grants but the results would not be known until next month at the earliest. The Home Office had acknowledged the strength of Portsmouth's Prevent work. In response to a query from Councillor Vernon-Jackson, officers could try accessing the UK Shared Prosperity Fund. Councillor Vernon-Jackson suggested writing to Penny Mordaunt MP to ask if the government were adhering to their promise to replace EU funding.

Mr Pericleous said there was a legacy aspect to Project Orpheus such as shared training products and as part of the "2 Seas" project had engagement with cities in Belgium, France and the Netherlands such as Calais that had similar characteristics to Portsmouth. David Williams said although extremism did not currently have such a high media profile it was important not to deplete resources and attention and let work slip. Officers should press for opportunities to fund the soft and sharper sides of Prevent work with city-wide partners such as the police and the University. Mr Pericleous said Portsmouth was cautious to deliver sensitively when addressing the Islamist risk and not target particular communities. The Chair agreed all types of extremism should be tackled, not just particular ones, and thanked officers for the report.

RESOLVED that the Health and Wellbeing Board support the continuation of Prevent delivery at current levels to meet the local authorities' statutory obligations under Section 26 of the Counter Terrorism and Security Act 2015.

6. Pharmaceutical Needs Assessment 2023 and wider pharmacy issues

Councillor Scott Payter-Harris read out a deputation from Councillor Daniel Wemyss and then made his own deputation. Deputations are not minuted but can be viewed on the council's website here

Agenda for Health and Wellbeing Board on Wednesday, 15th February, 2023, 10.00 am Portsmouth City Council

Matt Gummerson, Head of Strategic Intelligence and Research, introduced the report and outlined the proposed streamlined process for agreeing responses to consolidations and closures. In response to the deputations objecting to the proposed closures of pharmacies in the north of Portsmouth, he said the HWB would object to them and that if they did close, another provider could open in the area. The PNA had been published in October 2022 but had to be revised because of the consolidation of the Elm Grove and Osborne Road pharmacies, with the HWB now wanting to identify a gap in provision. The revised PNA would return to the Board for approval in June after consultation with specified organisations. Only those sections necessary to identify gaps would be updated. Further closures and consolidations would be likely to create additional gaps but officers would issue a supplementary statement rather than revise the PNA. New pharmacies would not be prevented from opening in those circumstances. Where there were clusters of pharmacies, such as in Cosham High Street, objections would be unlikely as if one closed it would not create a gap.

Councillor Horton had objected strongly to the consolidation of the Elm Grove and Osborne Road pharmacies because of the human element. Getting medication for relatives was time-consuming and frustrating and had removed their independence (though the situation had now improved with a new pharmacy). Consolidating the period of time for responding to gaps would help.

Councillor Gosling asked what the HWB was doing to facilitate more use of pharmacists as prescribers as the Integrated Care Board (ICB) had the power to launch a trial. Simon Cooper said expressions of interest for prescribers would be received by the end of February, not specifically for community pharmacists, but prescribing from pharmacies. The Local Pharmacy Committee and the ICB were supportive of Portsmouth being a pilot. There was funding for seven specialist pharmacists to work as prescribers across all GP practices had been agreed with the caveat they had to work within their competencies and that the initiative would gradually evolve.

Councillor Vernon-Jackson was concerned about the proposed closures in Drayton and Farlington and there should be no more. He proposed an additional recommendation to the report that the HWB should actively work with local pharmacy providers to fill gaps in provision. Portsmouth was lucky to have local providers which many other areas did not. Pharmacies were closing as they were becoming uneconomic. The budget granted to pharmacies in 2017/2018 did not allow for inflation and was now about three-quarters of its real value in 2017. The cuts in government funding since then were the root cause of the problem.

Jo York explained that the ICB had assumed responsibility from NHS England for pharmacy, optometry and dentistry in July 2022, which was positive as the ICB could understand the local impact. The ICB needed to understand the national pharmacy contract and figures could be given to the HWB if requested. All contracts were currently being reviewed at a national level so the ICB needed to influence upwards as well supporting close working with local pharmacies to get the best service for residents.

Simon Cooper, Director of Primary Care & Medicines Optimisation, (himself a pharmacist), gave a presentation on community pharmacy services. There might be more rationalisation with the workforce spread more thinly; community pharmacy is not always seen as exciting. From 2026 all newly qualified pharmacists will also be qualified prescribers. In response to questions, he said Lloyds had offered their pharmacies for sale and were open to approaches in case other providers wanted to take them on; it was not known if the online services were included. Employment rates were skyrocketing so employing locums was less viable. Use of distance and online pharmacies had increased and they accounted for the increased number of prescriptions. They were good for repeat prescriptions but people could not get advice from them. Elderly people (especially over 80) were the highest users but it was more likely to be adult children registering on their behalf. Age UK was not surprised at the age range of online pharmacy users as their youngest client was 42 and they were looking to work with people in their 20s and 30s.

Jo York mentioned the unintended consequences of online pharmacies which had resulted in lower growth of high street pharmacies. Organisations needed to recognise the challenges and opportunities and think not just about strategy but operational issues. Local challenges were deprivation and the impact of the cost of living crisis. It should be noted pharmacies were all independent businesses. In the past there were inherent perverse incentives, for example, the way flu vaccinations were managed, but issues had to be resolved so they could play a role in the primary care system.

Members agreed pharmacies could play a greater role than just issuing prescriptions, which could be seen as positive as they could help to address challenges associated with deprivation. They noted the most vulnerable residents used community pharmacies, for example, for substance misuse support and stopping smoking. Pharmacies were a first port of call during Covid. Mr Cooper said historically pharmacies were commissioned to provide prescriptions but this historic reliance was now outdated and no longer fit for purpose. Pharmacies had offered many other non-commissioned services and organisations needed to consider how they maintained the viability of pharmacies.

Members thought being able to prescribe would have a big impact on GPs and might make pharmacy a more popular career if it offered more autonomy. They thought most community pharmacies could close in the next ten years if they uneconomic as they were not charities. However, they kept people out of primary care so closures would increase pressure on acute services. The model would probably change significantly with either substantial subsidies or the NHS providing pharmacies directly. Major changes would be problematic in a city with low levels of functional literacy.

The Chair thanked officers for the report and Mr Cooper for his presentation. Cutting face-to-face services had a detrimental impact on people and in the absence of private sector provision local organisations had to make the most of resources.

RESOLVED that the Health and Wellbeing Board

1. **Approve the proposed changes in section 4 that will form part of revised PNA 2023.**
2. **Agree that the draft PNA can be signed off for consultation by the joint-chairs of the HWB by 1st March 2023.**
3. **Agree that the HWB response to future consolidation applications can be approved by the joint chairs of the HWB as part of a revised process set out in section 6.**
4. **Actively work with local pharmacy providers to fill gaps in provision.**

7. Health & Wellbeing Strategy - Education

Mike Stoneman, Deputy Director, Education, gave a presentation on progress on the three priorities within the strategy for education ie support for families in pregnancy, developing a culture of aspiration, and attendance. Mr Stoneman provided some context and confirmed that the majority of schools (70%) were now part of a Multi Academy Trust (MAT) who were responsible for raising standards in those schools. Mr Stoneman said that Portsmouth has been allocated £1.8m as a Priority Investment Education (PIE) Area to focus on literacy, maths and attendance. Maths has been added as a ninth priority to the Education Strategy. Although reading results had improved others had decreased and the gap with national had widened for most performance measures. Increased secondary school absence, mainly due to Covid, was a concern. Mr Stoneman highlighted a range of work and initiatives that have been implemented to address the three priorities in the strategy. This included:

- **Supporting families in pregnancy and the early years to give children the best start** - successful bid to the DfE for the Start for Life/Family Hub Investment Programme to develop the universal Family Hub Network offer, with a significant focus on the first 1001 days.
- **Raising aspirations**: Aspirations Week, National Apprenticeship Week, Careers and Enterprise Show, the Youth Hub, SEND Employability and Enterprise Forum.
- **School attendance**: Relational Practice in schools, multi-agency approach to addressing severe absence (below 50%), LA Link Co-ordinators, support for neuro-diverse children in schools, mental health support teams, refresh of the school attendance campaign.

Mr Stoneman concluded with an ask of all agencies and services to support improvements to school attendance and that it was everyone's business to lean into this and to have those conversations with families and children to reinforce the importance of school attendance.

Councillor Norton welcomed the support for families and mental health, as the latter often put unwanted pressure on the police. However, attainment was not improving despite strategy after strategy and reassurances it would recover after Covid. Much is due to behaviour in schools. Councillor Norton felt that relational practice was effectively an in-house way of managing behaviour but despite leading to fewer exclusions attainment had yet to improve. However,

there was some work to be done with the police and it was recognised that more schools were requesting police engagement.

Mr Stoneman did not disagree. Attendance was inextricably linked to attainment. Being a PEIA with a focus on literacy, maths, attendance and underperforming groups has put the spotlight on Portsmouth to raise standards but the funding is welcome. Councillor Horton said schools were judged on exam results (though attainment could not always be measured by league tables) and agreed it was a conundrum why Portsmouth was not doing as well as similar areas, despite most schools being judged by Ofsted as Good or better. Covid should not be used as an excuse but it would have had a disproportionate impact on disadvantaged families as home schooling would have been much more difficult. Attendance was key and everyone needed to work collectively on why a child was not in school. Mental health help was a vehicle to support families. Lifting the aspirations of our families and children was an important part of the strategy. As an example, Trafalgar School combined Live Well events with a parents' evening. The city had the right values to resolve its complex issues and the Board was the best platform to do so. Jo York agreed and asked if HWB members, as some of Portsmouth's biggest employers, were doing enough to sell their career opportunities. Mr Stoneman said health and care had some representation but more could always be done; he offered to put Jo York in touch with people. In addition, anyone was welcome to give feedback on Aspirations Week.

The Chair said from his own experiences as a school governor and family's experience as a teacher he knew the efforts schools made to get children to attend. Covid had a big impact as it broke routines. He thanked officers for the work they were doing which he recognised as a long process.

RESOLVED that the Health and Wellbeing Board note the report.

8. Combatting Drugs Partnership Needs Assessment and Plan

Alan Knobel, Public Health Principal, introduced the report, noting that the Plan could be adapted to meet priorities. He said there were about 500 people with substitute prescribing who used community pharmacies to access medication so fewer pharmacies would be a struggle. The Board thought it was an incredible report.

RESOLVED that the Health and Wellbeing Board

1. **The Health and Wellbeing Board note the substance misuse needs assessment.**
2. **The Health and Wellbeing Board approve the Substance Misuse Plan for Portsmouth 2023-2026.**

9. Superzone update

The Board agreed to consider the Superzone update at its meeting on 28 June as there was not enough time to consider it at today's meeting. It was also going to the Cabinet on 7 March.

RESOLVED that the Health and Wellbeing Board consider the update at its next meeting.

The next meeting is on Wednesday 28 June at 10 am.

Remaining meetings in 2023 are 27 September and 29 November (both Wednesdays at 10 am).

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Councillor Matt Winnington and Dr Linda Collie (Chair)

Portsmouth CITY COUNCIL

Title of meeting:	Health & Wellbeing Board
Subject:	Integrated care Board Joint Forward Plan update
Date of meeting:	28th June 2023
Report by:	Sarah Reese – Director of Strategic Planning
Wards affected:	All

Purpose of this Report

1. This paper aims to update the committee on the requirements for the Integrated Care Board to publish a Joint Forward plan (JFP) by June 2023

Recommendation(s)

That the Health and Wellbeing Board:

2. Receive the report and support the approach to the development of the joint forward plan

3. Note the work in progress to develop the joint forward plan

Executive Summary

4. Hampshire and Isle of Wight Integrated Care Board is working with NHS and system partners to develop a system-wide, multi-year 'joint forward plan' that addresses the underlying factors driving its financial and operational pressures.

5. To ensure that system plans, priorities and programmes will effectively deliver against the challenges faced, a joined up and systematic approach to the planning process has been undertaken to:

- Identify the drivers of our current pressures
- Articulate priority areas for transformation, quantify their impact and initiate the programmes
- Shape a system approach to accountability and management of risk and quality impact

- Outline how the ICB and partners will deliver against the ambitions set out in the Integrated Care Strategy

Approach to planning and transformation

6. The ICB is required to publish a joint forward plan by the end of June 2023. In Hampshire and Isle of Wight the 2023/24 operating plan forms year one of the joint forward plan.

7. There is no formal requirement for a submission to NHS England, as the joint forward plan is a requirement of the Department of Health and Social Care. However, the ICB fully expects to share our final plan with NHS England. Work is ongoing to develop the plan across ICB and Trust teams, and with wider partners.

8. In the short term the focus is on 'system reset', recovering activity levels, staffing and spend to pre pandemic levels, including through enhanced grip and control and priority transformation programmes focused on urgent care, local care, discharge and elective care.

9. Transformation is required to support the reset, and will continue impact positively in the medium term as the benefits of working together as an integrated care system are realised, developing new care models, maximising capacity and reducing unwarranted variation.

10. Ultimately, in the longer term, the aim of the work focussing on the priorities identified in the Integrated care Strategy is to improve the health, happiness, wealth and wellbeing of the local population. In doing so the system will:

- Tackle health inequalities
- Reduce the demand for health and care services
- Further improve the quality of services provided
- Relieve pressure on the people who work in our organisations
- Be able to live within our financial means on a sustainable footing

11. Four transformation programmes are core to the 23/24 plans with further impact projected into years two and three. The redesign and delivery of new models of care for urgent and emergency care, local care, discharge and elective care will support the rebalancing of how and where services are delivered, focussing on preventative and proactive care as well as timely access in a setting appropriate to need.

12. Areas of opportunity with regards to productivity and efficiency through collaboration and partnership working have also been identified and will be further developed as the recovery process progresses. These will also feature in the joint forward plan document.

13. Alongside the transformation programmes described above the Joint Forward Plan will set out the detail of how the ICB will deliver the five Integrated Care Strategy

priorities of children and young people, proactive care, mental wellbeing, workforce and digital. The system wide working groups for these priorities are still developing but the ICB will be working closely with local authorities as well as voluntary and community organisations to shape the plans.

14. The transformation programmes described above combined with the delivery of priorities within the interim integrated care strategy and the development of new ways of working require a two to three year timeline to achieve full impact. Bringing these together into the joint forward plan will provide a clear, quantified and aligned system recovery plan against which delivery and impact can be monitored.

Next steps

15. Working with partners throughout June the ICB will:

- Fully establish the programmes and programme architecture to deliver transformed models of care and monitor their impact.
- Finalise a system accountability framework and risk and quality management approach.
- Deliver a quantified recovery and transformation plan as the core content of the five-year joint forward plan, which has been codeveloped and widely tested, refined and supported including through Health and Wellbeing Boards.

Sarah Reese – ICB Director of Strategic Planning……
Signed by (Director)

Appendices:

Guidance on developing the Joint Forward plan Dec 2022

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NHS
Hampshire and Isle of Wight




Hampshire and Isle of Wight - Forward Plan

DRAFT V3.0 for circulation to ICB Board 7 June 2023

Introduction

Building a better future together

The Hampshire and Isle of Wight integrated care system is committed to improving the health, happiness, wealth and wellbeing of the population. Building on our strong track record of working together as partners and with local people, we look to the future with great optimism. We are united in our work with people and communities, creating a society in which every individual can thrive throughout the course of their life, from birth to old age. Our mission is to deal with the pressures and challenges of today, seize opportunities and together build a better future.

We are focused on the following aims for our integrated care system. In doing so we will reduce the demand for health and care services, further improve the quality of service we provide, relieve pressure on the people who work in our organisations and be able to live within our financial means.

Our joint forward plan is set in the context of an increasingly difficult operating environment for all partner organisations. Overall, our population is ageing and living with increasing frailty and multiple health needs, and some of our communities are amongst the most deprived in the country. Our system has recovered relatively well in operational service delivery terms following the pandemic but is significantly financially challenged.

The scale of the challenge faced by the system requires a multi year recovery focus, which not only addresses core aspects of the drivers of the deficit, but also addresses long standing issues which have resulted in fragmented and inconsistent pathways of care, resulting in inequity for our patient population.

Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This plan, alongside our partnership strategy, is a living document. It will continue to iterate as we evolve and embed new joint working arrangements and make progress together. Our strategy and plan is not about simply doing more, it is about taking a radically different approach, and always improving services.

Our two-phase plan

Resetting the system: Our focus in 2023/24, is on 'system reset', recovering activity levels, staffing and spend to pre pandemic levels, including through enhanced grip and control and priority transformation programmes focused on urgent care, local care, discharge and elective care, with NHS and wider partners at system and through local delivery. This reset and transformational work will enable us to eliminate our system deficit by the end of 2024/25 and continue to impact positively in the longer term as we realise the benefits of working together as an integrated care system, developing new care models, maximising capacity and reducing unwarranted variation.

Renewed focus on population health and wellbeing: Alongside our system reset, our renewed focus on population health and wellbeing will deliver impact through prevention and health promotion in years 1-3 and ultimately, in the longer term, improve the health, happiness, wealth and wellbeing of the local population; thus reducing the need for health and care services.

The population we serve

The Hampshire and Isle of Wight integrated care system is the 10th largest of the 42 systems across England. Our four places – Hampshire, Portsmouth, Southampton and Isle of Wight - are the foundation of our system.

Overall, our population is ageing and living with increasing frailty and multiple health needs, especially in rural areas, particularly west Hampshire and the Isle of Wight. In urban areas such as Southampton, Portsmouth, and north-east Hampshire, the population is more ethnically diverse compared to the rest of the area (overall 93.8% white). There are also higher levels of deprivation and mental health vulnerability in these areas. The age of people living on the Isle of Wight is similar to other places popular with retirees, but more people live alone. We also have coastal communities; 92.7% of the Island's population are resident in areas defined as coastal. These areas have lower life expectancy and higher rates of many diseases.

Healthy life expectancy has decreased in most areas, meaning people are living more of their lives in poor health. This is particularly the case for people living in the most deprived areas. Smoking, poor diet, physical inactivity, obesity and harmful alcohol use remain leading health risks, resulting in preventable ill health. In Hampshire and Isle of Wight we see:

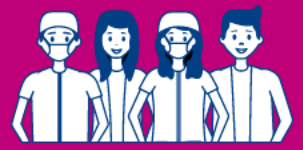
- Higher levels of emergency care compared to the rest of England, especially in more deprived areas, where access to primary care, outpatient and planned care are lower.
- Deaths from cancer, circulatory and respiratory diseases are the greatest causes of the differences in life expectancy between the most and least deprived. More deprived areas see higher levels of heart disease, diabetes, chronic obstructive pulmonary disease and mental health issues. People living in these areas are also more likely to experience not just one, but multiple ongoing health conditions.
- A boy born in our most deprived areas will live on average between 6.1 years to 9.1 years less compared to a boy born in our least deprived area, and for a girl, between 2.3 years to 5.5 years less.
- Covid-19 has created additional health and social care needs and disproportionately impacted people living in more deprived areas, people with learning disabilities, older people, men, some ethnic minority groups, people living in densely populated areas, people working in certain occupations and people with existing conditions.
- Premature mortality in people with severe mental illness is higher than the national average on the Isle of Wight, Southampton and Portsmouth.

Alongside our work as a whole system partnership, various partners will continue to work together to do all they can to meet the health and care needs of local people in increasingly effective ways. This includes:

- Partnerships in each of our places, e.g., Hampshire, Southampton, Isle of Wight, Portsmouth and at neighbourhood level;
- Partnerships working with people with very specific needs, for example around housing;
- Collaboration within 'sectors', e.g.: primary care, acute hospital trusts and the voluntary and community organisations.

Hampshire and Isle of Wight

77,500



NHS AND SOCIAL CARE STAFF

3 ACUTE HOSPITAL TRUSTS

4 HEALTHWATCH PARTNERS

SERVING A POPULATION OF

1.9 MILLION

WHO WE ARE:

- 139 GP practices
- Over 200 optometry services
- 42 primary care networks
- Over 200 providers of dental services
- Over 900 suppliers of domiciliary care
- 2 community and mental health trusts
- Over 300 pharmacies

AN ALLIANCE OF VOLUNTARY AND COMMUNITY ORGANISATIONS WORKING IN PARTNERSHIP

ANNUAL BUDGET:
£3.8 BILLION

OVER 19,300
BIRTHS ANNUALLY

1
AMBULANCE SERVICE

1
ONE INTEGRATED TRUST PROVIDING ACUTE, MENTAL HEALTH, COMMUNITY AND AMBULANCE SERVICES

4
UPPER TIER LOCAL AUTHORITIES:

AND 10 DISTRICT AND BOROUGH COUNCILS

Tackling health inequalities

Our Public Health Directors and their teams, have been central to our work as a system in understanding and addressing health inequalities common across our geography and specific to our local places, neighbourhoods and communities. Our Prevention and Inequalities Board provides strategic leadership in ensuring we maximise health and wellbeing through the prevention of ill-health and the reduction in health inequalities, by working together as a system and with communities. Tackling inequalities features as a core pillar across the breadth of our joint forward plan priorities. Through the work of our Inequalities Board, we bring together clinical, managerial and public health leadership to focus on defined priorities, provide leadership for the development and implementation of the prevention and inequalities elements of the Integrated Care Strategy and joint forward plan to ensure our system wide work and plans align with place-based plans such as Health and Wellbeing Boards and place-based partnerships.

Our system wide **work programmes** include use of the Core20plus5 framework to reduce healthcare inequalities and leadership for the five high impact actions to reduce health inequalities:

1. strengthening leadership and accountability
2. restoring elective services inclusively
3. mitigating digital exclusion
4. improving data recording with a focus on ethnicity
5. accelerating prevention

Our Prevention and Inequalities Board has agreed the **plus priority adult populations** for Hampshire and Isle of Wight:

1.People experiencing homelessness
2.Minority ethnic communities most affected by Covid-19
3.People with a learning disability
4.People with a Serious Mental Illness
5. Asylum seekers, refugees and unaccompanied minors

Our Prevention and Inequalities Board has also agreed the **plus priority children and young people's populations** for Hampshire and Isle of Wight:

1. Looked after children and children leaving care
2. Children experiencing homelessness
3. Children in gypsy and traveler communities
4. Children of adults in the Core20plus5 groups

In relation to Core20plus5, core delivery programmes are in place to reduce inequalities in access, experience and outcomes for our plus populations including those experiencing homelessness, those with a serious mental illness and asylum seekers and refugees .This includes the Health Begins at Home programme, work on intermediate care via a specialist homelessness in reach service into Portsmouth Hospitals Trust, a mental health transformation "step out of housing" model, trauma informed specialist outreach, work to build on the 'Everyone In' initiative and a Minding The Gap programme. For those with Serious Mental Illness there is an Advancing Mental Health Equalities programme which oversees the delivery plan covering areas such as No Wrong Door, co-occuring conditions work and a new aligned model of support aligned to primary care networks building on the voices of people with serious mental illness. Through this programme there has been a continued improvement in the number of people with serious mental illness receiving a physical health check. There is also an Afghan Mental Health Project which aims to better understand the mental health needs of Afghan refugees living in hotels in Hampshire. There is also a Core20plus5 Community Connectors programme which is bringing forward the voice of lived experience into service redesign and an innovative health hub model which has provided a wide range of health services to communities including those from the more deprived areas in non-traditional settings.

We are working with local communities to understand what is most important to them

NHS
Hampshire and Isle of Wight

In developing this plan, we have reflected on insight from our local communities, which partners across the partnership have sought in a number of ways. We considered the below in creating our strategic priorities.

What we did

- Surveys on a range of topics, online and face to face, in clinical and community settings, with many directly targeted to different local communities
- Co-design groups, workshops and events on topics such as our community involvement approach, digital transformation and the development of the new integrated care partnership
- Attended local community events, both in person and virtually
- Discussed issues at regular integrated care board and other groups with representatives from across communities
- Focus groups on a range of topics
- Funding partners such as Healthwatch and community groups to undertake targeted research
- Engagement programmes to support procurement and transformation plans

What we heard

- People want more join up between different services, from GPs to hospitals to social care; education and housing too
- People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them
- Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography
- Whilst people say digital technology has its benefits, it is important to ensure that no-one is left behind. Face to face appointments are still highly valued
- Cost of living is a concern across the system. Also people see opportunities to improve and expand the health and care workforce including use of volunteers
- Other issues weigh on people too. For example, in rural areas, equipment and plant theft are big concerns. In urban areas people are concerned with protecting their homes and property
- Travel for Access patients need services to be accessible; having them nearer to home, access to good transport links, including public transport.
- Carers and young carers support, and greater collaboration with schools, primary care and other health services is vital

Financial context

The NHS in Hampshire and Isle of Wight receives £3.8bn for the health and care of its population, equating to approximately £2,000 per head of population. This is a relatively high level of funding per head of population compared to the rest of the country; however, in the context of increasing demand for services and rising costs, we will continue to see a challenged financial environment.

Nationally and in our system, local authorities are facing financial pressures in adult and children's social care, public health and the broader services that impact health and wellbeing outcomes. At the same time the health and care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector.

All NHS organisations have a statutory duty to break even. In 2022/23, the Hampshire and Isle of Wight system reported a deficit.

Over 2023/24 and 2024/25 we will 'reset' our financial position, to return to a balanced breakeven position.

[Placeholder for chart of trajectory to breakeven]

We are on a journey to return to a sustainable and balanced financial position, over the coming years, which will require achievement of the joint aims set out in this plan, to transform and reshape our services to meet the needs of our population and live within our means.

The scale of the challenge faced by the system requires a multi year recovery focus, which not only addresses core aspects of the drivers of the deficit, but also addresses long standing issues which have resulted in fragmented and inconsistent pathways of care, resulting in inequity for our patient population.

Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This plan, alongside our partnership strategy, is not about simply doing more, it is about taking a radically different approach.

Longer term financial strategy

Following our return to financial balance, our collective transformation will continue over the following 3-5 years, to develop a stable, sustainable and affordable model of care.

With our partners, we will review and reshape our total investment in health and care to increase the proportion of spending in primary, community and mental health care, to better prevent and manage healthcare needs and reduce growth in demand for the most expensive hospital and specialist services.

We will achieve this by:

- Supporting the capacity and stability of primary care, pharmacy, optometry and dental services across Hampshire and the Isle of Wight to ensure people can access the right care when they need it.
- Commissioning to actively reduce health inequalities across our populations.
- Work with our local authority partners and the wider Integrated Care Partnership to ensure our collective resources are keeping people safe, well and healthy, including through using section 75 arrangements to further integrate services.
- Working together to carefully prioritise capital investment in Hampshire and the Isle of Wight, to achieve our strategic goals, unlock transformation, and support better healthcare.
- Developing our business intelligence and strategic commissioning capability, so we can analyse and review spending in new ways to align our spending more closely to the current and future health needs of our populations.
- Reshaping our contracting models and financial flows where needed to support transformation, including moving away from transactional ‘fee for service’ models to exploring contracting for whole care pathways, or for ‘year of care’ for specified patients or populations.
- Looking across care pathways from primary care to community, acute and specialised care to identify opportunities to deliver care more effectively and efficiently, capitalising on the opportunities presented by the delegation of primary, pharmacy optometry and dental, and specialised commissioning from NHS England to integrated care boards.

Understanding our challenges

NHS Hampshire and Isle of Wight

The scale of the challenges faced by the Hampshire and Isle of Wight system requires a multi-year recovery focus, which addresses long standing issues which have resulted in fragmented and inconsistent pathways of care, resulting in inequity for our patient population, as well as core aspects of the drivers of the financial deficit.

Productivity

- **Productivity has declined**; despite a rise in income there has been a decline in financial positions since 2019/20
- **Occupied Bed Days have increased**. People are spending more time in a hospital bed after treatment has ended due to challenges in getting them back to their usual place of residence
- **Workforce costs have risen**: There is increased use of temporary staffing despite core workforce numbers increasing.
- **Non-pay costs are higher than envisaged.** The cost of drugs and services are higher than planned

Excessive System Pressures

- **Emergency activity has risen** above 2019/20 levels and 8% higher than nationally.
- **Rising emergency lengths of stay**, partly due to delays in discharge linked to the availability of physical and mental health and care services in the community.
- **Short-term operational pressures** has led to inefficiencies and under-delivery of Cost Improvement Programmes (CIPs); many focused on closing escalation beds, improving discharges, reducing agency spend and improving procurement, which were not delivered due to a mix of activity levels and inflation.

Population health needs

- **Significant areas of population growth in some areas of the system.** Test Valley and Basingstoke and Dean - 12% and 10% respectively compared to 6% England average (2011 – 2021).
- **Models of proactive, preventative physical and mental health care not yet scaled** to impact across the system footprint. Outcomes and activity indicate that focusing on cardiovascular disease prevention and proactive care for older people are priorities

Underlying Challenges

- **High levels of independent sector choice** within the Hampshire and Isle of Wight integrated care system
- **Some estates are no longer fit-for-purpose** leading to inefficient use of buildings.

Structural Issue

- Delivering 24/7 services on the Isle of Wight requires **additional cost to ensure sustainable and resilient service delivery**
- The Hampshire and Isle of Wight system is over target for its population allocation, and as at 2023/24 a significant reduction is required

In order to address these challenges we have identified priority transformation schemes that will support the rebalancing of the system in the medium term alongside the longer term impact of our interim integrated care strategy.

Approach to planning: system recovery and transformation

Hampshire and Isle of Wight

In developing our joint forward plan, with a particular focus on system recovery, we have concentrated on four key areas. These elements also set us up for the delivery of our broader integrated care partnership strategic priorities.

