Portsmouth City Council
Market Position Statement

December 2015

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Contents

Executive summary

Portsmouth City Council wants to support and encourage providers to develop personalised, integrated care and support services in Portsmouth that offer quality and choice for customers. To support providers achieve this aim, Portsmouth's first Market Position Statement has been developed. The aim has been to take a fresh look at the social care and health market locally, taking into account work underway to provide integrated support services and provide a tool to help providers identify opportunities and make decisions about how to develop their services in Portsmouth that could maximise impact and success of a redesigned or new service offer.

Our Market Position Statement (MPS) includes information that will help providers to:

- **Grow your business** - it can help providers make decisions about which services to invest in for the future. It includes detailed intelligence on current levels of activity and forecasts future supply and demand.

- **Identify gaps in the market** - at a time of great change, it can help with innovation. For example, how new requirements in the Care Act 2014 will affect providers' business (in terms of new responsibilities for providers and how to meet the needs of a wider range of customers, especially self-funders).

- **Respond to new business opportunities** - it can help providers to find out about customer demand. It can tell you more about how many people have personal budgets and what they are choosing to spend their budget on.

The MPS will inform planning and decision-making by commissioners and providers. The content takes into account the wider public policy context in which social care support is commissioned and delivered. It includes detailed intelligence on current levels of activity and forecasts future supply and demand. The information contained in the MPS will help commissioners to develop the creative, efficient and cost-effective approaches required to address local need in a climate of reducing resources, public service reform and personalisation that will see more people holding personal budgets and making decisions about how their care is provided. We welcome the changes in national policy that are driving significant change within and across organisations in the city. For example, since 1 April 2013, Public Health functions have been delivered by the Council; at the same time Portsmouth Clinical Commissioning Groups came into force to replace Portsmouth’s Primary Care Trust. Alongside our Public Health colleagues we are currently engaged in widespread and detailed integration work with the various facets of the NHS to ensure an improved customer journey for citizens requiring health and social care services.

Changes to the commissioning of NHS services have placed a far greater focus on integrated planning, commissioning and provision of services. The drivers for integrating health and social care commissioning include:

- Recognition of a new architecture for the NHS;
- The challenge of meeting the needs of an ageing population in which chronic medical conditions are increasingly prevalent;
- The need to use resources more efficiently;
- A joint approach between the NHS and local government with a focus much more on preventing ill health, supporting self-care; through personalisation, enhancing primary care, providing care in people’s homes and the community wherever this can be done more appropriately than in hospital settings;
- Need for increased co-ordination between primary care teams and specialists, and between health and social care, and;
- A requirement to support carers, addressing their health and social care needs, to acknowledge the considerable contribution this group of individuals make in supporting the health and social care needs of those they care for, and the void that would be created were they no longer able to do so.

Opportunities for providers are far-reaching; with an increasing vulnerable population, improving technology and changing culture, even traditional service provision provides scope for 'doing things differently'. Most notably, gaps currently exist in personalised service provision for those with complex and/or challenging needs

(including those with a need spanning health, social care and public health) and those with more effective approaches to achieve outcomes are likely to be achieved through increasing collaboration amongst providers.

1. Our vision

Our vision for the city is one in which Portsmouth residents are able to achieve their full potential by ensuring that support is available to help improve their health and wellbeing through access to the right help at the right time, with an increased focus on how education, training, work, skills and local community assets can contribute to improved health and wellbeing. We will promote greater personalisation through individual budgets, commission services at city, neighbourhood and individual level and work across Health, Social Care, other Council services and the independent and voluntary sectors to develop more coherent customer journeys that reduce dependency upon complex and costly services, and help people to be as independent as possible. Our ambition is to build strong partnerships supported by an accessible business market that responds flexibly to supply and demand, providing diverse, high-quality and sustainable services at affordable prices.

We want to work across sectors and with providers to maximise the benefits of early intervention and preventative initiatives, building life skills that help people live independently and healthily for longer. This is an investment in better outcomes for people, which will enable them to contribute to the community and the local economy, build stronger neighbourhoods, have better futures for themselves, and reduce the cost of dependence on health and social care services. It will contribute to the wider agenda of building a stronger economy, bringing more jobs to Portsmouth, reducing inequality and promoting localism.

The Council will work to influence and support the market to develop these characteristics and to attract new providers and investment. We anticipate that Government funding will continue to reduce in the foreseeable future and that we will need to encourage and stimulate local businesses, investors and social enterprises to enter the health and social care market place as providers or funders. Along with our commissioning and provider partners, we will monitor quality, outcomes and value for money.

2. Background

2.1 National context

The Care Act[1] places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

Our key drivers are similar to those that are driving public sector delivery elsewhere. These can be summarised as financial, legislative and quality within a constantly moving environment, increasing vulnerable population and changing expectations.

National public policy is a significant driver of local authority commissioning intentions and behaviour. For a number of years public policy has encouraged greater personalisation of health and social care. This policy is not only radically altering the nature of care and how it is provided; it will also transform the role (and therefore structures) of the NHS and local authorities for many years to come. Commissioners must ensure that local markets are able to respond flexibly to make greater personalisation a reality. This will mean offering people more choice and control over the care, treatment and support they receive while at the same time maintaining the quality and safety of those services.

[1] The Care Act 2014 is explained at https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets

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The Government introduced new policy and legislation that will have a fundamental impact on the way in which public health, health services and social care are delivered. These changes included giving local authorities, through HWBs, a new role in encouraging joined-up commissioning across the NHS, social care, education, public health and other local partners.[2]

The NHS Forward View 2014[3] and the NHS Call To Action 2013[4], sets out the challenges facing the NHS. This includes more people are living longer but often have more complex conditions. This increases costs for the NHS at a time when funding remains flat but expectations as to the extent and quality of care continue to rise. As things are, a funding gap nationally of £30 billion has been predicted between 2013/14 and 2020/21; this is on top of the £20 billion of efficiency savings the NHS is already working towards meeting.

The NHS Forward View 2014 recognises that the NHS has performed remarkably well despite the biggest financial challenge in its 66 year history. However it articulates that there is a need for change addressing the three gaps:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

The paper describes the vision for the future and the journey to get there including making the case for additional government funding. It calls on all partners in the system to work together to implement change.

The key point of the Call to Action is that the health and care system needs to do things differently and challenge the status quo. There is a need to embrace new technologies and treatments, but there is a cost attached and thought needs to be given to delivering services in a different way with less focus on buildings and more on patients and services. The Better Care Fund[5] is an example of how different approaches are being developed to meet the challenge locally, and more broadly this strategy shares the same goals as the Call to Action.

No Health without Mental Health[6] is the government's mental health strategy, emphasising parity of esteem for mental health. This means giving equal weight to both physical and mental health, with mental health outcomes being seen as central to the four national outcomes frameworks (Public health, adult social care, CCG and NHS). The implementation framework of the strategy suggested local mental health needs should be reflected in local plans. The idea of parity of esteem between physical and mental health is not new, but was made an explicit duty on the Secretary of State through the Health and Social Care Act 2012. In March 2013, the Royal College of Psychiatrists published a report into achieving parity, writing that a “parity approach should enable NHS and local authority health and social care services to provide a holistic, ‘whole person’ response to each individual, whatever their needs.”

The Marmot Review[7] highlights that our health and wellbeing is influenced by a range of complex and interacting factors - "the determinants of health". These are the conditions in which people are born, grow, live, work and age such as housing, income, education, social isolation, disability and social status. Improving the health and wellbeing of local people includes taking action across a wide range of these layers of influence and a joint strategy that shapes the commissioning decisions of key parts of the health and social care system is part of that process. The Marmot Review made six key policy objectives: give every child the best start in life; enable all children, young people and adults to maximise their capabilities and have control over their lives; create fair employment and good work for all; ensure a healthier standard of living for all; and create and develop healthy and sustainable places and communities and strengthen the role and impact of ill health prevention.

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[2] The Health and Social Care Act 2012: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted http://www.england.nhs.uk/ourwork/futurenhs/

[3] http://www.england.nhs.uk/ourwork/futurenhs/

[4] The NHS belongs to the people: a call to action: http://england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf

[5] https://www.portsmouth.gov.uk/ext/news/portsmouth-better-care-launches-to-join-up-health-and-social-care.aspx

[6] 4 No Health Without Mental Health https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

[7] Institute of Health Equity. Fair Society, Healthy Lives: http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

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The council wants to work with community providers to develop services that help to keep people well and independent and identify local support that can help people to access these services. The council, working with the NHS, will look to provide a range of services which are aimed at reducing needs and helping people regain skills, for example after a spell in hospital. The council wants to work with service providers in both the private and voluntary sector along with healthcare commissioners to help to stimulate and shape the market for personal care, social care, (public) health and related housing and support services. The council will continue to deliver some of its statutory duties on behalf of citizens, through the commissioning of services from external organisations. Future investment will also be targeted toward preventative services that reduce further demand and improve health and social care outcomes for our citizens.

The council and the CCG have a joint statutory duty to produce a Joint Strategic Needs Assessment (JSNA) to inform all health and social care planning. The JSNA (https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf) directly informs the Health and Wellbeing Board's Joint Health and Wellbeing Strategy.

The NHS Outcomes Framework 2015/16[8] is a set of 68 indicators which measure performance in the health and care system at a national-level. It is not intended to be an exhaustive list of health indicators; it is a set of outcomes that together form an overarching picture of the current state of health and care services in England. The NHS Outcomes Framework indicators are grouped into five domains which set out the high-level national outcomes that the NHS should be aiming to improve.

The domains are:

- One - Preventing people from dying prematurely,
- Two - Enhancing quality of life for people with long term conditions
- Three - Helping people to recover from episodes of ill health or following injury
- Four - Ensuring that people have a positive experience of care
- Five - Treating and caring for people in safe environment and protecting them from avoidable harm

For each domain, there is a small number of overarching indicators followed by a number of improvement areas. Overarching indicators are designed to cover the domain as broadly as possible. Improvement area indicators are included to target those groups not covered by the overarching indicators and/or where independent emphasis is merited. See Portsmouth JSNA for information about Portsmouth's performance on NHS Outcomes Framework, Adult Social Care Outcomes Framework, CCG Indicator dataset and PHOF http://data.hampshirehub.net/data/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/links-between-outcomes-frameworks.

The Public Health Outcomes Framework for England, 2013-2016[9]; In *Healthy Lives, Healthy People: Update and way forward*[10] the Government promised to produce a number of policy updates setting out more detail on the new public health system. The Public Health Outcomes Framework (PHOF) sets out the broad range of opportunities to improve and protect health across the life course and to reduce inequalities in health that still persist. See Portsmouth JSNA for information about Portsmouth's PHOF: http://data.hampshirehub.net/data/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/public-health-outcome-frameworks

The Adult Social Care Outcomes Framework 2015/2016[11] (ASCOF) is the Department of Health's main tool for setting direction and strengthening transparency in adult social care. The framework was first published in March 2011, and since then has been kept under constant review to ensure a continued focus on measures that reflect the outcomes which matter most to users of adult social care services and their carers.

