Title of meeting:	Health and Wellbeing Board
Date of meeting:	20th June 2018
Subject:	Delivering the Portsmouth Blueprint Commitments - Progress Update
Report by:	Jo York, Director, New Models of Care, Portsmouth CCG
Wards affected:	n/a
Key decision:	No
Full Council decision:	No

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1. Purpose of report

1.1 The purpose of this paper is to provide an update to the Health and Wellbeing Board regarding the progress to date of the Health and Care Portsmouth (HCP) programme, the City wide transformation programme to deliver the Portsmouth Blueprint.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

a. Note the progress made through the adults' delivery element of the Health and Care Portsmouth programme to deliver the Portsmouth Blueprint.

3. Background

3.1 As the health and care landscape becomes more complex and challenging, and as demand for services and financial pressures increase, the need for change has been recognised both locally and nationally. The NHS 5 year Forward View, published in 2014, sets out the options for new models of care delivery including Multi-specialty Community Providers (MCPs) and primary and acute care systems (PACS) as new vehicles for achieving more integrated delivery and improved outcomes; as well as improving commissioning and contractual levers to enable the transformational change to be achieved.

3.2 Locally, The Portsmouth Blueprint was developed in 2015, in partnership with all health and care organisations in the City and outlines the high level vision and ambition for changes to the way services are offered across the whole spectrum of health and care. The actions to deliver The Blueprint feed into the Portsmouth and South East Hants Accountable Care system improvement plan and the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) to achieve the delivery of new models of care across the system.

3.3 As part of the HCP transformation programme, there is a great deal of work underway in all organisations and services, as business as usual, in order to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint.

3.4 Over the last 12-18 months, the CCG has expressed a commissioning intention to explore the development of a MCP model of care to deliver the vision set out in The Blueprint. Engagement has been undertaken with practices, existing providers, and other key stakeholders resulting in a partnership agreement and 'virtual MCP' governance arrangements being put in place between NHS Portsmouth CCG, Portsmouth City Council, Adult social Care, Solent NHS Trust and the Portsmouth Primary Care Alliance (PPCA) to support the development and delivery of transformational change required to achieve a new out of hospital model of care.

3.5 In the future, it is envisaged that the MCP will become the delivery vehicle to support the transformational change programmes, enabling the development of a new model of community based care for all client groups.

3.6 This paper explores the progress of this approach to date, in light of changes to the wider health and care system, and the challenges and next steps for partners to continue to achieve the Portsmouth Blueprint.

4. Strategic context

4.1 The context in which the local health and care system operates is detailed below:

4.2 ***Hampshire and Isle of Wight Sustainability and Transformation Plan***

Health and care systems across HIOW have come together in partnership to develop an STP, setting out the strategic aims and objectives for transformation across the county. The key aims and objectives of the Portsmouth Blueprint are reflected within this wider system plan. There is a shared desire to build a strong primary and community care service which is the foundation for the delivery of the Portsmouth Blueprint. It has been agreed that delivery of the STP needs to take place at local level, within local delivery systems. The City of Portsmouth forms part of PSEH (Portsmouth and South East Hampshire) delivery system. Health and care partners in PSEH have come together to form an ACS (Accountable Care System).

4.3 ***Accountable Care System***

The aims, objectives and key work programmes to deliver the Blueprint are reflected in the ACS plans. The PSEH ACS has been developed as an added value vehicle for delivering the New Models of Care set out in the NHS 5 year forward view and the programmes outlined in the STP at a local level. The ACS aims to address the behaviours and capacity issues that exist within the

Portsmouth and South East Hants system that are causing progress to be slowed or stalled. The ACS focuses on flattening and reducing demand by concentrating on rapid acceleration of programmes that are focused on improvement for patients. It is viewed this in turn will rapidly accelerate and refocus key projects to scale up and ensure sustainability by driving out non-value adding costs in the system and aligning quality, innovation, productivity and prevention (QIPP) and cost improvement programme (Quality) schemes to reduce costs.

4.4 ***Multi-layered Planning Approach***

This multi-layered planning approach (figure 1) enables system partners in the city to focus the delivery of the commitments through either local delivery or with wider system partners where it makes sense to do so and whereby, in coming together, maximum gains can be achieved. Across the wider system, we are working on the principles that transformation must be based on local needs and where possible delivered locally. However, effective partnership working across PSEH and STP allows us to work together in areas of commonality and where there are shared aims. This will ensure alignment and ability to operate on a wider footprint to achieve efficiencies from a truly 'do it once' approach, where it makes sense to do so.

