Portsmouth

Better Care Fund

2021-22 Plan

1. Executive summary and stakeholders

- Priorities for 2021-22
- key changes since previous BCF plan
- Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)
- How have you gone about involving these stakeholders?

This plan sets out Portsmouth's Better Care vision for current year, 2021-22, continuing to build upon the Portsmouth Blueprint to deliver better outcomes for our population. The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that underpins how the key health and care organisations in the city will work together to reduce health inequalities and deliver sustainable health and care services. Our vision is for everyone in Portsmouth to be supported to live healthy and independent lives for as long as possible, with health, social care and support integrated around individual needs at the right time and in the right place – in the community where possible, with use of acute services where there is a true need to do so.

Health and Care teams have been in the forefront of the response to Covid-19 and despite the significant challenges have achieved a huge amount over the last 18 months, successfully adapting to new ways of working and supporting service users, their families and carers. Most Better Care funded schemes have continued into 2021-22, with health and care pathways projects designed along key principles of:

Early intervention and self care - improving healthy life expectancy and reducing dependency on health and care services through upgrading prevention, early intervention and self care; effective prevention and management of long term conditions in the community by joined up services. By developing and improving a range of low-level preventative services people can be supported to make choices to meet their individual needs and remain safe, healthy and independent for as long as possible.

Admission avoidance and effective discharge - supporting people home from hospital, providing effective urgent care in the community, and rehabilitation and reablement support to avoid emergency admissions; to ensure no-one stays longer in an acute or community bed longer than they need to and reducing readmissions.

Pro-active care – planned, pro-active integrated health and care management; focus on single assessment and truly integrated professional teams so people only have to tell their story once with services providing a holistic view of their individual needs.

Our focus continues to be delivery of the Portsmouth Blueprint aspirations through Health & Care Portsmouth - NHS Portsmouth CCG and Portsmouth City Council, in particular Adult Social Care and Housing, and working with our partners Solent NHS Trust, the Portsmouth Primary Care Alliance, Portsmouth Hospitals University NHS Trust and Voluntary, Community and Social Enterprise groups across the City.

A key priority for 2021-22 is development of the Portsmouth Integrated Community Programme, which is informing the future development and design of community bed-based and home-based services to ensure Portsmouth has the right capacity and capability, in the right places.

2. Governance

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

The CCG already has in place a number of joint arrangements with Portsmouth City Council including: Continuing Health Care, Better Care Fund and the Health and Care Portsmouth Commissioning Team.

A robust programme management and governance approach has supported delivery of Better Care from the outset. This approach continues in 2021-22. The Partnership Management Group (PMG) oversees the Section 75 Agreements for the Better Care Fund and Health & Care Portsmouth Commissioning. The group is comprised of representatives from the CCG and City Council and meets bi-monthly, providing strategic direction on individual schemes and projects, reviewing and agreeing pooled financial schedules and activity information. 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).

Work has recently been undertaken with Bevan Brittan to ensure that our local governance arrangements, including for the recently re-established Joint Commissioning Board, are robust. This has included consideration of the current agreements that we have in place to enable joint working, including Section 113 and Section 75 agreements. We are aiming to develop an overarching Section 75 agreement which would set a framework for joint working, with a series of individual schedules developed to set out key areas including the Better Care Fund. This would help bring 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.

3. Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including

strengths-based approaches and person-centred care.

