Notice of Health and Wellbeing Board

Date: Thursday, 20 July 2023 at 1.30 pm

Venue: HMS Phoebe, BCP Civic Centre, Bournemouth BH2 6DY

Membership:

Chair: to be elected

Vice-Chair: to be elected

Cllr D Brown	Portfolio Holder for Health and Wellbeing
Cllr R Burton	Portfolio Holder for Children and Young People
Cllr K Wilson	Portfolio Holder for Housing and Regulatory Services
Graham Farrant	Chief Executive (BCP Council)
Jess Gibbons	Chief Operations Officer, BCP Council
Cathi Hadley	Corporate Director - Childrens Services, BCP Council
Phil Hornsby	Director ASC Commissioning
Sam Crowe	Director, Public Health (BCP Council)
Patricia Miller	NHS Dorset
Siobhan Harrington	University Hospitals Dorset NHS Foundation Trust
Dawn Dawson	Dorset Healthcare Foundation Trust
Mufeed Niman	NHS Dorset Clinical Commissioning Group
Simon Watkins	NHS Dorset Clinical Commissioning Group
Louise Bate	Healthwatch
Karen Loftus	Community Action Network Bournemouth, Christchurch and Poole
Marc House	Dorset & Wiltshire Fire and Rescue Service
Mark Callaghan	Dorset Police

All Members of the Health and Wellbeing Board are summoned to attend this meeting to consider the items of business set out on the agenda below.

The press and public are welcome to view the live stream of this meeting at the following link:
https://democracy.bcpcouncil.gov.uk/ieListDocuments.aspx?MId=5703

If you would like any further information on the items to be considered at the meeting please contact: Louise Smith, Democratic Services or email democratic.services@bcpcouncil.gov.uk

Press enquiries should be directed to the Press Office: Tel: 01202 454668 or email press.office@bcpcouncil.gov.uk

This notice and all the papers mentioned within it are available at democracy.bcpcouncil.gov.uk

GRAHAM FARRANT
CHIEF EXECUTIVE

12 July 2023

DEBATE NOT HATE

Available online and on the Mod.gov app

Maintaining and promoting high standards of conduct

Declaring interests at meetings

Familiarise yourself with the Councillor Code of Conduct which can be found in Part 6 of the Council's Constitution.

Before the meeting, read the agenda and reports to see if the matters to be discussed at the meeting concern your interests

What are the principles of bias and pre-determination and how do they affect my participation in the meeting?

Bias and predetermination are common law concepts. If they affect you, your participation in the meeting may call into question the decision arrived at on the item.

Bias Test	Predetermination Test
In all the circumstances, would it lead a fair minded and informed observer to conclude that there was a real possibility or a real danger that the decision maker was biased?	At the time of making the decision, did the decision maker have a closed mind?

If a councillor appears to be biased or to have predetermined their decision, they must NOT participate in the meeting.

For more information or advice please contact the Monitoring Officer (susan.zeiss@bcpcouncil.gov.uk)

Selflessness

Councillors should act solely in terms of the public interest

Integrity

Councillors must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships

Objectivity

Councillors must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

Accountability

Councillors are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

Openness

Councillors should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

Honesty & Integrity

Councillors should act with honesty and integrity and should not place themselves in situations where their honesty and integrity may be questioned

Leadership

Councillors should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

AGENDA

Items to be considered while the meeting is open to the public

1. Apologies

To receive any apologies for absence from Councillors.

2. Substitute Members

To receive information on any changes in the membership of the Committee.

Note – When a member of a Committee is unable to attend a meeting of a Committee or Sub-Committee, the relevant Political Group Leader (or their nominated representative) may, by notice to the Monitoring Officer (or their nominated representative) prior to the meeting, appoint a substitute member from within the same Political Group. The contact details on the front of this agenda should be used for notifications.

3. Election of Chair

To elect the Chair of the BCP Health and Wellbeing Board for the 2023/24 Municipal Year.

4. Election of Vice Chair

To elect the Vice Chair of the BCP Health and Wellbeing Board for the 2023/24 Municipal Year

5. Confirmation of Minutes 5 - 10

To confirm and sign as a correct record the minutes of the Meeting held on 23 February 2023.

6. Declarations of Interests

Councillors are requested to declare any interests on items included in this agenda. Please refer to the workflow on the preceding page for guidance.

Declarations received will be reported at the meeting.

7. Public Issues

To receive any public questions, statements or petitions submitted in accordance with the Constitution, which is available to view at the following link:

https://democracy.bcpcouncil.gov.uk/ieListMeetings.aspx?CommitteeID=151&Inf o=1&bcr=1

The deadline for the submission of a public question is 4 clear working days before the meeting.

The deadline for the submission of a public statement is midday the working day before the meeting.

The deadline for the submission of a petition is 10 working days before the meeting.

8.	**Joint Forward Plan 2023- 2028: Making Dorset the healthiest place to live** This report provides members with an overview of the Dorset Integrated Care Board Joint Forward Plan 2023-2028 which was developed with partners from across the health and care system in Dorset. The plans sets out five pillars which the ICB will focus on and how through these it will support the delivery of the Integrated Care Partnership Strategy and the Health and Wellbeing Strategies.	11 - 110
9.	**Adult Social Care CQC Assurance** The Health and Care Act 2022 creates a new duty for the Care Quality Commission to review local authorities' performance in discharging their adult social care functions under the Care Act 2014. This report sets out the work that has been undertaken to date and further work that is planned to ensure the Council is best placed to achieve a positive outcome from any review of the Council's services.	111 - 116
10.	**Better Care Fund 2023-25** This report provides an overview of the content of the Better Care Fund (BCF) plan for 2023-25. The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing and other public services, which is fundamental to having a strong and sustainable health and care system. National planning guidance was released in April 2023 advising that plans needed to be completed and submitted for national assurance by NHS England by 28th June 2023. The plan needs to be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements and so the draft planning document has been submitted to meet the deadline but is pending Board approval.	117 - 156
11.	**Pharmaceutical Needs Assessment: Supplementary statement** To update on changes since the Pharmaceutical Needs Assessment (PNA) was published in October 2022.	157 - 164
12.	**Review of Membership of the Board** To consider the Membership of the BCP Health and Wellbeing Board.	165 - 166
13.	**Forward Plan and development session** To consider the development of the BCP Health and Wellbeing Board's Forward Plan and a future development session.	167 - 172

No other items of business can be considered unless the Chairman decides the matter is urgent for reasons that must be specified and recorded in the Minutes.

BOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND WELLBEING BOARD

Minutes of the Meeting held on 23 February 2023 at 2.00 pm

Present:-

Cllr J Kelly – Chair

Present: Cllr K Rampton, Cllr M White, Jess Gibbons, Cathi Hadley, Sam Crowe, Patricia Miller, Siobhan Harrington, Dawn Dawson, Louise Bate, Heather Dixey, Stuart Gillion and Karen Loftus

68. Apologies

Apologies were received from David Vitty, Mark Callaghan and Mark House.

69. Substitute Members

Phil Hornsby substituted for David Vitty, Heather Dixey substituted for Mark Callaghan and Stuart Gillion substituted for Mark House.

70. Election of Vice Chair

It was Proposed, Seconded and RESOLVED that Patricia Miller, Chief Executive, NHS Dorset, be elected as Vice Chair for the remainder of the 2022-2023 Municipal Year.

71. Confirmation of Minutes

RESOLVED that the Minutes of the Health and Wellbeing Boards held on 9 June 2022 and 13 October 2022, having previously been circulated, be confirmed as accurate records, and signed by the Chair.

72. Declarations of Interests

There were no declarations of interest on this occasion.

73. Public Issues

There were no public issues on this occasion.

74. Strategic Greenspaces Priorities

The Strategic Lead for Greenspace and Conservation and the Project Manager – Future Parks presented a report, a copy of which had been

circulated to each Member and a copy of which appears as Appendix 'A' to these Minutes in the Minute Book.

BCP Council owned green spaces already provided crucial support for our residents and local communities' physical and mental well-being. New green space priorities set out how our parks, gardens and nature reserves could play an even greater role in supporting people, as well as with nature recovery. Supporting the Big Plan and Corporate Strategy through our outstanding natural environment and with our vibrant communities playing their role in green spaces.

The report sets out these priorities, projects and strategy that would develop them further as BCP sought to collaborate, work in partnership, and maximise potential from our green spaces and advocate and inspire others to follow.

The Board was provided with a presentation which detailed:

- Strategic Green Space priorities and links to health and wellbeing
- Health and wellbeing benefits of green space
- Green Infrastructure Strategy
- GI Evidence base
- The Parks Foundation – Nature Recovery Project
- Nature Recovery Plan – Branksome Recreation Ground
- Green Heart Parks and criteria
- Stour Valley Park
- Next steps and opportunities with the Integrated Care Partnership.

The Board discussed the report and presentation and comments were made, including:

- A Board Member who represented a volunteering network advised they had a long history of working with the Parks Foundation and offered support to help with funding if needed. She also stressed that going forward enabling local communities and volunteers to sustain green spaces was essential for a sustainable and successful model.
- The was some detailed discussion around how the Board could support the strategic priorities and the positive impact in could have on all of BCP's residents' overall health and wellbeing and thereby reducing pressures on health services.
- The Chair concluded that the Board was very supportive, and the Director of Public Health Dorset advised that this work could be considered further through the development session being proposed for the Board later on the Agenda.

RESOLVED that the Health and Well-being board note the work being undertaken by BCP Council Strategic green spaces team and consider opportunities for further partnership working that improve these spaces and make a difference for residents.

75. Better Care Fund 2022-23

The Director of Commissioning presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'B' these Minutes in the Minute Book.

The report provided an overview of the content of the Better Care Fund (BCF) plan for 2022-23.

The BCF was a key delivery vehicle in providing person centred integrated care with health, social care, housing and other public services, which was fundamental to having a strong and sustainable health and care system.

National planning guidance was released in July 2022 advising that plans need to be completed and submitted for national assurance by NHS England by 26th September 2022. The plan needed to be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements and so the draft planning document had been submitted to meet the deadline but was pending Board approval.

This would again be a year of minimal change to BCF plans with more significant changes expected next year with a greater period of planning lead in time.

The Board had no questions on the report having previously considered it.

RESOLVED that the Health and Wellbeing Board approve the Better Care Fund Plan for 22/23 taking into account the investment and delivery plans as outlined in the report.

Voting: For - Unanimous

76. Update on the Integrated Care System strategy and next steps for implementation

The Director of Public Health Dorset presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'C' to these Minutes in the Minute Book.

The purpose of the Report was to ensure that the Health and Wellbeing Board was clear on the priorities and approach set out in the ICS strategy, and the Board's role contributing to improving outcomes for the BCP Council 'place' and to ensure that the part the board could play in improving health and wellbeing was captured as part of the refresh of its Joint Health and Wellbeing Strategy.

The report updated Members of the Health and Wellbeing Board on the new ICS strategy (Appendix 1), published December 2022. It also identified next steps in implementing the strategy, and how the Health and Wellbeing Board would support this through its work programme and new duties.

The Board discussed the report, including:

- The Chair of the Board agreed that further discussion should be undertaken at a development session to ensure that the Health and Wellbeing Strategy was refreshed and relevant.
- The Vice Chair thanked the Director of Public Health for leading the process. She advised it was important to note that the joint working regarding this was crucial in turning the strategy into action and seeing change for local communities for the better.

RESOLVED that the Board:

1) **Note and support the ICS strategy as a broad framework for securing the fastest possible improvements to the health and wellbeing of residents.**
2) **Agree to consider the strategy in detail at a development session to help develop its work programme, and refresh of the Joint Health and Wellbeing Strategy – focusing on priorities most relevant to the BCP Council population.**
3) **Note and support the next steps in implementing the strategy, as agreed by the ICP.**

77. Developing a work programme for the Health and Wellbeing Board

The Director of Public Health Dorset and the Head of Service Planning, Public Health Dorset presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'D' to these Minutes in the Minute Book.

The purpose of the Report was to ensure that the Health and Wellbeing Board understood the new responsibilities in relation to Integrated Care Strategy (ICS); and was able to act as an effective place leader for health and wellbeing, setting clear direction on the most important priorities for the BCP Council population.

The report updated Members of the Health and Wellbeing Board on the new responsibilities of Boards, following updated guidance in the wake of integrated care systems being established. It proposed that the Board would benefit from a development session to consider these responsibilities, in the context of developing a work programme to support its strategy delivery.

The Board discussed the report and comments were made, including:

- The Chair advised the Board she felt it was important to consider the place based work and to ensure there was not duplication of work. She felt it would be useful to meet with the Dorset Health and Wellbeing Board to consider that.
- There was some discussion about the upcoming Integrated Care Strategy place based workshops and realising any opportunities or

overlap of them and the work done by the Board and it was decided that the Chief Commissioning Officer and Chief Executive, NHS Dorset advised they would consider how best to combine them.

- The Board had a discussion over what place meant and it was felt it could hold different meanings for different partners, however it was determined as the footprint of the BCP Council and would form the design operational arm of the Health and Wellbeing Board.
- The Vice Chair concluded that although the definition of place was useful, the real work and focus needed to be at a neighbourhood level where change could really be felt.

RESOLVED that the Board:

1) **Note the new responsibilities and duties of Boards as set out in the new guidance;**
2) **Agree to hold a development session to consider the ICP strategy, and identify other potential elements of a work programme including refresh of the Joint Local Health and Wellbeing Plan.**

The meeting ended at 3.15 pm

CHAIR

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BCP Council Health and Wellbeing Board

Report subject	Joint Forward Plan 2023- 2028: Making Dorset the healthiest place to live
Meeting date	20 July 2023
Status	Public report
Executive summary	This report provides members with an overview of the Dorset Integrated Care Board Joint Forward Plan 2023-2028 which was developed with partners from across the health and care system in Dorset. The plans sets out five pillars which the ICB will focus on and how through these it will support the delivery of the Integrated Care Partnership Strategy and the Health and Wellbeing Strategies.
Recommendations	**It is RECOMMENDED that:** 1) Members note and support the Joint Forward Plan and the 2) next steps in its implementation.
Reason for recommendations	To ensure that the Health and Wellbeing Board is clear on the priorities and approach set out in the Joint Forward Plan and hoe this contributes to the delivery of the Health and Wellbeing Boards Strategy.
Portfolio Holder(s):	Councillor David Brown, Portfolio Holder Health and Wellbeing
Corporate Director	Neil Bacon, Chief Strategy and Transformation Officer, Dorset Integrated Care Board
Contributors	
Wards	All Wards
Classification	For Noting

Background

1. NHS England published its national guidance *'Developing the Joint Forward Plan'* on 23 December 2022. This guidance set out how Integrated Care Boards and their partner trust should:
    - develop the plans in partnership with LAs, voluntary sector and NHS
    - describe the local NHS contribution to delivery of the Integrated Care Strategy, universal NHS commitments and regard to Health and Wellbeing Board Strategies
    - reflect Long Term Plan Refresh
    - reflect local priorities and address four core purposes of the ICS
    - share the final version with their integrated care partnership (ICP) all relevant health and wellbeing boards (HWBs), and NHS England.
2. This report introduces the first Integrated Care Board *Joint Forward Plan: Making Dorset the healthiest place to live* (**Appendix 1**). The plan has been developed with partners across the system which included Board level development sessions, partnership workshops and informed by:
    - what communities have told us is important to them
    - what colleagues working in health and care feel are important to prevent illness
    - information showing where there are differences in services in different areas
    - the Joint Strategic Needs Assessment
    - understanding what might happen if we do nothing
    - being ambitious for change.
3. Our vision is to make Dorset the healthiest place to live. To achieve our vision we have set out a clear commitment to focus on:
    - preventing illness and promoting wellbeing
    - ensuring those that need medical help and support are able to access care when needed
    - creating communities which enable best chance of people living a healthy life by creating opportunities and the right environments to make and act on healthier choices.
4. We have three values for how we work which focus on working together with people and communities and our partners to achieve the best possible outcomes. This will see us move to a more person-centred approach, working together to make better use of our staff, facilities, and funding.
5. Our work will see the improvements in the following five outcomes (pillars):
    - improve the lives of 100,000 people impacted by poor mental health
    - prevent 55,000 children from becoming overweight by 2040

- reduce the gap in health life expectancy from 19years to 15years by 2043
- increase the percentage of older people living well and independently in Dorset
- add 100,000 healthy life years to the people of Dorset by 2033.

6. Our plan supports the three priorities of the health and wellbeing strategies as follows:
   - **empowering communities:** our plan focuses on working to help people live independently and access the services they need, paying special attention to those with the greatest needs
   - **promoting healthy lives**: our plan outlines how we will improve outcomes for our children, young people, and adults with mental health conditions. We also aim to ensure our children have a healthy start in life by addressing issues like being overweight and obesity. We want to reduce differences in health outcomes, such as how high blood pressure is managed
   - **supporting and challenging:** our plan explains how we will work with other health and care organisations to develop joined up health and care services which meet your needs.
7. The plan was published on 30 June 2023 (https://nhsdorset.nhs.uk/wp-content/uploads/2023/07/Joint-Forward-Plan.pdf, the next steps following publication are:
   - for each outcome (Pillar) identify and confirm the lead triumvirate with representation from the local authorities, health and voluntary sector
   - identify how each workstream contribute to the delivery of the outcomes
   - communicate and share the Joint Forward Plan with all stakeholders, supporting what it means to them
   - review the plan to understand any gaps to inform the annual review of the plan.

Summary of financial implications

8. There are no financial implications to note

Summary of legal implications

9. The Joint Forward Plan is legal requirement of the Health and Care Act 2022.

Summary of human resources implications

10. There are no workforce implications to note.

Summary of environmental impact

11. Page 11 of the plans sets out our plans to improve environmental sustainability.

Summary of public health implications

12. The plan supports the supports early intervention and prevention approaches wherever possible to promote the greatest possible improvements in health and wellbeing for residents.

Summary of equality implications

13. There are no equality implications to note.

Summary of risk assessment

14. HAVING CONSIDERED: the risks associated with this decision; the level of risk has been identified as:

    Current Risk: LOW
    Residual Risk: LOW

Background papers

Appendix 1: Joint Forward Plan 2023–2028: Making Dorset the healthiest place to live

NHS
Dorset

Making Dorset the healthiest place to live

Joint Forward Plan:
2023-2028

2023-2028

Making Dorset the healthiest place to live

Joint Forward Plan: 2023-2028

Contents

Elements of this document are clickable.

Introduction

We all want Dorset to be a healthy place where you can live your best life. This means taking care of our bodies and minds to stay well. The way we provide services is changing to meet your needs. We still need to give medical help when you need it, but we also want to work with you to focus on preventing illness and promoting wellbeing.

When we improve our physical and mental health our communities become healthier places. Our goal is to make sure everyone in Dorset has a chance to live their best life, and this plan shows how we will achieve it. The review into integrated care systems by Patricia Hewitt encourages more investment in prevention, and on moving the focus from simply treating illness to promoting health and wellbeing.

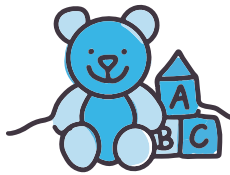
One important focus of our plan is wellbeing. We want to create communities where you have the best chance of living a healthy life. By creating opportunities and the right environments for you to make and act on healthier choices, we can transform our communities and make Dorset the healthiest place to live.

When it was founded in 1948, the NHS was the first universal health system to be available and free for everyone. As we celebrate 75 years of the NHS, it is a reminder that the NHS has always evolved and adapted to meet the needs of each generation. This is still the case today.

Working side by side with you, health and social care organisations, community and voluntary organisations, and with local businesses, we can make Dorset the healthiest place to live.

Our plan has five areas of focus — our five outcomes are:

We will **improve** the lives of **100,000** people impacted by poor **mental health**.



We will prevent **55,000 children** from becoming **overweight** by 2040.

We will **reduce the gap** in healthy life expectancy from 19 years to **15 years** by 2043.

We will **increase** the percentage of older people living well and **independently** in Dorset.

We will add **100,000** healthy **life years** to the people of Dorset by 2033.

"This is an exciting time for the NHS. Building on the progress we have already made as an integrated care system we can improve outcomes and tackle inequalities. By working together and listening to local people we can truly make the changes we need so people can live healthier lives for longer."

Jenni Douglas-Todd
Chair
NHS Dorset

Read more about these outcomes and how we will achieve them on page 26.

Dorset's integrated care partnership

The integrated care partnership is a group jointly formed between NHS Dorset and local councils. It brings together a broad range of people who are concerned with improving your care, health, and wellbeing. This includes police, fire, higher education providers, the business community, and voluntary and community groups.

Dorset has an Integrated Care Partnership Strategy – Working Better Together.

www.ourdorset.org.uk/strategy

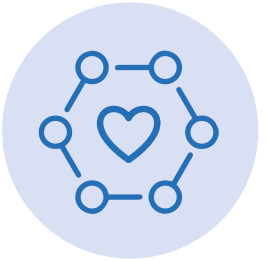
This strategy explains where we are now, what we hope to achieve, and how we're planning to do that. It sets out how the NHS, councils, and other members of the integrated care partnership will work together to make the best possible improvements in health and wellbeing for everyone. This means changing the way we work to provide the right health and care services across Dorset.

This joint forward plan outlines how NHS organisations in Dorset will support the aims of the integrated care partnership Strategy working with you and other local organisations.

Prevention and early help

Thriving communities

Working better together



Illustrative map of Dorset

About us

NHS Dorset Integrated Care Board was established on 01 July 2022. We have a legal responsibility to plan and make sure you have the health and care services you need. You can see what we mean by health and care services below.

Pharmacies

- Experts in medicine who help with minor health concerns
- Provide medicines either prescribed by a doctor or those you can buy yourself

Dentists

- Your main point of contact for mouth, teeth and gum health
- Some services are provided on the NHS and some on a private basis

Opticians

- Your main point of contact for your eyes
- Provides eye tests, fits glasses and contact lenses

NHS 111

- General health information and advice
- Help with an urgent need that is not life threatening
- Major or minor injuries
- Appointment bookings for urgent care
- Out of hours GP practice services

GP practices

- Your local GP practice is the main point of contact for general healthcare needs.
- Practices employ a range of people including nurses, physiotherapists as well as doctors
- They help with ongoing health issues, illness that doesn't improve with self-treatment and any worries you have about your health

LiveWell Dorset services (provided through Public Health Dorset)

- Helps people live healthier lives focusing on moving more, managing weight, stopping smoking and drinking less
- Provides information, personalised coaching and support

Social care (provided through local councils)

- Helps people with social care and what support they may need
- Supports people to stay well at home
- Supports carers who are look after people

Community services (including mental health)

- Minor injuries units and urgent treatment centres can treat you if your injury is not life threatening or serious
- Supports communities to stay well through district nurses, clinics and therapies
- Provides mental health services, crisis support and specialist services in hospital

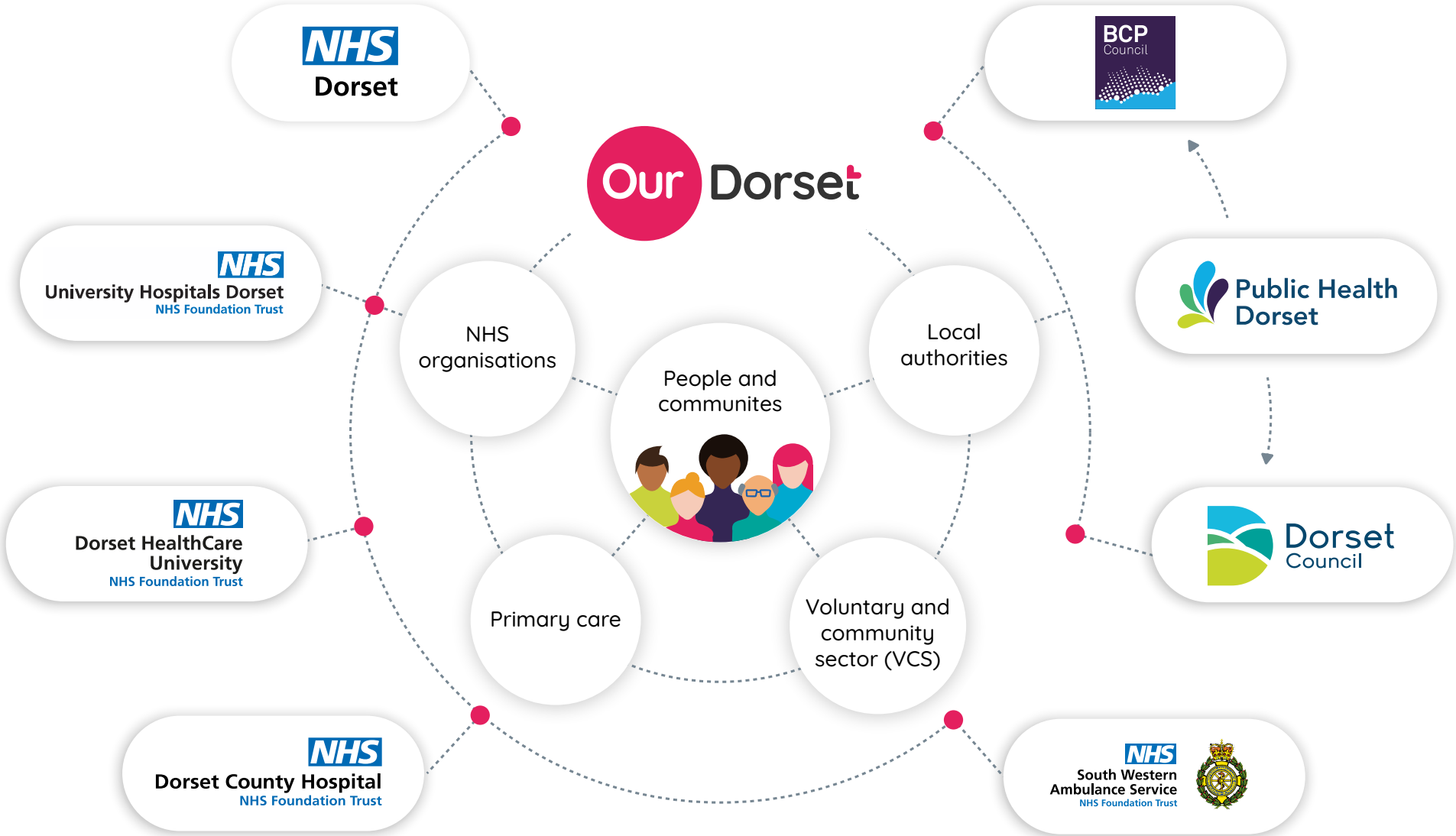
Acute hospitals

- Specialist medical treatment including surgery
- Diagnostics including samples, imaging (x-rays) and analysis
- Accident and emergency departments for life threatening injuries and conditions

Ambulance service

- Call us on 999 if you have a life threatening situation
- Provides ambulance and paramedic care
- Transfers people to a hospital or other setting for more services

We are part of the Dorset integrated care system which is made up of several organisations, working together locally, to deliver health and care services to you. You can see each organisation in the illustration below.



