Public Document Pack

Health and Wellbeing Board

Date: Wednesday, 26 June 2024
Time: 2.00 pm
Venue: Meeting Room 1, County Hall, Dorchester, DT1 1XJ

Members (Quorum: 5)
Cllr Steve Robinson, Cllr Clare Sutton, Cllr Gill Taylor, Jan Britton, Sam Crowe, Stewart Dipple, Marc House, Margaret Guy, Nicholas Johnson, Theresa Leavy, Martin Longley, Patricia Miller, Jonathan Price, Simon Wraw and Simone Yule

Chief Executive: Matt Prosser, County Hall, Dorchester, Dorset DT1 1XJ

For more information about this agenda please contact Democratic Services
Meeting Contact 01305 224185 - george.dare@dorsetcouncil.gov.uk

Members of the public are welcome to attend this meeting, apart from any items listed in the exempt part of this agenda.

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Agenda

Item **Pages**

1. APOLOGIES

To receive any apologies for absence.

2. ELECTION OF CHAIR

To elect a chair of the Health and Wellbeing Board for the year 2024-25.

3. ELECTION OF VICE-CHAIR

To elect a vice-chair of the Health and Wellbeing Board for the year 2024-25.

4. MINUTES 5 - 10

To confirm the minutes of the meeting held on 20 March 2024.

5. DECLARATIONS OF INTEREST

To disclose any pecuniary, other registrable or non-registrable interest as set out in the adopted Code of Conduct. In making their disclosure councillors are asked to state the agenda item, the nature of the interest and any action they propose to take as part of their declaration.

If required, further advice should be sought from the Monitoring Officer in advance of the meeting.

6. PUBLIC PARTICIPATION

Representatives of town or parish councils and members of the public who live, work, or represent an organisation within the Dorset Council area are welcome to submit either 1 question or 1 statement for each meeting. You are welcome to attend the meeting in person or via Microsoft Teams to read out your question and to receive the response. If you submit a statement for the committee this will be circulated to all members of the committee in advance of the meeting as a supplement to the agenda and appended to the minutes for the formal record but will not be read out at the meeting. The **first 8 questions and the first 8 statements received from members of the public or organisations for each meeting will be accepted on a first come first served basis in accordance with the deadline set out below.** For further information read Public Participation - Dorset Council

All submissions must be emailed in full to george.dare@dorsetcouncil.gov.uk by 8.30am on Friday, 21 June 2024.

When submitting your question or statement please note that:

- You can submit 1 question or 1 statement.
- a question may include a short pre-amble to set the context.
- It must be a single question and any sub-divided questions will not be permitted.
- Each question will consist of no more than 450 words, and you will be given up to 3 minutes to present your question.
- when submitting a question please indicate who the question is for (e.g., the name of the committee or Portfolio Holder)
- Include your name, address, and contact details. Only your name will be published but we may need your other details to contact you about your question or statement in advance of the meeting.
- questions and statements received in line with the council's rules for public participation will be published as a supplement to the agenda.
- all questions, statements and responses will be published in full

within the minutes of the meeting.

7. COUNCILLOR QUESTIONS

To receive questions submitted by councillors.

Councillors can submit up to two valid questions at each meeting and sub divided questions count towards this total. Questions and statements received will be published as a supplement to the agenda and all questions, statements and responses will be published in full within the minutes of the meeting.

The submissions must be emailed in full to george.dare@dorsetcouncil.gov.uk by 8.30am on Friday, 21 June 2024.

Dorset Council Constitution – Procedure Rule 13

8. URGENT ITEMS

To consider any items of business which the Chair has had prior notification and considers to be urgent pursuant to section 100B (4) b) of the Local Government Act 1972. The reason for the urgency shall be recorded in the minutes.

9. BETTER CARE FUND 2023-2025: END OF YEAR PLAN FOR 2023/24 AND 2024/25 PLANNING TEMPLATE 11 - 64

To consider a report by the Head of Service for Commissioning for Older People and Home First.

10. PHARMACEUTICAL NEEDS ASSESSMENT 65 - 70

To consider a report by the Consultant in Public Health.

11. THRIVING COMMUNITIES 71 - 78

To consider a report by the Deputy Director of Public Health and the Thriving Communities Partnership Manager.

12. IMPROVING SOCIAL MOBILITY IN DORSET

To consider a report by the Social Mobility Commissioner.

(Report to follow)

13. SAFEGUARDING FAMILIES TOGETHER EVALUATION 79 - 134

To consider a report by the Corporate Director for Quality Assurance and Safeguarding.

14. WORK PROGRAMME 135 -

To consider the Health and Wellbeing Board's work programme.

15. EXEMPT BUSINESS

To move the exclusion of the press and the public for the following item in view of the likely disclosure of exempt information within the meaning of paragraph x of schedule 12 A to the Local Government Act 1972 (as amended). The public and the press will be asked to leave the meeting whilst the item of business is considered.

There are no exempt items scheduled for this meeting.

Dorset Council

HEALTH AND WELLBEING BOARD

MINUTES OF MEETING HELD ON WEDNESDAY 20 MARCH 2024

Present: Cllr Jane Somper (Chairman), Cllr Cherry Brooks, Sam Crowe, Anna Eastgate, Marc House, Margaret Guy, Paul Johnson, Jonathan Price, Simon Wraw and Simone Yule
Present remotely: Theresa Leavy and Cllr Byron Quayle

Apologies: Patricia Miller, Richard Bell, Jan Britton and Cllr Spencer Flower

Officers present (for all or part of the meeting):
Rachel Partridge (Assistant Director of Public Health), Matt Prosser (Chief Executive), George Dare (Senior Democratic Services Officer), Tony McDougal (Communications Business Partner - Adults and Housing), Sarah Howard (Deputy Director of Place, NHS Dorset) and Sarah Sewell (Head of Service - Commissioning for Older People, Prevention and Market Access)

Officers present remotely (for all or part of the meeting):
Andrew Billany (Corporate Director for Housing) and Jennifer Lowis (Head of Strategic Communications and Engagement)

36. **Apologies**

Apologies for absence were received from Cllr Spencer Flower, Jan Britton, Patricia Miller and Chief Supt. Richard Bell.

37. **Minutes**

Proposed by Sam Crowe, seconded by Jonathan Price.

Decision:
That the minutes of the meeting held on 15 November 2023 be confirmed and signed.

38. **Declarations of Interest**

No declarations of interest were made at the meeting.

39. **Public Participation**

There was no public participation.

40. **Councillor Questions**

There were no questions from councillors.

41. **Urgent items**

There were no urgent items.

42. **Better Care Fund 2023-25: Quarter 3: Quarterly Reporting Template and Case Study**

The Head of Service for Older People and Prevention Commissioning introduced the Better Care Fund quarterly reporting template and case study. A presentation, which is attached to these minutes, highlighted the performance against the Better Care Fund metrics, the spend and Activity, and the case study on the Homes First Accelerator.

The Board discussed the report and members made the following points:

- There were voluntary sector initiatives for helping with discharge from hospital.
- There was a start to looking at carers as part of the Better Care Fund, however there also needed to be conversations about young people and care leavers.
- There needed to be a piece of work that looked more widely at the Better Care Fund, rather than just the parts relevant to the Board.
- Further working at place and neighbourhood levels would improve working with community initiatives.
- Senior leaders needed to have an understanding of the Better Care Fund and where the resources were going.
- Healthwatch were planning to create patient diaries on the integration of care.
- The Better Care Fund was a 2-year plan however there were opportunities to change the 2nd year.
- The Better Care Fund was a pooled fund, so it would be possible to include budgets from Children's Services and Housing in it.

Proposed by Sam Crowe, seconded by Jonathan Price.

Decision:
That the Better Care Fund Quarter 3 2023/24 Quarterly Reporting Template and supporting Case Study, be retrospectively approved.

43. **Joint Strategic Needs Assessment: Narrative Update**

The Director of Public Health introduced the Joint Strategic Needs Assessment (JSNA) Narrative Update. It represented insight from service users and front-line

staff, as well as data which is normally included. The JSNA was a high-level strategic summary and a statutory responsibility. It was framed against the priorities in the Integrated Care Strategy and needed to be taken into account when developing the Integrated Neighbourhood Teams. The Director thanked everyone who had taken part in preparing the JSNA.

Members discussed the report and raised the following points:

- There was an improvement in the number of young people in treatment for drugs and alcohol.
- Isolation was an issue for people living in rural areas. People needed to be empowered to bring people together in communities.
- There was alignment between this report and the Better Care Fund and Integrated Neighbourhood Teams reports. Thought needed to be given to how pooled budgets could be used, like the Better Care Fund, to improve health in individual neighbourhoods.
- Ensuring that mental health and inequality in suicide was not being overlooked.

Proposed by Simon Wraw, seconded by Jonathan Price.

Decision:

1. That the updated Dorset Joint Strategic Needs Assessment be noted.
2. That the publication of the Joint Strategic Needs Assessment be approved.

44. **Place and Integrated Neighbourhood Development**

The Deputy Director of Place, NHS Dorset, introduced the report on the development of Place and Integrated Neighbourhood Teams.

Board members discussed the report and raised the following points:

- There were services that overlap with services being provided by GPs. It was important to see what was right for local populations.
- Co-production in Portland was important and a good example of partnership working.
- With regard to who would be leading and resourcing Integrated Neighbourhood Teams, consideration is being given to this so there were options depending on the direction of the new administration following the local elections.
- It would not be necessary or right to have some specialist services in a local place. There needed to be honest conversations about this.
- There would need to be evidence to ensure that integrated neighbourhood teams were wrapping around communities.
- That Healthwatch was involved with the leadership group, and that the Dorset Parent Carer Council should be part of the group to ensure that youth voice was involved.

Proposed by Jonathan Price, seconded by Cllr Somper.

Decision:

That the Board endorse and agree the approach to implementing integrated neighbourhood teams, based on the “Portland Together” approach.

45. **Families First for Children Pathfinder and Pan-Dorset Safeguarding Children’s Partnership Annual Report 2022-23**

The Executive Director of People – Children introduced the report and gave a presentation. The Families First for Children Pathfinder included four key reform strands which were Family Help, Child Protection, Family Networks and Safeguarding Partners; each of these strands were summarised. The locality model for Children’s Services had been enhanced through around 60 new roles which were part of the Pathfinder reform.

The Pan-Dorset Safeguarding Children’s Partnership Annual Report was in partnership with BCP Council. The key areas of the report were highlighted and the priorities for 2023-25 were outlined. Although there were shared priorities between both councils, different approaches were taken depending on the needs of the local area.

The Chairman congratulated the Executive Director on the work completed on the Pathfinder and the successful recruitment to posts. She raised a concern around the risk of funding not being continued for the pathfinder. The Executive Director responded that the Department for Education has provided some additional funding and there have been indications of a new funding arrangement for councils. The new posts had been recruited on a permanent basis.

46. **Work Programme**

Members suggested items for the work programme which included:

- Continued oversight of integrated neighbourhood development.
- The Physical Activity Strategy
- Suicide prevention through the Mental Health Delivery Board
- Tobacco control work in hospitals.
- Switching to vaping: Swap to Stop

Due to the importance of housing on health and wellbeing, it was suggested that a representative of the Housing Directorate be invited to join the membership of the board. This had full agreement from board members and options to update the Terms of Reference for this change to take place would be explored with the Monitoring Officer.

The Senior Democratic Services Officer would write to NHS England to consider whether they would like to appoint to their vacancy on the Board.

47. **Exempt Business**

There was no exempt business.

Duration of meeting: 2.00 - 3.42 pm

Chairman

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Health and Wellbeing Board

26 June 2024

Better Care Fund 2023-2025: End of Year Plan for 2023/24 & 2024/25 Planning Template

For Decision

Cabinet Member and Portfolio:
Cllr S Robinson, Cabinet Member for Adult Social Care

Local Councillor(s):
All

Executive Director:
Jonathan Price, Executive Director of People - Adults

Report Author: Sarah Sewell
Title: Head of Service for Commissioning for Older People and Home First
Tel: 01305 221256
Email: sarah.sewelll@dorsetcouncil.gov.uk

Report Status: Public

Recommendation:

1. To retrospectively approve the Better Care Fund (BCF) Reporting Templates for:
   - 2023/24 End of Year
   - 2024/25 Plan

Reason for Recommendation:

1. 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 mid-year, and at the end of the year.

2. There is usually a relatively short window of time between NHSE publishing the reporting templates and the submission date. NHSE allow areas to submit their plans under delegated authority, pending HWB approval. At the HWB meeting on 12 January 2022 delegated authority to approve BCF plans, if a HWB meeting could not be convened within the NHSE sign off period, was granted to the

Executive Director for People – Adults, following consultation with the HWB Chair.

3. NHSE published year end and new financial year templates during quarter 1 of 2024/25. The Year End Template had a submission date of 23 May 2024 and the Planning Template for 2024/25 was due on 10 June. Therefore, submission was made on behalf of Dorset Council and Dorset NHS in line with delegated approvals. Retrospective approvals are now sought from the Board at its meeting on 26 June 2024.

1. Introduction

1.1 The 20234-2024 Year End Report is at Appendix A, and the 2024-2025 Planning Template is at Appendix B. The contents of both reports follow a consistent BCF approach and consist of:

1.1.1 Confirmation that National Conditions are being implemented

1.1.2 Reporting of local performance against the BCF Metrics, and forecasts of performance for the year ahead.

1.1.3 Details of BCF expenditure and outputs achieved and / or expected

1.1.4 Demand and Capacity of resources to meet hospital discharge and community need.

1.2 From 2023 NHSE moved to a two year planning approach, which has streamlined elements of the reporting requirements. Funding for Dorset via the BCF is as follows:

1.2.1 2023/24: £147,571,615

1.2.2 2024/25: £152,958,153

1.3 This report has been set out to highlight key elements of the reporting templates, Appendices A and B. For 2024/25, Section 6a and 7 of Appendix B provides specific details as to how funding is allocated and key plans within hospital discharge and admission avoidance pathways to develop services.

2. Performance Metrics across our Plans

2.1 As reported in Appendix A, 2023/24 performance against the BCF Metrics was in line with Quarter 3 reporting to Board on 20 March 2024. We met our targets for 2023/24 for:

2.1.1 Discharge to Normal Place of Residence

2.1.2 Falls

2.2 The areas of performance that required on going focus for improvement were:

2.2.1 Avoidable Admissions

2.2.2 Rate of Permanent Admissions to Residential Care

2.2.3 Reablement – number of people remaining at home 91days after discharge from hospital into reablement services.

2.3 For 2024/25, as reported in Appendix B, we have measures and plans in place to secure improvements in performance as follows:

2.3.1 Avoidable Admissions; this metric remained challenged during 2023/24 as demand increased for Urgent Emergency Care. For 2024/25 a 2% reduction target has been set as focussed workstreams centred on reducing preventable admissions are planned. These include establishing step-up frailty virtual wards, as well as building better connectivity between the different existing service offers such as urgent response offers and frailty services. In addition, development of intermediate care services is key, where we need to shift our collective focus from step-down to step-up care. This will enable earlier intervention in the community and prevent the need for admission to a hospital ward.

2.3.2 Rate of Residential Admissions; In the report to HWB on 15 November 2023, performance in relation to permanent admissions to residential care was explained in detail (please refer to link at Section 11). As previously reported, we have invested BCF Funding into initiatives in both Pathway 1 and Community long term care, which has greatly reduced, if not eliminated, the need to use residential care as alternative to homecare which had been adding pressure to this metric in 2022/23. We maintained our improved performance against this metric through Quarter 4 of 2023/24, and have plans in place to enable continuation of this trajectory going through 2024/25. Due to the nature of the metric, it may take some time to fully meet the target.

2.3.3 Reablement performance; as has been reported previously to HWBB, the availability of therapy support continues to challenge our ambitions for Reablement in Dorset. This, linked with hospital partners reporting increasing acuity on admission, means that when people are discharged from hospital at the earliest point, when they no longer clinically need to be in remain, they will be less well, and have had less time to recover so are likely to have more complex needs. This may result in changes after returning home such as not being able to

remain at home/being readmitted etc. This factor is impacting this performance metric. Whilst we work across Health and Social care to understand re-admission data, we are continuing to monitor and review our reablement outcomes. Our core Home First / Discharge to Assess (D2A) offer supports a growing number of Dorset residents to access, and benefit from, reablement. This provides the best opportunity to achieve independence-based outcomes in the longer term.

2.3.4 Due to wider changes in how NHSE collect data from Local Authorities on Short and Long term care, from 2024/25 there are changes to the Residential Admissions metric and that for the effectiveness of Reablement. Residential admissions metrics will continue to be reported but will be set against alternative data provisions, (referenced in section 8.4 of Appendix B), whilst Reablement metric is under development via NHSE. Therefore, this has been initially removed from the reporting template, but we continue to collect this data locally.

3. Demand and Capacity Reporting

3.1 In both returns we were required to provide updated information on actuals and forecasted demand and capacity. This is across pathways supporting demand for hospital discharge and from the community. Sections 4.2, 4.3 and 7 of Appendix B detail the forecasts and provide narrative for 2024/25.

3.2 There is live work in train via the National BCF Support Programme; a structured approach containing two workstreams; one to review how our Discharge to Assess Pathways are working, and identify how we may improve. The second to review our current Leadership approach, in order to strengthen how we work together across our ICS to drive positive change. The outcomes of this programme will be key to how we move forward with shaping our Intermediate Care model, and this may require us to update our demand and capacity modelling and plans.

4. Financial Implications

4.1 The Council and Dorset NHS are required to work within the financial envelope and to Plan, hence continuous monitoring is required. Joint commissioning activity and close working with System partners, including Acute Trusts, allow these funds to be invested to support collective priorities for Dorset.

4.2 The Joint Commissioning Board of the Council and Dorset NHS continue to monitor BCF budgets and activity for 2024-25 Plan.

5. Environmental Implications

5.1 All partner agencies are mindful in their strategic and operational planning of the commitments, which they have taken on to address the impact of climate change.

6. Well-being and Health Implications

6.1 Allocation of the BCF supports individuals with health and social care needs, as well as enabling preventative measures and promoting independence.

6.2 Dorset, like many other areas across the South West and nationally, is continuing to experience many challenges in providing and supporting the delivery of health and social care. For Dorset, as referenced above, the highest risks continue to be the increasing acuity of health, care and support needs of those being supported both in the community and in hospital, and also lack of lack of therapy led care and support to promote the regaining and maintaining of longer term independence.

7. Other Implications

7.1 Dorset Council and Dorset NHS officers will continue to work closely with Dorset System Partners to plan measures to protect local NHS services, particularly around admission avoidance and hospital discharge to ensure flow is maintained to support and respond to additional demand.

8. Risk Assessment

8.1 Dorset Council and Dorset NHS officers are confident Appendices A and B provide appropriate assurance and confirms spending is compliant with conditions.

8.2 The funds provide mitigation of risks by securing continuation of essential service provision and provides preventative measures to reduce, delay and avoid demand.

8.3 Dorset is actively working to alter approaches that enable enhancement of provision to mitigate risks, and promote recovery, regaining and maintaining of independence.

9. Impact Assessment

9.1 It is important that all partners ensure that the individual needs and rights of every person accessing health and social care services are respected, including people with protected characteristics so the requirements of the Equalities Act 2010 are met by all partners.