System working

Systems working

Establishing shared accountability and system wide risk-management, quality impact and programme delivery architecture

Productivity and efficiency

Productivity and efficiency

Collective focus on addressing pay and non-pay opportunities including temporary staffing and areas of significant growth in 2022/23

Establishing grip and control

Grip and control

Establishing effective governance, monitoring and reporting to ensure we are jointly tackling the scale of our financial challenge in a proportionate, responsive and robust way

Developing new models of care

Ensuring people receive the right physical and mental health care for their needs, in the right setting, quickly and efficiently; implementing new care models for urgent and emergency care, local care, discharge and elective care that improve outcomes, reduce non-elective activity, release unfunded beds and restore elective capacity

We have also identified critical enablers to our recovery and longer term transformation:

Strategic partnerships

Systems working

Progressing the partnerships supporting sustainable care on the Isle of Wight; bringing together community, mental health and learning disability providers; developing our integrated care partnership; supporting provider partnership on the elective care hub and other acute services; enabling effective and impactful place partnerships

Enhancing our use of digital, data and business intelligence

Digital and data

Developing, adopting and scaling digital technologies to support productivity and demand management programmes; embedding use of data and business intelligence to identify areas of unwarranted variation in access, outcomes and productivity; development of data-driven population health management, system evaluation and benefits-realisation

5 YEAR FORWARD PLAN

NHS
Hampshire and Isle of Wight

OUR CORE PURPOSE:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support social and economic development

Key to achieving these outcomes:

- Providing swift access to efficient, high-quality care for those who need it
- Keeping people as healthy and independent as possible

OUR SYSTEM PRIORITIES:

Delivered through whole system partnership working and described in our strategy and plans:

DECEMBER 2022 - ICP strategy published:

Focus on underlying health, happiness, wealth and wellbeing of population

Addressing inequalities within and between communities - more widely than access to and experience of healthcare

MAY 2023 - NHS Operating Plan:

Describes 2023/24 plans to deliver Year 1 of the strategy and joint forward plan

Focus on immediate steps to enable system recovery

COMING JUNE 2023 - Joint Forward Plan:

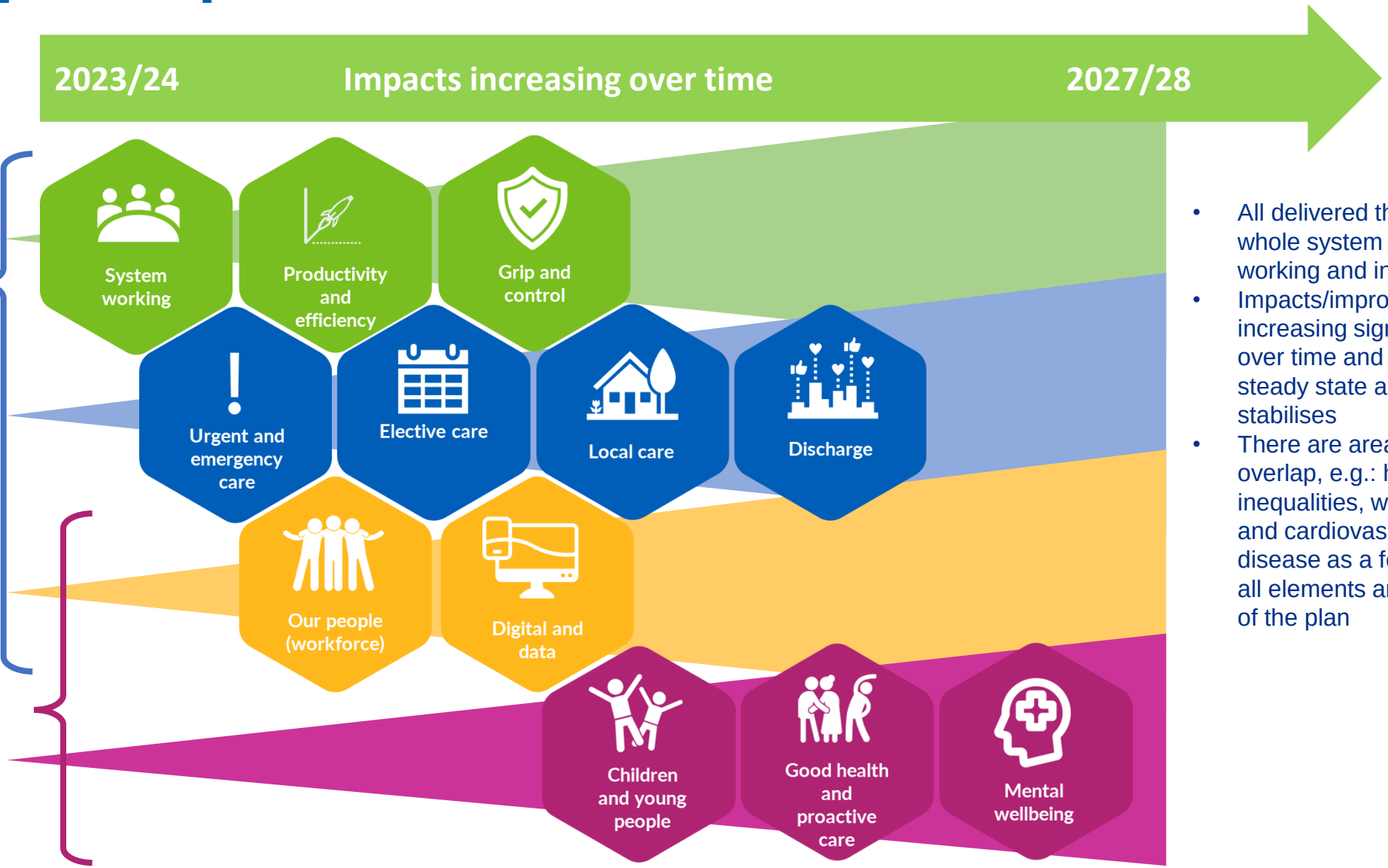
Focus on quality, efficiency and sustainability of care models and services

Tackling inequalities within healthcare

Plan for the next 5 years

Partner organisations' strategies and plans

Our two-phase plan



Resetting the system **- our Integrated Care Board and NHS Trust Partner priorities**
Delivering impact and improvement from 2023/24

Renewed focus on population health and wellbeing **- our Integrated Care Partnership priorities**
Prevention and health promotion impacts from 2023/24 and delivering improved population heath and wellbeing in medium to longer term

- All delivered through whole system partnership working and integration
- Impacts/improvements increasing significantly over time and become steady state as system stabilises
- There are areas of overlap, e.g.: health inequalities, workforce and cardiovascular disease as a focus across all elements and phases of the plan

Our priorities

System transformation programmes focus on improvements in models of care. Much of this work will continue in delivery and benefits realisation into years 2 and beyond of our plan

NHS Hampshire and Isle of Wight

Free up beds and reduce demand in acute care

Reduce acute demand

- Reduce conversion rates (attendance to admission).
- Reduce outpatient follow ups and 'did not attends.
- Reduce emergency hospital attendances.
- Primary/ community care coverage.

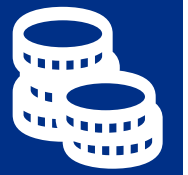
Increase flow out of hospital

- Support discharge of patients who no longer meet criteria-to-reside.
- Reduce bed days for unplanned care by reducing numbers of long staying patients and addressing length of stay in pathways for discharge home with health and care support.

Focus on care for older people (local care)

- Reduce readmissions to hospital for >75s.
- Reduce bed days for unplanned care in community hospitals.
- Reduce admissions for >80s through proactive, integrated community-based care.

Increase elective activity income



- Attracting additional income from achieving 109% elective recovery fund target
- Increase productivity in elective capacity – e.g., improving theatre utilisation, delivering outpatient impact outlined above

Transformation Programmes

Urgent & Emergency Care Programme

Best practice, standardised approach to Urgent and Emergency Care delivery, optimised use of alternative pathways and improved efficiencies and scaled up urgent community response and virtual ward provision (includes integrated urgent care, urgent treatment centres, same day emergency care, community models and increased capacity in NHS 111 and 999 call handling).

Local Care Programme

Preventative and Proactive Case Management roll out starting with frailty; same day access to primary care; enhanced integrated care closer to home and neighbourhood model of care; focused cardiovascular disease and diabetes work targeting areas of deprivation/ inequalities.

Discharge Programme

'Home First' model of discharge and improved processes within discharge pathways.

Elective Care Programme

- Meeting national waiting time targets including through mutual aid and system waiting list.
- Outpatient transformation including promoting use of Advice and Guidance and Patient Initiated Follow Ups and improved access for specific specialties.
- Elective Hub
- Reduced variation
- Diagnostics strategy including community diagnostics centres

Underpinning enablers and new ways of working include

Our joint forward plan also describes how we intend to deliver our integrated care partnership strategy, setting out our initial areas of focus as a wider system partnership

- **Focus on the "best start in life" for every child** in the first 1,001 days of their life
- **Working together to improve children and young people's social, emotional and mental health** through prevention and early intervention
- Co-locate services to enable a **family-based approach**

- **Improving outcomes and management of cardiovascular disease for those at risk and those with early signs of developing cardiovascular disease**
- **Improve social connectedness and decrease social isolation** by working with communities to understand their needs and to develop and ensure the sustainability of community assets

- **Developing trauma informed approaches across services to reduce health inequalities and improve emotional wellbeing**
- **Promoting emotional wellbeing as a system,** aligning our messages and co-ordinating our communications and ensuring people know how to access wellbeing support when they need to.

- **Develop integrated workforce planning** to understand key issues from a workforce perspective for all partners
- **"Back to basics" programmes** to attract and recruit future workforce, supporting retention with aligned career structures
- **Identify shared challenges and solutions to increase recruitment with voluntary and community sector partners**

- **Improve how we share information** between organisations and remove the organisational, digital, data and technology boundaries
- **Increase digital skills,** awareness, and empowerment of patients

The "Hampshire and Isle of Wight way"

As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership

Behaviours and mindset:

- Building trust and rapport
- Active listening
- Valuing the contributions of all partners
- Being brave, bold and curious
- Remembering that everyone is participating with the best intent
- Giving permission and trying new activities

NHS Hampshire and Isle of Wight

Alongside our system wide priorities, we also have plans to address local priorities, as identified by our health and care partnerships in each place

Hampshire

- Improve physical, mental health and emotional **resilience for children, young people and their families**
- Support people to **live healthier lives**, focussing on lifestyle risks
- Support people to **stay well and independent into old age**
- Collaboration for **palliative and end of life care**, including bereavement support for all ages
- Reduce unwarranted variation in health outcomes

Isle of Wight

- Embed **prevention** into all health and care pathways
- Deliver **at-scale prevention**, with a focus in redressing health inequalities
- **Fully integrated frailty pathways** across the Island
- Making 'home' and the community the 'hub' of care
- **Work in partnership** with others on island and mainland
- New workforce models
- **Optimise approach to accessing services**, especially for people **experiencing crises** e.g. 'no wrong front door'
- Reduce **unwarranted variation** in care pathways - access and outcomes

Portsmouth

- Embedding the **population health management approach**, including proactive case management
- supporting **primary care resilience** and developing community based services
- Specific focus on adults with **neurodiversity and substance misuse**
- Holistic approach mental wellbeing and **reduce mental ill health** in adults
- Improve children's services with a focus on **education, safeguarding, physical and mental health outcomes**
- Improve **community care and support options** for individuals

Southampton

- **Reduce inequalities** in early childhood and improve outcomes
- **Improve mental health and well being for all ages**
- Tackle loneliness
- Make use of **digital tools to support independence** and healthier living
- **Promote mental health and wellbeing** (increase access)
- **Proactive Care** - 'One Team' approach and integrated community care
- Develop **community networks** (e.g. virtual care and 'remote offers')
- Maximise **prevention and early intervention**, make every contact count
- **Improve** coordination around **end of life care**

Place-based health and care partnerships:

- Understand and work with communities
- Join up and coordinate services around people's needs
- Address social and economic factors that influence health and wellbeing
- Support quality and sustainability of local services

Delivering our joint forward plan

Our priorities – Local Care

NHS Hampshire and Isle of Wight

Deliver Local Care in a person-centred and joined up resilient teams across primary care, community services and partners.

Deliver same day access to urgent and episodic care, proactive and preventative care for people with chronic disease and complex care.

Aims and objectives	Key actions	Impact
• To ensure that people receive care in the right place, at the right time, in their homes and communities where possible, focusing on proactive care, avoiding unnecessary hospital admissions and enabling timely discharge. • To have same day access for urgent & episodic care by implementing a streamlined, scaled model to deliver urgent and episodic care. Releasing capacity to focus on proactive, chronic disease management and complex care. • To focus on proactive care and prevention for people with chronic disease to provide longer term stability to the system, reduce non-elective acute admissions for people with chronic disease and improve outcomes. • Inequity in service access and outcomes is reduced. • Address and reduce health inequalities and inequity in service access and outcomes. • That services support people to stay well and take greater responsibility for their own health, decreasing and delaying the need for longer term health and social care support.	**Improving Same Day Access model for Urgent and Episodic Care** • Full definition and planned roll out of scaled model for same day access to primary care, streamlining urgent and episodic care management and including direct access pathways. Building on Acute Repository Infection /same day access targeting defined cohorts. • Identify the resource required to manage a single point of contact same day hub • Transitional implementation plan at Place for urgent and episodic care ahead of Winter. **Providing more proactive and preventative care for people with Long Term Conditions** • Full definition and planned roll out of proactive and preventative care model with key clinical conditions. • Fully defined frailty and complexity plan by place based system, including Proactive case management, virtual wards and urgent community response, To include: • Optimising virtual ward capacity, urgent community response capacity and frailty provision against agreed trajectories • Development and implementation of frailty clinical pathway and enhanced neighbourhood model of care across all systems. • Build clear preventative care strategic priorities and plan using Population Health Management. **Diabetes, Cardiovascular disease and respiratory disease** • Diabetes / Cardiovascular disease defined strategic priorities and proactive/preventative care plan at Place. • Respiratory defined strategic priorities and delivery plan at Place. • Consistent achievement of key clinical outcomes delivery for diabetes and Cardiovascular disease across all Primary Care Networks/practices to deliver demonstrable improvement, specifically targeting areas of deprivation/inequalities. **Integrated Care Closer to Home** • Integrated neighbourhood teams improvement and resourcing plan at Place. • Development of Primary Care Networks/ practice integrated neighbourhood teams against core principles to hold proactive and preventive caseload and enhance integrated care closer to home.	**For our residents:** • More people receiving proactive care in their home environment. • Ability to access same day care from primary and community care teams. • Fewer people living with and suffering from the complications of preventable disease. • Reduction in the gap in healthy life expectancy. **For NHS organisations:** • Increased primary and community-based capacity and utilisation. • Emergency care activity at 19/20 levels (attendance and unplanned admissions greater than 1 day). • Improved workforce retention within primary care. **For the system:** • People living healthier, longer lives, reducing reliance on services. • Teams working together, reducing duplication. • Data driven care stratification, identifying areas of unwarranted variation.

Our priorities – Elective Care

- This programme covers planned care (inpatients and outpatients), diagnostics and cancer.
- Providing patients with high quality, equitable and research led care delivering an enhanced patient and carer experience.
- Meet the national operating plan targets and providing a high quality, and value cost-based system built around the patient.

Aims and objectives	Key actions	Impact
• Delivering equitable access to care across Hampshire and the Isle of Wight • Reducing time to diagnosis and treatment • Delivering this by working collaboratively across all of our NHS, Independent Sector Providers and Networks • Delivering this productively and efficiently • Transforming the way care is delivered by introducing new diagnostics tests, changing care pathways, working virtually or digitally	• Create a single Patient Tracking List in some specialities to balance patient referrals and waiting lists between the providers. This will be a phased approach across specialities with a completion date of March 2024. • Phased roll out patient initiated follow up and advice and guidance as standard across agreed specialties. • Change outpatient pathways by increasing patients who have direct access tests, whose clinical team are able to access advice and guidance, see patients virtually where suitable and increase patient initiated follow ups, currently on going speciality by speciality. The specialities agreed for this year will be completed by March 24, however this is a phased approach to completion and more will follow through 24/25. • Open 1 new Community Diagnostic Centre and increase the number of tests delivered in Andover, Portsmouth, Lymington and Southampton. • Work with our clinical leads across Hampshire and Isle of Wight to improve theatre efficiency, day cases rates and length of stay. The planned care board approved the approach to this in the April board meeting and establishing an Integrated Care System wide theatre services group by end of quarter one. • Review and transform end of end pathways including tier 2 services and access to the independent sector for NHS care. Ongoing, March 24 completion. • Create a new Endoscopy Network and seek approval to expand endoscopy capacity in Southampton and Portsmouth. The endoscopy expansion is due to open in 24/25. The planned care board is taking a paper in the next board meeting on endoscopy which will include the network set up for approval. • Complete the business case and start work on the new elective hub based in Winchester. The completion for the hub is 24/25. The business case is well in progress with a view to be finalised by quarter one. • Invest in our Cancer Pathways to support earlier referral and quicker diagnosis and care. On going improvement pathway.	**For our residents** • No patients will wait more than 65 weeks for treatment by March 24. • No more than 6.4% of patients with Cancer will wait longer than 62 days for their care to commence. • 75% of Cancer will be diagnosed by day 28 of the pathway. • 85% of patients will have their diagnostics tests completed with 6 weeks of referral. **For NHS organisations:** • Only when is it absolutely necessary will patients be followed up in Hospital Outpatients, reducing outpatients follow ups by 25%. • An improvement in the use of theatres, increasing to 85% utilisation, an increase in day case rates and a reduction in length of stay by 23/24. • Improve outpatient did not attend rates by reducing did not attends by 25%. **For the system: TBC**

Our priorities – Urgent and Emergency Care

Focuses on significantly reducing acute demand through improved delivery of the right care in the right place to avoid unnecessary admissions.

Reduce the number of people in acute hospital without a meeting the criteria to reside.
Through creating a more consistent approach to delivery, maximising capacity and efficiency and targeted use of non-recurrent funding allocations.

Aims and objectives	Key actions	Predicted impact

• Maximise the impact and capacity of admission avoidance schemes to support timely access to appropriate care including:
1. Increasing Same Day Emergency Care
2. Increasing capacity in 111 and 999 to direct people to the right services
3. Integrated Urgent Cares
4. Urgent Treatment Centres
 	
• Reduce the number of people in acute hospital not meeting the criteria to reside.
 	
• Create a more consistent approach to delivery, maximising capacity and efficiency and targeted use of non-recurrent funding allocations.
	• Establish and embed standard tools to plan, drive and track delivery of initiatives
	• Develop Integrated Care System wide Plan to achieve the financial and activity targets – including triangulation of activity, finance and workforce, based on Local Delivery System level plans.
	• Continue to refine Local Delivery System plans. To include agreed Place based plans and trust agreed trajectories for increasing same day emergency care and build on process mapping workshops to further develop plans to optimise use of alternative pathways and improve efficiencies .
	• Urgent and Emergency Care Board to explore Hampshire & Isle of Wight task and finish groups to take forward key priority areas to enable a more consistent and standardised approach to Urgent and Emergency Care delivery to include:
	  • Integrated Urgent Care,
	  • Urgent Treatment Centre, same day emergency care,
	• Implementation through 23/24 inline with outputs of task and finish groups & financial constraints across Hampshire and Isle of Wight and Local Delivery System level delivery.
	• Develop dashboards to track impact and facilitate delivery
		For our residents:
		• Increasing access to Same Day Care
		• Reducing wait times for patients who require Urgent & emergency care services
		
		For NHS Organisations
		• Seeing patients in the right place, in the right time
		• Reduction in occupied bed days
		• Increased performance against constitutional targets
		• Overall reduction in cost of delivery of services
		
		For the System
		• People living healthier, longer lives, reducing reliance on services
		• Teams working together, reducing duplication
		• Data driven care stratification, identifying areas of unwarranted variation

Our priorities – Discharge

Drive a robust 'Home First' model of discharge to support more people to safely return home with appropriate interventions to meet individual assessed needs thus enabling people to receive the right care, at the right time, in the right place by the right person.

Aims and objectives	Key actions	Impact
• Improve processes within discharge pathways • Optimise productivity and efficiency against existing schemes/capacity and reduce liability against Hospital Discharge Pathway spend. • Reduce the number of people in hospital not meeting criteria to reside • Reduce requiring permanent care home placements	• Develop Hampshire and Isle of Wight trajectories using trend data to achieve reduction in not meeting criteria to reside based on Local Delivery System level plans - Completed March 2023. • Refine/agree delivery plans in each Local Delivery System in line with the planning timetable. • Established governance structure for programme, regular meetings in place with board to launch in May with addition of working group (Completed April 2023). • Implementation of Hampshire & Isle of Wight not meeting criteria to reside plans during 23/24 through discharge task and finish group and Local Delivery System Bronze & Silver Forums. • Develop short term service specification. • Establish Discharge Programme Board inaugural meeting 22/05/23, membership agreed, draft terms of reference developed. • Workshops held during May including review of Hospital Discharge Pathway discharge capacity spend further workshops scheduled to review short term discharge beds (utilisation, criteria, purpose, clinical effectiveness etc) and to also review single point of access to address any unwarranted variation. • Work in conjunction with Fusion Programme to introduce Discharge Programme and agreed Fusion lead. • Map and test existing discharge flows – Clinical team visits to sites to 'test' discharge pathway flows – end May/early June.	• Improve discharge rates - 50% reduction in bed days related to patients with no criteria to reside. • Reduce average length of stay for patients <80 years and 80% reduction in patients staying in hospital significantly longer than necessary. • 95% people able to be discharged to their own homes (increase from 84%) on Priority 0 & Priority 1 pathways. • Length of stay reduction in short term services.

Our priorities - Children and Young People

This programme sits within our integrated care partnership strategy and aims to ensure all children to have the best possible start in life, regardless of where they are born, and have positive physical, emotional and mental wellbeing.

Specific intended benefits include: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, improved educational attainment, better inclusion and engagement in schools, societal benefits e.g. reduction in crime.

Aims and objectives	Key actions	Impact
• Focus on the "best start in life" for every child in the first 1,001 days of their life; Deliver a coherent cross-agency pathway of support for the first 1001 days of life – from pregnancy through to age 2.5 – to secure the best possible outcomes for children as they approach early years. • Working together to improve children and young people's social, emotional and mental health through prevention and early intervention; to ensure young people and their families are able to access information, advice and support at the earliest possible stage. This will ensure that, so far as practical, we are able to support needs before they escalate and further impact of the young persons long-term outcomes. • Co-locate services to enable a family-based approach; Transformation of Family Hubs and Start for Life services (0-19 years), in line with published Department for Education /Department of Health and Social Care guidance. This programme will share learning and practice across the Integrated Care Board footprint, maximising resource, skills and transformation potential.	• Develop clear performance metrics at Place and System across the Plan – including baselining data for the ages and stages questionnaire scores. • Delivery of the Hampshire & Isle of Wight Maternity Programme (linked programme). Alignment of local maternity and neonatal system and Local Delivery System -based Commissioning Arrangements. Ensure effective Local Delivery System -based Maternity Commissioning and relationship with local maternity and neonatal system. • Portsmouth, Isle of Wight and Southampton - Delivery of Family Hubs Programmes. Sharing best practice with Hampshire. • Agree commissioning approach for the Healthy Child Programme delivered by the new NHS Community Provider (from 2024) between Place-based Public Health Teams and Local Authority Children's Service, focussing on integrated service delivery models with Local Authority's. • Launch programme to ensure consistency and sustainability of Digital Platforms for young families – (Family Assist, Healthier Together etc). • Reviewing Public Health Healthy Child. Programme including learning from more intensive early support model. • Explore a unified Digital Offer for new parents across the Integrated Care System (e.g. enhance Healthier Together, roll-out Family Assist etc.). • Pilot emotional health training in Portsmouth and Southampton to the wider workforce who come into contact with Children and Young People with Anna Freud Centre	• Improve Access and Waiting Times for Children and Young People Mental Health Services. • Increase focus on prevention and early help working with Public Health and Local Authority Children's Services. • Increase the community based and self help offers for Children and Young People. • Families have access to a seamless and welcoming support offer which is accessible for families when they need it; supported by an empowered workforce that supports the Start for Life programme. • Improve service quality and access for Children and Young People in mental health crisis. • Improve transition for 16-17 years olds and access to mental health services for 18 – 25 year olds. • Improve service quality, develop the workforce and embed the use of data and outcomes to demonstrate service effectiveness. • Increase equity of access, experience and outcomes for most vulnerable children and young people. • Activity and financial impacts of delivery are a work in progress currently.

Our priorities - Mental wellbeing

Prioritising and promoting mental health and wellbeing is a priority across all partners, for all population age groups

“Focus on illness is too strong and should be more of a focus on wellness”

“Secondary care in mental health is just the tip of the iceberg - there needs to be many rafts of supporting scaffolds in place”

“We need to challenge ourselves that access is the same and equitable”, and continue to improve parity of physical and mental health

We need to state tangible solutions with ambitious targets and do a few things well

Aims and objectives	Key actions	Impact
• Developing trauma informed approaches across services to reduce health inequalities and improve emotional wellbeing. • Promoting emotional wellbeing as a system, aligning our messages and co-ordinating our communications and ensuring people know how to access wellbeing support when they need to. • Improve emotional wellbeing and prevention of risk factors for mental health - including excess morbidity and excess mortality associated with severe mental illness. • Addressing inequalities in access and outcomes and enabling people to navigate through services.	• Develop joined-up place-based signposting to local services and support that promote positive mental health and wellbeing as well as support those at times of distress building on the current No Wrong Door programme. • Increase access to appropriate and local mental wellbeing support and early intervention support for all residents. • Reduce the burden of mental wellbeing due to the cost of living pressured through increased access to support and focused work on financial anxiety and mental wellbeing. • Senior leaders across the 18 organisations who signed the Trauma Informed concordat commit to delivery of the Trauma Informed Strategy, allocating any necessary resources and providing support and commitment at a senior level. • Through designated Single Point of Contact across the 18 organisations and with support from senior leaders, the 18 organisations deliver their bespoke delivery plans. • Commitment from Integrated Care Partnership partners to provide overarching support to the trauma informed Board, supporting coordinated delivery of one overarching trauma informed Strategy. • Map the range of mental health and wellbeing support that is available to people working across Hampshire to enable policy and workforce development programmes to be embedded in all organisations e.g.: Mental Health First Aiders.	• Self-reported wellbeing - people with a low happiness score. • Self reported wellbeing: people with a high anxiety score. • Reduction in rates of deaths by suicide. • Research shows the potential public health and economic benefit of programmes that target and prevent mental health problems and empower more people to live well. • Reduction in people adopting harmful coping mechanisms as a result of trauma (drug and alcohol addiction, eating disorders, self-harm, gambling, smoking, risky behaviour, multiple sexual partners). • Improved use of trauma informed language in communication and assessments over 3 years due to having a greater understanding of the story behind the presenting behaviour. • Improved self-care and wellbeing amongst staff. • More of the workforce trained in being adverse childhood experience aware and trauma informed. • The best start in life for every child in the first 1000 days. • Reduced demand on children needing mental health support. • Improved children and young people’s social, emotional and mental health.

Our priorities - Good Health and Proactive Care

NHS Hampshire and Isle of Wight

If trends continue, preventable ill-health and deaths will grow, as will health inequalities and our services will become increasingly unsustainable. There is a great deal we can and are doing, but there is more we could do together.
Deprivation is often hidden in rural communities – we need to prioritise areas of greatest need/ inequality – recognising we can't do all of this at once.
There is a role for all partners in improving health of our population, not just in terms of managing the conditions that people have already been diagnosed with, but addressing some of the wider determinants of health, so that people can live more years in better health.

Aims and objectives	Key actions	Impact
• Improving outcomes and management of cardiovascular disease for those at risk and those with early signs of developing cardiovascular disease, focusing on narrowing the gap in health inequalities, reducing unwarranted geographical variation through: 1. improving opportunities for physical activity, healthy eating, reducing harmful drinking and stopping smoking 2. identifying those at risk earlier • Improve social connectedness and decrease social isolation by working with communities to understand their needs and to develop and ensure the sustainability of community assets. • Take a life course approach to improve social connectedness, thereby reducing social isolation and loneliness and building social capital through supporting organisations and individuals/communities across Hampshire and Isle of Wight and addressing inequalities in specific communities. • Improve mental and physical health for all ages and increase independence in older adults, reducing the need for health and care services as well as reducing unemployment and increasing productivity.	• Develop a system-wide Cardiovascular disease approach including communications, priorities and trajectories articulated, using a population health management approach and community insights to inform priorities for action Commitment from Integrated Care Partnership partners to develop organisational plans by 30th September 2023 to address risk factors for Cardiovascular disease. • All Integrated Care Partnership partners to produce an organisational plan to tackle loneliness at work. • Produce a Integrated Care Partnership framework to support co-production of place based plans to build social connectedness within local communities, alongside community voluntary sector colleagues and primary care. • Develop a system level communications plan to reduce stigma associated with loneliness, signpost to support and share local opportunities / positive stories supported by all Integrated Care Partnership partners and delivered at place.	• Halt the fall in Healthy Life Expectancy and the increasing gap between the most affluent and the most deprived in Hampshire and Isle of Wight. • Reduction in heart attacks and strokes over 3 years. • Improve detection of Cardiovascular disease risk factors and close the prevalence gap across core Cardiovascular disease risk factors. • Decrease the % of adults who feel lonely often or always or some of the time (public health outcomes framework 2019/20 baseline) • Including reducing differences by ethnicity, employment status, disability, deprivation, age and sex • Increase % adult carers & social care users who have as much social contact as they would like public health outcomes framework. • Improve self-reported wellbeing: satisfaction, worthwhile, happiness, anxiety public health outcomes framework. • Increase workplace productivity and reduce workplace stress / sickness absence. Equip local residents with skills to increase employability. Percentage of people in employment (public health outcomes framework: 16-64 years and 50-64 years).

Our priorities – Our People (workforce)

We have significant shared system workforce challenges spanning recruitment, training and retention. Our collective workforce is our area of greatest opportunity and where we can make a powerful shared impact. We know that we will not be able to begin to deliver on our shared strategy without our people.

Aims and objectives	Key actions	Impact
• We will develop a set of shared values, strengthening partnerships and working together on integrated workforce planning. This will support us to understand how we meet our current workforce challenges together, including addressing inequalities, and reducing practices leading to competitive behaviours. • We will get back to basics with Integrated Care Partnership programmes to attract, recruit and retain our workforce • The wellbeing of our workforce is essential, we employ a large number of people across Hampshire and Isle of Wight, will work with our Good Health Programme to ensure Integrated Care Partnership employers across Hampshire and Isle of Wight fully engage with the opportunities this presents.	Working through the Integrated Care Partnership we will bring partners together to develop shared values and approaches to workforce planning.	Shared set of values supports consistent behaviours throughout the Partnership, fostering strong relationships needed to orchestrate change. Addressing inequalities in our workforce supports developing a workforce representative of our population and helps to address health inequalities in our communities. Improving workforce wellbeing, improves attendance, reduces temporary staffing and increase productivity

Our Priorities – Digital and Data

By harnessing the power and innovation of technology it will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles.
Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient.

Aims and Objectives	Key actions	Impact
<u>Empowering people to use digital solutions:</u> Supporting people to see digital care as being as valuable as traditional care, eg: widespread access to digital health records, home monitoring, virtual consultations and practical support to help people engage with digital care, underpinned by face-to-face care for those unable to.	1. Maximise digital uptake especially through promoting and enabling our citizens to access and engage in digital services. 2. Promote inclusion and provide resources and support for citizens to engage in digital to ensure equality of access to all health and care services 3. Incorporate citizen-centred service design in the implementation of digital solutions through user-feedback and consolidation of services to simplify their use. 4. Bridge the gap between digital and non-digital solutions to widen digital offering for citizens of all levels of competency.	**For our residents:** • They can view and input information into their own health and care records. They only need to provide information once. • They can receive care at home where appropriate, are involved and have control of their care • They can manage their own appointments: book, cancel, and re-schedule • They can access a range of services, both digitally and non-digitally. They trust that their information is safe and secure. **For NHS organisations:** • Frontline workers are able to spend more time with their patients. • They have modern, reliable and fast digital solutions and equipment that enable them to work more productively • Frontline workers can review and update patient records when and where they need to, using joined up systems that talk to each other **For the system:** • Colleagues can easily communicate with each other across different organisations involved in the care of our patients • Transfers of care between teams and partners are seamless and smooth • We have access to real-time information to understand service performance and to help make decisions • We understand the health of our population and can work effectively with partners
<u>Supporting our workforce: S</u>taff will be able to access joined up care records, across our system, without multiple log-ins. They will have the skills and confidence to work digitally and flexibly. Our leaders will enable delivery of our digital ambitions and we attract talented digital experts to work here.	1. Oversee the creation of a digitally competent workforce through the evaluation and education of our workforce in digital skills and best practice 2. Ensure that equality, diversity and inclusion is embedded as a requirement in digital transformation, ensuring that no-one is left out or left behind 3. Develop a design and usability awareness and specialist capacity across the system to drive efforts in improving the user experience of digital tools.	
<u>Improving how we share and use information:</u> In the future everybody can easily access their own comprehensive digital health record and add to it themselves. Analysis of joined up patient information will play a crucial role in providing proactive care and support, that improves our population's health and reduces inequalities.	1. Develop our Shared Care Record by increasing the breadth and depth of information shared and enable better sharing of citizen information between our partners. 2. Reducing boundaries by reducing the number of systems, consolidate systems where appropriate and encouraging collaborative procurements. 3. Enable collaborative working, for example improving primary and community care through integration of tasking and care planning.	
<u>Modernising and integrating our digital systems:</u> We want all of our organisations' to be digitally mature, investing in implementing new digital health records that connect across organisations and support joined up care. Up-to-date infrastructure will provide strong foundations for the future.	1. We will level up the Digital Maturity of all providers by continuing to invest in Electronic Patient Record solutions. 2. Digitally transform Diagnostics & Imaging to enable workforce planning, reduce rework and improve the turnaround of results. 3. In primary care we will continue to provide core capabilities and work to deliver enhanced capabilities where required, and in social care we will deliver Digital Social Care Records.	

Our Priorities – Digital and Data: Population Health Management

Hampshire and Isle of Wight

By harnessing the power and innovation of technology it will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles.
Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient.

Aims and Objectives	Key actions	Impact
Our system will be described as a system with 'maturing' population health management (PHM) capability by 2025 as described in the NHS England Population health management maturity matrix with some aspects of population health management capability in the system classified as 'thriving'. Therefore population health management data and insight is being used across the system to inform targeted actions and decision-making to improve outcomes and reduce health inequalities.	• All primary, secondary, mental health and community data linked in HealtheIntent (population health management platform). • All system partner organisations (including local authorities, police, fire, and where appropriate, voluntary and community organisations) are signed up to the population health management data sharing agreement to support shared working. • Delivery of wrap-around facilitation and support programme for use of population health management data to deliver local priority. • Delivery of wrap-around facilitation and support in use of population health management data and analytics to inform and support our systemwide cardiovascular disease programme. • Population health analytics regularly used within multidisciplinary teams (primary and secondary) to support rapid improvement cycles. • Social care individual linked in HealtheIntent platform. • Analytical support available for Primary Care Networks to help understand high/rising risk patients. • Population health finance and cost data brought into HealtheIntent and used to forecast demand and risk to inform new contracting models.	• Clinical, operational and strategic workforce across our system have access to high quality population data for planning and direct care resulting in more effective care, commissioning, planning and prevention programmes. • Workforce across our system using population health management data and intelligence to improve care, reduce health inequalities and integrate services due to increased population health management capabilities. • Population health data and insight are contributing to an improved financial position for the system as services are better targeted, less duplicative and thoroughly evaluated.