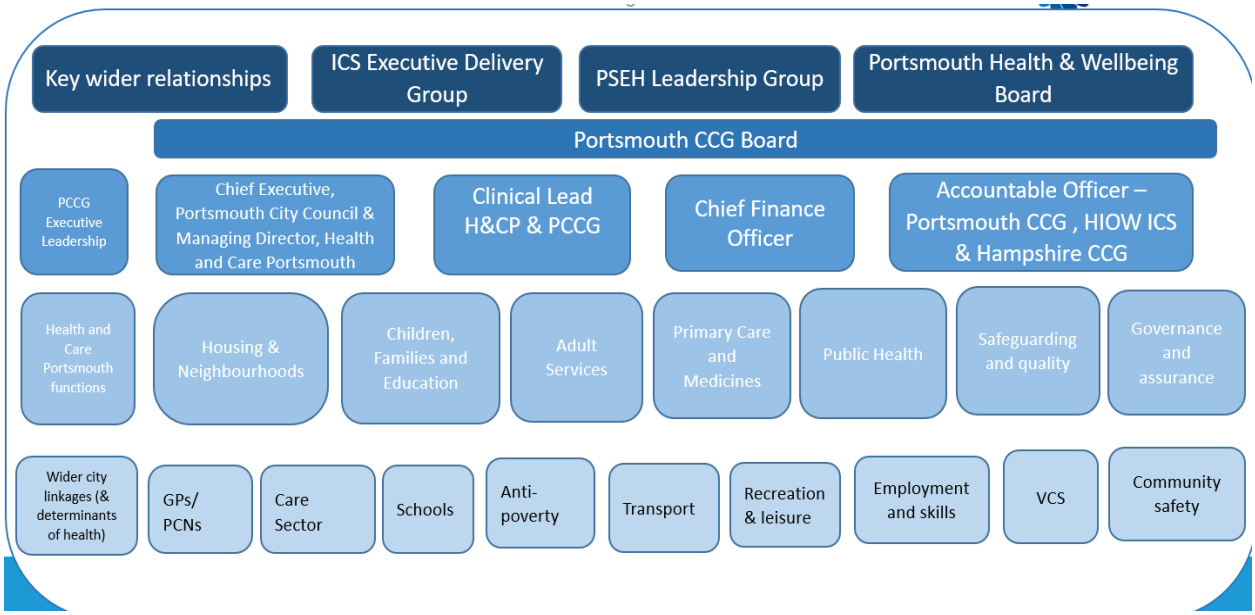
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21

There is a strong history of joint working between the City Council and CCG and we continue to strive to remove the barriers between the organisations to ensure that we are providing the most effective services to residents. Part of this is ensuring that as far as possible, we are commissioning services together, putting resources together where appropriate to ensure that provision is based on a clear understanding of need, and joined-up as far as possible. We continue to value the principles set out in the Blueprint for Health and Care Portsmouth that residents should experience services that are seamless.

The Blueprint commitments have been refreshed for 2020-23:

1. We work continuously to improve the quality of health & care in Portsmouth, for all individuals and communities, visibly demonstrating how the diversity of local communities is reflected in the work.
2. We 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 their preferred point of care co-ordination; we continue to improve access to primary care services when people require it on an urgent basis.
3. We underpin this with a programme of work that supports the individual to maintain good health and prevent ill health. We strengthen the support for local people's health and care from both statutory and community organisations so that people become more resilient and know how to access community services when needed.
4. We 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.
5. We are committed to having a well led, well organised, highly professional and engaged workforce that uses data well to inform services and care and continuously learns from frontline practice.
6. We establish a new constitutional way of working to enable statutory functions of public bodies in the City to act as one and to improve local people's involvement and influence in health & care in the city. This includes 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.
7. We establish improved and integrated ways of delivering health and care services for the City. This will be achieved through a range of ways including the formal integration of some services. For local people this will mean they do not have to experience multiple assessments, will be offered choices about how they are treated, be offered opportunities to explain what is most important to them and be referred more straightforwardly to the services they need.
8. We simplify the current configuration of urgent, 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
9. We focus on building capacity and resources at a local level and in communities in 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.

Health & Care Portsmouth operating model / partnership:



The CCG and City Council share a number of aspirations:

1. Personalisation of care and support – including domiciliary care intervention and review, end of life care planning and future care planning, Continuing Healthcare assessments
2. 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
3. Strengthening primary and community care services – including integrated intermediate care to avoid hospital admissions and links with Primary Care Networks
4. Supporting vulnerable people - through the prevention and management of long term conditions, supporting people in care homes and within the wider care sector
5. Improving access to acute /secondary or specialist services – including system resilience, urgent care and elective care pathways and TrUE (Transforming urgent and elective care)
6. 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

These aspirations are intertwined with the principles of Portsmouth's Better Care funded schemes and projects.