10. Appendices

A: Dorset's Better Care Fund 2023-24 Year End Reporting Template

B: Dorset's Better Care Fund Planning Template 2024-25

11. 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)

Health & Wellbeing Board, 20th March 2024, Item 7 : BCF Q3 Reporting Template.pdf (dorsetcouncil.gov.uk)

Health & Wellbeing Board, 15th November 2023, Item 8 : Better Care Fund2023-25 Q2 Quarterly Reporting Template.pdf (dorsetcouncil.gov.uk)

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

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:	Dorset	
Completed by:	Sarah Sewell	
E-mail:	s.sewell@dorsetcouncil.gov.uk	
Contact number:	01305 221256	
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:	Wed 26/06/2024	<< Please enter using the format, DD/MM/YYYY

Checklist	Complete:
	Yes
	Yes
	Yes
	Yes
	Yes
	Yes

Better Care Fund 2023-24 Year End Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Dorset

			Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes		Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off			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: Dorset

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)	152.0	125.7	133.8	118.3	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 with increasing demand across the UEC system.	Investment in P1 and P2 capacity has provided additional step-up options for people requiring intermediate care support but there is opportunity to use these to greater scale and impact	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.0%	92.0%	92.0%	92.0%	On track to meet target	Levels continue to be consistently in 91-92% range and inline with 23/24 plan.	BCF investment in Pathway 1 continues to provide capacity to support more people to home for their ongoing recovery from hospital	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,401.2	On track to meet target	Increase in activity level over the first 9 months of 23/24 (Apr-Dec23) 16.7% (256) increase in admissions recorded as linked to fall in 65+ cohort over this period.	Targeted response services in place with intention to prevent avoidable admissions will have contributed to this delivery.	Yes

Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	371	Not on track to meet target	** As per previous returns the population data in this template is incorrect *** (denominator should be 115,068 , ONS MYE 2022) Plan for 2023/24 is 429.*****This has been raised with BCF Manager on several occasions. End of Year performance is 501. With the change to statutory reporting Dorset's method for reporting this indicator will change to mirror the DHSC calculation from April 2024. As previously reported, this is an area that the Local Authority have been closely analysing as despite an improving availability of homecare, admissions are higher than we have planned / expected. Since the last quarterly report, we have remained stable, with the rate of admissions appearing to have slowed from the strong trajectory seen over the 18 months prior. Despite the increased rate of permanent admissions and suggestion that there is an increased need for Care Home beds, the DC funded care population has remained stable. There is an increased rate of turnover (death in care increase) which is offsetting the increased rate of admissions. Care Home occupancy (from Capacity Tracker) is around	BCF investment in Pathway 1 continues to provide capacity to support more people home whereever appropriate. Therefore, the need to use residential placements as a temporary alternative to getting a person home , which often leads to a permenant placement, is greatly reduced.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	84.9%	Not on track to meet target	Year End Performance is 74.17 % High levels of acuity on discharge and availability of therapy support continues to challenge our ambitions for Reablement in Dorset. Collaborative work across the System is ongoing, with proposals in train in order to attract therapists that can be dedicated to support implementation of therapy led Reablement. The BCF Support Team have live work in train in Dorset so we look forward to understanding the recommedations and how they may support us address the challenges in this pathway.	Dorset continues to develop the Discharge to Assess Model, reducing the number of restrictions within the admission criteria. This is enabling people to be supported home via our Core Offer, which includes Reablement. This is providing more equality of access, and swifter opportunity to get home (or avoid admission) for more Dorset residents. We are planning to further develop the core offer to understand where there are further opprotunities to better align our Reablement offer to Partner Clinical oversight in the community that may improve performance and outcomes agianst this metric.	Yes

Better Care Fund 2023-24 Year End Reporting Template

5. Income actual

Selected Health and Wellbeing Board: Dorset

Income

	2023-24
Disabled Facilities Grant	£4,514,793
Improved Better Care Fund	£12,450,566
NHS Minimum Fund	£33,167,357
Minimum Sub Total	£50,132,716

Planned		Actual		
NHS Additional Funding	£39,139,399	Do you wish to change your additional actual NHS funding?	No	
LA Additional Funding	£58,299,500	Do you wish to change your additional actual LA funding?	No	
Additional Sub Total	£97,438,899			£97,438,899

	Planned 23-24	Actual 23-24
Total BCF Pooled Fund	£147,571,615	£147,571,615

Additional Discharge Fund

Planned		Actual		
LA Plan Spend	£1,745,550	Do you wish to change your additional actual LA funding?	No	
ICB Plan Spend	£2,834,000	Do you wish to change your additional actual ICB funding?	No	
Additional Discharge Fund Total	£4,579,550			£4,579,550

	Planned 23-24	Actual 23-24
BCF + Discharge Fund	£152,151,165	£152,151,165

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	£151,788,822

Do you wish to change your actual BCF expenditure?	No	Yes

Actual	£151,788,822	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		Yes

Better Care Fund 2023-24 Year End Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Dorset

Checklist							Yes			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?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
2	Strong and sustainable care markets	Residential Placements	Care home	iBCF	£4,251,898	£3,188,924	£4,251,898	68	136	154	Number of beds/placements	No	Please note, as reported in Q3 return, for all our LA led outputs, since our initial submission Dorset Council has implemented enhancements in our data capture, monitoring and reporting, which is now providing greater integrity in our data. We have also enhanced alignment between finance and performance data to meet the requirements of this report.
3	Strong and sustainable care markets	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£1,241,282	£856,485	£1,241,282	55	63	80	Hours of care (Unless short-term in which case it is packages)	No	
9	Maintaining Independence	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£4,152,450	£3,169,750	£4,152,450	1,150	599	810	Number of adaptations funded/people supported	No	As reported in Q3 return; Error in initial plan: Planned output should read 850, so output v planned is within reasonable tolerance. Planned outputs for schemes 9 and 11 incorrectly entered.
10	Maintaining Independence	Residential Placements	Nursing home	Minimum NHS Contribution	£2,525,252	£1,868,686	£2,525,252	42	42	69	Number of beds/placements	No	Performance here is better than planned, and links to commentary re metric re Residential admissions; we are seeing higher turn over of placements and therefore reduced Length of stay.
11	Maintaining Independence	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£637,277	£477,957	£637,277	850	1,101	1140	Number of beneficiaries	No	As reported in Q3 return; Error in initial plan: Planned output should read 1150, so output v planned is within reasonable tolerance. Planned outputs for schemes 9 and 11 incorrectly entered.
17	Carers	Carers Services	Respite Services	Minimum NHS Contribution	£116,099	£110,325	£116,099	300	346	384	Beneficiaries	No	
18	Carers	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£268,891	£167,840	£268,891	73	155	181	Beneficiaries	No	
19	Carers	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£117,667	£78,770	£117,667	60	295	335	Beneficiaries	No	
20	Carers	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£7,769	£8,614	£7,769	1,120	65	94	Beneficiaries	No	Error in initial plan: 20 and 23 the numbers were incorrectly input, Planned output should be 60, so better performance than planned.
21	Carers	Carers Services	Respite Services	Minimum NHS Contribution	£478,196	£256,282	£478,196	350	208	244	Beneficiaries	No	
22	Carers	Carers Services	Other	Minimum NHS Contribution	£8,391	£7,455	£8,391	86	74	111	Beneficiaries	No	
23	Carers	Carers Services	Other	Minimum NHS Contribution	£115,928	£131,255	£115,928	60	1,774	2206	Beneficiaries	No	Error in initial plan: 20 and 23 the numbers were incorrectly input, Planned output should be 1120., so again far more people supported via this scheme than planned.

24	Maintaining Independence	Assistive Technologies and Equipment	Community based equipment	Additional LA Contribution	£1,144,700	£867,401	£1,144,700	1,439	2,957	3915	Number of beneficiaries	No	As reported in Q3, we have expanded access of these resources, particularly via the D2A approach which has allowed more beneficairies to access, and benefit, than forecast.
25	Strong and sustainable care markets	Residential Placements	Care home	Additional LA Contribution	£55,058,800	£43,540,437	£55,058,800	884	469	941	Number of beds/placements	No	Error in initial plan - planned outputs should be 664 (entry error) Since submitting our plan we are seeing a stabilising of weekly costs for residential services, bringing closer to fair cost rates. We have therefore supported more people than planned within the scheme line budget.
27	Maintaining Independence	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£2,829,022	£2,733,471	£2,829,022	3,620	3,500	4660	Number of beneficiaries	No	The increased numbers supported is in line with scheme 24
32	Maintaining Independence	Assistive Technologies and Equipment	Assistive technologies including telecare	Additional LA Contribution	£574,000	£361,174	£574,000	683	953	1139	Number of beneficiaries	No	
38	Strong and Sustainable Market	Home Care or Domiciliary Care	Domiciliary care packages	Local Authority Discharge Funding	£1,400,000	£1,400,000	£1,400,000	62	217	299	Hours of care (Unless short-term in which case it is packages)	No	Since Q3 performance has remained far better than planned; this is due to focussed training this year with specific providers delivering this scheme; more focus on regaining and maintaining independence, use of tech and equipment to reduce longer term care hours. In general terms, this has led to more people receiving support via less hours of care.

Better Care Fund 2023-24 Capacity & Demand EOY Report

7.1. Capacity & Demand

Selected Health and Wellbeing Board: Dorset

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.	148	148	121	138	144	128	151	201	184	228	219	240
Short term domiciliary care (pathway 1)	Planned demand. Number of referrals.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Planned demand. Number of referrals.	75	75	85	99	87	87	70	105	139	134	97	137
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Planned demand. Number of referrals.	5	15	11	10	15	17	28	36	38	24	36	19

Actual activity - Hospital Discharge

Service Area	Metric	Actual activity (not spot purchase): 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.	130	120	148	149	170	148	168	187	166	162	189	184
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	91	104	120	98	117	127	118	118	115	106	160	150
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	0	0

Actual activity - Hospital Discharge

Service Area	Metric	Actual activity in spot purchasing: 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
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
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
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	19	16	28	35	34	26	43	41	46	28	65	46

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

7.2 Capacity & Demand

Selected Health and Wellbeing Board: Dorset

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.	362	421	415	375	372	361	331	427	348	442	328	436
Urgent Community Response	Planned demand. Number of referrals.	240	260	161	174	159	150	151	163	220	224	208	235
Reablement & Rehabilitation at home	Planned demand. Number of referrals.	123	123	123	123	123	131	131	147	147	147	147	147
Reablement & Rehabilitation in a bedded setting	Planned demand. Number of referrals.	10	15	13	10	12	9	13	6	13	13	10	11
Other short-term social care	Planned demand. Number of referrals.	2	2	2	2	2	3	3	3	3	3	3	2

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.	177	175	230	224	277	292	376	416	307	381	273	277
Urgent Community Response	Monthly activity. Number of new clients.	184	200	196	218	184	183	366	596	716	722	622	622
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	141	139	154	156	150	132	155	159	123	171	147	107
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	11	13	21	21	23	23	24	26	28	25	25	23
Other short-term social care	Monthly activity. Number of new clients.	0	0	1	0	0	0	0	0	1	0	0	0

Checklist Complete:
Yes
Yes
Yes
Yes
Yes

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: Dorset

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
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Examples of improved joint working include additional funding into development of Dorset's Intermediate Care Schemes - Home First Accelerator and Recovery and Community Resilience Contracts
2. Our BCF schemes were implemented as planned in 2023-24	Strongly Agree	Investment made to Plan
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	BCF funding enable joint working in localities via direct schemes (funding of Locality Teams), but also schemes that enable local resources to be deployed; Integrated Equipment Service, Carers supports etc

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	6. Good quality and sustainable provider market that can meet demand	This links to our Success 1 last year around integrated workforce and training / upskilling. This year we have reaped the benefits, within our local Home Care Market, of our Home First Accelerator Programme; Reablement beds, and optimised, sustainable domilicary care rounds have led to availability of care when needed, removing waiting lists. Long term care requirements following hospital discharge are being reduced via the enhanced offer via Reablement services, both from bedded provision but also via Recovery & Community Resilience (RCR) schemes, which is leading to greater independence for indviduals. As reported last year, joint working at locality (CLuster) level has improved working approaches, amongst Health and Social Care partners, which has been extended to Providers in these Schemes. As a System we have invested in development of enhanced skills in RCR provision and improved workflow between providers and System Partners to make more efficient use of our collective resources, for example joint discussion in MDTs. There is still more to do, but we are proud of what we have achieved this year , particularly within Pathway 1 of D2A.

Success 2	8. Pooled or aligned resources	For 2023-25 BCF Plan, we added annual invesment lines to the BCF totalling £ 8m. These lines have performance well and we have further plans in train to enhance further. We have one truely pooled budget, Integrated Community Equipment Service, which has supported more people than forecast this year. We now need to reveiw current level of ambition set within the pooled budget to reflect contract operation and better integration, and we will want to revisit return on investment, and risk and gain share.

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	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	Whilst we have made great strides in our D2A approach in Dorset this year, rising acuity and our ability to support complexity in the community continues to challenge us. Whilst, as a local system, we have invested additional funding into initiatives to address this in the longer term, such as Home First Accelerator, and made good use of additonal national funding such as Sustainability funding, the lack of long term funding is challenging our ability to fully plan the longer term approach.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	In Dorset we have gaps in resources in the Care Homes market to support more complex and challenging care, support and health needs, including advancing dementia. In some cases, this is leading to prolonged hospital stays for some individuals. We are however, working across ICB to improve core pathways to make access to support more equitable and we have plans in place for development of Dementia support for people at all stages of their dementia journey. This will include joint working across Health and Social care to ensure Dementia support is adequately support and training investment made into developing the workforce skillset. At the time of writing we are out to tender for Care Home Services for Over 65s that we hope will improve how we commission services, and be the ground work for a programme of service development to grow the higher acuity services needed.

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

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.

9. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority

- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£)2024-25:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend.

This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This was a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2024-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2024-25.

Some changes have been made to the metrics since 2023-25 planning; further detail about this is available in the Addendum to the BCF Policy Framework and Planning Requirements 2023-25. The avoidable admissions, discharge to usual place of residence and falls metrics remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics.

The effectiveness of reablement metric will no longer be included in the BCF as there is no direct replacement for the previous measure.

The metric for rate of admissions to Areas should set their ambitions for these metrics based on previous SALT data.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:

- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:

- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2024-25. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the
- The population data used is the latest available at the time of writing (2021)

- Actual performance for each quarter of 2023-24 are pre-populated in the template and will display once the local authority has been selected in the dropdown box on the Cover sheet.

- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:

https://future.nhs.uk/bettercareexchange/view?objectId=143133861

- Technical definitions for the guidance can be found here:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls

- This metric for the BCF requires areas to agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter the indicator value as well as the expected count of admissions and population for 2023-24 and 2024-25 plan.
- We have pre-populated the previously entered planned figures for your information and further more recent data will be available on the BCX in the data pack here: https://future.nhs.uk/bettercareexchange/view?objectID=116035109

Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to usual place of residence.

- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. Areas should agree ambitions for a rate for each quarter of the year.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet where available else we will use the previously entered plan data.

4. Residential Admissions:

- This section requires inputting the expected and plan numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2023-24. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Although this data collection will be discontinued it is anticipated this will map across to the new CLD extract once this becomes available.

Better Care Fund 2024-25 Update Template

2. Cover

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.

Health and Wellbeing Board:	Dorset	
Completed by:	Sarah Sewell	
E-mail:	sarah.sewell@dorsetcouncil.gov.uk	
Contact number:	01305 221256	
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 HWB is expected to sign off the plan:	Wed 26/06/2024	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	TBC: Cllr	Steve	Robinson	cllrsteve.robinson@dorsetcouncil.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Patricia	Miller	patriciamiller@dorsetnhs.nhs.uk
	Additional ICB(s) contacts if relevant		Kate	Calvert	kate.calvery@dorsetnhs.nhs.uk
	Local Authority Chief Executive		Matt	Prosser	matt.prosser@dorsetcouncil.gov.uk

Local Authority Director of Adult Social Services (or equivalent)		Jonathan	Price	jonathan.price@dorsetcouncil.gov.uk
Better Care Fund Lead Official		Mark	Tyson	mark.tyson@dorsetcouncil.gov.uk
LA Section 151 Officer		Aidan	Dunn	aidan.dunn@dorsetcouncil.gov.uk

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: Dorset

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£4,529,287	£4,529,287	£0
Minimum NHS Contribution	£35,044,629	£35,044,629	£0
iBCF	£12,450,566	£12,450,566	£0
Additional LA Contribution	£58,299,500	£58,299,500	£0
Additional ICB Contribution	£37,554,921	£37,554,921	£0
Local Authority Discharge Funding	£2,909,250	£2,909,250	£0
ICB Discharge Funding	£2,170,000	£2,170,000	£0
Total	**£152,958,153**	**£152,958,153**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£9,907,649
Planned spend	£21,130,466

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£13,914,160
Planned spend	£13,914,163

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)	145.6	151.1	156.7	151.2

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	1,972.8	1,933.3
	Count	2392	2344
	Population	113053	113053

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)	92.0%	92.0%	92.0%	92.0%

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	468	397

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	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: Dorset

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing											
	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)	-10	-3	-13	-5	-35	-5	-53	-41	-9	-48	-46	-41
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	26	18	18	34	18	3	31	12	17	0	10	34
Other short term bedded care (pathway 2)	5	5	5	5	5	1	5	2	5	1	2	5
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-17	-15	-25	-22	-26	-39	-22	-32	-18	-26	-12	-6

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 currently commission a home from hospital service frrom 2 local VSCE organisations. These organisations have a staff member based in the discharge lounge at Dorset County Hospital, and who attend regular ward rounds and meetings discussing patient discharges to identify opportunities to offer support. The support may include deep cleans, small repairs or small home appliances. Other support could be through signposting or volunteer support which can include, but is not limited to, moving furniture, buying food parcels on behalf of the person, collecting prescriptions or befriending. We are in the process of developing the service to include welfare check phone calls for when people return home, and looking closer at admission avoidance opportunities.

185 referrals have been made to the service since the 1st October 2023 when the service was first commissioned, which is approximately 26 people per month (approx. 312 per annum). Referrals have been around 30 per month since establishing a base in the hospital and It is anticipated as the service becomes more well known throughout the hospital referrals will increase. 28% of referrals were because of Environmental issues in the home. 88% of the referrals were for people who live alone, and the ongoing trend seems to be mostly males that live alone and are over 65.

