Title of meeting:	Health and Wellbeing Board
Date of meeting:	21st September 2022
Subject:	Better Care Fund plan 2022/23
Report by:	Jo York, Managing Director, Health and Care Portsmouth
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 The purpose of the report is to update Health and Wellbeing Board members on the Better Care Fund (BCF) for 2022/23 and seek formal Health and Wellbeing Board sign-off for the BCF plan that will be submitted to NHS England and NHS Improvement.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

i. Approve the Portsmouth Better Care Fund plan for 2022/23, to be submitted to NHS England and Improvement (NHSE/I) by 26th September 2022.
ii. Note work ongoing to support integrated health and care provision that is funded via the BCF.

3. Background

3.1 NHSE published the Better Care Fund planning requirements for 2022/23 in July 2022. BCF plans are required to be submitted to NHSE/I by 26th September 2022.

3.2 For 2022/23 BCF plans consist of:

i. A narrative plan
ii. A BCF planning template including planned expenditure, confirmation that national conditions are met, ambitions for national metrics and additional contributions to BCF section 75 agreements.
iii. Capacity and demand plan (this will not be subject to assurance)

3.3 Use of BCF funding streams is jointly agreed by the Integrated Care Board (ICB) and City Council, via the BCF and Health and Care Portsmouth

Commissioning Partnership Management Group, which is comprised of the relevant officers from both organisations and oversees the Section 75 agreements.

3.4 Local areas were not required to submit BCF plans in 2020/21 due to system pressures of the Covid-19 pandemic. In 2021/22 BCF plans focused on continuity of integrated health and care, supporting recovery from the pandemic and building on partnership working across Health and Care Portsmouth to benefit people across the city.

3.5 The BCF plan for 2022/23 continues to support the well-established principles of the refreshed Portsmouth Blueprint to deliver better outcomes for our population. 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.

4. Reasons for recommendations

4.1 The Better Care Fund policy framework indicates the national conditions that BCF plans must meet:

i. A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
ii. NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
iii. Invest in NHS commissioned out-of-hospital services.
iv. Implementing the BCF policy objectives.

4.2 The plan reflects well established joint commissioning and partnership working arrangements that continue with the transition from Clinical Commissioning Groups to Integrated Care Boards and Health and Wellbeing Board members are asked to sign off the attached 2022/23 Portsmouth BCF plan.

5. Integrated impact assessment

5.1 An integrated impact assessment is not required as the recommendation does not directly impact on services that are already being delivered. Schemes and services within the BCF are subject to the appropriate ICB or City Council Integrated, Equality or Quality Impact Assessments.

6. Legal implications

6.1 Legal considerations have been taken into account where appropriate for individual schemes and projects within the BCF.

7. Director of Finance's comments

7.1 Financial oversight and approval of BCF expenditure is via the Partnership Management Group, which comprises the relevant members of ICB and City

Council Finance directorates. BCF allocations for 2022/23 are authorised as noted in the planning template.

……
Signed by:

Appendices:

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

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

Title of document	Location

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

……
Signed by:

*{**BELOW FOR VERSION INFO**}*

1. *Narrative Plan (Word doc) – FINAL 090922*
2. *Summary tab info from Excel planning template – FINAL 090922*

Portsmouth

Better Care Fund 2022-23

Narrative Plan

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

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

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

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

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board
Portsmouth

1a. Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils
NHS Hampshire & Isle of Wight Integrated Care Board, Portsmouth City Council, Portsmouth Hospitals University Trust, Solent NHS Trust, Southern Health NHS Foundation Trust, Portsmouth Primary Care Alliance, Social Care providers including, Housing Renewals Team, Healthwatch, and Voluntary, Community and Social Enterprise groups across the city.

1b. How have you gone about involving these stakeholders?

Work continues with alongside the development of the Portsmouth Health and Wellbeing Strategy 2022-2030, and Portsmouth's City Vision for 2040. Stakeholder engagement takes place through regular forums and working groups, such as the Dom Care Provider Forum that meets every 6 weeks and the Care Home Managers forum that meet monthly.

During an online event hosted by Hampshire and Isle of Wight (HIOW) ICB the 6 partner members of Health and Care Portsmouth (NHS Hampshire and Isle of Wight Integrated Care Board, Portsmouth City Council, Portsmouth Hospitals University NHS Trust, Portsmouth Primary Care Alliance, Solent NHS Trust and HIVE Portsmouth) came together to discuss the challenges arising from the pandemic and the opportunities that the ICB and Integrated Care System offers, and the need to refresh and agree priorities for the city in the Health and Care Portsmouth Blueprint.

2. Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

This plan describes how Health and Care Portsmouth and Portsmouth City Council, along with other key partners in the city, will work together to further strengthen the place based health and care integration across the wider hospital footprint and the Hampshire and Isle of Wight (HIOW) geography of the new Integrated Care System (ICS), to ensure the successful development of an ICS for our region that is able to fulfil all the ambitions set out in the White Paper. We will work closely, understanding local needs and designing services to meet them in line with the issues and challenges identified as part of the city's Health and Wellbeing strategy, and the Blueprint for Health and Care in Portsmouth, which identifies significant health inequalities, but also the strengths that exist when we come together to improve and support the health and wellbeing of our residents.