Our priorities – Productivity, efficiency & grip and control

Achieve our return to financial balance as a system by controlling costs, increasing productivity, and aligning our finances to deliver our wider objectives.

Aims and objectives	Key actions	Impact
Increase workforce productivity and reduce overall pay costs, through: • Substantial reductions in agency expenditure (less reliance and lower rates). • Revised provider staffing establishments. • Substantial reduction in integrated care board workforce capacity through restructuring and running cost allocation reduction. We recognise the importance of our partnership and contributing organisations as Anchor Institutions within our communities, and the positive impact that we can therefore make. Deliver reduced non pay costs through: • Consolidation opportunities and strategic partnerships e.g. joint procurement, consolidation of corporate functions. • Reviews of partnership and joint funding arrangements to support best use of collective resource (including all age continuing health care and BCF arrangements) • Integrated care board corporate non-pay review	• Review of all investments made in the last three years to ensure they are sustainable • Strengthening of all core interventions and procedures relating to workforce expenditure and controls. • Capitalise on opportunities afforded by natural turnover to 'rebalance' workforce capacity, team structures, pay grades, and skill mixes. • Integrated care board workforce to be resized. • Identify and capitalise on opportunities arising from adoption of innovation (i.e. automation/ digitalisation). • Undertake opportunity analysis on consolidation of support and back office functions. • Identify areas for greatest cost efficiency through system-wide efficiency planning for 23/24 and 2024/25 with clear measures of success. • Establish appropriate system controls and contractual arrangements for non-pay costs – particularly drugs and supplies and services. • Scope and establish joint procurement initiatives, evaluate existing contracts and approaches to contracting and identify areas for de-prioritisation. • Create a cultural shift (clarity, transparency) to a system approach to efficiency savings	• Reduce agency staffing costs to 2019/20 levels, or below, and agency cap not to be breached. • Substantially reduce pay costs associated with 2019/20 to 2022/23 workforce growth to achieve sustainability. • There is a planned agency reduction in 2023/24. • Additional staffing costs to be modelled potential benefits could deliver in Q4. • As a system we are able to 'grow our own' and make a positive impact as Anchor Institutions in our community.

Systems working

Alongside our transformation priorities, we also have three major cross-organisation strategic change programmes

We will continue to progress our major cross-organisational strategic change programmes to leverage longer-term sustainability across the system

NHS Hampshire and Isle of Wight

	Mental health and community services	Isle of Wight sustainability partnership	Hampshire Together – New Hospital Programme
Purpose	**To improve mental health and community services, by addressing unwarranted variations in provision, access and outcomes across Hampshire and Isle of Wight**	**To achieve sustainable health services for the Isle of Wight population, by working in partnership with larger specialist providers in Hampshire**	**To modernise our hospitals and health services, bringing 24/7 acute services together and ensuring care is delivered in buildings that are fit for purpose**
Case for change	Complexity and fragmentation make it hard to access care Pathways are fragmented, with inconsistent models of care Unwarranted variation in patient access and outcomes Service provision is not aligned to need Historical inequity in the distribution of resources Workforce gaps, particularly in mental health services	Small (140,400) and physically-isolated population facing inequalities and deprivation. Sub-scale services that are: • Fragile, often relying on a single clinician, and at risk • Disproportionately expensive to cover on a 24/7 basis Overstretched leadership team across range of services: acute, ambulance, mental health and community	Replace outdated estate – Trust has 11th worst estate in country, and it would cost less replace than to refurbish Address sustainability issues – both clinical and financial, with 24/7 specialist services spread across sites now Respond to population needs – growing and changing Redesign services – embracing digital developments etc.
Proposals	**To take forward recommendations from recent review** 1. Develop a shared clinical strategy for integrated care 2. Develop a strategy for place and place-based leadership 3. Review use of community physical health bed capacity 4. Establish a more strategic approach to funding services 5. Bring services together into a new Trust across system	*From* **Strategic partnerships** The partnerships continue to be crucial but are not sufficient for the scale of challenges faced. *To* **Transfer responsibility to specialist providers** The Isle of Wight NHS Trust will be an acute provider, with other services transferring to specialist partners.	We have undertaken intensive engagement to develop options for consultation. Proposals are: • **To consult the public** on options for reconfiguring hospital services and for building a new hospital • To use the opportunity of £550m capital investment via the **New Hospital Programme**
Next steps	We are undertaking a joint programme of work across partners in response to the five recommendations. This will be further iterated as we develop the operating plan and joint forward plan. The strategic case for the new Trust has been developed and agreed through Boards (provider and ICB). The case was submitted to NHS England on 13 March for review and approval to proceed to the next stage: Full Business Case.	Our approach is set out in a Joint Strategic Case: • to develop the island health and care partnership • to transfer non-acute services to specialist providers (ambulance, mental health and community) • to form a hospital group The ICB Board and system partners confirmed support for the Joint Strategic Case in March, with partners committed to implementing the next steps for each health sector.	We are awaiting national confirmation of £550m and ministerial review of the conditions relating to this funding. In the meantime, we continue to: • Respond to the further work identified through Stage 2 assurance of the pre-consultation business case • Improve our understanding of the population and their needs, particularly to explore the scope to re-dress inequalities for groups with protected characteristics
Recovery	**Service strategy and care models aligned across the integrated care system, with a more proactive approach and greater focus on local care services. All strategic cases for major initiatives reflect the strategic direction and explain how the changes proposed facilitate delivery of these care models across Hampshire and Isle of Wight.**		

Systems working

NHS
Hampshire and Isle of Wight

We will increase our effectiveness as a system through the development of our Integrated Care Partnership

Our Integrated Care Partnership provides the framework for health, social care, wider public sector, voluntary and community services to work together in a coordinated and collaborative manner. This is key to addressing our challenges around better management of complex and long term care needs and managing resources in a more joined up way to improve efficiency. The Integrated Care Partnership is a key vehicle through which we work together to deliver our overarching system partnership strategy, to tackle the wider determinants of health such as housing, education, employment and the environment that people live in, as these wider determinants affect people's health and quality of life and drive greater need for health and care services.

Progress in 2022/23: Our Integrated Care Partnership has made great progress over the last year, including:

- Designing the model for the Integrated Care Partnership – Joint Committee, assembly and a way of working
- Defining the purpose and the governance for the Integrated Care Partnership – drafting a terms of reference for the Integrated Care Partnership Joint Committee
- Holding two Integrated Care Partnership assembly events to engage broadly on the development and the delivery of the Integrated Care Partnership strategy
- Engaging with Health and Wellbeing Boards on the Integrated Care Strategy and the development of the Integrated Care Partnership structures
- Publishing the Interim Integrated Care Partnership Strategy in December 2022.

Ongoing development

- Delivering year one of the Interim Integrated Care Strategy: establishing programme structures, deliverables and measures of success to ensure the delivery of the strategy supports improved outcomes of our four places
- Ensure robust and effective governance in place to realise collective benefits
- Establish mutual accountability for the delivery of the vision of the integrated care system
- Continuing culture and development work including vision and charter of behaviours.

Our Priorities – Always Improving

In addition to our strategic Integrated Care Partnership priorities and the activities we have identified as most crucial to our financial recovery, we are committed to the delivery of a number of ongoing transformation programmes. These include programmes spanning Mental Health, Learning Disability and Autism, End of Life and Maternity transformation.

Aims and Objectives	Key actions	Impact

Our Southampton, Hampshire, Isle of Wight and Portsmouth Local Maternity and Neonatal System works together to improve outcomes for women, pregnant people and their babies across Hampshire and Isle of Wight. This is done through cocreation and reshaping of maternity and perinatal health services. We tackle inequalities in outcomes, experience and access for all women and pregnant people's experience of maternity. We work with community, primary care and system partners to deliver simpler, safer, and more joined-up care at the right time.	• Our Local Maternity and Neonatal System has set five year strategic transformation plans. We will:
	  • Implement recommendations around coproduction and health inequalities to shape how we review and improve services.
	  • Align our maternity transformation to our Integrated Care Partnership strategic priorities particularly around health inequalities and against the first 1001 days of life.
	  • Implement patient safety recommendations on oversight and quality so the Local Maternity and Neonatal System can act as oversight.
	  • Develop a long-term workforce strategy and plan for maternity services.
	  • Deliver Maternity Transformation Plans 23/24 onwards (including Ockenden and East Kent recommendations, and Long Term Plan ambitions).
		• Our strategic transformation plans will:
		  • Put coproduction at the foundation of any strategic intent in maternity services transformation plans
		  • Improve the maternity services health outcomes for our most vulnerable communities
		  • Deliver system oversight of quality improvement for maternity services Plan for a future workforce that is fit for purpose.
		  • Transform our services to the best standard through responding to national recommendations in the Ockenden and East Kent reviews and Long Term Plan ambitions

Palliative and End of Life Care remains a priority: we know the impact that we can make through early identification and planning, we know that the projection in number of deaths will include, and there are many variation and inequalities in our services that we can address which will help to support the workforce, reduce costs and meet national directives. It is the right thing to do for our patients, carers, their loved ones, our communities and to support our staff.	• Strengthening the Palliative and End of Life Care Board, in particular strengthening system leadership.
	• Delivery of our key workstreams: 1 Strategy, 2 Wessex Anticipatory Care Planning Audit, 3 Training and Education, 4 Community Engagement, 5 Bereavement and Care After Death.
	• Finalise and deliver our all ages strategy, built on engagement with our community This will help us to agree focus areas and through a strong delivery plan increase pace of programme delivery.
	• We will continue to embed work and perspectives at every level of the system.
		• Transformation is built upon 6 ambitions in outcomes:
		  • Each person is seen as an individual (care is personalised).
		  • Each person gets fair access.
		  • Maximising comfort and wellbeing.
		  • Care is coordinated (through shared care records and joined up evidence and information).
		  • All staff are prepared to care (and we can evidence their confidence, knowledge and skills).
		  • Each community is prepared to help

Our Priorities – Always Improving

NHS Hampshire and Isle of Wight

In addition to our strategic Integrated Care Partnership priorities and the activities we have identified as most crucial to our financial recovery, we are committed to the delivery of a number of ongoing transformation programmes. These include programmes spanning Mental Health, Learning Disability and Autism, End of Life and Maternity transformation.

Aims and Objectives	Key actions	Impact
We believe that children, young people and adults with a learning disability and/or autism have the right to the same opportunity as anyone else to live healthy lives, achieving their goals and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.	Our 5-year strategic transformation plans show we will: • Use data and insights to identify themes for service improvement across short, medium, and long term. • Increase update in annual health checks, and improve consistency of health action plans. • Utilise Core20PLUS5 to address inequality. • Deliver keyworker pilots to improve outcomes for Children and Young People. • Invest in diagnostic capacity and provision of services to meet growing demand. • Support workforce training, retention and recruitment e.g. through mandatory roll out of Oliver McGowan training, and supporting workforce planning. • Embed coproduction into service development. • Develop new care models across the Integrated Care System and deliver more services in the community.	Our strategic transformation plans will: • Move people into the community reducing reliance on inpatient care. • Address inequalities and increase prevention. • Reduce overmedicalisation and prevent avoidable deaths. • Increase health and wellbeing for children and young people, particularly in first 1001 days. • Meet increasing demand. • Help us to recruit and retain staff. • Give people with lived experience a bigger voice in what services are developed and improved.
By the end of 2027/28 there should be no observable barriers to access for community mental health services, in whatever community you feel to belong to and whether the care is provided in primary care, secondary, by the voluntary sector, or from local councils at any tier. Collaboration between mental health staffing from any organisation should be business as normal. Individuals should not experience a cycle of assessment, rejection and re-referral. People will be able to access support within and from their community .	Key actions already underway: • Develop a mechanism to enable people to self refer into community mental health services • Bridging the gap with Voluntary, Community and Social Enterprise colleagues by targeting and supporting work in 12 communities of interest e.g. people affected by alcohol to support with their mental health. • Received 46 applications for grant funding, 18 organisations have been successful in receiving their grants to support programmes such as; 1. support for carers for people living with dementia, 2. trauma informed therapies • To hold an information and network event with the 18 successful organisations to share their learning and best practice and to understand what the future plans are.	• People will be able to self refer for community mental health services. • Each Primary Care Network will have multidisciplinary and multi organisational collaboration arrangements. • Workforce delivery of care will be personalised and guided by a trauma-informed approach. • People with lived experience will be fundamental to design and delivery of services. • Mental health and substance misuse services will be integrated to support people with co-occurring conditions. • Equalities will be advanced.

Our Priorities – Always Improving

In addition to our strategic Integrated Care Partnership priorities and the activities we have identified as most crucial to our financial recovery, we are committed to the delivery of a number of ongoing transformation programmes. These include programmes spanning Mental Health, Learning Disability and Autism, End of Life and Maternity transformation.

Aims and Objectives	Key actions	Impact
Our Integrated Care System's strategic vision and transformation for health and care pathways for adults living in Hampshire and Isle of Wight who experience a self-defined mental health crisis or mental health emergency is to provide safe, high quality, equitable and seamless 365 day services for acute and crisis mental health care, with incremental improvements in every year from 2023/4.	• 'All Age' Psychiatric Liaison Model – bring together two separate teams to build a financially sustainable service which provides a Core 24 service. • Deliver one Crisis Resolution and Home Treatment model, bringing together existing teams and reducing variations in the service model. • Full evaluation of current nine Crisis Alternative services to understand benefits and inform future commissioning decisions. • Reduce variation in the therapeutic inpatient offer across the system including workforce model.	• Co-produce and engage both with communities and strong multi-professional clinical networks to develop new and improved models of care and support. • Integrate population health, prevention of trauma, prevention of crisis and population level suicide prevention approaches into the programme and across all mental health care for acute and crisis. • Ensure that financial investment within the acute, crisis and mental health emergency is effective, value for money, equitable and delivers improvements for communities and people.
Children and Young People's Mental Health spans two of our Integrated Care Partnership priorities. Despite exceeding national targets wait list for assessment and treatment in specialist services continue to grow. There are real life consequences to this delay.	• Develop an implement a dedicated needs-based neurodiversity service • Address significant workforce challenges in terms of vacancies and the fragmented nature of service delivery. Take a coordinated approach across partners on this challenge.	• Improved access and waiting times for children and young people's mental health services. • All children no matter what level of need will be supported to recover well locally, either at home with a personalised care & support package, or in an appropriate health or care facility. • Our services promote resilience, build life skills and competencies through strong prevention and early intervention services delivered in partnership. • We have an appropriate workforce providing high-quality children and young people's mental health services.

Capital and Estates

Capital investment is an important reflection of our strategic priorities. As a system we have worked together to allocate the capital available to us for 2023/24 and 2024/25 to enable our major strategic schemes as well as to support building maintenance and refurbishments, equipment and vehicle replacement, and investment in digital.

During 2023/24 we will develop an integrated care system infrastructure strategy that identifies the key estates and infrastructure priorities for our system, to support delivery of the joint forward plan, address key estates risks and support productivity.

Over the coming years, major capital schemes include:

- Isle of Wight Trust: Investing In Our Future, a scheme to deliver (a) an Integrated community hub in Newport High Street. (b) High Care Unit - Refurb and expansion of intensive treatment unit (c) A major refurbishment and expansion of the emergency care floor (d) Reconfigure acute beds. Redevelop underutilised space in level B pathology. New 18 bed acute ward to enable reconfiguration of acute bed, better elective and emergency separation. Start of consolidating cold services in the north of the site.
- Western Community Hospital
- New emergency department at Portsmouth
- Diagnostic equipment and endoscopy
- Electronic patient records and frontline digitalisation
- Primary Care – improvement grants, general practice information technology, big third party schemes
- On the horizon:
  - Hampshire Together
  - Elective hub

For 2025/26 – 2027/28, we will work as a system to prioritise our capital spend according to a transparent set of criteria, including for example strategic importance, clinical and operational risk, productivity impact and contribution to Net Zero. Each year we will publish capital resource use plans to set out our investment decisions.

Sustainability

Our region faces significant risks from climate change - many of the causes of climate change are also the causes of ill health and health inequalities in our region. The carbon footprint of the Hampshire and Isle of Wight Integrated Care System is over 760,000 tonnes CO2e. In October 2020, the NHS became the world's first health service to commit to reaching carbon 'net zero', in response to the growing threat to health posed by climate change. The 'Delivering a Net Zero Health Service' report sets out a clear ambition and two evidence-based targets:

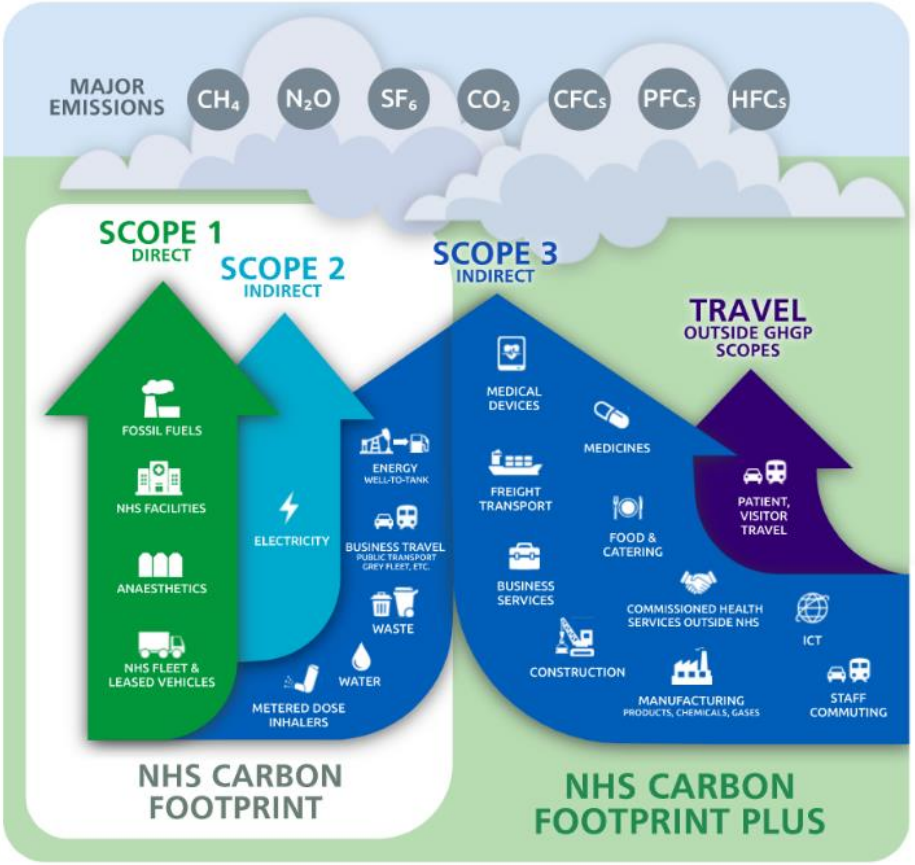
NHS Carbon Footprint: Directly controlled emissions arising from the use of energy and water, the generation of waste, the use of travel for Trust business, anaesthetic gases and metered dose inhalers. Target: to reach 'net zero' by 2040 and an ambition to reach an 80% reduction by 2028 to 2032 (compared with a 1990 baseline).

NHS Carbon Footprint Plus: As well as the above this includes other emissions which can be influenced; arising from NHS supply chains (from goods and services procured) and within communities, such as those arising from staff commuting and patient and visitor travel to NHS sites. Target: reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 (compared with a 1990 baseline).

In support of the NHS becoming the world's first health service to commit to reaching carbon 'net zero', primary and secondary care organisations in the system are undertaking some great work – but more needs to be done. To speed and scale up carbon reduction across primary and secondary care we need to integrate and coordinate good practice across the system and our region. As a system, we will leverage the transition to net zero and public health improvement at a strategic and system level across primary and secondary care, by:

- Acting as a leader and catalyst for transformation within communities and partners.
- Ensuring system wide accountability.
- Enhancing collaboration across the integrated care system and beyond.
- Aligning with local authorities and other key partners.
- Ensuring consistency in approach.

This will help NHS organisations progress faster than they would otherwise, reduce costs across the system, prevent unnecessary duplication of effort and enhance protection of the most vulnerable from climate change. We will prioritise initial effort on procurement, medicines, sustainable and digital care, air quality, travel and transport, estates, communications and capability building; those topics where greatest improvement can be made at a system level.



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Portsmouth CITY COUNCIL

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

Title of meeting:	Health & Wellbeing Board
Subject:	Health and Care Portsmouth Project Fusion update
Date of meeting:	28/06/2023
Report by:	Andy Biddle, Director of Adult Care
Written by:	
Wards affected:	All

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1. Requested by

Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health & Care

2. Purpose

Supported by the Integrated Care Board, the four NHS providers of community mental health and learning disability services across Hampshire and the Isle of Wight established a programme of work, with the working title of Project Fusion, to take forward the recommendation to create a new organisation. The four NHS provider organisations involved are Solent NHS Trust, Southern Health NHS Foundation Trust, Isle of Wight NHS Trust and Sussex Partnership NHS Foundation Trust. This paper provides an update on Project Fusion.

3. Information Requested

PROJECT FUSION
Bringing together community, mental health and learning disability services

NHS

Progress
In March, a Strategic Case was formally approved by the Boards of the four provider Trusts. It was also supported by the Integrated Care Board and has since received support from NHS England.

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The approval of the Strategic Case was the first milestone in creating the new organisation by April 2024. It describes why we want to bring services together, the options we considered, and the emerging strategy for our clinical services. It also sets out how we are approaching the next phase of the programme.

Since the approval of the strategic case, we have continued speaking with staff, partners and communities, involving people in the development of the clinical strategy for the proposed new Trust, the vision, common values, and culture to which the new Trust should aspire, as well as the models for communication, engagement and co-production. This work is informing the development of a Full Business Case which is a piece of work that is happening now. The Full Business Case is due for approval by Trust Boards in October 2023 before being formally submitted to NHS England.

Alongside the development of the Full Business Case, work is also ongoing to look at what needs to happen to create the new provider organisation by 1 April 2024.

It is important to emphasise that the bringing together of existing services of the four organisations does not in itself change services. Bringing the organisations into one Hampshire and Isle of Wight-wide organisation will provide the platform from which services can be improved or changed and help strengthen place-based centre provision where beneficial to patient care and population health and care. Any emerging proposals to change services will be individually engaged and consulted upon with partners as appropriate.

All parties involved are committed to the principle of one organisation with services delivered locally.

Clinical strategy
Central to the new organisation will be its clinical strategy, this is being developed alongside partners and informed by the needs of people using services, their families and local communities. Existing collaboration in several clinical areas has already been taking place between the organisations involved prior to Project Fusion. A Clinical Transformation Group of ten workstreams, addressing the most significant priorities in mental health, physical health and primary care, has been established to support this collaboration to deepen and accelerate. The workstreams will also inform the clinical strategy for the new organisation.

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The Clinical Transformation Group workstreams:

Other clinical areas not directly part of the workstreams above, such as Child and Family services and NHS Talking Therapies, are also working closely to bring their teams and services together.
Already, Project Fusion is enabling clinical colleagues from across the organisations involved, as well as partner organisations, to further extend the way they work together. There is real enthusiasm about the unique opportunities that becoming a single organisation will bring to benefit the people using services and local communities.

Working with local people and communities

Throughout the programme, we have been sharing our plans with service users, communities, and partners and listening to their feedback. This work is overseen by our 'Working towards a new organisation group' which includes people from different community groups and community partner organisations we work with. Engagement activities to date have included discussions at existing forums and bespoke events on the mainland and the Island, with a range of diverse groups. This will continue throughout the length of the programme and beyond once the new trust has been formed.

Ensuring the voice of people with experience of living with a specific condition or accessing services is central to the work we are doing across all workstreams in Project Fusion. In addition, a Lived Experience Group has been set up in recent weeks. People on this group are providing support to the clinical, workforce and organisational development (OD)

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workstreams and are also working on specific projects relating to peer work, recovery college, and coproduction.

Examples of engagement activity to date include:

- Collating what we have already heard from recent feedback in terms of what works well, and what needs to be better, about community, mental health and learning disability services.
- Identifying groups and communities which have not had a voice to date, enabling us to focus on those not yet heard going forwards.
- Setting up a steering group including Healthwatch colleagues and community partners to help develop our overall communications and engagement approach.
- Meetings between executive leads from the NHS Trusts with the chairs and chief officers of all local Healthwatch organisations to provide clarity and address questions.
- A programme of engagement events with staff from the organisations involved.
- Engaging with existing patient, carer and community groups and forums within the organisations and the local system to build awareness and seek initial views. This includes local Community Engagement Groups across Hampshire during January.
- Engagement events with partners.
- Engagement events with Isle of Wight community partners.
- Meetings with partners, for example Public Health leads and Solent Mind colleagues.
- Conversations with local MPs as part of regular meetings.

There has been much excitement from a number of clinical services who are already working to see how services can be improved through closer collaboration. If any substantial service changes emerge these will be separately consulted upon as appropriate.

Next steps

The full business case is due to go before Trust boards in October 2023 for approval before being submitted to NHS England. A key focus in the coming months will be upon more extensive engagement to help shape the development of the full business case and the clinical strategy for the new organisation.

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……
Signed by (Director)

Appendices:

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

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	28 June 2023
Subject:	Better Care Fund Returns
Report by:	Jo York, Managing Director, Health and Care Portsmouth
Wards affected:	N/A
Key decision:	Yes
Full Council decision:	Yes

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1. Purpose of report

1.1 To update the Health and Wellbeing Board on the Better Care Fund Returns for 2022/23 and 2023-25

2. Recommendations

2.1 The Health and Wellbeing Board is requested to ratify the submitted Better Care Fund End of Year Return 2022/23 v1.3.

2.2 The Health and Wellbeing Board is requested to approve the draft Better Care Fund Narrative before submission to national NHS England Better Care Fund Team on 28 June 2023.

2.3 The Health and Wellbeing Board is requested to approve the draft Better Care Fund Planning Template 2023/25 before submission to national NHS England Better Care Fund Team on 28 June 2023.

3. Background

3.1 The Better Care Fund (BCF) requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF Programme.

3.2 The BCF End of Year Return 2022/23 for Portsmouth was approved by Dr Linda Collie 22 May 2023 and Cllr. Matthew Winnington 23 May 2023 on behalf of the Health and Wellbeing Board and was submitted to the national BCF team 23 May 2023.

3.3 The national BCF team then requested an amended version that adjusts both the income and expenditure, due to an overspend, a revised version (v1.3) was submitted 16 June 2023 and attached for ratification.

Portsmouth CITY COUNCIL

3.4 In addition to the BCF End of Year Return 2022/23 there is also a requirement for all areas to provide a Narrative and Planning return covering 2023/25. These returns reflect local arrangements for integrated working.

3.5 The 2023/25 submission is based on 22/23 agreed activity uplifted where appropriate should information be available. The final formal budget for 2023/24 is still being agreed and has not yet been presented to BCF Partnership Management Group (PMG), as a result, this submission is on a best-efforts basis with the information available at the time. For income allocation to task, this have been achieved on a best-efforts basis, with elements allocated to the largest areas of spend. For clarity, income is not tracked at a scheme level operationally.

4. Reasons for recommendations

4.1 Assurance of final plans will be led by Better Care Managers (BCMs) for each region with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs).

4.2 The regionally let assurance processes will confirm that the content of local areas plans enable significant progress towards delivering against the BCF objectives and priorities outlined in the BCF policy framework and planning requirements.

4.3 A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region, following this recommendation for approval will be made by NHS England regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released subject to ongoing compliance with the conditions.

5. Integrated impact assessment

An Integrated Impact Assessment is not required for this report.

6. Legal implications

6.1 The Secretary of State for Health and Social Care has published a direction to NHS England under section 223B of the NHS Act 2006 to ringfence £5,059 million to form the NHS contribution to the BCF in 2023-24. This figure includes additional funding for discharge via ICBs (£300m) in 2023-24.

6.2 The BCF planning requirements 2023-25 represents NHS England exercising its powers under section 223GA of the 2006 Act. It sets out the detail in relation to the conditions and requirements agreed with the government in relation to the receipt and use of NHS and local government contributions to the BCF, including details of how conditions and requirements will be monitored to ensure they are met. This guidance is also an annex to the NHS operational and contracting guidance for

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2023/24. ICBs should ensure that plans for use of the NHS minimum contribution, discharge funding in ICB allocations and assumptions related to capacity and demand for intermediate care align to their wider activity and financial plans.

7. Director of Finance's comments

7.1 It is acknowledged that the BCF returns were completed in conjunction with Portsmouth City Council and ICB finance representatives.

……
Signed by: Jo York Managing Director, Health and Care Portsmouth

Appendices:

1. BCF End of Year 2022/23 Final v1.3
2. BCF Narrative 2023-25 Draft
3. BCF Planning 2023-25 Draft

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

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

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Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview
The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS). The key purposes of BCF reporting are: 1) To confirm the status of continued compliance against the requirements of the fund (BCF) 2) To confirm actual income and expenditure in BCF plans at the end of the financial year 3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans 4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above. BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.
Note on entering information into this template
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:
Data needs inputting in the cell
Pre-populated cells
Note on viewing the sheets optimally
To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.

2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	Portsmouth	Yes
Completed by:	Denise Perry	Yes
E-mail:	denise.perry5@nhs.net	Yes
Contact number:	07919 920950	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Portsmouth

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Portsmouth

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	827.0	Not on track to meet target	The current predicted year end indicator is 881 which is above our planned value. Some of the mitigating factors in the underachievement of this indicator are: - Challenges in capacity and demand in	The development and setting-up of the Acute Respiratory Infection (ARI) hub supported patients to remain in the community The development of UCR and Virtual Wards	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.6%	Not on track to meet target	The current value, based on April 22 to March 23 data, is 90.96%, which is below our planned value. The mitigating factors in the underachievement of this indicator include:	Reviewed and implemented changes in discharge planning by Portsmouth Transfer of Care Team (PTOC).	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	537	On track to meet target	As at March-23 the number of admissions to nursing and residential placements in Portsmouth was 164 (data source PCC BI data) against our planned target of 170. This is 518 per 100,000 population against our	The development of the integrated D2A model to support people to return to their own home rather than as a residential admission.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	86.9%	Not on track to meet target	The acuity of patients that have been discharged to community rehab and reablement services has increased over the year, and therefore due to this higher level of acuity re-admissions have increased	Q1 84%, Q2 80% and Q3 83% indicating that we are not on track to meet target this financial year (Q4 figures will be available in July). We have commenced a review of our rehab	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Portsmouth

Income

	2022-23	
Disabled Facilities Grant	£2,059,689	
Improved Better Care Fund	£8,616,489	
NHS Minimum Fund	£16,814,564	
Minimum Sub Total		£27,490,742

	Planned	Actual		
NHS Additional Funding	£6,243,436	Do you wish to change your additional actual NHS funding?	Yes	£7,818,258
LA Additional Funding	£2,881,000	Do you wish to change your additional actual LA funding?	Yes	£12,995,949
Additional Sub Total	£9,124,436			£20,814,207

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£36,615,178	£48,304,949

ASC Discharge Fund

	Planned	Actual		
LA Plan Spend	£742,014	Do you wish to change your additional actual LA funding?	No	
ICB Plan Spend	£1,420,000	Do you wish to change your additional actual ICB funding?	No	
ASC Discharge Fund Total	£2,162,014			£2,162,014

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£38,777,192	£50,466,963

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	At plan submission in 2022-23 the new Better Care Fund schemes were in development and budget setting in both the LA and NHS was not finalised. Additional budget was identified to bring into the pooled budget to develop integrated services.

Expenditure

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes

	2022-23
Plan	£36,615,178

Do you wish to change your actual BCF expenditure?	Yes	Yes

Actual	£48,304,949	Yes

	ASC Discharge Fund
Plan	£2,162,014

Do you wish to change your actual BCF expenditure?	No	Yes

Actual	£2,162,014	Yes

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	At plan submission in 2022-23 the new Better Care Fund schemes were in development and budget setting in both the LA and NHS was not finalised. Additional budget was identified to bring into the pooled budget to develop integrated services.	Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Portsmouth

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	BCF supported the integration of Jubilee House (NHS managed) and Southsea Unit (Social Care managed) into a single Health and Social Care unit called the Jubilee Unit. This now supports a blended discharge to assess model including rehabilitation. The BCF has continued to support:	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	The BCF schemes were implemented as planned including the UCR, bed based community rehab model, Virtual care delivery programme and PCAT discharge service.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	The intermediate care model which includes all partners across Health and Social Care teams working in the community, actively supported people to remain safe and live healthy independent lives in their own homes, or place they call home, for as long as possible.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	9. Joint commissioning of health and social care	BCF supported the integration of Jubilee House (NHS managed) and Southsea Unit (Social Care managed) into a single Health and Social Care Unit called the Jubilee Unit. This now supports a blended discharge to assess model including rehabilitation.	Yes
Success 2	8. Pooled or aligned resources	Solent NHS Trust and Portsmouth City Council pooled and aligned resources to develop an optimal UCR and Virtual Ward model that meets national requirements and the needs of the local population. This model supported the delivery of our admission avoidance plans to provide a single pathway to support Portsmouth patients in crisis, supported by clinicians within Community Localities and PRRT.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	7. Joined-up regulatory approach	The challenges with the Jubilee Unit transfer around NHS and Local Authority guidelines, regulations and policy differences. For example food hygiene standards, infection prevention and control standards, agenda for change and Local Authority employment policy.	Yes

Challenge 2	9. Joint commissioning of health and social care	Workforce recruitment for nurses, social workers and other health and care professionals	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Portsmouth

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.
The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.