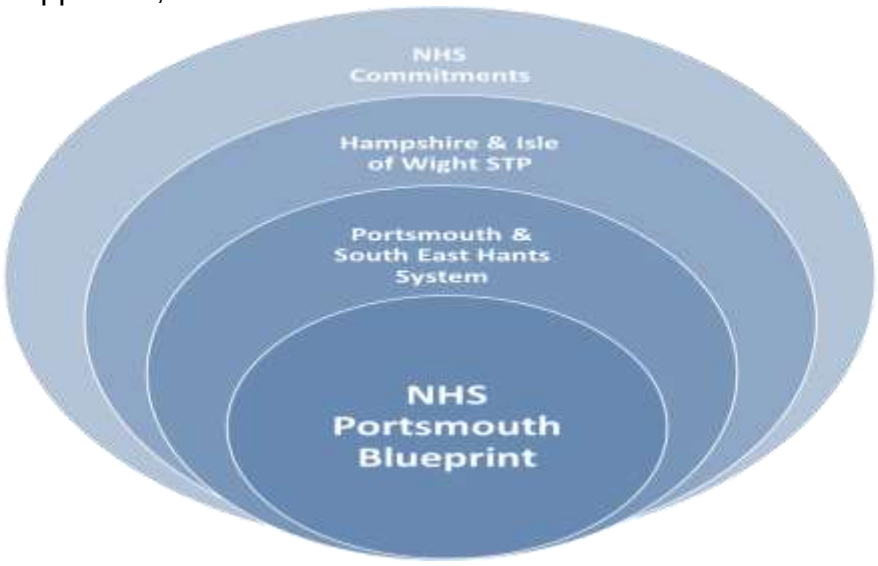

Figure 1 - How the plans fit together

5. The Portsmouth Blueprint

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

5.2 The Blueprint sets out a vision for the delivery of health and care services in the City that will be less fragmented and better able to support people to stay well and remain independent, through the delivery of 7 key commitments. The

delivery of the Blueprint is integral to improving the long term health of the population.

5.3 The Blueprint set out 7 commitments for change that all partners signed up to.

- We will build our health and care service on the **foundation of primary and community care**, recognising that people have consistently told us they value primary care as generalists and preferred point of care co-ordination; we will **improve access to primary care services** when people require it on an urgent basis."
- We will underpin this with a programme of work that aims to **empower the individual** to maintain good health and prevent ill health, **strengthening assets in the community**, building resilience and social capital."
- We will **bring together important functions** that allow our organisations to deliver more effective community based front-line services and preventative strategies; this includes functions such as HR, Estates, IT and other technical support services
- We will establish a **new constitutional way of working** to enable statutory functions of public bodies in the City to act as one. This would include establishing a **single commissioning function** at the level of the current Health & Wellbeing Board **with delegated authority for the totality of health (NHS) and social care budgets**
- We will **establish a single or lead provider for the delivery of health and social care services for the City.** This would involve looking at organisational options for bringing together health and social care services into a single organisation, under single leadership with staff co-located. **The scope of this would include mental health, well-being and community teams, children's teams, substance misuse services and learning disabilities**. In time, it could also include other services currently residing in the acute sector or primary care
- We will **simplify the current configuration of urgent and emergency and out of hours services**, making what is offered out of hours and weekends consistent with the service offered in-hours on weekdays so that people have clear choices regardless of the day or time
- We will focus on building capacity and resources within defined **localities** within the City **to enable them to commission and deliver services at a locality level** within a framework set by the city-wide Health & Wellbeing Board.

5.4 A key element of the Blueprint is the need to radically transform the way we commission care to support the integration of front line services and the delivery of more person centred care approaches. As an Integrated Personal Commissioning (IPC) demonstrator site we are committed to developing a completely different approach to planning and commissioning health, community, social care and other services, with the adoption of evidence-based approaches to delivering personalisation at scale. This will enable an outcome based approach to commissioning, supported by increased use of personal health and care budgets to enable people to have more choice and control in the delivery of their health and care needs.

5.5 IPC is characterised by five key shifts in current models of care (figure 2). Together these will drive improved outcomes for people, the system, and the tax payer. Delivery of this will be central to how we commission services to deliver the Blueprint and we will measure ourselves against them.