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

1. Health improvement – focusing on addressing health inequalities and improving outcomes.
2. Children's services (0-25) – The overarching strategic aims/objectives of commissioning under this scheme specification are to deliver on the priorities identified in the Children's Trust Strategic Plan.
3. Vulnerable adults – we want to:
    - Reduce harm caused by substance misuse including alcohol misuse.
    - Reduce suicide and self-harm in the city by delivering the outcomes in the Suicide Prevention Plan.
    - Implement a comprehensive Adult Mental Health Strategy to:

    - Improve wellbeing through increased access to community-based support.
    - Strengthen primary and community mental health service provision.
    - Timely access to secondary care provision.
    - Improved crisis service response.
  - Implementation of a clear dementia pathway, including strengthened support for carers, integration with physical health services and a delirium pathway.
  - Implement Homelessness and Rough Sleeping Strategy.
  - Deliver on Health and Wellbeing Strategy priorities in the Safer Portsmouth Plan.
  - Alleviate causes and effects of poverty in Portsmouth, as expressed in the Anti-Poverty Strategy.
4. Primary and community services integration – The Better care Fund is organised around three strategic themes:
  - **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, with effective prevention and management of long-term conditions in the community provided 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** – Portsmouth City Council and Solent NHS Trust have been working together to support people needing help to leave the Hospital. In Portsmouth, social workers, nurses, physiotherapists, occupational therapists, and other professionals are working together with people in hospital to understand their immediate needs. Once ready to be discharged, they can leave hospital in a timely way, getting the care and support they need. Patients are supported with 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 to reduce readmissions.
  - **Proactive 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.
5. Person centred care planning – continuing health care, and independent sector care purchasing.

A series of smaller sub-groups are being established for each priority area and a further event will take place in September to finalise the Blueprint. It is then anticipated that we will officially launch the new plan in October.

Portsmouth has a dedicated integrated Children's Commissioning Team sitting across Portsmouth City Council and Health and Care Portsmouth working with families and providers to design and deliver effective services and pathways for physical and mental health of children and young people.

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

A key transformation programme during 2022/2023 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.

3. Governance

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

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

Work was undertaken with Bevan Brittan LLP to ensure that our local governance arrangements, including the Health and Care Portsmouth Place-Based Partnership Board (previously the Joint Commissioning Board) were robust. This included consideration of the agreements that we have in place to enable joint working, including Section 113 and Section 75 agreements. Prior to the dissolution of the CCG an overarching Section 75 was developed which set out the framework for joint working across health and social care within the city. A number of individual schedules were included within the framework, one of which was the revised Better Care Fund – enabling and bringing together a wider range of staffing and financial resource within the Health and Care Portsmouth model in line with the integration agenda in the city. This has now transferred to the Integrated care Board.

This framework also describes and supports a robust programme management and governance approach which has supported delivery of Better Care from the outset and will continue into the future. The Partnership Management Group (PMG) oversees the Better Care Fund schedule of the section 75.

The group is comprised of representatives from the Integrated Care Board 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)

4. Overall BCF plan and approach to integration

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

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning

- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

There is a strong history of partnership working with a clear city vision led by the community to establish an agreed HWB strategy for 2022-2030, Health and Care Portsmouth Blueprint, and operating model, which includes integrated service delivery models and robust integrated commissioning arrangements to address the challenges coming out of the pandemic and need to refresh and agree priorities.

There is the opportunity as part of ICS development to strengthen the partnership arrangements to improve health outcomes and reduce health inequalities both locally and working at scale in the ICS.

Our new commitments within the Portsmouth Blueprint are:

- Our local health services will reflect the diversity of populations and needs in our communities.
- We will build services as locally as possible to reflect the needs of the community but recognise that it will make sense for some things to be led at a different scale.
- We will always design services from the perspective of the person using them, and make these as seamless as possible, joining up functions and organisations for better experiences and outcomes for service users.
- We will remove barriers to accessing services so that everyone can get the help and support they need.
- We will involve people in designing services for them and those they care for.
- We will make sure that we have a well-led, well-organised and well-supported workforce that we empower to work across organisational boundaries to improve the experiences and outcomes for service users.
- We will be honest about what we can and cannot do and explain why.
- We will work with people in their communities to develop the relationships and opportunities they need to stay healthy, independent, and active in the places they live.

We bring together important functions that allow our organisations to deliver more effective community based front-line services and preventative strategies; this includes HR, Estates, IT, and other technical support services.

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 and 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.

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

and opportunities to explain what is most important to them, with referral in a straightforward way to the services they need.

- 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.
- 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.

