

Title of Paper: iBCF / BCF D2A Investment Request

Date: 14th August 2018

Subject: Increasing Reablement from Acute Setting on Interim Basis until Integrated Locality Teams are in Place from 1st April 2019

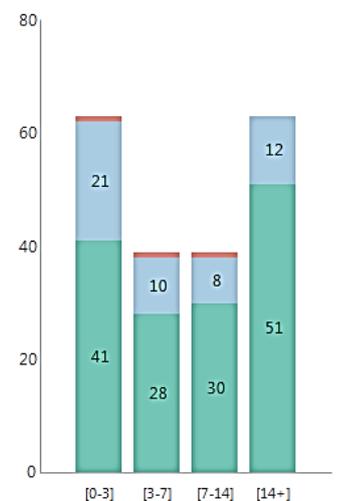
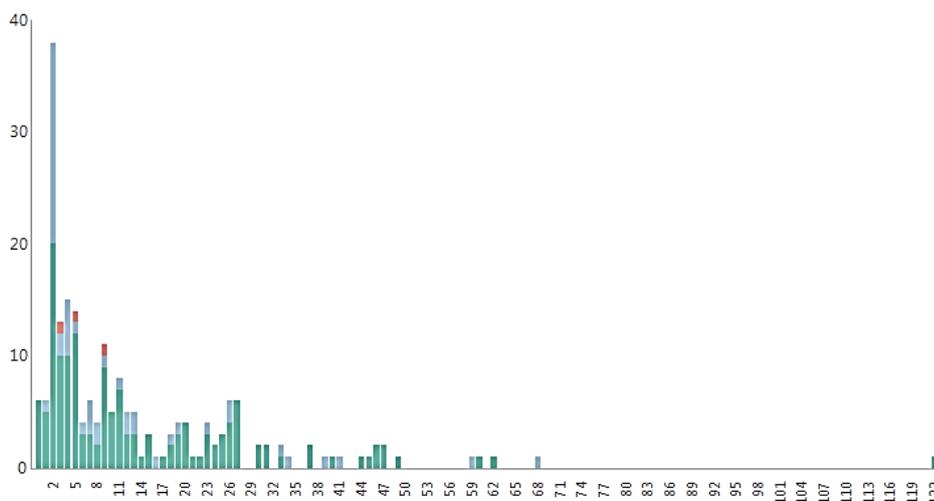
Report by: Simon Nightingale - ASC Senior Business Manager

1. Executive Summary

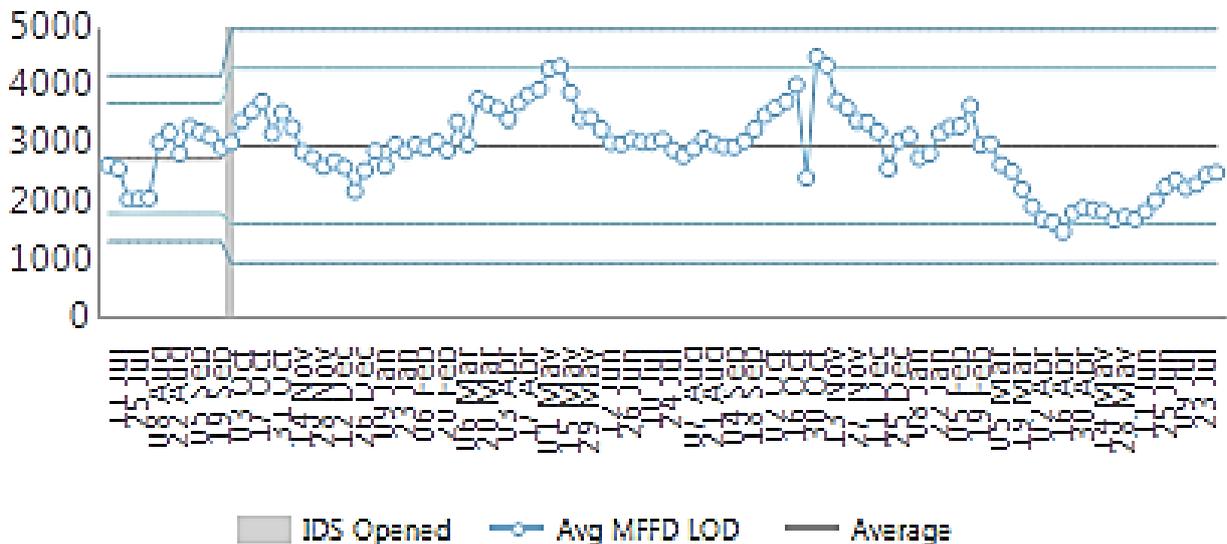
1.1 The number of patients at PHT who have been declared medically fit for discharge, but who are still in hospital – the “MFFD backlog”, fluctuates between 200 - 250 patients (at its peak). There are currently over 2500 bed days being lost due to the delay in discharging people within 0 - 3 days, which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