There are four key areas we must achieve. These are improving outcomes, tackling inequalities, improving productivity and value for money, and supporting social and economic development. This is not something we can do alone. We will only achieve this by working with you, other health and care organisations, local businesses, higher education and the wider community and voluntary sector. You can see how we plan to do this below.

Improve outcomes in population healthcare

- Put the health and wellbeing of people at the heart of everything we do
- Commission services based on outcomes which are codesigned with citizens
- Utilise data, research, and evidence to improve outcomes
- Develop a clear assurance process built on relationships of trust

Tackle inequalities in outcome and access

- Put Population Health Management (PHM) at the centre providing critical insights
- Target resources and funding toward communities focusing on PHM critical insights
- Focus on people and diverse needs ensuring we are outcome focused
- Support our people to act as inequality ambassadors

Enhance productivity and value for money

- Identify opportunities through benchmarking and best practice
- Monitoring through a range of techniques
- Develop ownership by all teams and capability to set, monitor, and analyse innovative ways of delivery through collaboration with wider system partners
- Develop processes and underpinning systems

Help the NHS deliver broader social and economic development

- Data driven understanding of our places
- Codesign and co-creation with communities
- Keeping things local
- Health and care as the employer of choice
- Partnership working to maximise value

We want to make sure services are high quality and meet your needs. We believe in listening to people and communities across Dorset. You can see how we are planning to do this on page 23. We want to understand things from your point of view and use your knowledge to create services which truly meet the needs of everyone. We want to make sure everyone has access to the right support so you can live your best life. Our goal is to help everyone live healthy, happy lives from birth until the end of life.

Our plan is important because it supports the things you have told us matter most to you. We are not starting from a blank page, we have made sure our previous plans have been taken into account, such as the Sustainability and Transformation Plan, the NHS Long Term Plan and the Clinical Services Review. Our plan also considers information from the Joint Strategic Needs Assessment. This is an assessment of current and future health and social care needs. It is very useful when developing plans because it is a structured way of reviewing the health and wellbeing needs of the Dorset population.

We have a strong history of inventive projects which have made a positive impact on people and communities in Dorset. We have faced various challenges along the way and have learned some valuable lessons. These experiences have been helpful in guiding and shaping the future of our health, care, and wellbeing services.

Vision and values

Our vision is to make Dorset the healthiest place to live. By working together, we can achieve the best possible improvements in your health and wellbeing.

"We have a clear vision – working together to achieve the best possible improvements in people's health and wellbeing. We want to support our communities to live their best lives. We know from listening to you that this can only be done by supporting you to create thriving communities. We want to support you to build strength in citizenship and the assets our communities already have, focusing on prevention and early help to support you to live long, not just healthy lives but also happy lives.

We are determined to put you at the heart of everything we do, trying hard to understand the challenges you face, making sure our decisions are driven by you and empowering you wherever we can to develop the right solutions.

If we are serious about reducing health inequalities, we need to play our part in developing our communities and local economy. We can only do this by first understanding what life is like for those who live in Dorset from many different backgrounds and experiences."

Patricia Miller OBE
Chief Executive
NHS Dorset

Themes

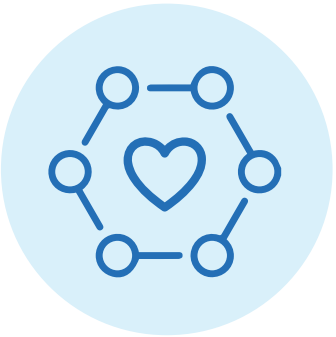
To support this vision, we have focused on three themes which are set out in the integrated care partnership strategy. These themes outline what we are doing to make this happen.

Prevention and early help

We listen and involve you in decisions about your health and wellbeing, care, and support needs. We adjust where needed to improve your outcomes, access, or experience, to improve equity, and reduce inequalities in health.

Thriving communities

We work more closely with communities and voluntary sector organisations to support you and improve your health and wellbeing. We will provide more opportunities for friends, family, and peer supporters to help you thrive, or to recover when you are unwell. We will look at variation in how well people are supported who live with long-term conditions.



Working better together

We put your needs at the heart of how we plan care and support. Health and care organisations work together to provide care as close to you as possible. We value the strength of voluntary and community organisations. We focus on improving your outcomes, access, and experience, and are careful with scarce resources like time and money.

Values

To deliver our vision we have three values for how we work. These focus on working together with you to achieve the best possible outcomes for you. Moving to a more person-centred approach means we can support you to improve your wellbeing by working together to make better use of our staff, facilities, and funding. This means you are at the centre of our decisions.

Ambitious

Community driven

Partnership

"We all have a duty to deliver the best services to the people of Dorset, whether they live in the towns or rural and coastal areas of Dorset, or in the conurbation towns of Bournemouth, Christchurch, and Poole. We created our three system values illustrating how we will work as a system ahead of the formal establishment of NHS Dorset because we recognised the importance of working together.

No single organisation can make Dorset the healthiest place to live. Our communities are at the centre of everything we do. We are passionate about the need to deliver the right outcomes for our people, and we are committed to continuously listening to our local communities and ensuring that we meet their needs. "

Graham Farrant
Chief Executive
BCP Council

Matt Prosser
Chief Executive
Dorset Council

"Working in partnership with people and communities is crucial if we are going to create a health and care system which works for everyone and tackles health inequalities. Healthwatch Dorset's role is to share local people's insights, bring our expertise in working with communities and to provide scrutiny to the system."

Louise Bate
Manager
Healthwatch Dorset

"A key element to achieving the best outcomes for people Dorset is to maintain strong and thriving local charities and community groups, supported by thousands of volunteers, working in partnership with our NHS and local authorities."

Karen Loftus
Chief Executive
Community Action Network

About Dorset

Dorset is a great place to live and grow. It has many beautiful natural areas. We have a mix of places including towns, villages, beaches, and countryside which gives us the perfect environment for staying healthy and happy. Our town centres are special because they bring us together and create a sense of community. People who live here feel proud because we have a diverse history that celebrates different cultures. Even though Dorset is beautiful, we also have some challenges.

We all know there are pressures on our health and care services, the number of people living with complex conditions is increasing, and as a nation we are becoming less healthy, both physically and mentally. We believe the key to addressing these challenges is through promoting health and preventing illness.

Often, we only start thinking about health and healthcare when we become ill, or our health starts to get worse. There are many benefits to having the tools and support you need to live a healthy and balanced life. These include being able to manage the challenges of life, increased self-esteem, feeling able to take control, feeling connected and less isolated, reduced anxiety, and improvement in mood.

Through feedback, many people have told us they feel empowered to question health professionals, but we know that is not always the case for everyone. We know people appreciate being acknowledged as experts in their own conditions and value peer support from others facing similar challenges.

> **"If you give me the tools to self-manage, I can look after my own physical and mental health."**

When people are equipped to take charge of their own health and communities have support to build groups and networks, we can create strong links to help each other to stay well.

You have told us social connections play a vital role in leading longer, healthier, and happier lives. But it isn't just family ties, close friendships, or group membership that make a difference. Having connections and building networks with neighbours and the wider community helps us feel part of something and gives us a sense of belonging. Networks with community spirit and purpose can enhance the quality of life for an entire community making it a better place to live.

> **"I live on my own so for me having a job and volunteering gives me that social aspect… helping at the food bank people start to recognise you and realise they can talk to you. It improves the links people have."**

We have a strong history of working together, it is crucial to invest in more resources and efforts into these partnerships to achieve our goals. Our plan doesn't just focus on what health services will do, it looks at how we can get involved early on and invest in wellbeing with everyone's help. By approaching these challenges in a different way, we will make sure you can access the right services and at the right time.

Health and wellbeing challenges

Dorset has good health outcomes compared with the rest of England. However, we know there are differences in the health and wellbeing outcomes for different people. It is important to address these differences to make sure everyone has an equal opportunity to live a healthy and fulfilling life.

Children and young people

- Services supporting parent and child health for children pre-birth to the age of three years are not provided consistently.
- How ready children are for school varies due to level of disadvantage. We know when a child starts school without meeting the milestones for being 'school ready' they can be disadvantaged for their whole life.
- Improved access to dentistry and oral health in early years is important.
- Emotional health and wellbeing support at an early stage is a real need. Late diagnosed mental health disorders affect children's lives for many years.
- We know that children living in more deprived areas are more likely to have poorer health outcomes.

Working age adults

- Unhealthy behaviours like smoking and harmful alcohol use are more common in disadvantaged areas.
- Support for mental health and wellbeing could be better by focusing on early support in the community and on living well with mental ill health.
- There is unacceptable difference in quality of support and access to services for people with long-term conditions, and we need to close the gap.
- Being more active and maintaining a healthy weight will improve healthy life expectancy and mental wellbeing and can dramatically reduce the chance of getting a range of health problems in older age.

Healthy ageing

- Mobility, risk of falling, and frailty are all key determinants of health in later life. By assessing risks, supporting people earlier, and fostering independence we can make big improvements.
- Social isolation and a lack of access to digital services are important issues. Dorset volunteers provide vital services helping maintain older people's independence for longer.

Care and quality

There are unfair differences in the quality of care across Dorset. How early you get diagnosed with a condition like diabetes can vary depending on where you live. Also, some children who are looked after by our local authorities may have different rates of getting vaccines or going to the dentist.

We want to make sure everyone gets the same good care no matter where they live. It's important to find out why these differences happen and make things better. By doing this we can make sure you stay healthy and get the help you need.

National quality standards are rightly high and continuing to rise. In most cases our services are good, but in some areas, we know we need to do more. Unfortunately, we have not be able to meet some national standards in some areas.

Our emergency departments and other units are seeing more people with more serious health issues. This makes it harder for them to provide your care quickly. When you need to stay in hospital, sometimes you have to stay longer than you need to.

There are more people needing urgent and emergency care which can affect planned appointments. Sometimes these appointments have to be moved or cancelled, which means you have to wait longer to get the care you need.

We know that some people have to wait longer for appointments than others; we need to do more to understand why this happens. We know waiting for tests and appointments is frustrating, we are working hard to improve the situation. Our goal is to make sure everyone gets the care they need in a timely way.

Our partnerships have become even stronger and more effective. We are dedicated to making sure services, such as care homes and wards in our hospitals, are better and safer for everyone. We are proud a high percentage of social care providers in our area are rated as good or outstanding, which means they provide excellent care.
We are continuously improving the quality and safety of our services, making sure you receive the best possible care and support.

Workforce

Health and social care in Dorset directly employs around 50,000 people, which is 15% of the total workforce in Dorset and accounts for 11% of Dorset's economy. There has been an increase in employment opportunities within health and social care, with a 23% increase over the past year. In just eight years, the total number of jobs has doubled, showing how important health and care employment is within our communities.

However, we are experiencing a shortage of staff, which means we don't have enough people to meet the demands for services. Despite our investments to increase staffing, it is difficult to keep up. We have challenges in recruiting and retaining a diverse range of staff with the right skills to deliver the services you need.

To address these challenges, we know we need to tackle underlying issues such as housing, transport, fair pay and reward, and flexible working arrangements. We want to create an environment where people are not only attracted to live in Dorset but are also motivated to work and/or volunteer in our health and care services. By creating the right conditions, job opportunities, and career pathways, we will increase our chances of retaining and attracting talented people to join our teams. This includes attracting people from communities who have been less likely to work in health and care services.

Those working and volunteering in the community and voluntary sector play a crucial role in supporting you, your family, and your community. By developing strong relationships with the community and voluntary sector we can create more inclusive, resilient, and vibrant communities thriving on collective and mutual support.

Everyone has an important part to play in prevention so we must equip our people and communities with the opportunity, skills and confidence to do this.

> **"Thousands of people are involved in voluntary and community services and activities that take place every day in our towns and villages. Together they provide a vast and wonderful tapestry of support of all kinds. This kindness and support within our communities is at the heart of everyone's health and wellbeing.**
>
> **Strengthening the links between public sector services and our communities gives us the best chance for everyone to thrive, to feel heard, and to feel cared for. Linking our aims, working together, and sharing our knowledge and resources makes us stronger and more responsive, and increases the impact of our care and support for one another. The more we work together, the better care and support we can provide in the places we call home."**

Jon Sloper
CEO
Help and Kindness

Finance and efficiency

There is increasing pressure on financial resources across all our health and social care organisations. The funds available are not enough to maintain our current way of working. We therefore need to find ways to become more efficient and effective to deliver the care you need whilst living within our means.

Together the NHS and local authorities in Dorset spend over £2.2 billion on public services (health spends £1.6 billion and local councils spend £0.7 billion). We need to be sure we use our resources, including our workforce, technology, and buildings, in a way that brings the greatest benefit and fair outcomes for everyone.

We are working hard to manage our budget and spend money wisely. Through our local councils we are also asking the government for better funding to support social care.

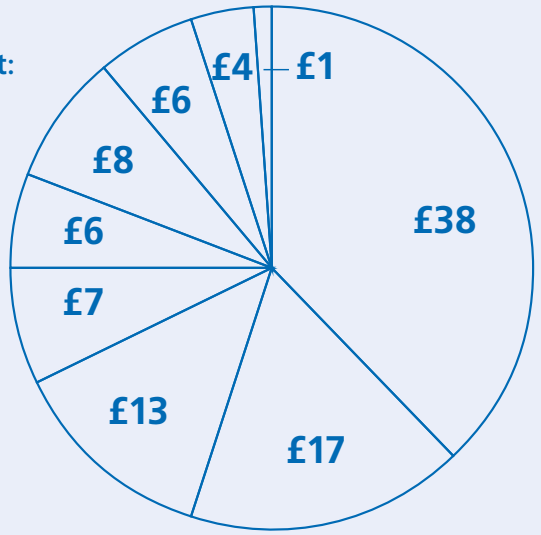
To make our goals a reality we know we need to make some changes. If we don't make changes, NHS services will have a funding shortfall of £98 million by the end of 2023/24. This includes a shortfall of £16 million on NHS England specialised services. Local councils also face significant financial pressures.

Our plan takes into account the challenges we face as we recover from the pandemic. We are working towards recovering our services, prioritising those people with the greatest need. We are committed to supporting the health and wellbeing of our staff as well as developing their skills to ensure they stay in Dorset. Finally, we are actively tackling our financial challenges to make sure our services are sustainable in the longer term.

Finance

Overall system budget:

£2.2B



For every £100 spent, the system uses:

£38 on hospitals and ambulances

£17 on primary care and community services through the NHS

£13 on adult social care through the councils with some NHS joint funding

£7 on mental health and learning disabilities through the NHS

£6 on children's services including education

£8 on other NHS commissioning

£6 on other council services including bins, street cleaning and libraries

£4 on supporting services and central functions including transformation

£1 on public health services including prevention

Environmental sustainability

We want to make sure we have a sustainable health and care system through delivering high quality care and improved public health, without impacting our environment. Sustainability means spending public money well and making the best use of natural resources, which in turn builds healthy and resilient communities.

A key element of sustainability is reducing the impact of climate change and adapting to a changing environment. The NHS has set two ambitious targets in its aim to be the world's first net zero national health service:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

One of our four key areas is to support social and economic development. We plan to contribute through social value. This is the wider role we have in helping to improve the economic, social, and environmental wellbeing of our communities. This means looking at how our services can improve the economy in local areas as well as improving the environment.

We have a Green Plan in place which sets out what we will do and how we will achieve our targets. Through our Green Plans, we will continue to work with NHS England to reduce our negative impacts on the environment and, deliver against our obligation to have a positive effect on the communities we serve, building health and resilience within Dorset and beyond.

Health and wellbeing board statement

We have two health and wellbeing boards, one for Bournemouth, Christchurch, and Poole Council and one for Dorset Council.

Health and wellbeing boards are groups which bring people together from the NHS, public health, and local government. Their goal is to support health and care organisations to work better together to provide joined up seamless care. They have a legal requirement, along with NHS Dorset, to assess your needs and develop a plan to improve your health and wellbeing.

Our plan supports the priorities of the health and wellbeing boards. These are:

Empowering communities: our plan focuses on working with you to help you live independently and access the services you need, paying special attention to those with the greatest needs.

Promoting healthy lives: our plan outlines how we will improve outcomes for our children, young people, and adults with mental health conditions. We also aim to ensure our children have a healthy start in life by addressing issues like being overweight and obesity. We want to reduce differences in health outcomes, such as how high blood pressure is managed.

Supporting and challenging: our plan explains how we will work with other health and care organisations to develop joined up health and care services which meet your needs.

"Working to support disadvantaged communities is a key priority for BCP Council. Being part of the integrated care system gives us the opportunity of working together at place level to tackle these inequalities in health outcomes, access, and experience."

Cllr Jane Kelly
Chair
BCP Health and Wellbeing Board

"Working better together gives us the opportunity to invest scarce public sector resources in the best possible way. Our integrated care system, if it is working well, should be less about our individual organisations' priorities, and more about planning care and support for people to enable them to live independently for as long as possible."

Cllr Jane Somper
Chair
Dorset Health and Wellbeing Board

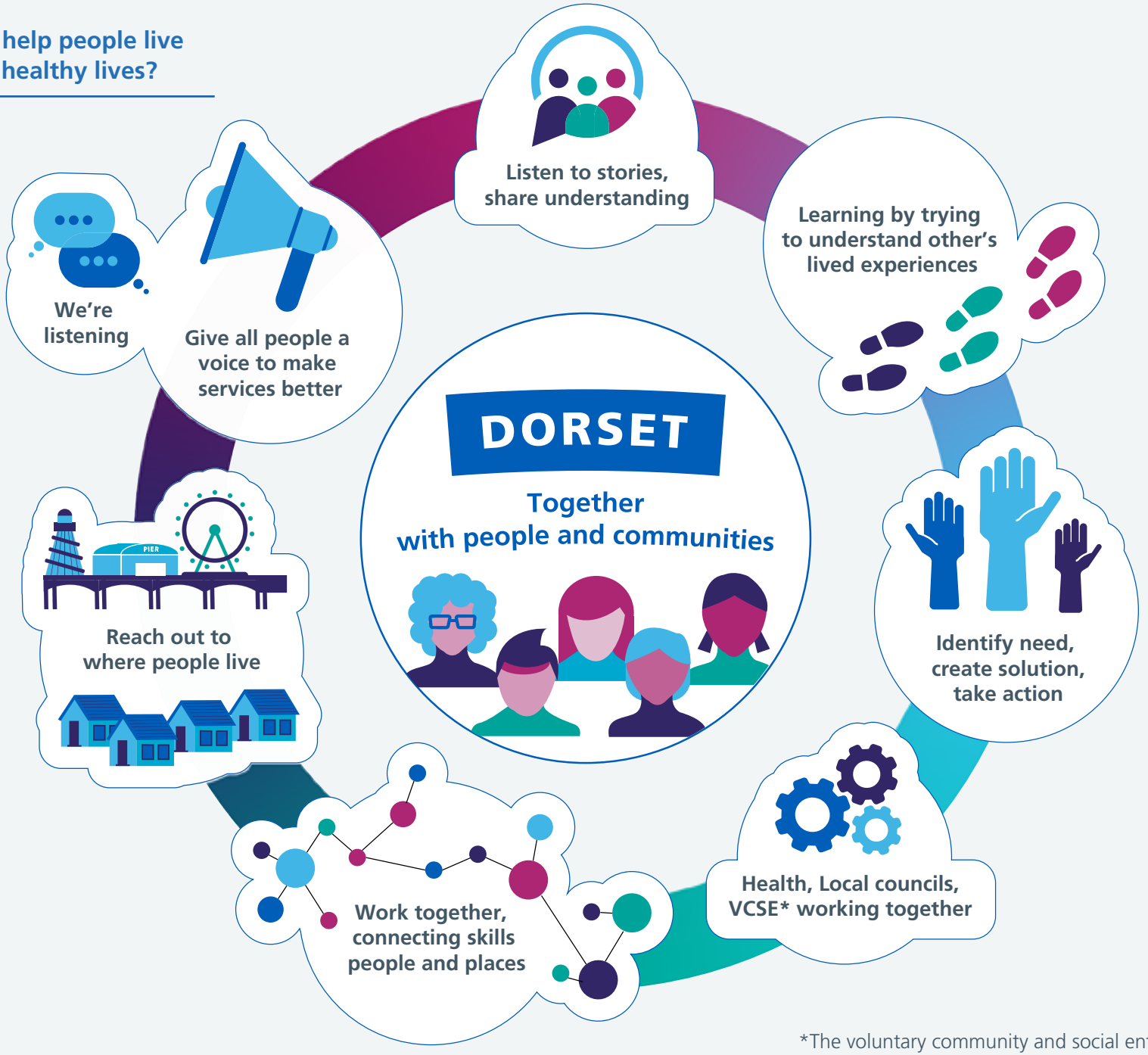
Working in partnership with people and communities

It starts with you. We want to empower you to inspire us. We want to listen to your ideas and experiences to help us to improve health and care services for the better.

> **"We need to listen and learn by trying to understand other's lived experiences. We need to design with you the services that people and communities in Dorset need going forward. We want to work with you and our partners to help everyone live not just a long, healthy life, but also long lives that enable individuals and families to thrive and achieve personal happiness."**

Patricia Miller OBE
Chief Executive
NHS Dorset

How can we help people live long, happy, healthy lives?



*The voluntary community and social enterprise sector (VCSE)

We have made a promise to have important conversations with you. We want to understand what people's lives are like and what is most important when it comes to your health and wellbeing. We have been asking you about what makes you feel good and healthy.

We are going to continue these conversations and make it a regular thing to listen to people in different communities, making sure we reach those who are less likely to be heard. We want to hear from you, your family, and your neighbours and understand their experiences and needs so that we can make sure our plans meet their expectations.

These conversations have given us a good understanding of the things you feel are most important when it comes to health and wellbeing.

If things are working well and services are being delivered seamlessly you will:

1. feel Listened to and involved
2. have a sense of purpose and belonging
3. not be passed around services
4. have access to services closer to home
5. remain independent by having the tools and opportunities to stay well
6. be able to easily use the natural environment for wellbeing
7. be considered as a whole person or family

community conversations

Our plan

In this part, we will explain how the work we will do will help people to become healthier and happier. Together, we can make Dorset the best place to live when it comes to health and wellbeing.

We have a great opportunity to make our goals a reality. We can work with you to improve wellbeing, not just for those currently living in Dorset, but for future generations. Working side by side with you, health and social care organisations, community and voluntary organisations, and with local businesses, we will transform what we do.

Our plan has five areas of focus — our five outcomes are:

We will **improve** the lives of **100,000** people impacted by poor **mental health**.

We will prevent **55,000 children** from becoming **overweight** by 2040.

We will **reduce the gap** in healthy life expectancy from 19 years to **15 years** by 2043.

We will **increase** the percentage of older people living well and **independently** in Dorset.

We will add **100,000** healthy **life years** to the people of Dorset by 2033.

These outcomes have been developed through:

- what you have told us is important to you
- what colleagues working in health and care feel are important to prevent illness
- information showing where there are differences in services in different areas
- the Joint Strategic Needs Assessment
- understanding what might happen if we do nothing.
- being ambitious for change

There are a number of principles which have been used when developing our outcomes:

Putting you at the heart

Making sure you receive the same outcomes no matter where you are treated or where you live

Using available information to guide us

Working with you and other health and care organisations

Using our money wisely to deliver the services you need

"The focus now is on what we need to do to prevent illness, address inequalities and the support communities need to manage their own health and wellbeing.

We know that when we make prevention the core of what we do, it will lead to better outcomes and quality of life, more personalised services and, vitally, will reduce the inequities across the county.

Prevention is a real and long-lasting way to reduce the unsustainable load on our health and care services. This is an exciting time for Dorset, and we all have an important role to play in this transformation."

Neil Bacon
Chief Strategy and Transformation Officer
NHS Dorset

Outcome one:

We will improve the lives of 100,000 people impacted by poor mental health.

Why it's important

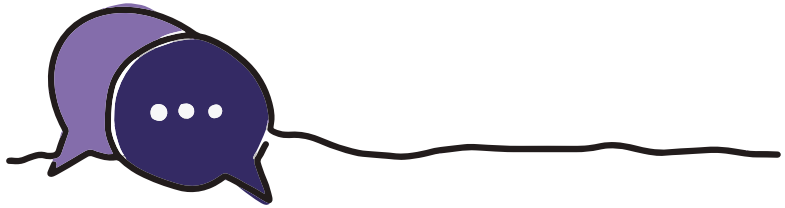
Mental health is everyone's business.

> **"We all have mental health. But not all of us experience good mental health all the time."**

Our mental health is always important throughout our entire lives, from when we are born until the end of our lives. It is our responsibility to create communities where people can promote wellness and receive the support they need to thrive. To make a positive change, we need to shift the culture to create environments that enable good mental health. Early intervention and involving families are crucial in providing the right support at the right time. By doing this, we can make sure that everyone has an opportunity to maintain good mental health.

Engaging with businesses and providing them with support is essential for building resilient communities. When businesses thrive, they create opportunities for people and communities to reach their full potential. When businesses succeed, they contribute to the economic growth of the community, which in turn leads to an improved quality of life for people.