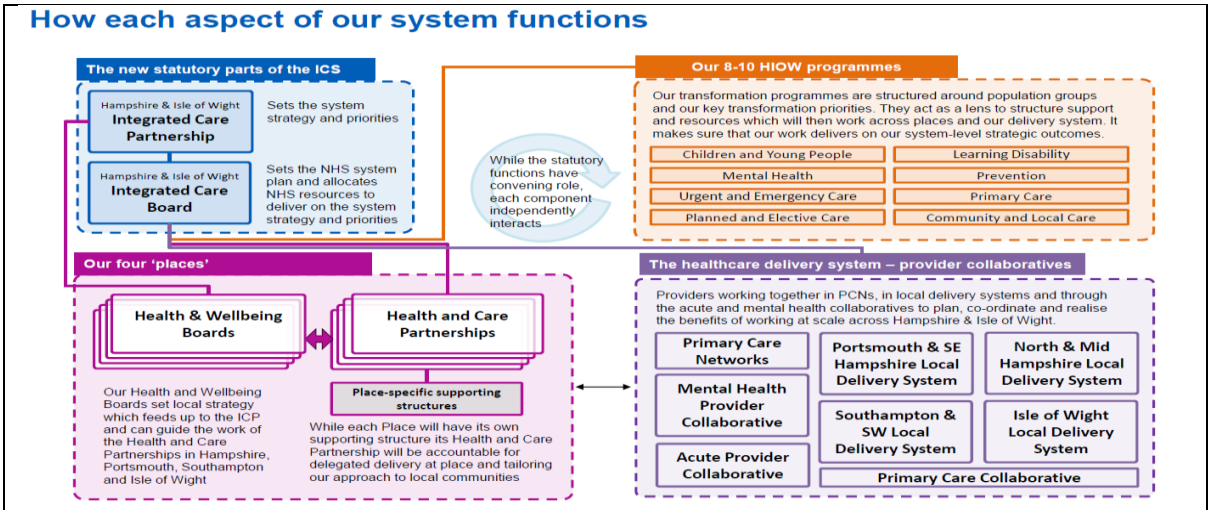
We also agreed some **key principles** for how all health and care partners would work together in the city:

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

Why integrated care systems?

Hampshire and Isle of Wight

How NHS England and Improvement explains the purpose and benefits of Integrated Care Systems



Our System Capabilities: priorities for 2022/23

NHS Hampshire and Isle of Wight

With different behaviours, ways of working and support we will be able to deliver the change in outcomes we aspire to as an Integrated Care System.

Key capability	Description
Adapting how we work	Looking at the values, behaviours, skillset, support and organisational design necessary to create very different ways of working within and as part of the system.
Strategy	Building our system strategy which is inclusive of our partners and appropriately ambitious for our future direction.
Clinical leadership	Fostering a widespread culture of clinical leadership, growing a strong clinical voice at every level of the system, providing active support to emerging clinical leaders.
Population health management	Embedding population health management into our system decision making and culture, driving a focus on outcomes and evidence-based practice.
Engagement	Developing a framework and upskilling our teams to engage broadly in the system with all system partners, citizens and patients and with neighbouring systems and the region
Delegation of resources	Our approach to the delegation of finances and resources to support the delivery of our four core aims and ensuring effective delivery as a system.

Portsmouth has a population of over 172,000 adults over the age of 18. Services covered by this Scheme Specification are available to all adults who live within the geographical area covered by the Council and HIOW ICB (Portsmouth Place Users)

The patient cohorts to be supported are:

- Service Users with long term conditions.
- Service Users with diagnosis of dementia.
- Service Users requiring end of life care.
- Service Users with health and social care circumstances adversely affecting their physical and mental wellbeing.
- Service Users over 75 year who will have a GP check and will receive care co-ordination and intervention as appropriate.

Service Users will be identified using risk stratification based on current and predicted use of health and care service.

Health & Care Portsmouth partners share a number of aspirations:

- Personalisation of care and support – including domiciliary care intervention and review, end of life care planning, future care planning, and Continuing Healthcare assessments.
- Improving health and well-being and strengthening our communities using an asset building approach – including partnerships with the VCSE sector, HIVE, community helpdesk and community development.
- Strengthening primary and community care services – including integrated intermediate care to avoid hospital admissions and links with Primary Care Networks.
- Improving access to acute/secondary or specialist services – including system resilience, urgent and elective care pathways and the Collaboration of Urgent, Elective and Diagnostic (CUED) Care Programme Group.
- 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 ICB.
- 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 ICB provided.
- Adult Mental Health – City Council and Solent NHS Trust provided.
- Integrated Learning Disability Service - City Council and Solent NHS Trust provided.
- Quality Team - City Council and ICB provided.
- Designated Setting – City Council provided.
- Common Record System across Primary Care, Solent NHS Trust, and Adult Social Care.
- Safety and cost-saving in the home – Home Energy Assistance top up grant and Home Improvement Loan.

Portsmouth aims to deliver several community transformational plans this financial year. The aim of these plans is to:

- Enhance the intermediate care offer across the City and ensure Portsmouth has the right capacity and capability, in the right places.
- Continue the development of the Urgent Community Response service.
- Deliver the national ambition for both virtual care and virtual health.

Inter-related workstreams of the programme are:

Urgent Community Response (UCR)

The Portsmouth UCR service provides admission avoidance and was developed and delivered in line with national guidance and expectation in financial Year 2021

to 2022. This was achieved through the amalgamation and enhancement of elements of the Solent NHS Trust Community Nursing and Portsmouth Rehabilitation & Reablement Team (PRRT) to form a single UCR service. The plan for financial year 2022 to 2023 is to continue to monitor and develop the service in line with the latest iteration of NHS England's guidance released in March 2022 Community health services two-hour urgent community response standard. The aim of the UCR is to provide an urgent community crisis response service within two hours, to people in their usual place of residence with an urgent care need, to provide the care they need to optimise independence and avoid preventable escalation of care to non-home settings including the Emergency Department, care home and hospital, where the person is safe to remain at their usual place of residence. The service predominately offers an assessment and short-term intervention(s) (typically lasting up to 48 hours) and where appropriate onward pathways to Virtual Wards, Community Nursing, Portsmouth Rehabilitation and Reablement Team (PRRT), Voluntary, Community & Social Enterprise (VCSE) and other Health & Care professionals.