Length of Delay since MFFD for Sun 05 Aug 2018
Current number of days since patient marked as MFFD

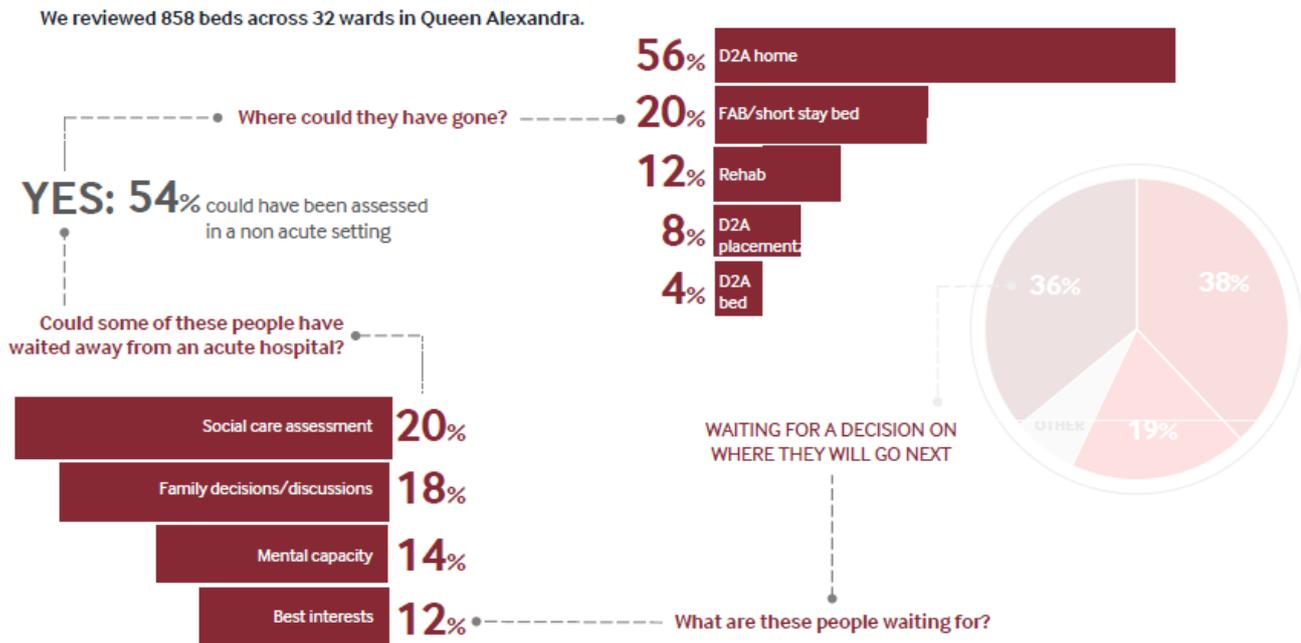
Date	HANTS		PORTS		OOA		Total	
	No. Patients	Bed Days Lost						
Sun 05 Aug	150	2100	51	583	3	17	204	2700