There are many factors that affect our mental health, and it is important to work together to make positive changes. We need to focus on helping people feel good and cope with mental health challenges, encouraging physical activity, making sure there are helpful services in our communities, supporting parents and families, making sure children get the help they need through early years



settings, pre-schools, and schools, eating healthy food to feel good and stay well, and looking after both our bodies and minds. By focusing on these areas, we can create a better environment for everyone's wellbeing.

In England, one in four people will experience a mental health problem each year, and one in six will experience a common mental health problem, like anxiety or depression, in any given week. If no action is taken, we could see 17% of the population experiencing depression by 2028. The financial cost of mental ill health in the UK is around £118 billion, which is 5% of GDP. For Dorset, this is about £1.4 billion.

Sometimes people need extra help, especially children and young people. Unfortunately, waiting times for this help are longer than they should be. Only a small number of people are offered an appointment within four weeks, which is much lower than the national target. We also see a lot of young people going to the hospital because they have harmed themselves, and more and more children with autism are experiencing mental health difficulties.

In Dorset, if someone is going through a tough time with their mental health, they might not be sure where to go for help. There are different places they can turn to such as their GP surgery, local emergency department, local community health team and community groups. It is important to know that there are options available, but it can be confusing to know which is the right choice.

What we've been doing

We want to make sure our children, young people, and their families get help for their mental health as soon as possible. We have a plan called the Emotional Wellbeing and Mental Health Strategy for Children and Young People to help us to do this. We have used a model called 'THRIVE' to change how we work so all children have the best chance to be happy and well.

We have also improved specialist help for parents who may have mental health difficulties during pregnancy or after having a baby. We know dads and partners need help too, so we have something called DadPad to give them support.

Community support is important to help you stay well. We now have more people called 'social prescribers' who help through GP practices. They can listen and support you to identify what is important to you, make changes in your life and connect you with things happening in your local area.

We have a special group made up of different organisations working together to prevent suicides. We have a plan to make sure we take action and help people when they need it most. We have been working hard to improve the services for those in crisis and need more support with their mental health and emotions. For university students in Bournemouth, we have created a special place called the 'University Retreat'. It is a safe place where students can go when they need help and support. It is important that they know they are not alone and that there are people who care about their wellbeing.

Sometimes it can be difficult to get all the different services running together smoothly. We have been working hard to make this better, especially in primary care. We want to make sure everyone gets the help they need. For example, we have been focusing on making sure people with a serious mental illness go for a yearly health check. This helps people stay healthy and get the right support. We also have a programme called LiveWell Dorset. It helps people make positive changes in their lives to become healthier both physically and mentally.

We have a group called the Health Inequalities Group (HIG) focusing on making sure everyone has a fair chance at being healthy. The HIG brings together people from a wide range of organisations to reduce health inequalities for people of all ages. The HIG works with the Community Conversations programme to understand what is important for people from different communities and to find ways to tackle the barriers to being healthy.

Looking after our staff who deliver services is important too. We have a number of staff wellbeing offers including an enhanced service through Here for Each Other and projects to help our staff to stay active.

wellnet.dorset.nhs.uk

What we are going to do

‘Your mind, Your say’ — Children and young people’s emotional health:

We know taking care of our mental health is important. That’s why we have a programme called ‘Your mind, your say’ to help children and young people with their emotional health. We want to make sure all our children feel strong and happy. We will provide support to help them build resilience and cope with their feelings. We will also make sure early years and pre-schools are places where children can learn and grow while feeling good about themselves.

It is important our children and young people have someone to talk to and get the help they need. We will train teachers and staff to have conversations with children and young people about their emotions.

We know sometimes people need a little more help. We will be looking at the support we can provide if things get really tough and more specialist support is needed.

Mental health integrated community care (MHICC):

We are developing integrated community care for mental health. It will be based in communities offering a range of services to support your mental health needs. This will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management, and support for self-harm and substance use. This includes looking at services for people with the most complex needs.

Perinatal mental health:

Some people might feel different or have changes in their feelings during and after pregnancy. In fact, one in five people might have a mental health condition during this time. That’s why we want to make it easier for those who need it to get help. By helping parents and improving their mental wellbeing we will also be helping children and young people.

Dementia:

We will continue our work to better support people with dementia and their families. This includes a memory assessment, employing more staff and provide training and development so staff have the right skills. Having staff with different skills means we will be able to diagnose dementia earlier and provide the support needed.

We will use our Population Health Management tools (Dorset Insights and Intelligence Service (DiiS) to make sure we understand where we need to focus our support, and we will target areas where we have lower than expected rates of dementia so we can diagnose people earlier and help people live well with dementia.

We will also continue to reduce the waiting times within our memory assessment service.

Learning disabilities

We continue to work closely with our local councils to plan and deliver services for people with learning disabilities and/or autism. We want to make sure people have the right care and support to help people with learning disabilities live their best life. We have plans in place to increase the number of children and young people accessing annual health checks to help us find any problems early, help people to stay healthy, and make sure the right care is being given.

We want to make sure all our children, young people, and adults with learning disabilities and or autism get the care they need in the right place.

We will reduce the number of people being cared for in hospital settings, unless necessary. We will support them to have different care in the community, however when people need to go into hospital, we will make sure they do not stay longer than they need to.

We are also reviewing our neurodiversity services. This includes learning difficulties, attention deficit hyperactivity disorder (ADHD), and autism. From this we will better understand the need and any gaps, and develop plans to improve the services.

How we are going to measure progress

We have a number of measures that we will monitor which will tell us if we are helping you to access the services you need in the right place.

You will see:

- More children and young people accessing mental health services when they need it. This includes access to children and young people's mental health services and eating disorders services
- More children who have a learning disability receiving an annual health check
- Fewer children who have a learning disability and/or autism receiving their care in a hospital setting where this is not needed
- More adults and older people getting quicker access to psychological therapies when they need it
- Fewer adults experiencing a mental health condition cared for outside of Dorset
- More people diagnosed with Dementia and getting the care and support they need
- People who are suffering from severe mental illness getting an annual health check and care to support them
- More people accessing perinatal mental health services when they need it

Your mind, Your say — children and young people's emotional health	Year 1-2	Year 3-4	Year 5+
• Reconfigure services against THRIVE framework/model.	✓	✓	✓
• Embed a 'no wrong door' approach.	✓	✓	
• Remodel to address workforce gaps via new skill mix and roles.	✓	✓	✓
• Implement crisis support team.		✓	✓
• Implement children and young people's Community Front Room (crisis café model).		✓	✓
• Improve access to perinatal mental health services.	✓	✓	✓
Mental health integrated community care (MHICC)			
• Wellbeing co-ordinators delivered through voluntary and community sector	✓	✓	
• Hubs and community spaces.	✓	✓	
• Age friendly communities in Bournemouth, Christchurch and Poole.	✓	✓	
• Reduce out of area placements for people suffering mental health conditions.	✓	✓	✓
Dementia			
• Memory assessment model.	✓		
• Review skills mix, recruitment, and training of staff.	✓	✓	✓
• Use DiiS to target support with lower than expected rates of dementia.	✓		
• Continue to reduce waiting times for the memory assessment service.	✓	✓	
Learning Disabilities			
• Increase the number of children and young people accessing health checks.	✓	✓	
• Continue to implement plans in reducing reliance on inpatient care for both adults and children with a learning disability and/or who have autism.	✓	✓	✓
• Undertake a review of our neurodiversity services to identify any gap and develop plans to improve services.	✓	✓	✓

Outcome two:

We will prevent 55,000 children from becoming overweight by 2040.

Why it's important

On average, in Dorset three out of ten 11-year-old children are overweight. In our most deprived areas this number will be even higher.

If nothing is done, nationally about 40% of 11-year-olds will be overweight by 2040. Obesity in children can have serious and long-term consequences on their physical health, mental health, and overall quality of life.

Why it is important to prevent obesity in children:

1. **Physical health:** being overweight means you are more likely to develop diseases such as type 2 diabetes, high blood pressure, heart disease, stroke, and certain types of cancer in adulthood. Being overweight or obese can have serious consequences on a child's health and wellbeing.

2. **Mental health:** children who are overweight are more likely to have depression, anxiety, and other mental health problems. They may also face bullying and unfair treatment, which can affect their mental health.

3. **Social and emotional wellbeing:** children may struggle with self-esteem and body image issues, which can affect their social and emotional wellbeing. They may also have difficulty taking part in physical activities and social events, which can lead to isolation and loneliness.

4. **Academic performance:** obesity has been linked to poor academic performanc. A range of things such as stigma, physical activity and school absence can affect a child's ability to concentrate and learn.

5. **Long-term consequences:** children who are overweight or obese are more likely to become obese adults, which can lead to more health problems and a shorter lifespan. Preventing obesity in children is crucial for their overall health and wellbeing. It can help them lead healthier and happier lives, both now and in the future.

In Dorset we are determined to do everything possible to prevent children from experiencing the serious and lifelong consequences of obesity. This will need us to make a long-term commitment with all our partners including NHS, local authorities, and the voluntary and community sector, as well as businesses.

We will need to improve the health and wellbeing of parents to be and families to support children in the first 1,000 days of their life and to work across both health services and in early years, pre-schools and schools.

What we've been doing

We work closely with our local councils to make sure our children and young people get the best start in life. One important programme is called Better Births, which helps pegnant people have personalised care plans and improves the care they get after giving birth. We want to make sure all expecting and new parents have access to the same level of care and support.

To support healthy pregnancies, we provide easy to understand information on our Maternity Matters website in a range of languages. We also offer advice and support on feeding and caring for newborn babies. We believe in the importance of breastfeeding, so we actively take part in the Dorset Infant Feeding Network. We have developed initiatives in our hospitals to create a welcoming environment for breastfeeding parents.

Dorset HealthCare plays an important role in delivering the Children and Young People's Public Health Service. They have a person called a clinical lead for nutrition who focuses on healthy eating for children and young people aged 0-19.

Right now, they are looking at a programme called Healthy Start. It helps families who don't have a lot of money to buy healthy foods like milk and vegetables and get free vitamins if they are pregnant or have a child under the age of four. These are important for young children and parents who are breastfeeding. By giving this support, we can help families have a healthier diet.

Public Health Dorset, Active Dorset and the Youth Sport Trust are teaming up to extend an exciting programme called Healthy Movers. This programme helps children understand why it is important to be physically fit, and support their development and wellbeing so they get a better start in life. They also have a project called the Whole School Approach. It's about making physical activity part of everyday life at school. They encourage things like the Daily Mile, where children run or walk for a short distance each day. They also teach children ways to feel less anxious and manage their emotions.

What we are going to do

Your mind, your say – children and young people's emotional health

In the previous outcome you would have read about our plans to help all our children and young people with their mental and emotional health. We recognise there is a link between mental health and weight. Overall, we want to make sure everyone's mental health is taken care of, and our children and young people can thrive and feel their best.

Oral health

Taking care of our teeth is important for overall health, and it is best to start developing good dental habits when we are young. That's why we encourage children to have regular dental checkups from an early age. By seeing a dentist regularly, we can prevent dental problems and keep our mouths in good shape. Taking care of teeth is not only important for our health, but it also helps us to be ready for school and stay healthy as we grow.

Nutrition is also really important when it comes to taking care of our teeth and is a key part of children's overall health.

Our programme follows guidelines called Core20Plus5 for children and young people. This helps us make sure that everyone gets the healthcare they need. This focuses on oral health too, which means we're working to reduce the number of tooth extractions which need to be done in hospitals for children under ten. We want to help those who are in the 20% most deprived areas, making sure everyone has a chance to have a healthy smile.

Healthwatch Dorset has been finding out people's experiences of NHS dentistry services. Over the next two years, we will be working on what matters most to people and finding new ways of doing things, so you can access to the dental care that you need.

Preconception and maternal care

We know the health and wellbeing of people before they become parents is really important for the health of their future children. But not many people think about this before they become pregnant. That's why we want to introduce something called preconception care. This is about helping people adopt healthy behaviours and manage a range of things that might get in the way of a healthy pregnancy, such as health problems, issues with relationships, finances or where they are living, before they become parents. We want to make sure local services are aligned to support people in this important phase.

To do this we are exploring how we can bring all the different services and support together. We are going to gather information and talk to you through our 'Community Conversations' approach. Doing this we can direct people to the services available to them within their communities.

Taking care of yourself when you're pregnant is important for you and your baby's health. In Dorset, we work together as a Local Maternity and Neonatal System (LMNS). We have plans and programmes to help pegnant people stay healthy and make sure all women can access maternity services and receive the same level of care, no matter who they are. National reports and investigations such as the Ockenden Review and Better Births help us to make maternity care safer, so parents and their families have a good experience during pregnancy and birth and in the weeks and months after a baby is born.

0 – 19 nutrition and activity

We want to make sure families have access to the right services to support their health. To do this, we look at the results from the National Child Measurement Programme. This programme helps us understand how children are growing and if they are a healthy weight. By looking at this information, we can see if there are any problems with children being overweight. This is important as being overweight can lead to health issues. We use this data to help us make decisions and create programmes to help families be healthier. The National Child Measurement Programme is part of the government's plan to tackle childhood obesity and it helps us see if what we are doing to help reduce it is working.

Our Children and Young People's Public Health Service is working hard to help children and families develop healthy habits right from the start. We know breastfeeding is a great way to give babies a healthy start in life. We also want children to be active and enjoy physical activity. That's why we're working closely with Active Dorset and schools to promote healthy lifestyles.

Active Dorset coordinates a national Sport England survey called Active Lives in schools to learn about how active children are, how much they know about staying physically fit and how their mental wellbeing is. At the moment not many schools take part in the survey, and we want to change that. By getting more schools to take part, we can gather important information about how active our children are and how we can help them to stay healthy. This data will help us understand the attitudes and behaviours of young people and how we can use this to reduce childhood obesity and promote better health and wellbeing.

In addition to supporting the national Healthy Start Scheme, we are keen to explore the possibility of partnering with our two councils to ensure all primary school children in Dorset receive free school meals up to and including those in year 6.

Public Health Dorset, Active Dorset and the Youth Sport Trust have teamed up to make the Healthy Movers programme available to more children. We want to extend this programme to 2-5 year olds in places like early years settings, childminders, libraries, and family hubs. Our goal is to have this running within the next two years.

We also want to support older children, starting from year 7 to live a healthier lifestyle. Public Health Dorset is working with young people to create an app which will give helpful information and tools to support our children and young people to make healthy choices. It's an exciting project that will be a follow-up to the National Child Measurement Programme.

We also have social prescribing for children and young people. Social prescribing is a way to help people by connecting them with activities, groups, and services in our communities. These things can help with practical needs like finding support. Right now, we have different services available across the county. We want to make sure all children and young people can access these services if they need them. To do that we are going to do something called a gap analysis. This means we'll look closely at the services we have and see if there are differences or gaps between different areas of the county. By doing this analysis, we can find out if there are unfair differences in how these services are available.

Active Dorset is working with the Department of Education to support schools to stay open for longer, outside of the school day, so communities can take part in a range of activities to help them stay active. The aim is to help areas that need the space the most and support people with additional needs to have a more active lifestyle.

How we are going to measure progress

We have a number of measures that we will monitor which will tell us if we are helping you to access the services you need in the right place.

You will see:

- more children accessing dental services
- fewer children experiencing poor dental health
- fewer children in reception year who are overweight or obese
- fewer children in year 6 who are overweight or obese
- more babies being breastfed beyond their first 6-8 weeks

We will measure these outcomes through the National Child Measurement Programme (NCMP).

Oral health	Year 1-2	Year 3-4	Year 5+
• Introduction of supervised toothbrushing.	✓		
• Child friendly dental practices.	✓		
• Elective recovery for routine paediatric extractions and long waiters.		✓	✓
• Improved access to dental care and response to population health needs, and working with Healthwatch Dorset to capture people's experiences.		✓	✓
0 – 19 nutrition and activity			
• Explore NCMP follow-up services, gap analysis and propose additional provision.	✓	✓	
• Explore the possibility of partnering with the two local councils to offer free school meals.	✓		
• Scale up the Healthy Movers Programme.	✓	✓	
• Complete the work on the app to support children and young people with healthy lifestyles.	✓		
• Explore the work Active Dorset are undertaking and the information available through the Active Lives Survey.	✓	✓	✓
• Gap analysis of social prescribing services for our children and young people and propose options.	✓	✓	✓
• Continue to support the review of local delivery of the national Healthy Start Scheme.	✓	✓	✓
Preconception and maternal care			
• Explore the potential to align work across the system, gap analysis and propose additional provision for preconceptual care.	✓	✓	
• Continue our work on the Local Maternity and Neonatal System (LMNS) equity and equalities action plan aligned to the Core20PLUS5 focus on maternity, actions associated with the Ockenden and East Kent reviews, Better Births, Saving Babies Lives, and the Maternity Incentive Scheme.	✓	✓	✓
• Support organisations to achieve UNICEF Baby Friendly Accreditation.	✓	✓	✓

Outcome three:

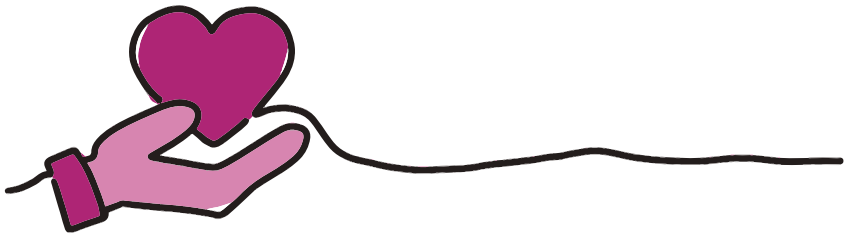
We will reduce the gap in life expectancy between most and least deprived areas from 19 years to 15 years by 2043.

Why it's important

In some areas of Dorset where people have less money and access to services or resources, they might not live as long or be as healthy as people in wealthier areas. It's not just about having access to good healthcare, but also other factors that affect our health. We know people in these areas tend to get a long-term condition at an earlier age and are less likely to go to the doctor. They can also find it harder to go to a hospital appointment and have less access to things that play a big part in keeping us healthy. These are known as 'wider determinants of health' and include having a good job, enough money, a good education, access to services, and a nice place to live. When we have all of these things, it helps us stay healthy.

Unfortunately, not everyone has access to these important things, which can make it harder for them to be healthy and live a long and happy life. That's why we need to work together to make sure everyone has a fair chance at being healthy. Our partners, such as local councils, community and voluntary organisations, Healthwatch Dorset, fire and rescue services, police, and our own communities, know that things like money, education, and access to services can affect our health and safety. In this plan, we explain how we will work together with communities to hear what matters to them, change how we do things to meet these priorities and take action on the things that are causing poor health. This means a change in how we do things and working closely with our communities.

Our goal is to be a health service that focuses on keeping people healthy instead of just treating them when they are sick. To do this, we need to address the impact of deprivation on communities, understand how people's lives can make it harder to take care of their own health and get in the way of getting the best from health and care services. By focusing on this, we can create a healthier and happier Dorset.



What we've been doing

We are not starting from scratch. We will build on the work we have been doing with you and other health and care organisations.

We have been working with other health and care organisations through our Health Inequalities Group to make plans to improve the health of communities. We also have a new way of working called 'place'. This means working closely with the communities where people live to make sure they have the services and support they need.

Using the information we have about our communities and the people living there means we can better understand their needs and target services to support them.

Through the Bournemouth, Christchurch and Poole Poverty Truth Commission, we have actively listened to and understood what makes a difference to you. A Poverty Truth Commission aims to challenge the 'status quo' and make change to remove injustices.

What we are going to do

We want to find new and better ways to help people who live in areas where there is poverty and less access to resources which help us to keep healthy. We have picked three specific areas in Dorset with higher levels of poverty and fewer resources to test our ideas and see what works. These areas have rich and diverse communities with skills and talents but are different from each other in terms of the people who live there and how the neighbourhoods are set up. By working closely with you we can learn what works best in different areas and find ways to make things better.

We have chosen three areas in Dorset to focus on:

- **Boscombe:** this area has a population that tends to move around more, and it is also more diverse with people from different ethnic backgrounds.
- **Portland and Weymouth:** these areas are geographically isolated and have a population that has been living there for a long time. They have been dealing with deprivation for a while, and they include both urban and rural areas.
- **North Bournemouth:** this area is home to families many of which have been experiencing deprivation across generations.

We will be working closely with these communities to find the best ways to improve their situations and make a positive difference.

We have four important things we're focusing on to make sure everyone in Dorset gets the help they need:

1. **Giving resources where they are needed:** we want to make sure the places and communities that need the most help get the right resources. We will use our money and support to make a big difference in these areas. We will also work on things that affect our health, like preventing problems and making sure people have what they need to stay healthy.

2. **Making services work better for everyone:** we know that different people have different needs and face different challenges. We want to make our services work for everyone, especially those who have been left out in the past. This means thinking about things like when services are available, how people can get them, and making sure that the information we provide can be understood by everyone.

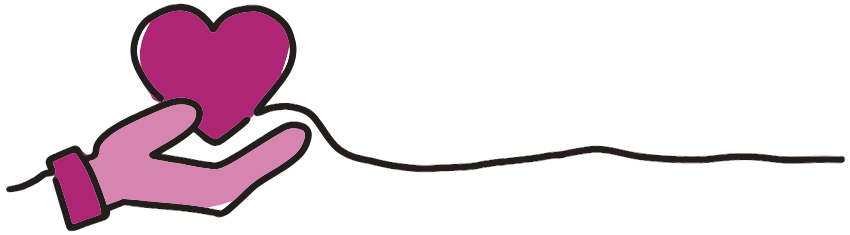
3. **Listening to the communities:** we value the skills, talents, and ideas of our communities. We want to involve people in shaping our plans and work together to make things better. By working with communities, we can understand what's needed and what gets in the way and make sure our shared plans and actions match those needs.

4. **Using our resources wisely:** we have a lot of people working in the NHS in Dorset and we have many buildings and vehicles. We want to use these resources in the best way possible to support communities that need them most. This means considering the impact we have on the environment, making sure our jobs are open to all, providing training, creating jobs and apprenticeships, and finding ways to use our buildings, land and the things we buy to address health inequalities and benefit local communities.

How we are going to measure progress

We want to make sure our efforts are making a real difference to the health of deprived communities. To know if we are doing well, we will use different ways to measure our progress.

Sometimes it takes a long time to see big changes in health between communities. That's why we need to start now and keep working towards our goals. We know it will take a lot of time and effort to create lasting improvements. To track our progress, we use indicators. These are like signs that show us how well we are doing. We are developing these to measure the steps we are taking to achieve our goals.



Making sure our plans in our priority communities are developed and implemented with our partners	Year 1-2	Year 3-4	Year 5+
• Test and agree the three areas and identify existing activity.	✓		
• Develop a framework of indicators and a model to track progress.	✓		
• Use our metrics to identify what to continue, what to stop, and what we need to do more/less of.	✓		
Aligning resources with need			
• Review resource allocation, service access, and uptake in the three areas and continue this over five years.	✓	✓	✓
• Allocate the NHS Dorset health inequalities funding to support achievement of shared priorities with a rolling programme and embed as business as usual.	✓	✓	✓
• Develop methodology and approach to NHS outcomes-based commissioning.	✓	✓	✓
Using community centred approaches			
• Work with the three areas to understand ambitions, priorities, strengths, and the barriers we create.	✓	✓	✓
• Evaluate and identify learning to support implementation in other areas.		✓	✓
• Develop listening programmes within the three areas, codesigning with then.	✓	✓	✓
• Identify and roll out 'quick wins' and identify further potential projects.	✓	✓	
• Implement targeted programmes for diagnosis, monitoring and management of hypertension, atrial fibrillation, high cholesterol, and diabetes.	✓	✓	
• Further expand condition specific briefings with a focus on case finding management.	✓	✓	
• Work together to identify the best ways to support and grow strong communities.	✓	✓	✓

Making the most of our role as an anchor institution	Year 1-2	Year 3-4	Year 5+
• Development of an integrated estates strategy	✓	✓	✓
• Implementation of estates strategy including community hubs.		✓	
• Expand and accelerate use of estate opening to wider community assets.	✓	✓	✓
• Continued implementation of the New Hospitals and University Hospital Build Programmes.	✓	✓	✓
• Understand resources within place/communities, workforce, estates, community groups.	✓		
Making our services work better for our underserved communities			
• Implement initial programmes to improve outcomes.	✓	✓	✓
• Routinely identify services where some groups do less well than others starting with waiting times and where people do not attend appointments.	✓	✓	✓
• Deliver improvement programmes for the clinical priority areas in the national CORE20PLUS5 programmes for children and adults.	✓	✓	✓
• Embed actions and learning from initial programmes rolling out within other communities.		✓	✓
• Systematically embed Equality and Health Inequality Impact Assessments.	✓	✓	✓
• Identify a roll out of another phase of programmes to improve outcomes.		✓	
CROSS CUTTING: Building capacity and capability for action on health inequalities and wider determinants of health			
• Review learning and development needs.	✓		
• Continue to build our shared Virtual Academy for health inequalities.	✓	✓	✓

Outcome four:

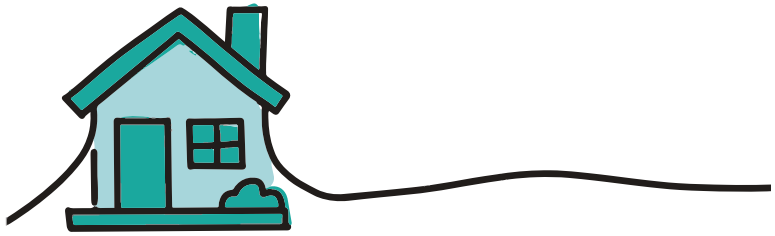
We will increase percentage of older people living well and independently in Dorset.

Why it's important

As people are living longer, there are more older people in our communities. Older people make a huge contribution to our community in Dorset, with retirement providing opportunities for volunteering and helping to keep local communities vibrant and active. However, for some people older age can provide challenges. It is important older people have a good quality of life and receive any support they need. Unfortunately, many older people face difficulties. Some struggle financially, while others don't get the help they need, which can make it harder for them to look after themselves. In these circumstances people sometimes feel like they have no one to turn to when they need help, which can make it harder to manage their health conditions, particularly if they have multiple health problems. When older people don't get the right help, it can affect their overall wellbeing and how they feel.