We have established enablers for partnerships across the City including:

- Health & Care Portsmouth Commissioning - Integrated Commissioning Service provided by the City Council and CCG
- Portsmouth Rehabilitation & Reablement Team – service provided by Solent NHS Trust and City Council, funded via the Better Care Fund
- Senior Responsible Officer for Hospital Discharge & Flow - City Council and Solent NHS Trust provided
- Continuing Health Care – City Council and CCG 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 CCG provided
- Designated Setting – City Council provided
- Common Record System across Primary Care, Solent NHS Trust and Adult Social Care

A key transformation programme this year is development of the **Portsmouth Integrated Community Programme**, which is informing the future development and design of community bed-based and home-based services to enhance the intermediate care offer across the City and ensure Portsmouth has the right capacity and capability, in the right places.

The aim of the Portsmouth Integrated Community Plan is to:

- deliver the national ambition set out in the Hospital Discharge Guidance (ensuring MOFD for Portsmouth is no greater than 20)
- deliver the requirement in the NHS '2021/22 priorities and operational planning guidance' to accelerate the rollout of the 2-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022
- achieve a sustainable rehabilitation and reablement offer (home and bed based), including D2A

The programme has 3 inter-related workstreams:

1. **Urgent Community Response** project aims to deliver a responsive crisis service that is built around place, ensuring Portsmouth patients have access to Urgent Community Response (UCR), with wrap around support to optimally manage their crisis needs at home and avoid unnecessary admissions. The Portsmouth Rehabilitation and Reablement Team (PRRT) service is funded through the Better Care Fund and is already commissioned to provide a home-based 2 hour crisis response and home-based routine rehab and reablement service for Portsmouth residents. PRRT is a multi-disciplinary, integrated health and social care team the purpose of which is to provide responsive support for people whose needs have intensified, often as the result of an acute illness. Solent NHS Trust is the lead for this service on behalf of both Solent and Portsmouth City Council.

   This project will focus on developing and implementing a plan to enhance the existing UCR service to ensuring the needs of Portsmouth residents are met.

2. **PCAT Hub** This project will develop and implement a Portsmouth Community Assessment Team Hub (PCAT Hub) to ensure the most effective and efficient use of Urgent Community Response (UCR), Rehabilitation & Reablement, D2A and all other intermediate care services. The focal point of the project will be the development of a central coordination hub that will coordinate all pathway 1, 2 & 3 discharges and all community referrals for 2-hour urgent community response and 2-day rehab and reablement responses for Portsmouth residents. This will be built on aligning the existing functions of Discharge Hub, PCAT Assessment Team and PCAT Spoke at PHU.

   It aims to deliver a city wide frailty service that 'pulls' patients into the community and avoids unnecessary admissions to the acute by coordinating resources and providing a single point of access for step up / step down provision, ensuring all services are

effectively utilised.

3. **Optimized Reablement & Rehabilitation (ORR)**
   This project focuses on reviewing the current D2A, rehabilitation, reablement and recovery support offer and develop and implement an optimised offer that is agreed by all key stakeholders within Health & Care Portsmouth. This will be supported by the development and implementation of a communications, education and awareness campaign to ensure all stakeholders are aware of the developments and changes to services.

An analysis of key stakeholders has been undertaken to identify the relevant and interested parties for this programme of work. Regular meetings and workshops have taken place since June 2021, in addition to continued less formal engagement, and will continue throughout the year. Stakeholders include the PPCA Integrated Primary Care Services (Acute Visiting Service, Clinical Assessment Centre and Out of Hours through PHL), Portsmouth Hospital University NHS Trust (Frailty Intervention Team / Frailty Assessment Unit, ED, PCAT, MAU, MAU, PHU Emergency Village), HIVE and VCSE groups, Discharge to Assess Hub, Primary Care - General Practice including PCNs, PCN Care Coordinator, Social Prescribers; P3; Community Pharmacy team; 111; South Central Ambulance Service; Solent NHS Trust - Community Nursing, Older Peoples Mental Health, Single Point of Access, Enhanced Care Home Team; Hampshire Care Association; Portsmouth City Council – Adult Social Care, Community Independence Service (CIS), Housing Services, HOSP, Telecare; Community Beds – Jubilee House, Spinnaker, Southsea, Victory, Gunwharf; Service users, carers and the general public via patient groups.