1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
Admin	Administration		£7,420	£7,420	N/A	N/A	No	N/A	Yes	This funding supported the administration of the ASC discharge fund schemes	None to report
Awaiting Assessment - Dom Care	Home Care or Domiciliary Care	Domiciliary care packages	£49,000	£256,849	12,665	Hours of care	Yes	The initial planned value covered a limited Dom Care cohort. As increased Dom Care pressures were experienced more broadly, funds were reallocated to provide better coverage for the Dom	Yes	Packages of care were readily available to support discharges.	None to report
Awaiting Assessment - Nur / Res	Residential Placements	Other	£332,000	£145,015	164	Number of beds	Yes	The initial planned value was based on a period of high activity. Volumes during the grant phase were lower than expected (allowing funds to be reallocated to the Dom Care remit).	Yes	Scheme provided sufficient capacity to support with placement requests.	Strong relationships were built with providers to support efficient flow
Bridging Care	Home Care or Domiciliary Care	Domiciliary care packages	£65,824	£48,677	1,820	Hours of care	Yes	The implementation of the plan was delayed (due to lead time required to amend provider contracts). Spend occurred over a shorter period than initially planned.	Yes	Bridging hours were utilised to support additional discharges	Due to the lead time required to amend provider contracts the scheme could
Care Assessment Capacity	Additional or redeployed capacity from current care workers	Costs of agency staff	£287,770	£218,512	2,388	hours worked	Yes	There were challenges in recruiting agency staff in the time frames, so spend lower than expected.	No	There were challenges in the existing workforce which meant the full planned additional capacity was not realised.	Difficult to recruit temporary staff for a short period of time.
Jubilee Unit	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£1,066,000	£1,066,000	10	Number of beds	No	N/A	Yes	The 10 surge beds remained open throughout winter and were fully utilised providing additional bedded D2A capacity to support discharges form the acute.	The surge beds provided additional capacity and are a good option for future surge
Mary Rose Manor (MRM)	Residential Placements	Nursing home	£269,000	£269,000	5	Number of beds	No	N/A	Yes	The block booking of 5 nursing beds supported complex discharges from the acute; the beds had 98% utilisation. Very strong working relationships with the home were developed.	Due to the success of this scheme the block arrangement continues into
PRRT Workforce	Additional or redeployed capacity from current care workers	Redeploy other local authority staff	£85,000	£85,000	3,537	hours worked	No	N/A	Yes	Additional resource supported an increase in PRRT caseload over the winter period.	Scheme has supported a review of our community rehab and reablement

Schemes added since Plan											
Community equipment to support discharge	Other		£65,541	£65,541		N/A	No		Yes	Community equipment supported the timely discharge of patients and reduced the likelihood of delayed discharges.	No specific learning to report

Planned Expenditure	£2,162,014
Actual Expenditure	£2,162,014
Actual Expenditure ICB	£1,420,000
Actual Expenditure LA	£742,014

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).
Portsmouth
Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).
NHS Hampshire & Isle of Wight Integrated Care Board, Portsmouth City Council, Portsmouth Hospitals University Trust, Adult Social Care, Solent NHS Trust, Southern Health NHS Foundation Trust, Portsmouth Primary Care Alliance, Primary Care Networks, Social Care providers including the Housing Renewals Team, Healthwatch, and Voluntary, Community and Social Enterprise groups across the city.
How have you gone about involving these stakeholders?
Work continues on the implementation of the Portsmouth Health and Wellbeing Strategy 2022-2030, and Portsmouth's City Vision for 2040. Stakeholder engagement takes place through regular forums and working groups. For example, at the John Pounds Community Centre in Portsea, various events / drop-in sessions have taken place, such as the HIOW ICB Partnership Assembly. The aim was to work with our partners and people in the community to develop the priorities and determine what we should deliver in partnership across the Hampshire and Isle of Wight geography, looking at what we already do and creatively thinking about the future approach based on evidence and insight. We also deliver Live Well sessions Live Well in Portsmouth - Portsmouth City Council where we get an understanding of the issues that matter to the community to help inform our direction of travel. A recent Social Value event was delivered called 'Broadening Horizons', this is part of an ongoing Portsmouth wide plan to network and engage with all private, public and VCSE organisations' who work in the City to showcase innovation and widen perspectives, increasing engagement and opportunities for all to maximise local impact by focusing on the health of our communities, individuals, and environment in line with the updated agreed priorities for the city in the Health and Care Portsmouth Blueprint.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area

During 2022/23 HIOW ICB (formally Portsmouth CCG) revised its arrangements with Portsmouth City Council to extend and further develop the integration and joint working previously in place. This was partly in response to the Health and Care Act (2022), the White Paper; Health and Social Care Integration: joining up care for people, places, and populations, published on 9th February 2022, and also from the desire for both health and care to better serve our local population. The White Paper outlines the benefits to staff and patients around better care through the introduction of Integrated Care Systems (ICS) to improve the links between health and social care and references Portsmouth's pioneering approach to integration through Health and Care Portsmouth.

The ICB (Portsmouth Place) agreed and signed its section 75 (s75) which set out the framework for joint working across health and social care within the city. Several individual schedules were included within the framework, one of which was the Commissioning Schedule which included a revised BCF scheme, enabling bringing together a wider range of staffing and financial resource within the Health and Care Portsmouth model in line with the integration agenda in the city. This has now transferred to the ICB as the successor body.

The BCF schedule of the s75 framework, is overseen by the Partnership Management Group (PMG) which was developed with legal advice and guidance provided by Bevan Britten, describes, and supports a robust programme management and governance approach to support the delivery of Better Care from the outset and will continue into the future.

Work continues on governance arrangements including the development of the Health and Care Portsmouth Place-Based Partnership Board (previously the Joint Commissioning Board) and the place-based operating model to ensure effective decision-making and reporting within the establishment of the ICB on 1st July 2022.

The BCF PMG currently meets bi-monthly, over the next 12 months it will be moving to a quarterly meeting model. The four core voting members from Portsmouth City Council and Hampshire Isle of Wight ICB (Portsmouth Place), representing Adult Social Care, ICB and finance (Local Authority & ICB) will oversee the transition providing strategic direction on individual schemes and projects, reviewing, and agreeing pooled financial schedules and activity information. This group will monitor, review, and challenge the delivery of the BCF programme including overseeing quality, performance and tackling inequalities. 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), any concerns will then be escalated to Health and Care Portsmouth Place Based Partnership Board.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

This plan describes how Health and Care Portsmouth and Portsmouth City Council, along with other key partners in the city, will work together to further strengthen the place-based health and care integration across the wider hospital footprint and the HIOW geography of the new ICS, to ensure the successful development for our region that is able to fulfil all the ambitions set out in the White Paper. We will work closely, understanding local needs and designing services to meet them in line with the issues and challenges identified as part of the city's Health and Wellbeing strategy, and the Blueprint for Health and

Care in Portsmouth, which identifies significant health inequalities, but also the strengths that exist when we come together to improve and support the health and wellbeing of our residents.

Partners agreed key commitments and principles for Health and Care Portsmouth as part of the Blueprint refresh and five place-based priority areas were identified:

1. Health improvement – focusing on addressing health inequalities and improving outcomes.
2. Children's services (0-25) – the overarching strategic aims/objectives of commissioning under this scheme specification are to deliver on the priorities identified in the Children's Trust Strategic Plan.
3. Vulnerable adults – focusing on reducing suicide and self-harm, implementing a comprehensive mental health strategy, supporting people with learning disabilities and those with the most complex lives, including substance misuse and the homeless population.
4. Primary and community services integration – using the BCF, focusing on frailty and people with long term conditions organised around three key themes:
   - Early intervention and self-care
   - Admission avoidance and effective discharge
   - Proactive care
5. Person centred care planning.

There is over a ten-year history of integrated working in Portsmouth for Adult Continuing Health Care (CHC). The council is the lead agency, with the Portsmouth place based ICB staff seconded to the Local Authority for Assessment and Commissioning. The Team is separate to Children's CHC services, but work is being undertaken to support an All Age CHC model across the ICB. Opportunities for joint working and learning are being established.

Portsmouth's integrated Children's Commissioning Team sits across Portsmouth City Council and Health and Care Portsmouth. The teamwork with families and providers to design and deliver effective services and pathways for physical and mental health of children and young adults.

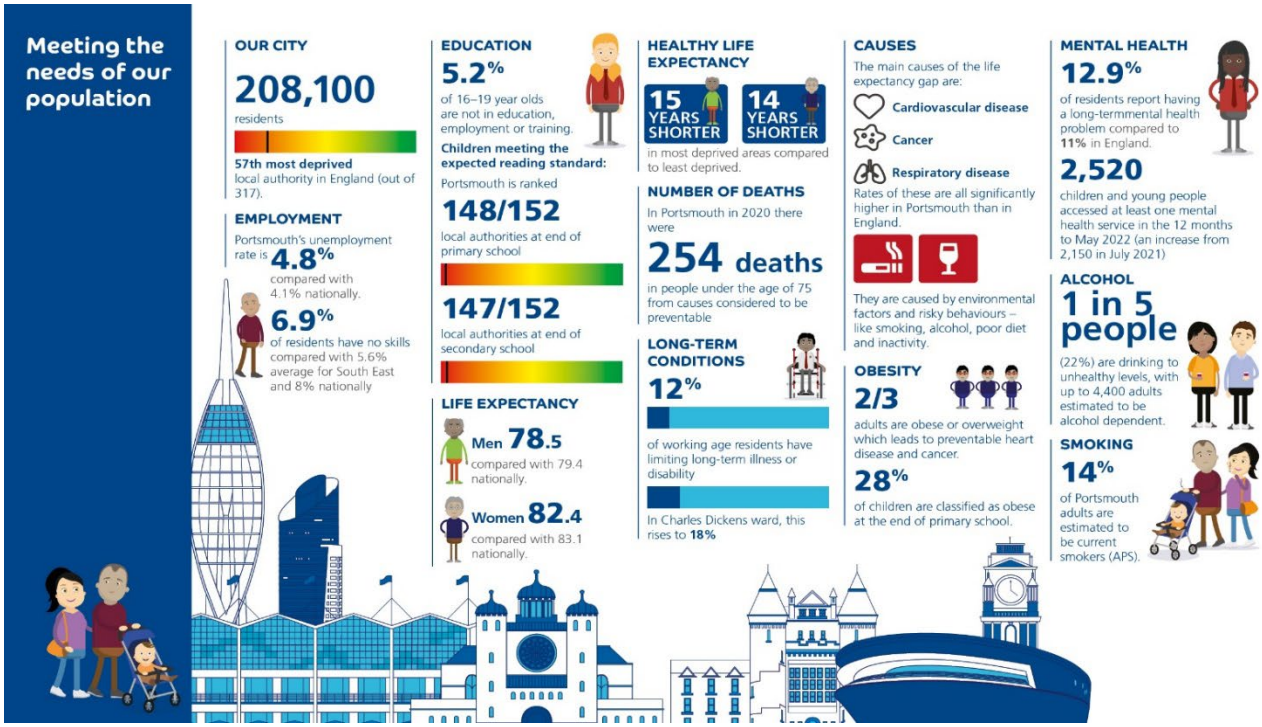
Our vision is for everyone in Portsmouth to be enabled to live healthy, safe, and independent lives, with care and support that is integrated around the needs of the individual at the right time and in the right setting. We will do things because they matter to local people, we know that they work, and we know that they will make a measurable difference to their lives.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The slide below shows an overview of key characteristics of the Portsmouth population:



There is a strong history of partnership working with a clear city vision led by the community to establish an agreed Health and Wellbeing (HWB) strategy for 2022-2030, Health and Care Portsmouth Blueprint, and operating model, which includes integrated service delivery models and robust integrated commissioning arrangements to address the challenges coming out of the pandemic and the need to refresh and agree priorities. There is the opportunity as part of ICS development to strengthen the partnership arrangements to improve health outcomes and reduce health inequalities both locally and working at scale.

Portsmouth's HWB Strategy 2022-2030 has been refreshed to understand the significant impacts on health and wellbeing in Portsmouth, and what we as a system can do to bring about some key changes. Our HWB brings together a wide range of partners including commissioners and providers of public sector services covering health and care services for all ages, community safety and education. Three cross cutting issues have emerged that will be explored further as this strategy evolves:

Community Development
Working with local people, groups and organisations in a way that recognises and nurtures the strengths of individuals, families, and communities, and helps to build independence and self-reliance, is a vital alternative to reliance on traditional services. The work with stakeholders to develop each of the priorities in the strategy reiterated this key message and it will underpin our approach; this builds on the commitment to working differently embodied in HIVE Portsmouth that played an essential role in the city's pandemic response.

Health, Equality and Diversity
Covid-19 has shone harsh light on some of the health and wider inequalities that persist in our society. It has become increasingly clear that the pandemic has had a disproportionate impact on many who already face disadvantage and discrimination. The impact of the virus has been particularly detrimental on people living in areas of high deprivation, on people from Black, Asian and minority ethnic communities (BAME) and on older people, those with a learning disability and others with protected characteristics.

Sustainability and Resilience
The link between sustainability, climate change and health is recognised globally. At its most basic level, a sustainable city requires a healthy population; one that is resilient to the challenges of future climate change

and one that is able to respond positively to the changes needed to enable sustainable communities, particularly as we move into post-pandemic socio-economic recovery. The climate crisis is a health crisis, and we recognise the need to promote equality, health, and quality of life in order to achieve a sustainable future. Covid-19 has enabled us to fundamentally re-assess what is needed to tackle the scale of change and transformation required, reinforcing that support for vulnerable people and communities is vital, and that we need to shift as a system from a focus on efficiency to one of resilience.

Over the longer-term, the Office for National Statistics (ONS) Health Index provides an objective framework for assessing the impact over time of the HWB's focus on the 'causes of the causes'. While there is a lag between activity and updated data, it gives a good baseline of our population's health before the pandemic and will allow the board to assess if we are making a measurable difference over time on the priorities the board identifies, if that is having an effect on the overall health of the local population, over time and in comparison, to other areas.

We have agreed some key principles for how all health and care partners would work together in the city:

- **Outcomes** - improving outcomes for Portsmouth people will be at the heart of place-based working.
- **Equality** – Our place-based working will seek to shape service delivery to reduce inequalities in the city.
- **Evidence** – Place-based working will be informed by the needs of local communities and evidence of what works.
- **Integration** – Place-based working will integrate service delivery around the needs of individuals and families.
- **Prevention** - Prevention and early intervention services will reduce dependency on public service delivery.
- **Participation** - Residents will be active participants in the co-production of services.
- **Accountability** - Resource allocation decisions will be transparent, contestable, and locally accountable.
- **Value for money** - Decisions will be driven by the goal to achieve optimum quality, value for money and outcomes.
- **Partnerships** - Strong and effective partnership is key to place-based working.

Health & Care Portsmouth partners share a number of aspirations:

- Personalisation of care and support – including domiciliary care intervention and review, end of life care planning, future care planning, and Continuing Healthcare assessments.
- Improving health and well-being and strengthening our communities using an asset building approach – including partnerships with the VCSE sector, HIVE, community helpdesk and community development.
- Strengthening primary and community care services – including integrated intermediate care to avoid hospital admissions and links with Primary Care Networks.
- Improving access to acute/secondary or specialist services – including system resilience, urgent, diagnosis and elective care pathways.
- Improving access to mental health services at all stages of the pathway; well-being, access to community support, primary mental health services, secondary care and planned and crisis services.

We have established enablers for partnerships across the City including:

- Health & Care Portsmouth Commissioning - Integrated Commissioning Service provided by the City Council and ICB.
- Portsmouth Rehabilitation & Reablement Team – service provided by Solent NHS Trust and City Council, funded via the BCF.
- Senior Responsible Officer for Hospital Discharge & Flow - City Council and Solent NHS Trust provided.
- Continuing Health Care – City Council and ICB provided.
- Adult Mental Health – City Council and Solent NHS Trust provided.
- Integrated Learning Disability Service - City Council and Solent NHS Trust provided.

- Quality Team - City Council and ICB provided.
- Common Record System across Primary Care, Solent NHS Trust, and Adult Social Care.
- Safety and cost-saving in the home – Home Energy Assistance top up grant and Home Improvement Loan.

The City has a thriving provider alliance arrangement through Portsmouth Provider Partnership (P3) comprising of Health and Care Portsmouth, PPCA, Solent NHS Trust, PCC, HIVE Portsmouth, PHU Trust, Healthwatch Portsmouth, and Primary Care Networks within the city who are committed to working together to integrate primary, community, social care and voluntary services in Portsmouth City. This has been and continues to be an important vehicle to improve provision of community care within Portsmouth.

Transformational activities have progressed well since the establishment of the partnership in trialling new ways of integrated working. P3 will support the establishment of the successful pilots into business-as-usual including providing more integrated services outside of hospital for example:

The establishment of a Breathlessness Hub, supported by P3 has been adapted to support incidental findings from the national Targeted Lung Health Check (TLHC) programme, such as mild emphysema diagnosis. P3 has also supported practices with an additional Pharmacist Technician to care for patients with a coronary calcification diagnosis. Both these services will help improve outcomes for patients, who were not previously known to need support.

From 24 April 2023 the newly built TLHC clinic facility at Rodney Road opened to patients. The updated process has become a one stop shop approach, rather than the previous virtual (phone call) followed by CT scan. This fully integrated offer is provided by Portsmouth Hospital University Trust, InHealth, Solent NHS Trust and Portsmouth City Council Wellbeing Service. Patients have full access to all the services to support them on their lung health journey; patient transport is also available to improve equity.

The P3 programme will be a key building block in the foundation of the HIOW ICS and the Portsmouth & South East Hants Integrated Care Partnership (ICP) and continues to be the enabler to delivering the outcomes set out in the Portsmouth Health and Care Blueprint.

The partners are committed to continued joint working across the system and there is a shared desire to build a strong primary, community, and social care service. The programme board is established by the partnership, whose participants remain sovereign organisations, to provide a financial and governance framework for the delivery of the P3 programme.

Portsmouth aims to deliver the following inter-related programmes of work:

- Urgent Community Response and Virtual Ward developments
- Community Rehabilitation and Reablement reconfiguration
- Non-Criteria to Reside reduction
- Telemedicine for Care Homes
- Voluntary Community Social Enterprise (VCSE) Wellbeing Collective
- Proactive Case Management
- Warmth on prescription
- Developing dementia extra care units

Urgent Community Response & Virtual Ward Developments

Portsmouth embedded a single pathway to support patients in crisis through implementing the Urgent Community Response (UCR) service in April 2022, which involved a reconfiguration and refocus of community services. Since the implementation of the UCR pathway, multiple workstreams including Call2Converse and a single UCR phone number have been embedded to increase admission avoidance within the LDS. The Portsmouth UCR service was featured in an ITV news article in March 2023: ITV Meridian feature on the Urgent Community Response Service

Portsmouth implemented a frailty Virtual Ward (VW) in August 2022, providing an alternative to acute care through step-up provision in the community. VW's support patients who would otherwise be in hospital, to receive the acute care, remote monitoring, and treatment they need in their own home or usual place of residence. Patients are admitted to the frailty VW through the UCR team who provide rapid assessment and intervention, an holistic approach to care, with a daily review, and a clear escalation and discharge pathway. Patients are monitored through technology and digital solutions alongside in-person care to deliver 'technology enabled care' to the frail patient cohort.

The Portsmouth UCR and VW services are provided by Solent NHS Trust and supported through the BCF. A phased trajectory was agreed locally for opening the VW beds, reaching the full commissioned capacity of 15 beds from March 2023 which remains the commissioned capacity in 2023/24. In 2023/25 we are planning to expand our UCR and VW provision to increase the patient cohorts that can be supported by the service. We have agreed a pathway to implement respiratory VW beds through increasing skills and competencies within the team, and plan to develop further pathways for the management of acute episodes for patients known to Specialist Services through the UCR hub.

Community Rehabilitation and Reablement Reconfiguration
Within Portsmouth there are currently multiple commissioned community rehabilitation and reablement services which are supported through the BCF. The Portsmouth Rehabilitation and Reablement Team (PRRT) is a well-established service which aims to support people to remain in their own home, through providing admission avoidance and facilitating discharges from acute care. Additional community service provision in the city that supports admission avoidance and discharge includes the Community Independence Service (CIS), community Occupational Therapy (OT) and community physio services.

A review of local rehabilitation and reablement services commenced in 2022/23, with an aim to provide a single rehabilitation and reablement offer across Portsmouth, ensuring that residents entering Health and Care services receive rehabilitation and reablement as a default offer, increasing their independence and decreasing their reliance on statutory services. The review utilised a systems-thinking approach, with aims including defining a single purpose, a review of demand, process mapping, and an analysis of current processes and pathways.

The review identified three key service delivery elements to local community rehabilitation and reablement provision: Discharge to Assess (D2A), short term care, and long-term care. The recommendations from the review will be taken forwards in 2023/25 to provide a true single rehabilitation and reablement offer across Portsmouth city, ensuring there is a defined staffing requirement for each service element, an appropriate skill mix, and capacity for growth. The future service provision aims to promote independence and prevent hospital admission, increase home first discharges, deliver a reduction/rightsizing in packages of care, a reduction in nursing and residential home placements, operating within a single budget and staffing establishment with increased integrated working.

Non-Criteria to Reside Reduction
To support the national drive to reduce the number of medically fit to discharge patients in our hospitals, local plans have been developed to deliver and maintain a 50% reduction in patients who no longer meet the Criteria to Reside (CtR) at PHU from October 2023. Portsmouth have agreed the following schemes to support this reduction, through services funded through the BCF:

- Implementing the findings from the Rehab and Reablement review discussed above to reduce reliance on statutory Health and Care services and increase home first (pathway 1) capacity.
- Reducing the length of stay in community beds to 18 days to increase pathway 2 capacity. The Jubilee Unit was established in October 2022 providing an integrated model consisting of rehabilitation and D2A beds. Length of stay in the unit has been affected by assessment delays which we plan to improve through increasing assessment capacity. Our initial focus aims to reduce length of stay to 18 days and we will continue to explore initiatives to reduce this length of stay further.
- Assessment capacity in the D2A team has been affected by workforce challenges and increased demand. A workforce proposal for the assessment team has been developed to ensure there is

sufficient assessment capacity, and a recruitment campaign is being developed with HR colleagues to increase the attraction to potential applicants.

Telemedicine for Care Homes

In Portsmouth and Southeast Hampshire (PSEH) there are 240 care homes providing care for over 5,000 residents. Telemedicine in care homes was introduced in 2019/20 to 130 of these homes by offering 24/7 clinical support via video consultations for residents. The service was developed to enable timely and proportionate escalation by care home staff for resident assessment, which would enable people to stay well within their home. The previous service provider contract was in place until the end of 2022/23 and from 2023/24 we are working with our primary care alliance partners to develop a local telemedicine solution through BCF funding.

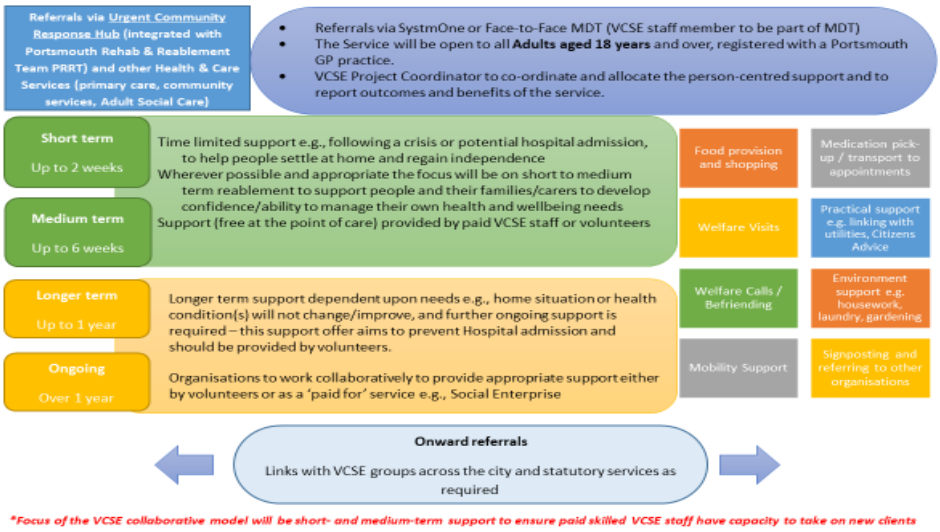
This programme will develop a local clinical hub model supporting all 240 care homes across PSEH through 24/7 clinical consultation reducing impact on primary care, reducing conveyances to hospital, ED attendances and non-elective admissions, maintaining the same level of service as the previous provider which enabled 90% residents to remain in the Care Home post the virtual consultation. We anticipate a reduction in non-elective admissions from care homes through this step-up service and have set ourselves a target of reducing the number of admissions by a further 500 in 2022/23. As the service is developed it is envisaged that it will increase support to Virtual Wards and Domiciliary Care.

Voluntary Community Social Enterprise (VCSE) Wellbeing Collective

The BCF currently supports the development of a Wellbeing Collective service model consisting of Hive Portsmouth, Salvation Army, and British Red Cross, who work together, with health and care services and the wider VCSE, to support people at most risk of hospital admission and those recently discharged from hospital.

The purpose of the development phase is to prove the concept of a VCSE collaborative approach for delivery of coordinated community social value support, rather than the previous model of separately commissioned VCSE support. The VCSE organisations have come together to develop a collective approach to delivery, each organisation supporting the others. The Collective received 655 referrals over a 13-month period (Nov 2021-Dec 2022) 87% of those referrals were for people over 65yrs of age. Over 3000 support interventions were provided (during last 6-month period).

The aim from April 2024 is to commission, via BCF funding, a longer-term VCSE Wellbeing Collective admission avoidance / discharge support service to enable both sustainability of the model to support Portsmouth residents and clarity for the VCSE organisations providing the service. Please see model below:



Proactive Case Management (PCM)
Portsmouth, alongside the HIOW ICB identified PCM as a key priority as part of the NHS Long-Term Plan commitments to support the population to age well and enable more individuals to be supported at home and remain independent. Over the last financial year, we have worked in collaboration with system partners and P3 to pilot a local PCM model, this includes Portsdown PCN commencing an in-depth review of a small cohort of patients that were identified as requiring additional support and at a higher risk of admission into emergency care, to understand their support needs and build a robust integrated proactive case management model.

This will help accelerate the Primary Care Network Directly Enhanced Service, while building on current P CN delivery models relating to health inequalities and personalised, proactive care. The BCF infrastructure will provide the additional enablers and levers to further integrated working in our places and neighbourhoods to provide proactive, joined up care for people with complex needs, including frailty, people experiencing health inequalities (defined as Core20PLUS) and people using emergency care for routine care needs.

The Proactive Care Framework will provide a blueprint for implementation and its model of care in alignment with the Fuller stocktake report. Integrated Neighbourhood Teams will be a key vehicle for implementing the model and creating a culture change towards proactive joined-up care, personalised to the individual.

Warmth on Prescription
Is an innovative Quality Improvement pilot project for 2023/24, involving integration and partnership working with Public Health, Portsmouth City Council, Primary Care, ASC, and the VCSE sector, to provide a systematic approach to addressing excess cold for patients registered at one GP surgery in the city. The aim of this project is to identify residents who are over 75, with respiratory conditions, who live in homes with a low Energy Performance Certificate (EPC) rating which indicates poor insulation. Pilot project partners will deliver targeted person-centred support, signposting to Switched on Portsmouth, the Household Support Fund and other support aiming to reduce fuel poverty, improve insulation, ventilation and heating, and to improve quality of life and reduce the number of hospital admissions and excess winter deaths relating to symptoms exacerbated by living in cold homes.

Dementia extra care units
In 2018 the Community Wellbeing Health & Care committee agreed 'that work continues on the re-purposing of the existing Edinburgh House site for the development of a specific dementia extra care facility, acknowledging that any development will be subject to securing sufficient capital funding'. Due to various factors including the increasing costs of building, 'fitting out' materials, labour and the impact of high interest rates. This is to ensure the proposed accommodation meets our future demands for Extra Care across the city, can be undertaken within the existing proposed cost model, and is aligned to the broader strategic approach for Adult Social Care accommodation. When the review is completed, the project will be revised based upon a set of options; the options are likely to be tabled during Summer/Autumn 2023.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches

- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Improving same day access for urgent and crisis care
This is a priority for Portsmouth and the development of a cohesive city-wide model of support is underway. The aim is to deliver triage hubs at a locality level supported by digital and telephony technology to get patients to the right place for help and support quickly, bringing together pathways of care such as respiratory, women's and men's health, mental health, and dermatology, to establish a best practice approach across the city.

Progress to-date is variable across the PCNs, some practices feel that there are only marginal gains to be made in this area as they already offer good levels of access, others are exploring opportunities for more joint working at a PCN level, particularly around shared practice roles to provide greater resilience.

Providing proactive and preventive care for people with long term conditions.
Through population health management we plan to identify at risk groups and/or potential unmet need as well as to segment and stratify the population using JSNA and HealtheIntent platform. The aim will be to utilise a range of workforce roles to reach communities and through joining up services to take a holistic and integrated approach to primary and secondary care and optimise the strengths of communities to look after their own health and wellbeing by involving communities and community leaders in defining appropriate strategies and designing care, both Community Champions and Social Prescribers are already fulfilling this role.

The aim is to develop long term condition virtual hubs to support people to manage their conditions, for example the Long Covid service which is provided by Solent NHS Trust and funded through the BCF. The aims are also to provide Wellbeing Hubs that provide a holistic approach to preventative and proactive care bringing services together. Current progress includes the development of a tier 2 weight management referral hub progressing with good engagement from the Wellbeing Service, Talking Change, and dietetics.

The proactive case management approach will identify high intensity users and provide frequent touchpoints to ensure the correct level of proactive, personalised care and support is being provided and there is rapid, priority access to community response services to support the person to remain safe and independent in their own home, avoiding the need for an admission and ensuring people only have to tell their story once, with services providing a holistic view of their individual needs. The Community Nursing Service, which is provided by Solent NHS Trust and funded through the BCF, forms part of the multidisciplinary team which supports the management of the individuals identified.

Integrated care closer to home.
We plan to develop a neighbourhood based multidisciplinary team with aligned leadership, delivering a single approach care model with a focus on proactive and preventative care rather than reactive care. The approach will initially target patients with the highest demand on health and care services and expand to cover a range of pathways and conditions whilst ensuring a person-centred approach (not condition centred).

The aim is to expand the virtual ward model through increasing social care and VCSE input to neighbourhood teams to enable discharge planning from the point of admission. For example, the VCSE Wellbeing Collective is already supporting this approach. The implementation of a 'no wrong door' approach to Portsmouth services with the aim of meeting patients' needs, will enable an integrated process ensuring patients are seen by the most appropriate team at the right time.

Carers support in Portsmouth.
This is well established with excellent cross organisational relationships across health and care organisations at an operational level. The challenge of being a small Unitary Authority with limited capacity combined with system pressures has meant that strategic leadership has historically been a challenge. Woven through our BCF narrative for 2023-2025 is our attempt to secure meaningful progress for carers in Portsmouth in terms of their access to support through a wider range of health and social care professionals, better identification in health settings, with carers being respected as expert partners in care recognising the health inequalities that carers experience.

Admission avoidance.
The Carers Service in Portsmouth is part of Adult Social Care and supports all adult carers, usually via a Carers Assessment to access support. The team take an early intervention and prevention approach seeking to build on strengths, use community assets and prevent more complex needs developing.

Assessments start at first contact, are proportionate, and scalable depending on the level of need and how the caring role progresses. The assessment and support planning process has been developed based on the principle of getting as close to perfect as possible for the carer and the person they are supporting, it meets the requirements of the NHSE 'different conversations' guidance and delivers both the legal requirements of the Care Act and the spirit of it. The service can offer joint assessments for the carer and the person they support, providing a single assessment and named worker where the care and support needs are not complex. The Carers Service does not have sufficient qualified staff to support complex cases but will work with qualified colleagues across adult social care to deliver a joined-up approach.