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
-10	-3	-13	-5	-35	-5	-53	-41	-9	-48	-46	-41
0	0	0	0	0	0	0	0	0	0	0	0
26	18	18	34	18	3	31	12	17	0	10	34
5	5	5	5	5	1	5	2	5	1	2	5
0	0	0	0	0	2	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
10	Contact Hours per package
0	Contact Hours per package
35	Average LoS (days)
42	Average LoS (days)
42	Average LoS (days)

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.	181	181	181	181	181	181	181	181	181	181	181	181	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)	6	6	6	5	5	5	5	5	5	5	5	5												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	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)	0	0	0	0	0	0	0	0	0	0	0	0												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	112	112	112	112	112	112	112	112	112	112	112	112	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)	14	14	14	11	11	11	8	8	8	8	8	8												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	11	11	11	11	11	11	11	11	11	11	11	11	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)	14	14	14	11	11	11	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	17	15	25	22	26	41	22	32	18	26	12	6
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)	51	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	**312**	**312**	**312**	**312**	**312**	**312**	**312**	**312**	**312**	**312**	**312**	**312**
Reablement & Rehabilitation at home (pathway 1)	Total	**191**	**184**	**194**	**186**	**216**	**186**	**234**	**222**	**190**	**229**	**227**	**222**
	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	75	72	75	73	84	73	91	87	74	89	88	87
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	27	26	27	26	30	26	33	31	27	32	32	31
	SALISBURY NHS FOUNDATION TRUST	11	11	12	11	13	11	14	13	11	14	14	13
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	57	55	58	56	65	56	70	67	57	69	68	67
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	11	11	12	11	13	11	14	13	11	14	14	13
	OTHER	10	9	10	9	11	9	12	11	10	11	11	11
	(blank)												
	(blank)												
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Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	SALISBURY NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
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Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**86**	**94**	**94**	**78**	**94**	**109**	**81**	**100**	**95**	**112**	**102**	**78**
	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	34	36	36	30	36	42	32	39	37	43	40	30
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	12	13	13	11	13	15	11	14	13	16	14	11
	SALISBURY NHS FOUNDATION TRUST	5	6	6	5	6	7	5	6	6	7	6	5
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	26	28	28	23	28	33	24	30	28	33	31	23
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	5	6	6	5	6	7	5	6	6	7	6	5
	OTHER	4	5	5	4	5	5	4	5	5	6	5	4
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Other short term bedded care (pathway 2)	Total	**6**	**6**	**6**	**6**	**6**	**10**	**6**	**9**	**6**	**10**	**9**	**6**
	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	3	3	3	3	3	4	3	3	3	4	3	3
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	1	1
	SALISBURY NHS FOUNDATION TRUST	0	0	0	0	0	1	0	1	0	1	1	0
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	2	2	2	2	2	3	2	3	2	3	3	2
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0	0	0	0	0	1	0	1	0	1	1	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**17**	**15**	**25**	**22**	**26**	**39**	**22**	**32**	**18**	**26**	**12**	**6**
	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	7	6	10	9	10	16	9	12	7	10	5	2
	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	2	2	4	3	4	6	3	4	3	4	2	1
	SALISBURY NHS FOUNDATION TRUST	1	1	1	1	2	2	1	2	1	2	0	0
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	5	5	8	7	8	12	7	10	5	8	4	2
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	1	1	1	1	2	2	1	2	1	2	0	0

	OTHER	1	0	1	1	0	1	1	2	1	0	1	1
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Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Dorset

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)	30	30	28	27	33	34	43	44	37	42	29	32
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
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.	328	326	306	300	362	370	477	483	407	461	321	354
Urgent Community Response	Monthly capacity. Number of new clients.	653	653	653	653	653	653	653	653	653	653	653	653
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	123	123	123	123	123	131	131	131	131	131	131	131
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	10	15	13	10	12	9	13	6	13	13	10	11
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)	298	296	278	273	329	336	434	439	370	419	292	322
Urgent Community Response	653	653	653	653	653	653	653	653	653	653	653	653
Reablement & Rehabilitation at home	123	123	123	123	123	131	131	131	131	131	131	131
Reablement & Rehabilitation in a bedded setting	10	15	13	10	12	9	13	6	13	13	10	11
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: Dorset

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Dorset	£4,529,287
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£4,529,287**

Local Authority Discharge Funding	Contribution
Dorset	£2,909,250

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS Dorset ICB	£3,561,600	£2,170,000	
Total ICB Discharge Fund Contribution	£3,561,600	£2,170,000	

iBCF Contribution	Contribution
Dorset	£12,450,566
Total iBCF Contribution	**£12,450,566**

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
Dorset	£309,000	£309,000	
Dorset	£57,990,500	£57,990,500	
Total Additional Local Authority Contribution	**£58,299,500**	**£58,299,500**	

NHS Minimum Contribution	Contribution
NHS Dorset ICB	£35,044,629
Total NHS Minimum Contribution	**£35,044,629**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding
NHS Dorset ICB	£34,387,142	£34,404,921	
NHS Dorset ICB	£4,000,000	£3,150,000	
NHS Dorset ICB	£1,359,986	£0	
Total Additional NHS Contribution	**£39,747,128**	**£37,554,921**	
Total NHS Contribution	**£74,791,757**	**£72,599,550**	

	2024-25
Total BCF Pooled Budget	**£152,958,153**

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

In relation to reduction in available investment from ICB Discharge funding allocation;
- Non-recurrent funding available last year not available this year - investments have had to be right sized to the funding available. Has been undertaken in dialogue/partnership with all partners
- Part of mitigating strategy is to use what we have more effectively – targeting LOS reduction and process simplification to reduce hand-offs and delays.

Better Care Fund 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Dorset

<< Link to summary sheet

Running Balances	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£4,529,287	£4,529,287	£0
Minimum NHS Contribution	£35,044,629	£35,044,629	£0
iBCF	£12,450,566	£12,450,566	£0
Additional LA Contribution	£58,299,500	£58,299,500	£0
Additional NHS Contribution	£37,554,921	£37,554,921	£0
Local Authority Discharge Funding	£2,909,250	£2,909,250	£0
ICB Discharge Funding	£2,170,000	£2,170,000	£0
Total	**£152,958,153**	**£152,958,153**	**£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	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£9,907,649	£21,130,466	£0
Adult Social Care services spend from the minimum ICB allocations	£13,914,160	£13,914,163	£0

									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?	Comments if updated e.g. reason for the changes made
1	Maintaining Independence	A combination of telecare, wellness and digital participation services	Other				0		Social Care		LA			Private Sector	iBCF	Existing	£2,329,214	£2,329,214	100%	Yes	This scheme supports promotion and maintaining of independence; Supports Prevention priorities
2	Strong and sustainable care markets	Funding of residential placements	Residential Placements	Care home		68	154	Number of beds	Social Care		LA			Private Sector	iBCF	Existing	£4,251,898	£4,251,898	7%	Yes	Updated activity figures based on actual outputs from 2023-24
3	Strong and sustainable care markets	Funding for domiciliary care	Home Care or Domiciliary Care	Domiciliary care packages		55	55	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	iBCF	Existing	£1,241,282	£1,241,282	5%	Yes	no change
4	Strong and sustainable care markets	Enabling service improvement	Other				0		Social Care		LA			Local Authority	iBCF	Existing	£1,102,300	£1,102,300	6%	Yes	no change
5	High Impact Changes/ Implementation	Social work staffing capacity to maintain DTOC performance	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Social Care		LA			Local Authority	iBCF	Existing	£2,223,817	£2,223,817	1%	Yes	MDT approach enables joint planning for discharge; supports future admission avoidance and promotion and maintaining of independence, therefore also supporting Prevention priorities
6	Strong and sustainable care markets	Resource to manage and review care market	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity			0		Social Care		LA			Local Authority	iBCF	Existing	£209,629	£209,629	1%	Yes	no change
7	High Impact Changes/ Implementation	Manage the impact of the confirmed NHS reductions to the existing BCF	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Social Care		LA			Local Authority	iBCF	Existing	£1,092,426	£1,092,426	5%	Yes	no change
8	High Impact Changes/ Implementation	Provision of reablement services	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£3,671,278	£3,671,278	18%	Yes	This scheme supports regaining, promotion and maintaining of independence; Supports admission avoidance and prevention priorities
9	Maintaining Independence	Dorset Accessible Homes Service administering DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		1150	1000	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	Existing	£4,152,450	£4,529,287	100%	Yes	Updated funding based on actual funding allocation. Final year end activity output was 810 compared to the plan of 1150. New activity figure reflects 2023/24 outturn and increase in activity based on additional funding.
10	Maintaining Independence	Mental health & dementia support - nursing home	Residential Placements	Nursing home		42	69	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,525,252	£2,525,252	16%	Yes	Updated activity figures based on actual outputs from 2023-24; this is long term care needs, increased forecast for 2024-25 is based on trends and anticipating greater demand due to increasing acuity.
11	Maintaining Independence	Dorset Accessible Homes Service provision of AT and equipment	Assistive Technologies and Equipment	Community based equipment		850	1140	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£637,277	£637,277	100%	Yes	Updated activity figures based on actual outputs from 2023-24 . This scheme supports promotion and maintaining of independence; Supports Prevention priorities
12	High Impact Changes/ Implementation	Integrated crisis and rapid response service	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£785,379	£785,379	4%	Yes	Rapid response services supports admission avoidance prioirites
13	Maintaining Independence	Occupational Therapy capacity to support minor aids and adaptations, maintain people living in their	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,443,189	£1,443,189	7%	Yes	This scheme supports promotion and maintaining of independence; Supports Prevention priorities
14	High Impact Changes/ Implementation	Various funding arrangements	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			0		Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,419,860	£1,419,860	7%	Yes	This scheme supports regaining, promotion and maintaining of independence; Supports admission avoidance and prevention priorities
15	High Impact Changes/ Implementation	Various funding arrangements	High Impact Change Model for Managing Transfer of Care	Other	Various funding arrangements		0		Social Care		LA			NHS Acute Provider	Minimum NHS Contribution	Existing	£165,716	£165,716	1%	Yes	no change
16	High Impact Changes/ Implementation	Various funding arrangements	High Impact Change Model for Managing Transfer of Care	Other	Various funding arrangements		0		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	Existing	£446,977	£446,977	2%	Yes	no change
17	Carers	Direct payment budget for carers	Carers Services	Respite Services		300	300	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£116,099	£116,099	10%	Yes	This scheme supports Prevention priorities
18	Carers	Carers case workers	Carers Services	Carer advice and support related to Care Act duties		73	73	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£268,891	£268,891	24%	Yes	This scheme supports Prevention priorities
19	Carers	Carer's support service to support those care for people with mental health	Carers Services	Carer advice and support related to Care Act duties		60	60	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£117,667	£117,667	11%	Yes	This scheme supports Prevention priorities

20	Carers	Carer engagement	Carers Services	Carer advice and support related to Care Act duties		1120	94	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£7,769	£7,769	1%	Yes	Updated activity figures based on actual outputs from 2023-24 . This scheme supports Prevention priorities
21	Carers	Respite care, short breaks for carers	Carers Services	Respite Services		350	350	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£478,196	£478,196	43%	Yes	This scheme supports Prevention priorities
22	Carers	GP practice carers support accreditations scheme	Carers Services	Other	GP training	86	86	Beneficiaries	Social Care		LA			NHS	Minimum NHS Contribution	Existing	£8,393	£8,393	1%	Yes	This scheme supports Prevention priorities
23	Carers	Carers training programme	Carers Services	Other	Carers training/ activities	60	2200	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£115,928	£115,928	10%	Yes	Updated activity figures based on actual outputs from 2023-24. This scheme supports Prevention priorities
24	Maintaining Independence	Dorset Integrated Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		1439	3900	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,144,700	£1,144,700	15%	Yes	Updated activity figures based on actual outputs from 2023-24. This scheme supports promotion and maintaining of independence; Supports Prevention priorities
25	Strong and sustainable care markets	Joint purchasing of care	Residential Placements	Care home		884	884	Number of beds	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£55,058,800	£55,058,800	88%	Yes	no change
26	Moving on from Hospital Living	Pooled budget of LD cohort to live in community	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,213,000	£1,213,000	27%	Yes	This scheme supports promotion and maintaining of independence; Supports Prevention priorities
27	Maintaining Independence	Dorset Integrated Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		3620	4600	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£2,879,944	£2,879,944	67%	Yes	Updated activity figures based on actual outputs from 2023-24. This scheme supports promotion and maintaining of independence; Supports Prevention priorities
28	Moving on from Hospital Living	Pooled budget of LD cohort to live in community	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£3,767,826	£3,767,826	73%	Yes	This scheme supports promotion and maintaining of independence; Supports Prevention priorities
29	Strong and sustainable care markets	Continuing Health Care placements	Integrated Care Planning and Navigation	Care navigation and planning			0		Continuing Care		NHS			Private Sector	Additional NHS Contribution	Existing	£26,592,162	£26,592,162	100%	Yes	no change
30	Integrated health and social care locality teams	District nursing capacity to support locality working	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£12,027,977	£12,027,977	100%	Yes	This scheme supports promotion and maintaining of independence; Supports Prevention priorities
31	Integrated health and social care locality teams	Combination of community services and intermediate care services	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£7,660,895	£7,660,895	50%	Yes	Joint working in the community enables greater opportunities for Right Care, Right, Time, Right Place - support Prevention priorities
32	Maintaining Independence	A combination of telecare, wellness and digital participation services	Assistive Technologies and Equipment	Assistive technologies including telecare		683	683	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£574,000	£574,000	100%	Yes	This scheme supports promotion and maintaining of independence; Supports Prevention priorities
33	Maintaining Independence	Work with Citizen's Advice to support information, advice and guidance	Care Act Implementation Related Duties	Other	Citizen's Advice		0		Social Care		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£82,269	£100,048	100%	Yes	Updated spend based on new contracted spend. Supports Prevention priorities.
34	Strong and sustainable care markets	Advocacy CHC appeals	Care Act Implementation Related Duties	Independent Mental Health Advocacy			0		Social Care		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£51,816	£51,816	100%	Yes	no change
35	Maintaining Independence	Integrated crisis and rapid response service	Integrated Care Planning and Navigation	Assessment teams/joint assessment			0		Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£592,987	£592,987	100%	Yes	Rapid response services supports admission avoidance prioirites
36	Integrated health and social care locality teams	Funding distributed over aligned budgets - Governance process to confirm exact funding split underway	Other				0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£2,454,719	£2,454,719	50%	Yes	no change
37	Maintaining Independence	Integrated crisis and rapid response service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Social Care		LA			Private Sector	Minimum NHS Contribution	New	£367,951	£367,951	2%	Yes	Rapid response services supports admission avoidance prioirites
38	Strong and Sustainable Market	Home care capacity investment	Home Care or Domiciliary Care	Domiciliary care packages		62	300	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Local Authority Discharge Funding	New	£1,400,000	£2,563,700	88%	Yes	Updated discharge fund and activity based on funding received. Services have strengths based approach to care and support in the home; supporting prevention priorities
39	High Impact Changes/ Implementation	RCR domiciliary care supporting people out of hospital	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)			0		Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£345,550	£345,550	12%	Yes	This scheme supports regaining, promotion and maintaining of independence; Supports admission avoidance and prevention priorities
40	Maintaining Independence	New schemes to be confirmed in line with priority developments	Other				0		Social Care		LA			Private Sector	Minimum NHS Contribution	New	£745,354	£745,354	100%	Yes	Support prevention priorities
41	Maintaining Independence	Home First Accelerator Programme	Community Based Schemes	Other	Sustainable Care Models		0		Social Care		LA			Private Sector	Additional NHS Contribution	New	£4,000,000	£3,150,000	52%	Yes	Updated contribution This scheme supports regaining, promotion and maintaining of independence; Supports admission avoidance and prevention priorities

42	Maintaining Independence	Recovery Focussed (RCR) enhanced home care	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)			0		Social Care		LA			Private Sector	Additional NHS Contribution	New	£1,359,986	£0	0%	Yes	Updated contribution This scheme supports regaining, promotion and maintaining of independence; Supports admission avoidance and prevention priorities
43	Maintaining Independence	Thriving Communities VSCE programme	Community Based Schemes	Other	VCSE		0		Social Care		LA			Private Sector	Additional LA Contribution	New	£309,000	£309,000	100%	Yes	no change
44	Maintaining Independence	Recovery Focussed (RCR) enhanced home care	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)			0		Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£2,434,000	£1,750,000	100%	Yes	Updated contribution - please see narrative on tab 5 reference reduction. This scheme supports regaining, promotion and maintaining of independence; Supports admission avoidance and prevention priorities
45	Strong and sustainable care markets	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment			0		Social Care		LA			Private Sector	ICB Discharge Funding	New	£400,000	£420,000	100%	Yes	Updated contribution

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: Dorset

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.

We have reviewed demand from 23-24, and compared that to the capacity available when we have set current 24-25 assumptions. For Pathway 1 we have made improvements in utilisation of capacity, which shows in our data by way of reduced length of stays in services, so we have factored this in also when making our assessment of 24-25 capacity. Our forecasts include a performance target to reduce the length of time from referral to commencement of care / support over the next 12 months starting from a baseline position of April 2024 performance.

Please note that whilst tab 4.2 is showing a shortfall in P1 capacity and a potential surplus in P2, as decribed below we have opportunities to flex between P1 and 2 in order to achieve good outcomes for people and utilise our resources to greatest effect. Therefore this is likely to be more balance in demand and capacity in P1 and P2 than the figures currently indicate.

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?

We have continued to ensure that our pre-commissioned services are utilised for as many indivduals as possible. We have been closely reviewing utlisation of pre-commissioned resources throughout the course of the year, particulary for Pathway 1, and we have reduced the volume of hours from 1st June 2024 to more accuratley reflect utilisation, and therefore demand. We plan to re-tender the Pathway 1 Reablement led services during Q3 and hope to strengthen our partnership working with providers via these new arrangements. Building in greater flexibility to meet seasonal and demand pressures is one key consideration of the P1 review. There has been a reduced allocation of ICB contributions to funding of Pathway 1 funding for 24/25, due to overall ICB budget challenges, so during Q2 we will continue to explore other funding options as a local ICS to secure sufficient P1 capacity as it has been a vital feature of our success to date.

We are yet to alter other existing commissioned pathways based on gap and issue analysis, but we have identified the need to enhance Pathway 2 in order to meet more complex needs, that at present, often lead to delays in people leaving hopistal and ensuring timely interventions and recovery outcomes outside of hospital. At the time of writing, we are beginning work to analyse in detail the nature of the types of health, care and support needs that we can not currently meet within our core pathways. Once concluded we will be clearer on longer term requirements in P2 pathways.

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

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

Once our review work above is completed and executed to provide enhanced P1 and P2 offers, this will increase the opportunities to avoid, reduce and delay the need for long term residential care. Within 2023/24 our performance against this metric has improved.
We can see from our data that we already deploy a good proportion P1 capacity as a 'step up' offer to enable people to stay at home and prevent an admission. We also utilise P2, but there is more we can do to extend the use in this scenario. In addition, we have run a successful pilot with a P1 Provider around admission avoidance directly from DCH Emergency Department and Short Stay Assessment Unit, which has been successful - over the 6 week trail period we prevented 35 admissions. We have extended the offer, and its now been running for 6 months; whilst we are proud of the achievements we now need to incoprate such avoidance schemes within our wider ICS programmes, such as Urgent Community Response so that prevention work can begin earlier to avoid the need for someone to present at ED before intervention and support is available. We also need to explore links to Urgent Community Care priorities too.

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

Once analysis completed we will be able to make improvements to Pathway 2 services so that more complex health, care and support needs can be met outside of an acute setting, at an earlier point in recovery. This will reduce the number of people who are currently waiting in hopsital to have their ongoing and longer term health, care and support needs assessed, reducing lengths of stay, preventing delays and enabling recovery to begin sooner outside of hospital. Longer term, this will also improve experiences for people being discharged on P3, as numbers will reduce as more people are supported via P2, we will be able to focus more resources into assessments in hospital for this reduced P3 cohort, improving outcomes and reducing delays.

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.

We have improved sharing and oversight of data and performance reporting across our ICS over the past financial year. The Dorset Single Point of Access (SPA)& ICB led System Control Centre are key hubs for co-ordinating our demand and capacity position on a daily basis, through a Sit Rep approach. This includes emergency community demand, in-patient capacity and community capacity within pre-commissioned pathways. We then use this consolidated view to inform our demand and capacity forecasts, using this to inform changes that may be required in capacity to manage demand. We are continuing to work on outcome/experience data and our current work with PPL includes a series of case reviews to understand improvement priorities.

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.