Weekly Average MFFD Days Lost



- 1.2 People who stay in hospital longer than necessary have poorer outcomes and experience increased rates of mortality as a result. An audit in June 2017 by PHT of 334 deaths in respiratory and medicine for older people's wards showed 8% were medically fit at some point during their stay, and 6% died in PHT whilst on an end of life fast track pathway.
- 1.3 This also means that there are 200 - 250 people (approx. 45 currently for Portsmouth) that not only need an improved experience in leaving the QA but also are not being supported by ASCs strategy to enable a delay to residential and nursing care and a reduction of domiciliary care package size through providing rehabilitation and re-enablement programmes of support before patients begin to deteriorate once being medically optimised and no longer needing to be in an acute care bed.
- 1.4 Newton Europe have worked with the health and care system in Hampshire and Portsmouth to identify the opportunities for increasing reablement for people and reducing delays to discharge:



- 1.5 In order to provide a social care service that meets the needs of Portsmouth residents awaiting support to leave the QA hospital, meets the Council's statutory duties within the Care Act and other relevant legislation and manage the demands of increasing needs and costs, ASC is proposing to implement an interim increase of reablement capability until our transformation work to further integrate with health in the form of integrated locality working is delivered. This supports one of our ASCs key strategic shifts which is to:
- 1.5.1 Have a focus on 'reablement' services that aim to help people get to a level of independence, rather than 'do for' people. Ensuring that responding to people who need help is at the right time and in the right place and that we learn from experience which builds the evidence as to what works.
- 1.6 If ASC are able to deliver this element of ASC strategy and optimise a person's independence sooner after being in the acute then we know care costs can be reduced. This means the cost to ASC of providing care could be approx. £480k less¹ if we provide reablement opportunities once someone has been deemed as being medically fit. This is based on national research which suggests that intensive rehab/reablement intervention at the appropriate time can result in savings for ASC averaging over £1,500 annually (£29 per week) per person on the average package of care a person would require if we can discharge people in a timely manner when they no longer need the services of an acute hospital. This is based upon healthy older adults with 10 days of bed rest leading to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of aging.

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

- 1.7 Funding is therefore being sought to temporarily increase capacity within PRRT (Portsmouth Rehab and reablement Team) to deliver a further 23 care spaces within their service which will see an additional 320 people over the next 8 months (until the Integrated Locality work has been completed) receive a reablement opportunity. Funding is requested to be sourced through the iBCF and BCF: The grant conditions for the IBCF require that:
- 1.7.1 Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
- 1.7.2 A recipient local authority must: a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption; b) work with the relevant Clinical Commissioning Group and providers to meet national condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and c) provide quarterly reports as required by the Secretary of State
- 1.7.3 <https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf>
- BCF National Conditions:
- 1.7.4 The current agreed conditions are:
- 1.7.4.1 National condition one: A jointly agreed plan
- 1.7.4.2 National condition two: NHS contribution to social care is maintained in line with inflation
- 1.7.4.3 National condition three: Agreement to invest in NHS-commissioned out of hospital services
- 1.7.4.4 National condition four Implementation of the High Impact Change Model for Managing Transfers of Care.
- 1.7.5 <https://www.england.nhs.uk/wp-content/uploads/2017/08/bcf-planning-requirements-faqs.pdf>
- 1.8 The exit strategy for this time limited funding is the Integrated Locality work. Once the learning has been rolled in to our community teams (from October 2018 onwards) we will begin to realise the efficiencies within our capacity and be in a position to reduce investment in existing iBCF / BCF schemes from April 2018 once the integrated way of working is fully operational.
- 1.9 Therefore this proposal recommends Option 1 from the **Options Appraisal** which is to increase the opportunity for reablement early in a person's discharge pathway out of the acute setting to meet the outcomes of ASCs strategy and improve the safety of patients whilst in the QA.