A table showing shared and complementary measures in the Health and Social Care Outcomes is at Appendix one. See Portsmouth JSNA for information about Portsmouth's performance on ASCOF, NHS Outcomes Framework, CCG Indicator dataset and PHOF http://data.hampshirehub.net/data/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/links-between-outcomes-frameworks

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216142/dh_129334.pdf
[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/375431/ASCOF_15-16.pdf

2.2 Local context

The Portsmouth Joint Health and Wellbeing Strategy[12] (see Appendix Four) is the mechanism for Portsmouth City Council (PCC) and Portsmouth Clinical Commissioning Group (PCCG) to address the needs identified in the Joint Strategic Needs Assessment (JSNA) [13], by setting out agreed priorities for collective action by the key commissioners – the local authority, the Clinical Commissioning Group and the NHS Commissioning Board. It is also an opportunity to identify how wider health related services could be more closely integrated with health and social care services. Local government and the NHS have a long and successful history of collaboration and cooperation, with other partners, communities and organisations across the city. We want to build on the civic pride and strong sense of identity that comes with living, working and visiting in Portsmouth to make significant improvements to the health and wellbeing of our local population.

NHS Portsmouth Clinical Commissioning Group (CCG) is led by five local GPs who are elected to represent all the GP surgeries in Portsmouth. Portsmouth Clinical Commissioning Group have a vision for Portsmouth residents to live longer and healthier lives, this is detailed in their 5 year plan to improve health and wellbeing in Portsmouth.[14] Portsmouth Clinical Commissioning Group have chosen four priorities[15] for the next five years, which reflect the whole spectrum of health needs in the city and apply equally to children and adults. *We believe concentrating on these priorities will make a difference to people's lives.*

- **Priority 1.** We want everyone to be able to access the right health services, in the right place, as and when they need them.
- **Priority 2.** We will ensure that when people receive health services they are treated with compassion, respect and dignity and that health services are safe, effective and excellent quality.
- **Priority 3.** We want health and social care services to be joined up so that people only have to tell their story once. People should not have unnecessary assessments of their needs, or go to hospital when they can be safely cared for at home or stay in hospital longer than they need to.
- **Priority 4.** With our partners, we will tackle the biggest causes of ill health and early death and promote wellbeing and positive mental health'

Our Regeneration Strategy 'Shaping the Future of Portsmouth' is the driving force behind the economic, social and physical regeneration of Portsmouth and sets out our vision to be a great waterfront city. The city is in line for more than £1billion worth of investment in the next 10 years and will see new homes, the regeneration of Tipner and a new city centre amongst other things. Factors such as poor health and living conditions affect individuals and families' capacity to drive forward the economic growth of the city and participate in the benefits it brings.

What do we mean by health and wellbeing? In 1946 The World Health Organisation defined health as*, '… a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*'. All aspects of our everyday life have an impact on our health and wellbeing[16]. Portsmouth's Health and Wellbeing Board jointly agreed five strategic priorities to meet the most significant health and wellbeing needs identified by the JSNA. These are:

1. Giving children and young people the best start in life
2. Promoting prevention
3. Supporting independence
4. Intervening earlier
5. Reducing inequality

2.3 Portsmouth adult social care budget

[12] https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf
[13] You can explore the JSNA at: http://protohub.net/jsna/portsmouth-jsna/
[14] http://www.portsmouthccg.nhs.uk/Downloads/Portsmouth%20CCG/2020%20Vision%20Brochure%20Web%20Version.pdf
[15] http://www.portsmouthccg.nhs.uk/clinical-priorities/
[16] Barton H and Grant M, 2006. A health map for the local human habitat. The Journal of the Royal Society for the Promotion of Health. November 2006 126: 252-253

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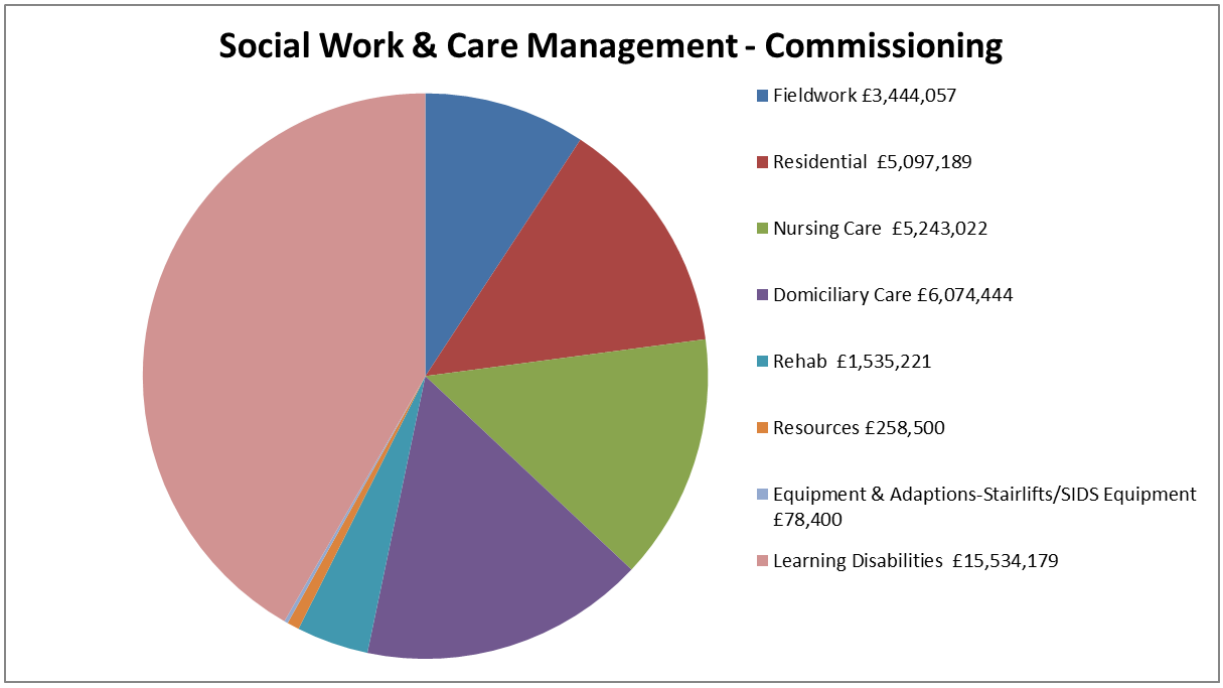
Local government has faced unprecedented cuts over the last four years that have impacted dramatically on adult social care and its capacity to deliver. The impact is ultimately felt by people who use social care services.

The short-term looks increasingly difficult. The scope for further savings is now reduced and at the same time the full impact of the Care Act can only be estimated but is expected to be high.

Portsmouth Adult Social Care currently has a gross budget of £62m. The commissioning budget is currently distributed as follows:



2.4 Portsmouth demography

Portsmouth is an island city on the south coast of England, with an estimated resident population of 205,000 people within 15.5 square miles. This makes Portsmouth the most densely populated city in the UK outside London. Six per cent of the city's population are aged 0-44 years; 11% are aged 5–14 years, 7% are aged 15 – 19 years, 62% are aged 20–64 years and 14% are aged 65+ years. Largely as a result of the large student population in the city, Portsmouth has nearly twice as many young people in their early 20s as the England average (the 20–24 years age group account for 12% of the city's population compared to 7% of the England population). The CCG's registered patient population is approx. 218,700, which is larger than the resident population as Portsmouth CCG has registered patients who resided outside of the city boundaries.

In terms of ethnicity, 84% of the population is White British, with the BME community accounting for an estimated 16% of the population. Between 2014 and 2021 Portsmouth's resident population is projected to grow by nearly 4%[17]. The 85+ year's population is projected to see the greatest increase - by 17% (to 5,200). The increases in the older age ranges will impact on carers and on local statutory and voluntary services.

The Office for National Statistics groups Portsmouth with other areas with a similar socio-economic profile - Public Health Outcomes Framework Indicator 'Overarching Indicators and Improving wider determinants of *health'*[18]*.* Portsmouth is ranked within the top three authorities in a number of areas including: school readiness, the gap in the employment rate between people with long term conditions and the overall employment rate; lower rate of hospital admissions for unintentional and deliberate injuries for young people;

[17] https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf

[18] https://hampshirehub-files.s3.amazonaws.com/PHOFTartanAug2014Rk.pdf

excess weight in adults; alcohol-related hospital admissions; infant mortality and hip fractures for the over 80s. To see the

However, Portsmouth has a significantly higher level of overall deprivation than the England average. The health status of people in Portsmouth is generally worse than the England average and that there are significant health and wellbeing inequalities. The city performs comparatively poorly on key outcomes including GCSE achievement, violent crime, people killed or seriously injured on the roads, smoking, and alcohol. Levels of children overweight or obese increase during primary school years (from 23.3% in Year R to 33.6% in Year 6). Portsmouth also has high rates of diabetes-related amputations. However, alcohol-attributable hospital admissions are declining.

Almost half of all deaths in Portsmouth are caused by heart disease, stroke, cancers and respiratory conditions. Compared to England, Portsmouth has significantly higher rates of mortality that is considered preventable (mainly by adopting healthier lifestyles) for all these conditions.

Portsmouth's JSNA[19] found that frontline statutory and voluntary services are reporting increasing numbers of people are in debt and needing support. Portsmouth has 14 electoral wards and there is a geographical correlation between the most deprived areas (Charles Dickens, Paulsgrove, Nelson and St Thomas wards) and poorer health status. Poverty affects over half of children and of older people in the most deprived areas. Inequalities also exist between genders, with males in the most deprived areas living about six years fewer than females in the most deprived areas, and living about 2.5 years fewer in the least deprived areas.

For those with conditions or diseases, compliance with health interventions can prevent or slow disease progression and enable people with long term medical conditions (e.g. heart attack, stroke, exacerbations of COPD, asthma and some hyperglycaemic episodes) to be stable and have fewer unplanned acute admissions. Many studies have found increased health and social care costs associated with poor compliance. Increases in both finance related to greater health treatment costs and reduction in quality of life both can be attributed to poor compliance and the associated unplanned treatment of exacerbations and critical events[20]. In Portsmouth there are 13,551 people over the age of 75 years with an estimated 4,900 people prescribed four medicines or more. Approximately 2,140 Portsmouth residents have some form of dementia (55% (1178) will have mild dementia, 32% (685) moderate dementia, and 13% (279) severe dementia). Effective support from the third sector, social care or NHS can deliver, for example, medical compliance and thereby reduce the need for costly admissions to the acute sector.
We are facing significant challenges due to longer life expectancies, lifestyle changes, demand for better choice and quality and a tough economic climate. 2013 saw an increase in GP, community nursing, and dementia appointments as well as an increase in the number of emergency hospital attendances. With growing demand for healthcare services, and decreasing resources, work needs to focus on targeting the biggest health and wellbeing issues affecting people in Portsmouth. The Portsmouth JSNA found that in order to address the known issues in Portsmouth, work should focus on:

- Promoting healthy lifestyles for young people and adults;
- Continuing to improve GCSE attainment;
- Working with communities
- Early intervention;
- Tackling poverty, and;
- Improving the health and wellbeing of males.