Demand, capacity and flow data for step-down intermediate care is collected daily through the Dorset Single Point of Access in partnership with the Dorset System Co-ordination Centre and Dorset Intelligence and Insight Service (DIIS)
This has established data feeds from all health and care partners, including acute hospitals, community health services and local authorities, that captures:

- All referrals for step-down intermediate care from acute and community hospitals.
- All discharged into intermediate care across P1-P3
- Capacity available each day in both P1 and P2 care across all partners (P3 is spot only)
- Length of time it takes to discharge a person from hospital into intermediate care.
- Length of time a person spends in an intermediate care service.
- Where someone is discharged to following their intermediate care intervention

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 invested our Disharge Funding to continue key aspects of our Home First Accelerator Programme (as outlined in our Case Study submission in Q3 2023/24 return). In summary this reduces discharge delays and improves outcomes as follows:
- Recovery and Community Resilience (RCR) Contracts; Reablement focussed P1 care and support delivered by Trusted Providers to enable indivduals home swiftly, focussing on promotion of recovery and regaining indepedence. Providers complete a Trusted Review of ongoing care and support needs at the end of the recovery period to enable swifter move on or ending of provision. We are cutting lengths of stay in RCR services for those being helped through and taking 100s of hours out of care delivery each week, compared to assessed needs at point of entry –30% of people have no long-term care needs after RCR.
- Trusted Assessment; run by the Dorset Care Association, where their assessors can act quickly in hospital to get people back home, with the right support on hand, as soon as they are fit. 60 people a month are being returned to their usual place of residence by the Trusted Assessment programme, with workers being up on wards within 40mins to get an assessment done and start the process of helping people to get back home.
- Investment into Homecare capacity; We have stabilised our homecare capacity. Over the past couple of years we have targeted our uplifts at providers who could work with us on our Dorset Care Framework. We have optimised homecare rounds, by working with providers across Dorset to reorganise their rounds between them to be more efficient. This built more capacity and reduced our collective carbon footprint. Over the past couple of years we have dramaically reduced waiting times for long term care. Now, some parts of our county can source long term homecare immediately, and most within just a couple of days.

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)
No changes to report, however the amount of available investment from the ICB Dicharge Funding allocation has reduced for the above workstreams for 2024/25

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?
Regular reviews back to the objectives and metrics ensure we remain on track. We have clear strategic and operational governance across the ICS to ensure we remain in line with objectives and metrics. This governance was outlined in the our Narrative Plan for 2023-2025 as submitted last year.

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: Dorset

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.
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	148.6	150.7	133.8	118.3	24/25 target is 2% reduction in level of avoidable admissions. Activity level in Qrt3 23/24 were 917 (50 more avoidable admission than the same period last year), although Qrt4 national figures are not yet available based on the annual average expected to be higher than plan levels. Rationally for 24/25 will be to address the increasing trend and look to reduce overall levels of avoidable admissions.	Focused system workstream in 2024/25 centred on reducing preventable admissions with key objective to drive up utilisation and impact of key services e.g. step-up frailty virtual wards, as well as build better connectivity between the different service offers available e.g. through the implementation of a care co-ordination hub with stronger links into frailty services. How we use intermediate care services is a key part of this plan, recognising the need to shift our collective focus from step-down to step-up care. This will be achieved through looking at where we can intervene earlier in the community, building links with integrated teams, and at the hospital front door to provide a strong inreach offers that enables more rapid turnaround at this stage of a person's journey and prevent admission to a hospital ward where this can be avoided.
	Number of Admissions	852	864	-	-		
	Population	381,292	381,292	-	-		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Indicator value	145.6	151.1	156.7	151.2		

>> 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	1,401.2	1,972.8	1,933.3	23/24 are estimating a 12% increase in activity. 24/25 plan is a 2% reduction on estimated 23/24 outturn performance which is inline with the overall ambition for avoidable admissions.	Continue to build on current community offers to prevent admission due to falls, including frailty SDEC services. Will be a key pathway as part of care co-ordination hub development linking into UCR and other admission prevention offers. More broadly, work to develop integrated neighbourhood teams will look at prevention/educaction opportunities as well as ensuring connectivity and access to the appropriate community support offers.
	Count	1,702	2392	2344		
	Population	112,275	113053	113053		

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 (SUS data - available on the Better Care Exchange)	Quarter (%)	91.0%	91.3%	92.0%	92.0%	24/25 ambition to achieve 92% discharge rate to their normal place of residence.	Continue work on stregnthening impact of P1 offer through blending of different health and care offers that enable more people to return home. This is tied to local transfer of care hub development. Key piece of work in 2024/25 to look at how the core intermeidate care offer can be extended to support people with higher dependency/need to recover at home. Where a person does require a step-down bed on leaving hospital, focused work across health and care teams to support people back to home as part of hybrid P1/P2 offer so focus for recovery remains at home.
	Numerator	7,522	7,681	7,066	7,273		
	Denominator	8,263	8,414	7,680	7,905		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Quarter (%)	92.0%	92.0%	92.0%	92.0%		
	Numerator	7,408	7,155	7,353	7,260		
	Denominator	8,052	7,777	7,992	7,892		

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	467.9	445.3	513.9	397.1	ONS MYE for 2022 65+ population is 115,068 for DC area, anticipated outturn for 2023-24 based on this population is estimated as 501.44. The population for 2024-25 is incorrect and relates to the old DCC area. For 2024-25, we are revising the way that we calculate this metric in line with CLD guidance from DHSC however, based on initial testing, we do not anticipate that this change will have a significant impact on the outturn for this metric.	Improved capacity in homecare to support long term need at home, has enabled us to reduce reliance on residential placements as an alternative over the past year, both for hospital discharge but also to support advancing needs in the community. As explained in 7. Narrative update and in our 2023-25 Narrative Plan, the Home First Accelerator Programme, funded via BCF streams, continues which is improving the reablement offer, and optimising how home care capacity is deployed, ensuring we make effecetive and efficient use of resources available.
	Numerator	529	500	577	545		
	Denominator	113,053	112,275	112,275	137,251		

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: Dorset

	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
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated (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	Yes			
	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			

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Dorset Health and Wellbeing Board
26 June 2024
Pharmaceutical Needs Assessment (PNA)

For Decision

Portfolio:
Cllr G Taylor, Public Health, Environmental Health, Housing, Community Safety and Regulatory Service

Local Councillor(s):
All

Executive Director:
S Crowe, Director of Public Health

Report Author: Jane Horne
Job Title: Consultant in Public Health
Tel: 01305 225872
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Report Status: Public

Brief 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 due by October 2025. This paper sets out a proposed scope and timeline for agreement by the Board. It also highlights key questions for consideration by the Board.

Recommendation:

1. To note the start of the 2025 PNA development process
2. To consider the scope of the PNA
3. To agree whether to have a single PNA across the Dorset system as in previous PNAs
4. To agree the provisional timeline set out under section 4.1
5. To consider any other representatives required on the Steering Group.

Reason for Recommendation:

To meet requirements set out in Regulations.

1. Background

1.1 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.

1.2 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.

1.3 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.

1.4 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.

2. Local Context

2.1 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. On the Dorset side this was 68 community pharmacies plus one distance-selling pharmacy.

2.2 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.
- Access could improve to support new housing developments in Dorchester and Poundbury. This should be by relocation of one of the existing pharmacies in the town, to provide a better spread.
- The pharmacy workforce challenge is a high priority for the Dorset system, and
- there should be a campaign to encourage patients to only order the medicines they need.

2.3 Since publication of the PNA in October 2022, eight community pharmacies have closed. In the Dorset council area there were two closures, one in Verwood and one in Portland. A new distance selling pharmacy opened on the Dorset side. Of eleven community pharmacies that opened 100-hours a week, none continue to do so. The four in the Dorset council area are now open between 72 and 78 hours a week. 17 community pharmacies have changed hands, nine on the Dorset side.

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

3. Scope of the Dorset PNA 2025

3.1 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.

3.2 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.

3.3 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.

4. Timeline and delivery plan

4.1 A provisional timeline for delivery of the Dorset 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 or delegated sign-off if agreed)
- Formal consultation — April to June 2025
- Final PNA completed and signed off — July to Sep 2025
    - (at Health and Wellbeing Boards or delegated sign-off if agreed)
- Publication — No later than Oct 2025

4.2 The Steering Group will invite representatives from:

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

5. **Financial Implications**

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.

6. **Natural Environment, Climate & Ecology Implications**

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.

7. **Well-being and Health Implications**

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.

8. **Other Implications**

Community pharmacies may help to maintain footfall in high streets and town centres.

9. **Risk Assessment**

9.1 Most risk falls on the NHS, as if the PNA is not robust there is a risk of challenge to their decision making.

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

Current Risk: LOW
Residual Risk: LOW

10. **Equalities Impact Assessment**

The PNA development work will include an Equality Impact Assessment.

11. Appendices

No appendices

12. 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

13. Report Sign Off

11.1 This report has been through the internal report clearance process and has been signed off by the Director for Legal and Democratic (Monitoring Officer), the Executive Director for Corporate Development (Section 151 Officer) and the appropriate Portfolio Holder(s)

Dorset Health and Wellbeing Board
26 June 2024
Thriving Communities

For Decision

Cabinet Member and Portfolio:
TBC

Local Councillor(s):
All

Executive Director:
S Crowe, Director of Public Health

Report Author:	Rachel Partridge & Dave Thorp
Job Title:	Deputy Director of Public Health; Thriving Communities Partnership Manager
Tel:	01305 225880
Email:	Rachel.Partridge@dorsetcouncil.gov.uk

Report Status: Public

Brief Summary:

The paper provides a summarised progress report on and proposal from a project, which was initiated by the Health and Wellbeing Board in June 2023, supporting place-based working in the Dorset Council area.

The Thriving Communities project had a specific aim to develop a plan which would result in growth of community support and capacity through the Voluntary and Community Sector (VCS), to support older people to remain living well and independently. To deliver the project through investment in the VCS infrastructure, the board approved the use of £309k from the shared service underspend in 2021/22.

It was noted that, in delivering this programme of work, Thriving Communities would positively contribute to delivery of both the Integrated Care Partnership and Dorset Council's strategic aims as well as enhancing closer working with the VCS. Through the creation and collation of a strong evidence base the project has naturally developed a close focus on providing care for our communities.

This paper seeks to provide the Board with an update on the research work carried out and the findings and insights gathered from the VCS, communities and older people across Dorset. The paper also sets out the key themes of issues identified and presents some options for the next phase of this work. The Thriving Communities Reference Group have considered a range of options and have provided their recommendation for the Health and Wellbeing Board's consideration on the next steps.

Recommendations:

1. The Dorset Health & Wellbeing board review the research findings and local insights contained within this Thriving Communities report.

2. The Board considers the options presented for the potential next phase of the Thriving Communities project.

3. If in agreement, the board to recommend the development of a project delivery and transition plan for Option 3: developing a VCS led Thriving Community Network model as supported by the Thriving Communities Reference Group.

4. The Board to agree a suitable Dorset Health & Wellbeing Board member sponsor to oversee the next phase of the project.

Reason for Recommendations:
The Thriving Communities project was provided support, direction, and guidance through a multi-agency Reference Group. That group, which included representatives from Dorset Council; NHS Dorset; Public Health Dorset; the VCS and Dorset Fire and Rescue Service, supported option 3 as the preferred route. The evidence base and community views signal that this option would generate greater commitment and momentum and as a result provide a much stronger and more resilient VCS model.

It was recognised by the Thriving Communities Reference Group that option 3 would require longer term commitment and resources from Dorset Council and ICS partner organisations. A project delivery and transition plan could be brought back to the next Dorset Health and Wellbeing Board in September for approval.

1. Background

1.1 Dorset's Council's population is growing older; in fact, we have the fastest ageing population in the UK supported by better than average life expectancy across most of our residents. Our older residents are a hugely valuable resource and play a vital role within our communities although there is recognition that there

may be increasing requirements for support for some through ageing, illness, grieving and dying.

1.2 Across Dorset the VCS already provides a huge variety of services and support that help older people live healthily, and independently for longer. However, there are significant and repetitive challenges that the sector faces which prevent increased capacity and capability, whilst leading to fragility, isolation, and exhaustion.

1.3 Through detailed research and a comprehensive, cross-sector collaboration on engagement which captured detailed views of over 250 participants, Thriving Communities has gathered evidence of effective practice both nationally and locally and identified opportunities which would reduce pressure on health and social care services and increase healthy life expectancy. The project report identifies 12 key issues which lead to evidenced based options:

1.4 Key issue 1: The need for local 'trusted people' in delivering support for older people to attract higher levels of participation.

Key issue 2: The use of known local, readily accessible, and sustainable 'trusted places' helps older people keep connected and healthy whilst reducing transport difficulties.

Key issue 3: The benefit of a clear communication mechanism to allow swift dissemination of risk issues, opportunities, learning and best practice.

Key issue 4: The momentum developed though 'connectivity and partnership working' at a local level.

Key issue 5: A fundamental gap in the coordination of VCS activity and networking

Key issue 6: The need to value and support volunteers to ensure retention and involvement of the next generation.

Key issue 7: Bureaucracy in funding, evaluating, and reporting requirements hinders VCS delivery of activities and support.

Key issue 8: The need to share best practice across groups supporting older people.

Key issue 9: Well-known, led, connected and 'trusted groups' can amplify their local messaging.

Key issue 10: The infrastructure foundations for local groups supporting older people need to be solid.

Key issue 11: The full impact of Thriving Communities will unfold as momentum grows over the course of several years, with its benefits being evident across multiple sectors and communities.

Key issue 12: Currently funding for Thriving Communities is concentrated on a 12-month delivery, yet maximising long-term impact will necessitate continued investment.

1.5 In all engagement Thriving Communities teams asked how the future should be viewed for older people in the area. The answers provided, in general, evidenced a broad understanding of the challenges facing health and social care services with an ageing community. There was a strong message that local groups and charities were needed, and if maintained the outlook could be bright for our older population. However, without investment and support the future would worsen and the health and social care challenges would be greater.

1.6 It was identified that understanding the strengths, depth and reach of the VCS in Dorset is the first step to a new and sustainable way of working in partnership. Whilst the development of trust through the creation of a network of local groups and organisations willing to work and engage in a new way will provide a framework for collaborative, place-based activity.

1.7 The Thriving Communities Reference Group met to review and consider all the research, data and insights gathered and identified and considered the following options for the next phase of this work.

1.8 Options for consideration for next steps:

(a) Develop a resource library for future projects and programmes:

Complete the research and engagement phases, develop a library of resources, documents and reports from which future programmes and projects can draw. Thriving Communities project to be closed or integrated into other work programmes.

(b) Develop a Public Service led Thriving Community Network model.

The Thriving Communities project is retained within Dorset Council and/or Public Health Dorset with a lead delivery resource identified and funded. Working with NHS Dorset and other partners, engagement with and coordination of a range of groups and organisations would be conducted to develop a Thriving Community Network of hubs designed to deliver on many of the health and care system's key priorities.

(c) Develop a VCS led Thriving Community Network model.

The Thriving Communities Network model led by the VCS, supported by a partnership of Dorset Council, NHS Dorset, Public Health Dorset, and other partners. Engagement with and coordination of a range of groups and organisations would be conducted to develop a Thriving Community Network of hubs designed to deliver on many of the health and care system's key priorities.

1.9 Through the growth of a Dorset Thriving Communities Network led by the VCS and supported by a partnership of Dorset Council, NHS Dorset, Public Health Dorset, the VCS and other partners, the VCS infrastructure would be strengthened and the local groups who support older people could become more resilient, effective, and voluminous. The Dorset Thriving Communities Network would also create opportunity to support the VCS in some of its challenges around leadership, development, governance, and administration, whilst also establishing opportunities to develop and grow cross sector working and understanding.

1.10 It is believed that the full impact of Thriving Communities Network would unfold as momentum grows over the course of several years, with its benefits becoming evident across multiple sectors and communities. Amongst other benefits the proposal would see:

- Support for all VCS infrastructure layers.
- Strengthened and more resilient local groups.
- Easier partnership working on strategic and operational priorities.
- Swifter and more effective partnership communication about, and work on, challenging or urgent issues.
- Simplification of bureaucracy.
- Swifter and easier funding.
- Direct and clear communication channels across sectors.
- Development of trust creating opportunity to empower the VCS to lead on complicated social issues.
- Provide simple methods to report, measure and evidence effectiveness.
- Provide resilient support at a local level.

1.11 In providing simple, clear processes and strong effective support, our community groups would be able to continue to work with confidence and would be equipped to grow and deliver even more to support older people to remain living well, healthily, and independently.

1.12 To deliver the proposed project delivery and transition plan will require several distinct stages, including:

(a) development of commitment and investment for the proposals for a 3-to-5-year programme to increase the capacity of the VCS sector infrastructure, in line with identified needs as set out in option 3.

(b) Report and evaluation back to the Health and Wellbeing Board

2. Financial Implications

2.1 The Joint Public Health Board agreed to invest part of the shared service underspend from 2021/22 into place-based working. The shared service is

funded by contributions from both BCP and Dorset councils' public health ring-fenced grant. The same conditions apply to any underspend held in reserves as apply to the original grant.

2.2. For the Dorset place-based partnership the share of these funds was £309k. The aim was to support a focused programme of work in line with health and wellbeing priorities.

2.3 For option 3 to deliver effective long-term; place-based support, there would need to be a more sustainable longer-term model of funding. Some detailed work looking at the potential costs to implement will form part of the project delivery and transition plan, but initial calculations based on evidence from elsewhere give an indication of very approximately £500,000 per year for an initial 3 year period.

3. Natural Environment, Climate & Ecology Implications

3.1. Supporting people to stay well and live independently by building strong community networks of support close to their homes should reduce travel and healthcare utilisation - both of which also have the benefits of reducing travel time and costs and in turn have a positive impact on the environment and reducing emissions.

4. Well-being and Health Implications

4.1. Working with people to understand what keeps them well and healthy, and building capacity in the voluntary and community sector to offer support around these needs, should improve healthy life expectancy – keeping people living for longer in good health. Working in this way to develop person centred approaches should also have benefits for people's personal sense of wellbeing.

5. Other Implications

5.1. Capacity needs to be identified to support this programme and will be addressed as part of the first phase.

6. Risk Assessment

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

Current Risk: LOW
Residual Risk: LOW

7. **Equalities Impact Assessment**

7.1 Any plan that is developed as a result of this programme of work will be subject to equalities impact assessment to ensure that people with protected characteristics are not disadvantaged from the proposal. In addition, information on reasonable adjustments that might need to be made for particular groups will be considered.

8**. Appendices**

Appendix A:

A selection of comments captured during the Thriving Communities engagement.

9. **Background Papers**

Dorset Health and Wellbeing Board – Thriving Communities Report – June 2023

Thriving Communities Project Report – May 2024

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Health and Wellbeing Board
26 June 2024
Safeguarding Families Together Evaluation

For Review and Consultation

Cabinet Member and Portfolio:
Cllr C Sutton, Cabinet Member for Children's Services, Education & Skills

Local Councillor(s):
All

Executive Director:
T Leavy, Executive Director of People - Children

Report Author:	Lisa Reid
Job Title:	Corporate Director, Quality Assurance and Safeguarding
Tel:	01305 228396
Email:	lisa.reid@dorsetcouncil.gov.uk

Report Status: Public

Brief Summary:

The purpose of this report is to share the outcome of a formative evaluation undertaken by the University of Bedfordshire in respect of the Safeguarding Families Together (SFT) pilot, in Chesil, Dorchester and West Localities within Children's Services.
SFT is based on the Family Safeguarding Model developed by Hertfordshire County Council in 2015. There have been numerous independent evaluations completed and the model has been complimented by Ofsted. Its success was hailed in the Independent Review of Children's Social Care published in 2022. The model is in use and being implemented by at least 21 other English local authorities (some with financial investment from the DfE). Key to its success is the initial intensive support provided to both children and the adults in their families. In providing this timely response and relationship-based approach, adult specialists were found to be crucial. Furthermore, the adult practitioners helped

to support a different way of thinking about risk and ways of working with families.