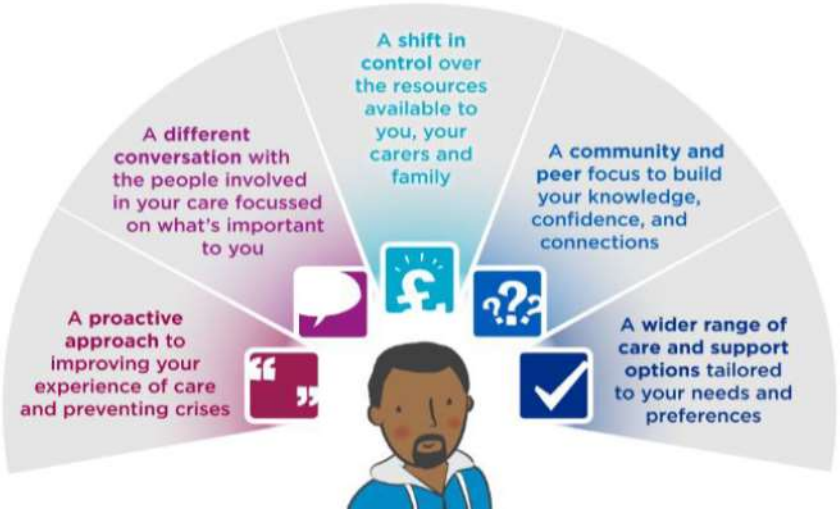

Figure 2: Integrated personalised commissioning - 5 key shifts

6. Delivering the Portsmouth Blueprint

6.1 **The new model of community based care -** The new model of health and care in the city is clearly articulated at a high level, in the Portsmouth Blueprint. As part of the MCP Programme, work is ongoing to further define the high level model and key outcomes. Work is ongoing with Healthwatch to develop and refine an outcomes framework and virtual MCP partners have agreed an out of hospital model of care, which will form the basis of the model of care to be to be delivered in the future.

6.2 This model is based on effectively supporting population health and preventing ill health to manage demand for services in future; ensuring the sustainability of primary care through the development of an integrated 24 hour primary care service to support urgent care demand, enabling improved and enhanced access to primary care during traditional out of hours periods. As well as the development of integrated primary and community case based teams to support people with complex needs.

6.3 The three fundamental principles are;

- Expedient discharge from hospital to a community setting for the assessment of long-term needs
- Community, social and primary care engaged through a single point of access and available 24/7
- People are triaged based on the urgency of the response required and the nature of their needs

6.4 This model will need to provide a more effective primary and community rapid response to prevent emergency admissions and facilitate early supported discharge, achieved through the provision of rapid assessment, triage, and care

‘wrapped around’ the individual so their health and care needs can be safely managed within their own home or a community environment.

6.5 Development of this model will enable a new integrated service and ensure the community in Portsmouth is more effective in preventing admissions to hospital as well as ensuring a robust 'home first' community based approach to effectively deliver discharge to assess pathways.