Through the Better Care Fund several contracts for the provision of Home from Hospital & Admission Avoidance are delivered by the VCSE sector and have been commissioned in the traditional format for several years. A collaborative conversation has taken place with the incumbent VCSE organisations, commissioners, and Portsmouth City Council Procurement to help identify what is working well and where there are opportunities to develop, innovate and expand the support offered by the VCSE as a collective. This has included a mapping exercise that highlighted the value of the current provision, including cross organisation working and added social value from wellbeing and social isolation support, and the longer-term sustainability for the VCSE that the BCF funding provides. An evolving, collaborative model with a focus on admission avoidance will be developed by partners with the aim of developing a longer-term sustainable model integrating VCSE support into the Urgent Community Response / PRRT / discharge hub.

Safe Space is one example of an integrated project commissioned through the Better Care Fund. The service is delivered by South Central Ambulance Service NHS Foundation Trust in partnership with NHS Portsmouth CCG, Portsmouth City Council and the University of Portsmouth. It provides a valuable ED attendance avoidance service when most other services are closed, providing a Safe Space for individuals who might need support on a night out. Due to the Covid pandemic, Safe Space was not open during 2020-2021, however due to the lifting of restrictions and a resurgence in the night-time economy it has re-opened and is now located in the central location of the City Council Civic Offices. It is open every Friday and Saturday from

10pm - 3am (and for additional events such as Fresher's week), to offer confidential and non-judgemental advice, immediate medical care, help for minor injuries and concerns associated with drug and alcohol, from trained professionals to anyone who needs it. If an onward conveyance to the emergency department is required, this will be organised via the most appropriate means. Long term, Safe Space will work with partners (Police, Street Pastors, Portsmouth University and PCNs) to provide a holistic approach to care and support to those people accessing the night-time economy. It is anticipated that the service will reduce the demand on other health and care services, as the service evaluation includes perceived avoided 999 call outs and subsequent reduction in ambulance conveyances. In addition it provides an accessible service for people who are either harder to engage or less likely to engage with traditional health care services.

The City has a thriving provider alliance arrangement through the **Portsmouth Provider Partnership (P3)** - previously the MCP - which has been, and continues to be an important vehicle to improve provision of community care within Portsmouth, and transformational activities have progressed well since the establishment of the partnership. The P3 Programme will be a key building block in the foundation of the HIOW Integrated Care System (ICS) and the Portsmouth & South East Hants Integrated Care Partnership (ICP).

The Blueprint recognised that the City operates within a wider context too, this centres around the acute hospital footprint of Portsmouth and South East Hampshire (PSEH), but also recognises the benefits from working at scale across the bigger geography of Hampshire and the Isle of Wight. We have well established planning mechanisms to support the PSEH Integrated Care Partnership, which brings together partners in the area across the Local Authority boundaries.

PSEH has established three transformation programmes to drive, enable, support, be accountable for and deliver on priorities to ensure we can restore and recover, whilst transforming the way we provide services, accelerate delivery and start to look ahead to achieving the Long Term Plan commitments: Managing flow; Place based care and Healthy communities. As part of the wider PSEH system we will work together where it makes sense to do so and adds value, to deliver the agreed set of priorities that will improve health and care for our local population.

4. Supporting Discharge (national condition four)

- What is the approach in your area to improving outcomes for people being discharged from hospital?
- How is BCF funded activity supporting safe, timely and effective discharge?

On 19 March 2020, the Government released Hospital Discharge Service Requirements, superseded 21 August 2020 to set out the requirements for supporting the NHS through creating acute and community capacity to meet an anticipated surge in demand as a result of Covid. The current requirements remain largely unchanged from the initial requirements in that once a person no longer meets the clinical criteria to require inpatient care in an NHS setting (CTR), they

will be discharged home the same day as becoming medically optimised (or within 24 hours), and any further assessment required (including CHC consideration) will be carried out within a community setting (D2A).

