Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

Note on entering information into this template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

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

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

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

ASC Discharge Fund-due 2nd May

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

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

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

Checklist (2. Cover)

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

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

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

2. Cover

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

3. National Conditions

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

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

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

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

4. Metrics

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

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

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

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

5. Income and Expenditure

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

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

Expenditure section:

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

6. Year End Feedback

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

Part 1 - Delivery of the Better Care Fund

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

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

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

Part 2 - Successes and Challenges

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

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

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

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

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

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

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

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

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

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

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

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

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Portsmouth

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

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Portsmouth

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

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

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

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

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Portsmouth

Income

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

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

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

ASC Discharge Fund

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

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

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

Expenditure

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes

	2022-23
Plan	£36,615,178

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

Actual	£48,304,949	Yes

	ASC Discharge Fund
Plan	£2,162,014

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

Actual	£2,162,014	Yes

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

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

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

Selected Health and Wellbeing Board: Portsmouth

Part 1: Delivery of the Better Care Fund

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

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

Part 2: Successes and Challenges

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

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

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

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

Footnotes:

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

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

Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Portsmouth

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

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

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

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

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

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

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

BCF narrative plan template

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

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

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

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

Cover

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

Governance

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

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

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

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

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

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

Executive summary

This should include:

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

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

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

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

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

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

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

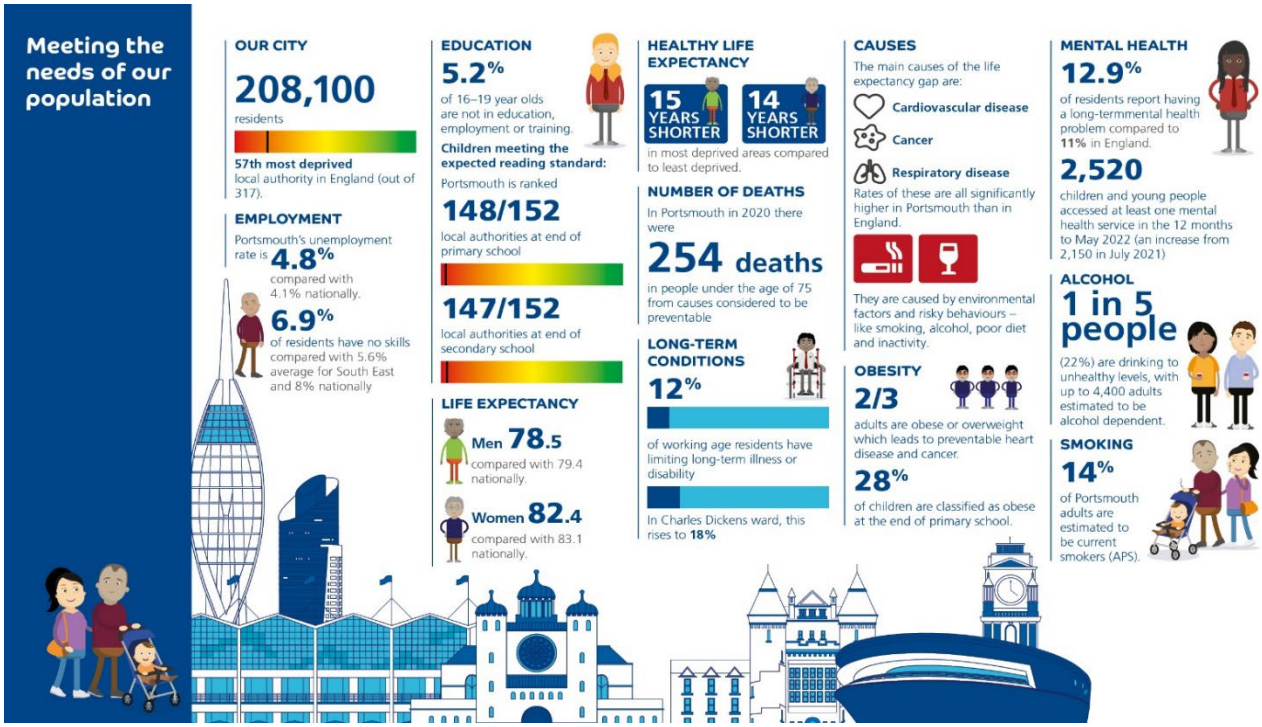
Our vision is for everyone in Portsmouth to be enabled to live healthy, safe, and independent lives, with care and support that is integrated around the needs of the individual at the right time and in the right setting. We will do things because they matter to local people, we know that they work, and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

National Condition 1: Overall BCF plan and approach to integration

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

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

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



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

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

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

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

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

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

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

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

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

Health & Care Portsmouth partners share a number of aspirations:

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

We have established enablers for partnerships across the City including:

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

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

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

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

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

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

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

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

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

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

Urgent Community Response & Virtual Ward Developments

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

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

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

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

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

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

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

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

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

Telemedicine for Care Homes

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

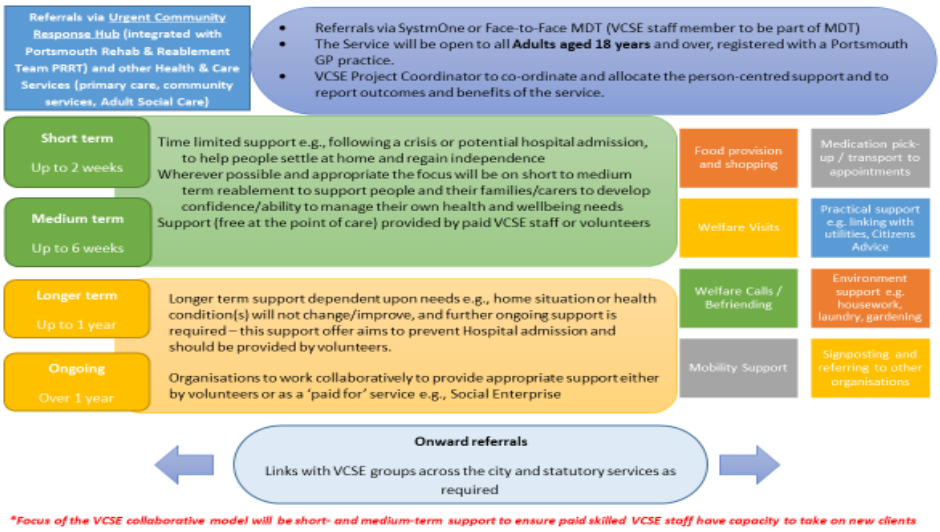
This programme will develop a local clinical hub model supporting all 240 care homes across PSEH through 24/7 clinical consultation reducing impact on primary care, reducing conveyances to hospital, ED attendances and non-elective admissions, maintaining the same level of service as the previous provider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

Voluntary Community Social Enterprise (VCSE) Wellbeing Collective

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

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

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



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

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

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

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

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

National Condition 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

National Condition 2 (cont)

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

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

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

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

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

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

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

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

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

National Condition 2 (cont)

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

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

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

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

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions

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

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

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

Plans to manage hospital admissions following a fall include:

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

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

Plans to manage admissions to residential and nursing care homes:

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

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

National Condition 3

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

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

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

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

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

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

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

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

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

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

National Condition 3 (cont)

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

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

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

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

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

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

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

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

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

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

National Condition 3 (cont)

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

- Discharge to usual place of residence

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

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

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

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

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

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

National Condition 3 (cont)

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

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

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

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

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

National Condition 3 (cont)

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

The Better Care Fund schedule of the S75 framework, which is overseen by the Partnership Management Group (PMG), describes and supports a robust programme management and governance approach which supports the delivery of BCF. The PMG is authorised within the limit of delegated authority of its members (which is received through their respective organisation's own constitution and scheme of delegation).

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

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

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

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

Supporting unpaid carers

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

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

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

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

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

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

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

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

Disabled Facilities Grant (DFG) and wider services

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

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

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

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

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

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

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

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

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

Additional information (not assured)

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

No

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

N/A

Equality and health inequalities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Active Travel and Air Quality

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

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

Actions that contribute to reducing differences in outcomes

Managing patient flow

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

Placed-Based Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

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

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

4. Capacity and Demand

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

5. Income

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

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

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

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

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

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

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

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

6. Expenditure

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

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

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

On this sheet please enter the following information:

1. Scheme ID:

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

2. Scheme Name:

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

3. Brief Description of Scheme

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

4. Scheme Type and Sub Type:

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

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

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

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

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

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

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

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

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

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

7. Metrics

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

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

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

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

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

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

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

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

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

8. Planning Requirements

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

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

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

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

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

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Portsmouth

Income & Expenditure

Income >>

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

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

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

Adult Social Care services spend from the minimum ICB allocations

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

Metrics >>

Avoidable admissions

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

Falls

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

Discharge to normal place of residence

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

Residential Admissions

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

Reablement

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

Planning Requirements >>

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

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Portsmouth

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

3.1 Demand - Hospital Discharge

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

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

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

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

Estimated levels of discharge should draw on:

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

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

3.2 Demand - Community

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

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

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

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

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

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

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

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

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

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

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

3.4 Capacity - Community

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

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

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

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

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

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

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

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

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

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

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

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Demand - Hospital Discharge

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

3.2 Demand - Community

Demand - Intermediate Care

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

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

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

3.4 Capacity - Community

Capacity - Community

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

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Portsmouth

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

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

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

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

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

Yes

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

Yes

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

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

Yes

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

Yes

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

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

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

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Portsmouth

<< Link to summary sheet

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

Required Spend

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

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

Checklist

Column complete:

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

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

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

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

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

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

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

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

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

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

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Portsmouth

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

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

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

8.2 Falls

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

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

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

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

8.4 Residential Admissions

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

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

8.5 Reablement

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

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

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

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Portsmouth

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

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

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