Data around admission avoidance has not been available locally, admissions due to carer breakdown are not routinely recorded so any data available is not reliable. However, the Carers Service works proactively with carers and those they support to avoid crisis point being reached and will work with colleagues elsewhere in the system to avoid admissions where possible. Work has begun to re-establish links between the Carers Service and the Discharge Teams with plans to maximise the potential of SystmOne, our shared client record system across health and social care.

Carers Strategic Plan.
The local Carers Strategy was due for renewal in 2020 and work began on the refresh in 2019. However, due to the pressures presented by the pandemic this work was paused, engagement plans were revisited, and a short, interim version of the plan was published in 2022. On Carers Rights Day 2022, coproduction of a new longer version of the plan commenced. The longer version seeks to address gaps in provision created by challenges in the care market and the ongoing challenge of creating greater shared ownership for the identification, recognition, and support of carers.

Trusted Assessor
The BCF this year will continue to support the Trusted Assessor which is one of the High Impact Change Model recommendations. The objective of this model is to reduce or stop the number of delays for patients who are waiting for an assessor from the Portsmouth care homes to visit the acute hospital in order to make an assessment as to whether the patients are appropriate for that particular home, and that the home could accommodate the client's needs. The Newton Report commissioned by Portsmouth and South East Hampshire, highlighted an average delay of 5.7 days per patient in PHU; the homes report that these delays were in part due to staffing pressures and difficulties identifying someone at the home who could carry out the assessment. Using the Trusted Assessor, we have reduced these delays to an average of 2 days for those homes who have agreed to using the model.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
- where number of referrals did and did not meet expectations

- unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
- patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Portsmouth have utilised the estimated capacity and demand to plan service provision. Intermediate care bed provision and community capacity has been based on detailed demand analysis to ensure optimal capacity is in place. Demand and Capacity planning from last year was improved to add seasonal trends where appropriate. The plan takes account of the capacity and demand planning to identify likely variation in levels of demand over the course of the year and Portsmouth have built the necessary workforce and service capacity to meet the estimated demand.

The community demand and capacity for social support has been calculated based on 22-23 activity undertaken by the VCSE Wellbeing Collective (the scheme is described above). The VCSE Wellbeing Collective supported on average 45 clients/patients a month, this includes both community and discharged patients. The split between community and discharged patients was not specifically captured and part of the plan for this year is to improve data collection to ascertain a more accurate split between the settings the support is provided. For the purpose of the demand and capacity planning, a 1/3rd to 2/3rd split has been applied to forecast the demand and capacity for community (2/3rd) and discharge (1/3rd).

Community demand and capacity for UCR has been calculated based on financial year 22-23 activity with a small additional expected demand, as referrals are expected to increase as UCR is further embedded within the system.

Community patients that require either ‘reablement at home’ or ‘rehabilitation at home’ will be supported by the Portsmouth Rehabilitation and Reablement Team (PRRT). The forecasted demand from community referrals is based on 2022/23 activity of community referrals to PRRT which accounted for 64% of all referrals to the service; the remaining 36% of referrals is from acute discharges. The activity has been split 50/50 between reablement/rehabilitation at home, therefore the combined figures provide our total forecast demand for supporting community referrals.

The capacity to meet this demand has assumed that the PRRT caseload size is 105, the utilisation is 92%, and the average length of stay on the caseload is 30 days. The PRRT capacity for community has been calculated based on 64% of total capacity utilised for community referrals; although it is worth noting that PRRT receive referrals from both community and hospital discharge and use capacity in a flexible manner to meet demand.

Community demand and capacity for rehabilitation/reablement in a bedded setting does not include fields with numerical values as our Virtual Wards currently support with step-up provision from the community through the UCR rather than step-up through physical beds.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65

- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

The BCF funds multiple community services across the local health and social care system, including Intermediate Care, Reablement, and Urgent Community Response. The following plans have been developed to meet the achievement ambition for the key metrics outlined above:

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions

Plans to provide more proactive and preventative care for people with Long Term Conditions (LTCs) include:

- The development of an LTC Hub model (virtual) that involves primary, community and secondary care to support people with LTCs to manage their condition and stay well.
- Exploring the potential rollout of the Acute Respiratory Infection (ARI) Hub model to support urgent, same day care.
- The development of a Pharmacy hypertension service.
- Continued development of lung health checks which will support LTC management.
- To engage with Hampshire and Isle of Wight ICB to tackle cardiovascular disease, diabetes, and respiratory; and to implement initiatives that are developed through these programmes of work.
- To work with Hampshire and Isle of Wight ICB partners with the review of locally commissioned services across Primary Care and build on opportunities for sharing best practice in relation to LTC management that will support patients to remain at home.
- Urgent Community Response Team and Virtual Wards to work with specialist services to increase capabilities and competencies to support specific LTCs.

Emergency hospital admissions following a fall for people over the age of 65

Plans to manage hospital admissions following a fall include:

- Working with system partners, including South Central Ambulance Service (SCAS), to increase falls related referrals into the UCR.
- A review of UCR processes to streamline pathways including the implementation of PCC Safe at Home (telecare) pathway for patients who have fallen and not injured.
- To build on and develop the Fire and Rescue Frailty Car in Portsmouth and Southeast Hampshire. The Fire and Rescue Frailty Car was piloted from December 22 to April 23 and demonstrated positive outcomes; plans are being developed to extend the pilot for a further 3 to 6 months whilst a longer-term more sustainable solution is agreed. The aim of this pilot was to test a Hampshire & Isle of Wight Fire and Rescue (HIWFRS) staffed Frailty Car service to support falls related referrals with the UCR Teams in Solent NHS Trust (Portsmouth area) and Southern Health NHS Foundation Trust (Southeast Hampshire area), with the aim to test and recommend a sustainable model across the Hampshire and Isle of Wight population. The longer-term plan is to establish processes and mechanisms to utilise existing HIWFRS assets in the locality (such as fire engines, special appliances, prevention team) to co-respond with UCR clinicians to support falls and mobility related patients.
- Assistive technology: Working with our safe at home team we are able to identify the correct falls assistive technology devices that can be recommended to support customers who fall and also to support vulnerable people who are at high risk of falling. The team can supply equipment with a built-in sensor, which will automatically detect that an individual has fallen and will trigger an alert. The alert can be raised to the external monitoring centre or designated carer. We also use “Just Checking” to monitor people who are on a reablement pathway following a fall; this technology monitors people’s activity in their own homes and enables practitioners to see what aids would help the individual return to independence.

The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Plans to manage admissions to residential and nursing care homes:

- Enhancing our integrated Discharge to Assess (D2A) offer to ensure assessments are completed in an appropriate setting. We are rightsizing our D2A team due to increased demand, ensuring timely assessments on pathways and reducing the need for ongoing residential or nursing care.

- We plan to reduce the length of stay at the Jubilee Unit which provides our community D2A beds, to improve flow through the unit and reduce temporary use of external placements in residential and nursing care homes. The primary delays in the unit have related to limited assessment capacity; we anticipate the rightsizing of our D2A team will support a reduction in length of stay.
- The community rehabilitation and reablement review will develop a robust offer for promoting independence and supporting people to remain in their own homes, with support from partners including the Voluntary Sector.
- The VCSE Wellbeing Collective aims to be an integrated system support offer to complement and enhance the professional health and social care input, to help people to stay well and independent at home and in their wider community for as long as possible.
- The Disabled Facilities Grants (DFGs) are an essential tool in enabling people to remain independent in their own homes and can delay the need to move into supported living or residential care settings, reducing the need for care packages.
- The Safe at Home service now operates on a fully digitalised service with digital equipment available for new and future customers supporting our vulnerable residents to live safely and independently in their own homes.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

The vision for Portsmouth is to enable people to receive the right level and type of health and care services in their own home and community wherever possible, enabling them to remain well and independent for as long as possible by maximising their recovery, managing their long-term conditions, and avoiding unnecessary hospital admissions. To support this vision, we have developed a local integrated intermediate care offer supported through the BCF which offers Discharge to Assess (D2A), rehabilitation, reablement and recovery support, primarily in people's home and in community beds where necessary, that meets the demand of the city.

We have an integrated discharge team supported through the BCF that follows one health and social care process with a continuous improvement approach that revises, and amends as required, and a single health and care leadership ensures rapid implementation of change where improvements are identified. The Portsmouth Transfer of Care Team manages all step-up and step-down care for Portsmouth City residents, including interim placements and onward care arrangements. This multidisciplinary team works in partnership with the Integrated Discharge Service (IDS) at Portsmouth Hospital University Trust (PHU) to facilitate hospital discharge and consists of staff from Portsmouth City Council (PCC), and Solent NHS Trust.

The local intermediate care offer has been revised across the city with Solent NHS Trust and Portsmouth City Council working in a more integrated way to utilise the bed stock across the city by adopting the national directive to fully embed 'a Discharge to Assess' and 'Home First' approach. The process enables people to have their longer-term needs assessed in the community outside the acute environment, supporting a reduction in lost bed days, improved utilisation of capacity to assess and meet people's needs, and a sharing of resources to where they are needed rather than based on organisational boundaries.

There are daily system meetings in place to review the current position in regard to the system pressures; this is held with all system partners and is reportable to 3 x weekly meetings in place with senior leads and Chief Operating Officers and is reported to CEO on a weekly basis.

The BCF funding supports multiple community services which aim to maintain people's independence at home. We have a strong integrated rehabilitation and reablement team and a Community Independence Service that, along with other VCSE provided services, aims to support people back home and prevent avoidable readmissions whilst optimising people's potential to remain living healthy and happy lives.

Discharge funding
Portsmouth implemented schemes to support discharges over winter 2022/23 though the discharge fund to increase social care and community capacity. Increased domiciliary, residential, and nursing care through the discharge grant enabled more people to return home more quickly. More innovative use of the fund allowed us to increase the care purchasing resource, to avoid care professionals from having to individually negotiate packages and free them to do the clinical work. Additional social work and OT resources made available through the discharge fund were appointed to impact on the assessment waiting times and follow up discharge in a timely way. Due to the positive impact of these schemes with supporting a reduction in delayed discharges, we have identified some key schemes to continue through 23/25 through the additional discharge fund allocation:

- An additional 10 D2A beds at Jubilee Unit throughout 2023/24 to increase community bedded capacity.
- Nursing and residential spot placements to support assessments completed outside the acute environment in a bedded setting as required.
- Increased domiciliary care to support home first discharges.
- Increased assessment capacity to improve flow through the community.
- Increased reablement resource to support people staying out of hospital.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
- where number of referrals did and did not meet expectations
- unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
- patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Portsmouth have utilised the estimated capacity and demand to plan service provision. Intermediate care bed provision and community capacity has been based on detailed demand analysis to ensure optimal capacity is in place. Demand and Capacity planning from last year was improved to add seasonal trends

where appropriate. The plan takes account of the capacity and demand planning to identify likely variation in levels of demand over the course of the year and Portsmouth have built the necessary workforce and service capacity to meet the estimated demand.

Demand to support hospital discharge has been estimated from using 22/23 discharge numbers from the acute hospital categorised by sub-pathway; previous demand estimates have been based on overall pathway numbers (1/2/3) and the sub-category information provides a more accurate estimate for specific demand requirements.

Social support is provided by the developing VCSE Wellbeing Collective, who supply a coordinated targeted approach. The support provided is focused on the individual's need and can be wide and varied (for example, food shopping including putting away, checking sell-by dates and balance of healthy food in cupboards). These support interventions add to the value of the overall pathway of discharge and admission avoidance care.

Hospital discharges that require either 'reablement at home' or 'rehabilitation at home' will be supported by the Portsmouth Rehabilitation and Reablement Team (PRRT). The forecasted demand for acute discharges is based on 2022/23 activity of acute referrals which accounted for 36%; the remaining 64% of referrals are from the community. The activity has been split 50/50 between reablement/rehabilitation at home, therefore the combined figures provide our total forecast demand supporting hospital discharges. The capacity to meet this demand has assumed that the caseload size is 105 and is 92% utilised, and the average length of stay on the caseload is 30 days. The capacity for hospital discharge has been calculated based on 36% of total capacity utilised for hospital discharges; although it is worth noting that PRRT receive referrals from both community and hospital discharge and use capacity in a flexible manner to meet demand.

The demand for short term domiciliary care has been calculated based on the previous year's activity and the capacity has been calculated based on the current commissioned activity.

Hospital discharge demand for support in a bedded setting has been based on 2022/23 pathway 2 demand, split by pathway sub-categories 'rehabilitation beds' and 'Discharge to Assess (D2A) beds'. The demand for 'reablement in a bedded setting' has been based on the D2A sub-category discharge numbers. The capacity has been estimated on current commissioned bed numbers (27 rehab and 30 D2A) operating at 92% occupancy with an assumed average length of stay of 18 days. Any unmet demand if the length of stay target is not achieved will be supported through external spot bed purchasing arrangements.

There is no demand and capacity forecast for 'short term residential/nursing care for someone likely to require a longer-term care' as this demand and capacity is captured within D2A above.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Portsmouth has adopted the national directive to fully embed a 'Discharge to Assess' and 'Home First' approach, which means that people are supported to safely leave hospital as soon as they are clinically able, that assessments of long-term care and support needs to happen outside of the acute trust and that for most people, all of this happens in their usual place of residence. The local intermediate care offer has been revised across the city with Solent NHS Trust and Portsmouth City Council working in a more integrated way, with the shared health and care resource in the BCF supporting this ambition.

The Portsmouth Transfer of Care (ToC) Team is supported through the BCF, which manages all step-up and step-down care for Portsmouth City residents, including interim placements and onward care

arrangements. This multidisciplinary team works in partnership with the local acute hospital to facilitate hospital discharge, consisting of staff from Portsmouth City Council (PCC), and Solent NHS Trust. The multidisciplinary team supports the identification and progression of discharge requirements, to enable people to be discharged safely into an appropriate setting.

The BCF supports our local community service provision, including rehabilitation and reablement services through health and care providers. We are reconfiguring our community rehabilitation and reablement services in 2023/25 to develop an integrated model which best meets the city's needs, including increasing home first capacity to support more people to be discharged to their usual place of residence. The reconfiguration will support the implementation of a 'no wrong front door' approach to accessing rehabilitation and reablement services for the city, in which patients will receive an inclusive, holistic assessment helping to meet their crisis needs and supporting them to return to independence following a crisis or deterioration by providing a strength-based approach, supporting individuals to access the support they require.

We are also reviewing and refining our short-term domiciliary care provision, working closely with providers to develop a robust offer to increase people receiving reablement support at home rather than in a bedded setting. These plans are supported through the BCF and are anticipated to meet our ambition to discharge people to their usual place of residence.

The BCF funds the Portsmouth Community Equipment Store; one of the key functions of the service is to provide equipment to support patients to be discharged to their usual place of residence. This service is jointly funded by Health and Local Authority, who work closely with the provider to ensure optimal delivery of this service. The monitoring of this service is conducted through routine contract review meetings, with the provider submitting reports which provide oversight of the quality and performance of the contract.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

The High Impact Change Model (HICM) self-assessment 2022/23 is currently being refreshed. A dedicated Discharge Programme has been established across HIOW ICB with a clear governance structure and the appointment of a leadership team from across the ICB and Hampshire NHS Trusts.

To date this programme of work has held two initial workshops in May 2023 with Local Authorities, Provider Chief Operating Officers, and a range of clinical leaders from across the system with an aim to prioritise the focussed workstreams. The next steps involve five main pieces of work:

1. The **completion of Local Delivery Systems Self Assessments** for the Department of Health 'Discharge' visit 22 May 2023
2. Working in conjunction with the Southern Health NHS FT and Solent NHS FT Fusion programme.
3. A workshop took place end of May **to review short term discharge beds** - availability, usage, admission criteria, purpose, clinical effectiveness across Health and Local Authorities with the aim to standardise the offer across HIOW, improve productivity and quality.
4. A workshop took place end of May **to review Single Point of Access** teams – to identify and address any unwarranted variation.
5. **Map and test existing discharge flows** – Clinical team visits to sites to 'test' discharge pathway flows (using a model used successfully in Dorset ICB to reduce non-Criteria to Reside delays) planned for June. The clinical visit methodology is currently being planned. The aim of the visits will have small multidisciplinary teams of clinical staff, ideally visiting all hospital and bedded capacity sites (acute and community, mental health), to speak to staff, patients, service-users, families about existing discharge processes and ways of working.

All the above scoping will take into account the HICM recommendations and the Discharge Programme will then feed into the development of a Transformation Programme for 23/24 and beyond.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The Better Care Fund schedule of the S75 framework, which is overseen by the Partnership Management Group (PMG), describes and supports a robust programme management and governance approach which supports the delivery of BCF. 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).

The primary focus of the Care Act is to promote wellbeing and to support people to maintain their independence. Through the integrated work of supporting hospital discharge and admission avoidance a coordinated approach of VCSE support is being developed. The VCSE Wellbeing Collective aims to be an integrated system support offer to complement and enhance the professional health and social care input, to help people to stay well and independent at home and in their wider community for as long as possible. Currently the service can see 45 people per month and of those, 80% remain at home after 6 months of support.

Other support to maintain independence is provided by the British Red Cross. They provide a community short-term (up to 12 weeks) equipment loan service, including wheelchairs, for the benefit of people who require aids to remain or return to living independently in their normal places of residence. This service is commissioned across most of Hampshire, excluding Southampton. Portsmouth funds their element of provision via BCF funding. In Quarter 3 2022/23, 2,070 were items issued, of which 909 for acute medical conditions, 256 for long term conditions, 62 for hospital discharge and 30 for palliative care. This service is different to, but complementary to the Portsmouth Community Equipment Store mentioned above.

Social Care Reablement Assessment Service supports the provision of direct social care support within Rowans Hospice for cases involving Palliative and End of Life Care. The aim is to provide direct patient and family support within the Hospice, home, or through the Living Well Centre Compassionate Hospice Care.

Portsmouth Primary Care Alliance (PPCA) is an integrated Primary Care service which supports the sustainability of General Practice as well as the delivery of locally commissioned and Direct Enhanced Services, including extended access to routine appointments and Out of Hours Services. It also provides an Acute Visiting Service to provide treatment to registered patients at home which helps to both reduce attendances at A&E and avoid unnecessary admission to hospital. BCF funding contributes to this service by providing individuals with more choice about the care they can receive in the community to help them stay well at home.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

BCF funds will continue to be focused on the operational delivery of carers support including the provision of breaks and ensuring as seamless an experience as possible for carers across the health and social care system. However, the Carers Service which is part funded by the BCF will make renewed efforts to capitalise on the opportunities presented by the Health and Care Act and the ICS structures to further the carers agenda.

Common things carers want help with are (quotes from carers and professionals):

Help to get a break - a member of staff called a carer up to see if the planned Direct Payment was in place and he was using the sitting service. The carer advised that "I have changed his life" he had been on

antidepressants for years (200mg) and he is now down to 75mg every other day. He is happy and he puts it all down to being able to have the time away and totally switch off from his caring role.

Information, advice and gaining useful knowledge - "Thank you ever so much for calling and being so understanding. I can't thank you enough, not just the Carers Centre but each person who works/volunteers there too! you really do make such a huge difference to our lives."

Emotional support, problem solving and risk management - Parkinson's nurse "I have just had a patient and his wife in my clinic. His wife has felt so very well supported by you at the carers centre. She has really benefitted from your meetings both at your centre and at your allotment and activities (breaks) you hold. She says she gets really excited when she receives a phone call inviting her to events that you hold. It has certainly provided her with a lot of emotional support, and she is coping so much better than she was when I saw her 6 months ago. It has also helped my actual patient as he feels happy that his wife is less burdened by him."

Planning for an emergency - The Carers Service works from the Carers Centre which is a community hub for a range of carer activity including groups, training, cooking activities and events, most of which are run by partners from a variety of organisations across the city. Examples include public health funded cookery sessions, carers peer support activities, young carer activities, training sessions and specialist clinics.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The purpose of the DFG is to provide funding to individuals living in owner occupied and privately rented properties, to help them make changes to their living environment. DFGs are an essential tool in enabling people to remain independent in their own homes and can delay the need to move into supported living or residential care settings, reducing the need for care packages. For all these clients, Housing Services work closely with Occupational Therapists from both health and social care under a section 113. We have amended our processes to simplify them and enhance client service.

During 2019-20, Portsmouth agreed with recommendations for the flexible use of the DFG allocation. This enabled Health and Care Portsmouth and Private Sector Housing to test new ways of working and operating structures to benefit residents requiring adaptations at home. In July 2020 with the success of a pilot scheme, changes were agreed by the BCF board on a permanent basis, with a further addition of exempting all DFG's from the means testing.

In November 2021 Portsmouth City Councils Private Sector Housing Financial Assistance Policy 2021 was adopted. This revised Policy included the implementation of the agreed changes to become permanent as follows:

- Remove Means Testing to all DFG's
- Increase the Grant limit (from £30,000 to £40,000)
- For grants in excess of £40,000 a Home Improvement Loan will be offered
- Make DFGs available to shared lives carers and special guardianship cases.

In January 2023 we had reached a point that the waiting list for clients had diminished. The above changes initially agreed had been adopted as discretionary assistance under the Private Sector Housing Financial Assistance Policy. This allowed us to progress, but in the event of budgetary restraints we could review the position and limit the discretionary works. We are now unfortunately experiencing significant budgetary restraints and therefore on 27th February the decision was made that the discretionary works would cease. From this point all new applications received would not be eligible for discretionary funding, for example these would be means tested. The result of this is that a waiting list for clients referred is beginning to build up and likely to increase further over this financial year while we focus on the mandatory DFGs with the limited budget available.

The Safe at Home service now operates on a fully digitalised service with digital equipment available for new and future customers supporting our vulnerable residents to live safely and independently in their own homes. In addition, the team have now undergone the full digital upgrade for all existing customers replacing analogue equipment to digital, enabling a robust and reliable service for those who have already undergone the changes in the city.

With the new service launch and web, the Safe at Home service within Housing continues to work closely with internal and external partners including health and social care. Technology cannot only help understand customer's needs but also be an additional option available to practitioners to support independent living and reduce pressures on their own services.

The DFG also helps to support PCC equipment purchases for the community equipment store, helping provide adaptations for people in the community and being discharged from hospital to maintain their independence at home.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

No

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding

N/A

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Tackling inequalities and disparities in the population 15inwhich contribute to poorer health outcomes has been a long-standing objective for Portsmouth Place, as reflected in the HWB strategy. Portsmouth is ranked 59th of 326 local authorities (where 1 is the most deprived)

Exploring sub-domains within the Health Index suggested several areas where outcomes are much worse in Portsmouth than in England. These helped to inform the selection of priorities, alongside other outcome data and local intelligence. For example, out of 149 local authorities, where 1 is the best, Portsmouth ranks 98th for child poverty, 112th for household income, 113th for children's social, emotional, and mental health, 133rd for GCSE achievement, 135th for air quality, 139th for self-harm, 141st for pupil absence, and 145th for road traffic volume. Many of these areas will have been significantly impacted by Covid-19 and existing disparities are likely to have been exacerbated.

Inequalities in health, access to, and experience of care can be linked to where people live (high deprivation) as well as gender, ethnicity, age, and ability. All of these determine the risk of a person getting ill, preventing sickness and opportunities to access care when ill health occurs.

Portsmouth's refreshed HWB strategy (2022-2030)
The refreshed strategy identified five key issues which we are describing as the "causes of the causes" – the underlying factors in our city that in turn influence health and wellbeing. Each priority has a named board-level sponsor, they will be responsible for providing an annual update to the HWB, on a rolling basis, that will give a narrative overview of system-wide efforts to address these issues:

1. Tackling Poverty
This priority represents a shared commitment across Portsmouth services that we will seek to help people to escape poverty and take action to mitigate the effects of poverty. We will do this by providing good quality employment to tackle in-work poverty, so that every employee receives a real living wage, has the security of sufficient working hours to meet their needs, can work flexibly to ensure those with additional needs or caring responsibilities can maintain employment, and can progress into and through work, with training and support, to fulfil their potential and increase their earning power.

Short term activity will focus on three key areas: Providing immediate support to people in financial hardship; helping people access the right employability support at the right time; and supporting a community level response to local needs.

2. Educational Attainment
In many key measures of educational attainment, Portsmouth is ranked lower than other cities. There is a paradox that the city is strong in terms of Ofsted judgements, with 92% of inspected schools and 96% of early years settings assessed to be good or better; however, the city has weak outcomes in terms of educational outcomes, particularly at the end of Key Stage 2 when children finish their primary school years and Key Stage 4 when they finish secondary schooling.

Short term activity will focus on three key areas: Supporting families in pregnancy and the early years to give children the best start; developing a citywide culture of aspiration and expectation, including consistent messages about what is needed to support children in their education; and developing models to promote school attendance and inclusion.

3. Positive Relationships in Safer Communities
Evidence shows that communities with high levels of social connectedness have longer and happier lives and are less dependent on public services. Strong connected communities have better outcomes for citizens and often meet local need far more effectively than public services. 'Restorative practice' provides a framework for building relationships, building communities, and reducing harm, hurt and conflict.

Portsmouth has over 300 care leavers, many of whom experience long-term impacts from family separation, including isolation. We will revise and enhance the care leaver offer, focussing on enabling young people to develop supportive networks through into adulthood.

Key activity in the short term includes adopting restorative approaches that aim to repair relationships where appropriate to support our most vulnerable; giving front-line staff the permission and the power to find the right solutions for clients regardless of which agency they approach; and engaging residents in community-based work to build social and relational capital in all areas of the city.

4. Housing
Portsmouth is a great place to live for most, although for an increasing number of people it is a challenge to do in a safe and healthy way due to issues related to their accommodation. Unfortunately, more and more people sleep on the streets of this great city and many others, and the pandemic raised the profile of this issue.

There has been a consistent growth since 2014 in people approaching the council for help as homeless, with over 2,000 homeless approaches to the council in 2020/21, 94% of whom were born in the city or with a long-term connection to it. Pandemic-related restrictions such as the eviction ban show no signs of easing the situation. Ensuring adequate and suitable homes in the city is a critical issue.

Short term activity will focus on three key areas: Implementing the Homelessness and Rough Sleeping Strategy to provide support for those vulnerable people in greatest need of housing; work to develop models of housing that suit people at different stages in their lives and reflect their needs; and develop stronger models of support for landlords and tenants to support long term, successful tenancies.

The Portsmouth City Council sheltered housing service is mainly for older people who need different levels of support with their daily living, the service provides housing-related support to enable residents to live as independently as possible in their own home working with other agencies as necessary to support their needs.

5. Active Travel and Air Quality

Air pollution is the greatest environmental risk to public health in the UK15, and it is known to have disproportionate effects on vulnerable groups. Air quality disproportionately affects the very old, the very young, and those with chronic conditions. It also has greater impact on those who live, work or go to school in more deprived areas.

Data from the Public Health Outcomes Framework (PHOF)17 indicates that in 2019, 5.6% of all premature deaths in Portsmouth could be attributed to air pollution (specifically long-term exposure to particulate matter), compared to 5.1% of all early deaths in England, and 5.2% in the Southeast. The burden of disease attributed to poor air quality in Portsmouth is therefore estimated to be greater than the regional and national average.

Actions that contribute to reducing differences in outcomes

Managing patient flow

We want the people of Portsmouth to be treated without avoidable delay and to receive the right care and support, in the right place, at the right time. Achieving this, in both elective and non-elective pathways, will help reduce pressure on acute services, and ensure our resources are organised and deployed in the most effective ways, to deliver the best outcomes and experience for local people.

Placed-Based Care

The objective of the Place-Based Care programme is to enable people to receive the support they need in their own home or in the community where they live, and for this care to be organised around them, to deliver the best outcomes and experience. This means joining up care at every level across health and social care in Portsmouth, working collaboratively with all partners to proactively manage both physical and mental health, and provide a rapid and efficient response in the event of crisis or deterioration.

Achieving this will enable people to live well at home for longer (including post-acute recovery) and reduce the risk of avoidable hospitalisation and need for long-term residential care. The delivery of this work is rooted in the localities where people live, bringing together community partners across the health, care, and the voluntary sector to develop solutions that meet the needs of their populations.

The Place-Based Care programme will work with these locality groups to:

- Support the delivery of local goals.
- Remove barriers to integrated delivery.
- Ensure our collective ambition brings benefits to the whole Portsmouth and Southeast Hampshire (PSEH) population (including the opportunity to ‘do things once’).

Healthy communities
We need to support the prevention of ill-health, focusing on early intervention and enabling people to keep well and live independently in good health. We will focus on where the biggest differences can be made, working together across PSEH, focusing on what we can do in partnership across health, care, and the voluntary sector.

The pandemic has had a disproportionate impact on some population groups. The Healthy Communities programme will advocate for:

- Tackling health inequalities across all PSEH programmes
- Building capability and capacity in population health management
- Personalised care approaches
- Behavioural change tools that can be rolled out across the local system and enable targeting of resources and expertise to areas of greatest need.

Live Well Sessions
Live Well sessions were started initially to improve the uptake of Covid-19 vaccines in the most deprived areas of Portsmouth, but these have now been developed into a whole series of health and wellbeing support sessions.

The sessions are delivered at places where people are already meeting, for example teams will attend local food banks to talk to people and provide support and advice on a wide range of issues in their lives. The Live Well sessions are a collaborative effort with PCC, Primary Care networks, social prescribers, Solent Mind, Talking Change, VCSE, a variety of services offering cost of living support, and Portsmouth wellbeing team designed to make it easier for local communities to access health and care services, by taking them out to people. This is particularly important in those communities where people might not have easy access to services for a number of reasons.

All these sessions consider groups with protected characteristics or at risk of health inequalities and a monitoring process is carried out through Contract Review Meetings for example the Solent Mind Adult Advocacy Support Service funded via BCF provides 5 key elements of support:

1. Advocacy for Older Persons and those with a Physical Disability and a Learning Disability.
2. Independent Mental Health Advocacy (IMHA) for those with a qualifying diagnosis living either within the community or as a patient at St. James hospital.
3. Statutory Independent Mental Capacity Advocate (IMCA) Depravation of Liberty Safeguards (DoLs) representation and support for those lacking capacity.
4. Relevant person representative for those deprived of their liberty under the Mental Capacity Act (2005).
5. Advocacy for parents at child protection case conferences supporting parents who require additional support to present their views either in person or via a report at conference.

The service user feedback received reflected the general view that the Advocacy Service is widely known. The existing service is quite effective in meeting the needs and desires of service users. Advertising of the service, by the winning provider would continue, so that social workers, clinicians, GP's community groups, providers of other services and all those involved in supporting vulnerable adults are as aware as possible of these services and can signpost individuals and their carers to them.

Community Connectors
The BCF contributes to the funding of community connectors who work within the Independence and Wellbeing Team (IWT). The aim of the IWT is to reduce dependence and demand on health and care statutory services by developing early intervention support and activities to help individuals learn and/or retain their skills and confidence, thus preventing and reducing need or delaying deterioration where possible. The aim of the community connectors is to specifically focus on reducing loneliness and isolation by supporting people to connect with their communities and draw on community assets. A strength-based approach is taken to identify and address inequalities in accessing these resources and supporting Portsmouth residents to grow their own support networks. This service is regularly quality assurance and

monitored including an integrated impact assessment, the service performs well and routinely scores highly against the KPIs.

The Health Inclusion Service
The service is led by Brunel PCN leading the work in collaboration with P3 partners, which provides a team dedicated to supporting people who are or have been homeless and/or those who struggle to access mainstream health services due to the chaotic nature of their lifestyles. This GP led services works throughout the city delivering Primary Care interventions to people currently being supported in homeless accommodation centres; Hope House, Kingsway House, and The Registry. The team will also support people on the street when it is deemed appropriate. Interventions are usually ad hoc, and the team will see the service user without an appointment booking being necessary as we know that the cohort they support are likely to be unable to attend timed and dated appointments.

The team is made up of a part time GP, a part time advanced nurse practitioner and a full time dual trained nurse. Recently the team have started hosting an MDT meeting with the health inclusion team, the drug and alcohol team and stakeholders from the VCSE to try and remove barriers and ensure the service user can access the support they need in an holistic way.

Early cancer diagnosis / Chronic respiratory disease
Portsmouth's early lung cancer diagnosis rate was particularly low at 38% (Stage 1 or 2). Since April 2022 the Targeted Lung Health Check (TLHC) programme is being delivered with an identified population of 24,000 people. The aim is to increase Portsmouth's early diagnosis to 75%. To date 50% of the eligible cohort have been invited for a TLHC, 4985 of those identified at risk, with 100 referred onto the Lung Cancer pathway, 39 cancers have been diagnosed, 80% at stage 1 or 2, which is exceeding our aim of 75%.

