BCF narrative plan template

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

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

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

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

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

Cover

Health and Wellbeing Board(s)

Bournemouth, Christchurch and Poole (BCP) Council

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

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

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

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

How have you gone about involving these stakeholders?

Specific stakeholders have been involved in shaping the individual schemes through consultation and standard planning procedures. The overarching plan, which is a collection of all the individual schemes, has been reviewed by the accountable colleagues described above. Much of this year's plan reflects and builds on schemes which were established in previous years, these schemes have been developed and refined through continual dialogue and review by the respective stakeholders.

The value of investment in each of the prioritised schemes is as follows:

Scheme Description	CCG contribution £000	BCP (Bournemouth Christchurch and Poole) contribution £000	Total £000
Maintaining Independence	8,384	13,892	**22,276**
Early Supported Hospital Discharge	6,082	3,065	**9,147**
Carers	1,233	0	**1,233**
Moving on From Hospital Living	7,428	2,182	**9,610**
Integrated Health & Social Care Locality Teams	22,027	0	**22,027**
Total	**45,154**	**19,139**	**64,293**

2.2 Key changes since previous BCF Plan

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

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

A new BCP Carers Strategy has been drafted to be published this year. This new strategy has been developed with our BCP Carers Reference Group and the wider Pan Dorset Carers Steering Group. It builds on what has already been achieved across BCP and wider Dorset. It has also been informed by carers' experiences during the pandemic. This will help shape the future direction of services funded for carers under the BCF We also recognise the changing ICS landscape and the opportunity this provides us to further develop place and neighbourhood services.

A complete review of all people funded under the Moving on from Hospital Living Programme has recently been completed, which will help inform future joint funding arrangements for the cohort of people with learning disabilities who moved on from hospital accommodation.

The current provider contract for our pan Dorset 'Equip for living' Integrated Community Equipment Service is in its final year. We have therefore gone out to tender for this service.

During the course of 2022/23 we will seek to review the application of the BCF and, where agreed by all partners, re-allocate funds to schemes and initiatives that might better support achievement of our shared goals for the BCF and any future government requirements for 2023/24.

Governance

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

This plan has been agreed jointly by NHS Dorset and BCP Council and will be monitored by both organisations with quarterly reports submitted to NHSE, as required. BCF planning submissions are approved by Dorset's Joint Commissioning Board on 23 September and subsequently approved by the Health and Wellbeing Board, which for this submission, will be on 13th October.

Prior to formal approval, this year's plan has been authorised by the DASS, Section 151 Officer and the Chief Executive for BCP Council, and by the Chief Commissioning and Chief Executive Officers for NHS Dorset.

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

Overall BCF plan and approach to integration

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

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

iBCF & BCF Schemes	What these include:
Maintaining Independence via Equipment and My Life My Care	Pan Dorset's Integrated Community Equipment Service BCP manage this contracted service on behalf of both Local Authorities and NHS Dorset. It has continued to support and enable people to maintain their independence. As stated above the current provider is in the last year of their contract. We are therefore currently out to tender for this service. Our revised service specification reflects the need for flexibility as we develop our emerging models for out of hospital and community-based care, especially in relation to our Home First programme and design of an integrated intermediate care service. **2021-2022** was the second year of the pandemic and the start of the recovery from Covid restrictions. Whilst same-day next-day ordering of community equipment reduced compared to the previous year, these priority activity levels remained high, (29% of contract spend), reflecting the continued focus on supporting hospital discharge. Unprecedented equipment supply costs caused by ongoing international shipping disruption also put pressure on the service's budget. **2022-2023** Financial contributions for the pooled budget this year have remained unchanged. This is the last year for the current contract and the impact of Covid over the past two years have made predicting contribution increases challenging. Quarter 1 has seen a modest falling back on gross costs and a recovery in credit performance. Equipment supply costs remain impacted by inflationary pressure which will impact on non-contact and to a lesser extent contract equipment cost. The service continues to see high, albeit now stable levels of same day/ next day ordering (down to 24% of spend in Qtr 1). There has been a 5% increase on 3-day deliveries up from 63% in 2021/22 to 68% in the first Qtr of 2022/23. Data source: 2022/23 Qtr 1 Financial Summary Report. Equip for Living Partnership. The service continues to cope well, albeit some stock challenges. In the first qtr of 2022/23 6,954 people received an equipment delivery in line with same qtr for 2021/22 and 2019/20, (note 2020/21 saw a drop in performance due to Covid). Collection performance has also returned to pre-covid performance levels. Over the last year, the online information and advice service My Life My Care has added new pages that have been co-designed with user and carer focus groups. The website received over 6,000 hits each month, with around