SFT aims to reduce children in need of child protection and those coming into care by using co-located multi-disciplinary teams, consisting of specialist adult practitioners and Children's Services social workers. The team provides wraparound support to the family to focus on and enable sustained change in key parent/carer challenges that impact on the safety of the children (Substance misuse, Domestic Abuse and Mental Ill-Health). The use of Motivational Interviewing and group supervision within the model addresses and overcomes barriers to reaching these families and enabling the change required for safety.

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Recommendation:
To receive and review the evaluation report and to consider what the partnership commitment to the wider roll out and any further expansion is, for example to care leavers.

For consideration, the partnership commitment could also include a review of commissioning arrangements that supports this way of working and could contribute to the model. Agencies not directly involved in SFT may also wish to consider how we track and evidence wider impact and what commitment can be offered by all partners to support this initiative being able to continue past March 2025

Reason for Recommendation:
To allow full consideration of the wider benefits of SFT in improving the outcomes for our children and young people and how as a partnership we can go further. The Board needs to advise how the partnership wishes to proceed post March 2025 and agree how funding can be secured or commitments to existing/new commissioning arrangements.

1. **Report**

1.1 The Formulative Evaluation was planned and undertaken during the period of September 2023 – December 2024 and included researchers from the University of Bedfordshire spending time in Dorset, interviewing families and practitioners. This has enabled the voice of our families to be represented in the evaluation findings. The final report was shared in March 2024.

1.2 The evaluation evidenced that SFT had been successfully implemented in the pilot areas. Key findings from the report are:

- Successfully implemented
- Shared aims & hopes for longer term preventive impact
- Created a new shared value-based language across professional groups & with families
- Improved information sharing & understanding of disciplinary perspectives for professionals
- Provided a more holistic, accessible & responsive service for parents
- High demand, recruitment challenges, social work caseloads and statutory deadlines create logistical barriers
- Opportunities to expand geographically and towards a wider partnership

1.3 The evaluation made recommendations for further positive enhancements to the service offered within Dorset, as well as planned widening the reach to include the North, East and Purbeck localities and to consider other service user groups who would benefit from this approach, such as Care Leavers. The recommendations and actions from the report to address are being overseen at the newly established 'Implementation Board' which also is overseeing the roll out to the other localities. The board is chaired by Lisa Reid, Corporate Director and promotes a partnership approach with membership from health, adult services, community safety, along with substance misuse services, mental health and domestic abuse partners. The Board reports into the Safeguarding Partnership through Strengthening Services.

1.4 There is good evidence during the first year of the pilot of promising outcomes for both families and practitioners, in particular around sustained engagement with families that had not previously been known to core adult services. This is in line with the trajectory of previous local authority roll outs and national evaluations.

1.5 SFT will continue within the three pilot localities (Chesil, Dorchester, and West) with Dorset Council Children's Services having funded since the launch in November 2022 and continued funding beyond the end of the pilot phase from April 2024 for one further year (2024-2025). This will also include all posts in the planned roll out across North, East and Purbeck from October 2024 (for 6 months) to enable SFT to be delivered to families in all locality areas. Funding post March 2025 is yet to be established.

2. **Financial Implications**

SFT aims to produce significant benefits to the partnership by reducing the numbers of children and young people coming into care and who are subject to long term statutory interventions. The services provided to adults who are parents and carers by SFT would reduce demand within the core services for adults. Albeit what we know with Domestic abuse services they aren't always being accessed by families under the core contracts due to different ways of working and reliant on families making the contact/engaging first time. Similarly with other services the repeat referrals and long waiting times are impacting access to resources. As a result, Public Health were able to make a contribution of 85K to support this model but other agencies have not yet contributed. It is expected, in line with outcomes in other Local Authorities, that significant cost benefits are experienced by partners such and reduced A&E attendances for mental health and domestic abuse, and a reduction in repeat police call outs/999 calls for incidents related to Mental Health, Domestic Abuse and Substance misuse. Currently the committed spend for the roll out is 1.7m for 2024-2025.

3. **Natural Environment, Climate & Ecology Implications**

None.

4. **Well-being and Health Implications**

SFT aims to improve the health and wellbeing of parents and carers within Dorset by addressing three key factors, Mental Health, Substance misuse, Domestic Abuse. Successful outcomes demonstrate reduction or abstinence in these areas and service users report better health and overall improved emotional wellbeing.

5. **Other Implications**

None to consider.

6. **Risk Assessment**

None to consider.

7. **Equalities Impact Assessment**

SFT offers a service which seek to reduce inequalities caused by the impact of Substance misuse, Mental Health and Domestic Abuse.

8. **Appendices**

Appendix 1: Safeguarding Families Together Evaluation report

9. **Background Papers**

None

10. **Report Sign Off**

10.1 This report has been through the internal report clearance process and has been signed off by the Director for Legal and Democratic (Monitoring Officer), the Executive Director for Corporate Development (Section 151 Officer) and the appropriate Portfolio Holder(s)

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University of Bedfordshire

Safeguarding Families Together

Evaluation report

April 2024

Lynch, A., Bostock, L. and Friel, S.
University of Bedfordshire

Dorset Council

Contents

Acknowledgments

The authors would like to acknowledge the support by the Safeguarding Families Together (SFT) programme team, particularly Tracey Old and Sarah Whilton who have coordinated delivery of the evaluation with professionalism and efficiency.

We would also like to thank all professionals who participated in interviews and focus group and facilitated the research, by identifying and contacting families on our behalf. This is a significant ask given work pressures and underlines their commitment to families taking part in the SFT service.

Finally, we are incredibly grateful to the parents who shared their experiences of SFT; the voices of family members remain under-represented in research on Family Safeguarding and a special thank you is reserved for their time and commitment to the research.

Executive summary

The project

Safeguarding Families Together (SFT) is a whole family, strengths-based approach to safeguarding children. As part of Dorset Council's Children's Services Transformation Programme, SFT was launched as a pilot project in November 2022 in Chesil, Dorchester and West localities, becoming 'live' by January 2023.

SFT is based on the Family Safeguarding model designed and implemented by Hertfordshire County Council in 2015. Now in its 10th year of implementation, Family Safeguarding has been adopted by a growing number of local authorities across England.

The aim of Family Safeguarding and SFT model is to combine professional knowledge and expertise to assess and provide timely support to meet the needs of the whole family, by supporting parents to achieve sustained change for their children. The design encompasses a co-located multi-disciplinary team that includes children's social workers and specialist adult practitioners from domestic abuse (to support both victims and perpetrators), substance use/recovery and mental health services.

The evaluation

Dorset Council commissioned a formative evaluation to develop learning from the SFT pilot. The evaluation was conducted in the first year of the pilot (data collection period: October to December 2023) and focused on exploring early implementation experiences and outcomes from the perspectives of parents, practitioners and strategic leads.

Data were collected and reviewed in relation to three strands:

- **Process of implementation** from the perspective of professionals to understand if SFT has been implemented as planned and what factors helped and hindered success (12 interviews and focus groups with 33 strategic leads, senior and middle managers and frontline practitioners from children's social work and each specialism)
- **Service experience** from the perspective of parents who have been allocated into SFT to explore their experiences of and outcomes related to SFT (five mothers who had prior experience of working with children's social care in relation to safeguarding concerns for their child(ren))
- **Performance outcomes** data as demonstrated via SFT's multi-agency outcomes framework (as reported in the Dorset Council SFT Business Case(1)).

Key findings

Between January and November 2023, the numbers of currently open and successfully closed cases of children and families within SFT were:

- Currently open (receiving help and support from SFT): 127 family groups; 267 children and 148 adults
- Successfully completed (cases closed following SFT help and support): 17 family groups; 36 children and 20 adults

Adult specialist workers were recruited into post incrementally over a twelve-month period (December 2022 to December 2023).

SFT successfully implemented

Strategic partners, managers and practitioners across specialisms indicated that SFT had been successfully implemented. There was a remarkably cohesive narrative about SFT's practice model and its focus keeping families together by working together more effectively.

Parents experienced SFT as a holistic, helpful and humane service that was focused on building respectful relationships to support them to make changes for themselves and their children.

Key elements of SFT

Frontline professionals consistently described the value of SFT's co-located, multi-disciplinary model for families. Sharing information, knowledge and best practice between individual specialisms was acknowledged as a learning opportunity across specialisms, meaning parents received a more seamless and responsive service.

Group supervision was identified as a pivotal practice forum, enabling shared responsibility around risk to children through generation of multiple perspectives. While logistical difficulties were noted, it afforded an opportunity to build team relations and share knowledge across specialisms while holding the child in mind.

Practitioners' experiences of MI were more mixed. While in line with social work values, it was challenging to routinely embed within their direct practice with families due to high caseloads and the complexity of work with families. Both domestic abuse and mental health professionals noted some incongruence with their existing practice models and expectations of change with prescribed statutory timescales.

Parents' experiences

Parents experienced SFT as holistic, characterised by working in partnership to build on their strengths. They valued working with a consistent group of professionals, whose inter-professional communication was effective, reducing the need to repeat themselves. Parents identified the flexible, accessible and responsive contact they had with professionals within the SFT team as a key strength.

Parents described increased self-knowledge and awareness, relating to mental health, domestic abuse and substance use and for some, developed a deeper understanding of the need for social work involvement. Crucially, parents highlighted how support from SFT had increased their vitality, sense of purpose and empowerment that enhanced their capacity to care for their children.

Success factors

At a strategic level, partners identified a shared vision and ownership of the SFT pilot. They described feeling valued and a willingness to explore differences in perspectives, noting that any challenge was largely constructive and focused on ensuring that SFT was successful.

Strategic partners described how SFT provided the opportunity to develop a longer-term, integrated strategic partnership, reflecting the shared aims and values across health and social care organisations to improve outcomes for children and families.

Implementation challenges

Implementation challenges cohered around three main themes:

- **Complexities in the commissioning process**, including recruitment of adult specialist practitioners reflecting national challenges in recruitment and the experiences of other local authorities introducing Family Safeguarding
- **Managing high demand for SFT within limited resources**, reflecting early implementation challenges regarding role and capacity of adult specialisms, referral pathways and social work values regarding the right of all families to receive SFT
- Practice tensions around the logistics of **managing group supervision** and the **congruence of MI** within statutory child safeguarding services.

Performance outcomes data

Review of performance outcomes data provided indicated a high number of referrals and level of need, with the highest level of need relating to mental health. Indicators of success include high engagement levels, both in relation to higher levels of engagement of individuals who were previously known to specialist partner services and new engagement from individuals who were not previously known to services. More nuanced and longer term data will be required to enable more meaningful evaluation.

Lessons for future implementation

Evidence from the formative evaluation supports the ongoing co-location of professionals from each specialism in the physical office spaces of each locality to provide families with support personalised to their needs.

Parents, strategic partners, professionals and their managers identified remarkably similar themes regarding the future development of SFT. They agreed that SFT should be promoted more widely, extended across localities and include other partners, such as housing.

Lessons for future implementation include:

- Clarifying the process of reviewing, developing and evaluating SFT referral processes
- Reviewing and reigniting the process of implementing Motivational Interviewing as a shared practice approach across SFT, with a specific focus on localities with a lower intake of training
- Reviewing and developing group supervision logistical processes and practices to maximise effectiveness
- Reviewing and developing the processes of outcome measurement, at the individual and cohort level to include qualitative and quantitative data.

Overview of the project

Introduction

This report presents findings from an independent evaluation of the Safeguarding Families Together (SFT) pilot project in Chesil and Dorchester and West Localities. As part of Dorset Council's Children's Services Transformation Programme, SFT was launched in November 2022, with a 'live' date of January 2023. The formative evaluation was designed to develop learning from the pilot, focused on the experiences and outcomes of the early implementation phase.

The evaluation aimed to identify key influences on the progress and effectiveness of SFT from the perspectives of parents, practitioners and strategic leads to inform future planning and implementation process, including in other Dorset localities (2). The evaluation was conducted between September 2023 and March 2024, with interview data collected October to December 2023. The evaluation was undertaken by a research team at the University of Bedfordshire who evaluated a series of projects within the Department for Education's (DfE) Children's Social Care Innovation programme(3–6), including Family Safeguarding Hertfordshire (FSH) (7).

Safeguarding Families Together in Dorset – building on evidence

Following review of models of best practice, Dorset Council developed a new approach to child safeguarding, Safeguarding Families Together (SFT)(1). SFT built on Dorset's Children Thrive model that had already created multi-disciplinary teams based in six localities to provide wraparound support for families. The approach was based on the Family Safeguarding model, designed and implemented by Hertfordshire County Council, as part of the DfE Children's Social Care Innovation Programme. FSH is now in its 10th year of implementation and the Family Safeguarding Model (FSM), or a model based on FSH, has been implemented by at least 16 further local authorities in England

FSM is a whole family, strengths-based approach to child protection with three key design features that have been adopted by SFT:

- **Co-location of a multi-disciplinary team** - that includes children's social workers and specialist adult practitioners from domestic abuse, substance use and mental health services. The aim is to combine knowledge and expertise to assess the needs of the whole family, providing timely support to meet those needs by supporting parents to achieve sustained change for their children. This combination of specialist knowledge is designed to address the factors – parental domestic abuse, substance use, and parental mental health problems - most

frequently present in the lives of children who experience abuse or neglect (8). It is intended to specifically to meet the needs of parents and build their confidence, thereby reducing risk to children and keeping families together where possible.

- **Motivational Interviewing (MI) as a shared model of practice** - MI is strengths-based approach originally developed in substance use services that has been adapted for the child protection context (9). At the heart of this approach is the relationship between parent and practitioner who works to draws out their thoughts and ideas about change, emphasising their choice and autonomy, while respectfully situating the responsibility of change for their children, with them as parents. MI is a highly skilled practice, one that takes time and support to develop.
- **Group-based supervision as the key practice forum** - to ensure that inter-professional care for families is co-ordinated, knowledge is shared, progress is monitored and outcomes are reviewed.

Although reports vary, at least 17 local authorities[1] have implemented a version of FSM, with at least 10 funded through DfE (10, 11). DfE supported the implementation of FSM in a further four local authorities as part of phase two Children's Social Care Innovation programme(12) and a further six local authorities as part of the Strengthening Families, Protecting Children (SFPC) programme, designed to support local authorities improve their work with families. Additionally, DfE provided funding through SFPC for the creation of the Centre for Family Safeguarding Practice to support implementation of FSM in new local authorities and to operate as a Sector Led improvement partner. Most recently, the Independent Care Review of Children's Social Care (2022) identified FSH as an exemplar of how combining investment can improve outcomes for children and families as well as benefit strategic safeguarding partners (13).

The growth of, and support for, FSM relates to the outcomes demonstrated in two independent evaluations, the initial evaluation of FSH over the first year of implementation (6) and the evaluation of FSH and the first four additional local authorities to implement FSM over a two-year period (10). Outcome domains included performance outcome indicators for children's services and specialist professional services, costing analyses, observations of social work practice and experiences of professionals and parents.

The evaluation of children's services performance indicators, with a focus on children aged under 12 years, demonstrated positive outcomes in relation to substantial reductions in:

[1] Bracknell Forest, Luton, Peterborough and West Berkshire (DfE Innovation Programme Round 2); Cambridgeshire, Lancashire, Swindon, Telford and Wrekin, Walsall and Wandsworth (SFPC); Merton, Portsmouth, Somerset, Surrey and West Sussex have implemented FSM with support from the Centre for Family Safeguarding Practice; Oxfordshire has implemented their own version of FSM.

- Number of children entering care, from 9% in Peterborough to 30% in Hertfordshire (6,10)
- Number of children on child protection plans from 7% in West Berkshire to 46% in Hertfordshire (6, 10).

The evaluation of specialist partner indicators with a focus on service use, demonstrated positive outcomes in relation to:

- Police - reduced contact, ranging from 26% in Peterborough to 67% in West Berkshire (hypothesis that majority related to domestic abuse incidents) (6,10)
- NHS - reduced emergency hospital admissions for adults (which reduced by one-half on average) (7)
- Mental health - reduction in the frequency of unplanned, reactive mental health contacts of between 75% in Bracknell Forest and 100% in West Berkshire (these were the only reporting local authorities), with approximately 80% of those receiving mental health support reporting an improvement in their anxiety and/or depression across the two reporting authorities (12).

Costing analyses demonstrated that the 'break-even' point of delivering the model (cumulative savings generated by the model exceeded the cost of delivery) occurred at eight months in Hertfordshire (10).

Evaluation of observations of social work practice (6) demonstrated only small improvements in MI practice skill during the first year of implementing FSH indicating the need to provide support to practitioners to acquire and develop these therapeutic skills and recognising the complexity of the statutory social work context.

Evaluation of professionals' experiences of SFT demonstrated a consensus in how they valued and were enthusiastic about the new way of working, with some challenges reported:

- Co-located teams providing and a joined-up working for children and families by improving risk assessment practice and providing immediate and appropriate support to families (14–16).
- Adopting MI as a new practice approach, spotlighting its role in eliciting change and providing the multi-disciplinary team with a shared value based and practice framework. Challenges were reported in relation to the time taken and support required to develop MI skills (14,17,18)
- Attending group supervision, a positive forum for embedding multi-disciplinary working and improving communication between agencies. The presence of specialist adult workers improved risk assessment practice and ensured that voices often identified at the fringes of conversations, such as the needs of

perpetrators of domestic abuse, were central to discussions about supporting change for children. Challenges were reported in relation to the logistics of arranging and attending group supervision (10,14,17).

Evaluation of parents' experiences of FSM largely report that parents valued the FSM approach. Parents recognised that their perspectives were valued and that FSM represented an opportunity to work together with professionals to improve their family's circumstances (12). Case study data from eight families who participated in the national evaluations highlighted the transformative impact of this way of working, with social workers and specialist adult practitioners working together as a team to understand their needs, strengths and resources and ensure that support was both effective and humane (7,12).

The FSM evidence base demonstrates positive outcomes in relation to service use and professionals and parents' experiences, with some variability and inconsistencies in outcome measures applied. Variability in outcomes across local authority contexts highlights the complexities in achieving change across the safeguarding system and the need for SFT to focus on the context of implementation and the quality of implementation processes. Inconsistencies in the range of outcome measures draws attention to the need for SFT to focus on developing meaningful and collectable outcome measures.

SFT implementation

As of November 2023, 127 family groups were currently open to SFT(1). Within these family groups 267 children and 148 adults were receiving help and support from SFT. In the first eleven months of the pilot (January to November 2023), SFT has completed work with 17 family groups (36 children and 20 adults) and their cases closed to children's social care.