To deliver this requirement, a discharge hub based at St Mary's Community Campus was established to manage 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), PCCG and Solent NHS Trust. The Discharge Hub and D2A unit went live in April 2020. Since then, the Portsmouth System has seen a significant reduction by 22 MOFD patients on average and 217 bed days lost. This has resulted in improved flow from the acute and reduced the risk to patients of infection, low mood, and reduced motivation, which can affect a patient's health after they have been discharged and increase chances of readmission to hospital.

This then enables people to have their longer term needs assessed in the community outside the acute environment. The benefits to the person are less time in the acute and more opportunities to remain at home being supported how people would like. For health and care organisations, there should be less lost bed days, better 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.

We have a strong integrated rehabilitation and reablement team and a Community Independence Service that, along with other VCS provided services, aims to support people back home and prevent avoidable readmissions whilst optimising people's potential to remain living healthy and happy lives.

The Trusted Assessor role is now full time, funded by Portsmouth BCF, working across the PSEH ICP patch and continuing to help support early discharge of people in hospital to nursing and residential homes – carrying out and co-ordinating needs-led assessments and providing effective discharge planning for patients and their carers.

Portsmouth and South East Hants CCG are working as system partners to ensure that robust metrics and systems are in place to ensure that the LOS and discharge profiles within the acute and community trust are effective and deliver flow within the health and care arena.

Areas currently being focused on due to system pressures:

- Maximising the use of Emergency Care Centre and ensuring timely movements from ED and AMU
- Maximising the use of alternatives and utilisation of all available out of hospital capacity including UTCs, CAS
- Assessing power onsite at QAH from both the Hub and SPoA to support with timely assessments and decision making
- Additional reviews of patients in a community setting or bed in order to maintain bed flow and support maintaining good capacity to facilitate discharges from QAH
- Declining mutual aid support from neighbouring systems to ensure capacity is only utilised

by patients within our local demographics

- Twice weekly LOS reviews in QAH led by Chief Nurse and Discharge Lead for PHU
- Hourly sprints with half-hourly ops huddles in PHU; man-marking every patient to ensure all discharges come to fruition
- Hub and SPoA providing timely escalation on potential delays to discharge throughout the day to ensure all discharges are maximised
- Clarence have moved to 78 beds open to support discharge & Southern have 9 surge beds open to support discharge
- Spinnaker has re-opened capacity and 4 beds at Jubilee remain open
- All conversations with patients/families/wards to include the possibility of a sideways step, minimise the element of choice, reiterate the government approach (letters available)
- Communications Teams are pushing messages to encourage families to support with their relatives discharge
- Tri-Daily updates on the system requirements for discharge overseen by the System Resilience Team

Discharge targets

The discharge targets have been developed and reviewed, to ensure all system partners agree with the level of ambition that has been set, and agreed with Chief Operating Officers.

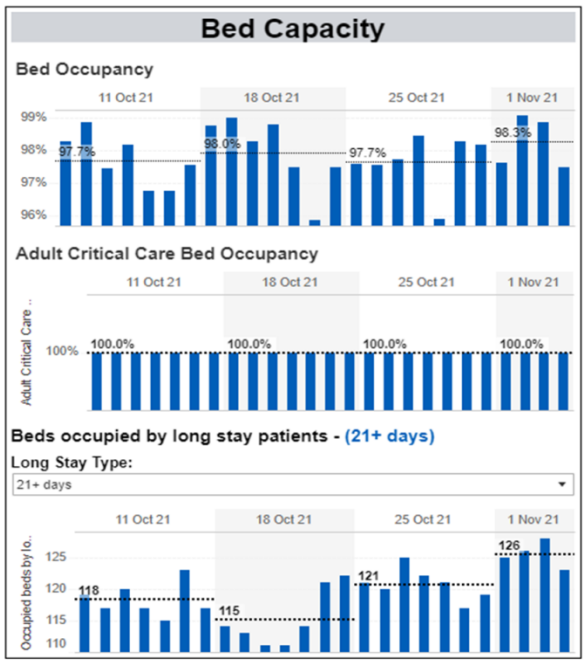
Targets are reviewed and set on a daily bases to ensure that they include the admission avoidance impact.