	20% of these users being returning customers such as health partners and social care staff and 80% being new visitors including our residents of the BCP area. My life my care will be decommissioned at the end of 2022 and the webpages and directory will be moved in house to the BCP website. This work will allow us to be more creative, improve the information and advice offer and add new functions such as newsreel banners and better search functions. Stakeholders are involved in this project and will be co-designing content, assisting with promotion and developing new information around prevention and wellbeing. Conversations are being held with health partners and voluntary organisations, as to how we can join up information and advice services, particularly our directories, so we can share resource and provide more robust signposting services that support the prevention agenda and working from a strengths-based approach. In addition, whilst not directly tied to our BCF plan for this year, NHS Dorset will be working with Aged Care Technologies on an Anticipatory Care proof of concept model that aims to help older people living at home report concerns about their wellbeing, independence, social connection and staying healthy, connecting them to sources of support. Sources of support will include: • access to information resources for self-management; • signposting to local services to address priorities for help; • referral for further assessment and intervention foundation to manage key risks at an early stage; • support their family carers by identifying those who would benefit from care assessment services. It will support the general development of population approaches to integrated, person-centred anticipatory care, using the most efficient methods for assessing needs and providing support making optimal use of community assets.
Early supported discharge	This scheme continues to respond to the national 8 high impact changes that make a difference to discharge planning. This includes working with acute hospitals in planning for safe discharge into community settings. A ICB Programme Board is introducing new governance arrangements to oversee the design and ongoing development of community based-services and out of hospital care-models, with strategic oversight through a new Integrated Neighbourhood and Community (INC) Oversight Group. Operation Directors and Senior Leads with key enabling/specialist leads as required will join a Home First Design and Delivery Group, reporting to the new INC, with a focus on integrated intermediate care. Proposals are to form two footprints (East and West), with system partners working together to align intermediate care and reablement resources and agree process that reduce hand-offs and manage the collective resource over the winter period and beyond. (With expectation that this will drive up utilisation and efficiency in the capacity we have).

	Reablement, rapid response services and step/down bed capacity will be increased to support system over the winter period. High level system wide outcomes/outputs include: 1. Reduction in no of patients medically fit for discharged and delayed (P1) 2. Reduction in LOS (average time of delay) 3. Increase in utilisation of P1 capacity 4. Improved patient outcomes 5. Improved staff experience
Carers	Please refer to specific section for update on Carers below.
Moving on from Hospital Living	This pooled budget funds integrated personalised care for people with complex needs who have moved on from long stay hospital accommodation. Since 1 April 2019, this has been a pooled budget between BCP Council and Dorset Clinical Commissioning Group/NHS Dorset covering Bournemouth, Christchurch and Poole, with a duplicate pooled budget between Dorset CCG/NHS Dorset and Dorset Council. A review of all individuals supported within the pooled budget has recently been completed and discussions are ongoing between partners to finalise the longer-term arrangements of the pooled budgets. The majority of people supported under this pooled budget agreement remain in settled accommodation.
Integrated Health and Social Care Locality Teams	A multi-disciplinary Health and Social Care approach continues to be further developed across physical and mental health teams; adult social care staff and the voluntary sector working closely with General Practice and Primary Care Network teams to support people who have long-term conditions; are frail and those with complex needs. These teams provide both proactive and reactive care and are a key to the development of our out of hospital care model, aligned with both anticipatory care and hospital flow. NHS Dorset's Ageing Well Programme includes the development of our urgent community response service, enhanced health in Care Homes work and anticipatory care all linked to our integrated locality teams. This year following the publication and commitment of ICS' to take forward the recommendations within the Next steps for integrating primary care: Fuller Stocktake Report, we will be working with all system partners to strengthen our MDT model and to further build our team of teams. The Home First Programme continues to review and enhance our rapid response services as part of a wider intermediate care pathway provided in the community as well as deliver in-reach into ED (Emergency Department) departments.