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

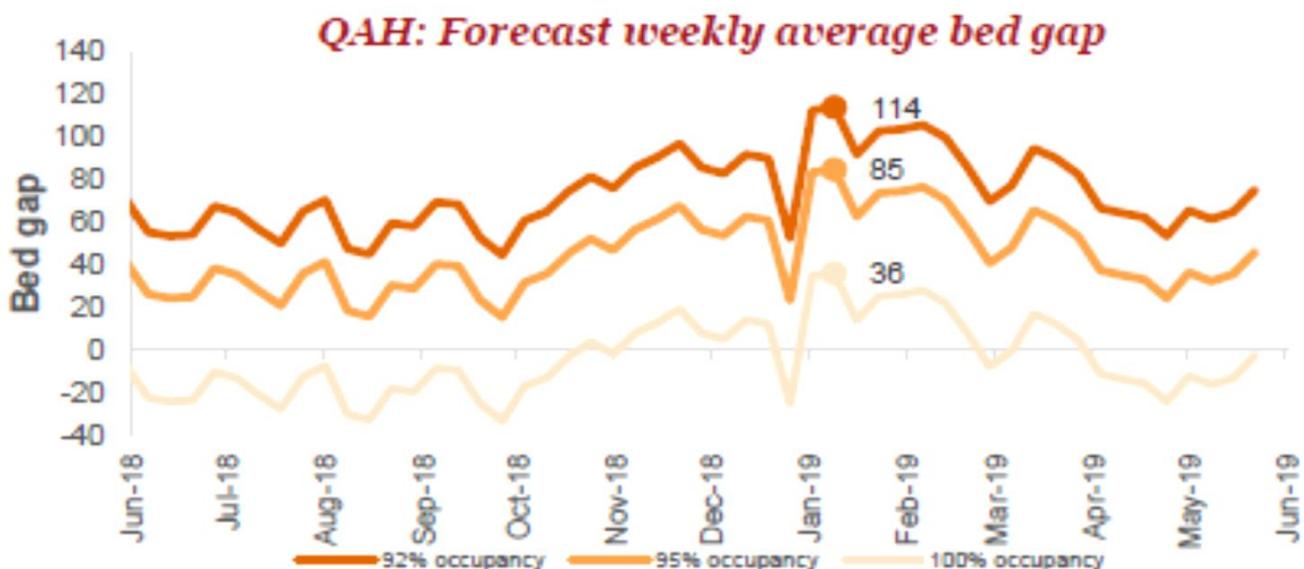
Funding Reconciliation:	£
No longer need transformation funding for Blue Team (3 year investment plan)	(563,944)
Replace with costs for new activity	654,895
Replace with costs to sustain existing capacity	683,434
Potential additional cost required from BCF	774,385

2 Background: P&SEH System Capacity Diagnostic

- 2.1 Winter 2017/18 saw the Portsmouth & South East Hampshire (P&SEH) health and care system come under extreme pressure, which manifested in a number of ways. For example, in December the number of A&E patients seen within four hours was 70% on average –at one point performance was as low as 49% at Queen Alexandra Hospital (QAH).
- 2.2 The national target is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The national average during this period was 85% (for all A&E types), and only two hospitals were able to hit the national target –Luton and Dunstable University Hospital and Yeovil District Hospital.
- 2.3 Additionally, bed occupancy at QAH averaged 97% across the winter period, well above the NHSE occupancy target of 92%. On many occasions, bed occupancy was close to, or at, 100%. Further to this there were times where half of ambulance handovers were delayed for over an hour.