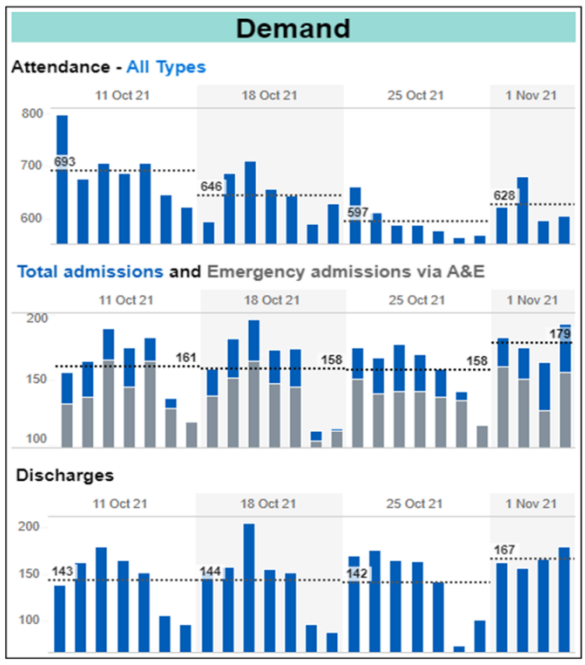
There are daily system meetings in place to review the current position regards the system pressures, this is held with all system partners and is reportable 3 x weekly meetings are in place with senior leads and Chief Operating Officers and is reported to CEO on a weekly bases.

This produces a weekly dashboard

Indicator (data updated at 05/11/2021 08:01)	Sat 23 Oct	Sun 24 Oct	Mon 25 Oct	Tue 26 Oct	Wed 27 Oct	Thu 28 Oct	Fri 29 Oct	Sat 30 Oct	Sun 31 Oct
					ED: Optimise utilisation and flow				
PHU									
ED Attendance	296	308	313	299	281	279	273	257	292
Time to treatment: Type 1 attendances seen within firs	38	52	67	75	53	59	63	77	98
Number of waits for admission 4-12 hours from DTA	28	15	39	59	48	52	52	74	55
Number of Patients >=12 Hours in Department	52	52	35	63	46	55	69	79	51
					Wards: Reduce occupancy				
PHU									
Occupancy - G&A bed occupancy (inc Surge)	96%	97%	98%	98%	98%	99%	96%	98%	98%
Number of Stranded	441	448	430	426	441	435	445	448	456
Number of Super Stranded	121	122	121	120	125	122	121	117	119
Number of MOFD patients - Portsmouth	39	36	29	36	31	41	35	39	35
Number of MOFD patients - Hampshire	80	84	72	98	85	93	85	94	59
Mental Health Occupancy									
					Discharges				
Pathway 0	86	56	94	107	87	84	102	60	61
Pathway 1	17	3	14	25	22	17	13	7	9
Pathway 2	7	5	8	10	11	18	10	10	6
Pathway 3	0	0	3	1	5	3	1	0	1
Community Bed Occupancy - SHFT	7	5	8	10	11	18	10	10	6
Community Bed Occupancy - Solent	0	0	3	1	5	3	1	0	1
Dom Care Capacity - Portsmouth									
Dom Care Capacity - Hampshire									

Bed Occupancy





Ops daily stand-up

Organisation	OPEL Status
System	OPEL 4
PHU	OPEL 4
SCAS	OPEL 3
Hampshire	OPEL 3
Portsmouth	OPEL 3

Organisation	Metric	Yesterday		Today	
		System Requirement	Actual	System Requirement	Level of Confidence (RAG)
Portsmouth	Discharges 1/2/3	15	9	15	
Hampshire	Discharges 1/2/3	25	24	23	
PHU	Discharges P0	116	93	95	

Key Questions
- Confidence to meet target (RAG)
- Actions to achieve
- Escalations or support needed

Key Data	Yesterday
Number of SCAS conveyances to ED	101
ED walk in attendances	193
Total ED Attendances	294
Admissions	129
Ambulance handover (hours lost)	82hrs
60 minute breaches	36
30 minute breaches	14
Total number of Discharges	114