As we age, our bodies find it harder to recover quickly and we can become weaker and less likely to get better from illness. Frailty is a term that is used to describe people who, through age, get exhausted quickly, find it harder to get around and to look after themselves. People who are frail are more likely to have falls, be admitted to hospital and need longer-term care. If an older person with frailty needs surgery, it can be more challenging for them if their frailty was not noticed earlier.

Our aim is to help older people to stay independent and live well in their own home. To achieve this, people need access to early help and support, in a way that suits them. It's important that people do not feel alone or lonely and remain connected to those who are important to them. Taking a proactive and preventive approach is crucial in accomplishing our goal of helping older people to live well.



What we've been doing

We work together with our two councils to create a plan called the Better Care Fund. These plans are designed to help improve the care and support available to you. We also connect with the councils' plans for adult social care and housing to make sure everyone is coordinated. We are also developing a plan specifically for carers.

Right now, our communities are facing different challenges. In Dorset, our community and voluntary sector have come together to provide support to people experiencing challenges such as cost of living or feeling lonely and isolated. This includes providing food banks where people can get emergency food, supplies and safe spaces where people can go if they are lonely or need help.The good news is our communities are coming together to tackle these challenges.

These initiatives show how strong our communities are and how we can support each other in difficult times. To make sure you get support tailored to your needs, we are using something called personalised budgets. This means you can decide how you want to use the support you receive based on what is most important to you It gives you more choice and control over you care.

Another approach we are using is called reablement. This approach is about helping you become more independent and stay in your own communities. Instead of going to hospital, we provide support and services to help you recover and regain your abilities. This way, we can reduce the number of hospital admissions and help people stay independent in their own homes.

What we are going to do

Integrated community care model

We will focus on helping you stay healthy by preventing problems before they start. It is important for each of us to take care of our own health and do what matters most to us. Following our Integrated Community Care Model, we will work with you to understand your needs. We will listen to your opinions and make sure we provide the services most important to you. We will support organisations in the voluntary and community sector to help people in the best way possible. We will review our services to make sure they are easy to access when and where you need them.

Anticipatory care

We are creating a programme called the Anticipatory Care Programme to help older people live well at home. Our goal is to make sure they can easily share any concerns they might have about their wellbeing, independence, social connections, and staying healthy. We want to connect people with the support they need, and we want to do this on a larger scale to reach more people. If older people have a fall this can be a trigger that affects how independent they can be. Using the information we have we can understand the needs of different groups of older people and provide the right services. Keeping physically active can help to prevent falls, while those who are already frail may need more targeted support.

Our approach is to be proactive and prevent any issues from becoming more serious. If you need help, we want to work closely with you to understand what you want in order to live your best life. It could be as simple as continuing to enjoy gardening, meeting friends, pursuing hobbies, or learning new skills. We believe in the power of community support.

For example, we can help create support groups like community kitchens that offer a lunch club. These places bring people together, provide them with a nutritious hot meal, and offer support and companionship.

We are working on a project to better understand the needs of frail residents in care homes. Our focus is on developing and testing a special plan called a frailty pathway in two areas. This pathway aims to prevent hospital admissions and help residents in returning home with support, focusing more on preventing admissions.

Virtual wards

To make sure people get the best care we are using a team of experts from various healthcare fields. They will work together to provide the right care for people in their homes whenever possible. We are also exploring the use of technology, like a smart application on a phone, to monitor residents' health, such as blood pressure. We are working with community partners and agencies like the police, fire services, and post offices to keep an eye out for any signs that someone may need help, like if their curtains are not drawn.

During this project, we will be testing different approaches in different areas. In one area, the focus will be on preventing older people from going to the hospital, while in another area, we will focus on helping people when they come back after being in hospital. An external company called Immedicare will help us identify any changes in the health of care home residents early on. This way, older people can get more help and support from a team of healthcare professionals.

At first, we will start testing this with just one or two residents, then gradually increase to 15 people in each area. As we learn more, we want to include frail older people who live in their own homes too. As the pathway develops, we will extend it to include frail people living in the community. We have a special virtual ward that can help up to 20 frail individuals. This will support us to make sure everyone who might be frail gets the right monitoring and support. When appropriate, we want to help people move from the virtual ward to needing less monitoring, so they can still be independent.
We are creating a hub to help monitor the health of people who have recently left hospital. This hub will be starting in the east and focus on supporting people with respiratory, cardiac, and frailty conditions. It will allow us to check their health from a distance. As we make improvements, we will also use the hub to prevent people from needing to go to hospital.

We are currently developing different plans for people with respiratory, cardiac, and frailty conditions. These plans are based on our Core20PLUS5 priorities and aim to keep these conditions stable and monitored. To make this all this happen, we need to work together with primary care and the councils to make sure you have access to digital technology and feel comfortable using it. This is important because having access to information, advice, and services, not just about health, will help you stay independent and feel more in control.

Urgent and emergency care

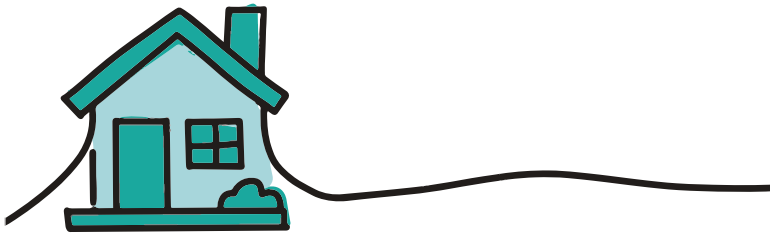
We are reviewing our urgent and emergency care services to make sure they work together in a more joined up way. Working with Healthwatch Dorset, we are finding out what you think about urgent and emergency care services and using your experiences to improve the services we provide. We want to work with you to develop services which mean you can be treated as close to home as possible. This might be through urgent community response teams, urgent treatment centres, and other units. But when you do need to go to a hospital, we want this to be as quick and as safe as possible. If you have to stay in hospital, we only want you to stay for as long as you need to and help you to get home as soon as possible.

How we are going to measure progress

We will monitor a number of measures which will tell us if we are delivering our goals.

You will see:

- fewer people being admitted to hospital as a result of a fall
- maintained or increased physical activity in older people
- more people being treated at home, or within their care home using digital monitoring, including virtual wards or integrated community services teams
- better access to urgent response services as close to home as possible. You should only have to go to an emergency department when you need to
- better access to same day emergency care
- more people waiting less than four hours to be seen in one of our emergency departments
- more people being discharged from hospital into their own home or place they are living quicker



Integrated community care model	Year 1-2	Year 3-4	Year 5+
• Work with local people to make sure we deliver required services which matter the most to people.	✓	✓	✓
• Invest in our voluntary and community sector.	✓	✓	✓
• Connect people with community and voluntary sector support including physical activity. .opportunities through social prescribing.	✓	✓	✓
• Review of community services.	✓	✓	✓
Anticipatory care			
• Implement the anticipatory care programme.	✓		
• Work with our local people to develop and implement the frailty pathway.	✓		
• Work with our local people to develop and implement the falls pathway.	✓		
Virtual Wards			
• Continued implementation of virtual wards and remote monitoring hub.	✓	✓	
Urgent and emergency care			
• Work with you to develop and put in place our urgent and emergency care recovery plan.	✓	✓	
• Work with you to develop and put in place our urgent care services.	✓	✓	
• Implement our hospital flow programme.	✓		
• Implement our ambulance additional services capacity plans.	✓		

Outcome five:

We will add 100,000 healthy life years to the people of Dorset by 2033.

Why it's important

We know you want to enjoy a long and healthy life. As well as providing high quality services for you when you are unwell, we are committed to supporting you to live the healthiest life you can by preventing illnesses as much as possible and addressing things that can lead to poor health and wellbeing.

There are several ways we can help you to live a longer, healthier and happier life:

1. **Prevention and early detection:** we will focus on preventing diseases by promoting healthy lives and finding diseases early through regular screenings and checkups and earlier access to healthcare for underserved groups.

2. **Chronic disease management:** we will focus on managing chronic diseases such as diabetes, heart disease, and cancer to stop things getting worse and improve your quality of life.

3. **Access to care:** it is important that everyone has access to quality healthcare services, regardless of where they live.

4. **Health education:** we will increase awareness of the steps people can take and the support they can get to be healthy, prevent disease and manage long-term conditions, so that people can have the best chance to tackle the things that get in the way of being healthy.

5. **Social determinants of health:** things like poverty, education, and housing have a far bigger impact on health than treating sickness. To improve the health of our communities, it is vital we look at these issues.

6. **Technology and innovation**: we will be bold and determined in using technical innovations to improve how we deliver healthcare services, increase efficiency, and improve your health outcomes. We want to be world-class in using data, artificial intelligence and digital solutions to improve lives. By doing this we will make sure we continue to provide services that meet the needs of people who are less able to use digital services.

By implementing these strategies, we will add to your healthy life years and improve overall health outcomes. Our ambition is based on adding five years of healthy life expectancy in our most deprived areas by 2043, aligned with national ambitions for life expectancy.

What we've been doing

We have a service called LiveWell Dorset. Through LiveWell you can get help to make healthy choices, look at the things that get in the way of being healthy, and make life better. The team are supporting people in moving more, managing weight, quitting smoking, and drinking less. You can access this service yourself or someone might put you in touch with them.

Right now, we are trying out new ways to help people with serious mental illness through LiveWell Dorset and our outpatient health villages. We are working closely with Active Dorset on a project which helps people with muscle and bone problems to be more active. The physical activity programme 'movement for movement' looks to support everyone to move a little more every day, with specialist help for those who would benefit most from moving more.

We have been helping pregnant people to quit smoking, and we have a service called tobacco dependency treatment to support them. We have expanded this support to all people staying in hospital and are testing it out for those who are getting long-term mental health services as outpatients.

Doctors in primary care can recommend a few national programmes to help people to lose weight. One is the National Diabetes Prevention Programme, which helps those who are at risk of developing diabetes.

Another is the Digital Weight Management Programme, designed for people who are overweight and have diabetes or high blood pressure. GPs and community pharmacies also offer NHS Health Checks to calculate the risk of cardiovascular disease and help lower it if possible. GPs take part in a national audit called the Cardiovascular Disease Prevent Audit to see how well we do as a system to identify and manage conditions like high blood pressure. We encourage you to 'know your numbers' and get your blood pressure checked regularly.

We are committed to providing cancer screening and supporting people in their recovery from cancer. This includes making sure that people with serious mental illness, learning disabilities and those who are homeless are able to get to screening services. Screening programmes focus on identifying various types of cancer, such as cervical, breast and bowel cancer. They also target people who are more likely to develop other health problems such as eye screenings for diabetic retinopathy and screenings for abdominal aortic aneurysm.

We have been focusing on digital innovations. This helps us to make sure everyone has fair access to digital health services. We use these innovations to identify the right people who can benefit from digital tools for managing long-term health conditions. We also track the outcomes and results of using these tools for self-management of health conditions.

What we are going to do

Health inequalities programme

As part of our plan in outcome one on page 28, we set out how we want to make things fair for everyone and prevent problems before they happen. We will focus on groups of people who are more likely to develop health problems and on areas of healthcare that are likely to lead to early death. This includes people living in more deprived areas and the five clinical areas for adults and children that are most likely to lead to poorer health. These are known as CORE20PLUS5. We will look at how we can make sure everyone gets fair access to services and support. We want to make sure that children, young people and adults can easily get help for their mental health and emotions. We will work hard to make sure that at least 60% of people with severe mental illness get regular physical health checkups. We will look closely at children and young people in different groups to understand their needs better.

As part of our plan in outcome three on page 43 we set out how we will work with communities to give resources where they are needed, make better services for everyone, listen to communities and use our resources wisely. This outcome builds on that, with a focus on some key areas we know we could do better working together. The cardiovascular disease audit has highlighted we could do better in by identifying people with high blood pressure.

Tobacco dependency treatment service

Working with Public Health Dorset, we will continue to support the roll out of the tobaccod dependency treatment service in our hospitals and other areas. We will also help more people take up the advice services offered by LiveWell Dorset so more people can live healthy lives.

Cancer

To help people with cancer, we will look at how different groups of people get access to treatments and how they recover. We want to make sure that everyone, no matter who they are, can get the right care. Working with our partners we will put in place programme to help prevent cancer, diagnose cancer early, achieve great outcomes, and treat our patients as individuals — with person centred, equitable care.

We will work with those affected by cancer to plan and find solutions. We will also find out what other needs people have when they are diagnosed with cancer. We will do this by talking to them and reviewing their health needs and then working with community organisations to make sure they are supported.

Elective recovery

We want everyone to have a fair chance at being healthy, so we work hard to make things equal. This includes how we design services, plan treatments and choose which services we provide.

We also look at how we organise our waiting lists. Last year, we used a tool to help us understand who might need more support. This year, we will focus on making sure that everyone waiting for the same treatment has equal results. To do this we will be changing how we manage our waiting lists and looking at things that are not always just related to medical reasons. We want to make sure people who need planned care can get it earlier, instead of waiting until their condition gets worse and needs emergency care.

Diagnostic investigations

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To make sure you get the tests you need as quickly as possible we are working on a programme called community ciagnostic centres. Our goal is to increase the number of people who get tests within six weeks. We also want to give GP practices the ability to directly ask for certain tests, which will help to speed things up. We will look to make sure that some people don't wait longer than others for their tests. This is part of a national effort to improve access to diagnostic tests for everyone.

Primary care recovery

We continue to support primary care development and recovery. We are looking at ways to further develop services in line with The Fuller Report recommendations so you get the right help when you need it, and primary care services are fair for everyone.

We are currently developing our primary care recovery plan in response to the national plan from NHS England which was published in May 2023. This will include plans for how we:

- help you to book your own appointments and manage your prescriptions
- use digital technologies to help you navigate your care
- increase the staff we have in primary care
- manage referrals effectively
- join up our teams so they work in a more integrated way.
- improve your access to urgent care when you need it
- make sure our buildings are fit for purpose
- make sure that there aren't groups of people who are not accessing primary care

Pharmacy, optometry, and dentistry services

From April 2023, we took on the responsibility for commissioning pharmacy, optometry, and dentistry services in Dorset. We are developing ways to improve access to these services and to make sure they are provided by joined up teams in communities.

Know your numbers

We will be encouraging you to 'know your numbers' and get your blood pressure checked regularly so you can take preventative measures to avoid future illness.

How we are going to measure progress

We will monitor a number of measures which will tell us if we are delivering our goals.

You will see:

- fewer people smoking
- more people taking up prevention services such as stop smoking, physical activity and weight management
- lower waiting times for our services such as tests, cancer services, planned appointments and surgeries
- better access to care closer to where you live including dental services, ophthalmology and pharmacy services.
- fairer access to our services so that some groups of people are not missing out.

Health inequalities programme	Year 1-2	Year 3-4	Year 5+
• Undertake a baseline assessment of the CYP population across the 5 clinical priority groups and the top 20% most deprived and any potential "+5" groups and agree, as a system, the "+5" local priority groups and develop plans to meet local need.	✓	✓	
• Develop and deliver plans to address adult Core20PLUS5 priorities.	✓	✓	✓
• Review high impact intervention guidance when published and incorporate in plans where relevant.	✓	✓	✓
• Develop and deliver high intensity user plans.	✓	✓	✓
• Review women's health strategy and identify any priority areas for action.	✓	✓	✓
• Develop our cardiovascular disease plan to focus on how we address differences between different groups.	✓	✓	✓
Prevention			
• Continue to support the roll out of Tobacco Dependency Treatment Services across providers.	✓	✓	✓
• Continue to work with Public Health Dorset wto improve the uptake of lifestyle services including through Making Every Contact Count (MECC) approaches.	✓	✓	✓
• Work with LiveWell Dorset and Active Dorset to implement healthier lives programmes.	✓	✓	✓
• Work with Active Dorset to support the aims of the physical activity strategy.	✓	✓	✓
Cancer			
• Analyse variation in access to cancer pathways and in cancer outcomes by equalities/health inequalities groups and develop plan to address.	✓	✓	
• Identify holistic needs of people diagnosed with cancer through cancer care reviews and individual health needs assessments and ensure adequate provision is available.	✓	✓	✓

	Year 1-2	Year 3-4	Year 5+
Elective recovery			
• Develop and agree a new approach to waiting list management focusing on non-clinical factors.	✓		
• Identify variation in waiting times and 'did not attend' appointments and develop plans to address the issues	✓		
Diagnostic investigations			
• Increase the percentage of patients receiving a diagnostic test within six weeks.	✓	✓	
• Increase GP direct access in line with the national rollout ambition.	✓	✓	
Primary care recovery			
• Continue to support primary care development and recovery.	✓	✓	✓
• Explore ways to further develop services in line with the Fuller Report.	✓	✓	
• Develop and implement our primary care recovery plan.	✓	✓	✓
Pharmacy, optometry, and dentistry services			
• Develop ways to improve access to services provided by joined up teams in communities.	✓	✓	✓
Know your numbers			
• Encouraging you to 'know your numbers' and get your blood pressure checked regularly so you can take preventative measures to avoid future illness.	✓	✓	✓

Enabling Plans

We have a number of enabling plans that will help us to deliver our outcomes.

You will find details of these enabling plans on the following pages.

82 Digital Plan

Digital Plan

New and emerging technologies can support flexible, personalised services to help you manage your health and wellbeing, and support stay independent. Technology can also tackle the challenges we face by giving people timely access to physical and mental health services.

Digital technologies can reduce pressure on our overstretched workforce, giving them more time for the treatment and caring only people can do.

We're using technology to help health and care professionals communicate better and enable you to access the care you need quickly and easily, when it suits you. By making more information accessible at your fingertips, we can give better access to the services you need, giving you more control over your own care.

We know that access to digital services may be harder for some groups, so our plans include thinking about what we can do to address this. We work with people called digital champions. They are a group of friendly volunteers who are good at explaining computers, without using jargon. They can help you use things like the NHS App to help manage your health.

What we are doing

We have been continuing the development of our digital services across each care setting including:

- Virtual wards.
- Enhancements to our population health management data.
- Additional functionality to share care records.
- A single maternity solution across our acute hospitals.
- Improvements to our cyber security defence.
- Plans for a one stop shop electronic patient record.

What we are going to do

It is vital the right information is available to staff when they are treating you for whatever service you need. All our technology is there to gather, process, display, or store data and provide it in the right context so staff have the information when they need it. The quality of data is also important.

We are working together with colleagues to improve the data we have and design systems which get the data to the right people at the right time as quickly as possible. Helping you access the information you need when you need it will help you to take proactive steps to managing your wellbeing. This in turn feeds in more data we can turn into intelligence, insights, and wisdom to improve things further.

Dorset Integrated Care System People Plan

Dorset Integrated Care System People Plan

One Dorset workforce

Our system is made of the people in it. To deliver our vision, "Working together to achieve the best possible improvements in people's health and wellbeing", we will need the collective people resources from all our organisations.

We want to have staff that are looked after, feel valued and respected, and are reflective of our communities. We want to be supported by compassionate leaders and have the opportunity for development and life-long careers.

Priority 1 – planning for the future

We act as an anchor system, attracting a talented and diverse workforce and plan effectively to address workforce supply issues now and in the future, responding to the shift to prevention and new models of healthcare and thriving communities. This includes improving access for deprived and other under-represented communities to the good quality jobs we offer.

Priority 2 – retaining our people

We look after our people, investing in and supporting lifelong, flexible careers where everyone feels valued, included and encouraged to reach their full potential.

Priority 3 – developing our people

Our people are our most valuable asset, and we offer everyone the opportunity to develop, learn and grow in response to the changes in how we deliver health and care for our population and for professional development.

Priority 4 – transforming people services for productivity and efficiency

Dorset has high quality people services and highly skilled people professionals, meeting the future needs of one Dorset workforce and realising the ambitions of this people plan.

The people plan will remain an iterative and 'live' plan to respond to the changing environments and priorities at a local, national, and regional level. Actions to be delivered will be identified as part of the ongoing work delivered through task and finish groups and long-term programmes of work.

88 Clinical Plan

Clinical plan

What we are doing

How we plan and deliver clinical care across Dorset will support our ambition of making Dorset the healthiest place to live. Our Clinical Plan is informed by the national health inequalities work known as Core20PLUS5 and Core20PLUS5 for children and young people. As part of this work, we are focusing on improving the health of our 20% most deprived population and highly vulnerable groups, and moving the focus to prevention. This work is closely aligned to the five objectives described in this plan.

As we move our focus to prevention, there are key points in life where lifestyle changes can improve long-term health outcomes. These are the early years of life, pregnancy, and middle age. We understand the importance of maintaining focus on the health and wellbeing of our young families and children to ensure the long-term health of our population. Identification and early intervention to prevent long term conditions in middle years will also support people to have the longer healthy years we all want.

We are currently developing a clinical plan, with short, medium, and long-term goals, which will be clinically driven and ensure the voice of local communities in Dorset is heard so we can truly codesign services with you.

What we are going to do

As part of this development, we have agreed some key principles which will support the clinical plan as we move forward in its development:

- There should be an active move to prevention and early intervention.
- Services should be co-designed both around the needs of local people and consider the location in both designing and delivering services.
- Joined up, seamless care ensuring people should only have to tell their story once regardless of the organisation.
- People's health and social care needs are considered as a whole instead of multiple conditions.
- Services must be designed to support and encourage people to manage their own conditions where possible.
- A focused investment to tackle inequalities in areas of deprivation and the greatest need.

We are committed to shift the focus of clinical attention towards prevention while recognising the need to deliver high quality, sustainable services when you need them.

8 Estates plan

Estates plan

The buildings and land (the estate) we own, lease, rent, or share provides the foundation from which we can deliver our services to you. From the large acute hospital sites and smaller community hospitals to individual GP practices and other local facilities we aim to provide the best possible services in the most suitable location.

We want you to be able to access the support you need as easily and close to your home as possible. Some of our estate is modern, well designed, well located and efficient to maintain and run, but some isn't. We have some older buildings that may cost a lot to maintain or need changes to allow our staff to deliver your care effectively, and some are no longer in the right place to support you.

Each organisation has a strategy describing how they plan to manage their estate and how this will support the Dorset system. We now need to develop our overall strategy so we can plan to have a system wide estate that is fit for purpose and allows us to deliver this plan.

What we are doing

We are creating our Dorset System Estates Strategy, which will be ready this year. It will include:

- a detailed stock take of all our estate. What do we have, what condition is it in, and how well used is it?
- comparing the facilities with current and future requirements, including where new housing will increase local needs and where inequalities need addressing.
- understanding the costs and available funding, both to manage what we have and to build and improve facilities.
- an agreed and consistent approach to estates planning so we can use our limited public money in the most appropriate way for the people of Dorset.

We will consider the impact of the digital and workforce plans as well as the green plan on the estate when making our decisions. Improving the estate can be slow, and expensive, so we need to be planning as early as possible for future years whilst still being able to respond to changing needs.

Our ambition is to extend the plan to work with other partners to have a single strategy for all the Dorset public estate which will provide further opportunities for delivering services to you as locally as possible.

We will have an estates plan that supports your needs and our priorities. It will enable us to make best use of our properties and ensure we are making the right decisions.

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Finance plan

Finance plan

Together with our local authority partners we spend £2.2 billion a year on public services for Dorset but, as we described on page 19, we currently have a funding gap of £98 million in Dorset's NHS organisations. We therefore need a plan to manage finances to ensure we can live within our means and deliver the right services in a sustainable and efficient way into the future. We are required to set a balanced plan, one with no shortfall, each year.

We believe the objectives described in this plan will deliver services in a more efficient way. We know, from comparing our services with good practice elsewhere and from our own experience, well designed services that meet your needs will be more cost effective. The financial pressures faced by Dorset public services make it more difficult to change because we may have to invest first before we see the benefits. We therefore need a clear and robust plan to manage our money over the next few years. We don't want to resort to cost cutting, we want to find better ways of working that mean we can do more for the same cost.

The financial challenges in the short term, together with uncertainty about future levels of funding and costs mean we must plan.

What we are doing

We know what the financial challenges are for 2023/24. We are now continuing our analysis and modelling to understand what the position looks like for future years.

By the autumn we will have a detailed understanding of the cost pressures across the Dorset's NHS organisations for the following four years. We will be able to describe how difficult the financial position will be if we do not make changes.

Using the plans outlined in this document we will understand how the changes we will make are going to improve the financial position and how we are going to be sustainable.

We know this will not be easy, particularly whilst new ways of working are just starting, so we will work with our national and regional colleagues to support our programmes of work and identify opportunities for additional funding if needed.

The outcome will be a financial plan that ensures the ongoing sustainability of health services in Dorset and supports and drives the changes needed to improve how we support you to live your best life.