2.5 Portsmouth City Council policies and strategies

To access the Council's Policies and Strategies, and to understand the key differences between a policy and a strategy, use the web link below:
www.portsmouth.gov.uk/ext/the-council/policies-and-strategies/our-policies-and-strategies.aspx

[19] www.jsna.portsmouth.gov.uk
[20] (York Study 2010) -Estimating the Cost of Waste Medicines in the National Health Service Chapter 5 The Economic Impact of Poor Compliance

3. Emerging areas of work

3.1 Better Care Fund

The Better Care Fund[21] is a Government initiative intended to transform health and social care services so that they work together to provide better integrated care. By pooling existing local funding it promotes joint planning for the sustainability of local health and care economies. This workstream will support the delivery of 'Better Care', a programme of health and social care initiatives in Portsmouth focused on older people and other adults with complex needs to be met by the NHS and adult social services.

The Better Care Fund, which combines £16 million of funding from Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group, takes effect from April 2015. The event builds momentum behind the plans for investing in services, particularly helping frail older people and adults with disabilities, so that people stay well, independent and hospital admissions reduce.

There are four main agenda's under the Portsmouth Better Care plan;

- Integrated locality teams
- Reablement services
- Reviewing our bed based provision
- Prevention support

One of the key workstreams within BCF relates to 'Integrated Locality Teams'. Under the BCF plan for integrated localities, we will move over time to co-locate and then integrate staff teams from the Council's Adult Social Care with teams from Solent NHS Trust.

The integrated localities project22 builds on earlier work in the city to integrate elements of health and social care - for example Portsmouth Rehabilitation & Reablement Team (PRRT), Continuing Health Care (CHC), and the virtual ward pilot schemes. Similarly, the Adult Learning Disability Team, the Adult Mental Health Teams, community occupational therapy (OT) staff from both adult social care and Solent are co-located and work to a largely integrated model. However, social workers, OTs and other staff employed by the Council currently work separately from colleagues in community nursing, physiotherapy and older person's mental health (OPMH), all of which are provided by Solent NHS Trust. Although staff in all teams work hard to ensure good communication when they are working with clients with multiple needs, this is made more difficult by the differences in the working arrangements, which include:

- Geographical model - adult social care community teams are split into North and South, whereas nursing staff are split across three localities.
- IT - social care and health teams record their interactions with clients on separate IT systems that are not currently inter-operable.
- Funding Model - health services are free at the point of use, whereas adult social care services can be chargeable, subject to means-testing.
- Case management and assessment - All teams work to slightly different case management and assessment processes and have their own data recording processes.

It is anticipated that the council' Adult Social Care Team and Solent NHS Trust will continue to work on integrating operational process into 2016/17. Once developed, the integrated model will enable practitioners to operate in informal teams around the client, with lead professionals able to pull on resources within the team to assist in complex cases, rather than making formal referrals across organisational boundaries, as at present.

3.2 Prevention

Future funding will be targeted to prevent avoidable harm to vulnerable people, and prevent deterioration to a point where social care intervention is required, wherever possible. For example, it is commonly acknowledged that some unplanned hospital admissions of older people may be reduced through earlier intervention in the

[21] https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf, Priority 3
[22]http://democracy.portsmouth.gov.uk/documents/s7044/hsc18Mar15DM%20BCF%20Integ%20Locality%20Teams.pdf

community. ‘Unplanned admissions of older people: exploring the issues’[23] explored the work of nine English councils that agreed to work in partnership with health and third-sector organisations to achieve the ‘headline target’ of a 20% reduction in Emergency Bed Days for people aged 75+ years, over a three-year period, and those admissions often led to very poor outcomes, including admission to long-term care. Services therefore need to be realigned to 'face the front door' (i.e. prevent admissions) of the hospital rather than the back door, alongside greater use of each community's own asset bases that can prevent needs from escalating and develop a more sustainable community and peer-led resilience required to manage life events.

3.3 Personalisation and Integrated Personal Commissioning

In the future the council will only invest in services that can show personalised outcomes for citizens that are both effective and affordable. We will challenge providers to work with us to demonstrate effective, affordable personalised outcomes - an evidence-base that has been talked of nationally for some time yet no clear methodology exists.

Building on the foundations of BCF, from April 2015 Portsmouth CCG and Portsmouth City Council will participate in the pilot Integrated Personal Commissioning (IPC) programme as one of nine pilot sites nationally, working with a range of provider stakeholders to co-design and co-own actions identified from integrated health, care and support plans. These integrated plans place the customer central to decision-making on products and services that will their improve health and well-being and could include pre-existing products or services; the challenge to all potential IPC stakeholders will be to develop products and services that can meet the needs of individual customers where pre-existing products or services are not desired or do not meet the need identified.

Alongside the production of integrated plans, the IPC programme will be developing an integrated financial model that will draw together funding sources from health and social care, providing a pooled budget that will be offered to a small cohort of older people with long term conditions in year one before being rolled out to other vulnerable groups. It is hoped through the IPC that take up of personal budgets will increase; to do so will require significant market stimulation and development, and improved provision of infrastructure support to provide Managed Accounts services.

3.4 Partnerships and collaboration

It is envisaged that in future, many services will be delivered via partnership arrangements. Provider organisations, including those in the statutory sectors of health and social care, will be encouraged to develop formal and informal collaborations and integrated services. Co-production (involving citizens, their families and carers in the design, delivery, monitoring and review of services) will be treated as a priority. New service delivery vehicles, including social enterprise, trading arms and co-operatives, will be supported where they will deliver value for money and better outcomes, and commissioners will work to engage business and commercial enterprises where that will strengthen the market and provide greater choice and other opportunities for local people.

3.5 Social value

In the past the successful commissioning of care arrangements was sometimes seen as an end in itself. In future, greater emphasis will be placed upon investment models that promote independence and reduce individuals’ dependency upon support and public funds. Commissioners are now required to build social capital within communities, stimulate enterprise and promote co-produced care and support. Organisations providing services are encouraged to evidence the ancillary benefits to the wider community of their activities in the form of social value. What are the economic, social or environmental benefits to the community of a proposal, e.g. creating local jobs, increasing volunteering opportunities or improving environmental conditions? PCC's approach to economic social value prioritises job creation and skills training, including apprenticeships, so evidence could include the use of apprentices, utilising a local supply chain or employing a local workforce.

[23] http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1618-136_V01.pdf - National Institute for Health and Research - '**Unplanned admissions of older people: exploring the issues'** Henderson, Sheaff, Dickinson, Beech, Wistow, Windle, Ashby and Knapp 2011.

3.6 Co-production

Numerous research has demonstrated that there are improvements in compliance and engagement *if* the individual has been involved in the decision-making, to the degree in which they feel able, and supported to have their voice heard. This is true both within and outside health and social care. Personal empowerment has long been a Portsmouth City Council commitment, alongside genuine co-production which not only involves the individual, but brings together all relevant stakeholders. As an equal partnership, we seek to design, develop and deliver services; in this way, use of each other's' assets and resources is maximised to improve efficiency and effectiveness, and achieve better outcomes.

3.7 Current provision and potential for development

Our priority is to support people to retain their independence for as long as possible, delaying or even avoiding the need for care. Preventative services to enable independence can include universal services such as information and advice, leisure, recreation, reablement, telecare/telehealth. Utilising individual and community assets, such as existing and expanding networks of support offers considerable potential to regaining and/or retaining independence. Given the scope of reduction to public sector funding, which in turn can lead to provision of reactive care, it is felt there is considerable capacity to increase the volume of preventative services and use of community and individual assets through a range of delivery vehicles and models. This includes increasing up-take of personal health and social care budgets that enhance choice and control.

4. Predictions of future demand, identifying key pressure points

The vision for Portsmouth City Council is to improve health and wellbeing by encouraging more people to adopt healthy lifestyles and to seek help and advice earlier when problems arise. We need more people of all ages to do this if we are to achieve the level of health improvement needed. The figures in the table below do not take these plans into account. Evidence shows the average lifespan is increasing within the general population, with improved treatments and outcomes enabling people with disabilities and health conditions to live longer. However, inevitably this will put additional pressure on services and budgets.
Locally, we expect to see an increase in our vulnerable person populations (tables overleaf).

Table 1

Predicted population aged 65+ years, Portsmouth	**2015**	**2020**	**2025**
Total Population 65 years and over	**29,900**	**31,900**	**40,400**
Population aged 65 -79 years	21,500	22,600	25,100
Population aged 85 years and over	8,400	9,300	10,400
Population aged 65 years and over predicted to live in a care home with or without nursing	800	869	999
Population aged 65 years and over predicted to have dementia	2,181	2,373	2,710
Population aged 65 years and over predicted to be admitted to hospital as a result of falls	622	680	784
Population aged 65 years and over unable to manage at least one mobility activity on their own	5,622	6,017	6,756
Population aged 65 years and over unable to manage at least one self-care activity on their own	10,175	10,853	12,201
Population aged 65 years and over unable to manage at least one domestic task on their own.	12,350	13,238	14,880

Predicted population aged 65+ years, Portsmouth	2015	2020	2025
Population aged 65 years and over predicted to have a learning disability	618	665	738
Population aged 65 years and over predicted to have autism	278	299	338
Population aged 65 years and over predicted to be providing unpaid care to a partner, family member or other person	3,949	4,142	4,617
Population aged 65 years and over predicted to be living with a limiting long term illness whose day-to-day activities are affected a lot (a little	(7736) 7,457	(8,281) 8,018	(9,305) 9,079

Source: Projecting Older People Population Information System (POPPI)

Compared to other age groups, older people are high users of domiciliary, extra care and reablement services. There is ample opportunity to increase take up of Shared Lives, direct payments and innovative services designed in and around the person's community, utilising their existing and potential networks of support.