Implementing the BCF Policy Objectives (national condition four)

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

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

Please use this section to outline, for each objective:

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

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

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

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

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

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

The Better Care Fund Plan is enabling further integration by developing and maintaining strong and sustainable care markets, but also shifting the focus to strengths-based approaches and asset-based commissioning. Key elements of this work are:

- Continued remodelling of Coastal Lodge care home to offer enhanced intermediate care beds for the ICS (Integrated Care System) as part of the Home First Programme.
- Reviewing the joint Homecare Framework for BCP and NHS Dorset which has exceeded its original targets and is now due for renewal.
- The Brokerage Service's Care Allocation Team which directly supports the hospitals with speedy discharge and flow.
- A single reablement provider working across the conurbation (replacing the tow legacy arrangements) to deliver an integrated reablement offer to facilitate with discharges and moving forward a greater focus on preventing admission.
- An extension of the Reablement service with additional winter pressures funding to meet growing demand and focus on admission avoidance so people receive the right care at right time.
- Provider relationship management and meaningful partnership working between the market and LAs (local authorities) continues, through dedicated forums for both residential care and home care.

Market Engagement and Quality Management

- Provider relationship management and meaningful partnership working between the market and LAs (local authorities) continues. Dedicated provider engagement incorporates forums, workshops, focus groups and information sharing have shifted from managing the pandemic to wider agendas of ongoing market sustainability and meeting demand.
- The Council's Service Improvement Team works Close with NHS Dorset Quality Team and has re-established a programme of actively, monitoring both care homes and domiciliary agencies, to ensure quality is delivered with the Council's contracted providers. This information is shared through the ICS Care Quality Monitoring and Intelligence Group and Quality Surveillance Group.
- The Council is in the process of completing a Fair Cost of Care Exercise which will help inform the commissioning of residential care and home care.

Enable people to stay well, safe and independent at home for longer

- BCP Council Extra Care Strategy and Home Care Strategy have now moved into implementation stage.
- A Care Technology review and options appraisal has been completed with proposals being considered for enhancing offer as a key preventative service in the future.
- A new Carers Strategy is in the process of final sign off before publication.
- A specialist housing needs assessment has been undertaken to inform future Housing delivery plans for young people in transition with and all adult groups to reduce reliance on residential care and out of area placements.
- Work continues with the Community Action Network (a voluntary sector collaborative) to support P0 patients at point of discharge and to support people in the community to avoid admissions.

More widely, the Dorset ICS has continued to have a focus on personalising care and this year we have the following key objectives and delivery plan:

Foster a cultural shift in the relationship between health and care practitioners and people

• Personalised Care Plan – (i) Map current personalised care implementation against the five major changes in the LTP (ii) Work alongside Age Care Technologies (ACT) to develop and implement a strategy and plan that encompasses insight, culture change and the development of a personalised anticipatory care approach for Dorset ICS (iii) capture the learning to inform future spread and scale of personalised care, tailored to Dorset system priorities.

• Baseline – Establish a baseline for Personalised Care activity across the system. Build on progress to date to improve coding, reporting and insights to measure activity and impact.

• Workforce Development – Building on progress to-date, continue to develop Workforce Plans to ensure the right skills across workforce to maximise personalised care (i) Framework offer for PCN's to support non-clinical roles – PCI accredited training; supervision; peer support community of practice (ii) Support the on-going development of a Competency Framework for Non-Clinical roles (iii) PCI accredited facilitator training to build capacity to deliver PC training across the system (iv) embed e-learning (v) embed personalised care training and workforce development into the development and deployment of the ACT tool.