Through the P3 programme the Breathlessness Hub was set up to support respiratory problems by providing breathlessness assessment, diagnostics, and management in a community setting. Since the delivery of the TLHC programme the Hub has been adapted to support primary care with the management of the newly diagnosed mild emphysema cases that have been identified through the programme.

Mental Health Phoneline
Residents across Portsmouth can access a free phoneline to get the most appropriate mental health support they need before they reach a crisis point. The creation of this comes directly from feedback gathered during events run by Health and Care Portsmouth with local voluntary groups and people with lived experience of mental health. Feedback from the workshops suggested a desire to develop an 'access hub' for mental health, to provide a clear point of contact for meaningful support and advice. In the workshops, people told us that the number of routes to access support was confusing, daunting, and unclear, and felt they were being sent from one service to another without getting the help or information they needed.

The phoneline is available to individuals aged 16 and over and carers, between 8am and 6pm. Fully trained call handlers will, in a kind and compassionate way, either arrange an appointment with services such as Talking Change or PositiveMinds or offer support to connect with local organisations including HIVE Portsmouth, or social support or substance misuse services. Beyond the phoneline aspect, it is intended that the service will be developed into a website and a mobile app where people can access support virtually and become known overall as The Portsmouth Mental Health Hub.

Portsmouth pledges to address inequalities for our people, patients and communities with real purpose and action, developing a strategy in partnership with our people and patients in conjunction with data from the NHS staff survey, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDRES), Gender Pay Gap, and Model Employer targets.

We continue to be committed to the Portsmouth City Council Equality and Diversity strategy and continue to promote Portsmouth as an employer of choice, providing all members of staff with a positive, inclusive work experience where they will feel valued and are given the opportunity to reach their full potential,

ensuring that Equality, Diversity & Inclusion (EDI) is a focus. This will include strengthening the EDI training offer for managers and staff to increase awareness and provide knowledge, mentoring programmes, and making sure that employment and opportunities for promotion are accessible to everyone, policies and recruitment materials are representative and build upon the Beyond Boundaries positive action programme for ethnic minority.

We are committed to making sure that there is equality and inclusion in all that we do, but more specifically:

- How we commission services on behalf of the population we serve.
- How we recruit and support the development of all our staff.
- How we proactively engage and support everyone who uses our services, especially given the diversity of our population.
- Improve our use of intelligence and technology.
- Embedding equality in the commissioning cycle, ensuring an Equality Impact Assessment (EIAs) is completed for all commissioning / transformation projects.

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.
12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	Portsmouth	Yes
Completed by:	Denise Perry	Yes
E-mail:	Denise.perry5@nhs.net	Yes
Contact number:	07919 920950	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	<Please Select>	No
If no please indicate when the HWB is expected to sign off the plan:		No

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Matthew	Winnington	Cllr.Matthew.Winnington@portsmouthcc.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Maggie	MacIsaac	maggie.macisaac@nhs.net	Yes
	Additional ICB(s) contacts if relevant	Dr	Linda	Collie (Joint HWB Chair)	lindacollie.hiowicb@nhs.net	Yes
	Local Authority Chief Executive	Mr	David	Williams	david.williams@portsmouthcc.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Andy	Biddle	andy.biddle@portsmouthcc.gov.uk	Yes
	Better Care Fund Lead Official	Ms	Jo	York	Jo.york1@nhs.net	Yes
	LA Section 151 Officer	Mr	Chris	Ward	Chris.Ward@portsmouthcc.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Integrated Care Board Chief Executive or person to whom they have delegated sign-off (jointly with Maggie)	Mr	Martin	Sheldon	martin.sheldon@nhs.net	

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Portsmouth

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,059,000	£2,059,000	£2,059,000	£2,059,000	£0
Minimum NHS Contribution	£17,766,269	£18,771,839	£17,766,269	£18,771,839	£0
iBCF	£8,616,489	£8,616,489	£8,616,489	£8,616,489	£0
Additional LA Contribution	£12,695,873	£12,368,661	£12,695,873	£12,368,661	£0
Additional ICB Contribution	£9,264,325	£8,087,796	£9,264,325	£8,087,796	£0
Local Authority Discharge Funding	£1,208,018	£2,005,310	£1,208,018	£2,005,310	£0
ICB Discharge Funding	£1,263,993	£1,762,164	£1,263,993	£1,762,164	£0
Total	**£52,873,967**	**£53,671,259**	**£52,873,967**	**£53,671,259**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,057,419	£5,343,669
Planned spend	£10,244,631	£10,922,989

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,428,402	£7,848,850
Planned spend	£7,521,638	£7,848,850

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	225.0	204.0	245.0	245.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,548.0	1,525.3
	Count	488	490
	Population	31524	32124

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.0%	95.0%	95.0%	95.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	710	581

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Portsmouth

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Hospital D&C: Demand to support hospital discharge has been estimated from using 22/23 discharge numbers from the acute hospital categorised by sub-pathway; previous demand estimates have been based on overall pathway numbers (1/2/3) and the sub-category information provides a more accurate estimate for specific demand requirements. Social support is provided by the developing VCSE Wellbeing Collective, who supply a coordinated

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! | Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Social support (including VCS) (pathway 0)	15	14	14	14	14	14	14	16	18	18	15	14
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Reablement at home (pathway 1)	11	12	11	12	11	12	12	13	16	16	13	12
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Rehabilitation at home (pathway 1)	11	12	11	12	11	12	12	13	16	16	13	12
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Short term domiciliary care (pathway 1)	34	35	34	35	34	35	35	36	39	39	35	35
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Reablement in a bedded setting (pathway 2)	45	45	45	45	45	45	45	45	45	45	45	45
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Rehabilitation in a bedded setting (pathway 2)	39	39	39	39	39	39	39	39	39	39	39	39
PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement												

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	30	29	29	29	29	29	29	31	33	33	30	29
Urgent Community Response	401	415	391	405	405	411	435	431	445	445	407	425
Reablement at home	21	22	21	22	22	21	22	23	26	26	22	22
Rehabilitation at home	21	22	21	22	22	21	22	23	26	26	22	22
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	15	14	14	14	14	14	14	16	18	18	15	14			100%
Reablement at Home	Monthly capacity. Number of new clients.	17	17	16	17	17	16	17	18	21	21	17	17			100%
Rehabilitation at home	Monthly capacity. Number of new clients.	17	17	16	17	17	16	17	18	21	21	17	17			100%
Short term domiciliary care	Monthly capacity. Number of new clients.	41	42	41	42	42	41	42	43	46	46	41	42			100%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	46	47	46	47	47	46	47	46	47	47	45	47			100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	42	43	42	43	43	42	43	42	43	43	40	43			100%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.															

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	30	29	29	29	29	29	29	31	33	33	30	29			100%
Urgent Community Response	Monthly capacity. Number of new clients.	401	415	391	405	405	411	435	431	445	445	407	425			100%
Reablement at Home	Monthly capacity. Number of new clients.	30	31	30	31	31	30	31	32	35	35	31	31			100%
Rehabilitation at home	Monthly capacity. Number of new clients.	30	31	30	31	31	30	31	32	35	35	31	31			100%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Other short-term social care	Monthly capacity. Number of new clients.															

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Portsmouth

Local Authority Contribution			
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	**Complete:**
Portsmouth	£2,059,000	£2,059,000	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£2,059,000**	**£2,059,000**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Portsmouth	£1,208,018	£2,005,310	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Hampshire and Isle Of Wight ICB	£1,263,993	£1,762,164	Yes
Total ICB Discharge Fund Contribution	£1,263,993	£1,762,164	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Portsmouth	£8,616,489	£8,616,489	Yes
Total iBCF Contribution	**£8,616,489**	**£8,616,489**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Portsmouth	£12,695,873	£12,368,661	No Comments
Total Additional Local Authority Contribution	**£12,695,873**	**£12,368,661**	

Yes

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Hampshire and Isle Of Wight ICB	£17,766,269	£18,771,839
Total NHS Minimum Contribution	**£17,766,269**	**£18,771,839**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Hampshire and Isle of Wight ICB	£9,264,325	£8,087,796	No Comments
Total Additional NHS Contribution	**£9,264,325**	**£8,087,796**	
Total NHS Contribution	**£27,030,594**	**£26,859,635**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£52,873,967**	**£53,671,259**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

The submission is based on 22/23 agreed activity uplifted where appropriate should information be available. The final formal budget for 23/24 is still being agreed and has not yet been presented to BCF PMG, as a result, this submission is on a best efforts basis with the information available at the time.
For income allocation to task, this have been achieved on a best efforts basis, with elements allocated to the largest areas of spend. For clarity, income is not tracked at a scheme level operationally.

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Portsmouth

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,059,000	£2,059,000	£0	£2,059,000	£2,059,000	£0
Minimum NHS Contribution	£17,766,269	£17,766,269	£0	£18,771,839	£18,771,839	£0
iBCF	£8,616,489	£8,616,489	£0	£8,616,489	£8,616,489	£0
Additional LA Contribution	£12,695,873	£12,695,873	£0	£12,368,661	£12,368,661	£0
Additional NHS Contribution	£9,264,325	£9,264,325	£0	£8,087,796	£8,087,796	£0
Local Authority Discharge Funding	£1,208,018	£1,208,018	£0	£2,005,310	£2,005,310	£0
ICB Discharge Funding	£1,263,993	£1,263,993		£1,762,164	£1,762,164	£0
Total	**£52,873,967**	**£52,873,967**	**£0**	**£53,671,259**	**£53,671,259**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,057,419	£10,244,631	£0	£5,343,669	£10,922,989	£0
Adult Social Care services spend from the minimum ICB allocations	£7,428,402	£7,521,638	£0	£7,848,850	£7,848,850	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):
58, 59,

										Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Carers	Carers	Carers Services	Other	Advice, support including respite services	553	553	Beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£1,064,500	£1,064,500	100%
2	Community Equipment	Community Equipment	Other						Social Care		LA			Private Sector	iBCF	Existing	£1,358,000	£1,358,000	50%
3	D2A Social Care Services	D2A Social Care Services	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF	Existing	£1,925,124	£1,925,124	46%
4	Independence & Wellbeing	Independence & Wellbeing	Prevention / Early Intervention	Other	Multidisciplinary teams that are supporting				Social Care		LA			Local Authority	iBCF	Existing	£822,827	£822,827	99%
5	In house Provision	In house Provision	Other						Social Care		LA			Local Authority	Additional LA Contribution	Existing	£10,995,600	£10,995,600	100%
6	Integrated Services	Integrated Services	Other						Social Care		LA			Local Authority	iBCF	Existing	£1,333,814	£1,006,602	46%
7	Leadership and Business Development	Leadership and Business Development	Enablers for Integration	Other	Leadership and Business Development				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£9,300	£9,300	100%
8	Social Care Services	Social Care Services	Other						Social Care		LA			Local Authority	iBCF	Existing	£3,176,724	£3,176,724	46%
9	Voluntary Sector Contracts	Voluntary Sector Contracts	Enablers for Integration	Voluntary Sector Business Development					Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£607,400	£280,188	100%
10	Disability Facilities Grant	Disability Facilities Grant	DFG Related Schemes	Other	DFG	£191.00	191	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG	Existing	£2,059,000	£2,059,000	100%
11	Other Community Services	Other Community Services	Community Based Schemes	Other	Community Based Schemes				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£884,214	£884,214	100%
12	Community Equipment	Community Equipment	Other						Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,385,735	£1,385,735	50%
13	Solent NHS Trust (Community BCF)	Solent NHS Trust (Community BCF)	Community Based Schemes	Other	Community Services				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£7,217,967	£6,890,755	100%
14	Jubilee Unit	Jubilee Unit	Bed based intermediate Care Services (Reablement,	Other	Bedded D2A & rehab	540	540	Number of Placements	Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£4,461,007	£3,962,836	100%
15	Spinaker	Spinaker	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		288	288	Number of Placements	Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£3,092,000	£3,092,000	100%
16	Portsmouth Rehab and Reablement Service	Portsmouth Rehab and Reablement Service	Home-based intermediate care services	Rehabilitation at home (to support discharge)		258	601	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£756,715	£1,762,285	100%

17	Jubilee Unit Surge beds	Jubilee Unit Surge beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		180	180	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£613,993	£1,112,164	100%
18	Spot purchase packages of care	Spot purchase packages of care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Other	Integrate NHS & Social Care Service	Joint	100.0%	0.0%	Private Sector	ICB Discharge Funding	Existing	£650,000	£650,000	40%
19	ASC Discharge fund schemes	ASC Discharge fund schemes	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Community Health		LA			Local Authority	Local Authority Discharge Funding	New	£1,208,018	£2,005,310	100%
20	D2A Social Care Services	D2A Social Care Services	Care Act Implementation Related Duties	Other	Care Act Assessment Capacity				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,249,976	£2,249,976	54%
21	Integrated Services	Integrated Services	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,558,886	£1,886,098	54%
22	Social Care Services	Social Care Services	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,712,776	£3,712,776	54%
23	Portsmouth Rehab and Reablement Service	Portsmouth Rehab and Reablement Service	Home-based intermediate care services	Rehabilitation at home (to support discharge)		584	241	Packages	Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£1,711,318	£705,748	100%
24	Independence & Wellbeing	Independence & Wellbeing	Prevention / Early Intervention	Other	Multidisciplinary teams that are supporting				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£19,073	£19,073	1%
25	Solent NHS Trust (Community BCF)	Solent NHS Trust (Community BCF)	Community Based Schemes	Other	Community Services				Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£0	£327,212	100%
26	Voluntary Sector Contracts	Voluntary Sector Contracts	Enablers for Integration	Voluntary Sector Business Development					Social Care		LA			Charity / Voluntary Sector	iBCF	Existing	£0	£327,212	100%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.

18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Portsmouth

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	236.3	204.1	258.3	200.0	Our ambition is to reduce our avoidable admissions by 5% (based on last years performance) in Q1, Q3 and Q4 (the Q4 5% reduction is based on the actual activity for Q3 continuing into Q4 rather than a 5% reduction based on the Q4 planned value). The plan for Q2 is to maintain the current excellent levels.	Plans to provide more proactive and preventative care for people with Long Term Conditions (LTCs) include: • The development of an LTC Hub model (virtual) that involves primary, community and secondary care to support people with LTCs to manage their condition and stay well.	Yes
	Number of Admissions	462	399	505	-			
(See Guidance)	Population	214,692	214,692	214,692	214,692			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	225	204	245	245			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,735.8	1,548.0	1,525.3	The stretch ambition for 23-24 is a 1.5% reduction based on last years estimated performance. The reason for a stretch target of only 1.5% is that Portsmouth is already perfroming very well in this metric; Portsmouth was ranked the 5th lowest when benchmarked against the region in 21-22. 22-23 data indicates	Plans to manage hospital admissions following a fall include: • Working with system partners, including South Central Ambulance Service (SCAS), to increase falls related referrals into the UCR. • A review of UCR processes to streamline pathway including the implementation of	Yes
	Count	550	488	490			Yes
	Population	30,938	31,524	32,124			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	90.4%	92.0%	90.3%	95.5%	Our aspiration for discharging patient to their usual place of residency is to attain the 95% target, although this is a very challenging ambition due to: - The general acuity of people being discharge from hospital is higher, increasing the complexity of patients being discharged and therefore not able to be discharge directly to normal place of	Portsmouth has adopted the national directive to fully embed a 'Discharge to Assess' and 'Home First' approach, which means that people are supported to safely leave hospital as soon as they are clinically able; that assessments of long-term care and support needs to happen outside of the acute trust and that for most people, all of this happens in their usual place of	Yes
	Numerator	3,781	3,989	3,716	4,945			
	Denominator	4,183	4,335	4,114	5,178			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
(SUS data - available on the Better Care Exchange)	Quarter (%)	95.0%	95.0%	95.0%	95.0%			
	Numerator	4,001	4,001	4,001	4,001			Yes

	Denominator	4,211	4,211	4,211	4,211	residency, therefore incrasing discharges	residence. The local intermediate care	Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	709.9	537.0	612.8	580.6	Portsmouth are aiming for a reduction in the long-term needs of older people met by admission to residential and nursing care homes by 18% based on 21-22 actual annual rate and by 5% based on 22-23 estimated annual rate. The estimate of 22-	Plans to manage admissions to residential and nursing care homes: • Enhancing our Discharge to Assess offer to ensure thorough assessments are completed in an appropriate setting. We are rightsizing our D2A team due to	Yes
	Numerator	217	170	194	187			Yes
	Denominator	30,568	31,657	31,657	32,210			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.2%	86.9%	86.6%	90.0%	Portsmouth are seeking a stretch target of 90% of the proportion of older people (65 and over) who were still at home 91 days after discharge from reablement / rehabilitation services. The development of the rehabilitation and reablement	Within Portsmouth there are currently multiple commissioned community rehabilitation and reablement services. The Portsmouth Rehabilitation and Reablement Team (PRRT) is a well-established service which aims to support	Yes
	Numerator	68	126	97	135			Yes
	Denominator	78	145	112	150			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Portsmouth

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	2. Cover sheet 2. Cover sheet Page 1 N/A Yes			Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Pages 19, 20 Pages 2, 3, 4, 5,6 Pages 4, 5, 20, 23, 24, 25 Pages 4, 5, 20, 21, 22, 23, 24,25 Pages 9, 20			Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Tabs 2.Cover Pages 19, 20 Tabs 2.cover 5.income, 6a Expenditure			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Pages 9, 10, 11 Tab 7.Metrics Pages 9, 10, 11 Tab 4. Capacity&Demand Pages 12, 13, 14, 15, 16			Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Tab 4. Capacity&Demand Tab 4. Capacity&Demand, Tab 7. Metrics Pages 14, 15, 16 Pages 7, 12, 14,15,16 Tab 4. Capacity&Demand, Tab 7. Metrics Page 15			Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Pages 10, 14, 21, 22, Tab 6a expenditure Pages 10, 14, 21, 22, Tab 4. Capacity&Demand Pages 10, 14, 21, 22, Tab 4. Capacity&Demand Page 17			Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	Expenditure plan tab			Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Tab 6a Expenditure Tab 6a Expenditure Tab 6a Expenditure Tab 6a Expenditure Tab 5. Income Tab 6a Expenditure Pages 10, 11,18, 19 Tab 6a Expenditure			Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	Tab 7. Metrics Tab 7. Metrics			Yes

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Title of meeting:	Health and Wellbeing Board
Date of meeting:	28th June 2023
Subject:	Pharmaceutical Needs Assessment
Report by:	Matthew Gummerson, Head of Strategic Intelligence and Research, Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 The Health and Wellbeing Board (HWB) has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). The current PNA was published in October 2022 and runs until 2025. In February 2023 the HWB agreed to consult on a revised PNA in light of a number of closures of pharmaceutical services[1]. This report sets out the responses to the statutory consultation on the draft PNA (revised, 2023) and sets out options for the HWB to consider in response.

2. Recommendations

2.1 The HWB is asked to:

2.1.1 consider the consultation responses in section 4 and appendix A;

2.1.2 decide which of the options (A and B) set out in section 5.1 and 5.2 to pursue with option B being recommended;

2.1.3 if option B is chosen, decide whether to agree the proposal regarding Supplementary Statements set out in section 5.4.

3. Background

3.1 The PNA is a report on the local needs for pharmaceutical services. It is used to identify gaps in current services or improvements that could be made to current or future service provision. The map at Appendix B shows the location of pharmacies in Portsmouth as at the end of May 2023. The PNA needs to be seen

[1] HWB, February 2023: Pharmaceutical Needs Assessment and wider pharmacy issues.pdf (portsmouth.gov.uk)

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within the wider context of the role of community pharmacies in supporting the vision and priorities of the Integrated Care System (ICS).

3.2 The HWB decided to consult on a redrafted PNA in order to allow a gap in service to be identified in relation to the Elm Grove site that closed following the consolidation application approved by NHSE in November 2022. While the redrafted PNA identifies additional gaps in relation to other closures, these could be addressed through a Supplementary Statement without a new PNA. The issue specifically with the Elm Grove site was that the HWB did not identify it as creating a gap in August 2022 when the application was submitted, basing its decision on the 2018 PNA that was still in place at that time.

3.3. The statutory 60 days consultation for the revised 2023 PNA commenced on 28th March and closed on 17th May 2023. All organisations required to be notified were informed and a total of 9 responses were received. These are summarised in section 4 below. The DHSC Information pack for HWBs[2] states that "*Health and wellbeing boards (although in reality this will be the local authority) therefore face the risk of a judicial review should they … fail to follow due process in developing their pharmaceutical needs assessment, e.g. by failing to consult properly or take into consideration the results of the consultation exercise undertaken*".

3.4 The HWB agreed an additional recommendation in February that the HWB would 'actively work with local pharmacy providers to fill gaps in provision'. A number of discussions with local and regional stakeholders including local pharmacies have taken place and the ICB are working on a pharmacy strategy for HIOW that addresses some of the challenges being seen locally. These discussions have informed the proposal in section 5.4.

4. Summary of consultation responses

4.1 Appendix A provides a summary of the responses to the consultation. Of the nine responses, around half of respondents disagreed with most aspects of the PNA including its overall conclusions. This is in contrast to the 2022 PNA where 100% of respondents agreed or strongly agreed with the PNA's conclusions.

4.2 A number of issues were raised by respondents in the free text, including:

4.2.1 That the focus should be on the quality of pharmaceutical services not the number of pharmacies, noting the workforce and training issues and unavailability of key products in some pharmacies.

4.2.2 That previous consolidations were granted on the basis that no gap was created and that, as the circumstances have not changed, these should not now be identified as gaps.

4.2.3 That the description of current services and gaps describes a desired provision of pharmaceutical services that does not form part of the Community Pharmacy Contractual Framework and may be unreasonable in its expectations of local

[2] Pharmaceutical needs assessments: Information pack for local authority health and (publishing.service.gov.uk), p.9

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providers, particularly in light of revised regulations that will effectively allow all 100-hour pharmacies to reduce their hours to 72 hours.

5. Options for HWB to consider

5.1 Option A is for the HWB to continue with the revised draft PNA as consulted. This could include some amendments to address the issues set out in 5.3.2 and 5.3.3 below. However, as the consultation responses have highlighted, this risks making it more difficult to sustain a strong and effective pharmacy offer in the city, with potentially destabilising effects on remaining pharmacy providers. There are also financial risks associated with the cost of addressing any challenges to the findings of the PNA.

5.2 Option B is for the HWB to withdraw the redrafted 2023 PNA and revert to the previously agreed PNA published in October 2022. This would recognise the issues raised and strength of feeling expressed in the consultation responses, and create an opportunity to continue the positive dialogue with a range of stakeholders around how to support the local community pharmacy offer going forward so that it best meets the needs of local residents. The conclusions of the 2022 PNA have already been used by the HWB to oppose the consolidation application by Rowlands Pharmacy in February 2023 to close the site on London Road and consolidate onto the site at 92 Kingston Crescent. The recommendation of the Director of Public Health is to pursue option B.

5.3 If option B is agreed then the HWB will need to agree whether a Supplementary Statement to the 2022 PNA is required in relation to the closures that have subsequently taken place. Supplementary Statements are statements of fact that update the existing PNA to explain changes that have taken place.

5.3.1 Option B part 1: the HWB is required to issue a Supplementary Statement confirming that the closing of the Elm Grove pharmacy "*does not create a gap that could be met by an application offering to meet a need for, or secure improvements or better access to, pharmaceutical services*". This provides the continuing pharmacy with regulatory protection for the remaining lifetime of the PNA (i.e. until 2025).

5.3.2 Option B part 2: the HWB can decide whether or not to issue a Supplementary Statement in relation to the closure of the Lloyds in Sainsbury's on Fitzherbert Road. The DHSC Information pack for HWBs (p.64) notes that "*one way of doing that is to consider whether, when the pharmaceutical needs assessment was written, if the pharmacy had not been there would it have been identified as a gap in the provision of pharmaceutical services?"* It could be argued that, given the limited number of scripts issued, low numbers of nearby residential units, and continued presence of a pharmacy serving the Drayton and Farlington community, that specific location would not have been identified as a gap when the PNA was drafted if the pharmacy had not been there.

5.3.3 Option B part 3: the 2023 revised PNA identified a gap for a pharmacy offering the 'out of hours' services (as provided by a 100-hour pharmacy) operating in the North locality, following the closure of the Drayton Community Pharmacy on 15th February 2023.

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5.3.3.1 Responses to the consultation and discussions with key stakeholders have highlighted that the same provider is working out of the Drayton Prime Pharmacy at 274 Havant Road and is engaged in discussions with the ICB and Local Pharmaceutical Committee about how best to secure the out of hours provision desired by the local health and care system. They have recently confirmed to NHSE their revised Supplementary Hours which totals 68 hours and includes evenings Monday to Friday and opening on Saturdays and Sundays.

5.3.3.2 New regulations have been laid since the revised draft PNA was issued that will effectively allow all 100-hour pharmacies to reduce their hours to 72 hours. They will be required to maintain Monday to Saturday evening opening hours until 9pm and also Sunday opening hours.[3] Identifying a gap for the coverage provided by a 100-hour pharmacy could therefore be considered unreasonable when it is not covered by the Community Pharmacy Contractual Framework nor by the regulations (as likely to be amended in 2023).

5.4 It is proposed that a supplementary statement is issued noting the closure of the Elm Grove site, and the updated supplementary hours being provided at the Drayton Prime pharmacy at 274 Havant Road. An updated map of pharmaceutical services that includes the closure of the Lloyds Sainsburys will also be issued. Primary care commissioners will continue to work with local pharmacies via the LPC to support the maintenance of the local community pharmacy offer including provision of out of hours services.

6. Reasons for recommendations

6.1 PNAs are relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications are contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly. They also inform commissioning decisions by local commissioning bodies. The content of PNAs is set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. There is a regulatory duty (NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013 No 349: Part 2: Reg 8) to have a 60-day consultation about the contents of the assessment it is making, and any revised PNA must have considered the responses to the consultation appropriately.

6.2 Option B (section 5.2) is the recommended option because it provides the best opportunity to secure the outcomes that the HWB wishes to see in terms of people being able to access an effective local pharmacy offer, in light of the changing regulations and challenging financial position for pharmacies in Portsmouth and the wider region. The proposal in section 5.4 builds on this to effect the change in a way that is sensitive to the issues described in section 5.3.

[3] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2023 (legislation.gov.uk)

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7. Integrated impact assessment

7.1 An Integrated Impact Assessment (IIA) was undertaken on the PNA in 2022. An updated IIA will be undertaken if the HWB decides to proceed with a revised PNA in 2023.

8. Legal implications

8.1 The report outlines the legal framework relevant to the process focussing upon consultation as an appropriate mitigation to risk associated with Judicial Review or the decisions outlined in this paper being challenged. Additionally, the paper sets out the reasoning and background relevant to the issues of "provision gap". The report refers to the correct statutory framework within paragraph 6.1 above.

9. Director of Finance's comments

9.1 There are no direct financial implications arising from the recommendations within this report.

……
Signed by:

Appendices:
Appendix A - summary of Consultation responses
Appendix B - map of current pharmacy provision in Portsmouth

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

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

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Appendix A Summary of PNA Consultation Responses 2023

Consultation was undertaken with the statutory consultees. The consultation was on the PNA page of the PCC website and so was open to the public, but was not promoted to the public as the bulk of the PNA remained unchanged from that consulted on widely in 2022.

9 responses were received: 1 from a pharmacist responding in a personal capacity, 1 other (not specified), and 7 from organisations such as the Local Pharmaceutical Committee, Local Medical Committee or neighbouring HWBs.

Overall, 2 respondents strongly agreed with the conclusions of the PNA. 4 respondents disagreed or strongly disagreed with the conclusions of the PNA.

Fig 1

One of the responses disagreeing with the conclusions summarised their position as follows:

"This is not in the spirit of the provision for, and protection of, consolidations and is not helpful for the remaining contractors. Pharmacies are being forced to close due to the extreme level of financial pressure resulting from the failure of the Government to take decisive action and invest appropriately in the community pharmacy network."

Responses were split as to whether the draft PNA reflects local need and provision of pharmaceutical services (see fig 2 below). 44% (n5) of respondents disagreed or strongly disagreed that the PNA identifies gaps in provision. The free text responses highlighted three issues in particular:

a) That the focus should be on the quality of pharmaceutical services not the number of pharmacies, noting the workforce and training issues and unavailability of key products in some pharmacies.

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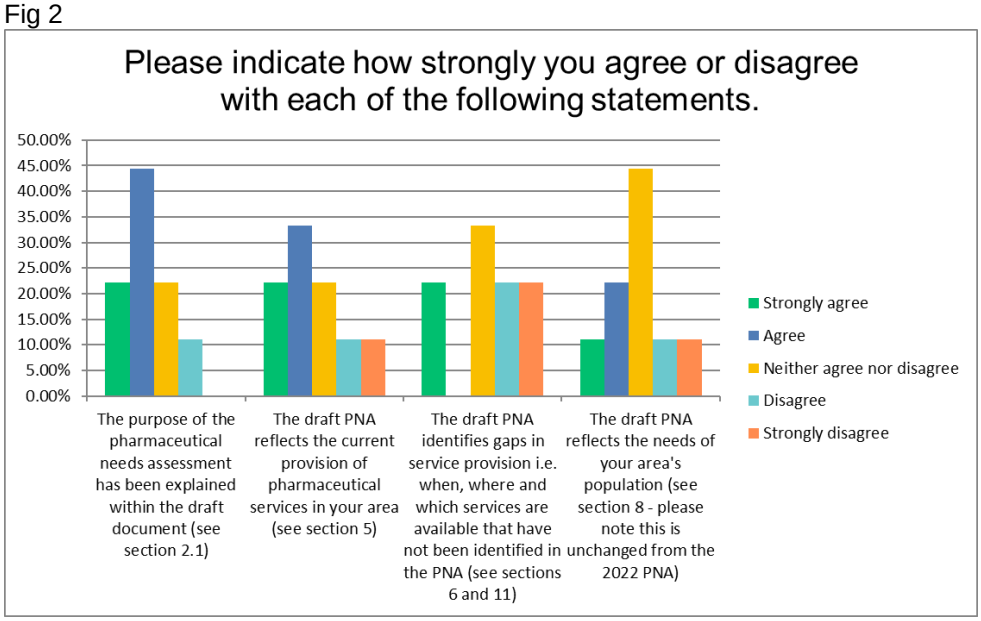
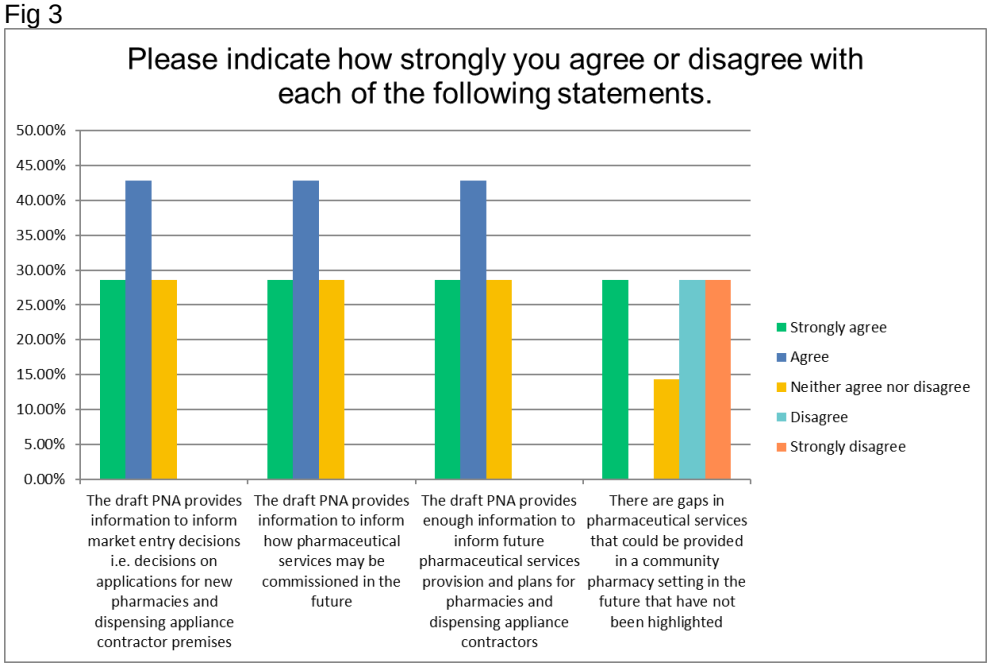
b) That previous consolidations were granted on the basis that no gap was created and that, as the circumstances have not changed, these should not now be identified as gaps.
c) The description of current services and gaps describes a desired provision of pharmaceutical services that does not form part of the Community Pharmacy Contractual Framework.