Table 2

Predicted population of adults aged 18-64 years with a learning disability or Autism Spectrum Disorder (ASD), Portsmouth	2015	2020	2025
Total Population 18-64 years	**138,500**	**141,500**	**142,800**
Population aged 18-64 years predicted to have a learning disability	3,422	3,493	3,535
Population aged 18-64 years predicted to have a moderate or severe learning disability and hence likely to be in receipt of services	780	796	809
Population aged 18-64 years predicted to have a severe learning disability and hence likely to be in receipt of services	214	218	222
Population aged 18-64 years predicted to have a learning disability and predicted to display challenging behaviour	62	62	64
Population aged 18-64 years predicted to have Down's syndrome	86	88	89
Population aged 18-64 years predicted to have autism spectrum disorders (ASD)	1,423	1,454	1,470

Source: Projecting Adult Needs and Service Information (PANSI)

People with a learning disability are high users of Shared Lives, day and supported living services; In 2013/14, 480 people aged 18+ years with a learning disability accessed adult social care services with an average age of 40.3 years. Opportunities in provision exist that enables individuals to gain skills that would afford them more equal opportunities in the workplace and community, and we acknowledge this support could come from reassessing individuals and their existing and potential networks of support, identifying and utilising strengths. We recognise Autism Spectrum Disorder (ASD) is a developmental condition, not a learning disability or mental health problem (though those with ASD may also have a learning disability and/or mental health problem). There are currently few community-based services targeted at those with ASD - , many of whom have the potential to lead independent lives with appropriate support, and great strides have recently been made in the use of technology to enable this.

Table 3

Predicted population of adults aged 18-64 years with a physical disability, Portsmouth	2015	2020	2025
Total Population 18-64 years	**138,500**	**141,500**	**142,800**
Population aged 18-64 years predicted to have a moderate physical disability	9,725	10,168	10,138
Population aged 18-64 years predicted to have a serious physical disability	2,706	2,882	2,950
Population aged 18-64 years predicted to have a moderate or serious personal care physical disability	5,506	5,832	5,942
Population aged 18-64 years predicted to have a longstanding health condition caused by a stroke	348	363	360
Population aged 18-64 years predicted to have either Type 1 or Type 2 diabetes	3,871	4,085	4,126
Population aged 18-64 years predicted to have a serious visual impairment	90	92	93
Population aged 18-64 years predicted to have a moderate or severe or (profound) hearing impairment	4,353 (37)	4,703 (41)	4,774 (42)

Source: Projecting Adult Needs and Service Information (PANSI)

Those with physical disabilities are high users of domiciliary care services. In 2013/14, 535 people with a physical disability accessed adult social care services, with an average age of 51.4 years. Significant opportunity exists to better utilise technology to learn, regain and retain daily living skills that previously have required support.

Table 4

Predicted population aged 18-64 years with a mental health problem, Portsmouth	2015	2020	2025
Total Population 18-64 years	**138,500**	**141,500**	**142,800**
Population aged 18-64 predicted to have a mental health problem:			
Common mental disorder	22,129	22,605	22,804
Borderline personality disorder	616	629	635
Anti-social personality disorder	497	508	513
Psychotic disorder	549	561	566
Two or more psychiatric disorders	9,958	10,173	10,266
Population aged 18-64 years predicted to have a substance misuse problem:			
Drug	4,761	4,865	4,912
Alcohol	8,437	8,622	8,708
Predicted mortalities of people aged 18-64 years from suicide:			
Male	8	8	8
Female	3	3	3
Population aged 18-64 years predicted to be survivors of childhood sexual abuse:			
Male	5,012	5,124	5,180
Female	10,704	10,928	11,008

Predicted population aged 18-64 years with a mental health problem, Portsmouth	2015	2020	2025
Population aged 18-64 predicted to have early onset dementia	45	50	52

Source: Projecting Adult Needs and Service Information (PANSI)

Those with mental health problems are high users of tailored mental health services, advocacy and supported living. In 2013/14, 817 individuals with a mental health problem accessed adult social care services (excluding advocacy where a breakdown is not available except for condition-specific services such as Independent Mental Health Advocacy and Deprivation of Liberty Safeguards) and 71 accessed substance misuse services with an average age of 46.8 years. Whilst a number of individuals will have enduring mental health problems, for others, their mental health needs will be short term. The challenge is to support the needs of those with long term mental health problems as well as addressing the short term mental health needs many are likely to experience, using a recovery-based model that will promote self-resilience to reduce likelihood of need in later life.

5. Public Health

Public health is currently reviewing their health and lifestyle services. Over the next two years, Public health is looking to further develop their model of smaller wellbeing services that are currently commissioned from GP's and pharmacies. The intention is to invite other providers in the future to tender for these services; especially from the voluntary and community sector based in local communities. Further information about the development of the wellbeing hubs can be found in the 'Joint Health and Wellbeing Strategy: Working better together to improve health and wellbeing in Portsmouth 2014-2017, page 15, section 3b'.[24] A review of Portsmouth sexual health services is underway, with a procurement tender due in 2018. Portsmouth Substance Misuse services are currently being remodelled over the next two years and work is underway to remodel the public health children's services; the aim being to develop multi agency teams to strengthen and improve services that will deliver the Healthy Child Programme[25]/ [26].

6. Portsmouth adult social care services

Portsmouth Adult Social Care[27] supports people aged 18 years and over to live independently or when that becomes difficult, to help choose the most appropriate way in meeting longer term care needs. A person may need care and support for a number of reasons, perhaps as a result of a physical or learning disability, mental health condition, or help with personal care as a result of growing older. We also support carers who look after someone else. We work with individuals to provide or arrange the services of their choice that will help to maximise their independence and prevent loss of independence in the future[28].

Within this MPS analysis of utilised capacity has focused on 2013/14, unless otherwise stated, as the most recent year verified data is available. (It is noted that, where necessary due to the provision of integrated/shared health and social care services, some services detailed in this section are health services.)

Although not considered an option due to the drivers for change, consideration of a 'stand-still' state of all services would still provide significant opportunity to improve, enhance and extend provision, as population needs are predicted to grow across all areas.

6.2 Four tiers of support

The services we provide, or help to arrange, fall into the following four tiers of support.

[24] https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf

[25] https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

[26] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_107566

[27] https://www.portsmouth.gov.uk/ext/health-and-care/socialcare/adult-social-care.aspx

[28] https://www.portsmouth.gov.uk/ext/health-and-care/socialcare/adult-social-care---help-with-specific-conditions.aspx

1. Early Intervention and Prevention: To make sure that everyone has access to reliable and up to date information and advice on care and support in Portsmouth. To make sure that people who pay for their own care feel supported to make informed choices. To encourage and support communities to be self-supporting and help individuals and families plan for, and maintain, their lifelong wellbeing.

2. Short-Term Care and Reablement: The Local Authority and health service will offer rehabilitative services in the community through services within the home and in short stay community beds with the aim of enabling people to live more independently for longer. Short term care is also available, for example, for people who may need support returning home from hospital or for carers who may need support through respite services.

3. Long-Term Care and Support: To support people in choosing the type of support that will meet their needs and how that will be delivered, be that through domiciliary care, day care support, residential or nursing care, including planned respite.

4. Safeguarding: The local Authority and health services will work with service users and partner organisations in order to put measures in place that reduces risk of abuse and investigate safeguarding concerns in relation to vulnerable adults as they arise, be that financial, institutional, emotional or physical. Safeguarding investigations will be undertaken within the framework of Making Safeguarding Personal.

6.3 Residential care

Portsmouth City has 10 nursing homes (including three supporting those people requiring rehabilitation before resettlement elsewhere), and 42 residential and care homes providing regulated services. Of homes tailored towards older people, almost 90% of bed spaces are available to those with dementia, whilst only 10% specialise in older person's learning disabilities. For those supporting residents of working age, seven homes provide for those with learning disabilities, two provide for physical disabilities and three for mental health conditions (two homes provide for more than one care group). This is in accordance with our approach in recent years, supported by government and legislation, to move individuals out of residential settings and provide individuals with support to live and participate in the, with approximately 55% currently in residential settings. Four residential homes for long term care, including provision of respite and rehabilitation services, are provided by Portsmouth City Council, with the remainder being provided by private or voluntary sector providers[29]. The council currently purchases 396 residential and 264 nursing beds (older people) and 183 residential and 9 nursing beds (working age people).

A number of care homes are in single ownership and some of these providers have stated that when the property market improves, they intend to retire and sell their property. It has already been identified that some of these homes are not viable mainly due to size but some are in a poor state of maintenance.

Our needs within regulated residential care, whether for assessment, short term or longer term placement, are more considerably focussed on those with high/more complex needs and co-morbidities, combining both residential and nursing care, particularly in the fields of adult mental health, physical disabilities and acquired brain injury (ABI). We would be keen to work with existing or new providers to increase this service provision offer. These areas reflect the increase in people affected by, for example, Korsakoffs syndrome, Huntingdon's disease, and conditions resulting in ABI, and aftercare provided under Section 117 (Mental Health Act, 1983).

There are increasing numbers of out of area placements, and though it is not expected Portsmouth will provide local nursing/residential placements to meet all needs, we are particularly keen to increase and enhance local service provision for those with challenging behaviour, building on commissioning work currently being undertaken to provide services for older people with co-morbidities and challenging behaviours.

6.4 Extra care

Extra Care is a modern, affordable alternative to residential and nursing homes. Extra Care comprises self-contained accommodation specifically designed to support those living with a disability or who are frail and with the availability of 24hr on-site care and support services to enable self-care and independence. Extra

[29] www.cqc.org.uk, February 2015

Care is available to shared home ownership and tenants, and couples or friends can continue to live together in this facility. Typically the care and housing services are delivered by different providers, mitigating the risk of monopolising the market place. Facilities and services, additional to domiciliary care provision, can include lunch clubs/meal provision, laundry services, assisted bathing, social activities, healthcare clinics and a hairdressing salon - such facilities and services are chargeable, therefore if a service has sufficient interest from residents, there is scope for a provider to set up additional services.

The city's 243 Extra Care apartments are managed by a registered social landlord, and eligibility criteria apply. We would like to explore the expansion of Extra Care, including provision for those less than 55 years in age, as an opportunity to meet increasing needs.

6.5 Sheltered housing

Alongside Extra Care, we also provide approximately 1,500 sheltered accommodation properties, designed or adapted to meet the needs of older or more vulnerable people. Mainly one-bedroomed flats, but also including bedsits, two-bedroom flats and a limited number of bungalows, Sheltered Housing accommodation differs from Extra Care in the level of on-site support and facilities available. All properties are linked to a 24 hour alarm system; some have communal lounges and laundry facilities, some have a general manager available on site during office hours and some accommodations share facilities. Specifically for older people with higher support needs but who do not meet the eligibility for Extra Care, we provide 7 properties in the city that:

- Have communal facilities, such as lounge, dining area and laundry room;
- Have private bathrooms. Some offer assisted bath or showers, such as Parker baths and wet rooms;
- A manager and support assistants on site 24 hours a day;
- Support staff able to prepare and provide a heated meal if requested;
- Can arrange for domestic support such as cleaning, and;
- Have a pull cord alarm call system in place.