Community Rehabilitation and Reablement review and reconfiguration
The Portsmouth Rehabilitation and Reablement Team (PRRT) is a well-established service in Portsmouth that provides admission avoidance and supports discharge from acute care into pathway one. The plan is to undertake a review of the service to determine the best strategic fit within the local Portsmouth health and care system. The need for this review is due to developments of the Urgent Community Response Service, Virtual Wards, and the national hospital discharge guidance for home first.

Bed based intermediate care model
The local intermediate care offer has been revised across the city to enable the realisation of the vision to:

Enable people to receive the right level and type of health and care services in their own home and community wherever possible, enabling them to remain well and independent for as long as possible by maximising their recovery, managing their long-term conditions, and avoiding unnecessary hospital admissions.

Solent NHS Trust and Portsmouth City Council are working in a more integrated way to utilise the bed stock across the city and are adopting the national directive to fully embed 'a Discharge to Assess' and 'Home First' approach.

Data analysis of the current bedded provision for rehabilitation and D2A shows that reprovisioning the bed stock will allow for a more efficient utilisation of rehab beds.

There was also a need to determine a sustainable operating model moving forward that complies with the Government requirements for D2A and home first which optimises people's independence and is able to flex based on individuals needs and demand. This model would also include the development of a full 7 day a week therapy service to support the maintenance of the 18-day length of stay.

In June 2022 there was agreement to develop a blended health and social care model for the Southsea Unit which would have 20 discharge to assess beds and 10 rehabilitation beds and additional surge capacity of an additional 10 beds.

The staffing of the unit would be with a blend of health and social care staff under a section 75 agreement with Solent NHS Trust being the lead provider. Social Care staff will transfer to Solent NHS Trust under a TUPE arrangement with a

collaboration agreement being drawn up with all partners (PCC, Solent NHS Trust and the ICB)

Virtual Care Delivery Programme

The virtual care programme main aim is to support admission avoidance and discharge from acute care. Portsmouth is working in collaboration with the South East Hampshire locality on a Virtual Wards and Virtual Care Delivery Programme that will deliver a sustainable transformational change with the golden thread of digital enablement, providing better connected, more personalised care in people's homes, including care homes.

Virtual wards support patients who would otherwise be in hospital, to receive the acute care, remote monitoring, and treatment they need in their own home or usual place of residence. Virtual wards provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital. Patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or Allied Health Professional (AHP) consultant) or suitably trained GP, via a digital platform that allows for the remote monitoring of a patient's condition and escalation to a multidisciplinary team.

Virtual Wards are suitable for a range of conditions that can be safely and effectively managed and monitored at home, or at a person's usual place of residence, including people with respiratory problems and COVID-19 (Covid@Home), heart failure or acute exacerbations of a frailty-related condition. Central to the approach is services working towards providing a model that is patient centred, and in which home is an option for care. This is part of the shared decision-making process, in line with personalised care principle.

Virtual wards will be fully technology-enabled (the management of patients via a digital platform) to optimise care of patients, support communication and enable the effective management of a patient's condition. Where relevant, patients may measure agreed vital signs and enter data into an app or website. In some cases, they wear a device that continuously monitors and reports vital signs. Clinical teams can see individual measurements for the patients they are responsible for via a dashboard. The platforms ensure that the team is alerted when any patient moves outside agreed parameters, allowing them to take appropriate action.

The key aims of this area of work are to:

- Design, implement and evaluate the expansion of virtual health models across the Portsmouth and South East Hampshire system
- Improve patient outcomes and experience.
- Improve flow and capacity, provide system resilience, and reduce hospital bed pressures.
- Be developed across systems and provider collaboratives, based on partnership between secondary, community, primary and mental health services. Consideration will also be given to partnerships with the independent sector where this will help grow capacity

VCSE Wellbeing Collective

Through the Better Care Fund several contracts for the provision of Home from Hospital and Admission Avoidance are delivered by the VCSE sector and have been commissioned in the traditional format for several years. We are seeking to change

the way that we work with the VCSE and move away from a commissioning model based on competing for contracts to one of collaboration and partnership working. The development process started in September 2021 with delivery of the VCSE Wellbeing Collective model from November 2021.

In line with the Health and Social Care Bill, "Integration and Innovation" (February 2021) this is a partnership approach with three VCSE organisations (HIVE Portsmouth, British Red Cross, and The Salvation Army) to strengthen links between health and social care and the VCSE sector in the city and to support people collaboratively to remain living independently and prevent hospital admissions. From the first 8-months of delivery (Nov 2021 – June 2022) the Collective received an average of 45 referrals per month. Referrals were mainly for; urgent food provision, ongoing shopping support, welfare, environment safety, mobility support and reablement. The Collective is in the process of establishing a Single Point of Access into the service to support the developing model.