Implementation of the SFT pilot depended on one-off project costs, including for MI training and IT, as well as seed funding for adult specialist practitioners. To enable co-location of multi-disciplinary teams, a series of partnership agreements were established with: substance use (HumanKind/Reach); Dorset Healthcare University NHS Trust (Steps2Wellbeing); domestic abuse – victims (Paragon); and domestic abuse - perpetrators (Probation)(1)

In line with other local authorities' experiences of implementing FSM (17–20), and reflecting the national position in health and social care recruitment challenges, it was not possible for the pilot to launch with the full complement of 12 practitioners in position. Adult specialist practitioners were recruited incrementally from December 2022 to December 2023 (domestic abuse – perpetrator). Table 1 details the timeline of

employment of specialist practitioners. Appendix 1 details the staffing position as of January 2024.

Table 1 Timeline for adult specialist practitioners joining SFT

Specialism	Timeline	Number of specialist practitioners[2]
Substance misuse	December 2022	3
Domestic Abuse – victim	December 2022 May - December 2023	1 2
Mental health	March 2023	4
Domestic Abuse – perpetrator	December 2023	2
Total number of specialist practitioners		**12**

The focus of implementing SFT for children's services included increasing additional duties by expanding the role of team managers' roles to oversee adult practitioners and SFT cases and lead group supervision.

Between August 2022 and January 2024, MI training was delivered across the three pilot localities to social work and specialist SFT professionals. In total, across the three pilot localities, 77 out of 102 (75%) social work (excluding Early Help) and 12 out of 12 specialist professionals (100%) attended training, with some variation in the proportion of social work professionals by role and locality (Table 2).

[2] Please note that full time equivalent (FTE) varied by post, see Appendix 1 for details.

Table 2 Social workers' MI Training attendance by role and locality (January 2024)

Service/Locality	Role	Number attended	Actual no. of posts	Percentage attendance
SFT Professional Workers	All roles	12	12	100%
	Total	**12**	**12**	**100%**
Chesil Social Care	SC Manager	5	6	83%
	Social Worker	38	47	81%
	Family Worker	3	5	60%
	Other	3	0	n/a
	Total	**49**	**58**	**84%**
Dorchester Social Care	SC Manager	3	3	100%
	Social Worker	8	20	40%
	Family Worker	2	2	100%
	Other	0	0	n/a
	Total	**13**	**25**	**52%**
West Social Care	SC Manager	1	2	50%
	Social Worker	12	14	86%
	Family Worker	2	3	67%
	Other	0	0	n/a
	Total	**15**	**19**	**79%**
Total Social Care	SC Manager	9	11	82%
	Social Worker	58	81	72%
	Family Worker	7	10	70%
	Other	3	0	n/a
	Total	**77**	**102**	**75%**
Social Care & Professional Workers	**Total**	**89**	**114**	**78%**

Developments in the national policy context

Since the launch of SFT, the Families First for Children (FCC) Pathfinder programme has been announced as part of the government's children's social care implementation strategy. Building on Dorset's Children Thrive model and the SFT pilot, Dorset was selected as one of three local authorities to implement its locally based, multi-disciplinary family help programme.

At the end of 2023, new Government guidance was issued: Working Together to Safeguard Children 2023 and the National Framework for Children's Social Care (21,22).

While the latter is focused on children's social care, it sets out six principles of practice that are relevant to the SFT partnership:

- Children's welfare is paramount
- Children's wishes and feelings are sought, heard, and responded to
- Children's social care works in partnership with whole families
- Children are raised by their families, with their family networks, or in family environments wherever possible
- Local authorities work with other agencies to effectively identify and meet the needs of children, young people, and families
- Local authorities consider the economic and social circumstances which may impact children, young people and families

In addition to the principles of working together to ensure that families stay together wherever possible, the focus on partnership working with parents reinforces SFT's approach to acknowledging the strengths within families by "holding a focus on the whole family [as] often the best way of improving outcomes for children and young people" (22).

Overview of the evaluation

Evaluation questions

To capture formative learning from the pilot, a primarily qualitative study was designed to identify key influences on the progress and effectiveness of SFT from the perspectives of parents, practitioners and strategic partners. The evaluation answers the following research questions:

1. Has SFT been implemented as planned and how has the process of change been experienced by stakeholders?
2. What were the factors that helped and hindered successful implementation?
3. How have families experienced the new service compared with their previous experiences of the service?
4. Are there indications that SFT is impacting on service and partner level outcomes?

Evaluation methods

To answer these questions, data collection and data review consisted of three strands:

- **Process of implementation** from the perspective of professionals to understand if implemented as planned and what factors helped and hindered success
- **Service experience** from the perspective of parents receiving SFT compared with their previous experience
- **Performance outcomes** data as demonstrated via SFT's performance outcomes framework on service use.

Interview and focus group data within strand 1 (process of implementation) and strand 2 (parental service experience) were collected between October and December 2023 (see Table 3 for numbers of participants by group). The performance outcomes strand was designed to review data collected via SFT's local multi-agency outcomes framework. At the time of writing the report, mechanisms for collating data against outcomes indicators were still in progress across the partnership. However, outcomes data from children's social care has been provided via SFT's business case (1) and included as part of our analysis (see Appendix 2 for more details of SFT multi-agency outcome indicators).

The first strand of the study explored the process of implementing SFT. Interviews and focus groups focused on the degree to which the core components of SFT were understood and adopted by key stakeholders, including strategic partners, senior managers, middle managers and frontline practitioners to understand if SFT had been implemented as planned. In total, 33 participants took part across five interviews and eight focus groups[3]. Of these, five interviews with six strategic partners were conducted with participants from Children's Social Care, Dorset Healthcare University NHS Trust (Steps2Wellbeing mental health services), Reach Dorset (substance use), The You Trust/Paragon (domestic abuse - victim) and Probation (domestic abuse - perpetrator). Twenty seven participants took part in eight focus groups, including social work service managers (4); social work team managers (3); social workers (11) and professionals from each service: substance use (4), domestic abuse (victim) (2) and mental health (3). Due to the timing of the focus groups, it was not possible to include domestic abuse perpetrator professionals.

A second strand focused on the experiences of parents and carers receiving SFT. Parents were identified initially via service managers and team managers, following consideration of criteria discussed with the research team. Criteria included: the nature of concerns and support from specialist adult practitioners; legal status i.e. Child in Need or Child Protection; age of child; and critically, where the parent had previous experiences of working with children's social care to compare with SFT.

Following identification of the sample of parents, social workers invited families to participate in a research interview, and where families agreed, the research team was provided with their details to confirm participation. Eight parents were contacted by the research team and agreed to take part in an interview. Three interviews did not take place due to parental illness and logistical problems. Five interviews were completed in October and November 2023; two interviews were in person at the parent's home and three interviews were by telephone.

The five parents were mothers of between one and four children who were subject of child in need and child protection plans and who all had previous experience of children's social work involvement. Within the group of five mothers, four discussed experiences of domestic abuse, one discussed experiences of childhood abuse, three discussed additional health needs, including a learning disability and neurological conditions, three discussed experiences of substance use and four discussed mental health needs including anxiety and post-traumatic stress disorder.

[3] All interviews and focus groups with professionals and parents were audio recorded, with the exception of the focus group with substance use workers where contemporaneous notes were made.

Table 3 Number of research participants by group and research format

Participant group	Number of participants	Research format
Parents	5	Interview (3 Telephone; 2 in person) (5)
Strategic leaders	6	Interview – MS Teams (5)
Senior and middle managers (Social work)	7	Focus groups (3)
Social workers	11	Focus groups (2)
Substance use workers	4*	Focus group (1)
Domestic abuse worker	2	Focus group (1)
Mental health worker	4	Focus group (1)
Total	**33**	

*included a student on placement

Ethics

Ethical approval was granted for the study via the University Research Institute's ethics committee (reference number IASR 03/23).

Key findings

Professional perspectives on SFT implementation

SFT implemented successfully

Interviews and focus groups with strategic partners, managers and practitioners across domestic abuse, mental health, probation, social work and substance use indicated that SFT had been successfully implemented. A striking finding from interviews with professionals was the remarkably cohesive narrative about SFT's practice model and its focus on keeping families together by working together more effectively. This included shared enthusiasm, commitment and understanding of the overall aims, objectives and key components of SFT. This was supported by positive experiences of changes in how professionals worked together and with families, including numerous case study examples of positive impact for families.

Shared thirst for SFT

Professionals across all positions and organisations shared an enthusiasm and commitment to SFT. SFT was described as 'an exciting opportunity' and a 'brilliant idea' which 'I absolutely buy into'. A social work team manager expressed their enthusiasm as: 'I don't want it to stop. I want it right across Dorset'. The enthusiasm for SFT extended beyond the partnership, with one social worker describing how: 'the judge has asked me in Court, "is it going to extend?"'.

Shared understanding of SFT aims

Keeping families together, where safe and appropriate, was understood as the fundamental aim of SFT. This was consistently expressed across interviews with professionals, succinctly articulated by a domestic abuse practitioner as:

> The whole concept really is for less children to be taken into care which is what everybody wants' (Domestic abuse professional).

This was understood as both benefiting families by preventing them from being 'torn apart' from which is 'damaging for the child, it's damaging for the parents', and in relation to public cost: 'if you take less children into care, it's almost like it will pay for itself'.

Strategic leaders across the partnership also discussed the longer-term aims of SFT, reflecting on the importance of a whole-system perspective. Longer-term and system-wide aims included 'breaking the cycle', including preventing later entry into the criminal justice system and changing the perception of Children's Services so that 'people should feel safe...to seek help and get supported'.

Embedding SFT's key elements

Multi-disciplinary working to wraparound families

SFT was understood as a whole family approach to child protection. This was articulated as developing an inter-professional, holistic approach to working together, to meet the needs of parents experiencing difficulties in relation to the 'trio of vulnerabilities' - domestic abuse, mental health and substance use - that were creating safeguarding concerns for children. The importance of 'better relationships', 'joined up working' and 'learning together' was identified as key to support effective inter-professional working:

> Before practitioners would see the mental health and the drug and alcohol separately, like you had to deal with the drug and alcohol problem before you could get them into health support and there'd have to be a three-month gap of you being sober before you could engage with the mental health. It's nice to see now that those two strands run alongside each other, because that's what they do, sometimes people use drugs and alcohol because they've got mental health problems, if you can't address those issues then you can't fix either problem. For me, that's been the most interesting to see that link up between those two and how that's helped our families that we work with (Social worker).

Sharing information, knowledge and best practice between individual specialisms was acknowledged as a learning opportunity across specialisms, meaning parents received a much more seamless, responsive service. For example, domestic abuse professionals discussed the importance of attending to language and meaningful use of the term 'domestic abuse'. They valued being able to share their expertise regarding the ebbs and flows of the process, including a parent's emotional journey and experiences of guilt and how this might impact on and lead to pauses in engagement. This contrasted with previous challenges in multi-agency working, due to pre-SFT 'siloed' operational structures:

> Creating that kind of wraparound approach is sometimes so difficult when you're in different services because the communication can be difficult. In the SFT team, we can share information freely. It's much more focused on working together (Mental health professional).

> We're getting a better understanding of their service and what they do, and they're getting a better understanding of our processes and what we do and how that fits in … that means that they're [adult specialists] communicating the information we need when we need it, because they know the processes now. And we also can go and learn about their assessment processes and where they signpost parents. So I think it's bringing together a better working together than it has been (Social worker).

> If one of my parents has called them, they'll say [adult specialists] "they sounded really upset"...I can jump on it immediately. Instead of going to voicemail, sending an email and me being out on a visit and not picking that email up, like I might have missed an opportunity to help the parent and therefore support the children. I like that element of that instant feedback (Social worker).

Experience of SFT by specialism

For domestic abuse professionals, specific benefits related to an enhanced understanding of adopting a whole-family perspective and understanding the child protection process, including the Court process.

> I think that's the core service [the rest of children's social care] misses out because it [SFT] is so person-centred. We have an understanding of how the Family Court process would need to see the family in terms of the perpetrator, where you've been actively making them feel safe (Domestic abuse professional).

For mental health professionals, specific benefits related to contacting social workers, a process that previously would have involved calling 'CHaD' and 'being on hold for an hour' and then 'playing ping pong' for a week. The benefit of being co-located means that professionals 'can just walk over' to speak with social workers, enabling sharing and understanding of 'little details' that are 'really helpful' to act on with parents.

This was confirmed by substance use practitioners who commented on value of inter-professional informal communication, meaning that social workers could – and did – 'walk over for little bits of advice', meaning decisions on actions could be taken quickly, such as and who is best placed to action something: 'are you going to call housing or shall I?'.

For social workers, specific benefits related to increased hope, a feeling of shared responsibility for safeguarding: 'we're not holding all the responsibility, it's a joint responsibility...it's all of us'. A social work service manager and team manager described the impact of SFT on the social work teams as "boosting people" by providing resources that create hope for change to keep families together:

> It gives them something to take away some of the hopelessness that they feel sometimes... "What am I going to do? I can't get other professionals around the table", it's actually giving them something...to change things...with a focus on keeping families together (Social work service manager).

A social worker reflected on how she had developed an understanding of the process of drug use recovery which had led to 'less risk averse' approaches to practice, enabling a much more empathic and understanding approach with families:

> Not go in and say, “Right, you’re using drugs, we’re going into the more safety planning and harder restrictions as you as a family,” whereas they’re saying actually this is all part of the process. So that’s been helpful (Social worker).

A social worker discussed how they had developed the confidence and capacity to include fathers, who had previously been under-represented in their plans of work, including ideas to initiate a ‘dads’ project’ to create a focus on intervention and support for fathers. Substance use professionals also highlighted work with fathers and how SFT was enabling this to happen in a way not previously experienced.

Group supervision

Group supervision was consistently identified as whole family-focused that enabled legitimately different perspectives to be raised to ensure that families got the best service available. All specialisms and social work team managers discussed how they valued the ‘powerful dynamics’ with group supervision and welcomed being part of, challenging conversations between professionals with different perspectives and areas of expertise. This enabled a shared responsibility for risk and more informed conversations about what might be happening within families:

> It’s my favourite part of the job...we all sit down and discuss where we’re at with each of these families. We all learn so much and decisions are made about what to do next...it’s just absolutely imperative...(Mental health professional).

> [It’s about] working as a team around that particular family, considering how are we going to help this family, move them forward, we can disagree… it’s a chance to educate each other... it’s sharing our skills and knowledge (Substance use professional).

> They’re always willing to understand that *could* be going on within a family, that it might not be quite as it seems. This is a wider story where you have to identify what needs to be done or what can be done to make it work (Domestic abuse professional).

> When it comes to group supervision it feels like those risks are kind of shared, it’s not all just on you...to be able to sit there and talk about it with other people who are going into the home and are seeing the families as we are, then it just feels like that risk and those decisions are shared a bit more (Social worker).

This included thinking together about where families might be in terms of change, using MI to help articulate where families were within the change cycle, while maintaining a focus on the safety of the child:

> We say where that individual is, are they in pre-contemplation? Are they in action? Whereabouts do we see them? Then what's the level of risk to the child? So the end of it does bring it back to the child where we say what is the RAG rating for this child's safety? (Social worker).

Crucially, group supervision enabled practitioners to 'think outside the box as to where we go next with this family", meaning families were more likely to receive a coherent and considered service.

Team managers and service managers discussed how they valued the business support role to record the minutes from group supervision, removing an administrative burden from team managers and enabling them to fully engage in their role as chair and contribute to the reflective discussions. The value of group supervision was recognised by strategic leads across the SFT partnership, who identified efficiency savings in terms of creating a multi-agency in person meetings, which prior to SFT would have been a much lengthier and more complex process involving identifying and inviting professionals with whom there was no existing working relationship.

Motivational Interviewing

Among practitioners and managers, there was consensus that MI as a new model of practice had been embraced. A substance use practitioner described the MI approach as 'the bedrock' of the model; and described how for them, MI underpinned a change in social work practice approach from what could sometimes be regarded as adversarial to becoming more strengths-based and non-judgemental, with recognition of parents' wider contexts.

A key benefit of co-location was the ability to hear, and learn from the MI practice of other SFT team members. Team managers described hearing social workers' using MI on telephone, with some social workers 'using it more and more'. Social workers welcomed the opportunity to learn from substance use practitioners, who expertly used MI during telephone calls with parents. Mental health practitioners described how MI dovetailed with their approaches, such as a shared core ethos of 'unconditional positive regard'. Domestic abuse practitioners discussed how they had embraced MI, with a case example indicating how MI had framed their practice, including explaining the 'cycle of change' to a parent:

> I said, "I can see you're stuck at the moment, and you really want to be doing the things they're asking of you [children's social care], but you're struggling to make that decision to do it. One comment she made which stuck in my head was, "If I go to them and say my mental health is really bad it's going to be held against me." This is where I explained the Cycle of Change, I said. "Look, you are addressing it

> and you are willing to engage and take the support that is being offered, you're not going to be frowned upon for that (Domestic abuse professional).

Impact of SFT for families

Improved working together with families

Professionals from across the SFT specialisms identified the positive impact of SFT for families. They discussed the 'huge difference' SFT had made for some parents and children's lives and how for families who were at the start of their SFT journey 'this process has kept the hope alive'. They how described it provided the 'best support possible for families that are struggling with their parenting' that was focused on partnership working:

> "Look, let's talk about you and what we can do for you," it seems to have worked really well… at a really difficult time in their life having the support for them I kind of explain to them, "Look, when you're engaging with me and working with me I can report this back and you're doing really well." So, I find that it seems to be working really brilliantly, it's really positive (Domestic abuse professional).

This was confirmed by a substance use professional: 'in parents' darkest moments, it's a privilege to be let in, to provide client centred help and support and guide them'.

Positive engagement with families

A consistent theme identified by all SFT specialisms was improved engagement achieved by working differently and offering more flexibility to families. A social worker described how a father who had previously not engaged with support had responded well to the consistent commitment from professionals to support him, resulted in a willingness to work with the SFT team, rather than 'disengage, disengage, disengage, close', with the cycle repeated. This had 'kept the hope alive' that he would be able to continue to care for his children. Another social worker reflected 'I've definitely seen an increase in engagement with my families because of the flexibility'.

A mental health professional described how parents were benefiting from the increased flexibility as engagement was higher, compared with the service as usual, with its 'very strict' attendance criteria, meaning that many individuals are discharged prior to completing treatment:

> I think by being flexible with rescheduling appointments...it means we actually get better engagement. I've rescheduled them [appointments] four times, however, they engage a lot better. You get that flexibility of it, it [session] can be an hour if it needs to be an hour rather than half an hour but then they get on so much better as a result of that... I think you're dealing with the most vulnerable people which if

> they came through the NHS, the structure of it is just never going to work. Where it's kind of proving that if you give them a bit of leeway, actually, it gives them the opportunity to engage (Mental health professional).

Social workers reflected on the benefits of SFT's 'personalised', 'accessible' and 'user friendly' approach' for parents. This contrasted with previous experiences of individual services as 'a building' which was experienced by parents as impersonal, anxiety-provoking and practically quite inaccessible for families, many with no access to a car, with the journey involving using a poor public transport service. They discussed the importance of the same professional visiting families at their home or meeting with them at an accessible venue, resulting in improved trusting relationships and parental confidence that they will get help and support for 'serious issues':

> People don't want to have to go into offices and talk about the most vulnerable areas of their life...It's clinical, isn't it, going into an office and being sat in a room. (Social worker).