6.6 Reablement

Reablement services are a cost-effective route to better outcomes and provide a period of support to enable the person to reach their maximum level of independence through developing confidence and skills, and, by doing so, aim to reduce avoidable admissions to hospital and residential settings. In 2013/14 a range of reablement services were piloted and, in 2014/15 following an evaluation of their impact and an analysis of current gaps in availability, 18 services were funded via a voluntary sector grants programme to increase the variety of schemes, alongside the funding of the Portsmouth Rehabilitation and Reablement Team (PRRT). PRRT is a joint service funded by Portsmouth City Council and NHS, with the majority of the roles provided by the local authority.

These diverse services included reablement support for those with memory loss and/or dementia, home from hospital support including transport, drop-in centres, telecare (targeting medicines compliance), a sensory impairment course, lunch clubs and other social activities, carer support and advise services. In 2015/16 it is our intention to tender innovative outcomes-based "Support at Home" services that will provide support to help people settle at home following discharge from acute settings. These services will complement the provision provided by PRRT.

PRRT currently provides two distinct services: rapid response and reablement. Rapid response, provided by a multi-disciplinary clinical and non-clinical team, is an at home triage service, used when an individual is in crisis but a hospital admission can be avoided through effective home triage and care package provision. The reablement function of PRRT provides up to six weeks of intensive reablement support to increase confidence and maximise independence. Alongside this provision, we fund a home-from-hospital service, providing transport, resettlement and immediate care needs, and a maintenance support programme, keeping in contact with those individuals following a safe return home to avoid re-escalation.

In 2014/15 reablement services from the VCS funded through the Council were provided to over 1500 cases in the city, with considerable savings (in time and finances) to the NHS and local authority through an expected

reduction in longer term care needs and a reduction in hospital readmissions, as well as improving the quality of life for those involved.

Within the city, we provide step-up and step-down services targeted at preventing avoidable residential or nursing home admissions and reducing the need for longer-term care packages. At the time of writing, 67 community beds are available to residents, alongside 36 beds for older people with mental health needs, and we do not envisage an increase in need due to the success and prioritisation of reablement services and our focus will be to expand the availability of, and breadth of outcomes achieved, via reablement services.

6.7 Domiciliary care

As of February 2015, 36 providers provide domiciliary care services in the home, including three solely specialising in learning disabilities, and supported by community mental, learning disability and physical health provision coordinated from Queen Alexandra, St Mary's, Frimley Park and St James' hospitals.[30]

Portsmouth City Council currently has 11 providers on its domiciliary care framework, providing care in the home services that tend to be traditional in their service offer to customers. In 2013/14, 1689 customers (that Portsmouth wholly or partially funds) and 700 self-funders and partial self-funders (including those with a direct payment "managed budget") who requested PCC arrange their care and support needs were assisted by our framework providers, and almost 74% of these individuals are older people.

With the availability of personal budgets and self-funders there are also opportunities for those providers not currently on our domiciliary care framework and it is estimated there are over 10 additional providers (excluding personal assistants) within the city. Anecdotal feedback from customers suggests provision is more innovative and outcomes-focussed and we encourage further innovation in the provision of outcomes-focused care at home.

Through the Community Care (Direct Payments) Act (1996) individuals are provided with the funding required to purchase their own care and support needs. In Portsmouth approximately 20% (approx. 286 people) of those receiving domiciliary care currently fund their care via a direct payment. As well as contributing to a person's sense of wellbeing and independence, direct payments also provide greater flexibility and freedom for the individual to tailor their care package, creating a personalised service to meet their needs. Following the take-up of direct payments, the market place nationwide has seen the emergence of self-employed personal assistants and, as we encourage greater take up of direct payments, we anticipate the market place responding positively to this with a stronger personal assistant (PA) market developing and growing. In Portsmouth, the PA Noticeboard service has supported 60 individual employers in searching for a PA. Currently, there are 100 PAs fully registered on the PA Noticeboard website, working independently of any organisation, and we recognise the training and support needs that these self-employed people will require to provide a safe, caring, effective and responsive service.

For those unable or unsure of managing a direct payment themselves, there is also the opportunity to place their direct payment, in the form of an individual service fund (ISF) with organisations who manage the direct payment on the individual's behalf, taking responsibility for employee payroll, banking and HR matters. However, there are currently no local organisations providing this service; a significant gap.

We are very supportive of increasing the take-up of direct payments which may be helped with the introduction of managed accounts.

Although we currently have sufficient numbers of providers on our framework, there is recognition that not all providers are able to provide consistency or longevity of care provision, particularly where needs are extensive or challenging. Whether this could be better managed by providers with a larger workforce to enable effective rota management, with specialist providers trained in managing challenging behaviour or whether this could be driven by an increase in personal assistants, with acceptable options in-between is unclear, and we would request that providers identify their solutions for consistency and longevity in provision (of double-ups, challenging behaviour customers, live-in support, multiple day or night visits).

[30] www.cqc.org.uk, February 2015

6.8 Supported living

Our supported living services are commissioned from 10 providers and are designed to empower and enable individuals to remain in their own home, or gain independent living skills to be able to move on into their own home, by providing tenancy-related support, assisting individuals with accessing community facilities and liaising with other services such as the Work Programme to initiate activity. The support provided varies according to need, from half an hour's provision to 24/7 support across a broad range of client groups including homelessness, people with learning disabilities, people with mental health problems, people with substance misuse problems, women fleeing domestic violence, ex-offenders and young people at risk. In 2014/15 over 900 Portsmouth residents received either long or short term housing support services (these services do not include those provided by adult social care only): 70% of those receiving long term housing support services maintained their independence and 86% of those receiving short term services were supported into more independent living.

We recognise the difficulty in shifting cultures for both recipients of services and providers to move towards creating more resilient, self-serving communities and we have identified opportunities to further develop the range of supported living services offered. This could include designing services suitable for group rather than individual purchase, services that better enable self-management of tenancies or services designed to promote greater access to existing community facilities or individual networks of support. This would encourage us to expand our housing provider base, as in-house council colleagues have historically demonstrated a greater ease of introducing flexibility into their model of provision. This is being addressed in areas such as learning disability where work is underway within the local authority Learning Disability Teams to develop a subgroup of interested parties to be involved in the future design of supported living services. This will include service users, providers and local authority directorates.

Individuals are also placed into Supported Accommodation, with floating support provided by our domiciliary care providers. Homes are currently provided by private, not-for-profit and voluntary organisations; at the time of writing, whilst there are numerous voids we are noticing a trend for our RSL partners to move away from providing this type of accommodation and opportunities may exist for providers with assets or who wish to enter the accommodation market. Whilst elsewhere within supported living it is our preference to mitigate risk by commissioning separate providers and landlords, within mental health our preference is to identify landlords capable of care provision for those with challenging behaviour due to their mental health condition/s.

As with the training needs identified within mental health residential and nursing accommodation, tailored mental health training alongside mandatory domiciliary care training would be of considerable benefit to our resident population and is therefore of interest to us.

6.9 Day services for people with a learning disability

Day services provide activities to engage, educate and stimulate in a supportive environment. Services are a mixture of Council operated (Portsmouth Day Services) and externally provided services, and non-council facilities currently utilised are predominantly out of the city, necessitating transportation which not only incurs a financial cost but takes time away from activity participation.

The four Portsmouth Day Service (PDS) centres provide services for adults with needs across the vulnerability spectrum including autism, learning disability, physical disability, mental health and older people. In 2013/14 these centres were attended by 268 working age people for an average of 3.46 days per week and by 311 older people for an average of 2.02 days per week (snapshots as at 31/03/14) for a total of approx. 81,000 'service days'. The range of activity currently provided is dependent on the cohort attending, with a focus on maintaining skills for older people (with skills acquisition being a key driver for working age attendees).

Portsmouth Day Services are embarking on a transformation programme; we would like to work with providers to develop a range of flexible services, whilst achieving the aim of providing meaningful activities and skills to individuals. We want to move towards supported living services for up to a maximum of 8 people; this will be more economical, and also reduce the possibility of housing people with supported living needs in large units; we want people to feel they are part of the normal communities, not stigmatised

We welcome input from providers and service users in the redesign of the Day Care Services. The transformation programme is being designed around the 4 core themes identified by people with learning disabilities: - employment, good health, independent living (choice and control over their life and good housing options) and community inclusion (friends, relationships and community). We recognise that there are alternatives to day services that have yet to be explored - whilst this will form part of the transformation programme, we remain keen to identify, with our partner providers, local opportunities for our most vulnerable residents to engage with, be educated and stimulated via alternative provision.

6.10 Carers

Portsmouth Carer Centre provides a range of services from information and advice, training and employment support, carer assessments, and co-ordination for sitting and respite services in collaboration with public, private and voluntary sector organisations with eligibility being determined based in the impact caring has on the individual and family unit. In 2013/14, the in-house respite service provided a day/weekend respite within a residential setting or take-a-break delivered in the home for 733 individuals. Providers are already responding to a need to develop a range of alternatives to accommodation-based respite. Carer services remain free at present and carer feedback indicates low cost services such as emotional support, a meeting place and facilitating community networks of support are preferred.

It is estimated there are over 17,500 carers in the city, and approximately 25% of these are known to the Carer Centre with over 2000 being provided with a carer's assessment (approximately 44% of these carers care for older people, with the remaining caring for children or adults of working age). Of known carers, the youngest is aged 6 years and the oldest, 104 years. The greatest number of carers are aged between 46 years and 83 years though it is recognised that the impact of caring is not only age-related but with consideration to other lifestyle factors.

We envisage a change in the cohort of carers, with more parents and younger people identifying themselves as carers and seeking support, and recognise a need to further develop and enhance our existing carer service offer. We further anticipate service development aligned with the strategic direction outlined in the independent review of carers' services following approval of the Carers Strategy in 2011.[31] The 11 priorities of the current strategy are based on what Portsmouth carers have told us is important. In support of Priority 11 'Support for children and young people who are carers' we offer carers the opportunity to use prepaid cards for short breaks (currently £25.00) both when they are identified as carers and after assessment as required. A prepaid card is a payment card that is loaded with a cash value. It can be used in a similar way to a credit card for purchases. The Carers' Strategy[32] is currently being refreshed.