Fig 2



Respondents agreed that the PNA provides information to inform decisions on new applications and to inform future decisions. 57% (n4) of respondents who answered this question disagreed or strongly disagreed that there are gaps that could be provided and which have not been highlighted.

Fig 3



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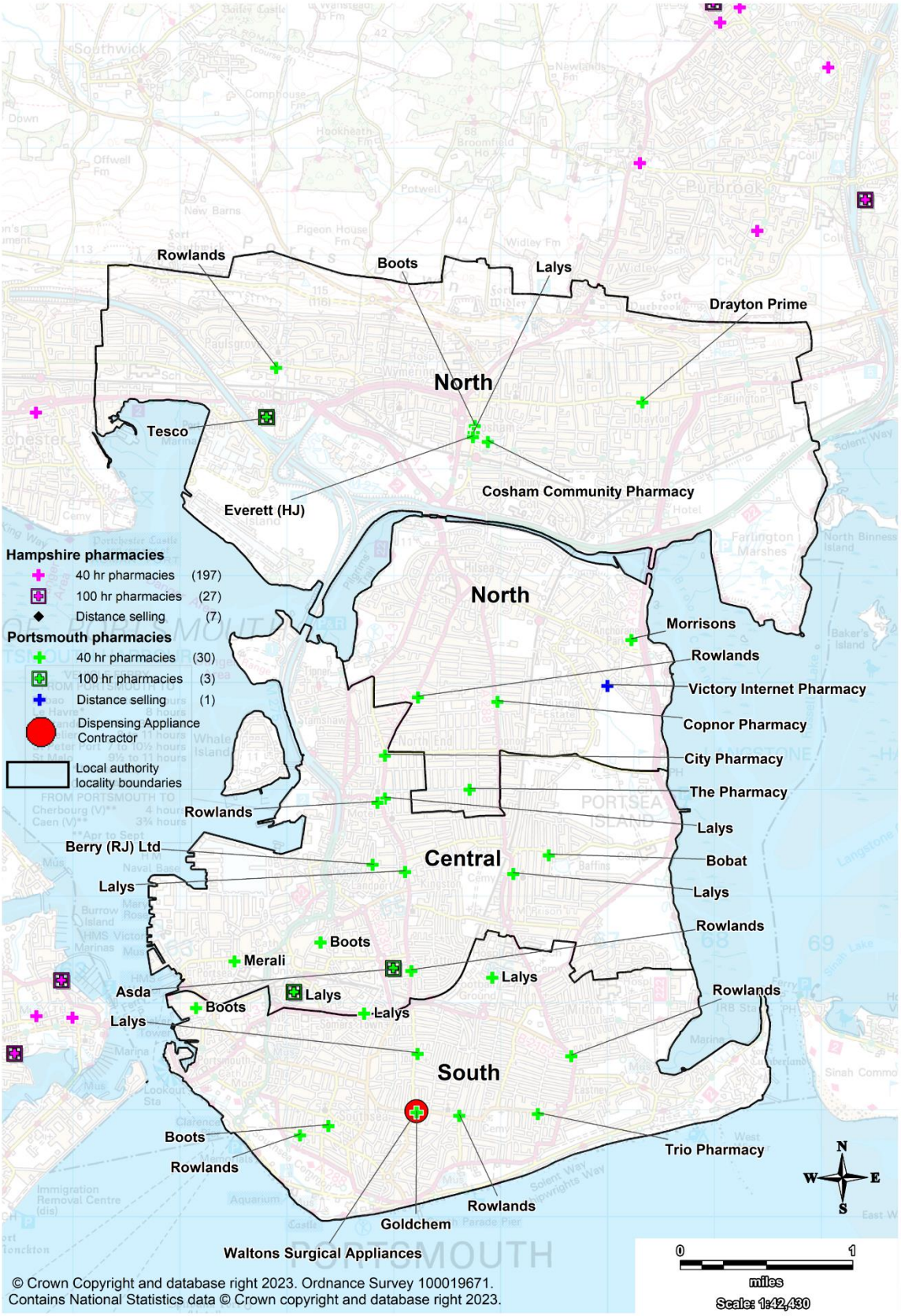
Appendix B - Current map of pharmacies in Portsmouth



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Title of meeting:	Health and Wellbeing Board
Subject:	Community Safety Plan - 2022/23 - Progress report
Date of meeting:	28th June 2023
Report by:	Lisa Wills, Strategy & Partnership Manager
Wards affected:	All wards

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1. Requested by

This report has been requested by Acting Superintendent Paul Markham and Councillor Ian Holder, Cabinet Member for Safety in the Community.

2. Purpose

2.1 To update members of the Board on the progress towards addressing the priorities in the Community Safety Plan 2021-22 (see Appendix 1) and;

2.2 Subject to the findings of the annual community safety analysis, that will identify any new or emerging priorities in November 2023, to recommend the current priorities are rolled forward.

2.3 To note that the findings from the strategic assessment (SA) 2023-24, due in November 2024, will be used to develop a new community safety plan for Portsmouth, alongside other related plans as explained below.

3. Background

3.1 The current community safety plan 2021-22 supports the City Vision 2040 and aims to make sure all our residents and communities feel safe, feel like they belong, and can thrive. The plan also supports the 'Positive Relationships' priority in the Health and Wellbeing Strategy 2022-30[1].

3.2 The impact of pandemic restrictions on data collection and analysis between March 2020 and January 2022, meant that the data analysis required to develop a new community safety plan was unreliable and the board agreed in June 2022 that the community safety priorities would remain unchanged for 2022/23.

3.3 In September 2022 the strategic assessment update was approved by the Health and Wellbeing Board and recommended more focus on 'violence against women and girls', but that

[1] See update in Appendix 3

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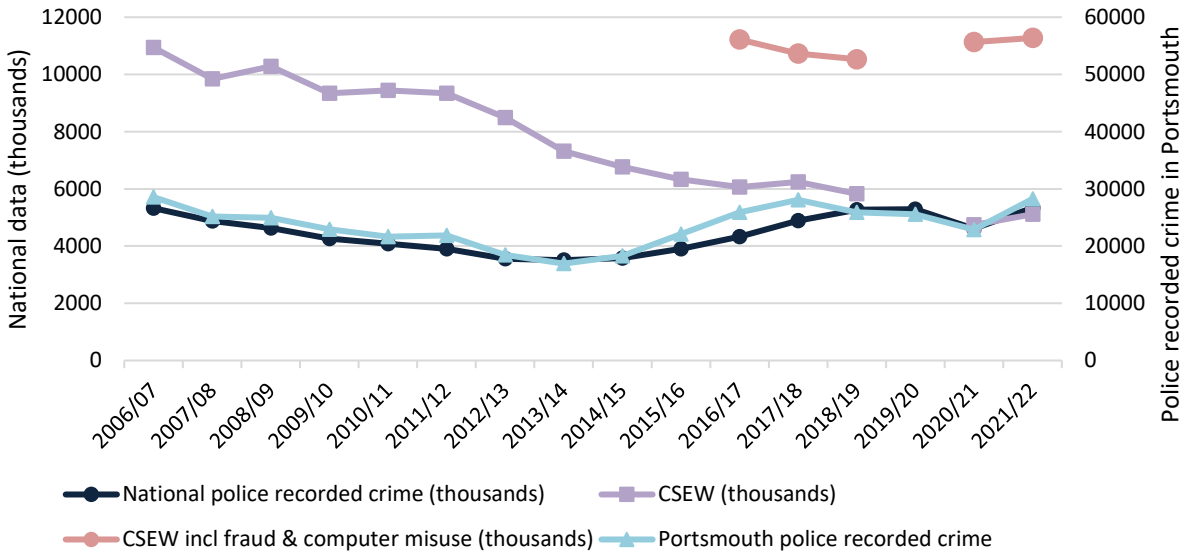
all other priorities remain the same. The key messages from the strategic assessment update can be found at Appendix 2.

3.4 This report drawers from the work of colleagues across the council. Thanks to Alan Knobel, Sam Graves, Lisa Morgan and Caroline Hopper for their input.

4. Reviewing Community Safety Priorities

4.1 Overall crime - The graph below clearly shows the downward trend of overall police recorded crime in Portsmouth is similar to the national trend. It is interesting to note the changes in levels of national police **recorded** crime, crime **reported** to the national Crime Survey for England and Wales and Portsmouth police recorded crime.

Figure 2.1: Comparison of long term police recorded crime and CSEW trends 2006/07 to 2021/22



4.2 While the September 22 SA update provided a summary of the key crime trends and issues, a detailed scoring matrix[2] is also used to identify or review crime priorities for the partnership. There were no significant changes in highest scoring crime types, compared with 2019/20[3]. The matrix is included in the SA Update here which can be found on the Safer Portsmouth Partnership website.

4.3 Considering the findings from the previous full Strategic Assessment for 2020/21 and the updated analysis for 2021/22, it is recommended that the previous priorities remain but that there is a renewed focus on violence against women and girls:

[2] The matrix takes account of volume, trends, benchmarking, public concern, personal harm and whether they were likely to have disproportionate impacts against sections of the community or were linked to drug and alcohol misuse.
[3] 2019/20 data is used as a comparison as data from 20/21 was unreliable.

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A. Tackling violent crime, continuing to focus on violence against women and girls, domestic abuse, knife-enabled violence, and sexual violence.

B. Tackling drug-related harm, with a focus on increasing access to treatment and closer working across physical and mental healthcare.

C. Early identification of, and interventions with children and young people at risk of exploitation or abuse, of misusing substances and of committing anti-social behaviour and offending,

4.4 Additional priorities: Improve accessibility and capacity of mental health provision for children, young people, and adults and increase the awareness of cyber-related harm and the impact on service users.

5. Community Safety Plan - 2022/23 progress

To avoid duplication and maximise collaboration and co-ordination, the current community safety plan pulls together delivery activity from across a range of existing strategies and plans that deliver against the priorities identified above. Many of these plans, including the Children's Trust Plan, the Domestic Violence Strategy and the Youth Justice Plan are in the process of being updated.

5.2 Priority A: Tackling violent crime, continuing to focus on violence against women and girls, domestic abuse, knife-enabled violence, and sexual violence.

5.2.1 Progress - *Domestic Abuse Strategy*

The following commentary is taken from the Domestic Abuse Monitoring Framework (Q4 2022/23), produced by Sam Graves, Community Safety Analyst, Public Health Intelligence, which was considered at the last meeting of the Domestic Abuse Strategy Group in March 2023. Some progress has been made against all the priorities identified, but more focus is required on challenging and supporting perpetrators who want to change, and holding those who do not, to account.

Demand and calls for service - local data for 2022/23 shows that domestic abuse-related demand for children's MASH contacts has been on a slight overall downward trend since 2013/14. Conversely, demand has been increasing for children known to be living in families experiencing high risk domestic abuse - 17% (n121) increase since 2021/22. More work is needed to understand why this is. There was also a 21% (n47) increase in referrals to the Independent Sexual Violence Advocacy (ISVA) service in 2022/23 compared to the previous financial year. The increase in referrals may be due the increased media coverage on sexual violence and violence against women and girls, which may have led to increased confidence in reporting to the police/seek support.

A. Promote healthy relationships - good progress made with all schools now having their Health, Relationship & Sex Education school policy available, 23,680 unique views of the Safer Portsmouth Partnership website domestic abuse pages (which is a 23% increase since 2021/22), and an increase (15%) in Right to Know disclosures by police and *'Is this Love'*

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delivered in all secondary schools across the city.

B. Improve identification and assessment - training is now provided by STOP Domestic Abuse and includes identification of and responding to perpetrators, as well as victims/survivors, and there has been an increase in numbers over the last two years.

Although the number of cases where domestic abuse is identified has reduced for children and families with a Single Assessment Framework, the number of adult safeguarding concerns triggering a Section 42 [4]has increased[5]. There has also been a reduction in the proportion of Society of St James clients where domestic abuse has been identified since the last time this data was available (5% in 2022/23 compared with 26% in 2017/18) and referrals from health providers to STOP Domestic Abuse remain very low.

C. Challenge and support those who use abusive or unhealthy behaviours - numbers of perpetrators receiving interventions are still low and there have been reductions in the portion of Up2U Creating Healthy Relationships clients experiencing a reduction in risk.

Feedback from Hampton Trust about CARA[6] completers (84% gave feedback), found that 89% said there had been an impact on their awareness of domestic violence and abuse and 87% said they experienced an impact on their relationships, how they viewed their behaviour and on levels of motivation to change.

D. Hold to account those who use coercive control and violence - while an increase in the number of perpetrators linked to high-risk offences suggests more people are committing more serious offences, a reduction in repeat occurrences may be positive. However, we cannot assume that all offences are coming to police attention, so caution should be applied when interpreting this finding.

Arrests resulting in a charge or caution have continued to fall over the last decade, although this trend appears to be stabilising with a marginal increase from 2021/22. The number of successful court outcomes for domestic abuse offences reduced by 9% from 2020/21, a continuation in the reducing trend since 2017/18. There has also been a reduction in the use of DVPNs and DVPOs[7] since 2021/22.

E. Are we making a difference - The risk reduction end of year snapshot for Refuge service users has been consistent at around 90% for the last three years. There has also been largely positive feedback to the client survey, with 92% of respondents feeling that they got the support they needed from STOP Domestic Abuse and 78% feeling safer.

[4] Section 42 of the Care Act 2014 states that an enquiry must take place if there is reason to believe that abuse or neglect is taking place or is at risk of taking place.
[5] where DVA has been identified as being involved
[6] Cautioning And Relationship Abuse is a series of awareness raising workshops for perpetrators - delivered by The Hampton Trust across HIPS area.
[7] Domestic Violence Protection Notice, Domestic Violence Protection Order

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"There was continuous support. I never felt as though I was on my own and felt secure knowing I could call them at any time."

"In the last few weeks it made me realise how low I had gotten and what I pulled myself out from. I don't think that I could have done this without support from them."

"Knowing that there was someone I can contact, and it wasn't all in my head. Being able to talk out loud and not being judged."

"My life isn't the same. My mental health is better and I am actually back at work. It has made a massive impact in my life. Has been amazing. I have a long way to go but feel like I have taken the first stepping stone."

5.2.2 Whilst Hampshire Police regularly attend the DA Strategy Group, they have also produced a separate Domestic Abuse Strategy 2023-25, based on the Government's Tackling Domestic Abuse Plan, launched in March 2022. The Hampshire strategy has three priorities: prioritising prevention, supporting victims, and pursuing perpetrators, and compliments the Portsmouth Domestic Abuse Strategy.

5.2.3 A new domestic abuse strategy will be developed over the next 12 months and will form one of the 'pillars' of the Violence Against Women and Girls strategy - see Plan 23/24 below.

5.3 Domestic Homicide Reviews (DHRs) - sadly, since 2019 there have been five domestic homicides Portsmouth. One review has been approved by the Home Office and published, and one has been submitted awaiting approval. The other three are ongoing.

More work is required to understand what, if anything, is driving this increase, although Portsmouth still has the lowest number of domestic homicides in Hampshire. We know from local analysis that domestic abuse remains the most significant driver for violence in the city, that incidents of domestic abuse have increased, that 'violence without injury' has increased (often associated with domestic abuse), but that conviction rates have fallen.

5.4 Tackling violent crime (knife enabled) - although serious violence in Portsmouth has remained stable since 2018/19, knife enabled violence has increased by 11% (n19) although numbers are very small.

Since 2019 Home Office funding for violence reduction, via the Hampshire Violence Reduction Unit (VRU) hosted by the OPCC, was used to support early intervention in Portsmouth to prevent children and young people going on to commit violent crimes. New arrangements from the beginning of 2023 mean that this funding has been withdrawn locally and will be centralised at Hampshire, IOW, Portsmouth and Southampton (HIPS) level and managed by the VRU Director and his staff, based at the OPCC.

5.5 Safer Streets – following success in previous funding rounds two, three and Safety of Women at Night (SWaN), Portsmouth City Council in partnership with neighbouring authorities has been successful in drawing in a further £733,000 of funding for Safer Streets four.

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The latest programme mobilised in October 2022 is now well into delivery, with 11 projects over five local authority areas (Portsmouth, Isle of Wight, Fareham, Gosport and Havant) focusing on addressing VAWG and ASB in key locations. Within Portsmouth this funding has enabled continuation of the We Stand Together Scheme with more venues in key locations being trained to recognise and respond to sexual violence, a train the trainer approach to continuing to deliver Mentors in Violence prevention within schools and colleges, continued delivery of Community in Motion active bystander training, continued work with women in the sex industry, development of an interactive trail and restorative photography project in the Hotwalls area, and new lighting, cycle hoops and art commissioned in Guildhall Walk. A fifth round of funding has been announced and further details are awaited.

5.6 Plans 2023/24:

Violence against Women and Girls (VAWG) - in November 2022 the Health and Wellbeing Board was updated on the local response to the VAWG agenda. The update identified several local workstreams already in progress, including the Domestic Abuse Strategy, and concluded that there was potential for a more connected response. Work has been undertaken to consider next steps, resulting in a proposal to establish a task and finish group to help develop a VAWG strategy.

The VAWG strategy will be framed around a continuum of understand, prevent, and respond, in alignment with the national statement of expectations, to develop a robust structure that will deliver priority outcomes. The VAWG strategy would remain within the governance and oversight of the HWB with existing workstreams such as the domestic abuse strategy sitting within the new structure. Other pillars of work including organisational change (White Ribbon), early intervention, and messaging (Is this Love), designing out crime (Safer Streets) and sexual crime will also be included.

Serious Violence Duty - the new Serious Violence Duty for local authorities is now in force[8]. The duty requires all local authorities to understand and address serious violence, using a public health approach. This is something we have always done in Portsmouth and is unlikely to have a significant impact on normal working arrangements. However, despite the duty resting with local authorities, the OPCC are keen to use funding provided by the Home Office to 'support' local areas by taking a co-ordinating role across the HIPS[9] area.

Helen Atkinson is the lead senior officer for Serious Violence under the Act[10], with support from Emma Seria-Walker, Matthew Gummerson and Lisa Wills.

[8] Police, Crime and Sentencing and Courts Act 2022
[9] Hampshire, IOW, Portsmouth and Southampton
[10] Police, Crime and Sentencing and Courts Act 2022

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6. Priority B: Tackling drug-related harm, with a focus on increasing access to treatment and closer working across physical and mental healthcare

Work to address this priority is now led by the Combating Drugs Partnership (CDP) chaired by the Director of Public Health, Helen Atkinson. Since its inception in June 2022, the new partnership has approved a comprehensive needs assessment and three-year delivery plan (2023-26) including measures of progress. Six key recommendations arising from the needs assessment have been translated into three strategic priorities:

1. Disrupt local drugs supply chains and drug related crime;
2. Improve the quality, capacity and outcomes of our drug and alcohol prevention and treatment services
3. Reduce misuse and harm caused to young people by drugs and alcohol

6.1 Portsmouth substance misuse needs assessment

The needs assessment, approved in February 2023 includes the following key recommendations:

I. To develop access to primary care services and expand homeless health care provision to address the significant unmet physical health need.
II. To improve mental health pathways, with increased provision of co-located posts including mental health workers within recovery services and vice versa to address the significant unmet mental health need.
III. Target resources to help reduce the high level of alcohol-related harm in the city, deal with an increase in demand for treatment services and tackle the low proportion of alcohol successful completions via an expanded alcohol-specific team.
IV. Set up a task and finish group to investigate and implement measures to increase the proportion of successful alcohol and non-opiate treatment completions.
V. Increase the capacity of provision for young people, considering standalone services as the needs of young people differ from that of adults (also 18-24years), and develop improved relationships with schools and services such as Portsmouth Youth Offending Team.
VI. Move away from silo commissioning, for example, work closely with rough sleepers' commissioners, to understand how resources can be utilised and funding complement existing workstreams without duplicating work.

6.1.1 Physical and mental health needs were both re-occurring themes through many of the sections. Poor physical health was prominent in the impact section, particularly the data on drug-related deaths and it was a common concern amongst stakeholders and service users.

6.1.2 Issues stemming from poor mental health were the most common concerns from the stakeholder feedback, including lack of resources, too many barriers to accessing services, stigma and discrimination and a lack of co-ordination between services with mental health and substance misuse services not treating mental health and substances misuse as co-occurring

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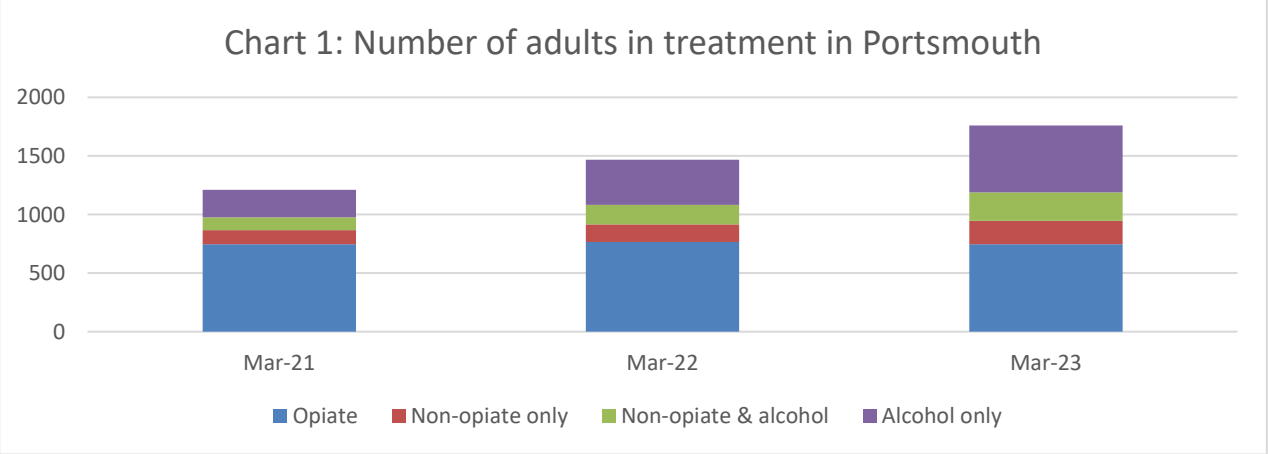
conditions. A large proportion of overdoses seen at A&E were due to paracetamol or antidepressant medications indicating a high level of mental health need in the city. The data for those in treatment also highlighted a high proportion had some level of mental health need, however approximately only half were getting any support or treatment.

6.1.3 Young people's substance misuse services in Portsmouth have been an area of disinvestment for some time. There has been a lack of capacity, with currently only one full time worker sitting within children social care. This lack of capacity has meant that referrals into the service and numbers in treatment are low. An increase in provision for young people would mean that pathways with key services such as the Portsmouth Youth Offending Team and education can be improved. Young people are more likely to try drugs than adults in Portsmouth and while it is believed that they are less likely to be dependent, the experimental stage increases a young person's risk of becoming dependent on drugs in adulthood. Young people's substance misuse contributes to much of the anti-social behaviour seen in the city and is a common factor in youth offending and young people's attendance at the emergency department.

As services are currently being resourced with an expected increase in funding over the next few years, it makes sense to work with other commissioners to understand what is happening in the city and where the unmet need and gaps in service provision are. Commissioned services should complement each other ensuring that those that need support in the city receive it.

6.2 Progress

There has been an increase of 20% (1468 to 1759) in the number of people in drug & alcohol treatment during 2022/23, building on an increase from the year before. Table 1 below highlights the total number of service users and the proportions of their presenting problem substance.



6.2.1 An unmet physical health need was a key theme identified through our needs assessment. The Recovery hub now runs 3 weekly health and wellbeing clinics which are always fully booked. People are offered a range of physical and mental health checks and interventions nurse led clinic.

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6.2.2 In 2020/21 around 60-65% of new presentations to drug and alcohol treatment have an identified mental health need. There has been a reduction in 2022-23 in the proportion of these new clients who have received no mental health treatment, from 49.0% to 43.7%. Within our rough sleeper drug and alcohol team we have employed a clinical psychologist and assistant psychologists to provide direct easy access psychological interventions to this hard to reach and complex group.

6.2.3 Due to staffing changes within our young person's service, we have seen a reduction in the number of young people receiving specialist treatment from 38 to just 15 new clients in the months to March 2023. This service is a priority for additional investment in 2023-24 with recruitment for a new team leader and additional staff under way.

6.2.4 Partnership working between different agencies to disrupt drug supply and drug related crime continues to develop, with increased co-ordination and information sharing. Projects such as the Southern Co-op funded Business crime navigator, see prolific shoplifters provided with support to access treatment services.

6.2.5 We have launched the Re:work project in Portsmouth, supporting people in treatment services to become work ready and then matching them with appropriate job placements. The Re:work team will then provide support to the employee and employer to sustain the job.

6.2.6 The Society of St. James, our lead provider for our substance misuse service, are currently scoping with the Integrated Care Board (ICB) the development of a support group for people who have a dependency to prescribed medication.

7. Priority C: Early identification of and interventions with children and young people at risk of exploitation or abuse, of misusing substances, engaging in anti-social behaviour and of offending.

Work to address Priority C is overseen by Children's Services and delivered mainly through the Youth Justice Plan alongside voluntary sector organisations across the city.

7.1 Progress

7.1.2 Youth Justice Plan - overall, Portsmouth made good progress against the initial aims and objectives set out in the 2021-23 plan. Key actions related to reducing first time entrants (FTE) include:

- Increase identification of SLCN[11] amongst children, recognising this as a critical driver of vulnerability to offending.
- Establish systems through MAT[12]s for identifying cohorts who may be at risk (e.g. via Childrens Insights Team)

[11] Speech and Language Communication Needs
[12] Multi Agency Teams

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- Increase number of schools where Playful, Accepting, Curious and Empathetic (PACE) and restorative approaches are in place.

The rate of young people entering the criminal justice system has fallen from 287 per 100,000 of 10-17 population in December 2021, to 229 at the end of December 2022. These reductions evidence the impact of work done across the partnership to strengthen early help and prevention, and the implementation of the Youth Diversion Programme which has been in place since November 2021.

Early intervention and prevention is a key element of reducing the number of young people entering the criminal justices system. Early (youth crime) prevention, is carried out by a range of partner agencies and voluntary organisations across the city, many of whom provide universal services and/or offer diversionary activity and access via self-referral. This includes our schools, youth and play services and housing, for example.

As of April 2023, Turnaround Youth Justice (TYJ) has offered interventions for children on the cusp of justice. With a Parenting Support Worker already based within the Youth Justice Service, and a Family Support Worker seconded from Early Help, this service will be able to offer support which has not previously been available to a number of young people and develop learning which will support future development of both Youth Justice and Early Help.

More detail is available in the Youth Justice Plan 2023-25 - see below.

7.2 Plans 2023/24:

7.2.1 Reducing FTE continues to be a key area of focus for the Youth Justice Plan for 2023-25.

7.2.2 In 2023-24 the Youth Diversion Programme will be evaluated by measuring outcomes and impact in partnership with Police colleagues, who will lead on that work. We will revise or enhance our delivery as required. We have also created a new Community Engagement Co-Ordinator post within the YOT team with a view to increasing the opportunities for diversion away from crime through community links, arts and sports initiatives.

7.2.3 We will further develop our partnership working with the Early Help and Prevention service and the wider Early Help System by developing the Youth Justice offer from the five Family Hubs in the City and supporting the ongoing development of the Early Help System by working with partners to embed the Supporting Families Outcomes Framework which includes outcome measures around children being safe from abuse and exploitation and supporting children, young people and their families to meet outcomes around crime prevention and tackling crime.

7.2.4 In Portsmouth, our partnership approach to Serious Youth Violence is delivered in collaboration with the Hampshire Violence Reduction Unit. The Hampshire VRU Director and Portsmouth Violence Reduction Manager both attend our local Management Board meetings. We will work together over the course of the next 12 months to enhance our understanding of the issue and develop future plans based on our existing partnership.

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7.2.5 There are also plans to establish closer links with the over-arching Health and Wellbeing Board via Youth Justice Partnership Management Board members to support increased strategic awareness and more informed decision making.

8. Additional priorities

8.1. In addition to the three priorities above, the SA identified the need to a) improve accessibility and capacity of mental health provision for children, young people and adults and b) increased awareness of cyber related harm.

8.2 Improved access to mental health provision is led by the NHS 'No wrong door' programme and further work identified in the Combatting Drugs Partnership Plan. Cybercrime is a national issue and the Online Safety Bill is still making its way through the parliamentary system. The Safer Portsmouth website has recently been updated with information about how to protect yourself from being scammed and what to do if your online security is compromised.

9. National context

There have been some national developments since last year's report that will influence work over the next 12 months:

9.1 The ***Serious Violence Duty*** for Local Authorities came into force in January 2023. Funding to support the new duty is being administered by the OPCC alongside the operational for of the Violence Reduction Unit. The co-ordination of the VRU has now been centralised under a new director, and funding for early intervention in Portsmouth has been withdrawn.

9.2 Domestic Abuse Act 2021- Part 4 of the DA Act places statutory duties on Tier 1 local authorities to understand the need for, and fund, safe accommodation and support for victims and their children. Funding allocations were agreed by the Domestic Abuse Strategy Group in autumn 2022.

9.3 National Policing Requirement - violence against women and girls - The strategic policing requirement for 2023 introduces violence against women and girls as a national threat. Police and Crime Commissioners and Chief Constables of forces across the UK must now consider the strategic policing requirement when carrying out their functions.

9.4 Community Safety Partnerships - national consultation is underway, led by the Home Office but instigated by an internal government review of the role of Police and Crime Commissioners. The review identified the need to 'improve the efficiency and functioning of community safety partnerships'.

9.5 ASB Action Plan was published in May setting out the response to one of the Prime Minister's priorities. There is no requirement, at the moment, for local areas to have a local ASB Action Plan.

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10. Community Safety Plan 2025

10.1 As previously explained, the new community safety plan will be based on the a) data analysis from 2023-24 in the full Strategic Assessment. Developing a new delivery framework pulling together activity from across the council and partner agencies to address the identified priorities.

10.2 Delivery activity will be summarised from a range of existing plans and strategies already in development. All these plans are overseen by existing multi-agency governance arrangements.

- Youth Justice Plan
- Portsmouth Safeguarding Children Plan
- Social Emotional and Mental Health Strategy
- Adults Safeguarding Adult Board Strategic Plan
- Domestic Abuse Strategy - (supported by local police DA improvement plan and aligned with the Hampshire Constabulary Domestic Abuse Strategy) - reported to the DA Strategy Group
- Mental Health Transformation Programme - No Wrong Door - Hampshire and IOW response to national NHS funded programme.[13]
- Combatting Drugs Partnership - delivery plan

10.3 The whole community safety plan will therefore be updated once these with other key strategies and plans in the city in the first quarter of 2024.

11. Conclusion

Overall, good progress has been made against the priorities identified in the Community Safety Plan and plans are in place to continue appropriate focus in the coming 12 months.

……
Signed by Acting Supt Paul Markham

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

[13] https://www.england.nhs.uk/mental-health/adults/cmhs/

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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

Appendix 1 - Community Safety Plan for Portsmouth - available here:

https://www.saferportsmouth.org.uk/our-plans/community-safety-plan-2021-22/

Appendix 2 - Key messages from Strategic Assessment Update - September 2022:

- Opportunities to commit crimes in public places have largely returned to pre-pandemic levels, but increased use of online platforms for working, shopping and socialising mean that there are still increased opportunities for online exploitation and cybercrime to take place.

- There were 28,119 police recorded crimes in Portsmouth during 2021/22, which equates to a crime rate of 131 per 1,000 residents and is higher than the average for other similar local authority areas (111 per 1,000). See Figure 1 below.

- Consideration of several data sources suggest that overall levels of crime have remained stable in comparison with 2019/20. This is consistent with the national picture, where reductions in acquisitive crime were offset by increases in cybercrime.

- Violence with injury and most serious violence have remained fairly stable since 2017/18, with the exception 2020/21 where lower levels were seen as a result of restrictions and behaviour changes associated with the pandemic.

- There have been increases in stalking and harassment, domestic abuse, violence without injury, sexual offences, robbery, knife-enabled serious violence, possession of a weapon, drug offences, and public order offences since 2019/20, although some of these increases may be driven by improved recording, increased reporting, or police activity.

- Domestic abuse continues to be the largest driver of violent crime, accounting for 44% of assaults recorded by police.

- There is some evidence that some victims/survivors of domestic abuse may be experiencing more and frequent incidents, while there has also been a reduction in charges and domestic abuse cases heard at court, highlighting the need to focus on holding medium and high-risk perpetrators to account.

- Data is showing a positive increase in awareness of unhealthy and abusive relationships, with the continuing success of the 'Is This Love' Campaign increasing hits to the domestic abuse web pages, more schools having their policies available, more 'Right to know'

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disclosures and 'Right to ask requests,' and more concerns raised by maternity services. There has also been an increase in domestic abuse being identified within adult social care, adult mental health services and children and families undergoing SAFs compared to a couple of years ago.