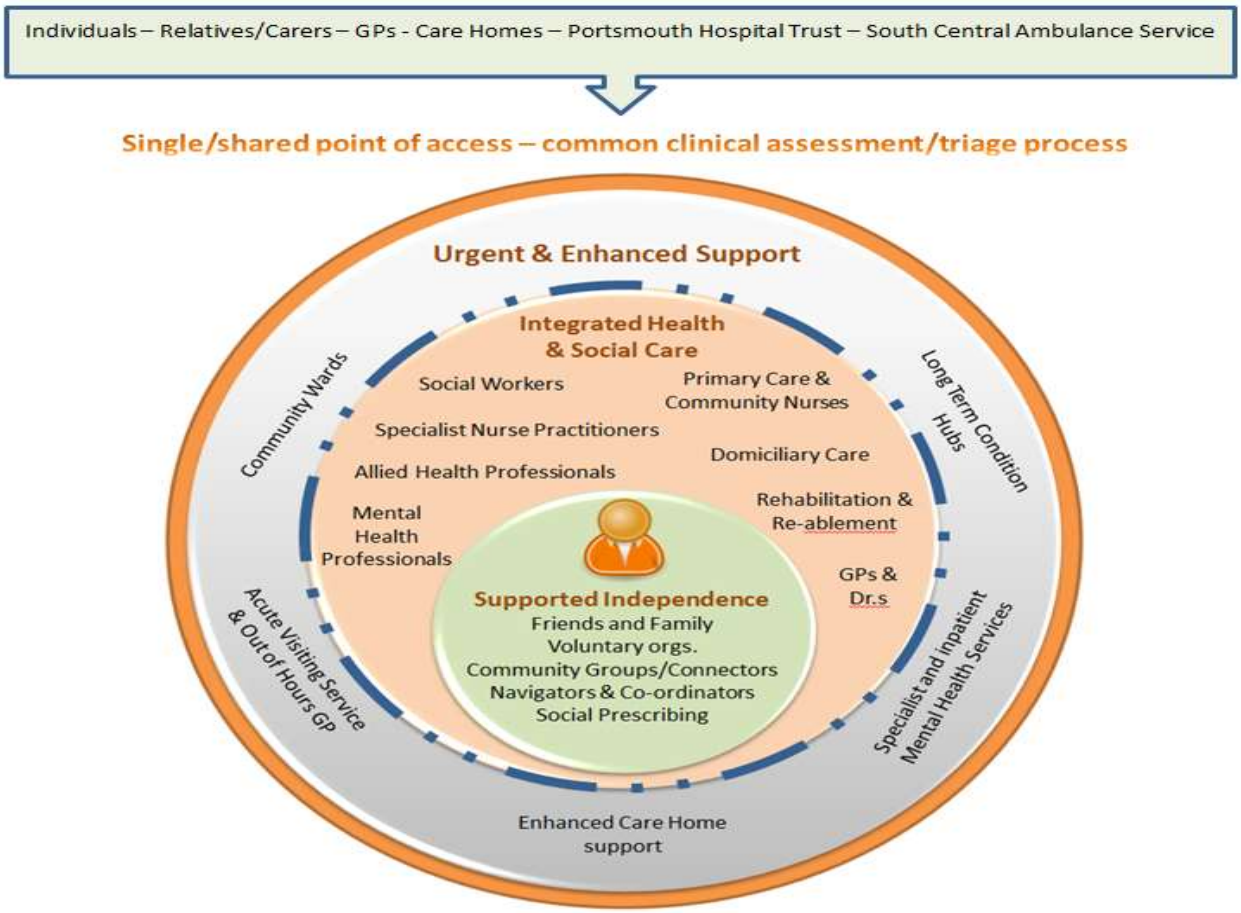

Figure 3: The Portsmouth Community Model

6.6 Early help and support is core to the model and this element aims to empower individuals to self- manage their long term conditions using social prescribing, the voluntary sector and assistive technology for support as required. The model provides early intervention where this is needed, incorporating health promotion and easy access to nursing and social services for frail and vulnerable people to support them to keep living ‘well’ in the community.

6.7 If, however, an individual should require additional support, the model enables a proactive rapid response from an integrated team, providing effective urgent care through a range of community support to prevent avoidable emergency admissions and repeated, unplanned primary care contact.

6.8 The integrated care team will be able to wrap services around the individual to return them to a well and independent position. This rapid response will form part of each 'locality' so that they can work with the short-term service as the needs of the individual de-escalate. This will mean the individual 'flows' through

the service without the need to have their case moved through different teams and buildings, and will also support better communication and case management.

6.9 Should an individual require a hospital admission, the same team will provide a crisis response and proactively in-reach into the hospital to 'pull' people out and enable more effective early discharge, both reducing the length of stay and the potential for decompensation. The team will be able to support the individual in the community, helping to prevent readmission to hospital and returning the person to supported independence where possible.

6.10 The final element of the model is proactive care management; should an individual require longer term care, the extended team will be in a position to better support individuals to remain in their own home reducing the need for a residential admission.

6.11 The work required to achieve this model will aim to move from the current position where health and care community services are co-located and work together side-by-side, to a position where true integration exists across the system. This will enable crossover in each person's care management and support referral free zones for professionals alongside a single assessment document so that each person truly only tells their story once.

6.12 Similar transformation work programmes are being developed specifically for mental health and children's services, all on similar principles of wellness and prevention through empowering people to self-care, with rapid access to support as required to enable recovery.