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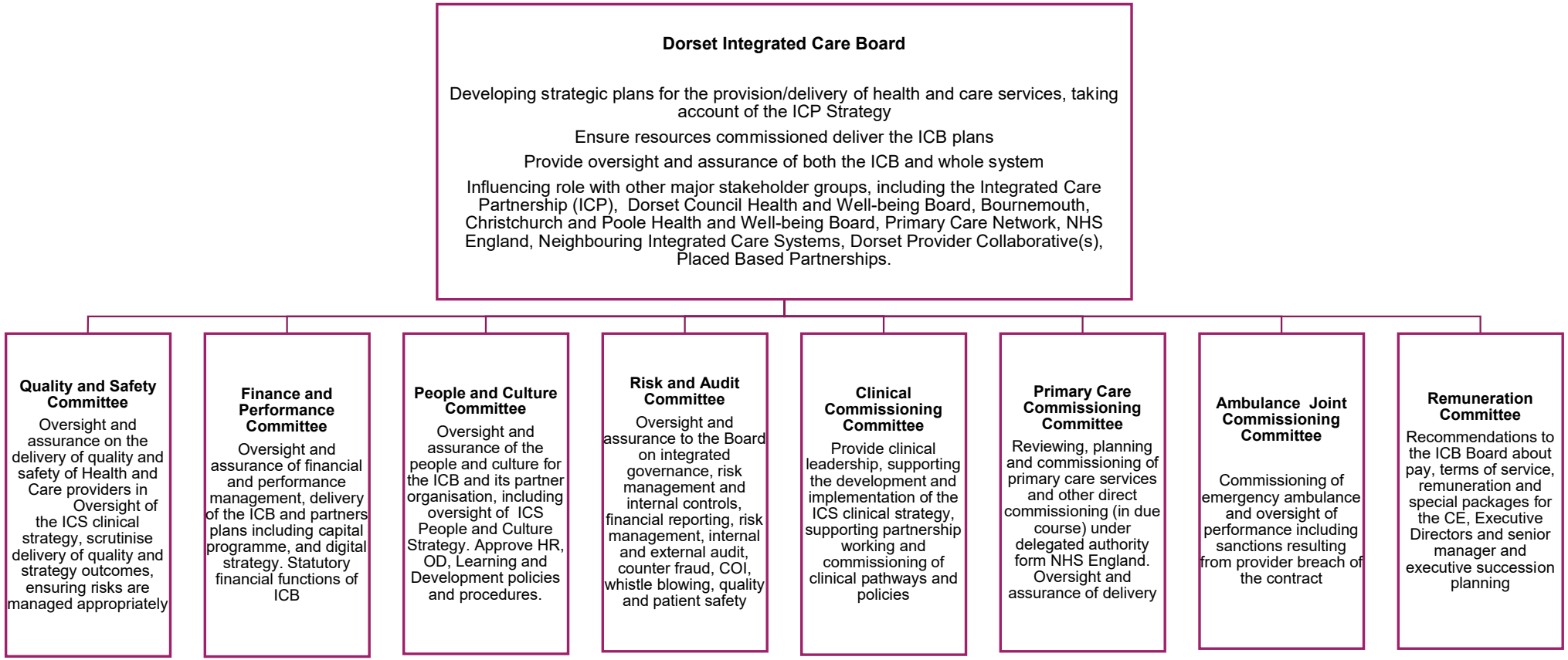
Appendices

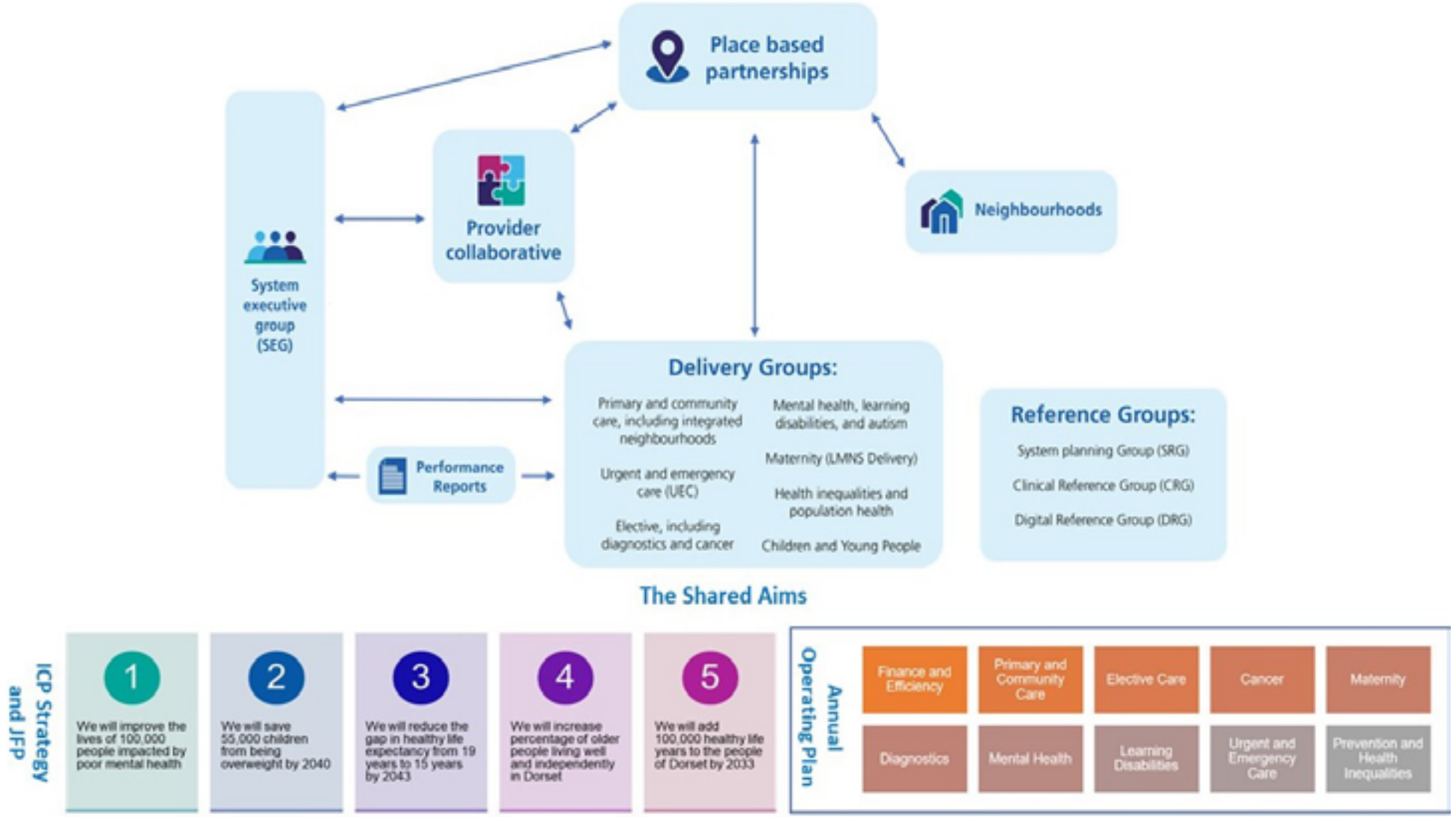
Governance

This section of the plans describes how we work and how we will monitor the delivery of our plan though our system groups and committees.



System ways of working

The below diagram shows how we work as a system.



Risk and Mitigations

Appendix 2

This section of our plans describes the risks we have considered when developing our plan and action we will take to reduce these risks.

Risk	Severity	Likelihood	Mitigating Action
Increases in urgent care pressures such as increase in the number of people in Accident and Emergency Departments, preventing the system to recover services	H	H	All our plans make sure they have considered the impact of seasonality e.g. holidays We have plans in place to use Independent Sector providers for planned care We have a System Control Centre and plans in place to manage and ease pressures when these occur.
Too many people 'with no criteria to reside' leading to delays in timely access to emergency departments, ambulance handover delays and reduced planned inpatient activity	H	H	We have plans for: • Integrate intermediate care and rehabilitation services • Discharge pathways • Implementation of virtual wards • Alignment of the Better Care Fund to support timely discharges • Implementation of the Urgent and Emergency Care recovery plan
Not enough money to provide the services we need meaning we are not able to live within our means	H	H	We have in place: • robust process to monitor our financial plans • our operational plan for 2023/24 which sets out how we will spend our money and live within our means We are developing a three year financial plan to setting out how we will manage and spend our money.

Risk	Severity	Likelihood	Mitigating Action
Not enough workforce with the right skills to deliver the services we need	H	M	We have in plans in place: • Dorset wide People Plan • Developing workforce expansion plans for Mental Health, Community Diagnostics, Additional Roles Reimbursement Schemes, NHS 111 First, discharge and primary care Workforce risk assessments have been completed for primary services and health providers and actions are being implemented as needed.
Not enough care home/ social care services (market) to support health and care	H	M	We have in place an integrated community oversight groups includes representative from both LA and Dorset ICB. Plans in place to understand what we need from and how we make sure we have enough social care providers to meet the needs of people in Dorset. We have brought more care home placements.
Not enough staff, money or other resources to deliver all the programmes of work we are planning to do	M	M	We have in place a clear operational plan which sets out what we are going to do in 2023/24, how we are going to do it and how we will monitor that we are delivering it. We have in place a Programme Management Support team to help our teams deliver the work set out in our operational plan.
Wider political appetite and support- balancing cost, quality, service delivery, outcomes and patient preference	H	M	Engagement and involvement, testing levels of ambition of all partners at each stage.
Not working well with our partners meaning we are not integrating the services and doing the work we need to do	M	L	We have in place delivery groups who have the right people to lead the groups Communications networks, stakeholder engagement and involvement plans. We have developed our priorities and action plans together.

Delivering our statutory functions

Appendix 3

This section of our plans describes how we will deliver our legal requirement set out by NHS England.

Legislative Requirement	How we deliver our requirements
1. Describing the health services for which the ICB proposes to make arrangements	Our Joint Forward Plan explains the health services that have been put in place to help us meet the needs of the people living in Dorset. Our Operational Plan gives more details about how the system is performing and what actions we are taking this year. On the websites below, you can find out more information about the services we offer in Dorset, a summary is on pages 6 to 7: • Dorset Integrated Care Board • Dorset County Hospital NHS Foundation Trust • Dorset Healthcare University NHS Foundation Trust • South Western Ambulance Service NHS Foundation Trust • University Hospitals Dorset NHS Foundation Trust We continue to support primary care development and recovery as part of our role as commissioners. We are looking at ways to further develop services in line with The Fuller Report recommendations which suggests ways to improve access to urgent care, neighbourhood and place services, which our plan focuses on, so that everyone gets the right help when they need it. From April 2023, we will be responsible for commissioning pharmacy, optometry and dentistry services in Dorset. We are developing ways to improve access to these services and also the healthcare that people receive. On page XX we explain how we keep track of how we are doing delivering our plan.

Legislative Requirement	How we deliver our requirements
	The NHS is also responsible for responding to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease such as Covid or a major transport accident. This is referred to as emergency preparedness, resilience and response (EPRR). The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded services, to show that they can deal with such incidents while maintaining services. The ICB is known as a Category 1 responder which means we must: • assess the risk of emergencies occurring and use this to inform contingency planning • put in place emergency plans and business continuity management arrangements • make information available to the public, including warning and informing in the event of an emergency • co-operate with and share information with other local responder. We coordinate the activities of all providers of NHS funded healthcare to plan for and respond to emergencies. The ICB represents the NHS at the Dorset Local Resilience Forum, which coordinates multi-agency partners to prepare for and respond to civil emergencies. The ICB has an Accountable Emergency Officer (AEO) for EPRR, who is responsible for discharging the ICBs responsibilities around EPRR and providing assurance to the board.
2. Duty to promote integration	We want to provide health services in an integrated way and that's why we made our Joint Forward Plan. Our Constitution and Governance Handbook explains how we work together to make decisions. Working with local authorities, we have agreed on Better Care Fund plans for 2023-25. These plans are for intermediate care, short term care capacity and demand, offering support to unpaid carers, and providing help with housing adaptations.

Legislative Requirement	How we deliver our requirements
	We have created Place based partnerships in Dorset and Bournemouth, Christchurch and Poole. This means leadership, governance, and plans at place are being developed, to be in place by 1 April 2024. Primary Care Networks and other partners will get help with developing integrated neighbourhood teams from the National Association of Primary Care (NAPC). This will create a model of integrated nursing as well as teams to help older people. We are already making progress with urgent community response, virtual wards, and proactive general practice.
3. Duty to have regard to wider effect of decisions	To deliver our goals set out in our Forward Plan, we will focus on and make sure that when we make decision we will consider the impact they have on health and wellbeing of people in Dorset, the quality of services and how efficiently and sustainably we use our resources. • **Health and wellbeing -** our Joint Forward Plan sets out five outcomes for delivery which are linked to the three themes of our Integrated Care Partnership Strategy and operational plan • **Quality of services** - we have a Risk Strategy and a Quality Framework in place which describes how we monitor quality and identify any risks for health services and across the Dorset System. We do this by using data and intelligence to monitor quality of service, health inequalities. • **Efficiency and sustainability**- we have a Finance and Performance Committee and an Operations and Finance Reference Group to help us manage our money. Our plan sets out the financial challenges we have over the next two years (see page 19) and sets out plans for how we will use our resources (money and workforce) in the best way to produce the best quality outcomes and make sure we live within our means. We have a performance framework which sets out how we will monitor the delivery of our plans through our groups and committees. It includes early warnings measure which will show when our performance is declining, what we need to do. The Framework includes all the main and supporting measure from the operating plan, CORE20Plus5 and forward plan which link to the ICP Strategy.

Legislative Requirement	How we deliver our requirements
4. Financial duties	The national financial framework sets our that each Integrated Care Board (ICB) and its partner trusts don't spend more money than they have been allocated. Each year we plan how we will spend our capital and revenue resources as part of the Operational Planning Process to make sure we do not spend more money than we have and still maintaining quality and access to services and improve outcomes. The details are seen in our Operational Plan for 2023/24. The financial plan for 2023/24 sets out what this entails, including our efficiency and productivity programmes. This is reported to the Board each month to show the progress we are making in delivering our plans and any risks that we may have. Our plans are shared with the Dorset Integrated Care Partnership and both Dorset and Bournemouth, Christchurch and Poole Health and Wellbeing Boards. By September 2023, we will have developed a medium term (3year) financial plan which will set out how we manage our resources. This plan will make sure that their goals and service improvements are met in a way that are sustainable. This will include our joint capital plan for 2023/24 and future years which will be reviewed each month.
5. Duty to improve quality of services	We work with our partners to make sure that all of our services are up to standard and safe. We have processes in place to do this which also set out what we do when our quality and safety standards are not being met. Our Quality Committee and System Quality Group is where our partners come together to discuss intelligence and learning on all quality matters across the system where we share responsibility for this. We use a number of measure so we can monitor our performance and use these measure to help us make decision with our partners. Our Quality Framework sets out how with our partners to monitor our services, to make sure everything is working and that our services are of good quality services. We want to make sure that we all improve together, that everyone is heard and that all services are meeting the needs of everyone.

Legislative Requirement	How we deliver our requirements
	We will know when we have reached our goal as: • We will always make sure that practice, structures, values & outcomes are discussed and recorded before major decisions are made • The ICS improves together • We listed to staff and service to make sure they are heard • All our partners will have a culture that reflects, appreciates, and shares learning • We will deliver high quality services, that best meet the needs of the people of Dorset.
6. Duty to reduce inequalities	In Dorset, people generally have good health and live longer than the England average. However, life expectancy is different between the most wealthy and the least wealthy areas. Our Integrated Care Partnership Strategy - Working Better Together has five goals to help the people who are in greatest need. We have a Health Inequalities Group that makes sure all the organisations involved work together in a way that helps everyone across Dorset. Through programmes of work such as CORE20Plus5 for adults and children. We have agreed that we will commit £2,128 million from the Dorset ICB for next year to help reduce differences in people's access and outcomes. Using our Dorset Intelligence and Insights Service we will be able to target the areas where people and communities most need help, where there are the greatest differences and improve the outcomes for the people who live there.

Legislative Requirement	How we deliver our requirements
7. Duty to promote involvement of each patient	We want to make sure people have more choice and control over their health and care. To do that, we will continue to develop our partnerships so we have a Universal Personalised Care Model across our organisations. This work will help us towards achieving our five outcomes for Dorset ICS. We want to use population health management and tackle health inequalities so that people have sustainable and high-quality health and care in Dorset. This approach is important for us to reach our goals at a system, place and neighbourhood level. We are going to spread and make bigger the Universal Care model in Dorset. This will help us to: 1. Change how health and care practitioners work and communicate with people 2. Help to reduce the differences in health care in Dorset 3. Make sure the right health and care services are in the right places 4. Make people healthier and get better care. We are working with our partners to: • make sure people have the skills needed to give personal care • will increase Personal Health Budgets, including temporary ones to help you after leaving hospital, stop you from going into hospital and keep you healthy • use digital technology to make it easier to get and receive non-medical support • make sure people get the care they need in Dorset and that personal care is in place • give people with long-term conditions the help and support they need to manage their own health and wellbeing, helping them cope with their condition and reducing the need for services. • make sure personal care is part of programs like Aging Well and Elective Care • help Primary Care Networks to deliver the goals from the Fuller Review for a personalised care network • use our population health tool (Dorset Information and Insights Services) to understand the difference in outcomes for people and tailor support to them and to make sure we know the impact.

Legislative Requirement	How we deliver our requirements
	We will know when we have reached our goal as: • We will always make sure that practice, structures, values & outcomes are discussed and recorded before major decisions are made • The ICS improves together • We listed to staff and service to make sure they are heard • All our partners will have a culture that reflects, appreciates, and shares learning • We will deliver high quality services, that best meet the needs of the people of Dorset.
8. Duty to involve the public	Our Working with People and Communities Strategy explains how we will work with people and communities. It describes our principles, how we will work and what we will do to make sure people and communities come first. Our plan matches the 10 principles for working with people that NHS England published.
9. Duty as to patient choice	We support our GPs to offer choice to people registered within their GP Practice, this in in line with NHS Constitution for England and the NHS Choice Framework . We make sure service users and GPs know about the different places they could go for consultant-led services, and the amount of time they would have to wait at each place. When service users need a consultant led appointment they are given a full choice list at the point of referral and we keep GPs up to date with the shortest waiting time. Information about services are publicised on local websites, we have more information in our access policy and Waiting Well information which is available on trust websites. We provide our services on ERS and use open procurement for any cases which don't fit this. This ensures the best care and value-for-money.

Legislative Requirement	How we deliver our requirements
10. Duty to obtain appropriate advice	Our Clinical and Care Professional Leadership Framework sets out how we make sure that there is a strong clinical and care professional involvement in advice and decision making across the system. When we make decisions we make sure that we take advice from lots of difference experts, some examples can be seen below: • Social care practitioners • Public Heath • Voluntary and Community Sector • Housing • Educations • NHE England • Clinical Networks and Senates There are lots of ways we seek this advice, we do this through our: • Integrated Care Board where there are clinical leaders such as chief Medical Officer, Chief Nurse and representation from primary care, ambulance service and local authority • Integrated Care Partnership where there are also professionals from fire, police, community and voluntary sector • Clinical Delivery Groups who have both clinical and non-clinical professionals e.g. Urgent and Emergency Care, Elective Care, Primary and Community Care, Mental Health • Developing Provider Collaborative and Place Based forums who include both clinical and non clinical professional.
11. Duty to promote innovation	We are a member of the Wessex Academic Health Science Network (AHSN) as part of this we look for the best ways to improve healthcare through looking a new ways to do things and technologies that can help us do this. Being part of the AHSN also helps us to do more to support the local economy.

Legislative Requirement	How we deliver our requirements
	In 2022, we set up the Dorset Innovation Hub (DIH). It's funded by the Health Foundation until 2024 and is based at University Hospitals Dorset. The DIH works to meet the needs of people in Dorset and make sure that innovation is connected with system priorities. It's headed by a group of voting members from different organisations.
12. Duty in respect of research	We want to make the most of the opportunities from research and use the maximising the benefits of research: Guidance for integrated care systems by building on and developing further the ICS research activities to inform how we do this. In 2021, we published a Research Strategy which set out how we will create patient-centred care that makes use of the newest technology and encourages everyone to take part in research that is relevant to them. Our research strategy sets out how we will deliver the national and local goals, by focusing on four themes which are: • **Our citizens** – giving everyone in Dorset the chance to take part in research near their homes • **Our workforce** – staff research opportunities and make sure they understand and use research • **Working in partnership** – partner with organisations so that different people and ideas can work together • **Management of research** – make research easy and efficient to manage across all our organisations We have set up two Research Clinical Trials Units in East and West Dorset, supported by two moveable units. This part of our Living Lab Project which covers the Dorset Health Villages in Poole and Dorchester. We also have Research Active Dorset which will work with the Clinical Reference Group. We are also member of the Wessex Health Partnership which is where we come together with other health and care, academic and research partners to look at how we can drive forward improvements in health and care through research, innovation and training which will help us to deliver our plans and improve the economy in Dorset.

Legislative Requirement	How we deliver our requirements
13. Duty to promote education and training	We know that education and training are key in helping us get the best care. We continue to make sure that all of our staff get the development they need to help them provide them best possible care. We work with education providers to make sure our staff and students have the best experience. Our professional faculties have education as part of their plan. Things we've done to make sure we have the right staff with the right skills to deliver the best care in Dorset and to help keep the staff working in Dorset include: • Giving extra training through Advanced Practice • Apprenticeships such as Nursing (HCSW, Trainee Nursing Associate) • International Recruitment and Return to Practice across all professional areas. We're also looking at new apprenticeships in areas where we struggle to recruit, like nurses, allied health professions and pharmacy careers.
14. Duty as to climate change	We want to do all that we can to help our communities develop and grow this means that we will also make sure we do all we can to help environmental, economic and social value. As part of this we approved our Green Plan in 2022. The Green Plan sets out how we across health partners will reduce our carbon emissions and support sustainability goals including supporting the two NHS targets in its aim to be the worlds first net zero national health service as follows: • For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032; • For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Legislative Requirement	How we deliver our requirements
15. Addressing the particular needs of children and young people	We want the best for children and young people. That's why our joint plan puts a bigger focus on early help, primary and secondary prevention. We're working with the local authorities to create a care plan for children and young people's mental health and emotional wellbeing. This will be based on the principle of helping children to thrive. We want to make sure there's 'no wrong door' for children and young people looking for help and that physical and mental health are integrated. These are the key outcomes from this work: • Children and families at the centre and design of service coproduced with CYP anf families creating a model that works for families. • Famillies to be trusted and have more control in relation to the tye of support they can access • Help and support avilable much sooner in the places CYP are, in communities, in schools. Immediate access to help when heading towards a crisis. • No wrong door, integrated, very few if any thesholds or barriers to accessing help and fully inclusive for any young person who needs support. • Services properly invested in to meet the level of need and anticipated need with a single agreed funding pot, ending arguments. We want to make sure children are healthy, so they can reach their potential. One of our priorities in our plan is to prevent and reduce levels of childhood obesity. We're working with local authorities, Public Health Dorset and education to focus on early years and the things that affect physical and mental wellbeing in children. This includes the Better Births programme, supporting and advising on infant feeding and giving children more physical activity with things like the Healthy Movers and the Daily Mile. We are working on the CORE20PLUS5 programme for children focussing on children from the worst off areas to understand what services they use, what they need and then to come up with possible solutions.

Legislative Requirement	How we deliver our requirements
	We have an ICB executive lead who looks after making sure that these solutions for children and young people are carried out. NHS Dorset is one of three organisations on the Pan-Dorset Safeguarding Children Partnership. The law makes sure these partnerships exist. The Partnership have set five main goals which are: • reducing neglect • reducing exploitation • emotional wellbeing and mental health • positive outcomes for children missing from home • agency effectiveness.
16. Addressing the particular needs of victims of abuse	We want to make sure everyone is safe, that's why the ICB and all the services provided by our partners must follow the NHSE Safeguarding Assurance and Accountability Framework. Our Safeguarding Strategy sets out our goals and what we plan to do, we have summarised these below: • Support the inter-agency response to the reduction of harm of child abuse • Reduce the harm of domestic abuse for victims and families • Support children to maintain positive mental health and emotional well-being • Reduce health inequalities for children in care and care leavers • Improve NHS services to safeguard adults • Contribute to the inter-agency response to the Serious Violence Duty • Reduce child mortality.

Legislative Requirement	How we deliver our requirements
17. Implementing any joint local health and wellbeing strategy	Dorset has two Health and Wellbeing Boards: • Dorset Health and Wellbeing Board • Bournemouth, Christchurch and Poole Health and Wellbeing Board Our plan aligns with the priorities outlined in our Health and Wellbeing Strategies. The priorities set out in the Health and Wellbeing Strategies and how we support the delivery of these are: **Empowering communities:** In our plan, we focus on working with communities to help them live independently and access the services they need. We pay special attention to communities with the greatest needs. **Promoting healthy lives**: Our plan outlines how we will improve outcomes for children, young people, and adults with mental health conditions. We also aim to ensure that children have a healthy start in life by addressing issues like overweight and obesity. Additionally, we strive to reduce disparities in health outcomes, such as high blood pressure. **Supporting and challenging:** Our plan explains how we will collaborate with partners across the healthcare system to develop integrated care solutions for communities and neighbourhoods. This includes urgent care services. We also highlight the importance of joining up health and care services through initiatives like the Better Care Fund.

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HEALTH AND WELLBEING BOARD

Report subject	**PREPARATION FOR CQC ASSURANCE**
Meeting date	20 July 2023
Status	Public Report
Executive summary	The Health and Care Act 2022 creates a new duty for the Care Quality Commission to review local authorities' performance in discharging their adult social care functions under the Care Act 2014. This report sets out the work that has been undertaken to date and further work that is planned to ensure the Council is best placed to achieve a positive outcome from any review of the Council's services.
Recommendations	**It is RECOMMENDED that:** **a) Health and Wellbeing Board note and comment on the content of this report**
Reason for recommendations	The Health and Care Act gives new powers for the Care Quality Commission to conduct reviews of the provision of Adult Social Care

Portfolio Holder(s):	Cllr David Brown, Portfolio Holder Health and Wellbeing
Corporate Director	Betty Butlin, Director of Adult Social Care Phil Hornsby, Interim Corporate Director for Well-Being
Contributors	Chris McKenzie, CQC Preparation Lead
Wards	All
Classification	For update and information

Background

1. The Government's Adult Social Care white paper "People at the Heart of Care" sets out the Government's vision for Adult Social Care and included new assurance, improvement, and data measures to support local authorities to deliver this vision.
2. The Health and Care Act 2022 puts Care Quality Commission (CQC) assessment of local authorities on a statutory footing. This creates a new duty for the CQC to review local authorities' performance in discharging their adult social care functions under the Care Act 2014. This new duty comes into effect from April 2023.
3. A draft self-assessment workbook has been produced by LGA and ADASS to support local authorities to prepare for CQC assurance.
4. The CQC have advised local authorities that there will be a single assessment framework which will use a consistent set of themes across their assessments of local authorities, integrated care systems and providers. This will ensure an aligned approach and will be based on what people expect and need from the support they receive.
5. The framework is being developed with reference to the national "Making it Real" framework, which is a set of co-produced personalised principles focussing on what matters to people. These are presented as a series of "I" and "We" statements that describe what good looks like from and individual's perspective and what organisations should be doing to live up to those expectations.
6. The assessment framework will focus on the following key themes with **Choice, control and personalisation** also threaded through the entire framework and approach:
    a. **Working with people** - assessing needs, supporting people to live healthier lives, prevention, equity in experiences and outcomes, well-being, information, and advice
    b. **Providing support** - markets (including commissioning), integration and partnership working

c. **Ensuring safety** - safeguarding, safe systems, and continuity of care

d. **Leadership** - governance, learning, improvement, innovation

7. Evidence will be gathered from the following sources: People's experience; feedback from staff and leaders; feedback from partners; observation; processes, outcomes and performance data.