Anticipatory Care Plan

Portsmouth as part of the Hampshire & Isle of Wight Integrated Care Board, has identified proactive case management as a key priority for this Winter to support admission avoidance. This will help accelerate the forthcoming anticipatory care Primary Care Networks Directly Enhanced Service, while building on current Primary Care Networks delivery models relating to Health Inequalities and Personalised Care. The BCF infrastructure will provide the additional enablers and levers to further integrated working in our places and neighbourhoods.

Portsmouth Provider Partnership (P3)

The City has a thriving provider alliance arrangement through P3 (previously the MCP) comprising of Health and Care Portsmouth, PPCA, Solent NHS Trust, PCC, HIVE Portsmouth, PHU Trust, Healthwatch Portsmouth, and Primary Care Networks within the city who are are committed to working together to integrate primary, community, social care and voluntary services in Portsmouth City. This has been and continues to be an important vehicle to improve provision of community care within Portsmouth. Transformational activities have progressed well since the establishment of the partnership. 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 P3 programme continues to be the enabler to delivering the outcomes set out in the Portsmouth Health and Care Blueprint.

5. Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy 2022/23 objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embe a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

The current requirements remain largely unchanged 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, the Portsmouth Community Assessment team manages all step-up and step-down care for Portsmouth City residents, including interim placements and onward care arrangements. This multidisciplinary team works in partnership with the Integrated Discharge Service (IDS) at Portsmouth Hospital University Trust (PHU) to facilitate hospital discharge and consists of staff from Portsmouth City Council (PCC), and Solent NHS Trust.

This then enables people to have their longer-term needs assessed in the community outside the acute environment. This means that there are 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.

The local intermediate care offer has been revised across the city with Solent NHS Trust and Portsmouth City Council working in a more integrated way to utilise the

bed stock across the city by adopting the national directive to fully embed 'a Discharge to Assess' and 'Home First' approach.

Data analysis of the current bedded provision for rehabilitation and D2A shows that reprovisioning the bed stock will allow for a more efficient utilisation of rehab beds. This model also allows for the development of a full 7 day a week therapy service to support the maintenance of the 18-day length of stay.

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 plan is to undertake a review of the service to determine the best strategic fit within the local Portsmouth health and care system.

The Trusted Assessor role continues to be funded by Portsmouth BCF and helps 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 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.

Partners in Portsmouth and South East Hampshire worked closely throughout the winter to manage and limit the pressure on the NHS and the impact of that on local residents. Health and care providers worked together on a campaign to reduce demand at Portsmouth Hospital University NHS Trust's Emergency Department at Queen Alexandra Hospital, increasing timeliness in daily discharges from hospital, and encouraging people to self-care at home where possible

Targets are reviewed and set daily 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 basis.

6. Supporting unpaid carers.

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

Carers support in Portsmouth is well established with excellent cross organisational relationships across health and care organisations at an operational level. The

challenge of being a small Unitary Authority with limited capacity combined with the pressures presented by the pandemic has meant that strategic leadership remains an ongoing challenge.

BCF funds are focused on the operational delivery of carers support including the provision of breaks and ensuring as seamless an experience as possible for carers across the health and social care system.

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

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

Data around admission avoidance has not been available locally, admissions due to carer breakdown are not routinely recorded so any data available is not reliable. However, the Carers Service works proactively with carers and those they support to avoid crisis point being reached and will work with colleagues elsewhere in the system to avoid admissions where possible.

Common things carers want help with are:
- Help to get a break
- Information, advice and gaining useful knowledge
- Emotional support, problem solving and risk management
- Planning for an emergency

The breaks offer includes non-chargeable one-off payment, replacement care equivalent to 6 hours p/w sitting service and chargeable access to 2 respite beds.

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

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social 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 from both health and social care under a section 113. We have amended our processes to simplify them and enhance client service. During 2019-20, Portsmouth agreed with recommendations for the flexible use of the DFG allocation. This enabled Health and Care Portsmouth and Private Sector Housing to test new ways of working and operating structures to benefit residents requiring adaptations at home. In July 2020 with the success of a pilot scheme, changes were agreed by the BCF board on a permanent basis, with a further addition of exempting all DFG's from the means testing. In November 2021 Portsmouth City Councils Private Sector Housing Financial Assistance Policy 2021 was adopted. This revised Policy included the implementation of the agreed changes to become permanent as follows:- - Remove Means Testing to all DFG's - Increase the Grant limit (from £30,000 to £40,000) - For grants in excess of £40,000 a Home Improvement Loan will be offered - Make DFGs available to shared lives carers and special guardianship cases. Flexible use of DFG was agreed due to the waiting list that had amassed due to limitations on inspections during the COVID-19 Pandemic, this is now being addressed and the underspend (approximately £500,000) was retained and balance carried forward into 2022/23. Feedback on the progress will be provided at relevant stages throughout the year. In May we held approximately 122 clients on our DFG waiting list. Whilst all efforts have been made to reduce this number, we did receive a high number of referrals in April, May and June. Typically, we can expect appx 26 referrals per month. In April, May and June we received approximately 42 per month, which has had an impact on ability to reduce the waiting list, which remains a similar number. This high number of referrals is not anticipated to be maintained and we expect in the upcoming months to receive closer to 26 per month. The timeframe clients are waiting has reduced down to approximately 4 months. 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 and home safety service (Safe at Home) supporting residents of all ages to stay

safe and live independently in their own homes across the city with a range of detectors and sensors. The entire telecare platform is being reviewed to ensure we provide a robust and reliable service for existing and future customers.