6.13 Through the PSEH ACS, both the new models of care and mental health workstreams are enabling the CCG to work with wider system partners to develop these new models of care in ways that are consistent across traditional local authority and NHS organisational boundaries. Recognising that whilst local delivery models may be different to meet local needs this should be within a consistent operating framework and a standard offer. In all areas, consideration is being given to how service models can be delivered once across Portsmouth and South East Hants, where this makes sense.

7. Progress against the 7 commitments to date and Next Steps

7.1 The table below outlines the achievements against the 7 commitments in the Portsmouth Blueprint and future developments.

Commitment one: We will build our health and care service on the **foundation of primary and community care**, recognising that people have consistently told us they value primary care as generalists and preferred point of care co-ordination; we will **improve access to primary care services** when people require it on an urgent basis."	
Achieved so far	**In progress**
There has been significant investment primary and community care services supporting improved access to primary care. **An Acute Visiting Service (AVS)** has been commissioned which provides a dedicated GP home visiting service on behalf of practices to registered patients requiring an urgent visit in their own home. This increase capacity enables patients to be seen quicker and helps to increase capacity within general practice and is delivering an additional 6,000 on the day home visits per annum. In addition, the **GP Enhanced Access service** is delivering urgent primary care appointments on Saturdays 08:00-18:00 and on weekday evenings from 18:30-20:00. The provision of routine appointments on Saturdays has also recently commenced, improving access to primary care services. To help enable GPs to focus their time on seeing patients who require their generalist expertise, a pilot has been established to deliver **Musculoskeletal (MSK) triage in general practice**. This service enables patients contacting their GP practice with an urgent MSK issue to access a physiotherapist the same day. Currently half the population of Portsmouth are benefiting from this service.	From June 2018 the CCG will commission an **Integrated Primary Care Service incorporating the provision of three interconnected services: Out of Hours (OOHs), the AVS, and GP Enhanced Access.** Integrated provision of the three interdependent services will ensure safe, effective delivery of primary medical care services 24 hours a day, 7 days a week, and improve access to primary care services by increasing capacity outside of core general practice operating times. In addition to this we will be exploring (through the development of robust business cases) further rollout of the MSK triage in general practice across the city. Ongoing work with practices to look at opportunities to increase capacity and capability within the practice to improve access, such as use of **care navigator roles, e-consult and on-line booking options**
Commitment 2 - We will underpin this with a programme of work that aims to **empower the individual** to maintain good health and prevent ill health, **strengthening assets in the community**, building resilience and social capital."	
Achieved so far	**In progress**

A collaborative approach has been taken to include the VCS as an equal partner in the provision of health and care to Portsmouth residents. Through **the signposting service**, an easy access route for GPs has been available to access non-medical support from the VCS for their patients. The creation of **Project Bridge** where representatives from a range of VCS organisations and the PCC and CCG have met to discuss known problems and identify solutions which can be jointly developed. Through the Project Bridge umbrella, a proposal for a 'sitting service' is being developed. A jointly agreed a commissioning plan for the development of **social prescribing** within the City. Existing contracts have been reviewed, with joint commitment for the development of a replacement integrated social prescribing service. Due to start in June 2018. **Adult Social Care strategy development** has led to establishing its Principles for Transformation which will enable *'Nothing for us without us '*embedded in service design, monitoring and evaluation; and *Core Outcomes agreed across ASC* (at individual, operational and strategic levels) of *good health, independent lives, meaningful days and employment, social inclusion.* Through the **Integrated Personalised Commissioning Programme** (IPC) we have seen the completion of over 2000 personalised care and support plans and the establishment of 500 integrated budgets which meet the criteria of **personal health budgets,** with a small number converting into direct payments. The relationship with the VCS and those with 'lived experience' is also particularly strong within the integrated mental health services. The role of **peer support workers in community mental health** services is now well established.	It is envisaged that both **the sitting service and the integrated social prescribing service will be co-located and operated through a Single Point of Contact (SPOC)** for access to VCS within the City. This will enable a more personalised and tailor made service for carers and their families to be made available through a strengthened VCS resource, offering economies of scale and establishing a strong presence within the City. ASC will be developing outcome-based commissioning across ASC that includes options for extending use of personal budgets, ISFs, micro enterprise etc. This work will be aligned with, supported by and build upon IPC pilot work which will include personal health budgets too. The development of a **Long Term Condition (LTC) Hub** in the city which would pool existing primary, community, and secondary care professionals into a single team, ensuring patients receive consistent, high-quality care. The LTC Hub will predominantly focus on empowering individuals to maintain good health by equipping them with education, skills, and knowledge leading to lasting self-management techniques and behavioural change. The current **well-being service**, which offers support lifestyle support to help people manage their weight, alcohol consumption and quit smoking, has been through a systems thinking intervention, leading to a re-design of provision, which in the long term will improve the offer and enable greater integration with the long term conditions hub. Through the Mental Health Transformation programme, the concept of a **'Well-Being House'** is being developed to increase support offered for people with low level mental health needs; enabling them to access VCS and community support to help them in a more person centred