• Clinical and Senior Leadership and Governance – (i) re-appoint a SRO for Personalised Care for Dorset ICS (noting Executive change within newly formed ICB) (ii) Ensure senior system leadership participation in the SWIPC Enabling Board (iii) ensure personalised care is embedded within the ICB and ICP to ensure focus on the right priorities and make decisions so that our ways of working become increasingly personalised over time.

• Commissioning for outcomes: Through the implementation of phase 1 and 2 of the ACT tool, we aim to build our understanding of, and reconfigure the way in which we specify and commission services so that they are able to work in ways that may be bespoke to individuals, families and communities.

Maximising the benefits of personalised care in tackling health inequalities

• ACT interventions reduce inequalities by ensuring that people less likely to report their concerns are targeted and encouraged to undertake an assessment. Furthermore, the needs identified by older people can be analysed for socio-economic variables to inform population health management.

• Explore how the adoption of a Health-Related Activation Tool for Dorset System could enhance personalised care and support planning.

• Personal Health Budget (PHB) Expansion – (i) Identify potential areas for expansion including: the development of One-Off PHB's to support Home First (admission avoidance and support discharge from hospital) (ii) PHB development in Primary Care – development of 'one off' budgets to support prevention, anticipatory care and admission avoidance– delivered through non-clinical roles / wellbeing team (including, but not limited to, care planning through the ACT tool). (iii) Identify areas in the system where PHB's / IB's are being used and ensure captured in NHSEI data return (vi) support system partners to develop a PHB / IB offer.

- **Optimal delivery of place-based integrated health and care**
- • Ensure the development of a place-based model of personalised care by (i) streamlining access to care and advice (ii) providing more proactive personalised care, supported through neighbourhood multidisciplinary teams and utilisation of community assets.
- • Supported Self-Management: (i) Review Dorset Self-Management Service contract – 2 x Place-based engagement events to inform service requirements from 2023-34. (ii) Support PCN's to deliver the DES requirements for personalised care – As part of a broader social prescribing service, PCN's must work with stakeholders including LA Commissioners, VCSE partners and local clinical leaders, to design, agree, put in place and review a targeted programme to proactively offer and improve access to social prescribing to an identified cohort.
- • Aging Well Programme: (i) Develop and embed digitally enabled PCSP in all interventions and care planning approaches including the adoption of the ACT tool. • Develop End of Life personalised care and support planning.
- • Service Design and Improvement - support health and care providers to implement personalised care across all care pathways.
- **Improving outcomes through Personalised Care**
- • Improving sustainability through personalisation – Develop Framework / guidance on evaluating the impact of Personalised Care for Dorset including: (i)) Measuring impact of self- management interventions and strategies for individuals, populations / cohorts and the system (iii) Planning and stratifying to help identify need and risk and inform commissioning and resource allocation.
- • Improve coding and reporting to enable performance management of services and support, including possible adoption of a Social Prescribing Platform interoperable with SystmOne and aligned to the developing national dataset for Social Prescribing.
- • Develop use of intelligence-led data – Develop DiiS Insights pages to improve proactive personalised care; combining effective use of population health management approaches to identify who and why and Personalised Care approaches in terms of what and how.
- • Elective Care - Support the elective care recovery (i) continue to support secondary care to develop shared decision-making and the use of SDM tools (ii) Embed Shared Decision Making (SDM) in S2M for all NHS standard contracts (iii) Support patients to 'wait well' for elective care by integrating supported self-management (social prescribing, health coaching and community-based support) into 'My Planned Care' (iv) support Patient Initiated Follow Up (PIFU).
- • UEC - Support system partners to optimise care pathways to deliver personalised care to High Intensity Users (i) Embed Social Prescribing and VCSE support to support admission avoidance and discharge arrangements.

- Alongside this NHS Dorset has a focussed programme of work to develop our out of hospital health and care model. We are working together across the system on a range of initiatives that are aligned to our BCF Plans, such as Ageing Well (Urgent Community Response/Enhanced Health in Care Homes and Anticipatory Care), Intermediate Care, and Virtual Wards.

