Health and Wellbeing Board

BCP Council

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

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

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

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

How have you gone about involving these stakeholders?

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

Governance

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

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

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

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

Executive Summary

This should include:

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

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

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

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

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

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

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

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

Key changes since previous BCF Plan

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

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

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

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

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

National Condition 1: Overall BCF plan and approach to integration

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

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

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

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

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

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

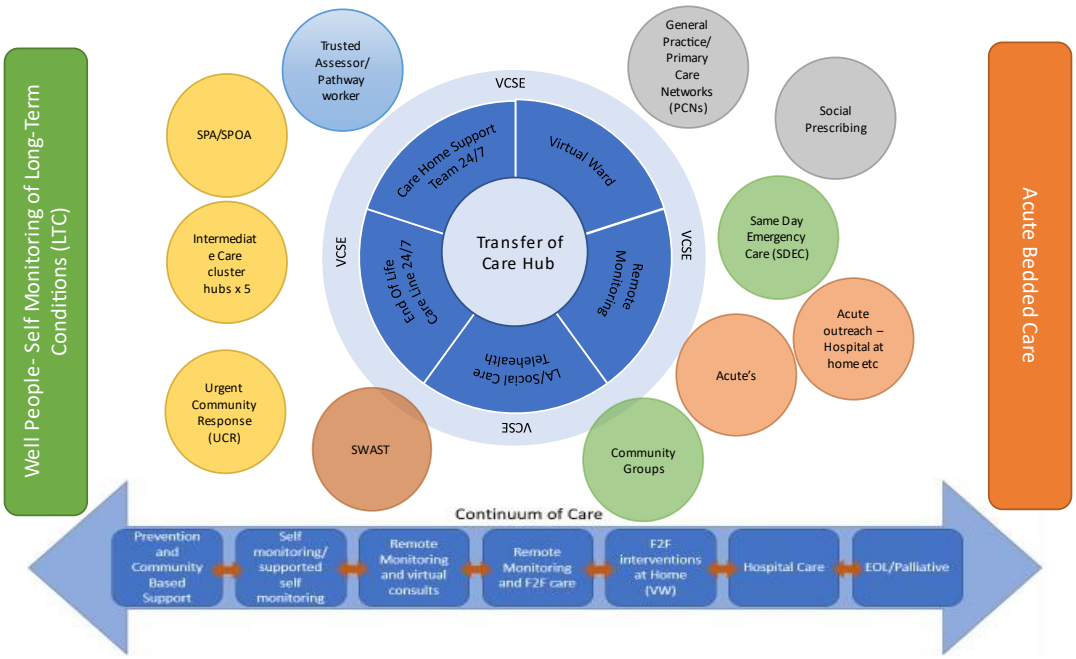
BCP is a key partner of the Dorset Integrated Community and Neighbourhood Oversight Group which reports into the Joint Commissioning Board. This group has oversight of the transformation programme to deliver an integrated community care model that supports more people to remain safe and well in their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

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

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

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

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



National Condition 2

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

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

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

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

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

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

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

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

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

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

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

  See National condition 3

National Condition 2 (cont) –

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

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

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

Approach to demand and capacity

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

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

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

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

Demand and capacity profile for 2023/24

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

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

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

Pathway 0 (VCSE offer)

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

Pathway 1 Rehab and Reablement offer

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

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

Pathway 2 Rehab and Reablement offer

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

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

Pathway 3 placements

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

Overall system flow

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

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

National Condition 2 (cont)

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

- Unplanned admissions to hospital for chronic ambulatory care sensitive conditions

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

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

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

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

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

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

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

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

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

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

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

National Condition 3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

National Condition 3 (cont)

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

- Discharge to usual place of residence

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

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

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

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

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

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

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

National Condition 3 (cont)

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

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

National Condition 3 (cont)

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

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

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

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

Supporting unpaid carers

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

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

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

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

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

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

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

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

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

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

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

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

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

Disabled Facilities Grant (DFG) and wider services

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

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

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

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

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

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

Looking forward 2023/24

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

Additional information (not assured)

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

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

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

Equality and health inequalities

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

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

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

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

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

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

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

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

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

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

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