Social workers discussed the benefits of the inter-professional SFT service for parents, in terms of a positive change from the previous model that they described as a series of separate services with complicated referral criteria, which created barriers to parents' timely access. They perceived that SFT's more holistic approach with 'strands that run alongside one another' in parallel was experienced positively by parents who could see that with the new model 'we're all singing from the same hymn sheet' and "actually you're here for us". The change to family-focused, flexible practice that was home-based was a noticeable feature across interviews with professionals, including strategic leaders:

> They're going to the home. They're not just giving appointments to people to turn up...It's breaking down barriers, it's a lot more accessible (Strategic leader)

> Being able to give the parent a better chance of getting that therapy... I feel really passionate about it. They would no way have got mental health support if we didn't go to them (Mental health professional).

> They're getting that treatment in their home where they feel safe and comfortable to speak. That's a real change, I think. And they're going to them, so quite often if mother or father are depressed or socially anxious, don't want to get on the bus, don't want to travel there, they've got the support, it's quicker … and improves engagement (Social worker).

Improved family outcomes from professionals' perspectives

Professionals from across specialisms, as well as managers and strategic leaders identified specific examples of how SFT had improved outcomes for children and families. A social work team manager described how SFT had made a positive impact for a family in which a mother and father's relationship was 'very toxic', and the children were exposed to relational violence. Through a domestic abuse and mental health worker working together with each parent, the professionals and parents developed a new perspective and understanding of underlying issues that related to the mother's experience of sexual abuse and trauma. While the work was continuing, the shared 'focus and understanding of trauma' had enabled a clear plan to be created and the children were 'not being exposed any more'.

> I think the mum that I've been doing EMDR with who was involved in something horrific and her life just has taken a wrong path after that...she stuck with the EMDR and that's been really difficult. That's really helped her with the trauma and that's really good because it's just been a rough ride, but she did it (Mental health professional).

From a substance use perspective, positive impact was described in terms of parents' engagement and successful completion of treatment programmes. SFT had provided a 'doorway' for many people who had previous experience of substance use but had not previously engaged with substance use services to access support 'at any level' and a 'gentle push' for people who had previous experience of the service but whose engagement had lapsed:

> In such a short space of time, less than a year, we are successfully moving people through treatment from a drug and alcohol service point of view. People, adults, families that have never been involved ... are now becoming engaged with us, going through the 12-week treatment programme, and successfully completing at the end (Substance use professional).

Factors supporting successful implementation

Shared vision and ownership

Strategic partners consistently identified a shared vision and ownership of the SFT approach. There was recognition of the value of reconfiguring the child safeguarding system as a shared approach with a 'shared agenda...shared leadership...shared funding' rather than the current model of being led by social care. They described how SFT provided the opportunity to develop a longer-term, integrated strategic partnership, reflecting the shared aims and values across health and social care organisations to improve outcomes for children and families:

> We all want better things, don't we as a partnership, for our children. All our services work with kids in care and kids on child protection, don't we? There's something better we can do. Here is the research...this is evidence-based practice. This is being promoted by the Government across the country as a good model (Strategic leader).

Partnership working was welcomed and willingness to adapt to suit individual partner agencies appreciated. They described feeling valued and a willingness to explore differences in perspectives, noting that any challenge was largely constructive and focused on ensuring that SFT was successful:

> Partner engagement has really worked well, the [local authority] team have been very, very open and supportive of challenge and want to work in partnership with us, to resolve any issues and being quite proactive to resolve issues as well. That is a real positive because that hasn't happened in other areas where I've worked, it's almost been, "this is what you need to deliver, deliver it," and it's kind of like well, that doesn't always work like that. So, I think having the ability to have those open conversations has been really beneficial for the project (Strategic leader).

Strategic leaders discussed the importance of navigating 'teething problems' during the early phases of implementation recognising that this was a pilot project. This was achieved by professionals committing to a relational, open and adaptable approach, based on having 'straight conversations' to 'negotiate pathways' from diverse professional positions and develop shared learning within the pilot:

> Teething problems that you would expect with a new project, with a new team, with a whole new concept. You're going to expect some bumps in the road...Of course we're flexible and of course we'll negotiate (Strategic leader).

Where possible, strategic leaders highlighted how they had adapted their practice protocols to ensure that SFT was flexible and family-focused. For example, mental health discussed how they had adapted the traditional three-step pathway from referral to assessment to treatment, to include two new MI phases for parents. The first MI phase falls prior to assessment, and the second prior to treatment. The MI phases are available for parents who are 'not quite ready' for the next phase. This has had a positive impact on engagement levels in the treatment phase, in terms of parents notifying the practitioner if they are unable to make the appointment and in attending the appointment.

Implementation challenges and areas for development

Strategic partners, managers and professionals identified a suite of challenges and areas for future development, including commissioning across complex structures; recruitment of specialist practitioners; managing high demand for services within limited resources; revisiting the logistics of group supervision; tensions between MI statutory processes.

Complexities in the commissioning processes

Strategic leads across the partnership discussed complexities within the commissioning process to secure additional available funding. Complexities included a lack of clarity in the budget holder's identity, the funding duration, and the length of contracts for adult specialist practitioners, which served to impact on recruitment processes: ‘I think people need to be aware of, is the different commissioning and funding through the different agencies’ (Strategic leader).

Recruitment of adult specialist practitioners

There were differences in the recruitment and retention of specialist practitioners by professional group. The substance use team experienced recruitment as a smooth process that enabled them to ‘hit the ground running’. Whereas recruitment challenges in domestic abuse, mental health and probation services - reflecting national challenges - meant that vacancies were filled incrementally over the SFT period (see Appendix 1 for breakdown of posts by employment start date).

> They’re valuable professionals, aren't they, like a lot in the public sector, and they’re valuable because they do brilliant work, but because there's not enough of them. So, we’ve got some empty posts in those adult services, professional discipline space...Even when you get that money, the challenge is can you recruit the right people? That’s not a Dorset problem, it must be nationwide (Strategic leader).

Similarly, while retention was mostly positive, it was identified as an issue in the mental health team, due to the promotion of two of the three professionals, leading to disruptions to the continuity of inter-professional and professional-parent relationships, resulting in increased waiting lists and waiting times.

Managing high demand with limited resources

Early implementation was marked by some confusion regarding which families should receive the SFT’s wraparound service to maximise impact in terms of outcomes for children. The lack of clarity concerning referral criteria for adult specialisms, resulted in some families being referred inappropriately, for example, where experiences of domestic abuse were historic, or where they had had previous need for substance use

input. This is part reflected in commitment to social work values regarding the right of all families to receive SFT. It also reflected initial lack of understanding about the role as well as the capacity of the adult specialist practitioners to provide the level of service demanded:

> Capacity is limited, which it always will be, we're never going to get around that, it's about the social care teams understanding our role better and I think you know, we have got there now, more or less there now and understanding the limitations of what we can do as a service and what support we can provide (Strategic leader).

This was compounded by the complex suite of needs experienced by families and the time to engage, identify priority needs and treat parents, 'it takes time. It's not a quick fix'.

From the perspective of children' social care, balancing the rights of families to the services with capacity to provide that wraparound support was challenging. Given parents had had positive experiences; they wished to offer the SFT to all parents in need of help and support:

> People are buying into it, seeing the results; they trust it so they put forward more families...that creates more demand (Social work manager).

> We want every family to be able to access it so that we're not picking and choosing who is and isn't worthy of that service or in greater need of that service, because we need to watch our outcomes down the line (Social work manager).

Social work professionals also reflected on how to manage endings and step-down parents from social work involvement when the level of safeguarding concern has reduced. They highlighted the challenge of withdrawing support toward the end of the programme and impact on family members:

> There's that balance...it would be wrong to say to a family "Okay you're doing really well, but actually we're going to take everything away now". It's really difficult (Social worker).

> We almost need a holding team to hold the ones that are no longer safeguarding but we can't just stop the other support (Social worker).

There was general agreement of the need for more specialist workers to meet the high level of parental need and to reduce and avoid waiting lists, 'We need more'. There was a shared desire for the model of inter-disciplinary working to continue and a hope that it would expand across the County so more parents would be able to access the specialist services to meet their needs.

Managing the logistics of group supervision

Managing the logistics of group supervisions was a consistent theme within interviews with team managers and professionals from all specialisms. Professionals noted challenges in the number of supervisions, including the logistics of bringing all the specialisms together, and for adult-focused specialisms, the impact of cancellations on clinical time meaning that they had less time for direct work with families. The volume of group supervisions was a specific issue for social work team managers who were struggling to meet demand:

> Some weeks, my weeks are full of group supervision and that's not really counted in the work we do...we wouldn't normally talk about a family for an hour...we don't have time to... (Social work team manager)

> I used to read all the case summaries before, so I was fully up to date. I don't have time for that now (Social work team manager).

Social work professionals also highlighted the unintended consequence of group supervision for families not receiving SFT, with fewer opportunities to discuss and reflect on their needs through 1:1 supervision. They also noted reduced opportunities for personal supervision: 'I haven't had supervision on my other cases or personal supervision, so I think that's a risk'.

Congruence of MI with statutory processes and existing practice models

From a social work perspective, MI was identified as in line with their value base but challenging to embed routinely into their practice. They understood that it took time acquire and apply MI as a therapeutic skill, meaning that 'it has got a little bit left behind'. There was shared agreement that practitioners and managers required further practice development opportunities to re-ignite the adoption and development of MI. However, they highlighted that high and complex caseloads reduced professionals' capacity to engage in training, reflective practice as well as to embody and enact MI principles: 'the complexity of the cases is so much more complex than I've ever known'.

From a mental health perspective, practitioners discussed differences between the structured CBT model and the incremental change approach of MI, meaning that it was not easy into integrate in practice: 'is it forcing two models that just don't fit together?'

From a domestic abuse perspective, practitioners raised the complexities of introducing MI as a therapeutic approach into statutory child protection process. They reflected on the lengthy change process for survivors of domestic abuse and the importance of identifying the appropriate time to use MI.

I think with domestic abuse it's really hard for people to make that change, especially if they don't feel supported or safe. If there's been a lot of control, making decisions for themselves, even simple ones like, "can I wear red lipstick today?" could be really hard. So for them to maintain the change that perhaps the social workers would like them to do, is really difficult. So for them, making even small changes means that they have done really well, like making contact [with services]. That's quite normal, but it's very hard especially when they're on a Child Protection Plan and the consequences of them not doing that is going into Court, or they're already in Court. So I think that's the difficult bit. You're supporting somebody when they may have been in a relationship for 20 years with someone who's controlled them, they love them no matter what they've done to them, they absolutely love them....They can change their mind, so you can do as much Motivational Interviewing as you like on every day and they'll agree, but you have recognise when they are a point where they want to change and you can start talking. That's where the motivational interviewing comes in for me (Domestic abuse professional).

Parental perspectives on experiences of SFT

Humane service

Parents experienced SFT as a holistic, helpful and humane service that was focused on building respectful relationships to support them make changes for themselves and their children. They identified the importance of partnership working, where they worked with a team of professionals who worked well together and offered accessible, flexible emotional and practical support and guidance tailored to meet their needs. They rated their overall experience of SFT at 8 to 10 on a 10-point scale in stark contrast to their previous experience of social work involvement, which was rated from zero to two; this was captured succinctly by one parent who observed, “it feels totally different”.

A parent reflected on how she sensed that the SFT approach was ‘holistic’ and that there was an acknowledgement of the complexity and the inter-relationships between her experiences of domestic abuse and poor mental health and the impact on her children:

> It seems like they’re looking at the whole, how everything interrelates, so the domestic abuse and then the mental health and then your children are part of that but not everything’s separate? So maybe that’s what this new project is doing is it’s enabling almost, yes, that word “holistic” to look at everything and around? (Parent)

Partnership working

There was an awareness of that SFT could potentially be overwhelming, given working with multiple professionals concurrently. However, one parent described how she valued the professionals’ invitation to co-create the plan for working together, and how her perspective was respected and informed the area of concern to focus on first:

> They asked me my opinion and obviously, what I felt and what worked for me and they went with it, so, and it’s worked really, really well (Parent).

Parents reflected how they valued working with a team of professionals characterised by continuity of professionals and strong inter-professional communicative practices. This was particularly welcome so that parents did not have to explain repeatedly their sensitive and emotional experiences; parents felt that members of the professional team had a shared and current understanding; in other words, they “were on the same page”.

> Having everyone talk to each other – not “I have to keep telling everyone”. They all do talk to each other because they are working together as well as with me. It’s fantastic...I feel it’s really worked together and you can see how they do talk to each other. It’s just, makes it twice as easy for me, so I don’t have to keep explaining everything, emotions... It helps (Parent).

Flexible and responsive

Parents identified the flexible, accessible and responsive contact they had with professionals within the SFT team as a key strength. They appreciated the benefits of professionals coming to their homes – rather than going to office-based appointments - and offering flexibility regarding timings. They shared examples of professionals being accommodating where they or their child was not well and how they valued being able to contact their worker by telephone in between appointment times, and critically the quality of professional responses:

> The contact with her is brilliant. (Parent).

> I love how flexible she is...she is really accommodating. (Parent).

> I did actually phone her ... she sent me a massive voice note. (Parent).

Strengths-based

Parents described how they valued the SFT team's practice approach; being listened to and understood by their workers who they regarded as "genuine", "supportive", "understanding" and "encouraging". They valued professionals' approaches to working with them which they experienced as non-judgemental, collaborative and strengths-based rather than "blaming" or "patronising" as per some prior experiences:

> They don't judge us...focus on the positive...pointing out the good stuff' (Parent).

> She understands and she doesn't patronise me. I've felt I've been patronised before (Parent).

Parental service by adult-focused specialism

Parents described the positive impacts of developing positive relationships with SFT as well as accessing practical and emotional support and guidance in relation to the areas that presented child safeguarding concerns. Parents reflected how through working together with the SFT team, they had developed new insights and self-knowledge relating to mental health, domestic abuse and substance use. This resulted in reduced alcohol and drug use, creation of safety plans, and improved mental health, energy and aspirations. They recognised that this had a positive impact for their children.

Substance use

Two parents who had worked with SFT substance use and mental health workers alongside their social workers, describe how their increased understanding of the impact of substance use had reduced their alcohol and drug use, resulting in improved physical energy levels and emotional wellbeing:

> [We] just had a chat and went through everything as to why [drugs and the alcohol use was problematic], and then she spoke to me from the safety point of view. She just went through all the effects that it can have on yourself, children, your genuine life, and then it can lead you to knowing the wrong people, all of that....Then we set up a plan for me to stop. Went through the symptoms of when you're giving something up. I cut down to cut out.... She only gave me the information on what I needed to know for what I was using at the time, and I found her so supportive and helpful. She went above and beyond as well, and I really found her really helpful and encouraging (Parent).

> It's been months now. I've not touched anything. The only time I have a drink is if we go out for a meal or birthday, you know, have a barbecue, that, that's it and I'm feeling so much better for it. I feel a totally different person. I haven't smoked anything for, well, I can't even count now, but ages. I feel good for that as well and I'm not tired all the time... I'm totally different from what I was a few months ago. (Parent).

Mental health

Two parents who had worked with a SFT mental health worker described how they had developed understanding of the need for social work involvement, their needs as an individual and their children's needs. They described a range of positive benefits from working together with their SFT worker, including: increasing their parenting capacity in relation to creating boundaries; developing new self-knowledge and awareness about the impact of how they were managing their anxiety and depression on their children; creation of new coping strategies resulting in a reduction in measured anxiety levels:

> It was for the overall welfare of myself and the children, and I think it was just me that needed educating a little bit...It definitely has helped me know myself a lot more than I ever have done...I'm quite surprised how well I've done in the short amount of time. I felt like my needs have been met, so now I can start meeting my own. More comfortable with making boundaries...especially with the kids...it definitely gave me new direction (Parent).

> It's definitely helping, it's helped so much. It's like she is unjumbling it all really, and I can think clearly...I see things much clearer now and she gives me little pointers...little tips on what to do if I'm in a downward dip... this time the scores were the best they have ever been...I do feel like I've turned a corner (Parent).

Domestic abuse

Two parents who had recently separated from abusive partners described how working with a SFT domestic abuse worker had enabled them to explore childhood and early

adult experiences of abusive relationships. They also described a range of positive benefits from working together with their SFT worker, including the importance of developing new insights into patterns of abusive relationships meaning that they felt more able to prevent this in the future; creating safety plans; and accessing advice and advocacy support in Court:

> We kind of talk about my childhood as well, because I experienced a lot of domestic abuse in my childhood, and how it's affected relationships since, obviously since I've grown up. She's helping me to spot the triggers before I'm too far into a relationship, because I've had several abusive relationships since recent adulthood, and she's helping me to spot the triggers so that I don't continue in this cycle of abuse (Parent).

> We'd sit and make a plan of safety action covering the children in the home, out the home, things like that. I've had a couple of Courts dates that I had to attend, she was really great at [helping to] prepare for Court and stuff, and she attended Court with me as well and she looks into things if I need any advice on things. (Parent).

Deeper impact of SFT for parents

In addition to experiencing positive impact in relation to the three areas of safeguarding concern, parents shared how their experience of working with the SFT team had created a broader and deeper impact on their lives. One parent discussed the impact of accessing the right support, making progress and "being listened to" in relation to "finally" feeling recognised as a human being:

> It's everything's just turned upside down and gone the right way and, yeah, being listened to. I actually finally feel like I exist, like people can see me (Parent).

Two parents discussed their employment aspirations in the health and social care sector as part of their longer-term goals and how they had been encouraged by the SFT team to explore volunteering opportunities. Developing links with employers and education providers is an area that could be developed further within SFT.

Impact of SFT on children

Two parents reflected on the positive impact that SFT had for their children, identifying how their increased vitality, sense of purpose and empowerment as individuals enhanced their capacity to care for, interact with and guide their children:

> I'm more likely to be more alive. I'm more out doing things, I'm more interactive with him. I've got more…I've got a reason (Parent).

They hated seeing me so upset and down. I tried to shelter them from it but I was either quiet, I would be happy with them because they make me happy, but I was crying a lot, I was getting angry, I was shouting...I've obviously done this and now I'm like, "Right, so now I've sorted myself out, I can now kit him with the tools" (Parent).

Opportunities for developing SFT

Parents, strategic partners, professionals and their managers identified remarkedly similar themes regarding the future development of SFT. The three areas of development identified were: promotion of SFT, extension of the SFT partnership and supporting development of social work practice, particularly adolescent safeguarding.

Promotion of SFT

Parents highlighted that SFT should be promoted more widely, celebrating that this was a different way of working with children and families that was focused on working in partnership with parents:

> Promote the SFT service amongst local communities, communicating the benefits of working together with the SFT team so people realise that they're not just there to take your kids away...it's not like it used to be..."we can actually help you" (Parent).

This was confirmed by professional participants who argued that the SFT should be launched into a new locality with a common start date, celebrating the new wraparound service offer to children and families. The benefit of a shared 'go live' date, from their perspective was the opportunity for common induction processes included MI training, safeguarding training, introduction to the statutory process, roles and responsibilities, protocols for sharing information. Strategic leaders understood the value of 'rolling out' SFT across Dorset, enabling more 'more consistent service that is not postcode based'.

Extend the SFT partnership

Participants in strategic and operational positions discussed opportunities for the development of SFT in relation to expansion of each professional group, including additional funding to increase overall capacity and resources in relation to each area of professional expertise and specific service offers. Specific service development opportunities included offering group work to parents. Domestic abuse professionals discussed the opportunity for an SFT offer of Hope2Recover, to enable parental engagement, maximising the parent-professional relationship:

> They know it's a friendly face, they've already seen us, so you know when you hear, "I don't like group work, I can't, there's going to be too many people." "Well, you know me, I'll be there, and we're going to have a smaller group", so it stops that anxiety' (Domestic abuse professional).