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

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



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

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

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

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

- 2.9 PwC have worked with stakeholders from across the system to develop a plan for winter 2018/19 that aims to close the capacity gap, achieve 92% bed occupancy, and achieve 90% ED 4-hour performance. This is believed to have been agreed across the system as an achievable goal, within the timeframe, and success will require full collaboration across the system and delivery at pace. The peak acute bed gap as predicted is 114 beds, however there is also a desire to convert a single ward into flexible capacity. Allowing it to be closed during summer and gradually reopened through winter. Therefore the total peak winter bed gap is 144 beds per week.
- 2.10 Portsmouth's proportion of the 144 beds is 23 beds with the remainder being attributed to Hampshire CC. This figure of 23 beds saved over the period relates to approximately 10 patients discharged earlier each week, each saving an average of 16 bed days in the acute hospital. If we assume that the proposal lasts a total of 8 months (from the beginning of August to the end of March), then this relates to 320 patients. Please see page 32 of the P&SEH System Capacity Diagnostic Report (**Appendices**) for further information.
- 2.11 Page 32 of the P&SEH System Capacity Diagnostic Report (**Appendices**) also provides detailed information regarding how the required investment for the Portsmouth Proposal has been quantified. In summary, PwC segmented the 10 patients per week into Pathways 1 (home with care), 2 (rehab or reablement) and 3 (accommodation based care). This equates to 62% on pathway 1, 19% on pathway 2 and 19% on pathway 3. These assumptions were developed based on the work carried out by Newton Europe (**Appendices**) which was similar to the capacity diagnostic work carried out by PwC. For each of these pathways, a level of daily care requirements has been assumed (see page 31 of the P&SEH System Capacity Diagnostic Report (**Appendices**)):
- 2.11.1 Pathway 1: 2 care hours per avoided acute/community bed day
 - 2.11.2 Pathway 2: 1 community hospital bed day per avoided acute bed day
 - 2.11.3 Pathway 3: 1 nursing or residential home bed day per avoided acute bed day
- 2.12 We also know on average how many acute bed days are avoided per patient based on PwC's long-stayer length of stay benchmarking which benchmarks patients at a HRG level - further details are on Page 83 of the P&SEH System Capacity Diagnostic Report (**Appendices**).
- 2.13 The daily requirement and the bed days saved translates into the care requirements (see page 33 of the P&SEH System Capacity Diagnostic Report (**Appendices**)) for Portsmouth. PwC calculated these to be 250 additional care hours per week, 0 community beds, 4 care

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

3 Opportunities for System Improvements

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

3.1.1 90 beds to be released through improving complex discharges

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

3.1.2 20 beds to be released through improving daily flow

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

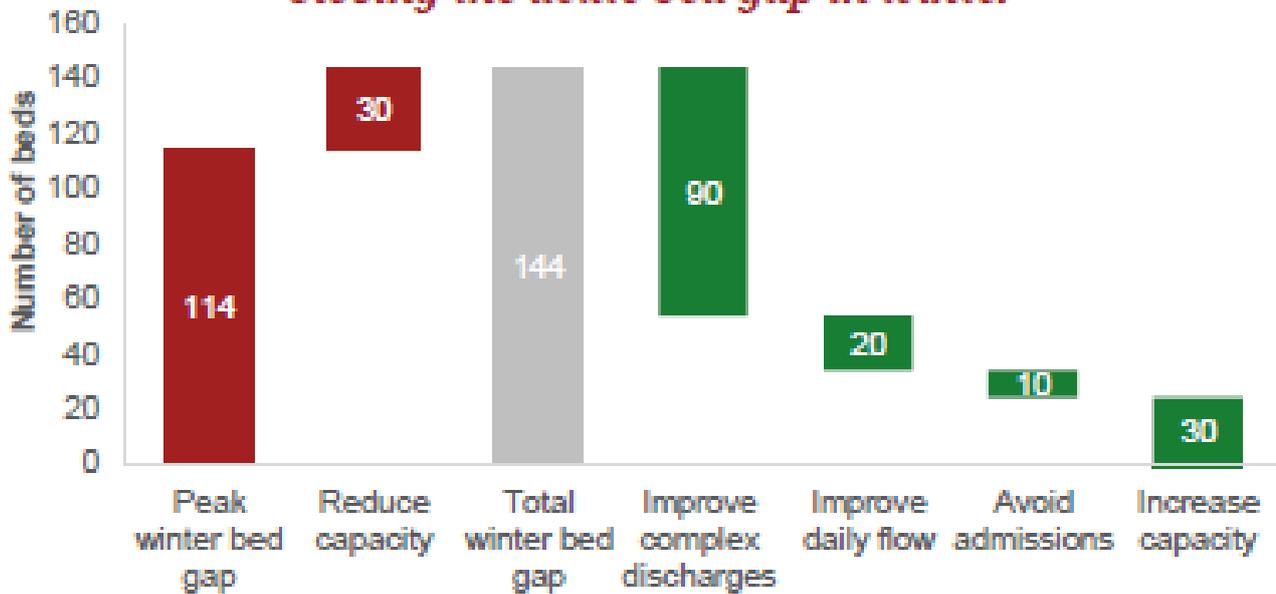
3.1.3 10 beds to be released through avoiding admissions