- In addition, we will be taking forward plans to develop our neighbourhoods and place governance and operational models.

Supporting unpaid carers.

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

A comprehensive review of the support available to unpaid carers, including young carers, is currently underway. The scope of the review has been co-designed with carers and in consultation with elected members. The purpose of the review is to develop a BCP carers strategy, distinct from the Pan Dorset Strategic Vision, which is also in the process of being reviewed and refreshed by the Pan Dorset Careers Steering group. We continue to see an expansion in membership of the carer's information service, which currently stands at 5731 carers, and an increasing number of contacts to the carers centre. Local measures identified that over 2400 carers had accessed services, information, and advice up to September 2021, which is an increase of over 100 carers since August 2021. This evidences the continued need for support following the impact of the Covid 19 pandemic with services such as Day Centres still not being fully available.

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

Carers Week was celebrated online in partnership with Dorset Council, the NHS and partner organisations and a video was produced to highlight the services available to carers across Dorset.

The provisional carers budget funded by the Better Care Fund for 2022/23 is as follows:

Carers Budget	**22/23 Provisional (£)**
Carers Support	509,000
Carers Team Staffing	144,800
Respite	577,200
Total	**1,231,000**

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

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

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

- Carers Information Service: provided by the BCP carers support service - CRISP
- Time to Talk counselling service by the Leonardo Trust: up to 6 free counselling sessions are available for carers who would benefit from this support
- Befriending and Mentoring service by Prama Life: this includes both one to one support and group sessions
- Carers Advocacy Service by Dorset Advocacy and Help and Care: free advocacy support specifically for carers
- Beach Huts: 4 beach huts are available across Bournemouth, Christchurch and Poole for carers to take a break
- Holiday Lodges: 2 holiday lodges are available in Brixham and Weymouth for carers to take a break
- Care Free Choir: a weekly choir for carers
- Carers Card: an ID card for carers which also providers discounts and concessions at local and national businesses

The new BCP Carers Strategy for 2022-27 is also going to be released this year which will outline 5 key priorities to improve outcomes for carers.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

- Significant proportion of DFG funding (circa £2m) is retained within Housing to support with complex adaptations in people's homes. This work was hampered during COVID but is now picking up pace.
- DFG Adaptations Staffing increased to cover needs of all of BCP area, following local government reorganisation in 2019, (delayed due to Covid).
- A Large proportion also funds the Community Equipment service, (circa £1.5) including provision of ceiling track and gantry hoists. These will all be part of the new tender.
- BCP Homes continues to fund adaptations work in own housing stock using the Housing Rent Account (HRA).
- DFG being used to part fund an Occupational Therapy post in the ASC Front Door Team, to provide short term interventions and advice as part of Right Care at Right Time.
- New policy and governance arrangements to manage discretionary funding requests for complex cases exceeding £30k threshold.

Looking forward 2023/24

- MDT outreach service to support homeless people and those under the Housing/Hospital Discharge Pathway, (University Hospital Dorset/ASC and Housing Staff) is currently funded through short term funding, but will require longer term funding for 2023/24 to continue. To discuss if appropriate for wider BCF funding as supporting hospital discharge and admission avoidance.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

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

A pan-Dorset Health Inequalities Group oversees our work on health inequalities. It is a multi-agency group supporting our approach to reducing health inequalities through raising awareness, creating learning and development opportunities and supporting services to think differently to create new ways of delivery. A series of workshops has explored topics such as 'What are Health Inequalities?', 'Health Literacy', 'Building resilience in Dorset's communities' and 'Tackling Health Inequalities'. Through the workshops attendees from across the local System identified what actions they could take on an individual, organisational and systematic basis in order to address the themes raised and discussed in each session. Further information can be found here: Health Inequalities – Our Dorset

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

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

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

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

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

This year will see the retender of the 'Equip for Living' community equipment service. An equalities impact assessment has been completed to inform the new specification for this service along with feedback from people accessing the service.