Unit	Unit Capacity	Beds Occupied @ 0800hrs	Empty Beds at 0800hrs	Empty Beds at 1630hrs
Clarence	78	66	12	0
Ark Royal	22	22	2 Cubs	1F
Collingwood	22	22	0	2F
Rowan	23	22	1F (2 Cubs)	1F
Cedar	24	24	2 Cubs	0
Southsea	30	28	2	0
Jubilee	12	10	2	1
Spinnaker	16	13	3	0
TOTALS	227	207	21	5

Acute Front Door	
60+ min ambulance holds yesterday - number	36x60 minute breaches and 14x30 minute breaches
Occupancy rate yesterday	101.7hrs
No in ED at 0900	39
Longest wait in ED	17hrs
Acute Capacity	
No of beds available	6
No of definitive discharges pre 1200	10
No of potentail discharges	88
MOFD	108 (73 Hants & 35 Ports)
Narrative - ie any key staffing pressures, IPC outbreaks	No IPC issues but staffing pressure remains high
OPEL status	OPEL 4
Community	
No of beds avaialble	6 community beds / 6 ports
Occupancy rate yesterday	93% / 87%
Planned discharges	12 across PSEH
Intermediate care team capacity - RAG	AMBER / RED
LA	
Available capacity in LA provided accommodation	6 across PSEH
Care home bed availability - Y/N	Care home beds available
Primary Care	
CAS in each system fully staffed	PPCA fully staffed / SHPCA – no red hub open in Waterlo
UTC Open and green on dos	Yes
SCAS 999	
Jobs outstanding - 999	6 outstanding
Minutes lost to handover yesterday	82hrs lost
Pressures / staffing position - narrative	Staffing pressures remain at AMBER with increased challe
SCAS 111	
Calls answered within 60 seconds	78%
Staffing position - narrative	Staffing pressures remain at AMBER with increased challe

5. Disabled Facilities Grant (DFG) and wider services

- What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

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 of these clients, Housing Services work closely with Occupational Therapists and 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. Following a successful pilot, in 2020 it was agreed that the scheme should continue and Portsmouth City Council has continued with the agreed steps:

- Reduced Means Testing (no means testing for stair lifts & level access showers)
- Increased Grant limit (from £30,000 to £40,000)
- DFGs available to shared lives carers and special guardianship cases
-

During the pandemic inspection processes have adapted to enable less complex cases to be progressed from home. With the support and input from Occupational Therapists, clients and builders through the use of closer communication and using technology to its full potential,

Housing services have been in a position to progress with more cases remotely. Funding has been allocated to provide additional short-term resource to help progress the recovery plan and reduce waiting times from referral to completion.

Health, Care and Private Sector Housing teams continue to link to ensure the most effective utilisation of DFG. Proposals and project updates are discussed regularly at the PMG and initiatives this year include:

- Research and development of digital service provision within the Telecare Project. Portsmouth City Council has an established in-house Telecare Service supporting residents to live independently across the city with a range of detectors and sensors and the entire telecare platform is being reviewed to ensure we provide a robust and reliable service for existing and future customers.

- 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.

6. Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Portsmouth is a busy, waterfront City of over 200,000 people, one of the most densely populated Local Authority areas in the UK, with many assets and a real sense of community. We do however face some serious challenges - the population is growing, there is significant deprivation in many communities and health outcomes are poorer than in many other places in the country. Life expectancy in the City is lower than the national averages for both men and women, along with many other indicators for health and wellbeing where we lag behind. Long standing and deeply rooted health inequalities that affect people's health, wellbeing and quality of life have been further exposed and exacerbated by the Covid-19 pandemic. These include gender, ethnicity, living situation, wealth, disabilities and mental illness. Many people face economic insecurity as the country begins to recover from the impacts of the coronavirus pandemic.

As part of the recovery work we will be working with partners to understand which of the changes that have arisen through Covid-19 are those we don't want to lose, for example the progress with digital services and addressing inequalities.