8. Sources of published intelligence and data will be reviewed by CQC prior to any assurance visit, for example, statutory return data, ombudsman judgements and reports, safeguarding adult reviews etc.

9. There will be new powers of intervention for the Secretary of State where local authorities are failing to discharge their duties under part 1 of the Care Act 2014.

10. The general responsibilities that local authorities have under the part 1 of the Care Act are:

    a. To promote individual well-being

    b. To prevent, reduce or delay the development of people's care needs

    c. To promote the integration of care and support with health and health related services

    d. To ensure that people can get the information and advice they need to make good decisions about care and support

    e. To ensure there are a range of high quality, appropriate services to choose from

    f. To co-operate generally with relevant partners

Summary of preparations to date

11. An interim CQC preparation lead has been recruited and has been in post since the start of January 2023.

12. A comprehensive self-assessment has been written with input from staff and stakeholders setting out our areas of strength and areas for development against each of the key themes.

13. A bespoke safeguarding review to assess our arrangements to safeguard adults was undertaken by an independent consultant in March 2023.

14. An LGA peer challenge took place in June 2023 to test our self-assessment and readiness for CQC assurance, using the CQC framework.

15. At the time of writing this report we are awaiting the report from the peer review team. Once received we will use the report to update the self-assessment and to create an action plan to address key considerations.

Summary of legal implications

16. CQC assurance arrangements are intended to provide assurance that Local Authorities are delivering their legal responsibilities under the Care Act and other relevant legislation.

Summary of human resources implications

17. There are no human resource implications arising from this report.

Summary of environmental impact

18. There are no environmental impact implications arising from this report.

Summary of public health implications

19. Effective partnership working with public health is essential to the delivery of effective Adult Social Care arrangements. This is particularly relevant to the Council's responsibilities under the Care Act to promote wellbeing, and prevent, reduce, and delay needs.

Summary of equality implications

20. Anti-discriminatory practice is fundamental to the ethical basis of care provision and critical to the protection of people's dignity. The Equality Act protects those receiving care and the workers that provide it from being treated unfairly because of any characteristics that are protected under the legislation.

21. The most recent draft of the CQC assurance framework includes a new sub-category of the theme "Working with People," which intends to measure "equity in experiences and outcomes."

Summary of risk assessment

22. There is a risk that a poor assessment by CQC of the Council's arrangements could lead to intervention from the Secretary of State.

23. The Council is seeking to mitigate the risk of a poor outcome by preparing for CQC assurance and has appointed a CQC assurance lead to ensure there is sufficient capacity to undertake this work.

24. The preparation work that has been undertaken to date is helping the Council to identify areas of service development that are being prioritised to improve the likelihood of a positive outcome.

Background papers

People at the Heart of Care: adult social care reform white paper - GOV.UK (www.gov.uk)

Health and Care Act 2022 (legislation.gov.uk)

Making it Real documents - About - Making it Real - Think Local Act Personal

Care Act 2014 (legislation.gov.uk)

Adult Social Care Strategy 2021-25 (bcpcouncil.gov.uk)

Carers Strategy 2022-27 (bcpcouncil.gov.uk)

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HEALTH AND WELLBEING BOARD

Report subject	**Better Care Fund 2023-25**
Meeting date	20 July 2023
Status	Public Report
Executive summary	This report provides an overview of the content of the Better Care Fund (BCF) plan for 2023-25. The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing and other public services, which is fundamental to having a strong and sustainable health and care system. National planning guidance was released in April 2023 advising that plans needed to be completed and submitted for national assurance by NHS England by 28th June 2023. The plan needs to be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements and so the draft planning document has been submitted to meet the deadline but is pending Board approval.
Recommendations	**It is RECOMMENDED that:** **The Health and Wellbeing Board approve the Better Care Fund Plan for 23/25 taking into account the investment and delivery plans as outlined in this report**
Reason for recommendations	This iteration of the BCF sees limited changes from last year and a continuation of plans and services which are already in place. Board approval is a planning requirement of the BCF.

Portfolio Holder(s):	Cllr David Brown
Corporate Director	Phil Hornsby, Interim Corporate Director for Wellbeing
Report Authors	Peter Courage, Head of Transformation & Integration
Wards	Council-wide
Classification	For Decision

Background

1. This report is a covering document for the content of the Better Care Fund Plan (BCF) for 2023-25 including the schemes, priorities, governance, metrics and spending for the year. This year's submission is made up of three key documents. The three templates were provided by NHS England and completed by officers in BCP Council and NHS Dorset. The documents are as follows;
    - A 'Narrative Plan' which describes the work that will take place under the BCF. This is attached as Appendix 1.
    - A 'Planning Template' which describes the financial breakdown of how the BCF will be spent, the metrics by which we can judge success and a capacity and demand plan which this year is included as part of the overall assurance process. This is split across two attachments as Appendix 2 and 3
2. Since 2013 the BCF has been a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.
3. The majority of the pooled resources for the BCF come from existing activity within the health and social care system such as Disabled Facilities Grants used for aids and adaptations, and additional contributions from Local Authority or NHS budgets. Also, extra short-term grants from central government have been paid directly to local authorities such as the Improved Better Care Fund which is used for meeting adult social care needs, reducing pressures on the NHS and ensuring that the social care provider market is supported. The Discharge Grant is also now wrapped up as part of the BCF and is subject to fortnightly reporting against spend and activity.
4. In addition, the BCF is funded by a NHS Dorset minimum contribution. An uplift to this contribution must be applied to meet one of the imposed conditions for meeting the national assurance process.

The Better Care Fund Plan 2023-25

5. There are a number of key conditions which the plans for the BCF have to meet, this year these are:
    - The Plans are jointly agreed

- Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer, including agreement on how to spend the additional discharge funding

- Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

- Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

6. In order to meet these key conditions there are a number of specific 'schemes' whereby collaborative work between; NHS Dorset, BCP Council, local providers and the voluntary and community sector, aim to meet the objectives and principles of the BCF.
    - Maintaining Independence
    - Early Supported Hospital Discharge
    - Integrated Health and Social Care Locality Teams
    - Carers
    - Moving on from Hospital Living

7. Further details of the activity under each of the individual schemes can be found in the narrative template provided at Appendix 1 and the expenditure tab in Appendix 2.

Summary of Financial Implications

8. The challenges to the sustainability of funding for both NHS Dorset and Local Authorities in Dorset means that managing the BCF budget creates risks for both. Whilst this is a 2-year plan elements of the 24-25 allotment need to be confirmed once the non-recurrent funding totals are confirmed.

9. This plan provides a very granular breakdown of the spending by scheme type, source of funding and expenditure (See Appendix 2). A high-level view of this is detailed in the table below:

Scheme Description	CCG contribution	BCP (Bournemouth Christchurch and Poole) contribution	Total
	£000	£000	£000
Maintaining Independence	8,660	14,003	**22,663**
Early Supported Hospital Discharge	6,424	2,954	**9,378**
Discharge fund	2,835	1,884	**4,719**
Carers	1,339	0	**1,339**
Moving on From Hospital Living	7,428	2,182	**9,610**
Integrated Health & Social Care Locality Teams	23,373	0	**23,373**
Total	**50,059**	**21,023**	**71,082**

Summary of Legal Implications

10. New Section 75 agreements, (in accordance with the 2006 National Health Service Act), will be put in place as prescribed in the planning guidance for each of the pooled budget components in the fund.

Summary of human resources implications

11. The services and 'schemes' funded through the BCF are delivered by a wide range of staff some of whom are employed by BCP Council and many who are commissioned by BCP to deliver these services. Should the funding for the BCF not be agreed and these services have to be ended or amended as a result, there may be an impact on the staff who deliver them.

Summary of sustainability impact

12. None

Summary of public health implications

13. The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing and other public services, which is fundamental to having a strong and sustainable health and care system.

Summary of equality implications

14. An Equalities Impact Assessment was undertaken for last year's submission and there are minimal changes this year. Additional EIAs will be undertaken if there are any proposed future changes to policy of service delivery.

Background papers

None

Appendices

Appendix 1: Better Care Fund Narrative Plan

Appendix 2: Better Care Fund Planning Template Part 1 *(Front cover, Summary, Capacity & Demand and Expenditure)*

Appendix 3: Better Care Fund Planning Template Part 2 *(Metrics and Planning Template)*

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Health and Wellbeing Board

BCP Council

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

BCP Council (Adult Social Care Commissioning and Services, Financial Services and Housing) and NHS Dorset have worked together to agree this plan.

There has been wider consultation with specific groups, forums, providers, user groups and voluntary organisations on the specific contracts and services which, when aggregated together, constitute this year's plan.

The plan has been (or will be) approved by the BCP Chief Executive, the Chief Executive of NHS Dorset, Dorset Joint Commissioning Board and ultimately the BCP Health and Wellbeing Board. As well as approving this plan, responsible officers and bodies will receive updates in relation to the allocation and spending and will also approve the end of year return.

How have you gone about involving these stakeholders?

Specific stakeholders have been involved in shaping the individual schemes through consultation and standard planning procedures. The overarching plan, which is a collection of all the individual schemes, has been reviewed by the accountable colleagues described above. Much of this year's plan reflects and builds on schemes which were established in previous years, these schemes have been developed and refined through continual dialogue and review by the respective stakeholders. Our plan is for this review to continue across the two-year lifespan of this plan so that an element of flexibility will allow us

Governance

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

This plan has been agreed jointly by NHS Dorset and BCP Council and will be monitored by both organisations. BCF planning submissions are approved by the pan-Dorset's Joint Commissioning Board and subsequently approved by the BCP Council Health and Wellbeing Board, which for this submission, will be on the 20 July 2023. Prior to formal approval, this year's plan has been authorised by the DASS, Section 151 Officer and the Chief Executive for BCP Council, and by the Chief Commissioning and Chief Executive Officers for NHS Dorset.

More widely, carers and other steering groups report into the wider governance structure and senior commissioners from both NHS Dorset and BCP Council are responsible for day-to-day monitoring of the services outlined in this plan and for ensuring performance reaches agreed targets. The Pan Dorset Equipment Service

also seeks approval from the Integrated Equipment Services Partnership Board and Joint Commissioning Board prior to submission.

Executive Summary

This should include:

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

The 2023-25 Better Care Fund (BCF) plan from BCP Council and NHS Dorset aims to build on previous BCF plans and responds to the requirements of the BCF guidance published in Spring 2023. Together with the accompanying planning template, this narrative plan should demonstrate that there is a jointly agreed plan in place which covers the key conditions in the BCF guidance, namely:

- The Plans are jointly agreed
- The Plans enable people to stay well, safe and independent at home for longer
- The Plans provide the right care in the right place at the right time
- The Plans maintain NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

The plan for the 2023-25 allocation of the Better Care Fund is similar to the previous year's submission having slowly emerged from the post-pandemic recovery. Working collaboratively BCP Council and NHS Dorset alongside input from the local NHS providers, the provider market and voluntary community sector have continued to invest BCF into the following schemes:

- Maintaining Independence
- Early Supported Hospital Discharge
- Integrated Health and Social Care Locality Teams
- Strong & Sustainable Care Markets
- Carers
- Moving on from Hospital Living

These schemes ensure that BCP Council meets the metric requirements of the BCF as set out in the guidance.

The value of investment in each of the prioritised schemes is as follows and additional funding has mainly been used to offset inflationary pressures incurred within the existing services.

Scheme Description	CCG contribution £000	BCP (Bournemouth Christchurch and Poole) contribution £000	Total £000
Maintaining Independence	8,660	14,003	**22,663**
Early Supported Hospital Discharge	6,424	2,954	**9,378**
Discharge fund	2,835	1,884	**4,719**
Carers	1,339	0	**1,339**
Moving on From Hospital Living	7,428	2,182	**9,610**
Integrated Health & Social Care Locality Teams	23,373	0	**23,373**
Total	**50,059**	**21,023**	**71,082**

Key changes since previous BCF Plan

No services have been decommissioned since 2019-20, however work has continued strategically to align services as part of Home First agenda and a more co-ordinated approach to intermediate care across system partners.

Hospital discharge and flow remains a key priority with significant pressures experienced within both acute and community hospitals, including mental health, alongside an extremely challenging care market in the wake of the pandemic.

A new BCP Carers Strategy was published in Autumn 2023. This new strategy was developed with our BCP Carers Reference Group and the wider Pan Dorset Carers Steering Group. It builds on what has already been achieved across BCP and wider Dorset. It has also been informed by carers' experiences during the pandemic. Implementing this strategy, which will be reviewed annually throughout its 5-year lifespan, will help shape the future direction of services funded for carers under the BCF.

Since last year's BCF the provider contract for our pan Dorset 'Equip for living' Integrated Community Equipment Service has been retendered, with significant additional benefit for the local system. It is building on previous success with additional work around engagement with people who use the service to continuously learn and implement more efficient delivery, by increasing stock capacity through larger warehouse sites, Saturday and 4-hour delivery options.

Support to self-funders will be achieved through a pan Dorset website "Safe & Well" that will provide both advice on useful equipment and where to buy it locally.

National Condition 1: Overall BCF plan and approach to integration

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

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

BCP Council work in partnership with Dorset Council and the NHS through the Dorset Integrated Care Board, which was formed in July 2022. There are two place-based partnerships, one covering each Council area, and the existing Health and Wellbeing Boards cover each place. There are 3 Foundation Trusts in the Dorset ICB area, 3 acute hospitals and 18 Primary Care Networks. The Dorset Integrated Care Partnership recently published a Working Better Together Strategy which sets out how the partnership will work together to deliver the best possible improvements in health and wellbeing.

The Council also works in partnership to develop and deliver a number of key commissioning strategies which set out our future plans which align to the BCF priorities.

A Joint Commissioning Board is responsible for delivering the commissioning aspect of “Our Dorset”, overseeing the delivery of jointly commissioned integrated health and social care services for the adult population of Dorset, Bournemouth, Christchurch and Poole, and is the vehicle for delivery of the Working Better Together Strategy.

BCP Council’s market sustainability plan (MSP) was published in March 2023 and has been produced in collaboration with local social care providers. The MSP sets out the challenges facing social care providers in the area today and possible ways in which the Local Authority can support service delivery in the future. The MSP builds on BCP Council’s current Market Position Statement (2021-2024) which was developed for all adults in conjunction with NHS partners and the Dorset NHS CCG at the time.

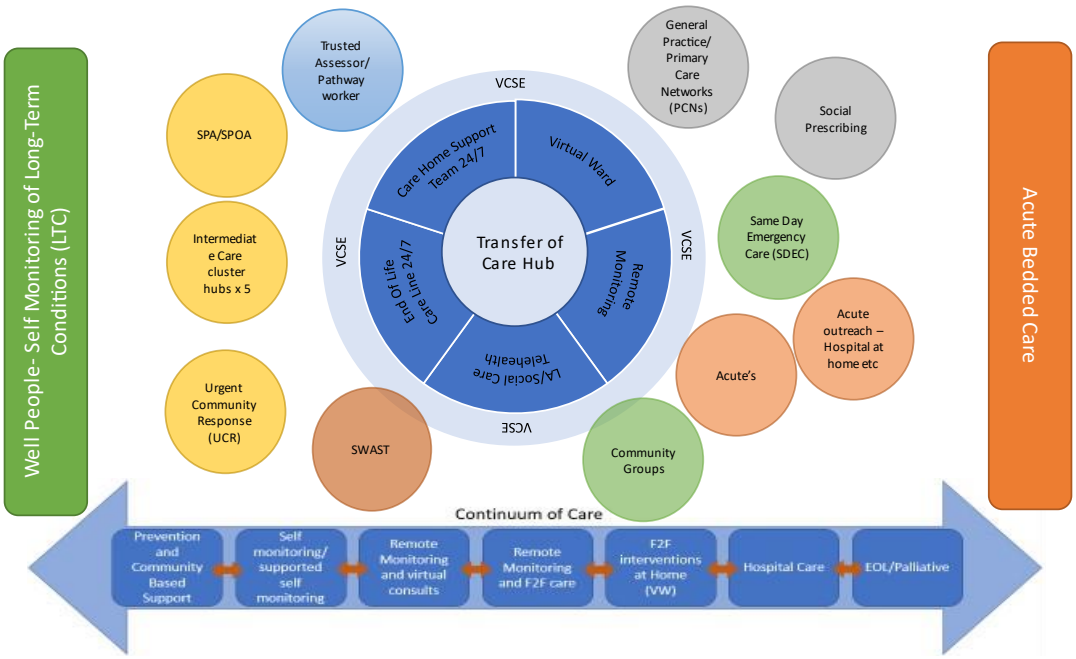
BCP is a key partner of the Dorset Integrated Community and Neighbourhood Oversight Group which reports into the Joint Commissioning Board. This group has oversight of the transformation programme to deliver an integrated community care model that supports more people to remain safe and well in their own homes and which enables them to return home following a period of ill-health with the support they need to live well and independently in Dorset. Key areas of delivery include:

- The development of a recovery-focused intermediate care (Home First) model that is organised at place level, integrated across health and social care and delivered in partnership with local primary and community services to support people to return to independence, ideally in their own homes. Much of the BCF investment is centred on growing our capacity and capability in this area with a focus on building effective rehabilitation and reablement services and strong partnerships with care providers and local communities that to support more people at home or which enables a return home at the earliest opportunity.

- Dorset ICB has commissioned the National Association of Primary Care (NAPC) to support the system with the development of an out of hospital integrated care framework, with a focus on health of older people. This framework will enable us to build on and strengthen the work that we have already undertaken to embed multi-disciplinary teams including those within the community and voluntary sector at both place and neighbourhood levels.

- NHS Dorset is leading on several primary care and community programmes, such as Virtual Wards, Care Home remote monitoring, urgent community response services and anticipatory care, all of which form part of our community continuum of care model. As we further develop this model, we will be bringing together these separate programmes of work into a single portfolio that will include the work we are doing within Home First. This will ensure that we maximise the opportunity of the investment and can better understand how our model, incorporating our Better Care Funded services, can collectively be delivered at local place and neighbourhood levels.

  The following diagram illustrates visually the range of services, providers community and voluntary sector and groups connected into our integrated community model.



National Condition 2

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

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

- Steps to personalise care and deliver asset-based approaches
  The Pan Dorset Equipment Service provides equipment at home prescribed by Occupational therapists, nurses and physiotherapists to enable individuals to either remain safety at home within the local community or to be discharged safely to their home after a stay in hospital. It provides the tools to live as independent a life as is possible within the context of their health and care needs.

- Implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches

  NHS Dorset and BCP are continuing to develop their proactive model of care, especially working alongside Primary Care Networks and Community and Voluntary Sector partners. We use our Dorset Intelligence and Insights Service to better understand need, as well as to risk stratify cohorts of people who for example are at higher risk of falling or may be frequent attenders of health services. We are then able to take a more proactive and targeted approach to supporting people in the right way and in the right place. As part of our strategy for out of hospital care, the Five Year Forward Plan sets out our ambition for healthy ageing where our ambition is to increase the number of older people living well and independently in Dorset, with a focus on prevention.

  NHS Dorset is currently re-procuring its Dorset Supported Self-Management Service that provides social prescribing and non-clinical health coaching that supports those with Long Term Conditions. In addition, NHS Dorset is exploring the use of technology that will enable integration across a range of non-clinical services that support someone's health and well-being.

- Multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake

  As discussed above NHS Dorset has commissioned NAPC to support the system with the development of an Out of Hospital Integrated Care Framework that will build on our multi-disciplinary Health and Social Care approach across physical and mental health teams; adult social care staff and the voluntary sector working closely with General Practice and Primary Care Network teams to support people who have long-term conditions; are frail and those with complex needs.

  These teams provide both proactive and reactive care and are a key to the development of our out of hospital care model, aligned with both anticipatory care and hospital flow. NHS Dorset's community work programme includes the further development of our urgent community response service linked to

virtual wards, enhanced health in Care Homes work, which has been further expanded this year with remote monitoring commissioned as a proof of concept for winter last year and anticipatory care, all linked to our integrated locality teams.

- How work to support unpaid carers and deliver housing adaptations will support this objective

  See National condition 3

National Condition 2 (cont) –

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

- Learning from 2022-23 such as
  - Where number of referrals did and did not meet expectations
  - Unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- Approach to estimating demand, assumptions made and gaps in provision identified
  - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

Approach to demand and capacity

- Step-down demand is profiled on last 12m referral activity via SPA split proportionately by organisation and pathway/service offer.
- Step-down is profiled on commissioned plans where available with assumptions applied for LOS and occupancy/utilisation taken from latest available data. Where hours are commissioned on block, assumptions have been made on caseload size to enable monthly profiling of likely capacity for new patients.
- No adjustments have been made based for expected impact of improvements this year but we have described below what we expect this impact to be and will monitor this over the coming months.
- Step-up demand is not captured in the same way and therefore an assumption has been made based on activity profiles in key service areas over the last 12m.

This means that demand and capacity are largely in sync but this may not be a true reflection of unmet demand.

We acknowledge there are limitations in our current approach, reflective of both a lack of interoperability between different health and care systems and different methods of data capture. We are at an early stage of developing e a comprehensive and agile demand and capacity model for the Dorset intermediate care system.

This is a priority delivery area for the Home First programme this year and we are currently working through with system partners how we improve on this approach to support better and more consistent planning as move forward. We will continue to review and refresh this over the coming months.

Demand and capacity profile for 2023/24

Our overall demand and capacity profile for 2023/24 looking at the totality of step-up and step-down care is largely aligned but there is evidence of in-month variation that is likely to cause peaks and troughs in our ability to consistently meet demand as it presents.

Equally there are opportunity for adjustments in-year to better match the capacity available to the demand profile. This includes:

- Refocusing some of our step-down capacity to meet step-up demand in line with our ambition to shift interventions further up-stream to prevent admissions and support more people at home
- Moving to a single operating model across rehab and reablement offers which are currently managed by different providers. This is a key objective our integrated intermediate care (Home First) objective
- Developing a more agile approach to using P0, P1 and P2 offer in conjunction with each other as part of graduated step-down approach built around a person's needs

Pathway 0 (VCSE offer)

- Demand and capacity in both step-up and step-down support is largely aligned with approximately 79% of activity (141 referrals per month) focused on a step-up response.
- There is ambition to continue to grow and evolve this offer with our VCSE partners to identify further gaps and opportunities to support people to return home as part of their recovery journey either as an alternative to, or in conjunction with, P1 support.

Pathway 1 Rehab and Reablement offer

- Headline analysis indicates that there is more capacity than demand in our current P1 offer but this does not take account of the current fragmentation between offers which means that a person can potentially be supported by more than one service.

- For example, the majority of BCP P1 discharges are taken out with an interim therapy-led service that is managed directly by the hospital. Once the initial assessment is complete, the individual may then be referred onto the community rehab and reablement teams for further input. It is not possible to show this in the current analysis which may explain the disparity
- The Home First programme is seeking to address this through developing an integrated operating model for intermediate care that bring together P1 service and is delivered at place level underpinned by a more granular demand and capacity analysis at 'cluster' level to better understand and respond to our service offer gaps
- This should offer more resilience and agility in our current P1 offers and help us to shape future commissioning plans to address gaps

Pathway 2 Rehab and Reablement offer

- Headline analysis indicates that we have more community bedded capacity than is required to meet current demand and this is an area which we have invested in over the last winter to provide us with additional capacity to support our roll-out of the D2A model
- This was necessary to provide us with the headroom needed to respond quickly to in-month peaks in demand as well as deal with the persistent backlog of people waiting for large packages of care or who needed a period of further assessment.
- Our plan is retain this additional capacity during 2023/24 as we seek to embed our D2A approach and move forward with our integrated P1 offer, both of which will enable us to have less reliance on bedded solutions. Our goals for 2024/25 would be reduce this commitment to bedded care.
- In 2023/24 we are planning to use this capacity in a more agile and recovery-focused way to support better outcomes for people that would otherwise be delayed in hospital. This includes:
    - People waiting for large packages of care. We know that there is insufficient capacity available to meet this level and intensity of demand and therefore are looking to use our bedded capacity as part of a 'pathway to home' approach that enable us to more intensive support in the early stages of a person's recover that reduces ongoing care need. This has the triple benefit of reducing their stay in hospital (and the associated risks of this), improving their longer-term outcome and increasing the likelihood of finding ongoing care if the care demands are reduced.
    - Enhancing our exiting health and care bedded capacity with additional therapy and discharge co-ordinator resource to ensure every community bed environment is recovery focused, can take a higher complexity of need in some areas and centred on returning someone home at the earliest opportunity
    - Linking our P0, P1 and P2 offer as part of a transitional approach that enables people to be 'pulled' from their bed to home to continue their

recovery at the earliest opportunity. This is linked into our single operating model approach for intermediate care.

Pathway 3 placements

- We currently discharge approximately 4% of total intermediate care demand on P3 (circa 13 referrals per month). However, the journey for these individuals cannot offer be protracted due to the multiplicity of their needs and the requirement for a brokered solution.
- Our plan for 23/24 is to put in place plans that expand our core intermediate care offer to accommodate some of this demand by looking at how we can enhance the wraparound support to our current offers to enable people to be supported safely in this environment. Challenging behaviours (associated with delirium/dementia) are key factors that reduce options and this is a target area of focus for this year.