6.10 Shared Lives

Shared Lives[33] is an alternative to home care and care homes; a Shared Lives Carer and someone needing support share their lives. For some, this is provided by the person needing support moving into the family home, and for others, the Shared Lives carer is a regular day time or overnight visitor to the person requiring support. Shared Lives is not new to the city - it has been in existence in various forms since 1979 when it began as Adult Placement. In March 2015 we had 46 households (individuals and couples) who offer long stays, short breaks and day support in their family home and 49 Shared Lives beneficiaries with 79% of our Shared Lives beneficiaries permanently living with their Shared Lives carer. Portsmouth's Shared Lives service has an on-going programme to approve new households through an assessment process and we are keen to see the service grow and extend its reach to meet the needs of older people (71% of beneficiaries are those with a learning disability, and whilst we wish to see this service provision grow also, we would like to stimulate the market to respond to the needs of other vulnerable groups).

[31] https://www.portsmouth.gov.uk/ext/documents-external/cou-carers-strategy-appendix4-110713.pdf
[32] Carers strategy - https://www.portsmouth.gov.uk/ext/health-and-care/carers/carers-strategy.aspx

[33] https://www.portsmouth.gov.uk/ext/health-and-care/socialcare/shared-lives-help-for-vulnerable-adults.aspx

6.11 Community Equipment Store

The Community Equipment Store (CES) is a service which loans community equipment (non-medical) to adults and children who are resident within the boundaries of Portsmouth, or those who live outside the local authority boundaries but who are registered with a GP practice in Portsmouth.

The service is jointly commissioned by Southampton City Council and NHS Southampton City CCG, Portsmouth City Council and NHS Portsmouth CCG.

The principal aim of the service is to enable those individuals in need of support, some of whom are vulnerable, to maintain their health, social care and educational needs and well-being in their chosen location for the foreseeable future and to help alleviate risk (e.g. falls, pressure sores), promote independence, prevent delayed discharge, prevent hospital admissions and facilitate end of life strategies.

Goods and services are provided to eligible clients and service users, following an assessment of need from an approved medical/nursing or therapy trained individual (both social and health care).

Equipment ranges from the simple bathing, toileting and mobility items (e.g. bath-boards, raised toilet seats and walking frames/sticks) aiding independence – to more technical and complex pieces of equipment (e.g. beds, mattress systems, electrically operated bathing lifts). Additionally, many of these same practitioners identify needs and refer clients to other installation and adaptation services – these ranging from the simple grab and banister rails to the more complex ceiling tracked hoists, community alarms etc. Equipment provided is supplied to all age groups.

6.12 Advocacy

Advocacy services are currently funded via a block contract arrangement, and include:

Community Advocacy: providing support to secure or exercise their rights, choices and interests to vulnerable people over the age of 18 years.

Independent Mental Health Advocacy (IMHA): providing support to secure or exercise their rights, choices and interests to individuals detained or receiving treatment under the Mental Health Act (1983).

Independent Mental Capacity Advocacy (IMCA): Including IMCA in DoLS: providing support to secure or exercise their rights, choices and interests to individuals designated as lacking the capacity to take decisions as per the Mental Capacity Act (2005) as amended by the Mental Health Act (2007).

Relevant Person Representative: to represent and support people deprived or potentially deprived of liberty safeguard (“the Relevant Person”) as defined by The Mental Capacity Act (2005) as amended by the Mental Health Act (2007).

Appropriate Adult Service: provides independent support as requested by Hampshire Constabulary in Portsmouth to any young person aged 17 and over or to any mentally vulnerable adult who is in police custody.

In 2013/14 almost 1000 episodes of advocacy were provided to Portsmouth residents, with over 50% being for the Appropriate Adult service and almost 15% for the IMHA service. As the introduction of the Care Act enhances the role and requirements of advocacy in the community, and, as our vulnerable persons' population increases, the need for advocacy, including support to self-advocate, is expected to increase also. This is likely to provide a challenge to both us as a Council, and to providers, as advocacy has traditionally been a service area that does not attract self-funders or sit within a commercial model, and we welcome the opportunity to further explore this challenge with suitable providers. In 2013/14 those aged between 30 and 59 were the greatest users of advocacy services.

6.13 Mental health

In partnership with the specialist service provider we are beginning a process of transformation in mental health services to embed a community recovery model. With almost 34% of Portsmouth residential and nursing homes in the city being registered to provide services for those with mental health conditions[34], opportunities exist in addition to direct care provision; that may include the provision of bespoke training to home staff to enhance the service offer already provided and ensure a focus on recovery where that is possible and ensure changing needs and any change in condition is addressed in the most suitable way and in consideration of any co-morbidities.

In 2013/14, 817 Portsmouth residents received support and recovery services. Where individuals are supported into recovery into the community, alongside our statutory mental health services provided by NHS and other partners and our own AMHPs (Approved Mental Health Professionals) who undertake the statutory assessments, we currently fund secondary community-based mental health services that provide recovery and maintenance support. This is focused on enabling individuals to positively manage their mental health, including a gaining meaningful employment where this is appropriate. Of significant interest to us for further development within mental health services is peer-led support. With prevalence of mental health needs increasing, the development of a peer-led service will, it is anticipated, provide a more cost and quality-effective solution to a growing problem.

6.14 Telehealth/care

Whilst we embrace new technologies as organisations, our offer to our residents has been limited. 307 individuals with either a learning disability, physical disability or mental health problem currently use telehealth/care equipment or adaptations, and 1,186 older people use telehealth/care technology (as this includes responder alarms the proportionate split is as expected), and whilst it can be assumed a large proportion of the population also own and use a mobile phone, aids such as sensor alerts are less well-used. Anecdotal feedback suggests this is, in part, due to our residents being uncertain of embracing new technology, and also a lack of skills, knowledge and experience of providers in this field. There is considerable opportunity for providers to better utilise telehealth/care across all service provision, and we welcome specific focus on this as perhaps the most excitingly viable opportunity currently available to our provider market. There have also been a number of small scale successful telehealth projects including the use of automatic pill dispensers for older people and monitoring devices for Chronic obstructive pulmonary disease (COPD) patients through self-assessment, but long term financial support for similar projects needs to be secured on a consistent basis to ensure that efficiency opportunities are realised.

7. Voluntary and Community Sector (VCS)

The voluntary and community sector (VCS) across Portsmouth is very diverse providing a range of niche, regulated, non-regulated and innovative services that directly impact on the health and wellbeing of the Portsmouth population. Often small-scale, these organisations provide services for smaller population cohorts where size or a need for highly specialised knowledge and experience acts as a deterrent for larger organisations.

With a corporate funding allocation of circa £750k, in 2014/15 we have funded services deemed less likely to receive grant or trust funding elsewhere by virtue of its provision, or services where high need and high impact has been identified, including infrastructure support, advice services, shopmobility, rape crisis and a domestic abuse service. These services are rarely provided in isolation, with their care pathways dovetailing with those provided by statutory sector partners. We recognise we have a continual role to play in strengthening this sector and brokering relations between this and other sectors to maximise impact and develop and promote examples of best practice.

We are fortunate that our voluntary and community sector organisations are skilled in securing external funding and we seek to continue collaborating with VCS colleagues in the co-design of these services and in

[34] https://www.portsmouth.gov.uk/ext/health-and-care/health/mental-wellbeing.aspx

the spirit of the Compact. We recognise the VCS community is a significant part of the solution to meeting future need and the Voluntary and Community Sector Commissioning and Funding Framework has been developed by the Integrated Commissioning Unit. The framework has been developed with a view to provide an opportunity to look at areas where the Council and CCG can re-model or transform services or develop new services with the VCS which can deliver our priorities and also achieve savings in areas that are under great pressure.

The framework aims to provide clarity to VCS colleagues as to what our expectations and plans around various service areas are in the current economic climate and where we see potential for a key role for VCS organisations. The framework will be supported by commissioning intentions which are currently being progressed by service areas and will be shared and developed with the Third Sector Providers Network as part of our on-going work. This framework has been presented to Portsmouth City Council Cabinet and the Health and Well-Being Board who have given their support to this work. You can read a copy of the framework by searching "Portsmouth Compact" at www.portsmouth.gov.uk:

For further information about the Voluntary and Community Sector, please see https://www.portsmouth.gov.uk/ext/community-and-environment/community/voluntary-and-community-sector.aspx

8. Challenges for 2015/16 and beyond

Like most local authorities, Portsmouth City Council cooperates within the context of reductions to public sector funding and increasing demographic pressures, particularly among older people and people with a learning disability. This simultaneous double impact of increased costs and a funding squeeze requires the council to make £37m of savings over the next 3 years[35]. It is anticipated that economic conditions are expected to be sustained and steady, but with the pace of growth slowing in 2016. It is noted that the public sector debt will remain high, currently standing at £1.45 trillion or 79.5% of Gross Domestic Product) and is likely to continue to rise through to 2020. The current Prime Minister has stated that growth alone will not fix the budget deficit and therefore unless there is a change in policy stance, public sector spending cuts will continue through to 2020 at least.

Over the last three years, the council has experienced government funding reductions of £44m (representing 30%). When combined with the need to meet unavoidable cost pressures, the council has had to make savings of £59m through efficiencies and service reductions. In context, £59m represents 22% of the Council's controllable budget.

In addition to the inevitable decommissioning of some services and reduction in budgets available for care management and staffing, there will be both opportunities and challenges to consider savings against the backdrop of The Care Act, the Better Care Fund programme (BCF) and the Integrated Personal Commissioning (IPC) programme. It is hoped that BCF and IPC, through the further integration of Health and Social Care services and pooling of resources, will help in addressing the financial challenges ahead. However, it is widely recognised this alone will not meet the funding gap experienced by Health and Social Care.

The council wants to support voluntary sector providers to come together to build more social capital in the city. It also wants to reduce requirements placed on providers to work within complex contractual arrangements and to make it easier for existing and new providers to enter the market and work with us. The council aims to continue to encourage local people to help influence local commissioning decisions and will always consult with its residents to shape the services they want.

8.1 Moving forwards - next steps

The health and social care market will need to respond to two key challenges over the forthcoming years, namely financial constraints, with the need to reduce demand and introduce personalised outcomes. This will necessitate commissioners to work with providers to become more creative and innovative in the design and

[35] http://democracy.portsmouth.gov.uk/documents/g2413/Public%20minutes%2009th-Dec-2014%2014.00%20Full%20Council.pdf?T=11

delivery of future services. There will be a need to demonstrate return on investment in much broader terms than the production of outputs including building social capital and adding value.

It is imperative adult social care needs and solutions are seen in a wider context. In recognition that needs often stem from multiple contributory factors, we aim to become more proactive in preventing an escalation of need, building on the integration of provision initiated via the Better Care Fund and working within a wider public health model through locality working. We seek to improve on the provision of innovative services that are less reliant on traditional funding mechanisms and that access and utilise the skills and strengths of our vibrant city communities. We look forward to welcoming providers to market warming events throughout 2015/16 to explore how we can jointly proceed in meeting the needs of our vulnerable residents in the context of challenges identified.