Mental health practitioners also discussed the opportunities to offer more low-level emotional wellbeing 'holding' support and group work around emotional regulation and counselling. They highlighted that the current offer of CBT was not appropriate for all

parents, and how parents with high level of needs required additional support, not currently available within SFT.

There was a consensus that the funded pilot and implementation period should be extended to allow SFT to embed and to create meaningful outcome measurement opportunities. Practitioners and strategic leads from across organisations suggested that periods of between two and six years are required to evaluate success and they would like to see SFT 'become the norm'.

Opportunities to scale SFT were identified by parents and professional participants, who identified the value of extending the partnership to improve capacity to meet families' needs. One parent discussed a need in relation to a learning difficulty and another in relation to a higher-level of mental health support:

> She said I need the next level up...high-intensity... but just the waiting times [for services were too lengthy] (Parent).

Opportunities to develop the SFT partnership include incorporating housing, adult social care, health, community mental health, education and employment to provide parents with a wider range of support for needs that create barriers to positive changes in their parenting capacity from being achieved.

Supporting social work practice

Parents highlighted that SFT worked better with young children, suggesting that there opportunities for revisiting the approach with adolescents. One parent discussed how she shielded her older children from social work involvement to protect them from experiencing stress and another reflected how while her younger, pre-school child had developed a positive relationship and enjoyed visits with the social worker, her teenage child experienced meetings as frustrating. This was confirmed by practitioners who also identified the importance of working holistically with all members of the family, discussing opportunities to expand SFT to re-unification teams within Children's Services.

Performance outcomes data

SFT have developed an outcomes framework incorporating outcomes measures across children's social care, mental health, substance use and domestic abuse (see Appendix 2). The evaluation team reviewed the data analyses that were reported in the SFT Business Case Report relating to children's social care, mental health, substance use and domestic abuse outcome measures (1).

Children's social care

Children's social care service outcome data was reported at two time points (November/December 2022 and November 2023) relating to the number in the overall cohort of children in Dorset and in each of the pilot localities. At both data levels, children were categorised as child in need, child protection, and looked after child.

Analysis of the two levels of data between the two-time points demonstrated variation in the number and proportion of cases that were categorised as child in need, child protection and looked after. It was not possible to draw any conclusions about trends in the children's services performance outcomes data relating to SFT.

Analysis of the number of children by category within and between the pilot localities compared with the overall cohort in Dorset demonstrated that:

- The number of children open to SFT at January 2024 (267) represented around a quarter (27%) of the combined number of children who were categorised as child in need and child protection cases across the pilot localities at December 2023 (Chesil: 392 and Dorchester and West: 303; overall: 695).

It is recommended that outcome measures are collected, reported and reviewed for the cohort of SFT children and families at an individual level so that it is possible to evaluate outcome measures at a more nuanced level.

Mental health

SFT mental health service use and engagement data was reported at November 2023. 141 referrals had been presented at SFT allocation, of which 72 (51%) were open cases. 68% of referrals and 72% of open cases were previously known to Steps2Wellbeing. Positive outcomes were reported in relation to engagement; parental engagement was 95% higher with SFT than with Steps to Wellbeing alone.

Substance use

SFT substance use service data was reported at November 2023. 89 referrals had been presented at SFT allocation, of which 48 (54%) were open cases. 28% of referrals and

29% of open cases were previously known to Reach. The high proportion of individuals who have been identified with a need for substance misuse support but who were not previously known to the Reach core service (71%) was reported to indicated a previous high level of hidden need understood in relation to barriers to self-referring that have been overcome through SFT.

Domestic abuse – victim

SFT domestic abuse (victim) service use data was reported at November 2023. 79 referrals had been presented at SFT allocation, of which 41 (52%) were open cases. 32% of referrals and open cases were previously known to Paragon/You Trust. Similarly, to the substance use service (above), the high proportion of individuals who have been identified with a need for domestic abuse support but who were not previously known to the Paragon/YouTrust core service (68%) indicates a previous high level of hidden need.

Domestic abuse – perpetrator

Not available due to recruitment start date of December 2023.

Conclusion

The data indicated a high number of referrals and level of need, with the highest level of need relating to mental health. Indicators of success include high engagement levels, both in relation to higher levels of engagement of individuals who were previously known to specialist partner services and new engagement from individuals who were not previously known to services. More nuanced and longer term data will be required in order to enable meaningful evaluation.

Additional data would be valuable to collect and report relating to analysis of pathways and outcomes following referral at the individual level, to indicate the status of individuals who have been referred, including:

- Areas of need
- Waiting by referral date/ RAG rating
- Closed prior to SFT support by reason
- Open by support from professional specialism including start date, duration and intervention, goals and outcomes
- Closed following SFT support with detail of intervention, duration, step-down, goals and outcomes

There is an opportunity to develop and refine outcome measures, exploring indicators that are currently collected within the service and the level of outcome analysis that would be most meaningful in relation to the domains of children and young people; parents and carers; SFT professionals; SFT services and the SFT system.

Lessons for future implementation

Within recent years, there has been a move toward embedding Family Safeguarding in child safeguarding services across England. Dorset's pilot experience of SFT demonstrates the potential for rolling out the model across all localities. Parents experienced SFT as a holistic, helpful and humane service that was focused on building respectful relationships to support them make changes for themselves and their children. The success of SFT was confirmed by strategic partners, managers and practitioners across specialisms who agreed that while there had been challenges, SFT had been successfully implemented. It is notable that all stakeholders – including parents – expressed that SFT should be promoted more widely, extended across localities and include other partners, such as housing.

Evidence from the formative evaluation supports the ongoing co-location of professionals from each specialism in the physical office spaces of each safeguarding locality in Dorset, to provide families with timely, accessible support personalised to their needs.

Recommendations for ongoing and future implementation are:

1. Support the ongoing co-location of professionals from each specialism in the physical office spaces of each social work locality to improve working together processes and practices and provide families with improved accessible support personalised to their needs.

2. Review and clarify the SFT referral process, including the criteria and capacity within SFT overall and each specialist pathway. Consider how to optimise the use of SFT where resource/capacity is limited, increasing clarity for professionals and avoiding parents' experiences of lengthy waiting lists. Introduce a mechanism to evaluate the effectiveness of referral pathways and processes.

3. Review and reignite the process of implementing Motivational Interviewing as a shared practice approach across SFT and children's services more broadly, including:
   - targeting areas with a lower uptake of MI training
   - exploring areas of congruence and misalignment with previous and current practice approaches and cultures, across and within children's services and each specialism
   - creating accessible ongoing opportunities for all professionals across specialism and roles to develop, share and reflect on MI practice

4. Review and develop group supervision logistical processes and practices to maximise effectiveness, including:
   - how to prioritise and set the frequency of discussions for each SFT family
   - a focus on creating achievable schedules to enable each professional to attend
   - the level and nature of reporting requirements prior to each group supervision to reduce unnecessary burden on practitioners and managers.

5. Review and develop the processes of outcome measurement, sharing learning and practices across specialisms and develop meaningful outcome measures at the individual, team, service, locality and cohort level, to include qualitative and quantitative data focused on outcomes domains relating to:
    - children and young people
    - parents and carers
    - SFT professionals
    - SFT services
    - SFT system

6. Explore opportunities to expand the implementation of SFT including:

    - review levels of parental need and available capacity/ resource in each locality to maximise the effectiveness of SFT design with a focus on the potential to employ more professionals to meet levels of high need in relation to substance use, domestic abuse and mental health
    - extend SFT across all Dorset localities and to other children's services e.g. reunification and leaving care
    - broaden the SFT partnership, including housing, health, adult social care, education, employment and community health with critical reflection on ‘who else needs to be round the table?’

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Appendix 1 Workers employment by role and date[4]

Mental Health (Steps to Wellbeing Service)

The Mental Health team have been in post since March 2023, cases were allocated from the end of March. Interventions currently provided are CBT; (Cognitive Behavioural Therapy), EMDR; (Eye Movement Desensitisation and Reprocessing). Trauma informed assessments are undertaken to inform which level of treatment is required.

FTE	**Mental health**
0.7	Clinical Lead (Team Leader)
1	CBT (Cognitive Behavioural Therapist) Practitioner (High Intensity)
0.5	Psychological Wellbeing practitioner (PWP)
0.5	Psychological Wellbeing practitioner (PWP)

Substance misuse (HumanKind)

The substance misuse team have been proactively supporting parents/carers since December 2022. The team are responsible for completing a full assessment and work collaboratively to monitor and review the family element of recovery/care plans and risk management plan.

FTE	**Drug and alcohol**
1	Team Leader
1	Recovery Navigator
0.8	Recovery Navigator

[4] Information provided via SFT business case (2024)(1).

Domestic Abuse – Victim (Paragon)

The domestic abuse victim team started operations in December 2022 with a single practitioner. Additional practitioners have joined the team in May and December 2023. The team assess and deliver effective interventions to increase safety and reduce risk.

FTE	**Domestic Abuse Victim**
1	Team Leader
1	DA Practitioner
0.8	DA Practitioner

Domestic Abuse – perpetrator (Probation)

The domestic abuse perpetrator team have been operation since the start of December 2023. They are tasked with work with perpetrators and the family to assess and manage risk of harm, with the aim of ensuring that the perpetrator accepts responsibility for their actions and is working to change behaviour.

FTE	**Domestic Abuse Perpetrator**
0.2	Senior Probation Officer (Within Probation) (*not co-located or included in the total number of workers*)
0.8	Probation Support Officer
1	Probation Support Officer

Appendix 2 SFT outcomes framework

Outcomes data currently collected in the table below.

Performance Indicator	Measure of outcome benefit and cost reduction
Reduction in number of new children (Under 18) coming into care.	Reduced under 18's CIC which leads to improved permanence outcomes for this cohort Also, consequent reduction in placement costs, case costs and court costs. (Costs associated with CIC across partners)
Reduction in the number of children who become subject to child protection plans (Under 18)	Costs associated with CP Cases (across partners)
Reducing the overall number of open cases to children's service	DC (Dorset Council)
Reduction in the average number of days children spend in care.	Children and young people in cohort

In addition, SFT have agreed an additional suite of outcome indicators with partners, the mechanisms for collating some of this external data is still in progress, see below.

Performance Indicator (family cohort)
Reduction in the number of care proceedings initiated
Improvement of educational attendance
Successful completion of treatment for substance misuse and no re-presentation within 6 months
Reduction in number of referrals to mainstream mental health services
Reduction in frequency of mental health crisis contacts
Improvements in depression and anxiety scores for adults

Reduction in number of Domestic Violence Incident call outs
Reduction in number of repeat Domestic Violence Incidents
Increase in number of successful completion rates of Domestic Abuse programs both victim and perpetrator
Increase in the number of referrals to SFT adult practitioners
Reduction in need for families open to statutory Children's Services

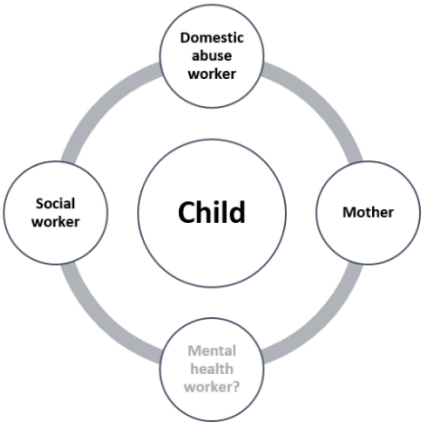
Appendix 3 Case study examples

Case Study 1

Working together to address safeguarding concerns relating to domestic abuse

- Arranged for mother to attend 'Me, you, mum' weekly course
- Created a 'safety plan' with mother
- Helped mother prepare for court
- Attended court with mother
- Arranged for additional security for the mother's home
- Advocating for mother with solicitor to extend non-molestation order

- Regularly visiting home to meet with mother and children
- Referred mother to domestic abuse worker
- Secured additional childcare hours for 3 year old daughter
- Changed nursery hours so that mother was free to attend 'Me, you, mum'



- Working with domestic abuse worker
- Created safety plan with domestic abuse worker
- Reported abuse
- Prepared for and attended court with domestic abuse worker
- Attending 'Me, you, mum' weekly course
- Developing understanding of the impact of domestic abuse on children and mother
- Meeting others who have been or who are in similar situations
- Sharing information about legal advocacy support domestic abuse worker is providing with social worker

Mother's positive experiences of Safeguarding Families Together

Mother re. positive experience of working with domestic abuse worker

We'd sit and make a plan of safety action covering the children in the home, out the home, things like that. I've had a couple of courts dates that I had to attend and preparing for dates and then preparing for court and stuff, which she was really great at doing and she attended court with me as well and she looks into things if I need any advice on things.

Mother re. positive experience of working with the SFT team

I'd probably give them a 10, to be honest, because they are brilliant...Between everyone, we've all worked really well, been able to do it.

Mother re. positive experience of working with social worker

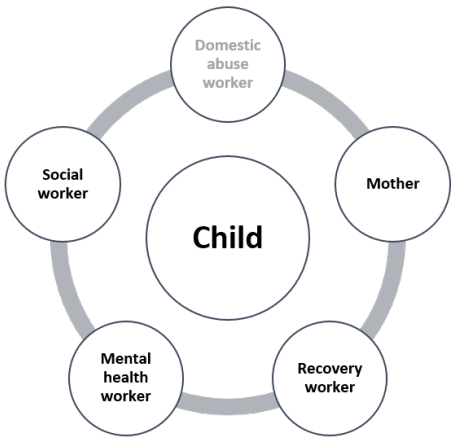
Really accommodating... pushing ... for the extra childcare when she needed it ... she's just really genuine and supportive and understanding as well.

Next step: Mother was waiting to access support for her complex mental health needs (mental health professional external to SFT)

Case Study 2

Working Together to address safeguarding concerns relating to substance misuse and mental health

- Next phase to include working together with a focus on domestic abuse



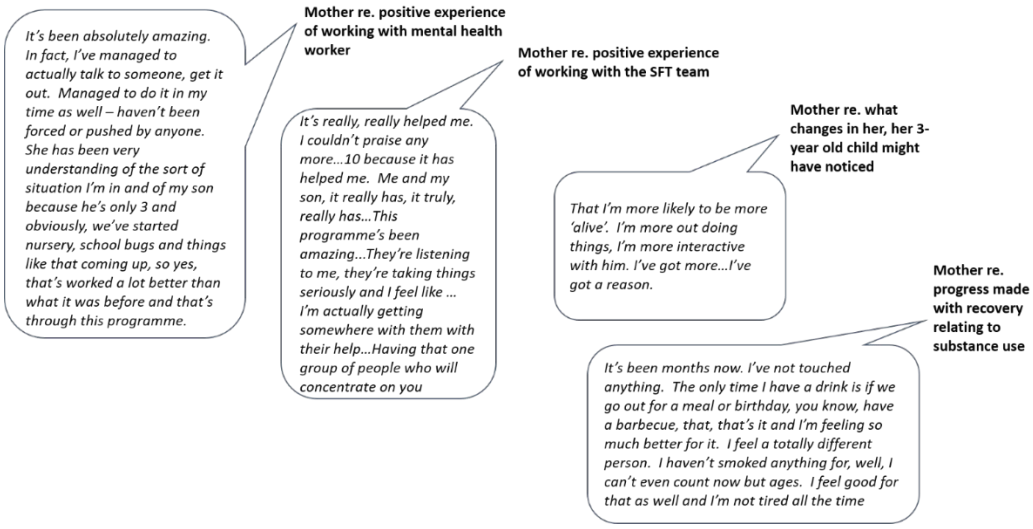
- New social worker
- Involvement less to-date

- Working with substance misuse worker in regular at-home sessions to explore issues of addiction and alternative coping strategies
- Working with mental health worker in regular at-home counselling sessions to support anxiety
- Attending 4-weekly core group meetings
- Planning to work with domestic abuse worker
- Planning to return to education
- Planning a career in health and social care

- Working with mother in regular at-home counselling sessions to support anxiety

- Working with mother in regular at-home sessions to explore and support issues of addiction
- Offering accessible telephone support
- Attending 4-weekly core group meetings

Mother's positive experiences of Safeguarding Families Together



Next step: Mother is due to start working with SFT domestic abuse support practitioner

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Health and Wellbeing Board
Work Programme

Meeting Date: 26 June 2024

Report Title	Description	Lead Officer	Cabinet Member(s)	Other Information
Better Care Fund 2024/25	Approval of the Better Care Fund 2024/25 Addendum.	Sarah Sewell, Head of Service for Older People and Prevention Commissioning	Cllr Steve Robinson – Cabinet Member for Adult Social Care	
Safeguarding Families Together Evaluation		Lisa Reid, Corporate Director – Quality Assurance and Safeguarding	Cllr Clare Sutton – Cabinet Member for Children's Services, Education and Skills	
Thriving Communities		Dave Thorpe – Thriving Communities Partnership Manager		
Pharmaceutical Needs Assessment (PNA)	Discussion on the development of the PNA.	Jane Horne, Consultant in Public Health	Cllr Gill Taylor – Cabinet Member for Public Health, Environmental Health, Housing, Community Safety and Regulatory Services	
Social Mobility		Sarah Crabb, Social Mobility Commissioner Alice Deacon, Corporate Director for	Cllr Clare Sutton – Cabinet Member for Children's Services, Education and Skills	

		Commissioning & Partnerships		

Meeting Date: 18 September 2024

Report Title	Description	Lead Officer	Cabinet Member(s)	Other Information
Birth to Settled Adulthood Progress Report		Paul Dempsey – Corporate Director for Care and Protection	Cllr Clare Sutton – Cabinet Member for Children's Services, Education and Skills Cllr Steve Robinson – Cabinet Member for Adult Social Care	
Health and Wellbeing Strategy Refresh			Cllr Gill Taylor – Cabinet Member for Public Health, Environmental Health, Housing, Community Safety and Regulatory Services	
Right Care Right Person		Dorset Police	Cllr Steve Robinson – Cabinet Member for Adult Social Care	

Meeting Date: 20 November 2024

Report Title	Description	Lead Officer	Cabinet Member(s)	Other Information
Health and Wellbeing Strategy Refresh			Cllr Gill Taylor – Cabinet Member for Public Health, Environmental Health, Housing, Community Safety and Regulatory Services	
Safeguarding Adults Board Annual Report	To receive and review the Safeguarding Adults Board Annual Report.	Sian Walker-McAllister – Independent Chair of the Safeguarding Adults Board	Cllr Steve Robinson – Cabinet Member for Adult Social Care	
Local Transport Plan	Consultation on the Local Transport Plan and its links to active travel.	Wayne Sayers – Transport Planning Team Leader	Cllr Jon Andrews – Cabinet Member for Place Commissioned Services	

Meeting Date: 19 March 2025

Report Title	Description	Lead Officer	Cabinet Member(s)	Other Information

Meeting Date: Unscheduled items

Potential Item	Description	Lead Officer	Cabinet Member(s)	Other Information
Tobacco control work and switching to vaping	Update on tobacco control work in hospitals and the Swap to Stop programme.		Cllr Gill Taylor – Cabinet Member for Public Health, Environmental Health, Housing, Community Safety and Regulatory Services	Possible for 18 September meeting
Integrated Neighbourhood Development	Continued oversight by the Board on the development of Integrated Neighbourhood Teams.			Possible for 18 September meeting
Physical Activity Strategy	Review of the Physical Activity Strategy.			Possibly links to the report on the Local Transport Plan.
Suicide prevention through the Mental Health Delivery Board				

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