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

3.1.4 30 beds to be reopened as escalation capacity through winter

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

Closing the acute bed gap in winter



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

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

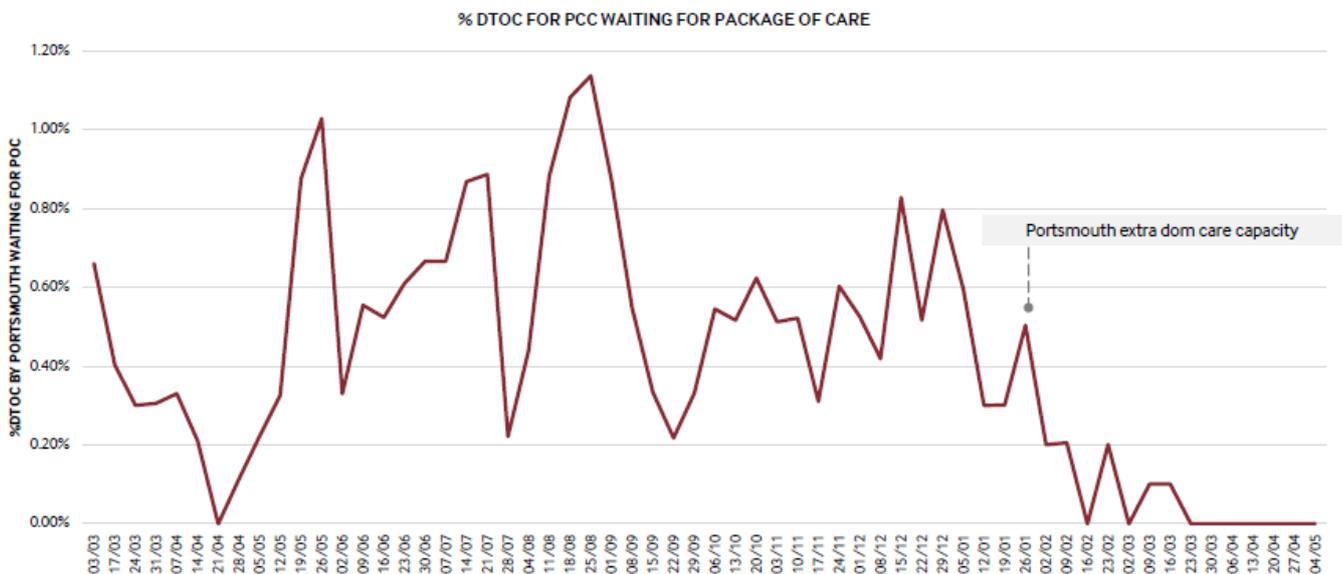
Requirement category	PWC requirement	Impact on beds	Proposal
Pathway 1: Sustain current provision [AginCare]	N/A	N/A	<ul style="list-style-type: none"> • 350-450 care hours p.w. through AginCare • MFFD / Blue Team • Social care assessment capacity in QA
Pathway 1: Additional provision	19 beds	19 beds	<ul style="list-style-type: none"> • 606 care hours p.w. (TDS x 2, 45 min sessions) • 2.1 WTE OT/PT
Pathway 2	0 beds	0 beds	<ul style="list-style-type: none"> • 0 beds
Pathway 3	4 beds	4 beds	<ul style="list-style-type: none"> • 4 care home beds delivered through transformation at Jubilee House (opportunity associated with EoL patients)
Total	23 beds	23 beds	

5 Rationale for the Portsmouth Plan

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

PORTSMOUTH FUNDING INTO DOM CARE HAS REDUCED WAITING FOR POC TO ZERO

Portsmouth have extra funding for 6 months from the 12/02/18 for 350-400 hours of additional dom care capacity