Overall system flow

Whilst there are few major misalignments in our current demand and capacity profiles, the reality is that we continue to hold a large backlog of people waiting for step-down intermediate care. This is indicative of improvement that we need to make to our process and arrangements for managing capacity that enables us to optimise our utilisation and flow through these spaces. Key areas of focus for 2023/24 includes:

- Review of transfer of care process between acute and community to ensure this based on a minimal, proportionate assessment in hospital that facilitates a swift transfer to the most appropriate community setting to continue a person's recovery. This will be supported by an evolved Transfer of Care hub over 7 days (building on our current SPA model)
- Enhanced MDT model in the community that brings together therapists, social workers, discharge coordinators, VCSE partners and trusted assessors at place-level with clear leadership and accountability for decisions and robust follow-up of individuals on a D2A pathway. Additional investment in workforce is planned to support this
- Single integrated operating model for place-based intermediate care that removed unnecessary hand-offs and decision-points that do not add value to a person's journey and enable full system oversight of home and bedded capacity and how it used.

National Condition 2 (cont)

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

- Unplanned admissions to hospital for chronic ambulatory care sensitive conditions

The out of hospital integrated care framework has a focus on health of older people, and will therefore look at our current multi-disciplinary teams and consider how these operate across Dorset, taking into account rural and urban areas. Whilst we have integrated health and care locality teams that support individuals in the community and support hospital discharge, we have not yet integrated these teams fully with all PCNs and practices. This is our intention over the next two years and forms part of the plan for implementing the Fuller Stocktake Report recommendations that fall within the scope of Integrated Care Boards.

There has already been work undertaken that sits outside the BCF but supports this objective including utilising digital technology to monitor long term conditions such as COPD , Cardiovascular Disease and Diabetes. This work will continue as we further develop our service offer.

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

As part of NHS Dorset's Ageing Well investment, PCNs were funded to support both a local urgent community response as well as taking a proactive response to supporting older people. Falls has been a theme for some Networks and will help shape the system pathway, which will be encompassed within our wider community programme, especially Virtual Wards, Urgent Community Response and remote monitoring, as for those who have fallen can be referred on for specific interventions to support and mitigate the risk of further falls.

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

BCP Council has a Care Home Strategy in place, setting the vision for care home services to 2030. A key part of the strategy is the aspiration to reduce unnecessary care home placements by 2030.

A range of services have been introduced to respond to immediate system pressures during and since the COVID pandemic in reference to a bedded setting, which has included:

- The use of extra care housing to provide short term support to people being discharged from hospital.
- Converted 18 care home beds at Coastal Lodge to be used as D2A model discharges to speed up the discharge flow.
- Block purchased 60 Step Down to Home beds to help with discharges during the Winter period.
- Commissioned a Brokerage Service for self-funders to support more timely discharges.
- Provided extra equipment funding to facilitate patients' discharge arrangements.

The BCF will continue supporting the above listed schemes These initiatives have increased the timeliness of discharge across the whole with an increase in the

proportion of people discharged with support, who are discharged within 0-5 days increasing from 42% in July 2022 to 52% in April 2023. From April 2023 new. Discharge to Assess arrangements have been introduced which we expect to further improve our arrangements. In addition, we are aiming to extend the scope of the Trusted Assessor model to all residential care placements

Another objective in the Care Home Strategy is to regularise and offer consistency in the way that fees are determined for care home placements. In this respect, there will be continued scrutiny of the cost of residential care home placements. The cost of care in 2022 demonstrated that the price of providing a residential care service locally is lower than the current average placement fee. Further work is required in this are to ensure that individual placements are sustainable when a person is discharged form hospital.

National Condition 3

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

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

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

The Council and system partners recognise that a step change is required to implement a discharge to assess approach linked to a robust intermediate care model to improve the experience for people who need to be discharged from hospital and to ensure that people in the community receive early help support to prevent admissions. A range of services have been introduced to respond to immediate system pressures and to support the homecare market in responding to these demands

- 2400 hours per week of 7-day per week, rapid response homecare provision across the BCP area. This includes discharge to assess community capacity

- Increased capacity in the reablement service to support people to increase independence on discharge. The outcomes achieved by people who receive reablement support are very positive, with over 95% of people discharged from hospital into reablement services still at home 91 days after discharge

- Additional rapid interventions within the integrated Equipment service with the addition of 4 hour turn around service and Saturday working.

- Block booked bed provision for people with nursing or higher-level dementia needs

- Additional capacity in extra care housing for people who cannot return home to their normal residence on discharge

- The employment of additional Occupational Therapists within the LA trading company, Tricuro, to proactively identify people who would benefit from reablement

- Support with recruitment of the social care workforce: Proud to Care social media campaign delivered over a variety of online platforms in 2022.

- Further development and delivery of Proud to Care initiatives to support the social care provider workforce locally including with recruitment, retention and recognition of social care staff working with strategically important local providers (Framework home care, extra care housing staff and contracted care home staff). Possible initiatives to be rolled out in 23/24 include free parking permits across BCP area, free childcare in school holidays, alternative transport e.g. e-bikes and mopeds (home care), further recruitment and reward campaigns.

Fundamentally all care should be about enablement, maximising people's ability to be independent and the council wishes to build an approach to preventing, where possible, people's need for higher levels of formal care than they might need. Therefore, investment needs to focus on Intermediate Care: rapid response and reablement alongside sufficient capacity to support long-term needs

The Dorset system has re-committed to implementing an at scale Discharge to Assess approach for all hospital discharges and this has been in place since April 2023. Our approach, supported by all health and care partners, builds on the learning from the past three years and is grounded in the principle of supporting more people with a 'pathway to home' approach that maximises their opportunity for recovery out of hospital and a return to independent living. Through the Home First programme, we have set an ambitious roadmap for 2023/24 which takes account of the High Impact Changes and is collectively focused on:

- The development of place-based integrated intermediate care teams across health and social care, that are enabled to work together to provide the right input and support to people at the right time, have joint processes for assessment that are aligned to D2A principles and have the ability to flex and blend capacity (home and bedded care) in order to maximise impact in both flow and outcomes. This is premised on only supporting people in a bedded environment for as long as they need and proactively looking to step-down dependence on care at the earliest opportunity (where appropriate)

- Embedding of new ways of working premised on person-centred care planning and delivery from earliest point of intervention. This includes working with our acute

partners to identify and plan for complexities that may impact discharge as early as possible, working with VCSE and community partners to put in place solutions that enable people to return home with alternatives to formal care that are premised on maximising people's confidence and connection into their own communities and increasing our focus on step-up responses through intermediate care that seek to prevent a hospital admission in the first place (initially looking at pathways out of ED). At the centre of this is a strengthened approach to engaging with individuals and their families at every step of the pathway to understand what is important to them and build on their own strengths and assets as part of their recovery plan

- Streamlining of our Transfer of Care processes over 7 days to enable people to be safely moved from hospital to a community setting once medically ready to leave and without avoidable delays. This involves a move to a minimal, proportionate assessment in hospital that is designed to affect a safe transfer to a community setting where a person's recovery goals can be better assessed and where they have the best opportunity for recovery. This will ideally be in someone's own home but could also include a short-stay in a community hospital or D2A bedded setting where more intensive support can be provided in order to maximise their improvement opportunity. To support this we are evolving our current pan-Dorset Single Point of Access to become a 7 day Transfer of Care hub that facilitates that swift transfer and enables us to have better oversight and management of the capacity available in the system.

- Further development of a pan-Dorset demand and capacity model to inform right-sizing of intermediate care capacity and skills at place level. We know that we do not currently have all the skills and capabilities in the right places or necessarily in the right quantum. Building on our BCF planning process, our plan is to evolve our demand and capacity modelling capabilities across health and social care to help us better understand where there are gaps in our intermediate care model and how we can best optimise the skills and capacity we do have to meet people's needs. This includes but is not limited to:
  - Scoping where we can extend our intermediate care offer to support more people and reduce reliance on one-off brokered solutions. Areas of focus include people with delirium, advanced dementia as well as solutions for younger people and those with LD who are often not easily support with core services
  - Developing a joint approach to workforce development across health and social care, particularly around use of therapists. We are committed to delivering a therapy-led reablement model as part of our intermediate care offer and are scoping how we can increase investment in non-registered roles that enable us to target our limited therapy resource at the most effective places. This includes use of therapy/rehab assistants, discharge co-ordinators and expansion of trusted assessment capabilities

As we move forward, our ambition is to shift our focus from step-down (supported discharge) to step-up (admission prevention) which brings together our intermediate care capabilities with those being developed via virtual wards and UCR services and which will enable us to better target our collective resource to supporting people in

their own homes. This requires us to continue to reduce the backlog of delays in hospital in order to create the necessary headroom to shift resources further upstream.

National Condition 3 (cont)

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

- Discharge to usual place of residence

BCP has commissioned a range of service to support people back to their usual place of residence and working towards a D2A model for all discharges, which will ensure the assessment of need is completed after discharge which demonstrates a valid picture of a person's care and support needs. We have and will continue to commission:

- Coastal Lodge which provides 38 D2A beds to aid speedy discharge of patients medically fit and waiting for their care needs assessment. This service provides reablement care to increase patient's independence, thus reducing the care required at point of optimisation and moving on to their long-term care.

- Approximately 1800 hours are designated to providing a recovery and community response service to patients medically fit. This service takes patients off the Interim services (intermediate care) whilst waiting for their long-term package. 450 of these hours are designated to taking patients in need of QDS or QDS double up care from either community hospitals or acute hospitals whilst waiting for their care needs assessment and long-term package.

- BCP is looking to enhance its self-funding independent living service to meet rising demand in the community because of the recent implementation of the D2A model.
- The Pan Dorset Integrated Equipment Service is implementing a new Safe & Well website to support self-funders with advice and support on equipment that will support ongoing independence in the home or timely discharge.

In addition, BCP Council works with the voluntary sector to develop preventative integrated support that supports people to achieve positive health and social care outcomes in the community. The Community Action Network (CAN) Wellbeing Collaborative was commissioned to develop integrated approaches to keep people safe and well at home and preventing hospital admissions. The approach is supported by pathway co-ordinators who work in the acute hospitals and the Adult Social Care Contact Centre to provide advice, guidance and to link people into community and voluntary sector support. This approach also offers a 24/7 virtual network and email support service, direct referrals to support hospital discharges, one off grant to support discharges, a wellbeing buddy service, public information access points in BCP libraries and wellbeing connector volunteers.

Pramalife have been commissioned to support Dorset Healthcare's Urgent Community Response (UCR) scheme which provides a 2-hour crisis response to support people

in their own homes to avoid hospital admission. Pramalife contact patients who have received support from UCR to ensure they are recovering well, that it is safe for them to remain at home and to connect them into support in their community.

National Condition 3 (cont)

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

We have embedded the High Impact Changes as core principles in our Home First programme. Adopting a universal D2A approach for hospital discharge, improving early engagement and discharge planning and increasing the efficacy of our MDT working are all key tenets of our improvement focus. Our 2023/24 plans reflect our commitment to expand trusted assessment capabilities, improve our relationships and support to care providers and achieve a more consistent response over 7 days. Key areas for further work this year will focus on further developing our demand and capacity capabilities as key to strengthening our longer-term strategy and commissioning plans and targeted work to source better and more timely solutions for people for whom housing and/or accommodation issues are a key factor in their discharge delay.

National Condition 3 (cont)

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

In terms of our duty to provide information and advice, one of our key channels has been the BCP Council Adult Social Care (ASC) information and advice service which was hosted on an external platform, My Life My Care for the past 7 years. In order to further develop and improve the offer, on 1st January 2023, all the information web pages, and Provider Directory was migrated to the BCP website. This is allowing us to be more creative, improve the information and advice offer and design new functions such as newsreel banners and better search functions. Stakeholders are involved in this work and co-designing content, assisting with promotion, and developing new information around prevention and wellbeing.

An adjoining project is underway, to look at how we can join up information and advice services with our partners in the Health and Voluntary sectors, in particular our directories. Agreements have been made to sign up to Open Reach standards, allowing partner directories to ‘talk’ to one and other and share information. This will provide a more robust signposting service across BCP, that supports the prevention agenda and working from a strengths-based approach.

The BCP Adult Social Care website pages received over 60,000 hits from 1st January 2023 to the end of May, and popular pages include how to contact ASC and ‘How to find the Right Help and Careline’.

Supporting unpaid carers

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

Following an in-depth review of support available to unpaid carers, the first BCP Council Carers Strategy was approved by Cabinet in September 2022. The strategy spans a five-year period and will be reviewed annually during this period. The findings from the carers review have informed the 5 Key Priorities in the strategy, which are:

- Identification, recognition, and involvement
- Information and advice
- Supporting carers physical, mental and emotional wellbeing
- A life alongside caring
- Collaborative working across Dorset

We are now in the process of implementing the strategy, which includes increasing the options for short breaks and respite, increasing take up of direct payments to provide tailored support for carers, and working with partners across Dorset to ensure an equitable offer of support county-wide. We are also in the process of reviewing the Dorset carers strategic vision with the Pan Dorset Carers Reference Group.

We continue to see an expansion in the membership of the BCP carers service – CRISP, which currently stands at 6,308. However, this only represents 18% of carers living in the BCP area, according to 2021 census data, so it is important that we continue to identify and recognise carers to ensure they can access support to remain in their caring roles.

The Carers Reference Group meets monthly and focuses on issues of interest such as hospital admission and discharge and we are looking to expand membership of the group to include a wider range of carers to ensure their voices are heard.

All eligible needs identified under a Care Act (2014) carers assessment are funded through the Better Care Fund. The following services are available for carers with eligible needs:

- Home Based Support: up to 120 hours of home care per year for the cared for person to give the carer a break
- Take a Break and cinema vouchers: a range of therapies and activities that the carer can enjoy for free
- Carers in Crisis scheme: free replacement care for up to 48 hours for the cared for person in case of emergency

The following universal services are also funded through the Better Care Fund and do not require a carers assessment:

- Carers Information Service: provided by the BCP carers support service - CRISP
- Time to Talk counselling service by the Leonardo Trust: up to 6 free counselling sessions are available for carers who would benefit from this support

- Befriending and Mentoring service by Prama Life: this includes both one to one support and group sessions
- Carers events run by CRISP
- Carers Advocacy Service by Swan Advocacy: free advocacy support specifically for carers
- Carers Representation Service for carers of people with a learning disability by Minstead Trust
- Beach Huts: 4 beach huts are available across Bournemouth, Christchurch and Poole for carers to take a break
- Holiday Lodges: 2 holiday lodges are available in Brixham and Weymouth for carers to take a break
- Care Free Choir: a weekly choir for carers
- Carers Card: an ID card for carers which also providers discounts and concessions at local and national businesses

Feedback from the carers review suggests that carers and care providers are finding our various voucher schemes more challenging to use, and they are labour intensive for us to administer. We also know that we have relatively low numbers of carers who receive a direct payment. We have therefore agreed that a portion of the allocated BCF uplift for 2023/24 will be utilised to recruit a dedicated carer Finance Officer who will assist with our transition from voucher schemes and switch to greater use of direct payments.

Also following feedback from carers, work is progressing to redesign the carer assessment process in line with broader practice developments for a strengths-based model based on the Three Conversations® approach.

Disabled Facilities Grant (DFG) and wider services

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

Significant proportion of DFG funding (circa £2m) is retained within Housing to support with complex adaptations in people's homes. Our DFG Policy 2021 is now embedded and includes discretionary funding opportunities for more complex and extensive works as well as beneficial works outside of the statutory terms to ensure people remain in their own homes.

DFG Adaptations Staffing increased to cover needs of all of BCP area, following local government reorganisation in 2019, (delayed due to Covid).

A Large proportion also funds the Community Equipment service, (circa £1.5) including provision of ceiling track and gantry hoists. These will all be part of the new tender.

BCP Homes continues to fund adaptations work in own housing stock using the Housing Rent Account (HRA).

Further project underway to bring all adaptations work together including the recruitment of a strategic role to oversee all adaptations including DFG, BCP Homes and minor works to ensure a clear and cohesive offer to BCP residents.

Looking forward 2023/24

MDT outreach service to support homeless people and those under the Housing/Hospital Discharge Pathway, (University Hospital Dorset/ASC and Housing Staff) is currently funded through short term funding but will require longer term funding for 2023/24 to continue. This service will be reviewed during the two-year term of this Better Care Fund round.

Additional information (not assured)

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

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

Our Disabled Facilities Grant Policy 2021 sets out our discretionary grant funding arrangements. There is no allocated amount for discretionary funding, as each case over and above the mandatory grant limit is considered on its own merit within the terms of our discretionary grant funding panel terms of reference and our overall grant allocation.

Equality and health inequalities

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

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

BCP Council, working with Dorset Council and NHS Dorset, are committed to addressing health inequalities, and this is a priority for the Integrated Care Board.

A pan-Dorset Health Inequalities Group oversees our work on health inequalities. It is a multi-agency group supporting our approach to reducing health inequalities through raising awareness, creating learning and development opportunities and supporting services to think differently to create new ways of delivery. A series of

workshops has explored topics such as ‘What are Health Inequalities?’, ‘Health Literacy’, ‘Building resilience in Dorset’s communities’ and ‘Tackling Health Inequalities’. Through the workshops attendees from across the local System identified what actions they could take on an individual, organisational and systematic basis in order to address the themes raised and discussed in each session. Further information can be found here: Health Inequalities – Our Dorset

The group are in the process of developing a virtual academy to support training and raising awareness, including free training, case studies and ideas from some of the top evidence-based international theories, to support service delivery, redesign and development to reduce inequality.

Data and intelligence is now more readily available via the Dorset Information & Intelligence Service (DiiS) and use is increasing amongst commissioners, as well as clinicians, so there is a greater understanding of populations from a Health & Well-being area perspective. It includes PCN and patient level detail to enable services planning to meet care and health needs. We strive to use the information to enable ‘place-based’ gap analysis to inform commissioning priorities.

The services which will benefit from the BCF are generally those which support timely hospital discharge, maintaining independence and carers. Therefore, older people with increased frailty and those with long term conditions are most likely to use these services and have the most acute needs. All these services are accessible to all the protected characteristic groups.

Recognising the diversity of carers and their needs are specific objectives within the new BCP Carers Strategy and an equalities impact assessment has been completed to support this. Changes are planned to improve the current Carers’ information and advice website, to make it more accessible.

Wider services under the BCF are designed to support individuals to maintain independence once discharged from hospital or through services to reduce the risk of more intensive forms of care, e.g. community equipment and home adaptations. There are no negative impacts as these monies will either support or enhance current services.

The ‘Equip for Living’ community equipment service has been retendered. An equalities impact assessment has been completed to inform the new specification for this service along with feedback from people accessing the service. The New ICES Contract has an engagement officer built in within the service provision who will be responsible for reaching out Dorset Communities to ensure that services is accessible to all.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

			Complete:
Health and Wellbeing Board:	Bournemouth, Christchurch and Poole		Yes
Completed by:	Peter Courage		Yes
E-mail:	p.courage24@bcpcouncil.gov.uk		Yes
Contact number:	1202128823		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	tbc	tbc - new chair will be appointed at next	tbc - new chair will be appointed at next	tbc@tbc.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Patricia	Miller	patricia.miller@nhsdorset.nhs.uk	Yes
	Additional ICB(s) contacts if relevant		Kate	Calvert	Kate.calvert@nhsdorset.nhs.uk	Yes
	Local Authority Chief Executive	Mr	Graham	Farrant	Graham.farrant@bcpcouncil.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Betty	Butlin	betty.butlin@bcpcouncil.gov.uk	Yes
	Better Care Fund Lead Official		Zena	Dighton	zena.dighton@bcpcouncil.gov.uk	Yes
	LA Section 151 Officer	Mr	Adam	Richens	adam.richens@bcpcouncil.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£3,518,312	£3,518,312	£3,518,312	£3,518,312	£0
Minimum NHS Contribution	£34,405,085	£36,352,413	£34,405,085	£36,352,413	£0
iBCF	£13,438,749	£13,438,749	£13,438,749	£13,438,749	£0
Additional LA Contribution	£2,182,000	£2,182,000	£2,182,000	£2,182,000	£0
Additional ICB Contribution	£12,818,959	£13,049,700	£12,818,959	£13,049,700	£0
Local Authority Discharge Funding	£1,884,092	£3,140,000	£1,884,092	£3,140,000	£0
ICB Discharge Funding	£2,835,080	£3,501,000	£2,835,080	£3,501,000	£0
Total	**£71,082,277**	**£75,182,174**	**£71,082,277**	**£75,182,174**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£9,824,929	£10,381,020
Planned spend	£20,889,059	£22,071,404

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£13,441,586	£14,202,380
Planned spend	£13,516,026	£14,281,009

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	1,047.0	899.0	1,111.0	990.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,033.9	2,033.9
	Count	1973	1973
	Population	86859	86859

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.8%	93.8%	93.8%	93.8%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	378	400

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	71.6%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	No
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

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

3.1 Demand - Hospital Discharge

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

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

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

3.2 Demand - Community

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

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

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

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

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

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

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	3	3	3	3	3	3	3	3	3	3	3	3
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		34	34	34	34	34	34	34	34	34	34	34	34
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Reablement at home (pathway 1)	1	1	1	1	1	1	1	1	1	1	1	1
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		13	13	12	13	11	11	12	13	11	12	13	15
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	10	10	9	10	9	9	9	10	9	10	10	12
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		117	118	102	113	97	97	100	115	97	108	112	131
OTHER		3	3	2	3	2	2	2	3	2	2	2	3
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	4	4	3	4	3	3	3	4	3	4	4	4
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		42	43	37	41	35	35	36	41	35	40	41	48
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	4	4	4	3	3	3	4	4	4	5	4	4
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		42	48	40	32	33	32	42	41	49	56	49	48
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	4	5	4	3	3	3	4	4	5	6	5	5
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		50	57	47	38	39	38	50	50	57	66	58	56
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	2	1	1	1	1	0	1	1	1	1	1	1
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST		17	7	11	11	15	4	9	12	14	13	13	14
OTHER		0	0	0	0	0	0	0	0	0	0	0	0

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	144	141	141	141	141	141	141	141	141	141	141	141
Urgent Community Response	194	191	69	102	113	95	97	92	161	127	127	116
Reablement at home	5	8	8	3	1	7	3	3	0	5	5	3
Rehabilitation at home	77	77	77	77	77	77	77	77	77	77	77	77
Reablement in a bedded setting	5	10	2	5	5	5	5	5	5	5	5	5
Rehabilitation in a bedded setting	0	1	4	1	1	0	5	2	0	6	4	2
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	38	38	38	38	38	38	38	38	38	38	38	38
Reablement at Home	Monthly capacity. Number of new clients.	27	15	20	29	23	13	24	25	30	26	27	35
Rehabilitation at home	Monthly capacity. Number of new clients.	178	178	178	178	178	178	178	178	178	178	178	178
Short term domiciliary care	Monthly capacity. Number of new clients.	12	16	27	27	27	27	27	27	27	27	27	27
Reablement in a bedded setting	Monthly capacity. Number of new clients.	86	86	86	86	86	86	86	86	86	86	86	86
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	49	49	49	49	49	49	49	49	49	49	49	49
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	19	8	12	12	17	4	10	13	15	14	14	16

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	144	141	141	141	141	141	141	141	141	141	141	141
Urgent Community Response	Monthly capacity. Number of new clients.	194	191	69	102	113	95	97	92	161	127	127	116
Reablement at Home	Monthly capacity. Number of new clients.	5	8	8	3	1	7	3	3	0	5	5	3
Rehabilitation at home	Monthly capacity. Number of new clients.	77	77	77	77	77	77	77	77	77	77	77	77
Reablement in a bedded setting	Monthly capacity. Number of new clients.	5	10	2	5	5	5	5	5	5	5	5	5
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	3	3
Other short-term social care	Monthly capacity. Number of new clients.												