The project continues to support our vulnerable residents with the digital switchover to live safely and independently in their own homes. The Safe at Home service now operates on fully digitalised equipment for new and future customers and the team have already supported over 200 existing customers with analogue to digital switchovers enabling a robust and reliable service for those who have already undergone the changes in the city. With the full digital upgrade for existing customers to be completed by end of 2022.

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

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

8. 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
- Changes to local priorities related to health inequalities and equality, including as a result of the Covid-19 pandemic
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Alongside the development of the Portsmouth Health and Wellbeing strategy 2022-2030 and Portsmouth City Vision for 2020, partners came together to discuss the significant challenges facing the city which are contributing to Portsmouth's health inequalities. This includes the cost-of-living crisis, demand and capacity pressures across the health and care system, residents struggling to access key services, workforce challenges, financial challenges and more.

In 2021, we worked with partners locally to consider how the Blueprint would need to develop for the future and our new commitments include:

- Our local health services will reflect the diversity of populations and needs in our communities
- We will remove barriers to accessing services so that everyone can get the help and support they need

We also agreed some **key principles** for how all health and care partners would work together in the city, including *Equality* - our place-based working will seek to shape service delivery to reduce inequalities in the City. The development of the ICS presents an opportunity to strengthen partnership arrangements to improve health outcomes and reduce health inequalities both locally and working at scale.

Aspirations to truly tackle health inequalities are woven throughout the NHS Long Term Plan (2019) and the Covid-19 pandemic has exacerbated issues for those who were already disadvantaged. The NHS operating plan for 2021/22 includes a significant focus on tackling health inequalities, aiming for equitable access, excellent experience, and optimal outcomes, as well as increasing access to Primary Care services as a priority.

The charity CRISIS reported that homeless people are almost 40 times more likely not to be registered with a GP and five times more likely to have difficulty getting onto or staying on a GP's list than the general public. Homeless people are probably amongst the most impacted by the inverse care law for both physical and mental health as their significant needs are often unmet, resulting in an over use of emergency and inpatient provision.

Portsmouth is establishing a Health Inclusion Service with Brunel PCN leading the work in collaboration with P3 partners, which provides a team dedicated to supporting people who are or have been homeless and/or those who struggle to access mainstream health services due to the chaotic nature of their lifestyles. The Primary Care Team will offer a transitional service for individuals, with an aspiration to manage any on-going needs through mainstream health and care services where possible. The team will have a co-located base with the mental health and substance misuse team, but also provide outreach into the existing support services, hostels and the street as necessary.

Some examples of our approach to supporting a reduction in health inequalities following the Core20PLUS5 principals:

- **Pulmonary Rehab** – this service has recently been adapted to make it more accessible and now offers a wide range of interventions including remote and face to face groups, liaising with Practice Nurses to try and identify the most appropriate referrals for long-term COPD management.
- **Breathlessness Hub** – this service has recently been set up as a pilot to support respiratory problems by providing breathlessness assessment, diagnostics, and management in a community setting.
- **Early cancer diagnosis / Chronic respiratory disease** – Currently Portsmouth's early lung cancer diagnosis rate is 38% (Stage 1 or 2), in April 2022 we started delivering the Targeted Lung Health Check (TLHC) programme with a targeted population of 24,000 people, the aim is to increase our early diagnosis to 75%. To date we have identified that 10% of the checked cohort have undiagnosed COPD, these patients have been referred to primary

care for treatment. In addition, 21 people have had cancers identified and are being treated by our acute hospital.

- **CVD/Hypertension** – We have successfully delivered BP at home monitoring project with 700 BP monitors delivered to Portsmouth practices for dissemination to their patients. Also the introduction of other CVD schemes such as pharmacy BP monitoring ICB working jointly with LA Public Health Wellbeing Service who are providing a CVD preventative programme of work.

Inequality of access and outcome:

- **Health:** Life expectancy for men and women in Portsmouth is significantly lower than the England average; and it is 7.8 years lower for men in the most deprived areas of the city than in the least deprived. Rates of under-75 mortality rate from cardiovascular diseases, cancer, respiratory diseases and liver disease are worse than the England average. In school year 6 (at the end of primary school) 21.5% of children are classified as obese.

- **Index of Multiple Deprivation (IMD):** Portsmouth (along with Southampton) ranks as significantly more deprived than any other district within Hampshire and Isle of Wight. Of 317 LA districts in England, Portsmouth is the 57th most deprived by the average rank of each LSOA, the 59th most deprived by average score of LSOA, and 72nd most deprived by the proportion of its LSOAs that are in the most deprived 10% nationally. With only 2 LSOAs in the least deprived 10% nationally, and 15 in the most deprived 10%, Portsmouth has pockets of affluence rather than pockets of deprivation.

- **Educational Attainment** - In many key measures of educational attainment, Portsmouth is ranked lower than other cities.