Some of the activities to help mitigate health inequalities include:

Work to address inequalities in Covid-19 uptake has been a collaborative effort across PCNs,

Solent NHS Trust, NHS Portsmouth CCG, Portsmouth CCG, the HIOW Covid-19 Vaccination Programme and HIVE Portsmouth. Tailoring vaccination provision has shown good examples of how care can be delivered with improved reach and acceptability, such as our BAME communities and rough sleepers. HIVE Portsmouth is recruiting volunteers to become Community Champions to help increase uptake of the vaccination, particularly within ethnically diverse communities. Community Champions will also seek to engage those in younger adult age groups around key Covid-19 messages.

Our community mental health framework activity engages with residents from across diverse groups to ensure that mental health services reflect the needs of all those who might need to access them.

The CCG is working in partnership with Solent NHS Trust to support residents with learning disabilities and reduce the number who need to be seen as inpatients.

We are part of the Hampshire and Isle of Wight CCG engagement work on online and video consultations and using technology to support health.

We will be working with PCNs and their health inequalities leads using a population health management approach to develop data and insights into particular populations experiencing inequalities, as well as community assets, to help design and develop interventions and inform engagement. This approach will be supported across Portsmouth and the Hampshire and Isle of Wight region.

HIVE Portsmouth works with the CCG, Local Authority and Solent NHS Trust to engage with and support our residents. Throughout the pandemic, as a locally based support service, HIVE Portsmouth has been able to identify changing needs and been agile to responding to the specific needs of the city and vulnerable groups. Many people and families in the city do not have access to computers or tablets. HIVE has established a digital loans library to enable self-support and access to online health and wellbeing support, as well as reduce social isolation. HIVE is connected with 56 diverse (BAME and Faith) groups across the City.

The Supported Intensive Recovery Service supports homeless and vulnerable people as they are discharged from hospital. The BCF funded service has been provided for a number of years and is part of the wider Public Health contract for an Integrated Drug & Alcohol Recovery, Supported Housing and Homeless Support Service. This is a service unique to Portsmouth which supports hospital discharge for a vulnerable cohort of patients, linking with other key agencies in the city to improve access to accommodation and support services. The service aims to support homeless people to access accommodation following a discharge from hospital; to improve access to accommodation and support services for those who have a dual diagnosis and provides intensive support with housing and all DWP benefit issues (including assessments). The service works in partnership with external services such as the Substance misuse Recovery Hub, ED and Alcohol Specialist Nurse Service at the acute hospital, homeless day services, local authority housing departments, Two Saints and other supporting services to try to reduce re-admissions to hospital.

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Portsmouth

Income & Expenditure

Funding Sources	Income	Expenditure	Difference
DFG	£2,059,689	£2,059,689	£0
Minimum CCG Contribution	£15,913,841	£15,913,841	£0
iBCF	£8,363,144	£8,363,144	£0
Additional LA Contribution	£2,561,000	£2,561,000	£0
Additional CCG Contribution	£3,767,000	£3,767,000	£0
Total	**£32,664,674**	**£32,664,674**	**£0**

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£4,530,099
Planned spend	£8,209,841

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,653,868
Planned spend	£7,848,000

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£487,000	(1.5%)
Carers Services	£1,002,000	(3.1%)
Community Based Schemes	£5,861,841	(17.9%)
DFG Related Schemes	£2,059,689	(6.3%)
Enablers for Integration	£604,000	(1.8%)
High Impact Change Model for Managing Transfer of Care	£858,000	(2.6%)
Home Care or Domiciliary Care	£4,174,183	(12.8%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£4,180,000	(12.8%)
Bed based intermediate Care Services	£4,337,000	(13.3%)
Reablement in a persons own home	£4,580,000	(14.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£336,000	(1.0%)
Residential Placements	£4,184,961	(12.8%)
Other	£0	(0.0%)
Total	**£32,664,674**	

Metrics

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Est.953	1,173.0

Length of Stay

tbc

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	8.8%	10.4%
	LOS 21+	4.0%	4.6%

Discharge to normal place of residence

		21-22 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)		91.7%

Residential Admissions

		20-21 Actual	21-22 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	622	596

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.2%