Appendix 3 - Positive relationships

The Health and Wellbeing Strategy includes a focus on the development of positive relationships in the community and in schools to help reduce conflict and anti-social behaviour, and ultimately, crime.

Schools - work has progressed in many of Portsmouth schools to embed relational and restorative practice:

- 31 schools (of 62) signed up in Waves one and two
- Continued strong inclusion outcomes in schools further ahead on implementation ()e.g. evidence of lower suspensions)
- Coaching in place for Heads and Senior Leaders
- Evaluation model emerging based on Theory of Change
- Self-assessment 'rubric' in place for schools
- £500k of resources secured for 3-year programme

Hotwalls and Camber Dock Restorative Support Group - work to build positive relationships across the generational divide in Old Portsmouth is a long-term project. Portsmouth Mediation Service, commissioned by the council, have worked with residents, businesses, organisations, artists, fishermen, Portsmouth International Port, bringing people together to find positive solutions to some of the perennial problems arising in the hot spring and summer months. The group met monthly from April 2022 and twice monthly from April 23 in the BAR Building on the Camber Dock.

Additional funding support has been provided by the Police and Crime Commissioner to increase the number of youth outreach workers based in the area during the summer holidays and increase the availability of diversionary activities for young visitors including paddle boarding, kayaking, photography, and other sporting activity.

An evaluation of the work will take place in the autumn to assess the impact of the work on the area.

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Title of meeting:	Health and Wellbeing Board
Date of meeting:	28th June 2023
Subject:	Developing a Violence Against Women and Girls Strategy
Report by:	Caroline Hopper, Corporate Projects Manager, The Executive
Wards affected:	All
Key decision:	Yes/No
Full Council decision:	Yes/No

1. Purpose of report

1.1 To Update the Health and Wellbeing Board on work to review existing plans in respect of VAWG and request that the HWB approve the development of a VAWG Strategy, building upon work to date, focusing on strengthening existing arrangements, closing gaps, and maximising impact.

2. Recommendations

2.1 For members of the Health and Wellbeing Board to approve the development of a city-wide Violence Against Women and Girls (VAWG) strategy.

3. Background

3.1 The term VAWG has come to embody a range of unacceptable and damaging behaviours including rape and other sexual offences, stalking, domestic abuse, 'honour-based' abuse (including female genital mutilation and forced marriage and 'honour' killings), 'revenge porn' and 'upskirting'[1]. Whilst men can also be victims of these behaviours, women and girls are disproportionally affected, and the term VAWG is used to refer to all victims of these offences regardless of the gender of the victim.

3.2 In November 2022 the Health and Wellbeing Board was updated on the local response to the VAWG agenda. The update identified several local workstreams already in progress, including Hampshire Constabulary VAWG tactical plan, Domestic abuse strategy, Safer Streets programme the Office of

[1] Tackling violence against women and girls' strategy, Home Office, July 2021 Tackling violence against women and girls strategy - GOV.UK (www.gov.uk)

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the Police and Crime Commissioner's (OPCC) VAWG task group and White Ribbon. The report concluded that there was potential for a more connected response to coordinate activity and ensure communication with the public is coherent and maximised across the VAWG agenda. The update also identified a need to bring in other relevant workstreams to create the societal step change required.

3.3 The Governments National Statement of Expectations details how local areas should commission effective services to ensure their whole system response to VAWG is "collaborative, robust and effective as possible"[2]. This includes an expectation that local strategies and services will:

3.3.1 put the victim at the centre of service design and delivery.
3.3.2 have a clear focus on perpetrators.
3.3.3 take a strategic, system-wide approach to commissioning and acknowledging the gendered nature of VAWG.
3.3.4 be locally led and safeguard individuals at every point.
3.3.5 raise awareness, engage, and empower communities to prevent VAWG.

3.4 In May 2023 Portsmouth City Council became a White Ribbon accredited organisation. The accreditation necessitates that as part of the Council's white ribbon action plan, 'in collaboration with key local partners, there is a joint strategic approach, to ending men's violence against women'. This is aligned with the national direction of travel in respect of VAWG.

4 Local Context:

4.1 Victims/survivors of domestic abuse and sexual offences are overwhelmingly women and girls (69% for domestic abuse and 80% for sexual offences)[3].

4.2 Domestic abuse continues to be the largest driver of violent crime in Portsmouth, accounting for 44% of assaults recorded by police. The proportion of assaults driven by domestic abuse has increased, driven by a 20%(n236) increase in violence against family members. Despite the increase in DA incidents, crimes and repeat perpetrators, the number of charges and cases heard at court have dropped considerably over the last few years.

4.3 There have been increases in police recorded sexual offences, since 2012/13, although some of these increases may be driven by improved recording,

[2] Commissioning services to tackle violence against women and girls, March 2022 Commissioning services to tackle violence against women and girls - GOV.UK (www.gov.uk)

[3] Community safety plan, strategic assessment, research and analysis programme, performance monitoring. The Strategic Assessment Update September 22, For-website-Strategic-Assessment-Update-2021-22-18.10.22.pdf (saferportsmouth.org.uk)

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increased reporting, or police activity. Sexual offences are known to be under reported, so a genuine increase cannot be ruled out. High Streets and areas with hospitality venues showed a higher number of reports[3].

4.4 There has been a significant increase in police recorded crime observed in 2021/22 against 2019/20 for stalking and harassment (74%, n1,593), although stalking and harassment offences have been increasing since 2013/14. This increase is likely to be driven by a combination of improvements in recording, the addition of new stalking offences in 2012 and an increase in reporting[3].

4.5 The Community Safety Survey 2022, the best measure of residents' views on levels of ASB and crime in the community, identified a higher proportion of women felt unsafe in certain parts of the city, than men[4].

4.6 A brief overview of key VAWG trends can be found in the Strategic Assessment of Crime, Anti-social Behaviour, Substance Misuse and Reoffending, but there has not been a VAWG (or domestic abuse) needs assessment. This means that there is no detailed assessment of the local picture for some elements of VAWG including: imaged based abuse, revenge porn, upskirting, and abuse within the sex industry.

5. Creating a step change - things to consider

5.1 Everyday normalised behaviours including gender inequality, sexism, objectification, micro aggressions, promotion of unhealthy relationships and victim blaming, both online and in the real world, when left unchecked, create a platform for more serious violence to occur. A city-wide strategy to address VAWG would need to seek to address these behaviours wherever they occur within educational settings, workplaces, business, public spaces, and on-line.

5.2 Further work is needed to understand the local VAWG context, and a mechanism for this would need to be agreed. There will also need to be some consideration to how additional complexities, such as health disparities, compound VAWG. Some groups may be experiencing additional barriers to accessing support and may require a more targeted response.

[4] Violence Against Women and Girls - Findings from the Community Safety Survey 2022, Portsmouth City Council Cabinet paper, September 2022

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5.3 The pervasive nature of VAWG, makes it a societal issue that requires a strategic response that everyone owns. Individual agencies will have their own plans to address VAWG, some based upon statutory requirements, but no one agency (The Police, Council, Health, Education or specialist services in the Charity and Voluntary sector) can be wholly responsible for the cities response to VAWG.

5.4 In considering how best to address VAWG coherently it is important to recognise the responsibilities of key agencies and ensure accountability is appropriately retained (for example the local authority's responsibility to provide safe accommodation, or the criminal justice system's responsibility to victims and perpetrators), to support a coordinated community response.

5.5 VAWG cuts across socio-economic factors. Any strategy to address it, will need to find a way to draw in other relevant agendas including education, regeneration, transport, culture, and leisure, in a sustainable way. It must ensure that universal as well as specialist services are equipped to respond. Place-making structures need to proactively design out crime, as well as retrospectively responding to crime and improving functioning.

5.6 VAWG is a topical issue with many stakeholders. It is important that any strategy developed is inclusive, clear about what the local offer is, manages expectation, and ultimately focuses on actions which are likely to have the greatest impact. It will need to ensure everyone's needs are represented regardless of sex or gender, whilst also keeping a focus on women's and girls' experiences in line with the national VAWG strategy.

6. Proposal

6.1 The Health and Wellbeing Board (HWB) is asked to approve the recommendation to develop a VAWG strategy for Portsmouth in partnership with key stakeholders.

6.2 A task and finish group will be established to develop the VAWG strategy, drawing upon local expertise from existing workstreams. The task and finish group will undertake a logical process, framed around a continuum of understand, prevent, and respond, in alignment with the national statement of expectations to develop a robust structure that will deliver priority outcomes.

6.3 Alongside the task and finish group, and in addition to local evidence already available, a multiagency workshop will be held to understand stakeholder views

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about the existing response, and how learning from this can be used to strengthen the strategy.

6.4 The VAWG strategy would remain within the governance and oversight of the HWB with existing workstreams such as the domestic abuse strategy siting within the new structure. Other pillars of work including organisational change, early intervention, messaging, designing out crime and sexual crime will also be included.

6.5 There is already a lot of work being delivered by a multitude of partners across the city, which creates a strong foundation for the development of a VAWG strategy. The new strategy is not seeking to replace or duplicate existing work, its focus will be on strengthening existing arrangements, closing gaps, and maximising impact. Organisations will retain their statutory responsibilities.

7. Reasons for recommendations

7.1 Within the Portsmouth area there are several existing arrangements for responding to VAWG with their own governance structures. Whilst each of these arrangements is distinctly separate, they are connected operationally though lead officers. Key partners, such as the police and the Council, are represented within each's governance arrangements. The development of a VAWG strategy would improve connectivity between these workstreams, reduce duplication and maximise effect.

7.2 The national VAWG strategy and associated statement of expectations make it clear that VAWG cannot be addressed by any single agency. Statutory services, voluntary organisations and communities need to work collaboratively to increase opportunities for victims, survivors, and perpetrators to seek and access support, and that effort needs to be sustained.

7.3 This proposal aligns well with and builds upon work to date to address some elements of VAWG such as domestic abuse through the multiagency Domestic Abuse strategy group.

8. Integrated impact assessment

8.1 An integrated impact assessment (ref IA524328056) has been undertaken in consultation with several key stakeholders including Public Health, Transport,

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Economic Development, Community Safety, and Equalities, Diversity, and inclusion.

8. Legal implications

8.1 There are no legal implications arising from the proposed recommendations. The report seeks to request a move to set a process in train and at this stage is purely information based, as such should active engagement occur in the future a reconsideration of this advice would be appropriate.

9. Director of Finance's comments

9.1 At this time there are no financial implications arising directly from the recommendation contained within this report.

9.2 In the event that work undertaken as a result of recommendation 2.1 identifies a financial commitment by the Council may be necessary, a further report including options for financing will be brought forward at that time.

……
Signed by:

Appendices:

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
Tackling violence against women and girls' strategy, Home Office, July 2021 Tackling violence against women and girls' strategy	- GOV.UK (www.gov.uk)
Commissioning services to tackle violence against women and girls, March 2022	Commissioning services to tackle violence against women and girls - GOV.UK (www.gov.uk)
Community safety plan, strategic assessment, research and analysis programme, performance monitoring. The Strategic Assessment Update September 22	For-website-Strategic-Assessment-Update-2021-22-18.10.22.pdf (saferportsmouth.org.uk)

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Violence Against Women and Girls - Findings from the Community Safety Survey 2022, Portsmouth City Council Cabinet paper, September 2022	Democratic Services

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

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Form name	Integrated Impact Assessment
Reference	IA524328056
Date	15/06/2023

Policy details

Request date	15/06/2023 21:47
Directorate	PCC Executive
Service	Strategy
Title of policy, service, function	Violence Against Women and Girls Strategy
Type of policy, service, function	New
What is the aim of your policy, service, function, project or strategy?	To build upon work to date to strengthen existing arrangements, closing gaps, and maximising impact in respect of addressing Violence Against Women and Girls (VAWG).
Has any consultation been undertaken for this proposal?	yes
What were the outcomes of the consultations?	Consultation has been undertaken with key stakeholders to consider existing workstreams in place and how these could be better connected with each other to improve outcomes via the development of a VAWG strategy. The proposal for the strategy is to be developed in partnership and includes additional consultation through multiagency workshops to understand stakeholder views about the existing response, and how learning from this can be used to strengthen the strategy.
Has anything changed because of the consultation?	yes
Please provide details	Consultation to date with public health and education colleagues identified the need to explore a pillar in respect of early intervention and messaging. Consultation with Police identified links to Serious sexual offences and rape work.
Did this inform your proposal?	yes

Please provide details	The proposal is to develop a strategy in partnership with key stakeholders. The new strategy is not seeking to replace or duplicate existing work, its focus will be on strengthening existing arrangements, closing gaps, and maximising impact. Organisations will retain their statutory responsibilities.

Equality & diversity - will it have any positive/negative impacts on the protected characteristics?

With the above in mind and following data analysis, who is the policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?	Victims/survivors of domestic abuse and sexual offences are overwhelmingly women and girls (69% for domestic abuse and 80% for sexual offences). This strategy will develop a response that addresses underlying causes of violence including gender inequality and sexism. Whilst men can also be victims of these behaviours, women and girls are disproportionally affected, and the term VAWG is used to refer to all victims of these offences regardless of the gender of the victim in alignment with the definition used within the national VAWG strategy.
Will any of those groups be affected in a different way to others because of your policy, project, service, function, or strategy?	Part of the strategy is to comprehensively understand local need. Although there is national research, we currently only have a partial understanding of VAWG locally. The strategy proposal sets out a need to understand how different factors including health inequality may impact some groups so that measures can be put in place to address these.
If you are directly or indirectly discriminating, how are you going to mitigate the negative impact?	The strategy will be addressing inequality, improving access to support and seeking to prevent gender based violence. In doing this it will not be advantaging any one group over another.
Who have you consulted with or are planning to consult with and what was/will be your consultation methodology?	Key stakeholders including Public Health, Education and Hampshire Constabulary. The Domestic Abuse strategy group will be consulted with and asked to support the development of the strategy. It is proposed that a task and finish group is formed to develop the strategy. In addition stakeholder workshops will be held.

How are you going to review the policy, service, project or strategy, how often and who will be responsible?	The strategy would remain within the governance and oversight of the Health and Wellbeing Board with existing workstreams such as the domestic abuse strategy siting within the new structure. Monitoring and review frequency will be agreed with the HWB - expected to align with other elements of the wider Community Safety Plan and Strategic assessment.

Crime - Will it make our city safer?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	In alignment with the National VAWG strategy, the development of a local AWG strategy is seeking to address all elements of VAWG to include: • Rape and Sexual Violence • Sexual and other forms of harassment • Stalking • Honour'-based abuse - female genital mutilation, and forced marriage • Domestic Abuse • Violence against women and girls in public places • Violence against women and girls perpetrated online • Prostitution and sex work. • Image based - Revenge Porn, and Upskirting
How are you going to measure/check the impact of your proposal?	Performance indicators will be agreed as part of the development of the strategy, with a focus on actions which are likely to have the greatest impact.

Housing - will it provide good quality homes?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	The Local Authority has a statutory duty to have a Safe Accommodation strategy. The Domestic Abuse strategic group will continue to have responsibility for the Domestic Abuse strategy, including governance of the Safe Accommodation duty.
How are you going to measure/check the impact of your proposal?	The domestic abuse strategy will be updated for Autumn 2024, to align with the statutory duty for local authorities to have a Safe Accommodation strategy.

Health - will this help promote healthy, safe and independent living?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	The strategy proposal sets out a need to consider health disparities and highlight groups which may be experiencing additional barriers to accessing support. More broadly there is a strong link between fear of crime and poorer mental health. In general people with a fear of crime exercise less, see friends less and participate in fewer social activities compared with less fearful individuals. The Community Safety Survey 2022, the best measure of resident's views on levels of ASB and crime in the community, identified a higher proportion of women felt unsafe in certain parts of the city, than men. More work is needed to know if fear of crime is preventing women from engaging in activities and this could be addressed within the designing out crime pillar that is proposed. The stress of experiencing violence is liable to impact significantly on an individual's attendance and performance at work. According to White Ribbon UK: 1 in 4 women have experienced sexual harassment in the workplace Around 60% of abused women missed at least three days of work a month The VAWG strategy will bring together existing workstreams including White Ribbon which focuses on organisational change to address VAWG.
How are you going to measure/check the impact of your proposal?	It is usually not possible to directly quantify improved health outcomes at a local community or individual level from schemes such as that proposed. This is for a range of reasons, not least that the cause-effect relationship is far from straightforward. However it may be possible to deploy some measures such as the Healthy Streets Tool kit to consider impact within the designing out crime pillar. There may be some observable correlation in respect of staff absence, and also some movement in take up of specific health services associated with efforts to break down barriers to access which may be observable.

Income deprivation and poverty - will it consider income deprivation

and reduce poverty?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Often, economic equality and safety from violence against women and girls are seen as separate issues. However despite the progress that has been made on gender equality, a gender pay gap still persists as the result of deeply rooted inequalities in societies and the economy including gender stereotypes and social norms. Women are over represented in care and domestic work, and underrepresented in STEM subjects. Women are therefore more likely to be financially dependent on someone else or on the state. Domestic abuse can occur within households of any income. Poverty does not cause domestic abuse. However, domestic abuse can contribute to higher rates of poverty among survivors due to the fact that it exacerbates the economic instability of those experiencing abuse. Economic abuse can happen alongside other forms of domestic abuse, making it harder for women to leave abusive relationships. Agenda's such as White Ribbon which will form part of the VAWG strategy are seeking to improve women and girls participation in traditionally male dominated working environments. Improving earning potential, also holds the potential to reduce women's economic dependence, which in turn increases their bargaining power within households, and provides additional outside choices.
How are you going to measure/check the impact of your proposal?	Organisations participating in White Ribbon are required to develop an action plan. This action plan includes organisational change work associated with improving gender equity within the workplace. Engagement of businesses across the city in white ribbon/ gender equality employment activities and measuring % of men/women in key roles may be one measure that could be used. However as with addressing health inequalities it would be difficult to attribute any success solely to the VAWG strategy.

Carbon emissions - will it reduce carbon emissions?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Evidence from the Transport Champions for Tackling Violence Against Women and Girls highlighted that as women and girls are more reliant on public transport and active travel modes for their mobility needs, their fears can reduce their life opportunities and ambitions. Fully reviewing the Transport Champion for VAWG recommendations against local context would be undertaken as part of the strategy development to understand what action is required to improve take up of active travel modes amongst women and girls.
How are you going to measure/check the impact of your proposal?	Locally scooter provider Voi have undertaken some analysis of scooter use within Portsmouth which indicates that there is some work required to encourage equal take up. This could form a baseline measurement in respect of that element of active travel.

Energy use - will it reduce energy use?

This section is not applicable to my policy	☑

Climate change mitigation and flooding - will it proactively mitigate against a changing climate and flooding?

This section is not applicable to my policy	☑

Natural environment - will it ensure public spaces are greener, more sustainable and well-maintained?

This section is not applicable to my policy	☑

Air quality - will it improve air quality?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Taking action to create a safer environment for women (prioritising active travel and improving the urban realm) may have the co-benefit of reducing air pollution. Similarly, some women may feel the need to drive to avoid walking, or using public transport, in areas perceived to be unsafe. Therefore improving these aspects of the transport network could reduce car dependence and air pollution.
How are you going to measure/check the impact of your proposal?	As with health, there a number of factors that would need to be considered when agreeing impact measurements.

Transport - will it make transport more sustainable and safer for the whole community?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	The National VAWG strategy and Transport Champions for tackling Violence Against Women and Girls have identified the role of Transport in addressing VAWG. A number of recommendations have been proposed to address the impact that transport solutions can have in reducing the fear associated with using transport and public places, which can in turn improve access to many opportunities for women and girls. As part of developing the VAWG strategy work will be undertaken to understand how those recommendations align with the local context, and what can be done to strengthen existing structures in respect of designing out crime and improving participation.
How are you going to measure/check the impact of your proposal?	Appropriate impact measures will be agreed as part of the strategy plan. As with health and income outcomes there are many factors that intersect that would need to be considered within any impact measurements.

Waste management - will it increase recycling and reduce the production of waste?

This section is not applicable to my policy	☑

Culture and heritage - will it promote, protect and enhance our culture and heritage?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Society teaches us through media and advertising that women, girls and sometimes boys can be portrayed as weak and submissive, existing mainly to satisfy others' needs. These messages dehumanize the victims of sexual violence, representing them primarily as objects of sexual desire rather than 'real' people, with feelings and rights. This objectification is an enabler of inequality and exploitation. Projects such as the Art for change International True stories 'Objectification' project in 2010, and 2018 evidence review Promoting gender equality through the arts and creative industries highlight the role of Art in challenging unhealthy and unsafe behaviours. Locally art projects like the mural of inspirational Portsmouth woman, Marie Costa, painted on Portsmouth Combined Court external wall, the transformation of Lake Road underpass as part of Safer Streets two, community mural in Belmont Path as part of Safer streets 3, and Safe and Strong vinyl project provide an active demonstration of the role of Art in transforming people's perceptions and experience within the built environment. The designing out crime pillar of the VAWG strategy will explore how through structures such as the local plan, a placed based approach to addressing VAWG can improve safety, and the image and perceptions of the city to attract residents, visitors, businesses, and investors by improving both day and night-time experiences.
How are you going to measure/check the impact of your proposal?	Improved natural surveillance, access control, territorial reinforcement, and space management. Improved feelings of safety reported in community safety survey. Reduction in incidents of VAWG crime in public places

Employment and opportunities - will it promote the development of a skilled workforce?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	In addition to the commentary in relation to gender pay gap within Income deprivation and poverty section, and a need to improve access to STEM careers, fear of crime can also impact on update of the employment opportunities that are available. Fear of using public transport and active travel routes incurs additional costs for women travelling in the city. For example, opting to use taxis instead. If these additional costs cannot be covered, the economic opportunities of women can be restricted. For example, not being able to accept a job role in an area which is considered to be unsafe, or with unsafe transport connections. This has a negative impact on the local economy, by constraining women's participation in the labour market. The cross cutting ambition of the VAWG strategy means that there is an opportunity approach to this issue through both the designing out crime and organisational change pillars.
How are you going to measure/check the impact of your proposal?	Organisations participating in White Ribbon are required to develop an action plan. This action plan includes organisational change work associated with improving gender equity within the workplace. Engagement of businesses across the city in white ribbon/ gender equality employment activities and measuring % of men/women in key roles may be one measure that could be used. However as with addressing health inequalities it would be difficult to attribute any success solely to the VAWG strategy. How confidence in public transport is measured would need to be considered in partnership with key service providers.

Economy - will it encourage businesses to invest in the city, support sustainable growth and regeneration?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	See response to Employment and opportunities. The Solent LEP Solent Skills Advisory Panel (SAP) works to understand existing and future skills gaps and priorities for the area. In 2022 it reported that the combined effects of the Covid-19 pandemic and Brexit had resulted in significant labour market volatility within the Solent, with many sectors reporting recruitment challenges and skills shortages - sectors including Construction, Digital and Technology, Haulage and Logistics, and manufacturing appear to be particularly affected. These are are also industries where women have been traditionally under represented within the workforce. In 2019 Ranstand, Building places post Brexit, Women in Construction report found that 72% of female construction workers had been subject to some form of gender discrimination while 41% reported receiving inappropriate comments from male colleagues. In 2022 Engineering UK noted the fact that women represent only 16.5% of those working in engineering should still be a major concern to the engineering sector. Improving equity within the workplaces through organisational change agendas such as White Ribbon and promoting STEM to girls as part of an early intervention and messaging campaign within the VAWG Strategy will alongside other work promote employment and growth within the city. This includes the LSIP (Local Skills Improvement Plan) led by Hampshire Chamber of Commerce for the Solent region, which extends the work of SAP under the Skills and Post 16 Education Act 2022. A draft LSIP plan has been submitted and work continues to address inequalities within workforces and skills opportunities based on employer collaboration Making the public realm feel safer for women through the designing out crime pillar proposed will have the overall benefit of improving the liveability of the city. A city that prioritises the safety and experience of residents will be an attractive city for investments and business.
How are you going to measure/check the impact of your proposal?	There may be some economic metrics that could be considered. The main indicators would be rising income levels amongst women and availability of skilled workers within industry's that draw upon STEM qualifications, however these would be long term pieces of work and subject to a number of variables.

Social value

Please explain how your policy, service, function, project or strategy delivers Social Value	The development of a VAWG strategy will increase the health, wellbeing and safety of a significant proportion of the local population, creating a more positive environment for all who live, work, study and visit the city.

Involvement

Who was involved in the Integrated impact assessment?	This impact assessment was informed by consultation with a number of key stakeholders including Public Health, Transport, Economic Development, Community Safety, and Equalities, Diversity and inclusion.
Name of the person completing this form	Caroline Hopper
Date of completion	2023-06-15

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Title of meeting: Health and Wellbeing Board

Subject: Stroke Recovery Service

Date of meeting: 28th June 2023

Report by: Jane Walker, Head of Adults Care and Support

Wards affected: All

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1. **Requested by** the Health Overview & Scrutiny Panel.

2. **Purpose**

   To provide an update on the decision to withdraw from recommissioning the Stroke Information and Support Service, commonly known as the Stroke Recovery Service.

3. **Information Requested**

   Background

   A four-year Stroke information and advice service contract was originally awarded to the Stroke Association in 2014 funded by PCC Adult Social Care. The scope of the contract was then extended in 2017, to include support to people being discharged from the acute hospital following a stroke. This element was funded through PCC's ASC contribution from the Better Care Fund. In 2018 the contract was extended for a further two years to 30/09/20, utilizing the full extension period within the contract.

   Due to the impact of the Covid pandemic, there was not resource available to undertake a procurement exercise at the end of the extension and two direct awards were made in 2020/21 and 2021/22. A further direct award was then agreed to cover the period 30/09/22 to 31/03/23 with the option to extend for 3 months to 30/06/23. This period was agreed to provide time to review the current service provision, reconfirm the availability of ongoing funding and to consider if the service was still needed.

   Over the period 2014 to date, the services provided by the Stroke Association have developed and this contract contributes to the delivery of what is currently known and marketed by the Stroke Association as their Stroke Recovery Service.

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Contract cost and funding sources

The current annual cost of the contract is £77,397.66. Of which £16,563.00 is provided through PCC's contribution from the Better Care Fund. The remainder is not linked to a specific budget line but was met through underspends in previous years. Due to pressures across the Adults Care and Support budget there is currently no funding that can be identified to support the remaining £60,834.66 plus uplifts, needed to deliver this contract going forwards. As such it represents an ongoing budget pressure.
As part of the work on the new S.75 schedules all contracts have been allocated to a budget manager and contracts team and as such this situation should not happen again with other contracts.

Contract delivery and performance

The Stroke recovery service is for stroke survivors (including TIAs/mini-strokes), and families and carers of people affected by stroke. The service works with people to identify personal support needs and priorities through telephone contact and in some cases a home visit. It provides:

- Emotional support
- Tailored information
- Assistance with accessing community-based support
- Support for carers and family members
- Signposting to other relevant organisations.

The service received 130 referrals in the first 3 quarters of the 2022/23 year. 65% of referrals came from health practitioners, 26% were self or family referrals, 3% from adult social care and the remaining 6% from voluntary sector and other organisations.

Of the 389 completed actions recorded in the first 3 quarters of the year 309 or 79% involved providing information, signposting and onward referral, 73 or 19% involved support and advice and the remaining 7 or 2% were recorded as other.

Rationale for decision

In February 2022 the NHS published a National Stroke Service model for an integrated community stroke service (ICSS). Since that time health organisations have been reviewing their stroke provision in line with the model. Whilst the model focuses on the core delivery of 3 pathways, 1. Home with ICSS input (most patients) 2. Home with ICSS input combined with daily social care support and 3. Discharged to residential/nursing home; Life after Stroke services including voluntary/charity support services are included within the scope of the model. It is suggested in the guidance that ICSS should work with the voluntary sector to develop appropriate life after stroke and support services.

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Whilst the ICSS model has not been implemented in Portsmouth, a comprehensive stroke service is delivered through the NHS. This consists of Stroke and stroke rehabilitation services, which are provided through inpatient beds at Portsmouth Hospitals University Trust, (PHU). A Community stroke Rehabilitation Team (CRT), which provides a stroke at home service typically for 6-8 weeks and longer-term clinical support, if needed, through the Community Neurological Rehabilitation Team (CNRT).

Adult Social Care also works collaboratively with both the CRT and CNRT to support people when they are discharged from hospital and for those people living in the community with eligible social care needs. This includes providing social work and occupational therapy support and a range of services from equipment and adaptations to reablement and domiciliary care as well as referral to local support services.

Support is also available through a variety of other organisations and services in addition to that available through the current stroke recovery service, which people are routinely signposted to:

- Think Ahead Stroke - a charity providing support, advice and information.
- National Stroke Association - Helpline, online support group, information and advice
- Different Strokes - Portsmouth based support group, providing support and activities.
- HIVE - provide a directory of services and support organisations.
- Age UK - advice information and support for older people
- Citizens Advice - support with various issues including work, housing and finances
- Carers Service - information, advice, and services for carers
- Community Connectors - support people to connect to local resources.
- Social prescribers and primary care support
- Mental Health Hub - support for people experiencing issues with their mental health.

In Portsmouth, the ICB does not have any current plans to commission a specific Life after Stroke provision from the voluntary sector and did not recommission in 2021/22 the stroke communication support service that they previously funded and was provided by the Stroke Association. This was deemed an expensive service that supported a small number of people.

The Stroke Association is a national charitable organisation, which is focussed on supporting people to rebuild their lives after stroke. It provides an online discussion forum, stroke helpline, various stroke publications, hardship grants and several other services, dependent on what is funded and developed in local areas.

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There is a mixed picture nationally across health and social care regarding the funding of voluntary sector stroke recovery services. Portsmouth is now somewhat of an outlier locally, in retaining a commissioned service funded by social care. The service fully funded by health in Southampton has now ceased and whilst the ICB did pilot a stroke recovery service last year it was proved not viable to extend or enter into a contract. A similar decision has also been made by the Isle of Wight Council and their commissioned stroke recovery service comes to an end on 30th June 2023 as a result of financial constraints within their budget setting for 2023/24.

Provision of a stroke recovery service is not a statutory responsibility of the local authority and has previously been provided under its discretionary powers. The clinical needs of those affected by stroke are the responsibility of the NHS and they will continue to meet these needs through the provision of the Stroke and stroke recovery service already in place. Whilst all ICBs are responsible for delivering against the ICSS within the term of the NHS long-term plan, current statutory obligations are being met through the services that have already been commissioned.

Summary

There is no doubt that the Portsmouth stroke recovery service has provided a tailored support service to the residents of Portsmouth, who are recovering from a stroke. However, because of budget pressures in ASC there is no specific funding source, other than that provided through the BCF to support the commissioning of this service beyond December 2023, when the current contract comes to an end. As a result, we are having to make the decision not to reprocure this contract. At this challenging financial time, we must focus on our ability to discharge our statutory duties, which inevitably means that some of the discretionary services we have provided historically, can no longer be provided, as they are no longer affordable.

The landscape around commissioning for integrated stroke services is slowly changing, as a result of the publication of the national ICSS model, with health services increasingly focussing resources on delivering the core elements of the pathway.

As the stroke recovery service funding is the only source of funding for the Portsmouth Stroke recovery service, the impact of the removal of this funding is closure of the service. However, people will continue to have access to the Stroke Association's national service including access to all their online resources; *My Stroke Guide*, which provides access to video resources to help people to understand stroke and manage its effects; a dedicated section for family and friends, which provides information on the impact of stroke and guidance on how to support a loved one.

Survivors can also be empowered to join the online community where friendly forums provide opportunities to connect with others from the comfort of their own home.

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Individuals can share their stroke experience, stories and tips, and find out how others manage recovery.

For people who prefer face to face support there is the successful stroke club - Different Strokes - which has run for many years, where stroke survivors and their families can meet for social interactions and support.

In addition, stroke survivors and their families are able to utilise both universal sources of advice such as those through Age UK or advice Portsmouth as well as the significant range of other statutory and non-statutory services that are available, including specific stroke services such as Think ahead stroke.

Extending the contract for a further 6 months to the end of December 2023, provides us with an opportunity to ensure that all existing customers of the service are offered alternative forms of support if needed. It also provides the stroke association with an opportunity to identify any alternative funding sources that would allow it to continue to provide the service, as it is not necessary for them to be commissioned by Portsmouth City Council to do so.

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Signed by (Director)

Appendices:

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
National Service model for an integrated community stroke service	NHS England and NHS Improvement 2022. Publication approval reference: PAR733

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