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

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

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

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

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

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

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

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

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

6 The Community Front Door Service

- 6.1 The decision to decommission Agin Care 24/7 care has been supported and further work on the flexibility within the 606 hours will be developed within the enhanced model with Agin Care.
- 6.2 The Blue Team will continue to provide choice for end of life care patients who wish to receive care at home to support the system to enable patients that are deemed to be end of life for discharge from acute care to be discharged in a timely and safe manner.
- Blue Team will continue to develop enhanced pathways for EOL choice
- 6.3 The Blue team will be monitored with a developing set of KPI's through the CHC PMG, there will be a review on the system impact in line with the closing the GAP.
- 6.4 The service will be coordinated from an embedded location; enabling daily prioritisation, continuous collaboration and fluid exchange of outcome data. Service priorities will be determined by PRRT.
- 6.5 The principles of the service:
- PRRT will in-reach into the acute and 'pull' patients when MFFD
 - High impact and needs led workforce solution
 - Will deliver a reduction in MFFD numbers in the system ahead of winter and sustain at a reduced level
 - Delivers the Home First principle
 - Multidisciplinary solution
 - Improved outcomes and well-being for people
 - Optimising independent living and reducing the risk of de-compensating
 - Increased independence through intensive wraparound therapies and re-enablement support services, use of assistive technologies and use of community support networks and services.
 - Net system savings and efficiencies
 - Blue Team will continue to develop enhanced pathways for EOL choice

7 Review and Monitoring

- 7.1 We already have a Project Management Group Established between NHS Solent and Portsmouth City Council that monitors the performance of PRRT and this structure would also be responsible for the oversight for delivering the additional capacity that will lead to a reduction of 23 acute beds in preparation for the winter.
- 7.2 In addition to the local monitoring, the Health and Care System at a local delivery level will also be monitoring the achievement of delivery and use of the resources. The measures and KPIs can be seen in the **Appendices** but as an example include the following:
- 7.3 The Blue team will be monitored with a developing set of KPI's through the CHC PMG, there will be a review on the system impact in line with the closing the GAP.

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

8 Summary of Costs Required from PCC and CCG

- 8.1 The figures below highlight the existing additional capacity brought on line during 2017/18 MFFD project and winter pressures which were not stood down (in yellow). These items of spend are at risk of ending this calendar year if we cannot secure on-going funding. This is due to the financial pressure both Portsmouth organisations are under in meeting our City wide commitments. The figures also include the additional resource being requested to achieve the increase in additional reablement throughput.
- 8.2 Due to the pressure referred to in 8.1, we have subsequently adjusted the proposal submitted to PwC and the System. The proposal was for an investment of **£1.7m**:
- 8.2.1 One scheme (Agincare 24 hour £0.2m) is not recommended to continue, which along with further slippage in other schemes brings the total investment request down to **£ 1.4m**.
- 8.2.2 Funding sources have been proposed to cover £1.0m of this, leaving a **worst case** funding gap of **£0.4m**:
- Total PCC contribution £0.6m
 - Total CCG contribution £0.4m
 - Worst case gap £0.4m
- 8.2.3 The table below suggests using Solent to cover some of the 606 hours gap, rather than using Agincare

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

Key: Yellow = Sustain, Clear = Additional

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

Notes:

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

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

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

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

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

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

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

8.4 Assumptions

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

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

8.5 Additional Capacity Breakdown of the PRRT Element

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

9 Options Appraisal

Option 1 -To increase reablement support to enable earlier discharge from the acute and increase throughput of reablement services.

The additional funding being requested (not sustained elements) equates to £2,831 per person per intervention. This is felt to provide the best balance of value for money (assuming £1500 saving in annual care costs) as it seeks to reable people sooner to prevent the opportunity for further deterioration whilst in hospital thereby reducing long term care costs for ASC.

Option 2 - Sustain existing level of performance

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

Option 3 - Relocate people awaiting discharge into a care home whilst awaiting onward assessment or service.

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

Option 4 - Do nothing

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

10 Appendices

Background list of documents:

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

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