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Bournemouth, Christchurch and Poole	£3,518,312	£3,518,312
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£3,518,312**	**£3,518,312**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Bournemouth, Christchurch and Poole	£1,884,092	£3,140,000

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Dorset ICB	£2,835,080	£3,501,000
Total ICB Discharge Fund Contribution	£2,835,080	£3,501,000

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Bournemouth, Christchurch and Poole	£13,438,749	£13,438,749
Total iBCF Contribution	**£13,438,749**	**£13,438,749**

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

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Bournemouth, Christchurch and Poole	£2,182,000	£2,182,000	See plan
Total Additional Local Authority Contribution	**£2,182,000**	**£2,182,000**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Dorset ICB	£34,405,085	£36,352,413
Total NHS Minimum Contribution	**£34,405,085**	**£36,352,413**

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

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Dorset ICB	£12,818,959	£13,049,700	See plan
Total Additional NHS Contribution	**£12,818,959**	**£13,049,700**	
Total NHS Contribution	**£47,224,044**	**£49,402,113**	

	2023-24	2024-25
Total BCF Pooled Budget	**£71,082,277**	**£75,182,174**

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£3,518,312	£3,518,312	£0	£3,518,312	£3,518,312	£0
Minimum NHS Contribution	£34,405,085	£34,405,085	£0	£36,352,413	£36,352,413	£0
iBCF	£13,438,749	£13,438,749	£0	£13,438,749	£13,438,749	£0
Additional LA Contribution	£2,182,000	£2,182,000	£0	£2,182,000	£2,182,000	£0
Additional NHS Contribution	£12,818,959	£12,818,959	£0	£13,049,700	£13,049,700	£0
Local Authority Discharge Funding	£1,884,092	£1,884,092	£0	£3,140,000	£3,140,000	£0
ICB Discharge Funding	£2,835,080	£2,835,080		£3,501,000	£3,501,000	£0
Total	**£71,082,277**	**£71,082,277**	**£0**	**£75,182,174**	**£75,182,174**	**£0**

Required Spend

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

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£9,824,929	£20,889,059	£0	£10,381,020	£22,071,404	£0
Adult Social Care services spend from the minimum ICB allocations	£13,441,586	£13,516,026	£0	£14,202,380	£14,281,009	£0

Checklist

Column complete:

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

>> Incomplete fields on row number(s):
58, 59, 60, 61,

									Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)
1	Integrated Health and Social Care locality schemes	Moving on from hospital living	Community Based Schemes	Other	LD campus reprovision				Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£7,428,193	£7,428,193
2	Integrated Health and Social care	Integrated health and social care locality schemes	Community Based Schemes	Other	other				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£9,320,204	£10,480,335
3	Maintaining Independence	Dorset Integrated Community Equipment Service	Community Based Schemes	Other	Integrated community equipment				Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£2,906,542	£2,906,542
4	Maintaining Independence	Advocacy, information, front door	Care Act Implementation Related Duties	Other	Early help and Learning Disabilites				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£221,000	£233,509
5	Maintaining Independence	Voluntary organisations shcemes	Prevention / Early Intervention	Other	Voluntary sector				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£183,000	£193,358
6	Maintaining Independence	High cost placements	Residential Placements	Learning disability		3	3	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£580,000	£612,828
7	Maintaining Independence	Dementia Placements	Residential Placements	Care home		38	38	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,390,026	£2,525,301
8	Maintaining Independence	Home care	Home Care or Domiciliary Care	Domiciliary care packages		64,250	64,250	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,517,000	£1,602,862
9	Maintaining Independence	Support to self funders	Prevention / Early Intervention	Other	social work support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£61,000	£64,453
10	Maintaining Independence	Dementia Placements	Care Act Implementation Related Duties	Other	Residential care				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£760,000	£803,016
11	Early supported hospital discharge	Residential, dementia and mental health placements	Residential Placements	Care home		32	32	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,982,000	£2,094,181

12	Early supported hospital discharge	Residential and dementia placements	Care Act Implementation Related Duties	other	Residential care				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£57,000	£60,226
13	Early supported hospital discharge	Hospital discharge and CHC teams	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,090,000	£2,208,294
14	Early supported hospital discharge	Intermediate care	Personalised Care at Home	other	rapid/crisis response				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£121,000	£127,849
15	Early supported hospital discharge	Reablement and rehabilitation	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		115	115	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£932,000	£984,751
16	Early supported hospital discharge	Reablement and rehabilitation	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		10	10	Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,100,000	£1,162,260
17	Early supported hospital discharge	Intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		0.8	0.8	Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£51,000	£53,887
18	Early supported hospital discharge	Support to self funders	Other		social work support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£91,000	£96,151
19	Carers	Support to carers various schemes	Care Act Implementation Related Duties	Other	Carers support				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£154,000	£162,716
20	Carers	Carers support	Carers Services	Other	Carers support	6500	6500	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£215,000	£227,169
21	Carers	Support to carers various schemes	Carers Services	Other	Various schemes including respite	6500	6500	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£970,000	£1,024,902
22	Integrated Health and Social care	Integrated health and social care locality schemes	Community Based Schemes	Other	other				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,234,120	£1,256,334
23	Integrated Health and Social Care locality schemes	Integrated Health and Social Care locality schemes	Community Based Schemes	Other	Other				Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£5,198,617	£5,292,192
24	Integrated Health and Social Care locality schemes	Integrated Health and Social Care locality schemes	Community Based Schemes	Other	Other				Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£42,402	£43,165
25	Integrated Health and Social Care locality schemes	Integrated Health and Social Care locality schemes	Community Based Schemes	Other	Other				Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£1,457,591	£1,483,828
26	Integrated Health and Social Care locality schemes	Integrated Health and Social Care locality schemes	Community Based Schemes	Other	Other				Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£6,120,349	£6,230,515
27	Maintaining Independence	Market shaping	Prevention / Early Intervention	Other	market shaping				Social Care		LA			Local Authority	Minimum NHS Contribution	New	£41,000	£43,296
28	Maintaining Independence	Housing schemes	DFG Related Schemes	Discretionary use of DFG		9110	9110	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£1,544,312	£1,544,312
29	Maintaining Independence	Housing schemes	DFG Related Schemes	Adaptations, including statutory DFG grants				Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£1,974,000	£1,974,000
30	Integrated Health and Social Care locality schemes	Moving on from hospital living	Community Based Schemes	Other	LD campus reprovision				Social Care		LA			Private Sector	Additional LA Contribution	Existing	£2,182,000	£2,182,000
31	Maintaining Independence	Staffing for lifeline/AT	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	iBCF	Existing	£35,000	£35,000
32	Maintaining Independence	Care home placements	Residential Placements	Care home		67	64	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£4,143,749	£4,143,749
33	Maintaining Independence	Packages of home care	Home Care or Domiciliary Care	Domiciliary care packages		256,200	243,000	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£6,049,000	£6,049,000
34	Maintaining Independence	Social Work	Other		targeted community social work				Social Care		LA			Local Authority	iBCF	Existing	£189,000	£189,000
35	Maintaining Independence	Independent Living	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	iBCF	Existing	£68,000	£68,000

36	Early supported hospital discharge	DOLS BIAs	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF	Existing	£268,000	£268,000
37	Early supported hospital discharge	Brokerage servces	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF	Existing	£58,000	£58,000
38	Early supported hospital discharge	Hospital discharge and CHC teams	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF	Existing	£288,000	£288,000
39	Early supported hospital discharge	Hospital to home	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		10	9	Number of Placements	Social Care		LA			Private Sector	iBCF	Existing	£550,000	£550,000
40	Early supported hospital discharge	reablement	Home-based intermediate care services	Reablement at home (to support discharge)		26	26	Packages	Social Care		LA			Private Sector	iBCF	Existing	£210,000	£210,000
41	Early supported hospital discharge	Step down beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		0.33	0.25	Number of Placements	Social Care		LA			Private Sector	iBCF	Existing	£21,000	£21,000
42	Early supported hospital discharge	Intensive packages, extended protected hours	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	iBCF	Existing	£1,195,000	£1,195,000
43	Early supported hospital discharge	rapid financial assessments	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			NHS	iBCF	Existing	£72,000	£72,000
44	Early supported hospital discharge	social workers	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	iBCF	Existing	£235,000	£235,000
45	Early supported hospital discharge	7 day working	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF	Existing	£57,000	£57,000
46	Early supported hospital discharge	Intermediate care	Personalised Care at Home	Other	rapid/crisis response				Social Care		LA			Private Sector	Local Authority Discharge	Existing	£317,000	£334,942
47	Early supported hospital discharge	Intermediate care	Bed based intermediate Care Services (Reablement,	Other	residential beds	5	5	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£336,000	£355,018
48	Early supported hospital discharge	Intermediate care	Personalised Care at Home	Other	extra care housing				Social Care		LA			Private Sector	Local Authority Discharge	Existing	£115,000	£121,509
49	Early supported hospital discharge	Intermediate care	Home-based intermediate care services	Reablement at home (to support discharge)		77	77	Packages	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£622,000	£657,205
50	Early supported hospital discharge	Intermediate care	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£494,092	£522,058
51	Early supported hospital discharge	Intermediate care	Personalised Care at Home	Other	rapid/crisis response				Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£953,000	£1,006,940
52	Early supported hospital discharge	Intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		18	18	Number of Placements	Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£1,882,080	£1,988,606
53	Early supported hospital discharge	Intermediate care	Community Based Schemes	Other	24/25 additnl funding to be agreed				Social Care		LA			Private Sector	Local Authority Discharge	New	£0	£1,149,268
54	Early supported hospital discharge	Intermediate care	Community Based Schemes	Other	24/25 additnl funding to be agreed				Social Care		LA			Private Sector	ICB Discharge Funding	New	£0	£505,454

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	217.1	186.3	230.2	200.0	Total of 4,020 avoidable admissions recorded in 22/23, representing increase in activity over the last 2 year as we recover from pandemic. Aim to reduce levels by 1% during 23/24. One of our challenges in Dorset has been variation due to legacy funding and service provision. The OOH Integrated Care Framework will help	NHS Dorset has commissioned NAPC to support the system with the development of an Out of Hospital Integrated Care Framework that will build on our multi-disciplinary Health and Social Care approach across physical and mental health teams; adult social care staff and the voluntary sector working closely
	Number of Admissions	1,058	908	1,122	-		
	Population	395,784	395,784	395,784	395,784		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	1047	899	1111	990		

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,278.2	2,033.9	2,033.9	Maintain 22/23 outturn, using local logic based on SUS dataset - to account for data quality and ensuring consistency in data capature via Acute PAS systems. We need to clearly embed falls intervention and prevention into our pathways of care especially in relation to those who are frail. We need to also be able to scale up and spread what has worked well within our	As part of NHS Dorset's Ageing Well investment, PCNs were funded to support both a local urgent community response as well as taking a proactive response to supporting older people. Falls has been a theme for some Networks and will help shape the system pathway, which will be encompassed within our wider community programme, especially Virtual Wards
	Count	2,210	1,973	1,973		
	Population	86,859	86,859	86,859		

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.6%	94.7%	93.7%	93.5%	23/24 plan to achieve 93.8% each quarter (overall average for 22/23)	We will: • block book at least 2 emergency/respite beds across at least 2 cares homes for hospital admission avoidance to ensure that carers are able to access short term respite services as required. • adopt the D2A model in its own care home, Figbury Lodge so that the 20 existing step up and step down beds can
	Numerator	8,135	8,072	8,289	8,140		
	Denominator	8,785	8,523	8,842	8,710		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	93.8%	93.8%	93.8%	93.8%		
	Numerator	7,894	7,997	7,835	8,151		
	Denominator	8,416	8,526	8,353	8,690		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	377.7	405.5	393.1	400.4	Based on Target of 405 per 100,000/p	Increased capacity in alternative services as follows: •Increased rapid access community-based home care – 1800 hours per week rapid discharge hours of which 700 is dedicated to D2A.
	Numerator	328	360	349	360		
	Denominator	86,843	88,785	88,785	89,917		

Additional transition flats in extra care

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	95.7%	95.7%	71.6%	71.6%	Based on 2022/23 outturn	We will increase capacity of the reablement service and work with the voluntary and community sector to connect people with community support following their reablement period, enabling them to live independently at
	Numerator	264	264	136	136		
	Denominator	276	276	190	190		

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	No		The Health and Wellbeing Board will not meet until 20th July	20th July 2023
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes			
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes			
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes			

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes			
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes			
Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes			

BCP HEALTH AND WELLBEING BOARD

Report subject	**Pharmaceutical Needs Assessment: Supplementary statement**
Meeting date	20 July 2023
Status	Public Report
Executive summary	To update on changes since the Pharmaceutical Needs Assessment (PNA) was published in October 2022.
Recommendations	**It is RECOMMENDED that:** **The Board** **(a) approve publication of the supplementary statement.** **(b) delegate authority to the Director of Public Health to publish such further statements as required.** **(c) note response to NHS England on a consolidation request**
Reason for recommendations	Each Health and Wellbeing Board must publish a PNA under section 128A of the NHS Act 2006 (amended). Part 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 sets out the detailed requirements. The Board must publish a new PNA every 3 years, or where there are significant changes. A Supplementary Statement can explain changes to the availability of pharmaceutical services, where: (i) There has been a change to the availability of pharmaceutical services and this change is relevant to the granting of applications to open a new, or relocate a pharmacy; or to provide additional services; and (ii) the HWB is satisfied that the publication of a revised PNA would be a disproportionate response or is already in the process of producing an updated PNA but is satisfied that there is a need for a supplementary statement in order to prevent significant detriment to the provision of pharmaceutical services. As further changes in pharmacy services are expected it would be helpful if further supplementary statements could be issued as they occur, hence the delegation to the Director of Public Health.

Portfolio Holder(s):	Councillor David Brown, Portfolio Holder Health and Wellbeing
Corporate Director	Sam Crowe, Director of Public Health
Contributors	Jane Horne, Consultant in Public Health
Wards	All
Classification	For Decision

Background

1. The Pharmaceutical Needs Assessment (PNA) is a statement of the need for pharmaceutical services in an area. In September 2021 BCP Health and Wellbeing Board agreed to develop a single PNA to cover both the BCP and Dorset Health and Wellbeing Board areas.
2. The latest PNA was published in October 2022.
3. Since then, there have been changes in the availability of pharmaceutical services. Three pharmacies in BCP have closed, 2 pharmacies in Dorset council area have changed ownership, and we are aware of applications for a further change of ownership in DC and a consolidation of two pharmacies onto one site in Poole. A recent application for relocation in DC has been declined.

Lloyds Pharmacy changes

4. Following a national review, Lloyds Pharmacy plans to close all its outlets inside Sainsbury's this year. The three BCP closures are because of this plan.
5. The closest alternative pharmacy for Lloyds in Castlepoint is the Boots at Castlepoint (1 minute on foot). For the Lloyds at Talbot Heath, the nearest alternative is in Wallisdown, 4 minutes by car or 12 minutes on foot. The Lloyds inside Christchurch Sainsbury's held a 100-hour contract. The nearest alternative pharmacy is in Somerford (4 minutes by car or 7 minutes on foot), however, this has a standard 40-hour contract so does not have the extended opening hours that the Christchurch pharmacy had. The nearest alternative 100-hour pharmacies are Castle Lane, or in New Milton, Hampshire, between 12 and 17 minutes by car.
6. In closing the pharmacies Lloyds is responsible for communication to patients about this, including supporting vulnerable patients to nominate a new pharmacy and contacting patients where medication has not been collected close to the closure date.
7. There are no further Lloyds pharmacies inside Sainsbury's across Dorset. However, Lloyds Pharmacy nationally have also sold, or are in discussion about selling, many of their other pharmacies.

8. We have ten remaining Lloyds' pharmacies. It is not yet clear whether locally we can expect further closures or changes of ownership, as Lloyds continue to review the need for their remaining pharmacies.

Choice of Supplementary statement or revised PNA

9. The Department of Health and Social Care publish guidance to support health and wellbeing boards develop their PNAs. This includes guidance on whether changes should result in producing a new PNA.

10. Core members of the virtual PNA Steering group, who oversaw the publication of the October 2022 PNA, considered the guidance and the changes in pharmaceutical services to date. They agreed that it was disproportionate to produce a new PNA including public consultation at this time because:

    - It is not yet clear that the situation has stabilised,
    - The current PNA does not identify any gaps, and an initial look at the data suggests that using a 20-minute drive time this would not change,
    - If the PNA were to identify gaps in the areas where closures have occurred, it is unclear whether there would be capacity for other community pharmacies to pick this up.
    - New legislation came into force 25 May 2023 that may result in further changes to 100-hour pharmacies oner the next few months.

11. A supplementary statement has therefore been drafted that sets out those changes that have already occurred. Once issued it will become part of the PNA.

Summary of financial implications

12. There are no significant financial implications from this report. Activity previously delivered at pharmacies that have now closed will be picked up either by other community pharmacies in the vicinity or through distance-selling pharmacies (online pharmacies).

Summary of legal implications

13. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 came into effect in April 2013 in line with changes in the NHS at that time. Responsibility for developing, updating and publishing local PNAs shifted to Health and Wellbeing Boards in local authorities.

14. The Regulations require PNAs to be reviewed and published every three years, however for the most recent PNA this interval was extended due to COVID.

15. The Regulations set out a Schedule of Information and a minimum 60-day consultation period with specified consultees as part of the development process.

16. Section 198 of the Health and Social Care Act allows two or more Health and Wellbeing Boards to make joint arrangements in how they discharge their functions. All local PNAs published since 2013 have been developed as a single PNA to cover the whole Dorset system.

17. The PNA is used by NHS England, via Primary Care Support England, to support commissioning intentions for pharmaceutical services and forms the basis for their decisions to:

    - grant applications for new pharmacies
    - grant applications to change the premises from which a listed pharmacy business is allowed to provide pharmaceutical services
    - change the pharmaceutical services that a listed pharmacy business provides.

18. The Health and Wellbeing Board is a statutory consultee for such applications to NHS England.

19. Schedule 2, paragraph 19(5) of the Regulations 2013 (as amended) requires Health and Wellbeing Boards to respond on applications to consolidate two pharmacies on one site. Appendix 2 sets out the recent response to a consolidation application for BCP.

Summary of human resources implications

20. There are no direct HR implications of the report.

21. The PNA published in October 2022 concluded that based on the consultation on the draft PNA the current pharmacy workforce challenge is a high priority for the Dorset system to address. Pharmacy leaders in Dorset recognise the workforce challenges in relation to registered Pharmacists and Pharmacy technicians. Various initiatives have been underway since 2019 to address some of the challenges, but none of them are likely to have rapid results.

Summary of environmental impact

22. The analysis within the 2022 PNA considered access, with drive time as the key measure. To balance access against the need for travel within the rural areas of the county, the PNA Steering Group agreed a 20-minute drive time as the right maximum cut-off to identify gaps.

23. When seeking views from local stakeholders about the recent application to consolidate two sites into one, comments highlighted that in the more urban area it may be appropriate to use different access criteria. Comments were incorporated into the consolidation response (appendix 2) and will be fed into the next PNA development round.

Summary of public health implications

24. Community pharmacies are a vital community asset. They see high footfall in places convenient to the local population. They may provide other services as well as pharmaceutical services. These may include public health services.

25. The 2022 PNA identified 142 community pharmacies in across Dorset (74 in BCP Council and 68 in Dorset Council), plus 2 distance selling pharmacies. All provide essential pharmaceutical services. The PNA stated that there is appropriate provision for the Dorset population, with no current gaps.

Summary of equality implications

26. The 2022 PNA included formal consultation. One of the questions asked about any consideration required to make sure services do not have adverse impacts on any specific groups of people. Comments were incorporated into a first stage Equality Impact Assessment (EQIA) for the PNA.

Summary of risk assessment

27. Risk that the PNA is not sufficiently robust will fall on the commissioner of pharmaceutical services as there is a risk of challenge to their decision making. NHS England delegated commissioning responsibility to NHS Dorset in April 2023.

28. Risk from closures of community pharmacies will also fall on public health who commission public health services from community pharmacies.

29. Risk is currently considered to be LOW.

Background papers

- Development of the PNA - HWB paper 14 October 2021
- Pharmaceutical Needs Assessment (PNA) - 2022-2025
- The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (legislation.gov.uk)
- DHSC - pharmaceutical-needs-assessment-information-pack (October 2021).pdf

Appendices

Appendix 1: Dorset PNA Supplementary statement, June 2023.
Appendix 2: Response on behalf of BCP Health and Wellbeing Board

Appendix 1: Supplementary Statement

Supplementary statement to the Public Health Dorset Pharmaceutical Needs Assessment 2022 – 2025, published October 2022

Public Health Dorset produced the 2022 PNA for Bournemouth, Christchurch and Poole (BCP) Health and Wellbeing Board, and Dorset Health and Wellbeing Board.

Date supplementary statement issued: July 2023

1. Closing of a pharmacy

The following pharmacies have closed:

- Lloyds in Sainsburys at 1 Lyndhurst Road, Christchurch (FHL51)
  This was a 100-hour pharmacy. It closed on 13 March 2023.
- Lloyds in Sainsburys at Castlepoint, Bournemouth (FDL19)
  This was a 40-hour pharmacy. It closed on 18 April 2023.
- Lloyds in Sainsburys at Talbot Heath, Poole (FRH25)
  This was a 40-hour pharmacy. It closed on 18 April 2023.

2. Change of ownership

The following pharmacies have changed ownership:

- the pharmacy at 1 Frederick Treves House, St. Johns Way, Poundbury, Dorchester.
  Aunpharma took over the ownership from Rowlands pharmacy on 1 March 2023. The new trading name is Poundbury Pharmacy (FN115)
- the pharmacy at 26 Abbotsbury Road, Weymouth.
  Weymouth Pharma took over the ownership from Boots on 24 April 2023.The new trading name is Weymouth Pharmacy (FPN51).

Supplementary statement issued by:	Jane Horne
Post:	Consultant in Public Health
Date:	to be added

Sent via email to:	Date: 5 April 2023
PCSE, Market Entry	Ref: **ME2383 - CAS-193016-G7V8V1**
	Email: publichealth-enquiries@dorsetcouncil.gov.uk
	Tel: 01202 224400

Dear Colleague,

Re: ME2383 - L Rowland & Co (Retail) Ltd - CONSOL - BH15 2PG - CAS-193016-G7V8V1

Thank you for advising us of this application for consolidation of two pharmacies onto one site. This letter sets out the Bournemouth, Christchurch and Poole (BCP) Health and Wellbeing Board view as required under Schedule 2, paragraph 19(5) of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

The Dorset Pharmaceutical Needs Assessment (PNA), published in October 2022 and available at Pharmaceutical Needs Assessment (PNA) - Public Health Dorset uses a definition of necessary services as dispensing of medicines and other essential services within a 20-minute drive time. The PNA notes that, based on this definition, here are no current gaps in the provision of necessary services identified in any of the localities across BCP Council. Although there is housing growth planned, based on the information available at the time of developing the PNA no future gaps have been identified in any of the localities across BCP council.

The application is for Rowlands pharmacy, currently at 315 Wimborne Road to consolidate with the Rowlands pharmacy at 14 Parkstone Road. There are other pharmacies within the local area and this change would have no impact on overall 20-minute drive time to pharmacies within the locality. The application confirms that there will be no reduction in opening hours, and that all the services currently offered between the two pharmacies will continue to be available at the 14 Parkstone site.

Based on the above, the application does not create a gap in pharmaceutical services. However, in discussion with local stakeholders there was strong support that consolidation on the 315 Wimborne Road site would provide a better spread of pharmacies leading to improved choice and better access than consolidation on the 14 Parkstone Road site.

We also noted that the application does not make specific reference to staffing levels, although we know that there is a shortage of pharmacists in Dorset. Consolidation may go some way to ensure that we make the best use of our staff, so further assurance that staffing levels will reflect the consolidated workload would be helpful. In particular assurance on continued levels of access to pharmacy professional advice and that there would be no reduction in activity for advanced services such as the New Medicines Service, Community Pharmacist Consultation service or Hypertension case-finding service would be helpful.

Yours sincerely

On behalf of the BCP Health and Wellbeing Board

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BCP Health and Wellbeing Board – Membership – updated 13/6/23

Members of the Board	Organisation
Cllr David Brown	BCP Council
Cllr Richard Burton	BCP Council
Cllr Kieron Wilson	BCP Council
Patricia Miller	Chief Executive, NHS Dorset
Graham Farrant	CE, BCP Council
Jess Gibbons	COO, BCP Council
Cathi Hadley	DCS, BCP Council
Phil Hornsby	ASCC, BCP Council
Sam Crowe	Director of Public Health
Siobhan Harrington	Chief Executive, University Hospitals Dorset NHS Foundation Trust
Dawn Dawson	Chief Executive Dorset Healthcare Foundation Trust
Mufeed Niman	GP
Simon Watkins	GP
Louise Bate	Healthwatch
Karen Loftus	Community Action Network Bournemouth, Christchurch and Poole
Marc House	Dorset & Wiltshire Fire and Rescue Service
Mark Callaghan	Chief Superintendent, Dorset Police
TBC	Education representative- currently vacant

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BCP HEALTH AND WELLBEING BOARD FORWARD PLAN 2023-24

Recommendation:

That the Health and Wellbeing Board consider the development of the Forward Plan

Item Title	Reason for item	Desired Outcome	Lead Officer(s)	Why has it come to the Board?
Development Session: Date TBC **Health Primary Care Networks** **Wellbeing Population Health Benefits** **Development Session: Date TBC** **Inequalities** **Community Empowerment**				
20 July 2023				
Review of Membership of the Board	Requested by Sam Crowe			
Joint Forward Plan 2023- 2028: Making	This report provides members with an overview of the Dorset Integrated Care Board Joint Forward Plan 2023-2028 which	It is recommended that Members note and support the Joint Forward	Neil Bacon, Chief Strategy and Transformation	

Item Title	Reason for item	Desired Outcome	Lead Officer(s)	Why has it come to the Board?
Dorset the healthiest place to live	was developed with partners from across the health and care system in Dorset. The plans sets out five pillars which the ICB will focus on and how through these it will support the delivery of the Integrated Care Partnership Strategy and the Health and Wellbeing Strategies.	Plan and the next steps in its implementation.	Officer, Dorset Integrated Care Board	
Adult Social Care CQC Assurance	The Health and Care Act 2022 creates a new duty for the Care Quality Commission to review local authorities' performance in discharging their adult social care functions under the Care Act 2014. This report sets out the work that has been undertaken to date and further work that is planned to ensure the Council is best placed to achieve a positive outcome	For the Board to note and comment on the Report	Betty Butlin, Director of Adult Social Care	

Item Title	Reason for item	Desired Outcome	Lead Officer(s)	Why has it come to the Board?
	from any review of the Council's services.			
Better Care Fund 2023-25	This report provides an overview of the content of the Better Care Fund (BCF) plan for 2023-25. The BCF is a key delivery vehicle in providing person centred integrated care with health, social care, housing and other public services, which is fundamental to having a strong and sustainable health and care system. National planning guidance was released in April 2023 advising that plans needed to be completed and submitted for national assurance by NHS England by 28th June 2023. The plan needs to be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements and so the draft planning document has been submitted to meet the	That the Health and Wellbeing Board approve the Better Care Fund Plan for 23/25 taking into account the investment and delivery plans as outlined in this report	Phil Hornsby, Interim Corporate Director for Wellbeing	

Item Title	Reason for item	Desired Outcome	Lead Officer(s)	Why has it come to the Board?
	deadline but is pending Board approval.			
Pharmaceutical Needs Assessment: Supplementary statement	To update on changes since the Pharmaceutical Needs Assessment (PNA) was published in October 2022.	It is recommended that the Board (a) approve publication of the supplementary statement. (b) delegate authority to the Director of Public Health to publish such further statements as required. (c) note response to NHS England on a consolidation request	Sam Crowe, Director of Public Health	
Forward Plan	To consider the Forward Plan and a future development session.	To provide a structured and focused Forward Plan for the Board.	Sam Crowe, Director of Public Health	

Future items to be allocated to meeting dates				
Place Based Partnership report from PwC	For consideration and information	TBC	David Freeman	Request from Sam Crowe.
Eliminating Food Insecurity: Access to Food Partnership	To discuss macro level chances that are needed to improve the situation around food insecurity	To enable the Board to monitor the Promoting Healthy Lives priority through the Eliminating Food Insecurities Theme	Jess Gibbons, Kelly Ansell	Identified as a theme within the Health and Wellbeing Strategy
Changes to hospitals, role of hospitals and responding to the needs of Communities				
Vibrant Communities Partnership Board	Report from the Co-Chair to the Board on the work of the Partnership Board			
BCP Local Plan			Laura Bright	Request from Chair
Household Support Grant?			Jess Gibbons	Added at Board meeting on 9 June 2022

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