In relation to **children's services**, HIOW is one of only four areas in the country where the STP includes a **clear workstream for children's services.** There are credible plans, partly delivered, in relation to supporting primary care around urgent and emergency care avoidance and family health literacy. **Future in Mind Mental Health Transformation** programme includes work in schools and support for the roll-out of consistent restorative practice across the city - seen by NHS England as a strong basis for further integration.	way and offer community based alternatives to the traditional service offering in order to improve health outcomes. The local delivery system is continuing to develop more effective whole system approaches to **children's mental health.** Promotion of the **Portsmouth Children's Trust Physical Health Strategy**, to tackle obesity, smoking, drugs and alcohol as well as self-help in lower level health needs. A more radical, effective and sustainable approach to care, support and education provision for **children with autism.**
Commitment 3 - We will **bring together important functions** that allow our organisations to deliver more effective community based front-line services and preventative strategies; this includes functions such as HR, Estates, IT and other technical support services	
Achieved so far	**In progress**
Considerable progress has been made towards utilising a **single clinical record across providers** to: improve communication between healthcare professionals; enable improved quality of care; and deliver safe, consistent provision. **All GP practices** within the city (bar two) and **Solent NHS Trust use TPP SystmOne as their primary clinical system**. From the remaining two GP practices not on the system, one is scheduled to go-live from April 18, and the other is in discussion with the CCG about transferring to SystmOne. The Communications and engagement teams have embarked on a programme of joint working and support and have developed a **shared communications and engagement programme** to support HCP. Working with partners across primary, community, secondary care, and the local authority, the CCG has utilised monies received from the national Estate and Technology Transformation Fund (ETTF) to	**Adult social care due to be operating on SystmOne by October 2018**. Leading to creation of **truly joint health and care record**. A request by social prescribing to be able to utilise SystmOne for ease of feedback to health and care professionals has also been made – this will require further investigation in terms of IG issues, appropriateness and cost. In recognition of the inconsistencies with existing healthcare estate within the city (in terms of condition, statutory compliance, functional suitability, quality, and accessibility), and the fact there is NHS and Local Authority owned buildings in the city that are not fully utilised, creating void space which incurs avoidable cost to the system, a project team has been created to devise and implement **a strategic estates plan** for the city, including primary, community, and local authority partners. This team will implement the projects commenced

undertake feasibility studies and options appraisals to assess estate potential in the city and progress the development of physical Hubs within the North and Central localities. **Children's teams** have already been co-located as part of three geographically focused multi-agency teams, working to deliver the **integrated strategic programme "Stronger Futures",** bringing together public health, mental health and social care/early help services.	under the ETTF and continue to develop suitable and sustainable estate solutions for the city. **Strengthening of integration of support for children with SEND** to provide more inclusive, affordable care and education, including the potential creation of a Portsmouth specialist SEND hub.
Commitment 4 - We will establish a **new constitutional way of working** to enable statutory functions of public bodies in the City to act as one. This would include establishing a **single commissioning function** at the level of the current Health & Wellbeing Board **with delegated authority for the totality of health (NHS) and social care budgets**	
Achieved so far	**In progress**
Partnership working between the CCG and PCC has increased, leading to the appointment of a Joint LA Director of Adults Services role and CCG Chief Operating Officer role. This has led to the creation of the Health and Care Directorate including and team approach across commissioning, transformation adult social care, quality and safeguarding. The BCF pooled fund arrangements have been increased to £27 million and now include additional services such as carers, and community beds for both health and care and OT services. Developing model of joint working across the CCG and NHS Solent with combined senior commissioning and Operations Manager post. The **integrated Early Help and Prevention service** has operated under one Head of Service since March 2017. This has supported the	Continuing to develop as a single adults health and care directorate, as well as strengthening integrated commissioning function. Continued discussions across CCG and PCC as to how we can explore further joint and pooled funding arrangements.