- **Skills -** Educational outcomes have implications for achievement at further and higher education. The most recent statistics show that the proportion of young people not in education, employment or training has risen to 5.2%. Many higher paid and higher skilled jobs are occupied by employees commuting into Portsmouth and not by residents. Resident salaries are lower than the national average despite city workplace wages being higher - this indicates the lower skills level of the local workforce.

The Covid-19 pandemic has had a disproportionate impact on many who already face disadvantage and discrimination, highlighting some of the health and wider inequalities that persist in our society. The impact of the virus has been particularly detrimental on people living in areas of high deprivation, on people from Black, Asian and Minority Ethnic Communities (BAME), on older people, those with a learning disability, and others with protected characteristics.

The pandemic has shown the importance of reorientating our efforts to address the broad outcomes that drive good health, recognising that the distribution of income and wealth matter in reducing health inequality. In Portsmouth, we have begun to address this through our use of the ONS Health Index as a measure of progress,

aiming to support a longer-term focus to our policy and investment decisions aimed at improving the health and wellbeing of our residents and communities.

Data from the ONS Health Index for Portsmouth in 2018 showed that health was worse than the England average in 2015, and that the city's relative position has decreased in the years since. Portsmouth's position has worsened in relation to health outcomes and wider determinants and improved in relation to health-related behaviours. Portsmouth is not an outlier in terms of its overall score – the City sits within a pattern in which more deprived areas have less healthy populations.

Since 2015, organisations involved in Health and Care Portsmouth have combined their knowledge and expertise to improve support for vulnerable people in the community across a range of different services including health visiting, school nursing and learning disability support.

The HWB strategy has been refreshed for 2022-2030 and takes a different approach where we have really tried to understand what about Portsmouth are the significant impacts on health and wellbeing, and what we can do as a system to bring about some key changes.

We have identified five issues which we describe as the "causes of the causes" – the underlying factors in our city that lead to some of the issues which in turn influence health and wellbeing. Rather than look at individual services and responses, we are looking at how we create the conditions for good health and wellbeing in Portsmouth around the following themes:

- Poverty
- Educational Attainment
- Positive Relationships
- Active Travel and Air Quality
- Housing

As a system, we collectively aim to meet the needs of all our communities through a combination of universal and targeted services and approaches; some of the activities to help mitigate health inequalities include:

- Working with Portsmouth City Council and Primary Care Networks to make COVID-19 vaccinations accessible to those groups who have lower uptake, such as our black communities, travelling community and rough sleepers.
- We are part of the HIOW ICB engagement work around online and video consultations and using technology to support healthcare.
- Increased engagement with communities that are underrepresented and disadvantaged.
- Work continues across Health and Care Portsmouth to develop support services to lessen inequalities for Autistic residents. Appropriate targeted support is being developed working in co-production with the community.
- HIVE Portsmouth works with the ICB, 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 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

This BCF funded service supports hospital discharge for a vulnerable cohort of patients as they are discharged from hospital. This is unique to Portsmouth and has been provided for a number of years as part of the wider Public Health contract for an Integrated Drug & Alcohol Recovery, Supported Housing, and Homeless Support Service 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.

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

The Covid-19 pandemic shifted the landscape globally and influenced every aspect of our lives and the way the NHS operates, in response to these changes and the publication of the NHS People Plan, and People Promise we have we reviewed our strategy and recognised the need to strengthen our position on EDI to ensure it is aligned to the new national NHS equality agenda and will create a culture that is positive, compassionate, and inclusive.

We continue to be committed to the Portsmouth City Council Equality and Diversity strategy 2019-2022 and continue to promote Portsmouth as an employer of choice, providing all members of staff with a positive, inclusive work experience where they will feel valued and are given the opportunity to reach their full potential, ensuring that EDI is a focus. This will include strengthening the EDI training offer for managers and staff to increase awareness and provide knowledge, mentoring programmes, and making sure that employment and opportunities for promotion are accessible to everyone, policies and recruitment materials are representative and build upon the Beyond Boundaries positive action programme for ethnic minority.

To work towards intentional inclusion requires deliberate action in addressing individual needs so that inclusion is evident in all we do, this means; actively listening and engaging with staff, patients, and communities, doing more to seek the experience of those that are seldom heard in line with the ambitions set out in Working Towards Intentional Inclusion and NHS England and NHS Improvement's Equality Objectives for 2022/23.

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

- How we commission services on behalf of the population we serve.
- How we recruit and support the development of all of our staff.
- How we proactively engage and support everyone who uses our services, especially given the diversity of our population.

Our work in embedding equality into the commissioning of health services is underpinned by regularly engaging with our stakeholders. We believe that engagement with, and drawing on the expertise of, patients, families, carers, residents, service providers and third sector organisations is critical and will ensure that the services we provide are of the highest quality, inclusive to everyone and will provide value for money satisfying the needs of our diverse population.

Embedding equality in the commissioning cycle
The ICB has a centralised view of projects and reporting that is co-ordinated by the Planning and Performance Team. All projects are set up on MS Teams. This includes a project plan which contains a risk register and list of steps to take to ensure good project governance. The process includes completion of and saving

completed Equality Impact Assessments (EIAs) on a project MS Teams Channel.