Reference Sources

This Market Position Statement has been produced by Portsmouth's Integrated Commissioning Unit following consultation with internal and external stakeholders. To provide feedback on matters of accuracy, request further information or seek guidance on market warming events, please email the Integrated Commissioning Unit ICU@portsmouthcc.gov.uk.

Reference sources

Table 1 - Older Person's prediction table, page 16

1. Population by age figures are taken from Office for National Statistics (ONS) subnational population projections by persons, males and females, by single year of age. The latest subnational population projections available for England, published 29 May 2014, are full 2012-based and project forward the population from 2012 to 2037.

2. Population by living status figures are taken from Office for National Statistics (ONS) 2011 Census, Communal establishment management and type by sex by age, reference DC4210EWL. Numbers have been calculated by applying percentages of people living in care homes/nursing homes in 2011 to projected population figures.

3. The most recent relevant source of dementia-related UK data is Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.

4. Falls data is based on a study of 647,721 A&E attendances and 204,424 admissions to hospital for fall related injuries in people aged 60 years and over. Scuffham, P. et al, Incidence and costs of unintentional falls in older people in the United Kingdom, Journal of Epidemiology and Community Health, Vol. 57, No.9, Sept. 2003, pp.740-744. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be admitted to hospital as a result of falls to 2030.

5. Mobility, self-care and domestic task figures are taken from Living in Britain Survey (2001), tables 29, 35 and 37. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the self-care activities listed, to 2030.

6. Learning Disability predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004.

7. The information about ASD is based on Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007 was published by the Health and Social Care Information Centre in September 2009.

8. Unpaid care figures are taken from the Census 2011 reference CT0224 - Sex by age by provision of unpaid care by general health. This dataset provides estimates that classify usual residents of England and Wales by provision of unpaid care and by age and by general health. The estimates are as at census day, 27 March 2011.

9. Limiting long term illness figures are taken from Office for National Statistics (ONS) 2011 Census, Long term health problem or disability by health by sex by age, reference DC3302EW. Numbers have been calculated by applying percentages of people with a limiting long-term illness in 2011 to projected population figures.

Table 2 - Learning Disability & ASD prediction table

10. Learning disability predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004.

11. Severe learning disability predictions are based on a set of prevalence rates for people with a complex or severe learning disability established as a proportion of those known via learning disability registers (the administrative rate as established by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004).

12. The prevalence rate for people with a learning disability displaying challenging behaviour is 0.045% of the population aged 5 and over. The prevalence rate is based on the study *Challenging behaviours: Prevalence and Topographies*, by Lowe et al, published in the Journal of Intellectual Disability Research, Volume 51, in August 2007.

13. Down's syndrome predictions are based on two studies which put the prevalence of Down's syndrome at between 5.9 per 10,000 general population (Mantry et al) and 6.6 per 10,000 live births (the Clinical and Health Outcomes Knowledge Base). The mean of these rates, 6.25 per 10,000 population, has been used.

14. ASD predictions are based on *Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007* was published by the Health and Social Care Information Centre in September 2009.

Table 3 – Physical disability prediction table

15. Physical disability predictions are based on the prevalence data for moderate and serious disability by age and sex included in the Health Survey for England, 2001, edited by Madhavi Bajekal, Paola Primatesta and Gillian Prior.

16. Personal care physical disability predictions are based on the prevalence data on adults with physical disabilities requiring personal care by age and sex in the Health Survey for England, 2001. These include: getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet. A moderate personal care disability means the task can be performed with some difficulty; a severe personal care disability means that the task requires someone else to help.

17. Stroke figures are taken from the General Household Survey 2007, table 7.14 Chronic sickness: rate per 1000 reporting selected longstanding conditions, by sex and age, ONS. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a sample of the general population resident in private households in Great Britain. Numbers have been calculated by applying rates of men and women reporting stroke to projected population figures to 2030.

18. Diabetes prevalence rates are taken from the Health Survey for England 2006 Volume 1*Cardiovascular Disease and Risk Factors in Adults*, The NHS Information Centre, 2008. The study provides prevalence data by age and gender, and by type of diabetes. The most significant factors for the onset of Type 2 diabetes are age and weight. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have doctor-diagnosed diabetes, projected to 2030.

19. Visual impairment predictions are based on The prevalence of visual impairment in the UK, A review of the literature, by Tate, Smeeth, Evans, Fletcher, Owen and Rudnicka, RNIB, 2005.

20. Hearing impairment predictions are based on the combined prevalence from two studies: Adrian Davis (Ed.), *Hearing in Adults* (1995), Whurr Publishers Limited, and Adrian Davis et al, *Health Technology Assessments* 11(42):1-294 (October 2007).

Table 4 – Mental health prediction table

21. Mental health problem predictions are based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2030.

22. The report *Adult psychiatric morbidity in England, 2007: Results of a household survey*, published by the Health and Social Care Information Centre in 2009, provides prevalence rates for both alcohol and drug dependence.

23. Mortalities from suicide predications are based on information contained in the Clinical and Health Outcomes Knowledge Base, a source of information on health outcomes generated by NCHOD (the National Centre for Health Outcomes Development), http://www.nchod.nhs.uk/. The data, released in December 2009, gives information on mortality rates from suicide between 2006 and 2008. The database provides mortalities from suicide per 100,000 population by Government Office Region and for England. This information is derived from Office for National Statistics data.

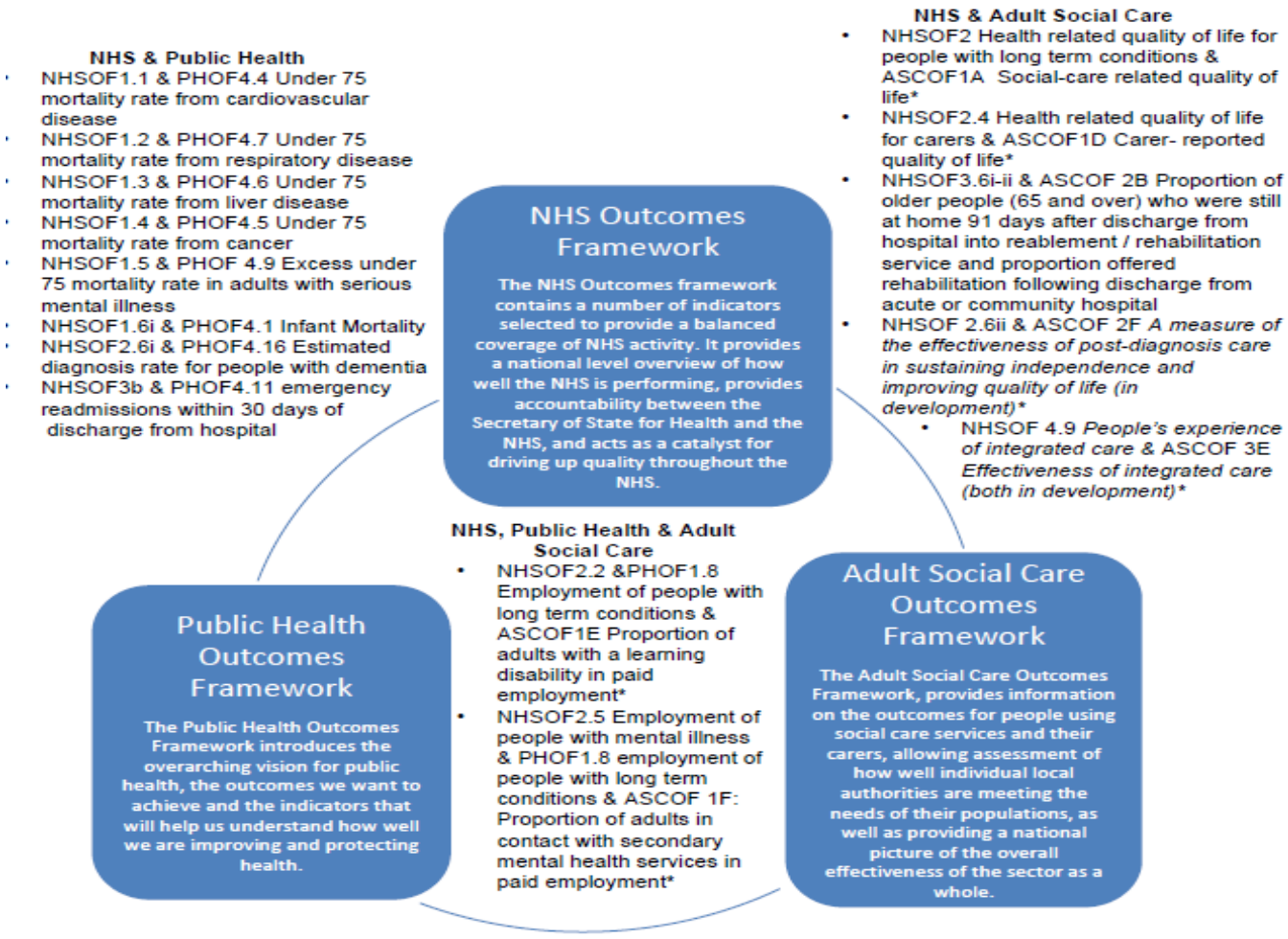
24. This table shows the estimated numbers of people in the adult population aged 18-64 who report having been sexually abused during their childhood, by gender, projected to 2025.

25. Survivors of sexual abuse predictions are based on the report by Cawson, P., Wattam, C., Brooker, S. and Kelly, G., *Child Maltreatment in the United Kingdom*, 2000, NSPCC. In this study the sample consisted of 2,869 young adults aged 18 - 24 years (1,235 men and 1,634 women). It found that 11% of respondents had been abused in childhood against their wishes or when they were 12 years old or younger, the prevalence being 7% for males and 16% for females. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers of people who report having been sexually abused during their childhood, projected to 2030.

26. Early onset dementia predictions are based on the Alzheimer's Society report, *Dementia UK - the full report*. This 2007 report into the prevalence and cost of dementia was prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society.