development of a new targeted health visiting offer, and a modernised delivery of universal support.	
Commitment 5 - We will **establish a single or lead provider for the delivery of health and social care services for the City.** This would involve looking at organisational options for bringing together health and social care services into a single organisation, under single leadership with staff co-located. **The scope of this would include mental health, well-being and community teams, children's teams, substance misuse services and learning disabilities**. In time, it could also include other services currently residing in the acute sector or primary care	
Achieved so far	**In progress**
A partnership arrangement has been agreed between the CCG, Solent NHS Trust, the Local Authority, and the PPCA (a GP federation representing general practice), effectively creating a **'virtual Multi-speciality Community Provider (MCP)'** in the city. The MCP programme includes a suite of transformational change projects for health and care services in the city working to provide more effective, efficient, and integrated care; that will delivered the plans for the community model (outlined in section 5), that has been developed jointly by the MCP programme team. A prime example of the partnership working, without boundaries, to date, has been the implementation of the **Portsmouth Enhanced Care Home Team Pilot.** This has provided 5 of the 27 Portsmouth Care Homes with regular clinical input from a nurse led Care Home Team. A further 2 Care Homes have received a full weekly Multi-Disciplinary Team meeting comprising of a GP, Physical and Mental Health Nurses, Pharmacists and Care Home Team staff. This team has direct access to Physio and Occupational Therapy support. The outcomes for these homes over a 3 month period have seen a reduction in 999 calls made by 32% and reduction in conveyances to hospital by 27%. At the ACS level a **PSEH Mental health transformation programme** has been established. This has led to partnership working between the two mental health providers to better manage acute in-patient mental	The CCG is seeking to progress the 'virtual MCP' arrangements further by exploring risk/gain share arrangements and Integration Agreements between the community provider and GP practices for suitable projects within the MCP programme. This work will enable the CCG to better understand the requirements of commissioning a **further integrated MCP arrangement**, through a formal procurement process at some stage in the future. Discussions are required to explore the potential of **Portsmouth Hospital Trust (PHT) and the VCS becoming represented in the partnership arrangement.** For the VCS, this could be through the development of a VCS collaboration, in a similar way to which a GP federation represents general practice. This will enable a much broader range of community services to become integrated. Enhanced support to Care Homes is also a system wide priority and commissioners from Fareham and Gosport, South East Hampshire and Portsmouth CCG are working with clinicians to produce the case for a Care Home Team model that will reduce utilisation of urgent care at scale.

health beds leading to a reduction in out of area placements for South East Hampshire patients, savings and improved utilisation of City acute in-patient beds.	
Commitment 6 - We will **simplify the current configuration of urgent and emergency and out of hours services**, making what is offered out of hours and weekends consistent with the service offered in-hours on weekdays so that people have clear choices regardless of the day or time	
Achieved so far	**In progress**
The CCG has issued to the market its intentions to work with existing system partners over a three year period to implement the national requirements of **Integrated Urgent Care (IUC),** which seeks to simplify and integrate the current configuration of urgent and emergency services. Alongside this, the St Mary's Treatment centre has been designated as a wave one **'Urgent Treatment Centre (UTC),'** again as part of a national initiative to simplify the urgent care offering across the country. Partnership working across PSEH to strengthen the Urgent Care Centre and GP streaming within ED to better enable people to receive the most appropriate care. In addition, mental health crisis services have been reviewed and implementation plans in plan for improvement.	As part of the development of the Integrated Primary Care Service, from June 2018 and linking with plans to implement IUC, UTC requirements, the CCG intends to amalgamate the existing and complex urgent care landscape into a simplified point of access for patients, which delivers consistent and integrated urgent and emergency care. This includes **linking the Integrated Primary Care Service with the Urgent Treatment Centre, Urgent Care Centre (GP Streaming at ED), a Clinical Assessment Service, and overnight community provision, to provide a compelling alternative to ED** available within 2018- 2019. Plans are also underway to establish a PSEH **mental health assessment unit**, to provide better support within ED and general acute inpatient services to people with mental health conditions; which it is envisaged will lead to a reduction in emergency admission or reduced length of stay
Commitment 7 - We will focus on building capacity and resources within defined **localities** within the City **to enable them to commission and deliver services at a locality level** within a framework set by the city-wide	
Achieved so far	**In progress**
A Good Neighbours network has also been established within the City. This promotes community help and wellbeing, with volunteer led groups developing in three initial areas within the City to offer health	The **neighbourhood team model**, which is at the heart of the delivery of the new Portsmouth Community model incorporating primary, community, and social care within an integrated team, is due to be piloted shortly.