Monitoring contracts with NHS provider organisations
ICB contracts with provider organisations are monitored at monthly and quarterly clinical quality review meetings with representatives of each provider organisation. Monitoring of provider contracts includes equality metrics. The main providers contracted by the BCF are; Solent NHS Trust, Portsmouth Primary Care Alliance and South Central Ambulance Service NHS Foundation Trust.

Our Equality Objectives
Objective 1 - Ensure the ICB fully understands and fulfils its responsibilities for equality and diversity in order to become a nationally recognised leader on quality, diversity and inclusion. This includes timely Equality Impact Assessments (EIAs) whenever new projects, proposals or policies, commissioning and strategies are being developed.

Objective 2 - Work in partnership with local stakeholders and embed a multiagency approach to the delivery of healthcare services. Address health inequalities in differential access to services and worse health outcomes for identified groups and in localities. For example, the following initiatives seek to address health inequalities working with our statutory and voluntary and community sector partners:

- Our community mental health framework activity engages with residents from across diverse groups to ensure that mental health services such as Positive Minds, Talking Change and The Harbour are co-produced and reflect the needs of all those who might need to access them. A range of virtual discovery events have been held to get ideas on how best to work together and to discuss what matters most about community mental health service. Sessions have been held for people with lived experience, carers, VCSE organisations and various age groups with more targeted sessions to take place.

- Home care recruitment - campaign developed in partnership with care providers across the city using insight from their staff and clients. The focus of the campaign is to attract new talent to the industry, capitalising on how social care was seen through the pandemic to provide resilience to the vital domiciliary care sector as demand for care at home continues to grow.

- Multi-agency working on the COVID-19 vaccination programme to raise awareness, address concerns and maximised uptake of the vaccine. To address vaccine inequalities the delivery model has included a roving (bus) model, walk in clinics and pop-up clinics in community settings. It has been informed by insight work to understand vaccine hesitancy amongst young people. Engaging with trusted community voices and provided bespoke messaging based on feedback and a range of media have been used. There are also a number of clinics across Hampshire and the Isle of Wight to help patients suffering from Long Covid.

Objective 3 - Improve access to healthcare for everyone routinely and when they need medical help fast but it is not a life-threatening situation. Achieve year on year improvement in bringing primary, community and adult social care together with specialists from local hospitals and third sector organisations as a single extended primary care team.

We continue to work with our GP members and statutory and voluntary and community sector organisations to remove traditional boundaries between the different organisations that provide health and social care. For example, in their role to tackle neighbourhood health inequalities, we are supporting identification of equality leads for each Primary Care Network in the city and 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 HIOW region.

Objective 4 - Engage with diverse communities and consult with them when undertaking equality impact assessments and other commissioning activities. There will be a particular focus on groups and in localities that face specific inequalities in health and health outcomes. Our assessment of equality impact on our commissioning projects and plans includes consultation and engagement with patients and members of the public. Patient experience data also informs individual projects and plans. Our EIA template includes questions specifically aimed at addressing inequalities in health and health outcomes.

Objective 5 - Strengthen commissioning and partnership working so that the communities we serve feel informed and supported to be as involved as they wish to be in decisions about their care. We have worked with stakeholders to deliver programmes including a new Adult Social Care Strategy which places co-production, choice and control over care and working with the community at the heart of services for adults in Portsmouth. The Strategy includes the creation of a monthly co-production working group with colleagues across Hampshire and the Isle of Wight. We have also developed *Supporting carers* – an eight-week programme of activities for carers to help them get out and about again after lockdown, and

promotion of Employers for Carers - advice for employers on supporting staff who are carers.

Objective 6 - Work with all levels of staff to ensure the CCG has a representative and supported workforce and inclusive leadership. Build on current work to strengthen staff partnership arrangements.

Shared local outcomes, shared local leadership and aligned financial goals is the way we have been working in Portsmouth. The encouragement to invest in our joint workforce and build on our use of intelligence and technology to improve lives is welcome and we look forward to developing the place of Portsmouth as part of our Integrated Care System.

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board:	Portsmouth

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,059,689	£2,059,689	£0
Minimum NHS Contribution	£16,814,564	£16,814,564	£0
iBCF	£8,616,489	£8,616,489	£0
Additional LA Contribution	£2,881,000	£2,881,000	£0
Additional ICB Contribution	£6,243,436	£6,243,436	£0
Total	**£36,615,178**	**£36,615,178**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,786,503
Planned spend	£10,513,564

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£7,030,477
Planned spend	£7,617,000

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£487,000	(1.3%)
Carers Services	£946,000	(2.6%)
Community Based Schemes	£8,190,000	(22.4%)
DFG Related Schemes	£2,059,689	(5.6%)
Enablers for Integration	£578,000	(1.6%)
High Impact Change Model for Managing Transfer of Care	£773,000	(2.1%)
Home Care or Domiciliary Care	£887,000	(2.4%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£4,519,000	(12.3%)
Bed based intermediate Care Services	£5,826,000	(15.9%)
Reablement in a persons own home	£4,350,000	(11.9%)

Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£273,000	(0.7%)
Residential Placements	£7,726,489	(21.1%)
Other	£0	(0.0%)
Total	**£36,615,178**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population	435	397	494	417

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.5%	95.6%	95.5%	95.5%

Residential Admissions

		2020-21 Actual	2022-23 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	537

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.9%

Planning Requirements >>

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