Appendix One - Shared and complementary measures in the Health and Social Care Outcomes Frameworks

Complementary indicators indicated by *[36]



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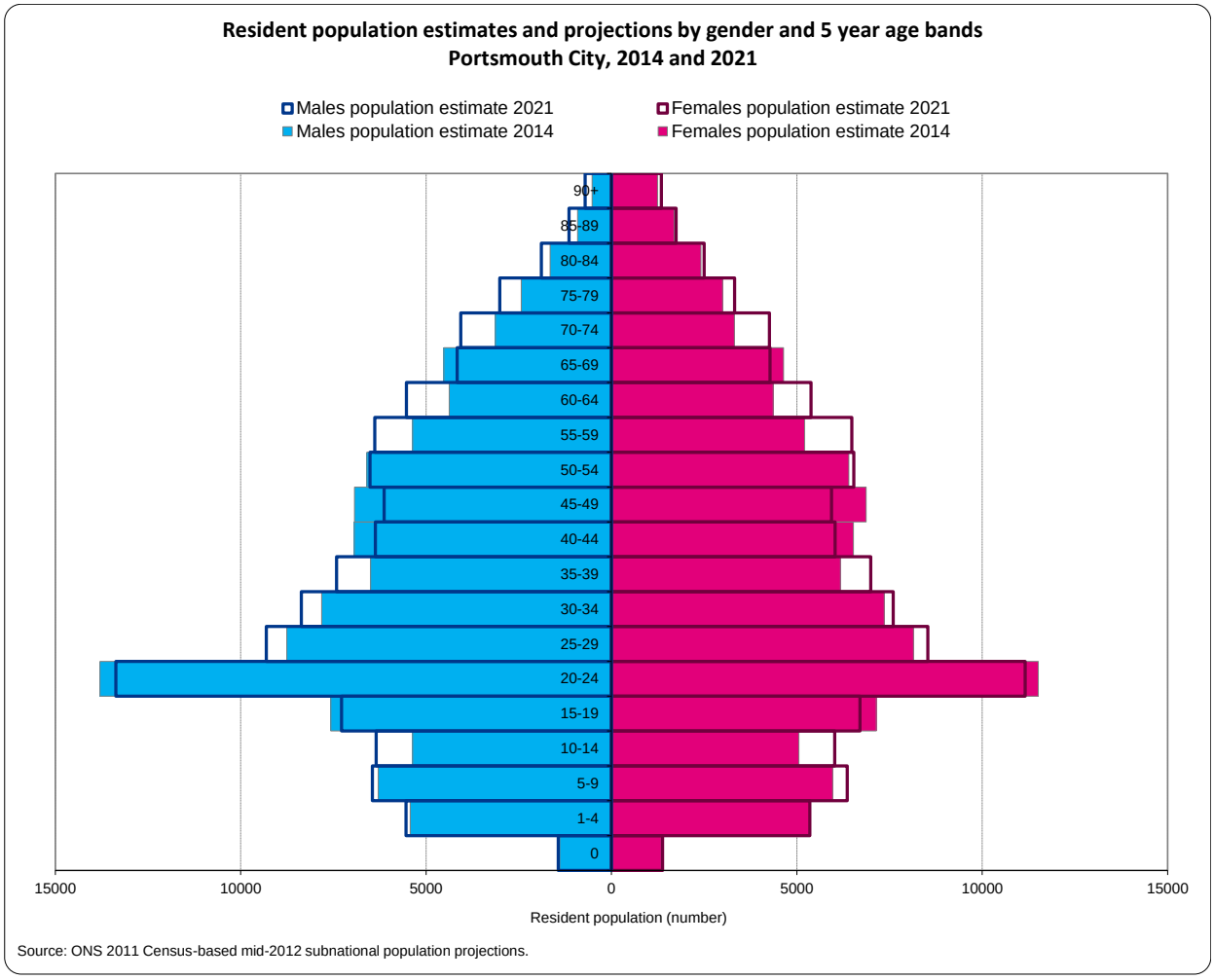
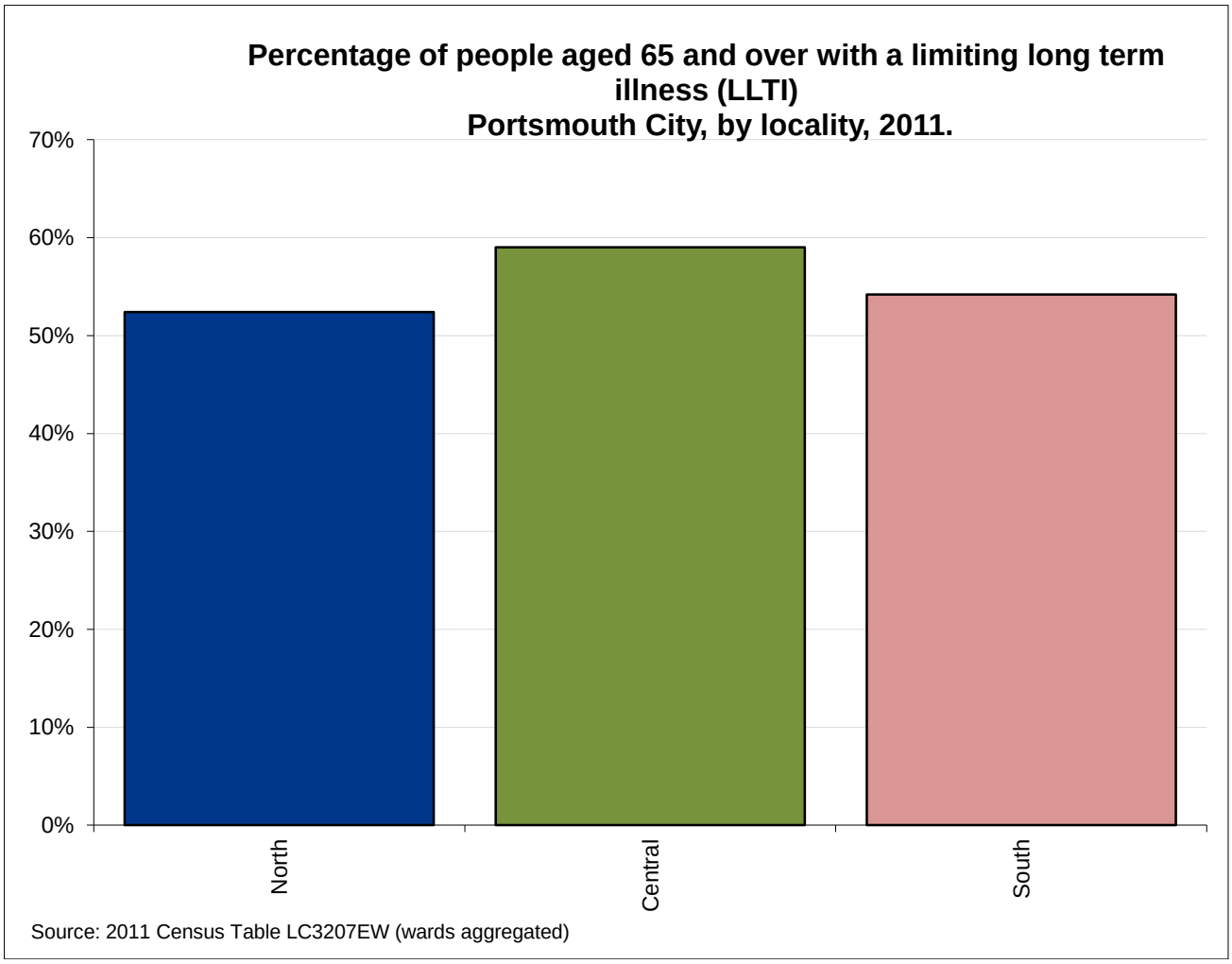
[36] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/375431/ASCOF_15-16.pdf

Appendix Two - Resident population estimates and projections by gender and 5 year age bands, Portsmouth City 2014 estimate compared to 2021 estimate



Source: ONS 2011 Census-based mid-2012 subnational population projections.

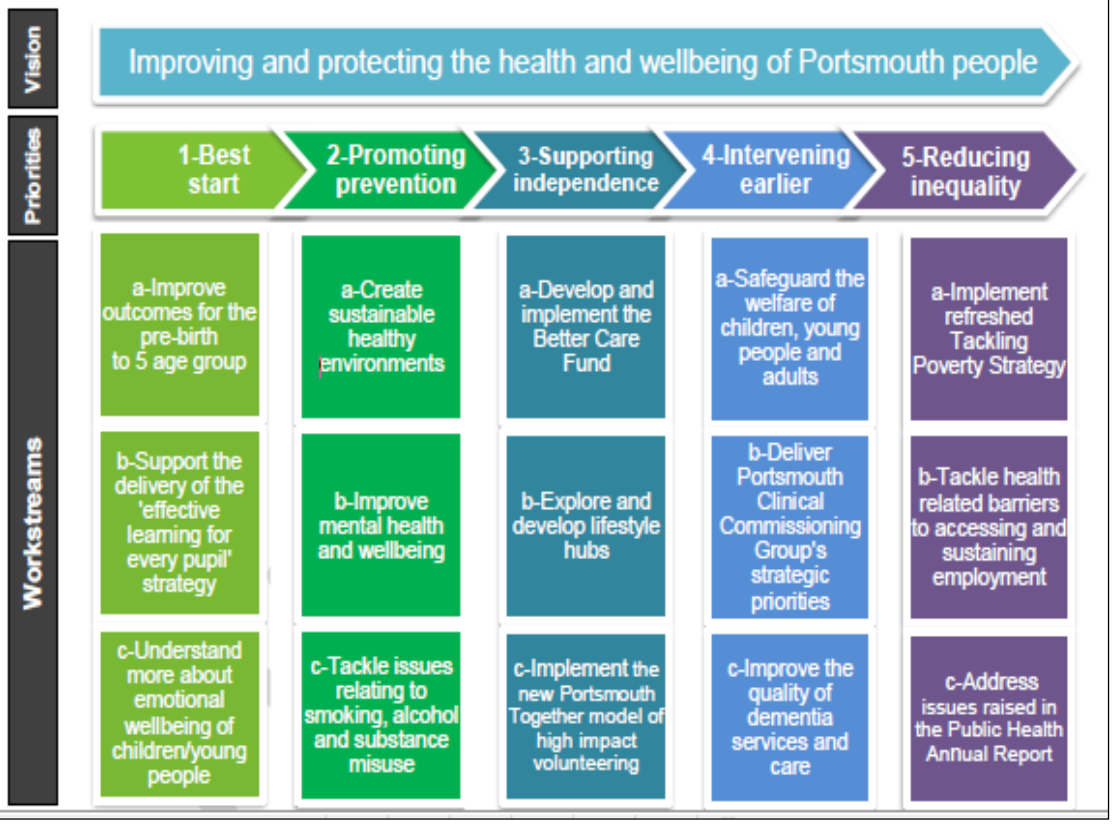
Appendix Three - Percentage of people aged 65+ years with a limiting long term illness (LLTI), Portsmouth City localities, 2011



Appendix Four - Portsmouth Joint Health and Wellbeing Strategy

Executive Summary

The JHWS's vision is to improve and protect the health and wellbeing of people who live and work in Portsmouth. The strategy has five strategic priorities, each supported by a set of workstreams that specifically respond to health and wellbeing needs in Portsmouth that have been highlighted through the JSNA.



Portsmouth
CITY COUNCIL

Integrated Commissioning Service

Portsmouth City Council & Portsmouth Clinical Commissioning Group
Floor 2, Core 2 / 3
Civic Offices
Portsmouth
PO1 2AL

www.portsmouth.gov.uk