and social transport, befriending and social activities, informal care and help with tasks.	We are due to start testing in May 18 which will see individuals that require additional support provided by the team either after they have left hospital in order to return them to independence or to wrap care and support around them when they are at risk of being admitted to hospital. Once tested and rolled out to one locality, the model will be rolled out to the 2nd then the 3rd. We will then need to ensure private provider services are commissioned and develop in a way that best works with the new model of care. Social Care will soon be carrying out a systems intervention on Domiciliary Care which will inform this. Solent are partnering with a domiciliary care organisation to test a new way of working with care providers. We will take this learning and establish a care offer that is able to respond how people needs it to whilst is more robust and sustainable against market influences experienced nationally (work force issues generally). Residential and Nursing care services in private homes will be reviewed in the context of Therapy Led Units (TLU) and the benefits of working in a different way to reduce DToC, MFFD and to reduce long term care placements. Linked to the current developments with VCS partners, we are also actively promoting opportunities for the asset development within communities, enabling communities to increase control over their own health and wellbeing. Community centre approaches offer a stronger way to use local resources and to reshape them to meet local needs. Coproduction will be integral to ensure that local needs are understood. An approach to ensure robust engagement for service development plans will be put in place.

8. Health and Care Portsmouth Communications and Engagement

8.1 To support the transformation programme, a single, shared communications and engagement work stream has been established; with representation from all partners who meet together on a weekly basis to enable closer joint working. Key pieces of work undertaken to date include:

8.2 A new website for the project has launched, and will provide a central point from which to communicate the changes happening to health and social care services across Portsmouth. The site is intended to:

- Provide a central place to direct people to for engagement around health and care system changes.
- Provide a platform from which to tell the stories around health and care system changes.
- Provide an organisationally neutral space from which to share changes with staff across the system.

8.3 The first Health and Care Portsmouth newsletter was sent on Saturday 3 March 2018, featuring updates around health and social care including winter wellness updates, a feature on the Shared Lives service and the Patient Activation Measure survey.

8.4 The Patient Activation Survey (PAM), using the 'Different Conversations' brand extension, was launched on 3 March 2018. This survey uses the PAM tool to benchmark the population's proclivity to manage their own care. The survey will run at the same time each year in order to monitor population-level changes in the ability of people to manage their own care.

8.5 Staff engagement work on two projects is also under way. A piece of staff engagement with co-located community teams sits under the 'new models of care' brand extension and aims to establish how best to support staff through changes. A second piece of workforce engagement sitting under the 'different conversations' brand extension will focus on practitioners across Portsmouth City Council, Solent NHS Trust and Portsmouth CCG, and aims to benchmark staff confidence around using the 'five key shifts' model proposed by the Integrated Personal Commissioning project.

9. Governance Arrangements

9.1 Each of the key transformation work streams, mental health, MCP and Adult social care transformation have a programme board to drive delivery of the change programme, which feed into and support an ACS level work programme.

9.2 To enable co-ordination and to drive the overall integration agenda for adults' services, the Adults' Delivery Board has been established to oversee all of the adult delivery elements of The Blueprint. This feeds into the Portsmouth Health and Care Executive and ultimately the Health and Well Being Board to continue to develop and drive the strategic agenda for the City. Oversight of arrangements for children's

services continues to be provided through the well-established children's trust board arrangements.

10. Conclusions

10.1 The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together. As part of the HCP transformation programme, there is a great deal of work underway in all organisations and services, as business as usual, in order to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint.

11. Equality impact assessment

11.1 A preliminary EIA was completed for the Portsmouth Blueprint on its development and concluded that there will be no negative impact on any of the protected characteristics arising from the strategy. Any individual projects or measures arising from the strategic approach outlined will be subject to impact assessments in their own right.

12. Legal implications

12.1 Legal implications are set out in the body of the report.

13. Director of Finance's comments

13.1 Not sought. This work will be undertaken using existing resources and will not incur additional costs.

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Signed by:

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 ……

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Signed by: