Notice of Health and Wellbeing Board

Date: Monday, 15 July 2024 at 2.30 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)
Betty Butlin	Director of Adult Social Care
Jillian Kay	Corporate Director for Wellbeing
Siobhan Harrington	Chief Executive, University Hospitals Dorset NHS Foundation Trust
Cathi Hadley	Corporate Director – Children's Services, BCP Council
Sam Crowe	Director, Public Health (BCP Council)
Matthew Bryant	Dorset HealthCare University NHS Foundation Trust
Patricia Miller	NHS Dorset
Heather Dixey	Dorset Police
Dawn Dawson	Dorset Healthcare Foundation Trust
Louise Bate	Healthwatch
Karen Loftus	Community Action Network Bournemouth, Christchurch and Poole
Marc House	Dorset & Wiltshire Fire and Rescue Service

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=5968

If you would like any further information on the items to be considered at the meeting please contact: Louise Smith, louise.smith@bcpcouncil.gov.uk 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

5 July 2024

DEBATE NOT HATE

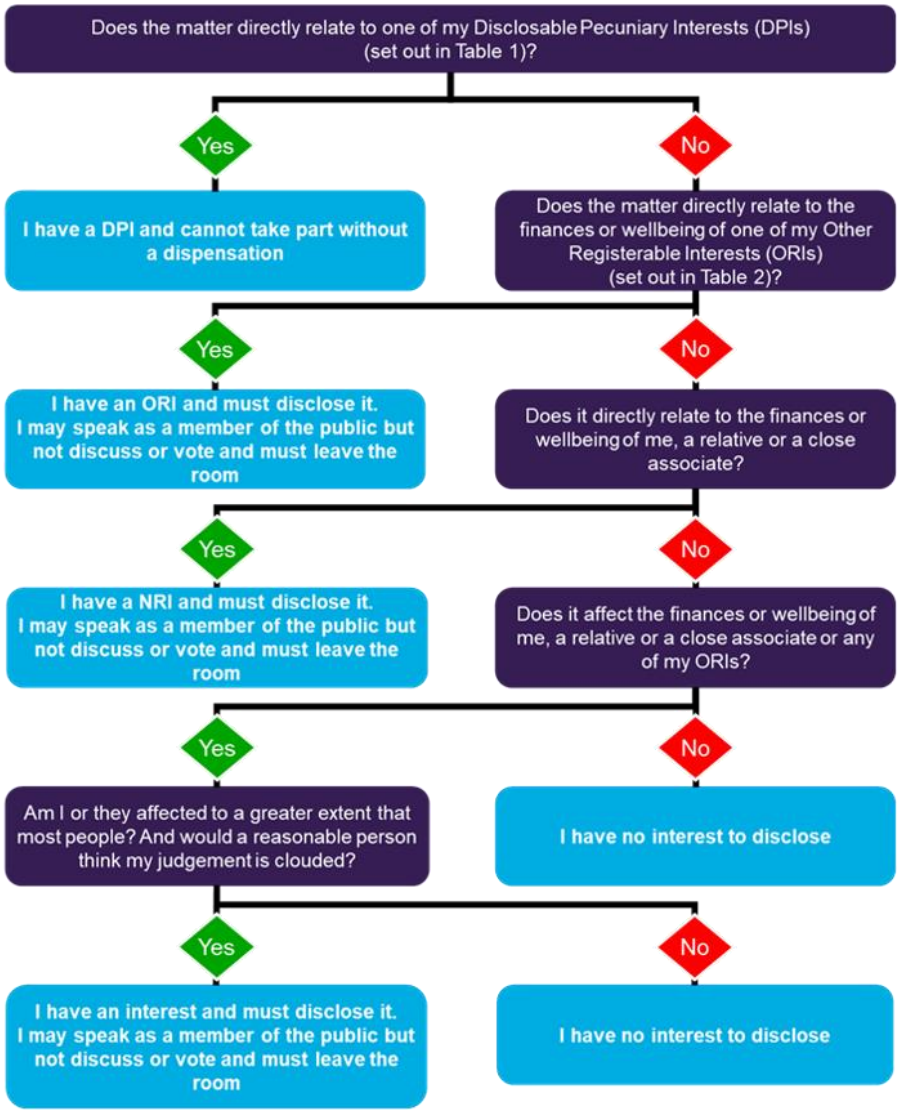
Available online and on the Mod.gov app

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 (janie.berry@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 24/25 Municipal Year.

4. Election of Vice Chair

To elect the Vice Chair of the BCP Health and Wellbeing Board for the 24/25 Municipal Year.

5. Confirmation of Minutes 7 - 12

To confirm and sign as a correct record the minutes of the Meeting held on 5 February 2024.

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. Further information on the requirements for submitting these is available to view at the following link:-

https://democracy.bcpcouncil.gov.uk/documents/s2305/Public%20Items%20-%20Meeting%20Procedure%20Rules.pdf

The deadline for the submission of public questions is 3 clear working days before the meeting (not including the date of submission and the date of the meeting).

The deadline for the submission of a statement is midday the working day

before the meeting.

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

ITEMS OF BUSINESS

8. Update on joint working in Health and Integrated Neighbourhood and Community Teams Programme 13 - 26

This presentation provides an update to the Health and Wellbeing Board on the development of the federated model between Dorset Healthcare University NHS FT (DHC) and Dorset County Hospital NHS FT (DCH). Additionally, it provides an update on the Integrated Neighbourhood Teams Transformation Programme.

9. Joint Forward Plan 2024/25 27 - 40

The purpose of this paper is to provide members with an updated on the refreshed Joint Five Year Forward Plan 2024/25.

10. BCP Access to Food Partnership update: Working together to address food insecurity & improve wellbeing 41 - 68

This report updates the Health and Wellbeing (HWB) Board on the work of BCP's Access to Food Partnership since October 2021. It has grown into a thriving collaborative network, with a breadth of partners, working together with place-based and strength-based approach to empower and build community resilience. The continued impact of the cost of living crisis has put significant pressure on frontline workers and food projects, but together they have shown strength in their ability to co-create new neighbourhood initiatives to respond to the evolving needs of local communities. The Partnership is now in the final year of its 3-year funding from the National Lottery Community Grant.

11. Pharmaceutical Needs Assessment (PNA) 69 - 74

Each Health and Wellbeing Board must publish a pharmaceutical needs assessment (PNA). There is legislation that sets out the process for this. Part of this is regular review, with a new PNA for the Dorset system due by October 2025.

This paper kicks off this process, with key questions for the Board. A proposed timeline is set out for agreement, and the Board should consider if this requires any delegated authority to ensure delivery.

12. Better Care Fund 2023-2025: Quarter 2 & 3, the End of Year Report 2023/24, 2024/25 Planning Template: 75 - 138

This report provides an overview of Quarters 2 and 3, the End of Year 2023/24, and the 2024/25 planning template 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.

The reports are a part of the planning required set by the Better Care Fund 2023-25 Policy Framework. The reports and plan need to be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements.

13. University Hospitals Dorset (UHD) Maternity update 139 - 144

To note this information only update regarding University Hospitals Dorset (UHD) Maternity services.

14. Forward Plan 145 - 148

For the Board to consider its Forward Plan.

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.

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BOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND WELLBEING BOARD

Minutes of the Meeting held on 05 February 2024 at 1.00 pm

Present:-

Cllr David Brown – Chair

David Freeman – Vice-Chair

Present: Cllr Kieron Wilson, Graham Farrant, Sam Crowe, Louise Bate, Siobhan Harrington, Jillian Kay, Rachel Trickey, Stuart Gillion and Rachel Gravett

23. Apologies

Apologies for absence had been received from Cllr Richard Burton, Betty Butlin, Cathi Hadley, Matthew Bryant, Heather Dixey, Karen Loftus and Marc House.

24. Substitute Members

Rachel Trickey substituted for Karen Loftus, Stuart Gillion substituted for Marc House and Rachel Gravett substituted for Cathi Hadley.

25. Confirmation of Minutes

The Minutes of the Meeting held on 18 December were confirmed as an accurate record subject to the addition of Siobhan Harrington's apologies being recorded.

26. Declarations of Interests

There were no declarations of interest received on this occasion.

27. Public Issues

There were no public issues received on this occasion.

28. Joint Strategic Needs Assessment (JSNA): Narrative Update

The Team Leader Intelligence, Public Health Dorset, 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.

Each Health and Wellbeing Board should produce a Joint Strategic Needs Assessment under the Health and Social Care Act 2012.

A Joint Strategic Needs Assessment (JSNA) looked at the current and future health and wellbeing needs of the local population. It provided an evidence base, pulling from both qualitative and quantitative data, of health

and wellbeing needs to support planning and commissioning and preparation of bids and business cases.

Locally, the Joint Strategic Needs Assessment was co-ordinated by Public Health Dorset, on behalf of both BCP and Dorset Health and Wellbeing Board's. An annual JSNA narrative was produced for each Board, highlighting data trends and qualitative insights relevant to the Board's local population.

The latest update collated insights from engagement on key health and wellbeing issues with Integrated Care System (ICS) organisations, health data and insight developed by ICS Intelligence/ Research teams including Healthwatch Dorset and qualitative insights from Local Authority resident's surveys and the Integrated Care Partnership 100 Conversations project.

The purpose of this report was to share with the board the latest annual update of the Bournemouth, Christchurch and Poole Joint Strategic Needs Assessment Narrative.

The Board considered the document and comments were made:

- In response to a query regarding what had changed from previous narratives, the Board was advised that a lot of the key national indicators were quite steady however what was different this year was the local insight from the 100 Conversations work which provided information regarding people's experiences of services.
- In response to a query from Healthwatch whether there were any gaps within the local insights which formed the JNSA, the Board was advised of two areas where more insight and exploration was needed which were mental health and wellbeing in the cost of living crisis and people who were living with multiple long term conditions.
- The Board was reminded that it was responsible for maintaining the JNSA and what was important was how it used the information to consider and influence changes and improvements in models of care.
- In response to a query regarding information regarding local access to services and necessary transport links, the Board was advised that data was available and was currently used when considering pharmaceutical needs assessments, but consideration could be given to how this data could be further utilised.
- The Vice Chair challenged the Board regarding how it used the information within the JNSA to consider where it could provide the greatest positive impact. An area identified within the assessment was higher than comparators levels of hip fractures within BCP and consideration to earlier intervention was required. It was highlighted that improvements in this area would not solely be the responsibility of health partners and that collaborative work within communities to identify residents at a higher risks of falls and what could be done to reduce them was needed.

- A Board Member referred to mental health and the gaps in the data and advised that this should be linked to the mental health transformation system work which was considering early intervention and prevention.
- A Board Member highlighted the importance of using the JNSA to build into conversations across all partners to effect change and welcomed conversations regarding travel and transport links to ensure positive outcomes for people.

RESOLVED that the Board:

1) Note the updated JSNA document; and

2) Approve publication of the document.

29. From strategy to action: next steps following the development session

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

A development session was held in December 2023 to discuss approaches to refreshing the strategy. Members considered the draft findings of the JSNA, the council's corporate strategy, and the overarching aims of the integrated care system strategy, Working Better Together.

Feedback from the session recognised the need for a focus on action, especially getting clarity on priority work programmes for the emerging place-based partnership. The existing strategy's themes were broad enough to serve as a framework. Members felt the emphasis should be on action through the place-based partnership rather than spending time refreshing the strategy.

Members recognised their leadership role in supporting a strong place-based partnership. The Board would offer a lead governance role to the partnership, to enable delivery, championing early help and prevention.

The purpose of the report was to update the board on the output from the development session held to consider next steps in updating the strategy. The over-riding message from board members was to focus more on practical actions to improve prevention and integration through the place-based partnership, with a light touch refresh of the HWB strategy. The report proposed some areas for the Board to consider, along with next steps for developing the partnership.

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

- A Board Member was pleased that both reports presented at the meeting had highlighted issues around local housing including its affordability, lack of provision and the impact that had on the health and wellbeing of people.

- In response about a concern regarding avoiding duplication of work, the Board was advised of the operating system being worked on by the Integrated Care Board and the Board's responsibility in challenging and holding place based partners to account.
- The Board was advised of the mapping work being undertaken by the Community Safety Partnership and the reasons for it. A Board Member advised of the potential to link that work in with the Access to Community Support Service project which included a digital service finder mapping services and activities in voluntary and community services.
- There was some discussion about how the output of the development session could be progressed further into tangible actions and the need for the Board to communicate and engage with stakeholders and public was highlighted.
- The Corporate Director for Wellbeing welcomed the Board's views on the report and detailed the next steps which included bringing a more detailed action plan and ambitions to the next meeting.
- The Board was also advised of the ongoing work regarding Integrated Neighbourhood Teams which included a working group of stakeholders and two pilot areas within BCP.
- The Director of Public Health acknowledged the need to be more explicit in the partnership working and engagement and advised the Board a draft strategy and more detailed delivery plan could come back for consideration at the next meeting of the Board. It was also highlighted to check whether public consultation would be needed. **ACTION.**

It is RECOMMENDED that:

1) Board members support the proposed approach to the strategy – i.e. light touch refresh with a clear focus on priorities for the place-based partnership workplan.

2) Members discuss and agree the next steps in developing the Board's lead governance role in relation to the place based partnership

30. Forward Plan

The Board discussed the Forward Plan, and it was noted that the items for April would include the draft strategy and action plan for the Board and further information on the Integrated Neighbourhood Teams pilots.

It was requested that the place based partnership report from PwC be removed from the Forward Plan as it was felt that was no longer relevant and had been considered in the development session.

A Board Member highlighted the changes in maternity services which would need to added to the Forward Plan at the closest meeting to June 2024.

The meeting ended at 1.55 pm

CHAIR

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Health and Wellbeing Board

Report subject	**Update on joint working in Health and Integrated Neighbourhood and Community Teams Programme**
Meeting date	15th July
Status	Public Report
Executive summary	This presentation provides an update to the Health and Wellbeing Board on the development of the federated model between Dorset Healthcare University NHS FT (DHC) and Dorset County Hospital NHS FT (DCH). Additionally, it provides an update on the Integrated Neighbourhood Teams Transformation Programme. The federated model is the form by which the joint working between DHC and DCH is described and formed. Each NHS Trust retains its identity and each Trust Board remains sovereign, whilst the Trusts collaborate by default and do things once where it is appropriate to do so. Joint Sub-Committees are being formed, supported by a Joint Executive Team and other joint roles. A Joint Strategy is being finalised. The Integrated Neighbourhood Teams Transformation programme is a priority programme for the Dorset Integrated Care System. It is co-sponsored by DHC and the GP Alliance with a commitment to working alongside key partners, particularly Local Authorities, and a connection to the Health and Wellbeing Board. The programme aims to bring together multi-disciplinary practioners from across health and care organisations to deliver services to meet the needs of their defined population by focussing on personalised care that is as far as possible anticipatory rather than reactive. The INT Programme is *part of* the wider 'Place' work, however, it is not the vehicle to deliver the whole 'Place' agenda or to undertake work to address the wider social determinants of health.
Recommendations	**It is RECOMMENDED that:** The Health and Wellbeing Board note and provide comment on the update.
Reason for recommendations	Partner expertise and involvement is important in informing and improving the way we work together for the residents of BCP.

Update: Joint working between DHC and DCH and Integrated Neighbourhood Teams

Working Together
Dorset County Hospital NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust

Dorset County Hospital

- Serves over 300,000 people in the west of the county
- 3,500 staff working in a range of locations including main hospital in Dorchester
- 300 beds, 10 operating theatres, 2 day surgery theatres
- Outpatient assessment centre in central Dorchester
- New Hospital Programme build for ED and critical care

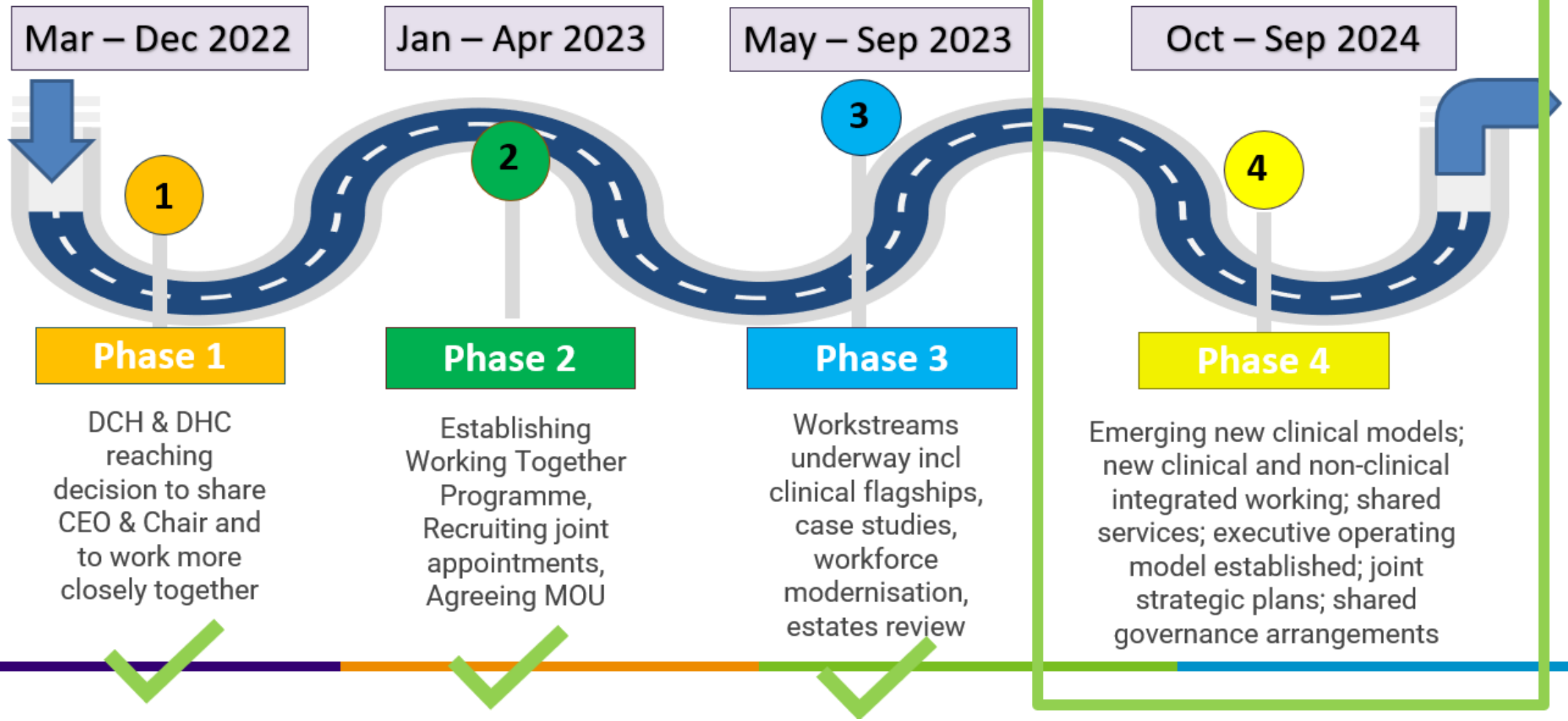
Dorset HealthCare

- Providing community and mental health services for 800,000 residents in Dorset and beyond
- Around 7,000 staff working at 300 sites
- Physical health: includes 12 community hospitals, district nurses, school nurses, sexual health, audiology and more
- Mental health: includes inpatients, CAMHS, eating disorders, perinatal, learning disabilities, veterans, Steps2Wellbeing and more
- New Hospitals programme projects to create CAMHS PICU in Bournemouth and improve inpatient facilities in Poole (St Anns)

Working Together

- New leadership model agree by Boards to:
  - help simplify decision-making
  - increase integration
  - improve quality and outcomes
- Our focus is on:
  - Preventing ill-health
  - Tackling health inequalities
  - Integrating physical and mental health more effectively
  - Joining up workforce planning and development

Working Together - where are we now?



Working Together

Dorset HealthCare University NHS Foundation Trust

Working in a federated way

Update on progress:

- An evolutionary approach that will be deepened over time
- Supported by effective communications, including the development of Q&A's
- Initial legal advice sought to ensure MOU and joint governance arrangements meet the requirements
- A review of progress is scheduled for Sep/October

In our approach to federation:

- Trusts retain individual sovereignty & accountability to NHSE, regulated by CQC, individual Boards hold Trusts to account
- Joint structures support new models of care
- Shared Executive Team, culture and sense of governance, back-office services
- Joint strategies

Our federation – what we've done so far

- Joint Chief Executive and Chair
- 5 joint chief officers (CMOs and COOs remain separate)
- Joint strategy and developing shared culture
- Working Together flagship programmes
- Clinical case studies
- Some shared governance arrangements
- Looking at opportunities in support services

Developing integrated health and care neighbourhood teams

Our Dorset

Integrated Neighbourhood Team Programme fit within Place

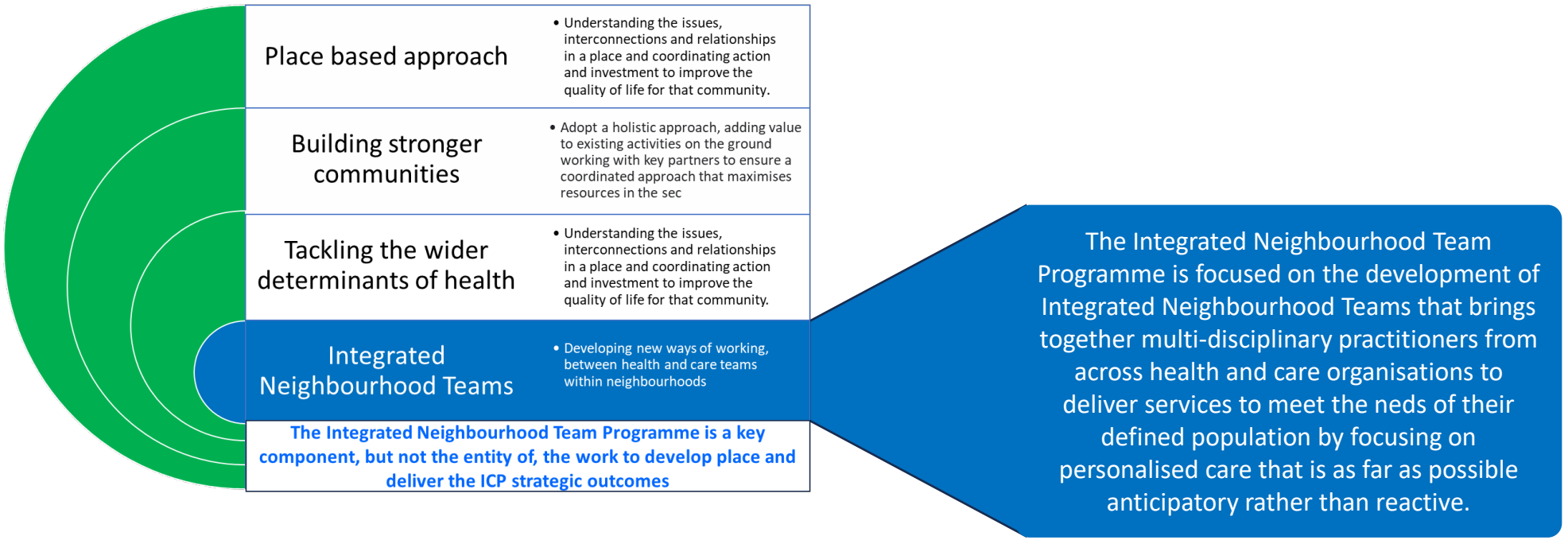
Our Dorset
Local NHS and Councils Working Together

Our vision

Dorset Integrated Care System works together to deliver the best possible improvements in health and wellbeing

ICP Strategy Key priorities

Prevention and early help
Helping you stay well by providing prevention support as early as possible
Thriving communities
Investing in communities, building string networks and developing high quality spaces in the community where we can work together
Working better together
Consider your needs at all stages of your journey through health and care services



Integrated Neighbourhood Teams (INT) Programme

Programme Aim

The development of Integrated Neighbourhood Teams that bring together multi-disciplinary practitioners across health and care providers to deliver services to meet the needs of their defined population by focusing on personalised care that is as far as possible anticipatory rather than reactive.

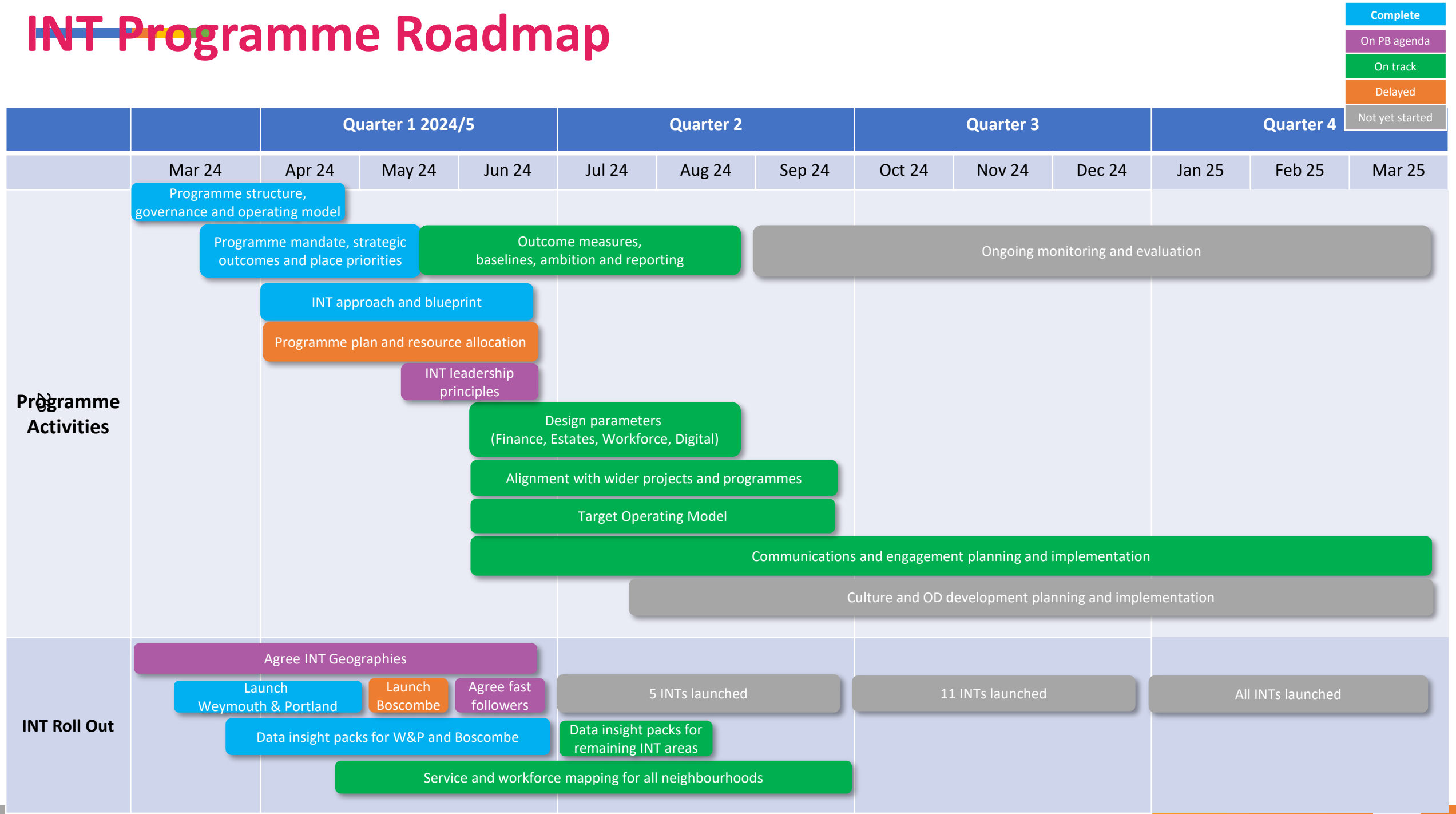
Our integrated neighbourhood teams, will improve the access, experience and outcomes for our communities, with a focus on three essential offers:

1. Streamlining access to care and advice for people who get ill but only use health services infrequently; providing them with more choice about how they access care and ensuring that care is available in their community when they need it
2. Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but ot limited to, those with multiple long-terms conditions
3. Helping people to stay well for longer as part of a more ambitious and joined up approach

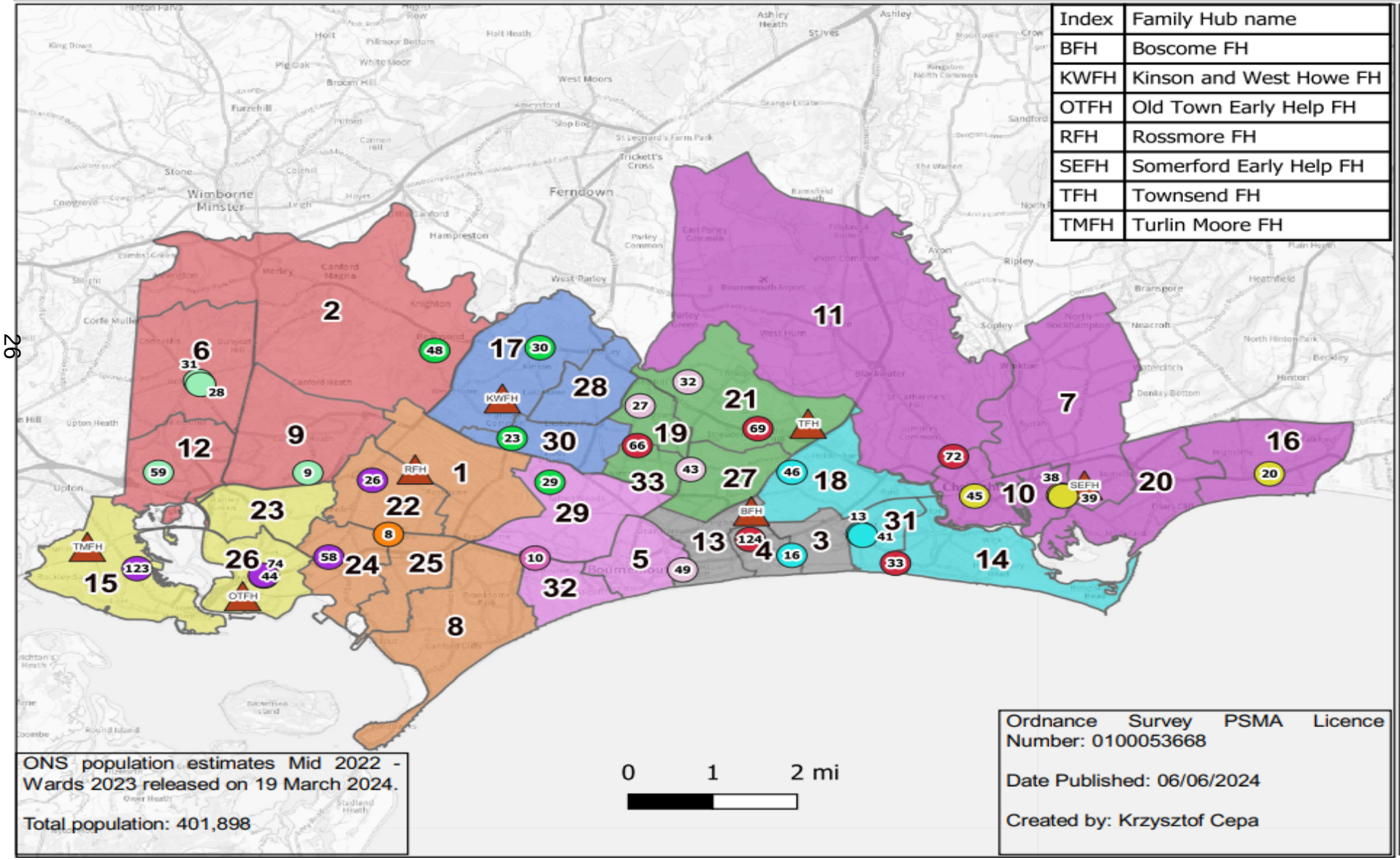
Realising the wider benefits of:

- Improved productivity and the satisfaction of providing care to local populations, through greater inter-professional collaboration between individuals working within local teams
- Confident and autonomous integrated MDTs who know the population they serve and have a shared ownership for improving health.

INT Programme Roadmap



Bournemouth, Christchurch and Poole - Wards (Groups) including GP practices (PCNs) and Family Hubs



Legend

Wards (Groups & population)

- Group 1 (49,890)
- Group 2 (28,944)
- Group 3 (50,891)
- Group 4 (41,927)
- Group 5 (66,531)
- Group 6 (39,031)
- Group 7 (38,456)
- Group 8 (38,208)
- Group 9 (48,020)

GP Practice (PCN split)

- Bournemouth East
- Central Bournemouth
- Christchurch
- North Bournemouth
- Poole Bay and Bournemouth
- Poole Central
- Poole North
- Shore Medical
- South Coast Medical

Family Hubs

- Family Hubs

Health and Wellbeing Board

Report subject	**Joint Forward Plan 2024/25**
Meeting date	15th July 2024
Status	Public Report
Executive summary	The purpose of this paper is to provide members with an updated on the refreshed Joint Five Year Forward Plan 2024/25.
Recommendations	**This Report is to update members.**
Reason for recommendations	On the publication of the refreshed Joint Forward Plan 2024/25.

Portfolio Holder(s):	TBC
Corporate Director	Professor Neil Bacon Chief Strategy and Transformation Officer NHS Dorset
Report Authors	Ashleigh Boreham Deputy Strategy and Transformation Officer NHS Dorset
Wards	All
Classification	For Update or Information

Background

1. The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires NHS Dorset Integrated Care Board and their partner trusts to prepare a Joint Forward Plan (JFP) setting out how they propose to exercise their functions in the next five years. These should be reviewed and/or revised before the start of each financial year.
2. NHS Dorset received its updated guidance for 2024 to further develop and/or revise the JFP they first published in July 2023.

Purpose

3. The purpose of this Report is to provide members with an update on the refreshed Joint Five Year Forward Plan for 2024/25, supported by a verbal update by the Chief Strategy and Transformation NHS Dorset along with supporting Slide Deck (Appendix 1). The refreshed Report will be published in **July 2024**

Executive Summary

4. The refreshed version of the JFP does not have any fundamental changes from the plan previously approved for 2023 – 2028, and without further consultation cannot be significantly changed around intent or approach. The refresh is an opportunity to look back on progress and impact since first publication in **July 2023**, and a look forward at priorities as set out for this year.
5. The refreshed version has been updated to include revised and new sections including:

   Vaccination Plans

   Urgent and Emergency care

   Neighbourhood and Place

   Research & Innovation

   Updated Clinical Plan

   Updated Finance Plan

   Population Health

Prevention Programme

Healthwatch Dorset

Women's Health Hubs

Estates strategy

Oral Health

Updated Governance Structure

6. The updated plan also includes a foreword from the Chief Executive to acknowledge and update the public on the challenges and issues that NHS Dorset ICS has faced in the last year e.g. financial constraints, capacity, workforce and industrial action, and the impact these have had on the plans, along with how we will manage these issues.

7. The ICB Communication and Engagement Team are developing case studies demonstrating progress and achievements in year one of the plan, across several areas and these will be published alongside the plan including:

    - Wellbeing hubs
    - South Walks House
    - Digital support – BP@home
    - Health Inequalities – Investment fund

    It is intended that case studies, patient stories and achievements are captured on an ongoing basis to keep the plan 'live' and will be hyperlinked to continually update the people on what we said and what we have done.

Summary of legal implications

8. Not Applicable.

Summary of human resources implications

9. Not Applicable.

Summary of public health implications

10. This is the Primary Focus of the Joint Forward Plan that will be discussed at the Board.

Summary of equality implications

11. Not Applicable as this is not for Board Approval.

Summary of risk assessment

12. Not Applicable.

Background papers

13. Not Applicable.

Appendices

Appendix 1	**Dorset ICB Joint Forward Plan Refreshed version July 2024 (to follow)**
Appendix 2	**Supporting Presentation for Joint Forward Plan July 2024**

Update of 5 Year Refreshed Forward Plan

BCP Health and Wellbeing Board

15th July 2024

Ashleigh Boreham

100 conversations - what we heard

- We thrive when we are connected and have support networks around us
- We want services to focus on providing easier and earlier access to support, leading to better health outcomes and help with crisis prevention
- We want person centered care, being seen as an individual, not defined by a condition “I’m a human not a patient”
- We want to be listened to, trusted and included in discussions and decisions around our care
- We had mixed experiences of getting fast and easy access to services and appointment
- We want services that work together and communicate more to give you more joined-up care when you need it
- We want physical and mental health to be given the same importance

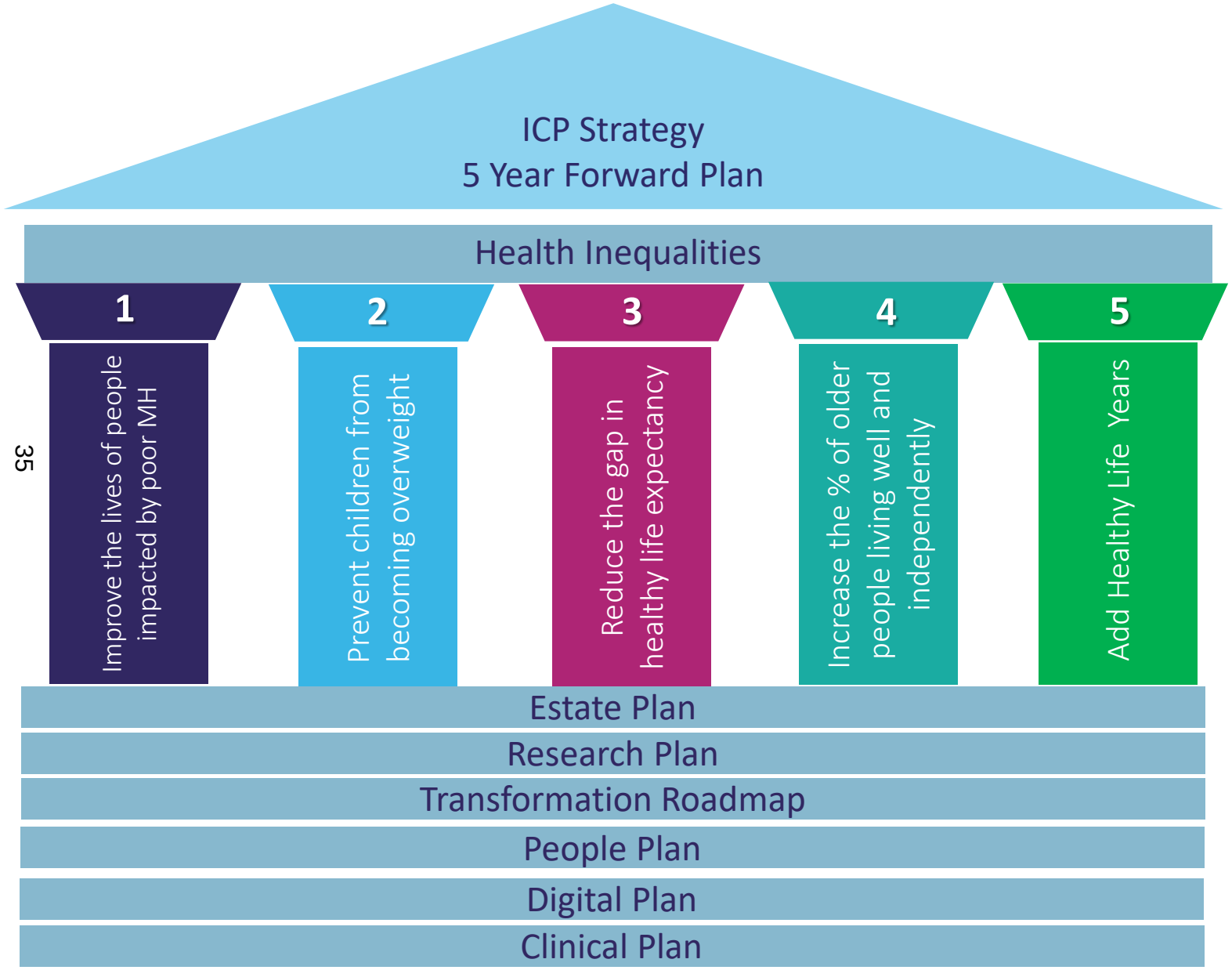
Joint Forward Plan Context

- The Joint Forward Plan approved by System Partners 2023 and published July 2023.
- The refreshed version does not have any fundamental changes and without consultation cannot be changed.
- Opportunity to look back on progress and impact.
- Look forward 2024/2025.
  - Set Context
  - Main Body the 5 Pillars:
    - What we have been doing
    - What we are going to do
    - How we measure Progress and Impact
- Each Pillar shows Year 1-2, Year 3-4 and Year 5 Plus.
- Enabling Plans.
- Governance.
- Risk.
- Case Studies that are continually updated.

Why we need to Transform – the Five Pillars

- To meet the expectations of Dorset citizens and the objectives of the ICB we need to focus more effort and resource on reducing inequity, effects of deprivation and to prevent disease and ill health.
- To do this we need to shift from a health perspective to *Dorset system-working* focused on the true drivers of poor health, inequity and sub-optimal life-outcomes.
- Prevention is fundamental to this – currently less than £1 in every £100 is spent on prevention: we mainly wait for people to get ill.
- SMART objectives and outcomes that matter to Dorset residents.

Making Dorset the healthiest place to live



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.

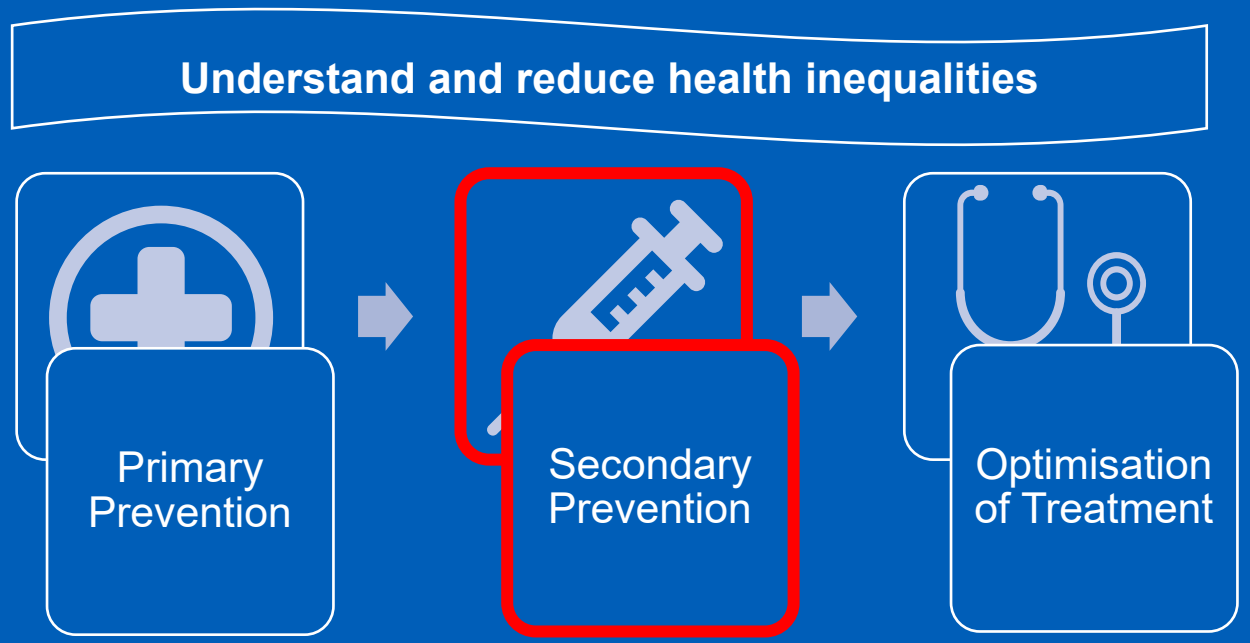
We will reduce the gap in healthy life expectancy from 19 years to 15 years by 2043.

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.

Transformation across the Health Continuum – Key Principles

- **Understand the impact** of interventions on **health inequality** in terms of access, experience and outcomes
- **Reduce unwarranted variation**
- Focus on
  - Primary Prevention
  - Secondary Prevention
  - Optimal management
- Outcome metrics / evaluation



'Some is not a number, soon is not a time'
Don Berwick

How we are doing it

- Prevention and Population Outcomes
- Data driven to focus on reducing inequity
- Shift from low value to high value
- Shift resource allocation – always within the financial envelope
- Dorset system working - Clinical Transformation Networks

Transforming population outcomes through networks

Primary Care

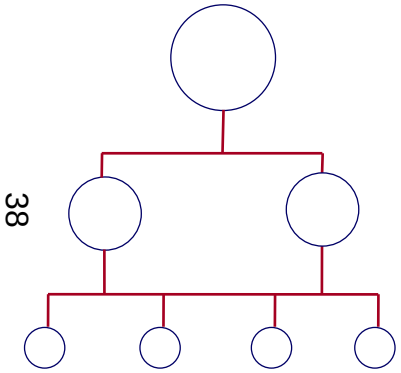
Local Authorities

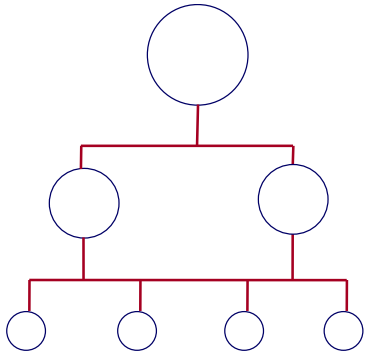
Higher Education

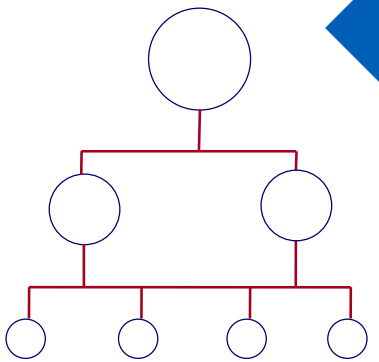
Industry

VCSE

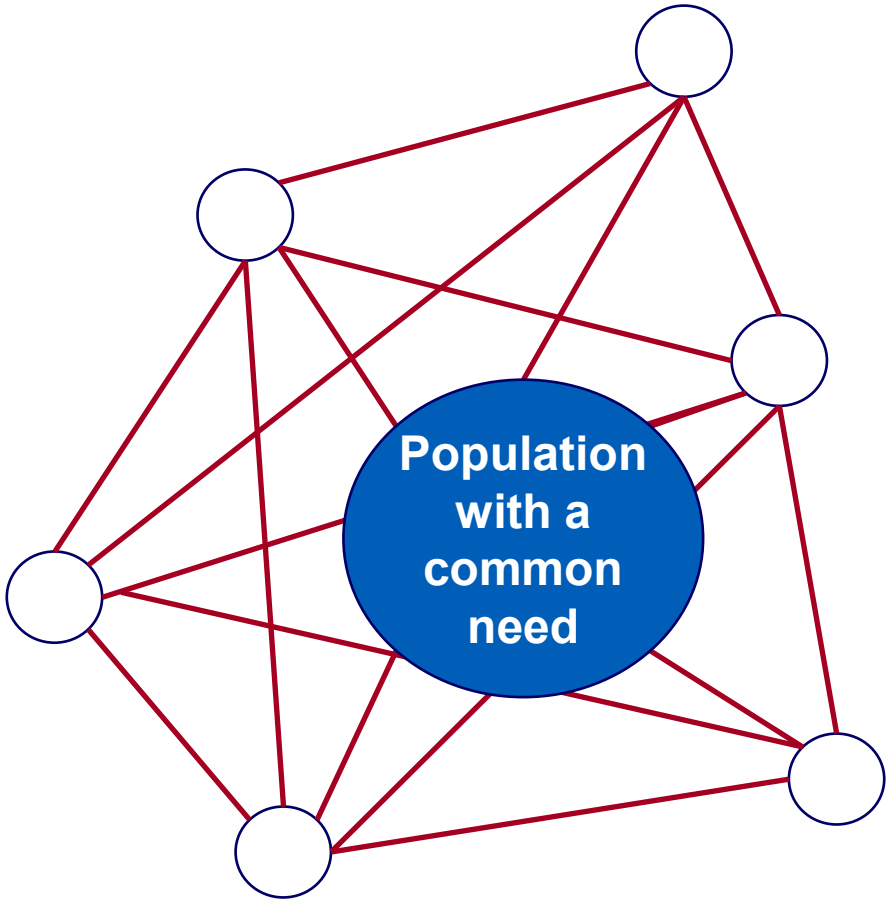
Hospital







From hierarchies to population-centred networks



Integrated Model of Care in Place at Place

CVD Prevent Team

Clinical Lead
Operational Lead
GP
Clinical Pharmacist
Advanced Nurse Practitioner
Healthcare Assistant
Digital Care Co-Ordinator
Care Co-Ordinator
Social Prescriber
Health Coach
Reception Staff

Public Health Dorset

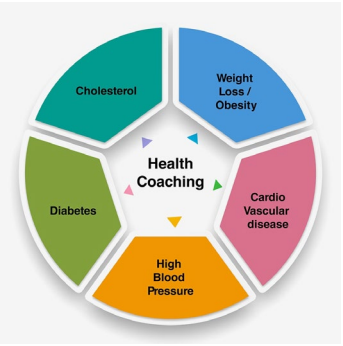
We're proud partners of Our Dorset Health, care & wellbeing

NHS Dorset

help & care

Does your health condition get in the way of managing your life?

Does life get in the way of managing your health condition?



Shift investment to where it has high value

"Those areas that spent relatively less on community care in terms of population need have seen higher-than-average levels of hospital and emergency activity, compared to those spending relatively more. On average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates, both statistically significant differences, together with lower average activity for elective admissions and A&E attendances."

Unlocking-the-power-of-health-beyond-the-hospital.pdf (nhsconfed.org)

HEALTH AND WELLBEING BOARD

Report subject	BCP Access to Food Partnership update: Working together to address food insecurity & improve wellbeing
Meeting date	15 July 2024
Status	Public Report
Executive summary	This report updates the Health and Wellbeing (HWB) Board on the work of BCP's Access to Food Partnership since October 2021. It has grown into a thriving collaborative network, with a breadth of partners, working together with place-based and strength-based approach to empower and build community resilience. The continued impact of the cost of living crisis has put significant pressure on frontline workers and food projects, but together they have shown strength in their ability to co-create new neighbourhood initiatives to respond to the evolving needs of local communities. The Partnership is now in the final year of its 3-year funding from the National Lottery Community Grant.
Recommendations	**It is RECOMMENDED that HWB Board Members:** **a) Acknowledge how the work of the Access to Food Partnership (A2FP) has contributed to upstream prevention by supporting those most vulnerable to the impact of health inequalities and the cost of living crisis in BCP.** **b) Commit to highlighting at a strategic level the importance of the A2FP in addressing food insecurity and hidden hunger in communities, and champion local system change to enable community and voluntary sector partners to continue to grow and thrive.** **c) Recognise the significant ongoing challenges in high levels of demand from local people struggling with the cost of living and support the A2FP to meet this need.** **d) Recognise the A2FP's increasingly important role as a point of trusted communication and collaboration in neighbourhoods and commit to ensuring that their frontline workers have up to date knowledge and**

	understanding of the A2FP. **e) Facilitate work between the A2FP and all system partners to enable better health outcomes and reduced inequalities.**
Reason for recommendations	The A2FP is a vibrant example of community-led activity across neighbourhoods to address the challenges of food insecurity and improve access to other preventative support services that helps to build community resilience. It demonstrates how communities working together on issues that matter to them can create meaningful connections of voluntary and community sector and Integrated Care System (ICS) partners. This offers new opportunities for early help, intervention and prevention to reduce health inequalities. This work requires the backing and support of all HWB Board organisations as part of a shared problem to ensure that the scale of hidden hunger and food insecurity is understood locally and remains on the agenda as everyone's problem. The cost of living situation continues to see high levels of need for community food support and local partners are working hard to respond to need, whilst also being challenged by lower levels of food and financial donations. It is important that frontline workers and senior management are better connected with the A2FP work and the community support that is available, so that together we can effectively help those most vulnerable in our communities.
Portfolio Holder(s):	Cllr Millie Earl, Portfolio Holder for Connected Communities Cllr David Brown, Portfolio Holder for Health and Wellbeing
Corporate Director	Jillian Kay, Director of Wellbeing
Report Authors	Access to Food steering group including: BCP Council - Amy Gallacher, Community Initiatives Manager; Faithworks Wessex - Alistair Doxat-Purser, Chief Executive and Chair of Access to Food partnership; Public Health Dorset – Bernadette Pritchard, Health Programme

	Advisor; Daisy Carr, Community Food Coordinator. BCP Council.
Wards	Council-wide
Classification	Recommendations

Background about BCP Access to Food Partnership

1. BCP's Access to Food Partnership (A2FP) uses a strengths-based approach to achieving its Vision of: "A Bournemouth, Christchurch and Poole where everyone is able to feed themselves and their family nutritious food, all of the time".
2. The A2FP is currently funded by a National Lottery Community Fund award of £194,000 over three years until April 2025. This includes a dedicated Community Food Coordinator (BCP Council post), alongside a budget to build infrastructure, host activities and events, and offer a small grant funding pot for partners to address arising issues and set up innovative 'grass roots' projects.
3. Since the start of the partnership in March 2020, the A2FP's membership has grown to include over 300 individuals from more than 150 organisations, supported by over 1,400 volunteers, all working to address food insecurity locally. It includes a breadth of knowledge, skills and experience from across the Integrated Care System, local businesses, voluntary and community sector groups and organisations.
4. Together, it focuses on using strengths-based approaches to build food skills and confidence across BCP communities. These include skills and access to grow, cook and eat together, and in turn creates the ability to feed themselves and their families nutritious food. The A2FP is also a critical trusted social and connection point, linking people with timely additional support, such as money management and debt advice, as well as other services and information.
5. One of the partnership's strengths is the collaborative working and knowledge share between community food partners, which helps to reduce duplication, share resources and better support the needs of the community through shared knowledge.
6. The work of the partnership is included the BCP Council's Corporate Strategy and it continues to work in partnership to help those who need support to receive it when, and where, they need it. The work also ensures households are supported with information to help with the cost of living situation.

The National Context:

7. Between April 2022 and April 2024, the cost of an average basket of food for a UK adult increased by just over 25% to £52.97 per week[1]
8. Between 2021/22 and 2023/24, foodbank use in England has increased by 37%[2]
9. Between Jan 2022 and Jan 2024, Food Insecurity (defined as 'insufficient or insecure access to food due to resource constraints'[2]) has more than doubled, now affecting 14.8% of all households.
10. Some households are more at risk than others; for example 20.0% of households with children reported experiencing food insecurity compared with 12.7% of households without children[3].
11. In single-adult households with children, 35% are experiencing food insecurity, with 17% of these adults admitting to having gone for a whole day without food[4].
12. 14.5% of workers in some kind of employment in England reported experiencing food insecurity. Our local partners are also seeing many in employment needing emergency support. The 2021 Census and the Trussell Trust have identified those groups at higher risk of food insecurity. These include people who are renting, from a minority ethnic group, are disabled, LGBTQ+, and unpaid carers[5] [6].

BCP: the local picture

13. Around 43% of households in BCP are likely to earn less than £30k per year (Source: Experian Mosaic, 2023). The UK median household income in the financial year ending 2022 was £32,300[7].
14. In BCP, 9.4% of all households (over 16,000) are single-adults with children. If we apply the Food Foundation's latest national findings[8], this equates to over 2,700 single adults with children having gone for more than a day without food.
15. In May 2024, average monthly private rents in BCP were £1,278, an annual increase of 11.2% from £1,149 in May 2023. This was higher than the rise in the South-West (7.0%) over the year.[9]
16. Based on national Food Foundation research and 2022 Census household numbers[10], there are at least 25,000 households in BCP living in food insecurity currently.

[1] Food Prices Tracker: April 2024 | Food Foundation
[2] Food banks in the UK - House of Commons Library (parliament.uk)
[3] Food Insecurity Tracking | Food Foundation
[4] Food Insecurity Tracking | Food Foundation
[5] 2023-The-Trussell-Trust-Hunger-in-the-UK-report-web-updated-10Aug23.pdf (trusselltrust.org)
[6] Characteristics of adults experiencing energy and food insecurity in Great Britain - Office for National Statistics (ons.gov.uk)
[7] Average household income, UK - Office for National Statistics (ons.gov.uk)
[8] www.bcpcouncil.gov.uk
[9] Housing prices in Bournemouth Christchurch and Poole (ons.gov.uk)

17. Pupils eligible for free school meals in BCP has risen from 14.6% in 2019/20 to 20.5% in 2023/2024[11].

18. There are 7,105 children (10.8% of total number of children) in BCP living in absolute low income families[12]

19. When faced with increased living costs, households reduce their food consumption. Research by the Office of National Statistics continues to show that poorer households need to spend proportionately more on housing, fuel and power.[13] BCP Citizen's Advice reports seeing increasing numbers of households in 'negative budgets', with outgoings exceeding monthly income.

20. Food-insecure households were more likely to be cutting back on purchasing healthy foods such as fruit, vegetables, fish, dairy and eggs.

21. Since September 2021, the Government's Household Support Fund (HSF) has helped households struggling with the costs of living. In 2023-24, BCP Council was allocated £5.3 million, which helped over 60,000 eligible BCP households with:

    - Household grants of up to £200 administered through Citizen's Advice BCP as mainly food and/or fuel vouchers to help with household bills.
    - School holidays food vouchers for families via local schools and the Family Information Service for eligible Under 5s. Vouchers of £15 per child per week every school holiday (£195 per child per year).
    - Energy support to households including insulation grants, home visits, practitioner referrals for appliances and emergency boilers.
    - Distributing £400,000 in small grants to approximately 60 local VCS organisations through the BCP Food and Energy Support Fund.

22. The Household Support Fund has been extended for a further six months until 30 September 2024. There are concerns if this Fund doesn't continue it will create a 'cliff edge' for those households relying on the payments to meet their basic needs. This is likely to lead to a significant rise in demand for A2F partners' support into the winter period and beyond.

BCP Access to Food Partnership progress:

23. The A2FP partnership reports give a comprehensive overview of key annual outcomes.

24. The A2F partners are dedicated to providing support for those in crisis that need emergency food, as well as look at ways to build resilience and help prevent further crisis.

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[10] Statistics about our population | BCP (bcpcouncil.gov.uk)
[11] Pupils known to be eligible for free school meals (used for FSM in performance tables)
[12] read · Starter Portal (powerappsportals.com)
[13] Family spending in the UK - Office for National Statistics (ons.gov.uk)

25. The partners are committed to working together to share resources and identify 'back up' plans and ways to respond to rising local demand.

26. Partners work together to effectively signpost people to other support that help people out of crisis, such as debt advice or other support to help with the costs of living.

27. Food partners are struggling with levels of supply, which is a national challenge, with reduced levels of surplus from supermarkets in some places, alongside fewer public donations. This is an issue in terms of responding to need as well as financing purchase of additional food. In June 2023, A2FP (in particular foodbanks and community food pantries) shared information about spend required to top up food supplies due to demand, which is estimated to be around £286,000 per year.

28. Following an application process, the recent BCP Food and Energy Support Fund (financed by Household Support Fund 5) has distributed £50,500 in grants to eight of the main foodbanks and community pantries across BCP to replenish food stock over the next 3 months (July - Sept).

29. Foodbanks and other community food projects are often regarded as a 'first responder' to those in emergency crisis, with the offer of a foodbank voucher providing a tangible, practical response to someone in need.

Collaboration and Working Together

30. Many A2FP workers and volunteers have lived experience of food insecurity – often ongoing. This means that the work of the A2FP is led by the people it supports, and partners are intrinsic to local neighbourhoods. Those accessing the support value the emotional and social support they receive from partners, and their trusted relationships with volunteers.

31. The A2F Forum is a quarterly in-person opportunity for all partners, stakeholders and volunteers to get together and discuss successes, challenges, and opportunities. The open agenda encourages partner-led discussions, facilitated by the Community Food Coordinator utilising practices developed by the Poverty Truth Commission[14].

32. The Partnership is further enhanced by a committed and active A2F Steering group, made up of key community partner organisations alongside ICS partners, meeting fortnightly.

33. The A2FP works closely with other partnerships and projects, including the BCP Homelessness Forum, Poverty Truth Commission, Together We Can, Adult Social Care's 3 Conversations team and other work across the ICS that are focused on place-based and strength-based approaches. We value HWB

[14] Poverty Truth Bournemouth, Christchurch and Poole – What If… Change is possible? (povertytruthbcp.org)

Board Members' insights into their own organisations to identify where we can work better with system partners across health, care and beyond.

34. The A2FP has shared much learning, experience and knowledge with Dorset Council and food partners. Following the success of the A2FP, Dorset Council has now secured funding to appoint a part-time community food coordinator to work with food projects across its Council area.

35. The A2FP was recognised nationally, through iESE's Public Sector Transformation Awards, achieving a Gold Award in March 2024 for the "Working Together" category.

Communication and raising awareness of support

36. The digital Access to Food Map has full details of 83 different initiatives, such as foodbanks, social supermarkets, community meals, community fridges, food parcels, cooking workshops, food growing projects and community cafes.

37. To date, the map has been used 42,661 times by both the public and frontline staff/volunteers. A range of frontline workers have reported how useful the map has been in supporting residents, including social prescribers, BCP Housing and Crisis advice line as well as community food projects themselves.

38. Non-digital resources including posters and business cards were distributed to over 250 venues, and cost of living posters were translated into eight of the most commonly-spoken languages in BCP. Over 7,000 business cards with a QR code to the Map have been distributed.

39. Partners are seeing increasing numbers of people with mental wellbeing issues including depression, anxiety and stress[15]. This has an impact on the wellbeing of their volunteers and workers. In 2022, in response to this need, Public Health Dorset provided Mental Health First Aid awareness training to 12 partner organisations. Attendees are now part of the ICS-wide Mental Health Champions network.

Sharing resources across the A2FP network

40. A small amount of grant funding is set aside for 'arising issues' throughout the year, meaning the A2FP can be agile and responsive in their approach to supporting community needs. For example:

    a. In 2022/23, in response to residents' concerns about using their ovens due to energy costs, as well as knowledge that others do not have access

[15] Food Insecurity Is Associated with Depression, Anxiety, and Stress: Evidence from the Early Days of the COVID-19 Pandemic in the United States - PMC (nih.gov)

to cooking equipment, the Partnership worked with 12 food projects to distributed more than 126 pieces of energy efficient cooking equipment.

b. This further led to partners wanting to share recipes (to avoid duplication and share resource) and together produced the "Start Cooking Recipe" book together, created by local community groups sharing recipe ideas, and working with Bournemouth University to evaluate different ways to share the recipe book to best engage people in using it.

41. In December 2023, partners co-created 'The One Stop Glut Hut'. Responding to last year's Christmas, when many volunteers were picking up surplus frozen turkeys from supermarkets on Christmas Eve and trying to store or redistribute them right up to until the early hours of Christmas morning! The 'Hut' operated over the Christmas period, with 3.5 tonnes of food being donated, shared and redistributed.

Working with diverse communities and in neighbourhoods

42. In January 2023, City of Sanctuary and International Care Network highlighted a desire to ensure that Muslim asylum seekers and refugees in the resettlement hotels could access culturally appropriate food (an ongoing challenge) and community activity throughout Ramadan and to connect asylum seekers with the wider BCP community and support. A2FP Grassroots Funding was invested to support projects and organisations providing community connection through Ifthar meals and celebrations. The Community Food Coordinator connected eight organisations who applied to the fund to develop their work further, including Inara Project, Unity in Vision, International Care Network.

43. The Community Food Coordinator hosted neighbourhood conversations to bring together projects in Winton. This led to two new local free voucher schemes for families in need to access fresh food on their local high street and also to enable them to enjoy a day out and a treat at the park.

44. The A2FP October 2021 presentation to the HWB Board generated further engagement with Dorset and Wiltshire Fire and Rescue Service's Safe and Well teams. We gathered insight on their knowledge of older peoples' behaviours around food insecurity, their coping mechanisms, and barriers in asking for support, as well as trained frontline workers on the A2FP support. This later led to a research project with Bournemouth University's PIER department with a Highcliffe lunch club, to better understand the 'hidden' barriers and solutions that will enable better access to relevant support for older people experiencing food insecurity.

Priorities for 2024-25

45. The A2FP's four priorities for 2024-25 are:

a. Prevention, Crisis Support
b. Resilience Building and Training
c. Communications and Engagement
d. Network-strengthening

46. In 2024/25, the A2FP wants to strengthen the 'no wrong door' approach by helping to create a well-informed ICS workforce to help those who need support to receive it when, and where, they need it.

47. The A2FP will provide a training and awareness package about community food support across the ICS. This will enable more timely and effective referrals to get the right support at the right time. A2FP has already established relationships with Dorset's Access Wellbeing delivery partners Help & Care and BCHA to ensure that the soon-to-recruited teams of 60+ Wellbeing Coordinators are welcomed into the partnership, ready for the BCP-wide rollout of the initiative.

48. The A2FP is focused on improving working together as a system to better help with the right support when needed, and ensure all frontline workers have the knowledge to be able to connect residents and communities to relevant help. This is already being seen with new models of working such as the coming together of support services at drop-in sessions at Henry Brown Centre in West Howe, with Shelter, BCP Housing, Citizen's Advice BCP and the foodbank all being present to provide advice and support. This has now been implemented with Christchurch Foodbank and other areas being considered.

49. Through Access to Food training and communications about its work, it is hoped the heightened workforce awareness of the current challenges and work will provide an opportunity to work together to increase food and financial donations to local projects.

50. Evidence and community insights will inform the delivery of our priorities over the coming year, ensuring that we are working with the right partners and frontline workers to reach seldom-heard communities and those most at risk of food insecurity.

Summary of financial implications

51. No set financial implications for the HWB Board except the request to consider how they can help with the long term sustainability of the partnership.

Summary of legal implications

52. None identified at present

Summary of human resources implications

53. BCP Council's Community Food Coordinator is currently funded through external funding by National Lottery Community Fund and has received short term funding.

Summary of sustainability impact

54. The partnership is focusing on growing initiatives and in turn this will help to reduce carbon emissions by growing local food.

55. It identifies surplus food wastage within the system and redirects this resource to local community food projects**.**

56. The cost of living crisis response has raised awareness on energy efficiency, such as more energy-efficient cooking equipment, which in turn is helping to reduce carbon emissions.

Summary of public health implications

57. Food insecurity is associated with poorer physical and mental health outcomes. It also disproportionately affects certain parts of our communities, already being unfairly impacted by other wider determinants of health (see section 12). Therefore, addressing food insecurity is a vital component of work to reduce health inequalities and deliver better health outcomes.

Summary of equality implications

58. The A2FP includes a workstream to focus on lived experience. This work seeks to engage with those that have experience food insecurity to better understand how they can be supported to access food in their neighbourhoods to recovery and prevention.

59. The A2FP gathers feedback from community food partners and frontline staff about how all communities and residents access food and any barriers or impacts resulting from service changes. These approaches demonstrate the principles of integrated neighbourhoods in action.

Summary of risk assessment

60. The Access to Food Partnership is currently reliant on limited resource and generous partnership working from the Chair and others. The Partnership lacks a longer-term sustainable resource and funding strategy.

61. The A2FP has funding through the National Lottery until the end of April 2025, but require more longer-term sustainability to ensure the partnership work is funded to continue beyond this date.

62. The Partnership's action plan includes several short-term objectives that could become delayed without sufficient focus and resources.

Background papers

- BCP Access to Food map and Access to Food partnership webpages
- Citizen's Advice – Universal Credit & Food Bank Briefing Letter
- The Food Foundation- The Impact of COVID -19 on Household Food Insecurity.

Appendices

Appendix 1. Access to Food Partnership Annual Review 2023/24
Appendix 2. Cost of Living report annual review 2023/24
Appendix 3. BCP Council Insights – Current and Future situation in relation to Food Insecurity in BCP

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Working together to address food insecurity & improve wellbeing

BOURNEMOUTH • CHRISTCHURCH • POOLE

ACCESS TO FOOD PARTNERSHIP

Who are the A2F Partnership?

‘A BCP where everyone is able to feed themselves and their family nutritious food, all of the time’.

The landscape we're in

An estimated 1 in 6 households are living in food insecurity in the conurbation.

Data sourced from Food Foundation's Food Insecurity Tracking Tool and BCP Council's Population Data and Census Data.

Citizen's Advice BCP reported issues around utilities, especially energy, grew by more than 80% in 2023.

Shared on Citizen's Advice BCP's Research & Campaign Bulletin

Citizen's Advice BCP reported the demand for help from Charitable Support and Foodbanks grew by 121% in 2023.

Shared on Citizen's Advice BCP's Research & Campaign Bulletin

The price of a weekly shop has increased by 25.5% for a man and 23.9% for a woman since April 2022.

Data sourced from Food Foundation's Food price tracker.

The most deprived fifth of the population would need to spend 50% of their disposable income to meet the cost of the Government's recommendation for a healthy diet. That is 46,000 people in BCP.

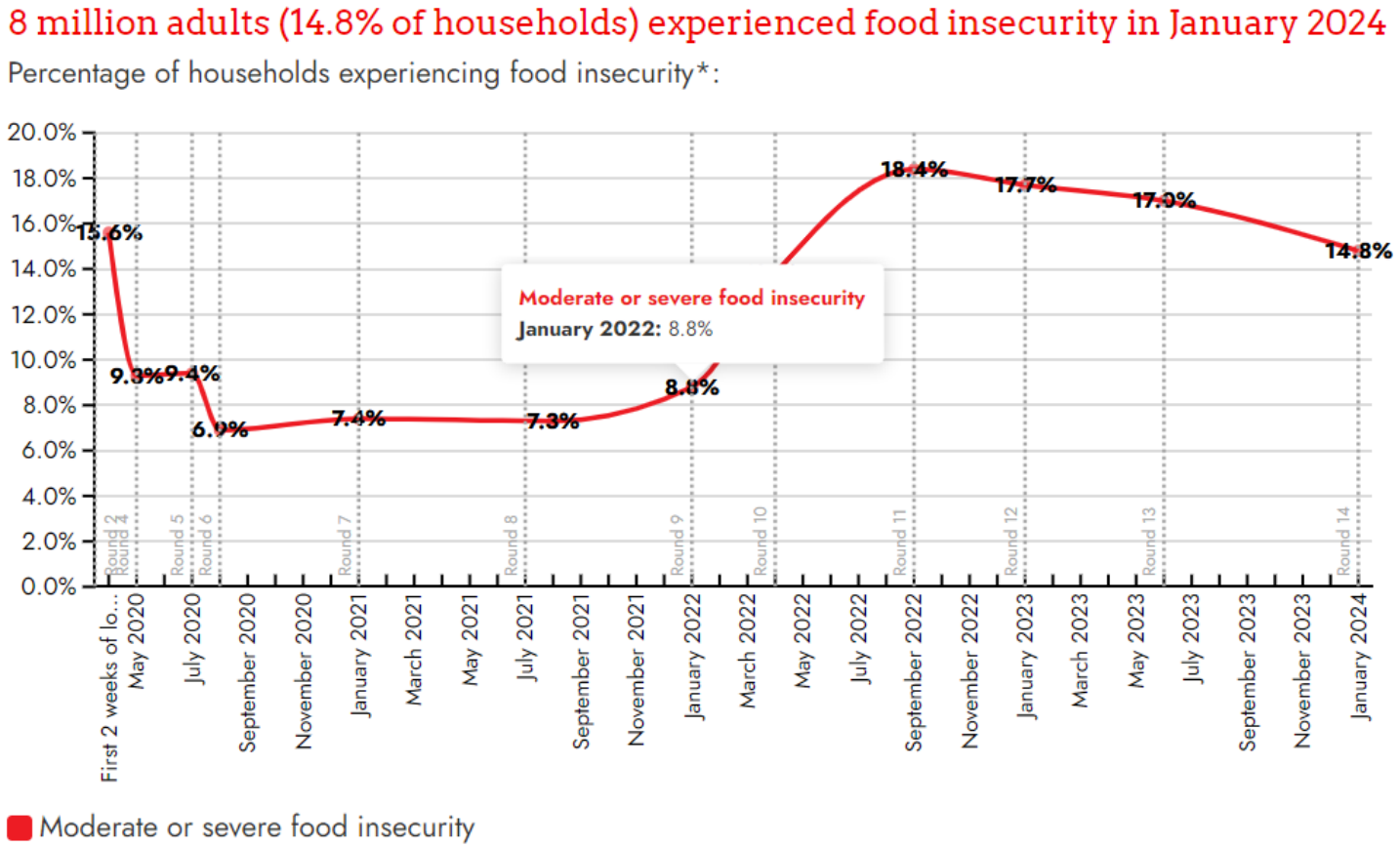
The Food Foundation's The Broken Plate 2023 Report

Demand high – Supplies dropping

Fewer food donations

Foodbanks/pantries spending ~ £286,000 per year to top up food supply

Lower food surplus from some supermarkets – varies across BCP



Source: Food Foundation tracking report - https://foodfoundation.org.uk/initiatives/food-insecurity-tracking#tabs/Round-14

Elements of our Partnership mission

a. Ensure everyone can access food when in crisis

b. Equip households with confidence, skills & resources to consistently feed themselves nourishing food

c. Bring local communities together to identify needs, seize opportunities and solve problems, using local strengths and community assets

d. Share good information about the local community food offering

e. Make access to food a priority in local policy and decision making

f. Develop a strong and resourced community food network

What the Partnership has achieved in 2023-24

338 A2F newsletter subscribers
164 A2F Facebook group members

83 listings and 5145 searches on the Access to Food Map

67 volunteers funded to complete L2 Food Hygiene Training

135 frontline staff trained in the community food offer

45+ surplus food offers shared & distributed across the network

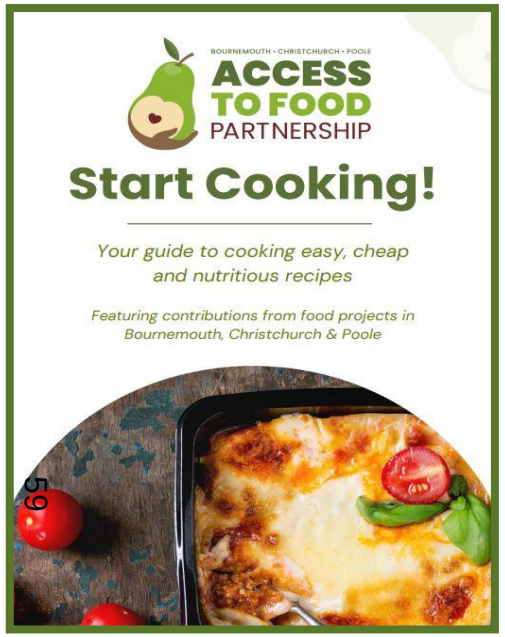
214 participants connecting and collaborating at events

£400,000 of small grants given through the BCP Food & Energy Support Fund (UK Government funded)

£8,650 to support arising issues (eg: Start Cooking Recipe Book) and the Grassroots Kickstarter fund

Awarded GOLD for Working Together at the iESE Public Sector Transformation Awards **2024**

B. Equipping with confidence, skills and resources



Start Cooking Recipe Book

Partners were duplicating their efforts in producing recipe cards, whilst others were struggling with capacity to do so, and recognised that together they could benefit from shared resources. A group of 11 partners came together and pooled the recipes they each used to create something that could be shared across the whole network.

Facilitated by The Friendly Food Club the group created a 50-page local recipe book entitled “Start Cooking!”, a guide to cooking easy, cheap and nutritious recipes based on contributions from local food projects and communities, aiming to:

- Build skills and confidence in cooking for residents using community food projects
- Signpost to local support & share stories of local people who have accessed support
- Demonstrate how community food projects are working together
- Build capacity by sharing tools and resources to help build resilience in communities.

William cooking with the Start Cooking recipe book, that he received from Poole Waste Not Want Not

C. Bring local communities together

Access to Food in Winton

Thanks to neighbourhood conversations in the Winton over 2022 local groups and organisations continued to connect through a Whatsapp group and felt encouraged to further work together on new initiatives.

Over the summer, Hope Hub, Lifehouse, Salvation Army and Winton & Parkstone Community Pantry worked with the Parks Foundation to offer a trial local voucher scheme for families to be able to 'purchase' refreshments in Parks Cafes during the school holidays. The Partners designed the scheme and built on the experience of previously funded highstreet voucher schemes. At the discretion of the local projects knowing those families that could benefit, the vouchers were distributed and helped alleviate some financial pressure often experienced with the cost of enjoying days out.

They were able to use their vouchers to enjoy free ice creams/juice/coffees at their local park alongside free holiday activities. A total of 125 vouchers were redeemed, and the pilot has continued into the winter period with a hot food offer.

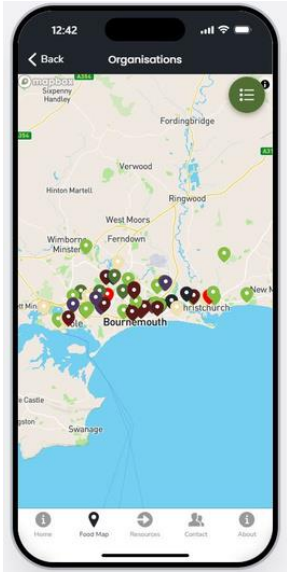
Winton Access to Food Partners and Parks Foundation at Winton Rec Cafe
Becca and Eli at the park enjoying a cornetto and a coffee paid for by the voucher scheme

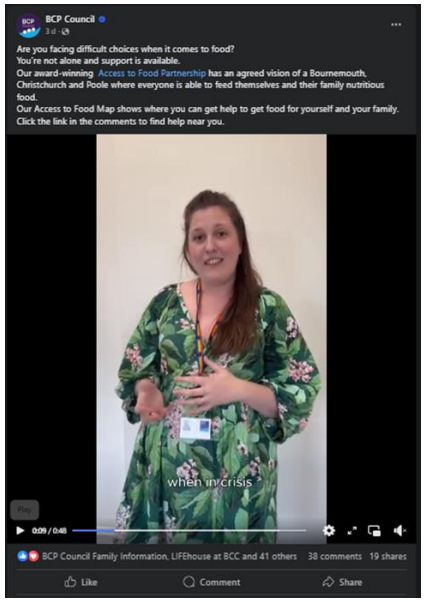
D. Share good information about community food

Access to Food Map and offline resources

- Local ‘access to food map’ - 83 community food settings viewed 42,661 times by the public and frontline staff.
- Non-digital resources to reach a wider audience not online
- Posters translated into 8 key languages that are most used locally
- Trained 135 frontline workers on Access to Food
- Developed social media channels

QR code for Map





F. Develop a strong & resourced food network

The One Stop Glut Hut

By providing a space where partners can manage and share their surplus produce, we have:

- **increased wellbeing of volunteers,** who would often bear the weight of managing surplus stock with limited storage space.
- **created stronger links and partnerships between community food projects,** allowing the flow of more resources and the desire to continue working together
- **gave access to produce that projects would not normally have access to**; ie Fresh fruit and veg.
- **nurtured creativity** in how community food projects made the most of the surplus that was made available e.g. a baby shower party and a youth club knickerbocker glory night!

The One Stop Glut Hut with George (Project Coordinator) and Unity In Vision making use of the packing space!

F. Developing a strong and resourced food network

> The Access to Food Partnership has given us a greater appreciation of our specific role within a network of services that together can offer cohesive support to local people experiencing difficulties affording food. **This has given us more focus and a drive for increased connection with other services**, improving the support we have been able to offer people. **Our involvement has helped us to feel connected, resourced, supported and understood**.

Susan, Citygate Community Hub & Foodbank

F. Develop a strong & resourced food network

Grassroots Kickstarter Fund

- The Hope Hub to offer community meals for all the family
- Impact Boscombe setting up a community fridge and cooking project in the school with Kings Park Academy
- Somerford Arc Community Lunch Club to offer extra take away meals
- St Michael's Primary to start an after school community meal
- Winton Access to Food Partners to pilot ice-cream vouchers with Parks Foundation
- We are Humans to develop their new community allotment with support from Grounded Community
- Bee Mission to host their Christmas Community Meal for the homeless community

Poster for Impact Boscombe's work with Kings Park Academy

Connecting with others

Building a stronger system to respond to crisis, prevention and building resilience

LiveWell Dorset

help&care

Dorset Community Foundation

…alongside Schools, Family Hubs and Primary Care Networks across BCP

Recommendations to the Health and Wellbeing Board

a) Acknowledge how the work of the Access to Food Partnership (A2FP) has contributed to upstream prevention by supporting those most vulnerable to the impact of health inequalities and the cost of living crisis in BCP.

b) Commit to highlighting at a strategic level the importance of the A2FP in addressing food insecurity and hidden hunger in communities, and champion local system change to enable community and voluntary sector partners to continue to grow and thrive

c) Recognise the significant ongoing challenges in high levels of demand from local people struggling with the cost of living, and support the A2FP to meet this need

d) Recognise the A2FP's increasingly important role as a point of trusted communication and collaboration in neighbourhoods and commit to ensuring that their frontline workers have up to date knowledge and understanding of the A2FP.

e) Facilitate work between the A2FP and all system partners to enable better health outcomes and reduced inequalities.

Points for Discussion: Building sustainability

- What are your thoughts / feedback on the report and the current situation about food insecurity in BCP? What stood out for you?
- Can you help - Donations and food supply?
- How do we create well informed frontline workers
  - Access to Food partnership training, internal comms, sharing the Map
  - Improving referrals by understanding needs- Better Referrers project
  - Deeper understanding and stronger working relationships e.g. foodbank open days, information workshops?
- Enabling better knowledge share across the ICS e.g. sharing knowledge between partnerships to provide better support to communities
- Longer term funding for food insecurity work – ideas?

BOURNEMOUTH • CHRISTCHURCH • POOLE

ACCESS TO FOOD PARTNERSHIP

www.bcpcouncil.gov.uk/accesstofoodpartnership

BCP Council Health and Wellbeing Board

Report subject	**Pharmaceutical Needs Assessment (PNA)**
Meeting date	15 July 2024
Status	Public Report
Executive summary	Each Health and Wellbeing Board must publish a pharmaceutical needs assessment (PNA). There is legislation that sets out the process for this. Part of this is regular review, with a new PNA for the Dorset system due by October 2025. This paper kicks off this process, with key questions for the Board. A proposed timeline is set out for agreement, and the Board should consider if this requires any delegated authority to ensure delivery.
Recommendations	**It is RECOMMENDED that:** **(a) The start of the 2025 PNA process is noted.** **(b) The Board agrees to support a single PNA across the Dorset system as in previous PNAs.** **(c) The provisional timeline set out under section 4.1 is agreed, and the Board consider any need for delegation required to support this.** **(d) The Board consider:** **(i) The scope of the PNA, and** **(ii) Any other representatives required on the Steering Group**
Reason for recommendations	To meet requirements set out in Regulations.

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

Background

1. Regulations (2013) set out the need for each Health and Wellbeing Board to:
   - publish a **Pharmaceutical Needs Assessment (PNA),**.
   - review and publish the PNA every three years,
   - include at least the prescribed Schedule of Information in the PNA, and.
   - consult with specified consultees for at least 60-days on the PNA before publication.

2. The purpose of the PNA is to:
   - assess the need for pharmaceutical services in the local area,
   - identify if there are any gaps in the current service provision,
   - understand if there are likely to be any future gaps in service provision,
   - consider how to ensure improvements and better access,
   - support the NHS in making decisions on market entry applications. This is where a service provider applies to open a new community pharmacy site.
   - Support the NHS in making other decisions about community pharmacies. For example, where a community pharmacy requests to change premises.

3. A national information pack (2021) gives guidance on the process. This recommends a Steering Group to oversee the process. It includes an indicative timeline of at least a year to develop the PNA.

4. The PNA does not, in law, provide an assessment of community pharmacy service quality. Service quality issues may arise during engagement and consultation. The Steering Group will consider any such issues and how they may be best taken forward if required.

Local Context

5. The current PNA (2022) covers both Health and Wellbeing Boards in the Dorset system. It looked at Primary Care Network footprints to consider need in more detail. There were 142 community pharmacies plus 2 distance-selling

pharmacies. For Bournemouth, Christchurch and Poole, there are 86 community pharmacies plus one distance-selling pharmacy.

6. The PNA used 20-minutes' drive time as the standard to identify any potential gaps. It concluded that:
   - there were no gaps in current provision,
   - there were no gaps in future provision,
   - working with current pharmacies was the best way to improve services and access. Integration with other services in an area would also help.
   - The pharmacy workforce challenge is a high priority for the Dorset system;
   - there should be a campaign to encourage patients to only order the medicines they need.

7. Since publication of the PNA in October 2022, eight community pharmacies have closed. Six of these were in the Bournemouth, Christchurch and Poole council area. Another site in Poole also closed when two Rowlands pharmacies were bought together (consolidated) onto a single site.

8. Of eleven community pharmacies that opened 100-hours a week, none continue to do so. The seven in Bournemouth, Christchurch and Poole are now open between 72 and 82 hours a week. 17 community pharmacies have changed hands, six in Bournemouth, Christchurch and Poole.

9. The many changes above, plus the expected time it takes to complete the PNA, mean we need to start work now.

Scope of the PNA 2025

10. There has been a single PNA in 2015, 2018 and 2022 to cover the whole Dorset system. Section 198 of the Health and Social Care Act allows this type of joint arrangement. The Board should consider whether it wants to take the same approach to the 2025 PNA.

11. The regulations require the PNA divides the area into smaller local areas. This allows more detailed analysis. The 2022 PNA used Primary Care Networks footprints. This was confusing because of overlaps in the geography that each network covers. Integrated neighbourhood teams are being established across the system. Footprints are still in development but would provide a good level of clarity and detail. This would also support improved integration of community pharmacies within local teams.

12. The PNA must identify what the standard of service should be so that it can determine whether there is a gap. There is no definition set out in the regulations,

nor is there a clear national benchmark. For the 2022 PNA the Steering Group considered various criteria before agreeing this. The standard set was access to a community pharmacy within a 20-minute drive time. With changes since the 2022 PNA this standard has come under scrutiny. Initial engagement with the public will explore this in more detail. The Board may wish to take a view on what standard to apply.

Timeline and delivery plan

13. A provisional timeline for delivery of the PNA 2025 is set out below. National guidance and experience from development of the 2022 PNA fed in. There are key points where progress may come back to the Board. Delegation of sign-off to the Director of Public Health, in discussion with the Chair, would help if timings do not line up with meeting dates.

• Set up Steering Group	June to July 2024
• Initial approval and governance	June to July 2024
○ Dorset Health and Wellbeing Board,	26 June 2024
○ BCP Health and Wellbeing Board,	15 July 2024
• First stage discovery work	June to Sep 2024
• Data gathering	June to Dec 2024
• Collation of content and first draft	Sep 24 to Feb 2025
• Agree consultation draft	Jan to March 2025
○ (at Health and Wellbeing Boards?)	
• Formal consultation	April to June 2025
• Final PNA completed and signed off	July to Sep 2025
○ (at Health and Wellbeing Boards?)	
• Publication	No later than Oct 2025

14. The Steering Group will invite representatives from:

- Public Health Dorset,
- other local authority representatives,
- NHS Dorset,
- the Local Pharmaceutical Committee, Community Pharmacy Dorset,
- the Local Medical Committee,
- Healthwatch Dorset, and
- consider any other representatives as needed.

Summary of financial implications

15. Development of the PNA has no direct financial implications other than staff time. The NHS takes account of the PNA in making commissioning decisions. Findings from the PNA may have budget implications for NHS Dorset in the future. The local authority may use the information from the PNA to inform commissioning. This could lead to budget implications in the future.

Summary of legal implications

16. The requirement for the Health and Wellbeing Board to publish a PNA every three years is set out in The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

Summary of human resources implications

17. Development of the PNA has been co-ordinated through Public Health Dorset, a shared service between BCP and Dorset councils. BCP council has given notice to end the shared service arrangement by 1 April 2025. The council will therefore need to give thought to who will deliver this after the shared service ends.

Summary of sustainability impact

18. Implications may depend on the standard of service used to determine whether there is a gap. Further assessment should be considered as part of the PNA development.

Summary of public health implications

19. Community pharmacies are key local community assets that support health and wellbeing. Since the 2022 PNA service provision has changed. Developing a new PNA will help to understand any impact of these changes.

Summary of equality implications

20. The PNA development work will include an Equality Impact Assessment.

Summary of risk assessment

21. Risk is likely to fall principally on NHS England, in that if the PNA is not sufficiently robust there is a risk of challenge to their decision making.

22. Having considered the risks associated with this decision using Dorset County Council's risk management methodology, the level of risk has been identified as:

    Current Risk: LOW

    Residual Risk: LOW

Background papers

Dorset Pharmaceutical Needs Assessment (PNA) October 2022
Pharmaceutical needs assessments: National guidance pack October 2021
The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

Appendices

There are no appendices to this report.

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HEALTH AND WELLBEING BOARD

Report subject	**Better Care Fund 2023-2025: Quarter 2 & 3, the End of Year Report 2023/24, 2024/25 Planning Template:**
Meeting date	15th July 2024
Status	Public Report
Executive summary	This report provides an overview of Quarters 2 and 3, the End of Year 2023/24, and the 2024/25 planning template 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. The reports are a part of the planning required set by the Better Care Fund 2023-25 Policy Framework. The reports and plan need to be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements.
Recommendations	**It is RECOMMENDED that:** **The Health and Wellbeing Board retrospectively approve:** • **Better Care Fund Quarter 2 Report** • **Better Care Fund Quarter 3 Report** • **Better Care Fund End of Year Report 2023/24** • **Better Care Fund 2024/25 Planning Template.**
Reason for recommendations	NHS England (NHSE) require the Health and Wellbeing Board (HWB) to approve all BCF plans, this is one of the national conditions within the Policy Framework. This includes planning documents at the beginning of a funding period, and template returns reporting progress against the plans quarterly.

Portfolio Holder(s):	Cllr David Brown, Portfolio Holder for Health and Wellbeing

Corporate Director	Phil Hornsby, Director of Commissioning
Report Authors	Scott Saffin, Commissioning Manager – Better Care Fund and Market Management Kate Calvert, Deputy Chief Officer, Commissioning - NHS Dorset
Wards	Council-wide
Classification	For Decision

Background

1. This report is a covering document for the content of the Better Care Fund Quarter 2 & 3, End of Year 2023/24 report, and 2024/25 Planning Template. Each report is made up of a single document template.
   The template was provided by NHS England and completed by officers in BCP Council and NHS Dorset. The document is as follows.

   - Confirmation that National Conditions are being implemented.
   - Reporting of local performance against the BCF Metrics year to date.
   - Capacity and Demand (C&D) Guidance & Assumptions
   - Spend and Activity data
   - Updates on narratives relating to C&D, the metrics, and expenditure of Additional Discharge Funding

2. The BCF is a Programme spanning both the NHS and Local Government which seeks to join-up health and care services, to promote people's ability to manage their own health and wellbeing and live independently in their communities for as long as possible.

3. The BCF pooled resource is derived from existing funding within the health and social care system such as the Disabled Facilities Grant and additional contributions from Local Authority or NHS budgets. In addition, short-term grants from Government have been paid directly to Local Authorities i.e. 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 monthly reporting against spend and activity.

4. In 2023/24 the BCF provides BCP Council with total funding of £71,082,277.

5. In 2024/25 the BCF provides BCP Council with total funding of £75,501,388.

The Better Care Fund 2023/24 Quarterly and End of Year Report

6. The health and social care landscape continues to challenge performance; but BCP Council were aligned to meet 2023/24 targets for:
    - Rate of permanent admissions to residential care per 100,000 population
    - Percentage of people who are discharged from acute hospital to their normal place of residence.
    - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

7. Performance is not on track on:
    - Unplanned hospitalisation for chronic ambulatory care sensitive conditions.
    - Emergency hospital admissions due to fall in people aged 65 and over directly age standardised rate per 100,000.

8. Performance in relation to "Unplanned hospitalisation for chronic ambulatory care sensitive conditions" is an area BCP Council and NHS Dorset have been closely analysing. Seen increased activity in both Q2 and Q3 compared to both 23/24 plan and level in comparable period in 22/23. Related to challenges within increasing demand across the UEC system. The ongoing work on step up beds will see an impact on these metrics, providing the right care before hospitalisation. The ICB hopes to increase virtual wards as they have had a positive impact to re-admissions.

9. Performance against the rehabilitation and reablement 91-day metric is on track to the target set in the initial 2023-2025 plan. BCP Council conducted a three-month sprint project in the last quarter to review reablement services in the context of the wider intermediate care offer, this sprint reviewed current services and pathways for people, identify opportunities for improvement. In parallel to this from a wider intermediate care system perspective, the BCF Support Team and a leadership consulting organisation will be working in partnership across health and social care to identify system wide areas for improvement.

10. Despite there being some gaps in capacity to meet some of the demand seen over the last quarter, BCP Council and NHS Dorset has a strong narrative around a collaborative system approach, particularly with Discharge to Assess which provides system resilience. Whilst winter has undoubtedly challenged the System, the refreshed capacity & demand assumptions in the Quarter 2 report showed the plans to support and respond to pressures.

The Better Care Fund 2024/25 Planning Template

11. The second year of the BCF 2023-2025 plan has commenced, requiring an addendum to the 2023-2025 BCF plans to set out the allocations of funding, 24/25 performance metrics, refreshed capacity & demand planning, and narrative updates.

12. The funding allocation for the financial year 2024/2025 is detailed in the Expenditure sheet of the planning document. This does not introduce any new schemes. Although there have been budget reallocations to existing schemes, the anticipated outputs have not changed.

13. The planning document includes refreshed metrics for the upcoming four quarters.

    - The benchmarks for Avoidable Admissions, Falls, and Discharge to Usual Place of Residence reflect the outcomes of the performance in 2023/24.
    - Residential Admissions metrics are derived from the past two years' performance trends and our current residential care capacity.
    - The previous Reablement metric has been removed from this year's planning document, with a new metric to be introduced at a later date.

14. The revised narratives provide insights into the development of the capacity and demand plan, highlights potential gaps, and details measures to address these gaps. Additionally, they confirm that these plans are aligned with the NHS Urgent Emergency Care Flow and the Market Sustainability and Improvement plans.

15. The planning requirements sheet dictate that this document is presented to the Health & Wellbeing Board on Monday, July 15th, for approval.

Summary of Financial Implications

16. The Joint Commissioning Board of BCP Council and NHS Dorset continue to monitor BCF budgets and activity for 2023-25 Plan.
17. This plan provides a very granular breakdown of the spending by scheme type, source of funding and expenditure (See Appendix 4). A high-level view of this is detailed in the table below:

Scheme Description	NHS Dorset ICB contribution	BCP Council contribution	Total
	£000	£000	£000
Maintaining Independence	8,989	14,322	**23,312**
Integrated Health & Social Care	11,736	0	**11,736**
Carers	1,414	0	**1,414**
Early Hospital Discharge	10,283	6,094	**16,378**
Integrated Health & Social Care Locality Schemes	20,477	2,182	**22,659**
Total	**52,903**	**22,598**	**75,501**

Summary of Legal Implications

18. 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

19. The services funded under the BCF are delivered by a wide range of partners some of whom are employed by BCP Council and many who are commissioned by BCP to deliver these services. There are no further human resources implications to note.

Summary of sustainability impact

20. Services are only sustainable as long as funding is available.

Summary of public health implications

21. 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

22. An Equalities Impact Assessment was undertaken when the Better Care Fund schemes were implemented 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

2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)

Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements - GOV.UK (www.gov.uk)

Appendices

Appendix 1: Better Care Fund 2023-24: Quarter 2 Quarterly Reporting Template

Appendix 2: Better Care Fund 2023-24: Quarter 3 Quarterly Reporting Template

Appendix 3: Better Care Fund 2023-24: End of Year Report

Appendix 4: Better Care Fund 2024-25: Planning Template

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

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

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

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

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

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

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

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

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

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

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

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

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

		Checklist: Complete:
Health and Wellbeing Board:	Bournemouth, Christchurch and Poole	Yes
Completed by:	Nicky Mitchell	Yes
E-mail:	nicky.mitchell@bcpcouncil.gov.uk	Yes
Contact number:	01202 128738	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Has the section 75 agreement for your BCF plan been finalised and signed off?	No
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	30/11/2023

Confirmation of National Conditions			Checklist
National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

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

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

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

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.
		Q1	Q2	Q3	Q4				
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	215.0	185.0	229.0	205.0	218.5	On track to meet target	Rationale for ambition (as submitted in Plan) Aim to reduce levels by 1% during 23/24, to pre pandemic levels. Q1 23/24 has shown no change on the comparable	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
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.8%	93.8%	93.8%	93.8%	94.53%	On track to meet target	Rationale for ambition (as submitted in Plan) 23/24 plan to achieve 93.8% each quarter. Latest performance at 94.5% is 1.9% higher than the comparable position in Q1	The development of the ambitions as detailed in the Local plan have commenced and is work in progress across the Dorset ICS. We are continuing to develop our recovery-focused
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,033.9	514.4	On track to meet target	Rationale for ambition (as submitted in Plan) Maintain 22/23 outturn, using local logic based on SUS dataset - to account for data quality and ensuring consistency in	As indicated within the Local Plan submssion, we expect Year 2 will deliver the full ambitions. We continue to develop our models of care across Dorset to support those who
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				367		On track to meet target	Q1- 55.3 Per 100k. Although there is an increase in the use of interim services to prevent permanent residential care placement, the demand and acuity is still high.	BCF investment in Pathway 1 is providing capacity to support more people home whereever appropriate. Therefore, the need to use residential placements as a temporary alternative to getting a person
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				71.6%		On track to meet target	Q1 performance ie at home in April/May/June was 68.6%. Feedback provided to NHS Dorset and DHUFT re discharge numbers - awaiting feedback.	Dorset continues to develop the Discharge to Assess Model, reducing the number of restrictions within the admissoin criteria. This is enabling people to be supported home via our Core Offer, which includes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
We have used the original figures for proposed hospital discharge demand for the period Nov23-March24 (excluding Social Support P1). These are the latest available figures, updated figures are not available	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
We have used the original figures for proposed hospital discharge demand for the period Nov23-March24 (excluding Social Support P1). These are the latest available figures, updated figures are not available	Yes
Capacity:	
For Pathway 1 we will review our capacity projections as we are able to provide more than previously predicted. The current provision is flexible and adapts to need providing an efficient P1 offer.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Using the MSIF we planned interventions to improve capacity for nursing care placements, respite and complex mental health (for community and hospital discharge purposes), but as these have not been implented at time of report, we have not accounnted for these. Please see our answer to Q6 where we show that predicted demand can now reduce for P2 due to a more robust service in P1.	
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
As per capacity plan produced in September, we have capacity challenges with sourcing nursing care placements and respite care at affordable rates. In addition, demand for complex mental health client plac	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
We have had to use the original figures for proposed hospital discharge demand and Urgent Community Response for the period Nov23-March24. These are the latest available figures, updated figures are no	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
We are aware of demand for nursing care placements, respite and complex needs, as per the capacity plan and have planned interventions in progress. We are reviewing Pathway 2 predicted demand as we are more successful at Pathway 1. Because of this we have been able to decommission approx 60 interim beds, which has effected our predicted demand although this hasnt been reflected yet in the figures in Tab 5.2 as demand figures have not been updated, hopefully this should be refreshed by the next quarterly reporting return.	

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Hospital Discharge	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	61	88	71	67	51	59	81	68	63	39	59	81	68	63	39
Short term domiciliary care (pathway 1)	-19	-12	-18	-19	-26	11	18	12	11	4	11	18	12	11	4
Reablement & Rehabilitation in a bedded setting (pathway 2)	34	18	0	17	20	-27	-43	-61	-44	-41	-27	-43	-61	-44	-41
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	1	0	-2	-1	-1	-2	0	-2	-1	-1	-2

Capacity - Hospital Discharge		Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing				
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	38	38	38	38	38	42	42	42	42	42	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	203	208	204	205	213	201	201	201	201	201	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	27	27	27	27	27	57	57	57	57	57	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	135	135	135	135	135	74	74	74	74	74	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	13	15	14	14	16	13	13	13	13	13	0	0	0	0	0

Demand - Hospital Discharge		Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Pathway	Trust Referral Source	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	**Total**	**38**	**38**	**38**	**38**	**38**	**42**	**42**	**42**	**42**	**42**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	3	3	3	3	3	0	0	0	0	0
	OTHER	1	1	1	1	1	0	0	0	0	0
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	34	34	34	34	34	42	42	42	42	42
	(blank)										
	(blank)										
	(blank)										
Reablement & Rehabilitation at home (pathway 1)	**Total**	**142**	**120**	**133**	**138**	**162**	**142**	**120**	**133**	**138**	**162**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	11	10	11	11	13	11	10	11	11	13
	OTHER	3	2	2	2	3	3	2	2	2	3
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	128	108	120	125	146	128	108	120	125	146
	(blank)										
Short term domiciliary care (pathway 1)	**Total**	**46**	**39**	**45**	**46**	**53**	**46**	**39**	**45**	**46**	**53**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	4	3	4	4	4	4	3	4	4	4
	OTHER	1	1	1	1	1	1	1	1	1	1
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	41	35	40	41	48	41	35	40	41	48
	(blank)										
	(blank)										
Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**101**	**117**	**135**	**118**	**115**	**101**	**117**	**135**	**118**	**115**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	8	9	11	9	9	8	9	11	9	9
	OTHER	2	2	2	2	2	2	2	2	2	2
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	91	106	122	107	104	91	106	122	107	104
	(blank)										
	(blank)										
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**13**	**15**	**14**	**14**	**15**	**13**	**15**	**14**	**14**	**15**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	12	14	13	13	14	12	14	13	13	14
	(blank)										

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	1	3	-3	-1	1	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:				
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	141	141	141	141	141	130	130	130	130	130
Urgent Community Response	Monthly capacity. Number of new clients.	92	161	127	127	116	92	161	127	127	116
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	80	77	82	82	80	85	85	85	85	85
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	8	8	8	8	8	35	35	35	35	35
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	141	141	141	141	141	130	130	130	130	130
Urgent Community Response	92	161	127	127	116	92	161	127	127	116
Reablement & Rehabilitation at home	80	77	82	82	80	85	85	85	85	85
Reablement & Rehabilitation in a bedded setting	7	5	11	9	7	35	35	35	35	35
Other short-term social care	0	0	0	0	0	0	0	0	0	0

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Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

1. Guidance for Quarter 3

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

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

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

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

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

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

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

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

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Hackney (due to a data breach issue) and Westmorland and Cumbria (due to a change in footprint).

5. Spend and Activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to the end of the third quarter (1 April to 31 December).

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	Units
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column I.** Enter the amount of spend from 1 April to 31 December on the scheme. This should be spend incurred up to the end of December, rather than actual payments made to providers.
- **Outputs delivered to date in column K**. Enter the number of outputs delivered from 1 April to 31 December. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.
- **Implementation issues in columns M and N.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column M and briefly describe the issue and planned actions to address the issue in column N. If you answer no in column M, you do not need to enter a narrative in column N.

More information can be found in the additional guidance document for tab 5, which is published alongside this template on the Better Care Exchange.

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

2. Cover

Version 2.0

Please Note:

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

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) 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.

Health and Wellbeing Board:	Bournemouth, Christchurch and Poole	
Completed by:	Scott Saffin	
E-mail:	scott.saffin@bcpcouncil.gov.uk	
Contact number:	01202 126204	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 22/04/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Spend and activity	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	No	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	29/02/2024	Yes

Confirmation of National Conditions			
National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

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

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

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

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	215.0	185.0	229.0	205.0	218.5	212.4	Not on track to meet target	Rationale for ambition (as submitted in Plan) Aim to reduce levels by 1% during 23/24, to pre pandemic levels. Q2 23/24 has been challenging on the comparable period last	New model of front door support has been tested over winter to support admission prevention. Early days but positive first steps	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.8%	93.8%	93.8%	93.8%	94.5%	94.2%	On track to meet target	23/24 plan to achieve 93.8% each quarter (overall average for 22/23) Overall performance remains consistent with first 6 months of 23/24 at 94.35% slightly above the desired target, ICS focus remains	Investment in P1 capacity is supporting more people to return home from hospital and there is an increased focus on blending/flexing care across the different P1 offers to meet demand. P1 capacity is	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,033.9	514.4	543.8	On track to meet target	Rationale for ambition (as submitted in Plan) Maintain 22/23 outturn, using local logic based on SUS dataset - to account for data quality and ensuring consistency in data	As indicated within the Local Plan submssion, we expect Year 2 will deliver the full ambitions. We continue to develop our models of care across Dorset to support those who	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				367	2022-23 ASCOF outcome: 398.3		On track to meet target	Q2- 314.3 Per 100k. Although there is an increase in the use of interim services to prevent permanent residential care placement, the demand and acuity is still high.	Contuining to focus on extra care packages has caused some relief to the permanent care home admissions. This is a key area of success for us as demand has been increasing greatly, and there has been great	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				71.6%	2022-23 ASCOF outcome: 71.6%		Data not available to assess progress	Pending Reablement performance data from Dorset Healthcare. Information should be available for next quarterly report.	Tricuro have employed 4 Occupational Therapists and 3 Occupational Therapy Assistants to identify patients to be discharged to Coastal Lodge or home with reablement, expediting discharge.	Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Checklist	Yes	Yes	Yes	Yes

Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
[illegible]	[illegible]	[illegible]	[illegible]	Minimum NHS Contribution	[illegible]	[illegible]	[illegible]	[illegible]	beds/placements	[illegible]	
7	Maintaining Independence	Residential Placements	Care home	Minimum NHS Contribution	£2,390,026	£1,792,520	38	38	Number of beds/placements	No	
8	Maintaining Independence	Home Care or Domiciliary Care	Domiciliary care packages	Minimum NHS Contribution	£1,517,000	£1,137,750	64,250	64,250	Hours of care (Unless short-term in which case it is packages)	No	
11	Early supported hospital discharge	Residential Placements	Care home	Minimum NHS Contribution	£1,982,000	£1,636,500	32	35	Number of beds/placements	No	
15	Early supported hospital discharge	Home-based intermediate care services	Reablement at home (accepting step up and step	Minimum NHS Contribution	£932,000	£699,000	115	115	Packages	No	
16	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Minimum NHS Contribution	£1,100,000	£825,000	10	10	Number of placements	No	
17	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Minimum NHS Contribution	£51,000	£38,250	1	1	Number of placements	No	
20	Carers	Carers Services	Other	Minimum NHS Contribution	£215,000	£161,250	6,500	6500	Beneficiaries	No	
21	Carers	Carers Services	Other	Minimum NHS Contribution	£970,000	£577,500	6,500	6500	Beneficiaries	No	
28	Maintaining Independence	DFG Related Schemes	Discretionary use of DFG	DFG	£1,544,312	£1,158,234	9,110	6737	Number of adaptations funded/people supported	No	
29	Maintaining Independence	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£1,974,000	£1,616,322		142	Number of adaptations funded/people supported	Yes	Staffing issues and increased workload as a result of the implementation of discretionary powers under the new policy (2022). Recruitment and re-organisation of team, additonal roles implemented, new process developed with Foundations.
32	Maintaining Independence	Residential Placements	Care home	iBCF	£4,143,749	£3,107,812	67	67	Number of beds/placements	No	
33	Maintaining Independence	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£6,049,000	£4,536,750	256,200	192,150	Hours of care (Unless short-term in which case it is packages)	No	
39	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	iBCF	£550,000	£412,500	10	10	Number of placements	No	

32	Maintaining Independence	Residential Placements	Care home	iBCF	£4,143,749	£3,107,812	67	67	Number of beds/placements	No	
33	Maintaining Independence	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£6,049,000	£4,536,750	256,200	192,150	Hours of care (Unless short-term in which case it is packages)	No	
39	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	iBCF	£550,000	£412,500	10	10	Number of placements	No	
40	Early supported hospital discharge	Home-based intermediate care services	Reablement at home (to support discharge)	iBCF	£210,000	£157,500	26	26	Packages	No	
41	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	iBCF	£21,000	£21,000	0	0	Number of placements	No	
47	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Other	Local Authority Discharge Funding	£336,000	£252,000	5	5	Number of placements	No	
49	Early supported hospital discharge	Home-based intermediate care services	Reablement at home (to support discharge)	Local Authority Discharge Funding	£622,000	£211,500	77	358	Packages	Yes	Recruitment difficulties to expand home based reablement service, funding spent on additional home care rapid response service. Due to lack of clarity, 358 represents a April 2023 - Decemeber 2023 figure.
52	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	ICB Discharge Funding	£1,882,080	£1,411,560	18	18	Number of placements	No	

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Better Care Fund 2023-24 Year End Reporting Template

1. Guidance for Year-End

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), working with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). An addendum to the Policy Framework and Planning Requirements has also been published, which provides some further detail on the end of year and reporting requirements for this period.

The key purposes of BCF reporting are:

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

BCF reporting can be used by local areas, including ICBs, local authorities/HWBs and service providers, to further understand and progress the integration of health, social care and housing on their patch. BCF national partners will also use the information submitted in these reports to aid with a bigger-picture understanding of these issues.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

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

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

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

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and spend from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.

2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

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

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The latest BCF plans required areas to set stretching ambitions against the following metrics for 2023-24:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Westmorland and Cumbria (due to a change in footprint).

5. Income and Expenditure

The Better Care Fund 2023-24 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Additional Discharge Fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2023-24 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2023-24 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2023-24 in the yellow boxes provided, **NOT** the difference between the planned and actual income. Please also do the same for the ASC Discharge Fund.

- Please provide any comments that may be useful for local context for the reported actual income in 2023-24.

6. Spend and activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to year-end.

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	Units
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column K.** Enter the amount of spend to date on the scheme.
- **Outputs delivered to date in column N**. Enter the number of outputs delivered to date. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term

services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.

- **Implementation issues in columns P and Q.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column P and briefly describe the issue and planned actions to address the issue in column Q. If you answer no in column P, you do not need to enter a narrative in column Q.

7.1 C&D Hospital Discharge and 7.2 C&D Community

When submitting actual demand/activity data on short and intermediate care services, consideration should be given to the equivalent data for long-term care services for 2023-24 that have been submitted as part of the Market Sustainability and Improvement Fund (MSIF) Capacity Plans, as well as confirming that BCF planning and wider NHS planning are aligned locally. We strongly encourage co-ordination between local authorities and the relevant Integrated Care Boards to ensure the information provided across both returns is consistent.

These tabs are for reporting actual commisioned activity, for the period April 2023 to March 2024. Once your Health and Wellbeing Board has been selected in the cover sheet, the planned demand data from April 2023 to October 2023 will be auto-populated into the sheet from 2023-25 BCF plans, and planned data from November 2023 to March 2024 will be auto-populated from 2024-25 plan updates.

In the 7.1 C&D Hospital Discharge tab, the first half of the template is for actual activity without including spot purchasing - buying individual packages of care on an 'as and when' basis. Please input the actual number of new clients received, per pathway, into capacity that had been block purchased. For further detail on the definition of spot purchasing, please see the 2024-25 Capacity and Demand Guidance document, which can be found on the Better Care Exchange here: https://future.nhs.uk/bettercareexchange/view?objectID=202784293

The second half is for actual numbers of new clients received into spot-purchased capacity only. Collection of spot-purchased capacity was stood up for the 2023-24 plan update process, but some areas did not input any additional capacity in this area, so zeros will pre-populate here for them.

Please note that Pathway 0 has been removed from the template for this report. This is because actuals information for these services would likely prove difficult for areas to provide in this format. However, areas are still expected to continue tracking their P0 capacity and demand throughout the year to inform future planning.

8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2023-24 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

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

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

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2023-24
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

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

Please highlight:

4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2023-24.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2023-24

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally. The 9 points of the SCIE logic model are listed at the bottom of tab 8 and at the link below.
SCIE - Integrated care Logic Model

HM Government

NHS England

Better Care Fund 2023-24 Year End Reporting Template

2. Cover

Version 2.0

Please Note:

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

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) 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.

Health and Wellbeing Board:	Bournemouth, Christchurch and Poole	
Completed by:	Scott Saffin	
E-mail:	scott.saffin@bcpcouncil.gov.uk	
Contact number:	01202 126204	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 22/07/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

When all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. I&E actual	Yes
6. Spend and activity	Yes
7.1 C&D Hospital Discharge	Yes
7.2 C&D Community	Yes
8. Year End Feedback	Yes

Better Care Fund 2023-24 Year End Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	No	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	22/07/2024	Yes

Confirmation of National Conditions			
National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the year:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-24 Year End Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

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

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

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

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4				
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	215.0	185.0	229.0	205.0	Not on track to meet target	Seen increased activity in both Q2 and Q3 compared to both 23/24 plan and level in comparable period in 22/23. Related to ongoing challenges within increasing demand across the UEC system.	Ongoing work on step up beds will see an impact on these metrics in the coming months. The ICB hopes to increase virtual wards as they have had a positive impact to re-admissions.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.8%	93.8%	93.8%	93.8%	On track to meet target	Levels continue to be consistently in 94% range and inline with 23/24 plan. ICB focus over 23/24 to support various programmes supporting the effective and timely discharge of patients as soon as	Success utilising the different patient pathways, such as using a commissioned care providers to deliver high intensity care packages helped mitigate patients being admitted into residential care. ICES	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,033.9	Not on track to meet target	Increase in activity level over the first 10 months of 23/24 (Apr 23-Jan 24) 10.2% (167) increase in admissions recorded as linked to falls in 65+ cohort over this period.	The ICB's Falls Prevention Service has shown success over Q4 in mitigating admissions into hospital linked to falls. A review of patients who are being admitted due to falls is underway to see if there's	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				367	On track to meet target	Challenges in obtaining higher complexity care packages has led to discharge delays in patients being admitted into residential care.	Our focus on Home First has helped to provide alternative care packages within intermediate care to give patients more independence and given them the choice to continue their recovery at home or	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				71.6%	On track to meet target	We are working with the BCF support team to review the services we currently commission. While we do this self-assessment work with the BCF Support Team, we only expect marginal gains	The BCF Support team has undertaken a 18 week programme that will review our reablement and rehabilitation services. They are seeking to encourage necessary improvements and, following their	Yes

Better Care Fund 2023-24 Year End Reporting Template

5. Income actual

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Income

	2023-24
Disabled Facilities Grant	£3,825,320
Improved Better Care Fund	£13,438,749
NHS Minimum Fund	£34,405,085
Minimum Sub Total	£51,669,154

	Planned	Actual		
NHS Additional Funding	£12,818,959	Do you wish to change your additional actual NHS funding?	No	
LA Additional Funding	£2,182,000	Do you wish to change your additional actual LA funding?	No	
Additional Sub Total	£15,000,959			£15,000,959

	Planned 23-24	Actual 23-24
Total BCF Pooled Fund	£66,670,113	£66,670,113

Additional Discharge Fund

	Planned	Actual		
LA Plan Spend	£1,884,092	Do you wish to change your additional actual LA funding?	No	
ICB Plan Spend	£2,835,080	Do you wish to change your additional actual ICB funding?	No	
Additional Discharge Fund Total	£4,719,172			£4,719,172

	Planned 23-24	Actual 23-24
BCF + Discharge Fund	£71,389,285	£71,389,285

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2023-24	

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes

Expenditure

	2023-24
Plan	£71,082,277

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

Actual	£71,389,285	Yes

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2023-24	Additional DFG uplift mid-year.	Yes

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Checklist Yes Yes Yes

Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Q3 Actual expenditure to date	Actual Expenditure to date	Planned outputs	Q3 Actual delivered outputs to date	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?
6	Maintaining Independence	Residential Placements	Learning disability	Minimum NHS Contribution	£580,000	£435,000	£580,000	3	3	3	Number of beds/placements	No
7	Maintaining Independence	Residential Placements	Care home	Minimum NHS Contribution	£2,390,026	£1,792,520	£2,390,026	38	38	38	Number of beds/placements	No
8	Maintaining Independence	Home Care or Domiciliary Care	Domiciliary care packages	Minimum NHS Contribution	£1,517,000	£1,137,750	£1,517,000	64,250	64,250	64,250	Hours of care (Unless short-term in which case it is packages)	No
11	Early supported hospital discharge	Residential Placements	Care home	Minimum NHS Contribution	£1,982,000	£1,636,500	£1,982,000	32	35	35	Number of beds/placements	No
15	Early supported hospital discharge	Home-based intermediate care services	Reablement at home (accepting step up and step	Minimum NHS Contribution	£932,000	£699,000	£932,000	115	115	115	Packages	No
16	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Minimum NHS Contribution	£1,100,000	£825,000	£1,100,000	10	10	10	Number of placements	No
17	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Minimum NHS Contribution	£51,000	£38,250	£51,000	1	1	1	Number of placements	No
20	Carers	Carers Services	Other	Minimum NHS Contribution	£215,000	£161,250	£215,000	6,500	6,500	6876	Beneficiaries	No
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28	Maintaining Independence	DFG Related Schemes	Discretionary use of DFG	DFG	£1,544,312	£1,158,234	£2,277,500	9,110	6,737	9194	Number of adaptations funded/people supported	No
29	Maintaining Independence	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£1,974,000	£1,616,322	£1,547,800		142	154	Number of adaptations funded/people supported	No
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33	Maintaining Independence	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£6,049,000	£4,536,750	£6,049,000	256,200	192,150	256200	Hours of care (Unless short-term in which case it is packages)	No
39	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	iBCF	£550,000	£412,500	£550,000	10	10	10	Number of placements	No

40	Early supported hospital discharge	Home-based intermediate care services	Reablement at home (to support discharge)	iBCF	£210,000	£157,500	£210,000	26	26	26	Packages	No
41	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	iBCF	£21,000	£21,000	£21,000	0	-	1	Number of placements	No
47	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Other	Local Authority Discharge Funding	£336,000	£252,000	£280,154	5	5	5	Number of placements	No
49	Early supported hospital discharge	Home-based intermediate care services	Reablement at home (to support discharge)	Local Authority Discharge Funding	£622,000	£211,500	£282,000	77	358	35	Packages	Yes
52	Early supported hospital discharge	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	ICB Discharge Funding	£1,882,080	£1,411,560	£1,882,080	18	18	20	Number of placements	No

Better Care Fund 2023-24 Capacity & Demand EOY Report

7.1. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Estimated demand - Hospital Discharge

Service Area	Metric	Prepopulated from plan: Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Q2 Refreshed planned demand Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Reablement & Rehabilitation at home (pathway 1)	Planned demand. Number of referrals.	144	145	126	140	120	120	124	142	120	133	138	162
Short term domiciliary care (pathway 1)	Planned demand. Number of referrals.	47	48	41	46	39	39	40	46	39	45	46	53
Reablement & Rehabilitation in a bedded setting (pathway 2)	Planned demand. Number of referrals.	102	116	97	78	80	78	102	101	117	135	118	115
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Planned demand. Number of referrals.	19	8	12	12	16	4	10	13	15	14	14	15

Actual activity - Hospital Discharge

Actual activity (not spot purchase):

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	Checklist Complete:
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients.	160	165	161	129	151	153	154	155	141	167	159	175	Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	50	55	54	43	51	51	52	52	47	56	53	59	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	104	109	85	93	92	89	88	78	65	90	91	92	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	21	19	24	18	12	12	22	16	7	19	20	20	Yes

Actual activity - Hospital Discharge

Actual activity in spot purchasing:

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	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	1	1	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

7.2 Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Demand - Community		Prepopulated from plan:							Q2 refreshed expected demand				
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)	Planned demand. Number of referrals.	144	141	141	141	141	141	141	130	130	130	130	130
Urgent Community Response	Planned demand. Number of referrals.	194	191	69	102	113	95	97	92	161	127	127	116
Reablement & Rehabilitation at home	Planned demand. Number of referrals.	82	85	85	80	78	84	80	85	85	85	85	85
Reablement & Rehabilitation in a bedded setting	Planned demand. Number of referrals.	5	11	6	6	6	5	10	35	35	35	35	35
Other short-term social care	Planned demand. Number of referrals.	0	0	0	0	0	0	0	0	0	0	0	0

Actual activity - Community		Actual activity:											
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 activity. Number of new clients.	128	171	169	169	152	144	207	155	168	209	154	235
Urgent Community Response	Monthly activity. Number of new clients.	152	168	166	176	144	152	314	542	638	638	552	590
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	47	74	86	58	81	79	82	67	74	100	88	88
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	6	11	8	7	15	13	24	21	23	29	33	41
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Better Care Fund 2023-24 Year End Reporting Template

8. Year-End Feedback

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

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Part 1: Delivery of the Better Care Fund

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

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	The implementation of the Better Care Fund in the BCP Council and NHS Dorset for the 23/24 plan has demonstrated the impact of collaborative efforts in health and social care. The integration of services, bolstered by the strong partnership between the involved parties, has led to enhanced communication, sharing of resources, and a	Yes
2. Our BCF schemes were implemented as planned in 2023-24	Strongly Agree	There were no issues implementing the services we planned for 23/24.	Yes
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The performance for "Discharged to Usual Place of Residence" and "Residential Admissions" metrics reflect the positive impact of the BCF 23/24 plan on the joint up approach of health and social care within the Bournemouth, Christchurch, and Poole locality. These indicators highlight our commitment to "Enable people to stay well, safe	Yes

Part 2: Successes and Challenges

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

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	9. Joint commissioning of health and social care	Our joint commissioned schemes have produced numerous successes within the Bournemouth, Christchurch, and Poole locality. The Integrated Equipment for Living Service (ICES) and the initiative for transitioning from hospital to home are some highlights. The 2023-2024 period marked the commencement of a renewed 5-year contract with NRS Healthcare, the service provider for ICES, which has been instrumental in providing service users with equipment to maintain their independence at home. This has been key in advancing our Discharge to Assess (D2A) strategy,	Yes
Success 2	5. Integrated workforce: joint approach to training and upskilling of workforce	Two Trusted Assessors have also been employed working across hospitals in the Bournemouth, Christchurch, and Poole locality who are assisting patients and care providers during their stay in hospital to make arrangements that will help patients be discharged to the right place with the right package of care. The Trusted Assessors also help with pre-admissions, and are showing early success, helping patients by using alternative offers to mitigate avoidable hospital admissions. Our Reablement provider, Tricuro have employed 4 Occupational Therapists and 3 Occupational	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	6. Good quality and sustainable provider market that can meet demand	Over the past year, BCP Council and NHS Dorset have faced challenges in addressing the complex care needs within local Care Homes, particularly for patients who require specialist, and higher complexity care. This has occasionally resulted in extended hospitalisations. The contineous and collaborative efforts in expanding alternative pathways have helped mitigate some of the demands seen. Initiatives are being developed to bolster Dementia care across all stages, which will involve coordinated efforts between Health and Social care sectors to ensure sufficient support and	Yes
Challenge 2	8. Pooled or aligned resources	In 2023/24, BCP Council and NHS Dorset faced challenges as reflected in the admissions for chronic conditions and falls, not meeting our expectations as we had planned. The latter part of the winter 23/24 season had unexpected pressures which had a impact on the above mentioned metrics and to the local health system as a whole, demonstrated by the Demand & Capacity data. Both partners have been working closely in our shared goal of reducing avoidable admission rates and improving patient outcomes by providing a range of preventative schemes	Yes

Footnotes:

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

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

Other

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BCF Planning Template 2024-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

6. Please ensure that all boxes on the checklist are green before submission.

7. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

4. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

4.2 Hospital Discharge

A new text field has been added this year, asking for a description of the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation. Please answer this briefly, in a couple of sentences.

The capacity section of this template remains largely the same as in previous years, asking for estimates of available capacity for each month of the year for each pathway. An additional ask has now also been included, for the estimated average time between referral and commencement of service. Further information about this is available in the capacity and demand guidance and q&a documents.

The demand section of this sheet is unchanged from last year, requesting expected discharges per pathway for each month, broken down by referral source.

To the right of the summary table, there is another new requirement for areas to include estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways. Please estimate this as an average across the whole year.

4.3 Community

Please enter estimated capacity and demand per month for each service type.

The community sheet also requires areas to enter estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2024-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations, DFG allocations and allocations of ASC Discharge Fund grant to local authorities for 2024-25. The iBCF grant in 2024-25 remains at the same value nationally as in 2023-24.

2. The sheet will be largely auto-populated from either 2023-25 plans or confirmed allocations. You will be able to update the value of the following income types locally:

- ICB element of Additional Discharge Funding
- Additional Contributions (LA and ICB)

If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

3. The sheet will pre populate the amount from the ICB allocation of Additional Discharge Funding that was entered in your original BCF plan. Areas will need to confirm and enter the final agreed amount that will be allocated to the HWB's BCF pool in 2024-25. As set out in the Addendum to the Policy Framework and Planning Requirements; the amount of funding allocated locally to HWBs should be agreed between the ICB and councils. These will be checked against a separate ICB return to ensure they reconcile.

4. The additional contributions from ICBs and councils that were entered in original plans will pre-populate. Please confirm the contributions for 2024-25. If there is a change to these figures agreed in the final plan for 2024-25, please select 'Yes' in answer to the Question 'Do you wish to update your Additional (LA/ICB) Contributions for 2024-25?'. You will then be able to enter the revised amount. These new figures will appear as funding sources in sheet 6a when you are reviewing planned expenditure.

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

6. If you are pooling any funding carried over from 2023-24 (i.e. underspends from BCF mandatory contributions) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field at the bottom of the sheet to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

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

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

6. Expenditure

This sheet has been auto-populated with spending plans for 2024-25 from your original 2023-25 BCF plans. You should update any 2024-25 schemes that have changed from the original plan. The default expectation is that plans agreed in the original plan will be taken forward, but where changes to schemes have been made (or where a lower level of discharge fund allocation was assumed in your original plan), the amount of expenditure and expected outputs can be amended. There is also space to add new schemes, where applicable.

If you need to make changes to a scheme, you should select yes from the drop down in column X. When 'yes' is selected in this column, the 'updated outputs for 2024-25' and 'updated spend for 2024-25' cells turn yellow and become editable for this scheme. If you would like to remove a scheme type please select yes in column X and enter zeros in the editable columns. The columns with yellow headings will become editable once yes is selected in column X - if you wish to make further changes to a scheme, please enter zeros into the editable boxes and use the process outlined below to re-enter the scheme.

If you need to add any new schemes, you can click the link at the top of the sheet that reads 'to add new schemes' to travel quickly to this section of the table.

For new schemes, as with 2023-25 plans, the table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet, please enter the following information:

1. Scheme ID:

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

2. Scheme Name:

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

3. Brief Description of Scheme

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

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.

- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn ""yellow"". Please select the Sub Type from the dropdown list that best describes the scheme being planned.

- Please note that the dropdown list has a scroll bar to scroll through the list and all the options may not appear in one view.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.

- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

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

- A change has been made to the standard units for residential placements. The units will now read as 'Beds' only, rather than 'Beds/placements'

6. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.

7. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.

- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.

- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.

- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

Better Care Fund 2024-25 Update Template

2. Cover

HM Government

NHS England

Version 1.3.0

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:	Scott Saffin		Yes
E-mail:	scott.saffin@bcpcocuncil.gov.uk		Yes
Contact number:	01202 126204		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:	Mon 15/07/2024	<< 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	Cllr	David	Brown	David.Brown@bcpcouncil.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		Graham	Farrant	graham.farrant@bcpcouncil.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Jillian	Kay	jillian.kay@bcpcouncil.gov.uk	Yes
	Better Care Fund Lead Official		Zena	Dighton	zena.dighton@bcpcouncil.gov.uk	Yes
	LA Section 151 Officer		Adam	Richens	adam.richens@bcpcouncil.gov.uk	Yes

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£3,837,600	£3,837,600	£0
Minimum NHS Contribution	£36,352,413	£36,352,413	£0
iBCF	£13,438,749	£13,438,749	£0
Additional LA Contribution	£2,182,000	£2,182,000	£0
Additional ICB Contribution	£13,049,700	£13,049,700	£0
Local Authority Discharge Funding	£3,140,153	£3,140,153	£0
ICB Discharge Funding	£3,500,773	£3,500,773	£0
Total	**£75,501,388**	**£75,501,388**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£10,381,020
Planned spend	£22,071,404

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£14,202,380
Planned spend	£14,281,009

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	214.0	209.1	255.4	226.2

Falls

		2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,237.3	2,192.6
	Count	2168	2125
	Population	86859	86859

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 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)	94.5%	94.5%	94.5%	94.5%

Residential Admissions

		2022-23 Actual	2024-25 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	398	408

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	No
	PR2	0
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	0
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 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing												Capacity surplus (including spot puchasing)											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	71	49	84	81	73	76	78	83	83	74	73	80	71	49	84	81	73	76	78	83	83	74	73	80
Short term domiciliary care (pathway 1)	-2	-4	2	11	0	7	4	4	8	0	3	1	-2	-4	2	11	0	7	4	4	8	0	3	1
Reablement & Rehabilitation in a bedded setting (pathway 2)	-12	-36	2	-4	-9	-9	-4	0	-1	-9	-11	-3	-12	-36	2	-4	-9	-9	-4	0	-1	-9	-11	-3
Other short term bedded care (pathway 2)	-1	-7	4	2	0	0	2	3	2	0	-1	2	-1	-7	4	2	0	0	2	3	2	0	-1	2
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-14	-10	-23	-20	-23	-13	-26	-23	-20	-15	-13	-4	0	0	0	0	0	0	0	0	0	0	0	0

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

We estimate 250 people to use our voluntary sector partner - CAN Wellbeing Virtual Hub to assist them post discharge from hospital. Estimated 80 referrals from hospital to our CAN Wellbeing service. Estimated 50 patients signposted from hospital to provide support following discharge. Overall we estimate 500 people will use our P0 pathway support schemes that our provided by our partners CAN and Pramalife to assist following discharge from hospital.

Capacity - Hospital Discharge		Refreshed planned capacity (not including spot purchased capacity												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	154	154	154	154	154	154	154	154	154	154	154	154	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	8	8	8	6	6	6	5	5	5	5	5	5												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	49	49	49	49	49	49	49	49	49	49	49	49	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	8	8	8	6	6	6	5	5	5	5	5	5												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	64	64	64	64	64	64	64	64	64	64	64	64	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	16	16	16	12	12	12	8	8	8	8	8	8												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	20	20	20	20	20	20	20	20	20	20	20	20	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	16	16	16	12	12	12	8	8	8	8	8	8												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	14	10	23	20	23	13	26	23	20	15	13	4
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	53	50	50	45	45	40	40	35	35	35	35	35												

Demand - Hospital Discharge

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Expected Discharges:	Total Discharges	**320**	**307**	**307**	**307**	**307**	**307**	**307**	**307**	**307**	**307**	**307**	**307**
Reablement & Rehabilitation at home (pathway 1)	Total	**83**	**105**	**70**	**73**	**81**	**78**	**76**	**71**	**71**	**80**	**81**	**74**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	15	16	14	12	15	13	14	13	13	15	14	14
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	68	89	55	61	65	65	61	57	58	65	67	60
	OTHER	0	0	1	0	1	0	1	1	0	0	0	0
	(blank)												
Short term domiciliary care (pathway 1)	Total	**51**	**53**	**47**	**38**	**49**	**42**	**45**	**45**	**41**	**49**	**46**	**48**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	4	4	4	3	4	3	4	4	3	4	4	4
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	45	47	42	34	44	38	40	40	37	44	41	43
	OTHER	2	2	1	1	1	1	1	1	1	1	1	1
	(blank)												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**76**	**100**	**62**	**68**	**73**	**73**	**68**	**64**	**65**	**73**	**75**	**67**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	6	8	5	5	6	6	5	5	5	6	6	5
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	68	89	55	61	65	65	61	57	58	65	67	60
	OTHER	2	3	2	2	2	2	2	2	2	2	2	2
	(blank)												
Other short term bedded care (pathway 2)	Total	**21**	**27**	**16**	**18**	**20**	**20**	**18**	**17**	**18**	**20**	**21**	**18**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	2	2	1	1	2	2	1	1	1	2	2	1
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	18	24	15	16	17	17	16	15	16	17	18	16
	OTHER	1	1	0	1	1	1	1	1	1	1	1	1
	(blank)												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**14**	**10**	**23**	**20**	**23**	**13**	**26**	**23**	**20**	**15**	**13**	**4**
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	1	1	2	2	2	1	2	2	2	1	1	0
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	13	9	20	17	20	12	23	20	17	14	12	4
	OTHER	0	0	1	1	1	0	1	1	1	0	0	0

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Community **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	19	10	5	5	1	3	0	10	15	0	0	0
Reablement & Rehabilitation in a bedded setting	16	20	25	25	20	25	10	10	11	5	5	10
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours	
Full Year	Units
3.5	Contact Hours
2	Contact Hours
59	Contact Hours
18.09	Average LoS
0	Contact Hours

Capacity - Community

Please enter refreshed expected capacity:

Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	Monthly capacity. Number of new clients.	145	130	125	115	105	115	165	155	155	195	170	160
Urgent Community Response	Monthly capacity. Number of new clients.	979	979	979	979	979	979	979	979	979	979	979	979
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	85	85	85	85	85	85	85	85	85	85	85	85
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	35	35	35	35	35	35	35	35	35	35	35	35
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Demand - Community

Please enter refreshed expected no. of referrals:

Service Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	145	130	125	115	105	115	165	155	155	195	170	160
Urgent Community Response	979	979	979	979	979	979	979	979	979	979	979	979
Reablement & Rehabilitation at home	66	75	80	80	84	82	85	75	70	85	85	85
Reablement & Rehabilitation in a bedded setting	19	15	10	10	15	10	25	25	24	30	30	25
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Bournemouth, Christchurch and Poole	£3,837,600
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£3,837,600**

Complete: Yes

Local Authority Discharge Funding	Contribution
Bournemouth, Christchurch and Poole	£3,140,153

Yes

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS Dorset ICB	£3,501,000	£3,500,773	
Total ICB Discharge Fund Contribution	£3,501,000	£3,500,773	

Yes

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

Yes

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

Yes

NHS Minimum Contribution	Contribution
NHS Dorset ICB	£36,352,413
Total NHS Minimum Contribution	**£36,352,413**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding
NHS Dorset ICB	£13,049,700	£13,049,700	
Total Additional NHS Contribution	**£13,049,700**	**£13,049,700**	
Total NHS Contribution	**£49,402,113**	**£49,402,113**	

Yes

	2024-25
Total BCF Pooled Budget	**£75,501,388**

Better Care Fund 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

<< Link to summary sheet

	2024-25		
Running Balances	Income	Expenditure	Balance
DFG	£3,837,600	£3,837,600	£0
Minimum NHS Contribution	£36,352,413	£36,352,413	£0
iBCF	£13,438,749	£13,438,749	£0
Additional LA Contribution	£2,182,000	£2,182,000	£0
Additional NHS Contribution	£13,049,700	£13,049,700	£0
Local Authority Discharge Funding	£3,140,153	£3,140,153	£0
ICB Discharge Funding	£3,500,773	£3,500,773	£0
Total	**£75,501,388**	**£75,501,388**	**£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).

	2024-25		
	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£10,381,020	£22,071,404	£0
Adult Social Care services spend from the minimum ICB allocations	£14,202,380	£14,281,009	£0

Checklist

Column complete:

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

>> Incomplete fields on row number(s):

272, 273, 274

									Planned Expenditure											
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Previously entered Outputs for 2024-25**	Updated Outputs for 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	Previously entered Expenditure for 2024-25 (£)	Updated Expenditure for 2024-25 (£)	% of Overall Spend (Average)	Do you wish to update?
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			No
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	£10,480,335			No
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			No
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	£233,509			No
5	Maintaining Independence	Voluntary organisations shcemes	Prevention / Early Intervention	Other	Voluntary sector				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£193,358			No

6	Maintaining Independence	High cost placements	Residential Placements	Learning disability		3	3	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£612,828	£598,615		Yes
7	Maintaining Independence	Dementia Placements	Residential Placements	Care home		38	38	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,525,301	£2,537,301		Yes
8	Maintaining Independence	Home care	Home Care or Domiciliary Care	Domiciliary care packages		64250		Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,602,862			No
9	Maintaining Independence	Support to self funders	Prevention / Early Intervention	Other	social work support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£64,453			No
10	Maintaining Independence	Dementia Placements	Care Act Implementation Related Duties	Other	Residential care		660		Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£803,016	£811,000		Yes
11	Early supported hospital discharge	Residential, dementia and mental health placements	Residential Placements	Care home		32	32	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,094,181	£2,096,000		Yes
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	£60,226			No
13	Early supported hospital discharge	Hospital discharge and CHC teams	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,208,294	£2,200,000		Yes
14	Early supported hospital discharge	Intermediate care	Personalised Care at Home	other	rapid/crisis response				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£127,849			No
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	£984,751	£986,751		Yes
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		10		Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,162,260			No
17	Early supported hospital discharge	Intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step		0.8		Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£53,887			No
18	Early supported hospital discharge	Support to self funders	Other		social work support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£96,151			No
19	Carers	Support to carers various schemes	Care Act Implementation Related Duties	Other	Carers support				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£162,716			No
20	Carers	Carers support	Carers Services	Other	Carers support	6500		Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£227,169			No
21	Carers	Support to carers various schemes	Carers Services	Other	Various schemes including respite	6500		Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,024,902			No
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	£1,256,334			No
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	£5,292,192			No

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	£43,165			No
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	£1,483,828			No
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	£6,230,515			No
27	Maintaining Independence	Market shaping	Prevention / Early Intervention	Other	market shaping		1		Social Care		LA			Local Authority	Minimum NHS Contribution	New	£43,296	£42,000		Yes
28	Maintaining Independence	Housing schemes	DFG Related Schemes	Discretionary use of DFG		9110	3348	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£1,544,312	£1,593,000		Yes
29	Maintaining Independence	Housing schemes	DFG Related Schemes	Adaptations, including statutory DFG grants			154	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£1,974,000	£2,244,600		Yes
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			No
31	Maintaining Independence	Staffing for lifeline/AT	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	iBCF	Existing	£35,000			No
32	Maintaining Independence	Care home placements	Residential Placements	Care home		64		Number of beds	Social Care		LA			Private Sector	iBCF	Existing	£4,143,749			No
33	Maintaining Independence	Packages of home care	Home Care or Domiciliary Care	Domiciliary care packages		243000		Hours of care (Unless short-term in which	Social Care		LA			Private Sector	iBCF	Existing	£6,049,000			No
34	Maintaining Independence	Social Work	Other		targeted community social work				Social Care		LA			Local Authority	iBCF	Existing	£189,000			No
35	Maintaining Independence	Independent Living	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	iBCF	Existing	£68,000			No
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			No
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			No
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			No
39	Early supported hospital discharge	Hospital to home	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		9		Number of placements	Social Care		LA			Private Sector	iBCF	Existing	£550,000			No
40	Early supported hospital discharge	reablement	Home-based intermediate care services	Reablement at home (to support discharge)		26		Packages	Social Care		LA			Private Sector	iBCF	Existing	£210,000			No
41	Early supported hospital discharge	Step down beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		0.25		Number of placements	Social Care		LA			Private Sector	iBCF	Existing	£21,000			No

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			No
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			No
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			No
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			No
46	Early supported hospital discharge	Intermediate care	Personalised Care at Home	Other	rapid/crisis response		0		Social Care		LA			Private Sector	Local Authority Discharge	Existing	£334,942	£0	0%	Yes
47	Early supported hospital discharge	Intermediate care	Bed based intermediate Care Services (Reablement,	Other	residential beds	5	0	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£355,018	£0	0%	Yes
48	Early supported hospital discharge	Intermediate care	Personalised Care at Home	Other	extra care housing		0		Social Care		LA			Private Sector	Local Authority Discharge	Existing	£121,509	£0	0%	Yes
49	Early supported hospital discharge	Intermediate care	Home-based intermediate care services	Reablement at home (to support discharge)		77	0	Packages	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£657,205	£0	0%	Yes
50	Early supported hospital discharge	Intermediate care	Enablers for Integration	Integrated models of provision			0		Social Care		LA			Local Authority	Local Authority Discharge	Existing	£522,058	£0	0%	Yes
51	Early supported hospital discharge	Intermediate care	Personalised Care at Home	Other	rapid/crisis response				Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£1,006,940			No
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	£1,988,606	£1,988,379		Yes
53	Early supported hospital discharge	Intermediate care	Community Based Schemes	Other	24/25 additnl funding to be agreed		0		Social Care		LA			Private Sector	Local Authority Discharge	New	£1,149,268	£0	0%	Yes
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	£505,454			No

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'		Outputs for 2024-25	Units (auto-populate)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	New/ Existing Scheme		Expenditure for 2024-25 (£)
55	Early supported hospital discharge	DOLS BIAs	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Local Authority Discharge	Existing		£107,000
56	Early supported hospital discharge	Support for self funders	Other		Social Work Support				Social Care		LA			Local Authority	Local Authority Discharge	Existing		£251,000
57	Early supported hospital discharge	Residential, dementia and mental health placements	Residential Placements	Care home			20	Number of beds	Social Care		LA			Private Sector	Local Authority Discharge	Existing		£2,782,153

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

In formulating our plan, we have integrated the principle that capacity is premised on the average monthly discharges over the last 12 months on each pathway, with a 10% uplift applied to account for unused capacity each month. This approach has been instrumental in shaping our assumptions for the 24/25 period. Although there is no planned increase in commissioned packages, our commitment to managing the fluctuations of peak seasons remains steadfast. Enhanced coordination with BCP Council and the ICB, through regular strategic meetings, will continue to be pivotal in optimising our intermediate care services' readiness during these critical periods. Insights gained from the 23/24 Demand & Capacity performance highlight the need for preparedness against unexpected demands, particularly in the latter part of Q4 in 23/24. By strengthening our collaboration with VCSE partners, we aim to bolster their capacity and enhance community awareness, thus mitigating service strain during peak times. Our review of community services has led to a more explicit definition of our social support, collaborating closely with partners Pramalife and CAN Wellbeing to assist post-hospital discharge and prevent admissions via community or hospital signposting.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

Community-based services are operating at a capacity that meets demand, with no anticipated gaps in the upcoming year. There is a potential deficit in P2 capacity following hospital discharge. It is expected that there will be movement to P1 services that will mitigate these shortfalls in P2. The BCF Support team has initiated an 18-week review of our reablement and rehabilitation offerings, with the goal of fostering enhancements where needed. Post-review, our objective is to implement a plan to bring consistency to our intermediate care provisions. Although this review is not expected to alter our service capacity, it is anticipated to enhance outcomes, potentially leading to a decreased demand within the forthcoming year.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

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, considering 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 continues to be our intention as we enter the next part of our two-year plan 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, with ambition that effective intervention will prevent avoidable admissions and admissions linked to falls and chronic ambulatory care conditions. Suitable, alternative pathways are encouraged upon discharge to limit residential admissions to long term residential care with the Local Authority commissioning additional packages of care to further support this. We aim to better utilise the capacity in our reablement services to ensure people can reach independence after being discharged from hospital, while also working with the BCF Support Team to

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

It is crucial to bolster our current health and care bedded facilities by integrating more therapy services and discharge coordination. Occupational Therapists are actively engaging with patients to evaluate their requirements and expedite their discharge with the right POC. Additionally, the implementation of extra care housing offers temporary assistance for those transitioning out of hospital care. Such measures have successfully expedited patient discharges, evidenced by the increase in the rate of supported discharges within 0-5 days from 44% to 52% in the first quarter of 23/24. Despite the potential reduction in certain capacities during the next 12 months, we have sustained a consistent number of new POC, aiming to maintain discharge rates by shortening the LOS for enhanced patient flow. Our review of reablement services has highlighted the need for better referral processes and a stronger therapy-led approach to foster independence. Moreover, we are refining our discharge processes to adopt a person-centred and strength-based methodology, ensuring that every person has a tailored early discharge plan that encompasses intermediate care services. In tandem, we are initiating discussions to strengthen both informal and formal partnerships across these services, with the ambition of improving outcomes for those we serve.

Linked KLOEs (For information)

Checklist Complete:	Linked KLOEs (For information)
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? 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 capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans. Pan-Dorset works together through sharing our capacity data frequently to co-ordinate the right pathway of care, with minimal waiting times and using trends in the data, we can estimate where the peaks will be in the upcoming year and are working towards how we will mitigate the anticipated demand, using the learnings of 23/24 as a guide. Assumptions have been made with historical data from 23/24 Demand & Capacity actuals and expected demand growth from ONS 24/25 population estimates. We have decided that this will be the best tactic to work out the demand, while using our commissioning habits to guide the capacity data.	Yes	Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?
Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	Yes	
Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care. The development of assumptions for intermediate care demand and required capacity is a collaborative process involving BCP Council and the ICB. The ICB informs how we should use the data from the NHS Urgent and Emergency Care (UEC) Demand, Capacity, and Flow model. This data helps to map out anticipated demands for intermediate care services, particularly for patients transitioning from hospital care to intermediate care settings. To support this, we have proposed that we will reduce the length of time from referral to commencement over the next 12 months, starting from a baseline position of April 2024 performance. The trajectory is consistent with what we have said in the UEC delivery plan, ensuring a strategic approach to meeting the needs as efficiently as possible. The process ensures that there is a comprehensive understanding of the needs and resources required to facilitate effective patient care and service delivery. The collaboration on this adheres to the BCF planning requirement of the need for joint agreement on plans, ensuring that all stakeholders, including local Health and Wellbeing Boards (HWBs), are aligned in their approach. This collaborative planning is crucial for maintaining a seamless continuum of care that supports patients in staying well, safe, and independent at home for longer, as well as providing the right care in the right place at the right time.	Yes	Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people. We continue to use the Additional Discharge Funding by commissioning schemes such as our Extra Care Housing that will support hospital discharges for people who are medically fit who could yet return to their normal place of residence. We are refining our expenditure schemes to adapt to changing needs, notably the increased funding of step up and step-down beds at Figbury Lodge, which are instrumental in delivering tailored care. This approach ensures people regain their independence optimally within an environment that encourages recovery, and providing independence, which is a part of the conditions that are stated by the ADF grant to allocate the funding. Also, we want to continue the sustained success achieved through our Rapid Response program, which we designate 1395 hours weekly for D2A processes, this has been instrumental in ensuring efficient patient discharge from hospitals and addressing their immediate needs.	Yes	Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Is the plan for spending the additional discharge grant in line with grant conditions?
Please describe any changes to your Additional discharge fund plans, as a result from **o local learning from 23-24** **o the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)** The performance in the Reablement metric demonstrated the need to review our Reablement services, and a 3-month sprint was conducted in 23/24 Q4 to evaluate how we currently deliver the Reablement services we have across the Bournemouth, Christchurch, and Poole locality. While we found the ADF did help patients with "no criteria to reside" to be discharged more promptly, the Reablement package they then undertook did not always deliver the outcome that was desired. We focus our spending from the ADF on home care hours and intermediate bed-based care. In 23/24, working with our Reablement provider we did try to improve workforce numbers, but this was unsuccessful, so we utilised the funding on rapid response hours and on step up and step-down beds to ensure we were still able to support people post discharge.	Yes	Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics? BCP Council has appointed a Better Care Fund Manager. This role will oversee the performance of the BCF metrics and objectives. They will enhance the quality of data collected relating to the metrics, spend & activity of the schemes, and collaborating closely with partners within the ICB and Local Authority. This collaborative effort is directed towards fulfilling the objectives outlined in our strategic planning document as well as adhering to the BCF 2023-2025 narrative from June 2023.	Yes	Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	218.3	213.4	229.0	205.0	24/25 target is 2% reduction in level of avoidable admissions. Activity level in Q3 23/24 were 1,270 (141 more avoidable admission than the same period last year), although Q4 national figures are not yet available based on the annual average expected to be higher than planned levels. Rationally for 24/25 will be to address the increasing trend and look to reduce overall levels of avoidable admissions.	Introducing two Trusted Assessors in the hospitals within the Bournemouth, Christchurch, and Poole locality. These assessors are instrumental in assisting patients to alternative care pathways, thereby supporting faster discharges. By leveraging community-based services, including social support such as CAN and Pramalife. As well as the Urgent Community Response team capable of intervening promptly, to ensure that people receive the right care at the right time	Yes
	Number of Admissions	1,064	1,040	-	-			
	Population	400,109	400,109	-	-			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
	Indicator value	214	209.1	255.4	226.2			Yes

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

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,033.9	2,237.3	2,192.6	23/24 are estimating an 8% increase in activity. 24/25 plan is a 2% reduction on estimated 23/24 outturn performance which is in line with the overall ambition for avoidable admissions.	The ICB Falls Prevention Service will integrate fall prevention and intervention within care pathways, focusing on the frail population. Scaling up effective practices from our Primary Care Networks is also crucial. Moreover, enhancing the visibility of Urgent Community Response (UCR) services will aid those who have experienced a fall, facilitating care before hospitalisation becomes necessary and aiding in their recovery. Collaborating with the BCP Housing team, we aim to adapt homes to improve safety and support individuals in maintaining their	Yes
	Count	1,973	2168	2125			Yes
	Population	86,859	86859	86859			Yes

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	94.6%	94.2%	93.8%	93.8%	24/25 ambition to achieve 94.5% discharge rate to their normal place of residence.	We want to continue the ongoing effectiveness of our Pathway 1 offerings, which include home-based reablement and rehabilitation, as well as short-term domiciliary care, we ensure that patients receive the right care, at the right place, at the right time. This approach not only supports the well-being of our patients but also reinforces the continuity of care that is vital for their long-term recovery and independence.	Yes
	Numerator	8,472	8,323	7,835	8,151			
	Denominator	8,957	8,837	8,353	8,690			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
(SUS data - available on the Better Care Exchange)	Quarter (%)	94.5%	94.5%	94.5%	94.5%			
	Numerator	8,706	8,462	8,785	8,515			Yes
	Denominator	9,213	8,955	9,297	9,010			Yes

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
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	398.3	367.0	398.1	408.0	In line with 23/24 performance, with a slight increase in proportion of estimated population growth. We will continue to reduce our reliance on residential care as stated in the BCP Council Care Home strategy as we drive towards enhanced intermediate care offers, while ensuring we are providing people with the right care, at the right place, at the right time.	Further utilisation of alternative pathways to assist people being discharged. This includes the provision of extra care housing, which offers temporary assistance to those transitioning from hospital to home, ensuring they can return to their usual residence promptly and safely. We also offer the use of D2A beds at Coastal Lodge to expedite patient flow from hospitals.	Yes
	Numerator	346	330	358	372			Yes
	Denominator	86,859	89,917	89,917	91,169			

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

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

Better Care Fund 2024-25 Update Template

8. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	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
C1: 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 (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* 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* Have all elements of the Planning template been completed? *Paragraph 11*	Cover sheet Cover sheet Cover sheet Cover sheet	No		For the Health & Wellbeing board to approve the plan in retrospec at the next meeting.	At the next Health & Wellbeing board meeting on Monday 15th July 2024.
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update					
	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? 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?	Cover sheet Planning Requirements	Yes			

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** - **Support people to remain independent for longer, and where possible support them to remain in their own home** - **Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?		Yes			
Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	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? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?		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**	PR 4 and PR6 are dealt with together (see above)					
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 and NHS commissioned out of hospital 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? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?		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? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? 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		Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?		Yes			

HEALTH AND WELLBEING BOARD

Report subject	**University Hospitals Dorset (UHD) Maternity paper**
Meeting date	15 July 2024
Status	Public Report
Executive summary	To provide the committee with an update on the provision of maternity services at UHD.
Recommendations	**It is RECOMMENDED that:** **The committee note the paper.**
Reason for recommendations	Committee update only.

Portfolio Holder(s):	Cllr David Brown, Cabinet Member for Health & Wellbeing
Corporate Director: Directors:	Jillian Kay, Director of Wellbeing Betty Butlin, Director of Adult Social Care Phil Hornsby, Director of Commissioning
Contributors:	Lorraine Tonge Director of Midwifery UHD Sarah Herbert Chief Nursing Officer UHD
Wards	All Wards (Maternity services)
Classification	For Update and Information.

1. Background

1.1 The paper is to provide public assurance of the maternity services at University Hospitals Dorset UHD and the current service provision. The paper will also highlight the planned move of maternity services to the new BEACH (Births, Emergency, And Critical care, children's Health) Building on our Royal Bournemouth Hospital site in Spring 2025 and outline planning and the preparation stages for this move.

2. Current Maternity Services at University Hospitals Dorset

2.1 The maternity service at UHD is located at St Mary's Hospital Poole and is an obstetric unit with a midwifery led birthing centre alongside. Care is shared between midwifery and medical staff and is undertaken in community settings across east Dorset and within the maternity hospital.

2.2 St Mary's Maternity Hospital is the centre for all high-risk care in east Dorset and is fully equipped to meet the needs of parents and babies with complications, as well as women with normal pregnancies and births.

2.3 From April 2023-March 2024 there was 3,629 babies born.14% were born in the midwifery-led birthing centre and 85% in the delivery suite and 1% at home. There were approximately 40% of babies born by Lower Segment Caesarion Section and

50% by normal delivery, with 10% having an assisted delivery. 1:1 care was provided in labour by the midwife 100% of the time ensuring safe care was provided.

2.4 Postnatal care is provided, either on the postnatal ward, or at home by the community midwives and maternity support workers. Length of stay will depend on the needs of the mother and baby and will vary for each person. For example, women with babies in the Neonatal Intensive Care Unit (NICU) or on the Transitional Care Unit may stay longer, as will women who have undergone an assisted delivery or caesarean section.

3 CQC maternity inspection

3.1 Our regulators the Care Quality Commission (CQC) inspected the maternity services in November 2022. The overall rating went down from the previous inspection from good to inadequate.

UHD maternity services were rated as inadequate for safe and well led because:

- The service did not always have enough midwifery or medical staff to keep women and babies safe.
- Systems and processes for assessing and responding to risk in maternity were not always effective, especially in maternity triage.
- The maintenance of the environment especially in relation to the emergency call bell systems were not sufficient to maintain patient safety.
- Managers did not always investigate incidents thoroughly or in a timely way.
- The delivery of high-quality care was not assured by the governance and risk management processes. (CQC maternity report March 2023).

3.2 The Trust has responded to this result by completing a detailed action plan which has been monitored through the Integrated care Board ICB. The trust looks forward to welcoming the return of the CQC to be able to demonstrate the progress we have made since the inspection.

Actions fully completed are:

- Midwifery vacancies now at 0% and new medical staff have started with remaining medical staff interviews booked in July.
- A full review of maternity triage has been completed, and the service was remodelled to provide 24-hour triage with waiting times monitored continuously. The service is now seen as one of the best within the country with other units following our model of care.
- A new call bell system has been installed and there is a system in place to monitor maintenance requirements ensuring repairs are done in a timely way.

- Managers have been developed and had training on investigations, risk and the governance processes.

3.3 The maternity team continues to strive to make improvements and we await a reinspection from the regulators.

3.4 Other improvements also continue following the national maternity programme for transformation and safety which also is monitored through the ICB Local maternity neonatal system (LMNS).

3.5 Some key achievements have been;

- Providing continuity of care for women in lower social economic areas and ethnic minorities (as national poorer outcomes and health inequalities for these women.)
- Improving pelvic health provision and physiotherapy services for antenatal and postnatal women.
- Improving mental health provision
- Increasing our provision of maternity voices partnership (service user voice) and working in collaboration on our service improvements.
- Digital inclusion to enable women who have digital poverty to have access to the internet during their pregnancy and for six months postnatally, as many of the sources of information from healthcare is on digital applications.

4. Our next steps in 2025

4.1 In Spring 2025 the maternity service located at St Mary's Hospital is planned to relocate to the new Beach building for all maternity services on the Royal Bournemouth Hospital site. This means parents who are pregnant over the summer may have their baby in the new building.

4.2 The maternity unit will be across three floors, including antenatal clinic, ultrasound, fetal medicine centre, antenatal ward, midwifery low risk birthing unit, obstetric labour ward, postnatal ward and transitional care unit. The neonatal unit is also adjacent to the ward, and we will work together in providing care for parents and babies.

4.3 The team are in the preparation stages for the move and working with the maternity and neonatal voices partnership hearing from service users and being involved in the move plans.

4.4 The move plans include:

- A communications strategy to inform services users of the changes. The ICB MNVP's are assisting with this work and all channels of communication will be used.
- Preparation of the workforce to ensure staff are confident in their new place of work with practiced simulation session and understanding of the new environment.
- A workforce plan has been agreed to ensure safe staffing on both sites as one site is moved, and the other unit is closed.
- The move plan is in development taking safety and risk assessing at each stage of the move. We are completing a full review, and a process is in place to ensure safety throughout the move period to all women.

4.5 The team is looking forward to this move and having an improved environment to deliver care for a better experience for all families in east Dorset.

4.6 Should the committee have any further enquires the team from UHD would be happy to attend as required. We would also be delighted to welcome members to our new BEACH building so we can show you the new facilities and so you can meet the team.

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Forward Plan - BCP Health and Wellbeing Board – 24/25 Municipal Year

Updated: 1 July 24

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
15 July 2024					
	Eliminating Food Insecurity: Access to Food Partnership	For the Board to receive an update	Committee report/presentation	Amy Gallacher, Community Initiatives Manager	
	Dorset Healthcare	To update the Board on the joint management structure with Dorset County and how this works for BCP residents.	Committee report/presentation	Matthew Bryant	Requested by the Chief Executive.
	NHS Dorset 5 Year Joint Forward Plan refresh and Performance Assessment	To provide the Board with an updated on the refreshed Joint Five Year Forward Plan 2024/25.	Committee Report	Professor Neil Bacon Chief Strategy and Transformation Officer NHS Dorset	Added by Jillian Kay
	Pharmaceutical Needs Assessment (PNA)	For the Board to consider proposals for the set up and governance of the pharmaceutical needs	Committee Report	Sam Crowe, Director of Public Health Dorset	Requested by SC via email on 24/5/24

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
		assessment which is due for publication October 2025			
	Better Care Fund 2023-25 Quarter 2 and 3, the End of Year Report 2023-24, 2024-25 Planning Template	To approve the Q2 and Q3 returns	Committee report	Scott Saffin, Commissioning Manager – Better Care Fund and Market Management	Requested by Scott via email on 12/3/24.
	Update on changes within maternity services	To enable the Board to be updated regarding the changes in maternity services	Information only report	Siobhan Harrington, Chief Executive, University Hospitals Dorset NHS Foundation Trust	Requested at Board on 5/2/24.
21 October 2024					
	BCP HWB Strategy and action plan	For the Board the consider the proposed Strategy refresh and action plan	Committee report	Sam Crowe and Jillian Kay	Requested at Board meeting of 5 Feb 24

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
Future items to be allocated to meeting dates					
Changes to hospitals, role of hospitals and responding to the needs of Communities		To consider the changes going on in local hospitals to include significant changes in mental health provision.		TBC – highlighted by Richard Renaut	
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
Better Care Fund		To receive a mid year progress update	Committee Report	Phil Hornsby?	Requested at meeting on 20 7 23.

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