

Better Care Fund Dorset
Performance & Finance Update Report
Health & Wellbeing Board 30th March 2022

1. Introduction

1.1 The Better Care Fund provides Dorset Council and Dorset CCG with a total shared annual funding stream of £136,827,560. This is made up of the following:

Funding Source	Amount
Disabled Facilities Grant (DFG) ¹	£4,152,450
CCG minimum contribution ²	£29,709,110
iBCF ³	£12,084,516
Additional from Local Authority ⁴	£57,990,500
Additional from CCG ⁵	£32,890,984
Total	£136,827,560

1.2 On 12th January 2022, the Health & Wellbeing Board (HWB) retrospectively approved the Better Care Fund Plan for 2021/22, which has subsequently been approved by NHS England (NHSE).

1.3 The reporting templates from NHSE require local areas to report funding allocations into standardised 'Schemes', examples include; Maintaining Independence, Supported Hospital Discharge, Moving on from Hospital Living and Integrated Health and Social Care Locality Teams.

1.4 NHSE set national conditions that each annual plan must meet, some are financial:

- a minimum total investment for the plan from the CCG
- inflation uplift for the CCG's contribution
- which grants must be included – i.e. Disabled Facilities Grant.
- investment in NHS community services to help people manage their health conditions at home.

1.5 Some of the conditions relate to mandatory performance outcomes that must be covered:

- improved outcomes for those being discharged from hospital

¹ Disabled Facilities Grant (DFG) - a grant provided to disabled individuals to make changes to their homes i.e. widen doors, install stairlifts and ramps etc.

² CCG Minimum Contribution – this is the minimum amount of funding contribution required.

³ iBCF - Improved Better Care Fund – the grant is paid via a S31 to Local Authorities to support integration, social care and health

⁴ Additional Local Authority Contribution – Local authorities contribution to the pooled budget relating to integration and social care

⁵ Additional CCG Contribution – CCG contribution to the pooled budget relating to integration, social care and health

- improved outcomes for those managing health conditions at home

1.6 This report shares Dorset's performance against the set metrics up to Quarter 3 of 2021/22:

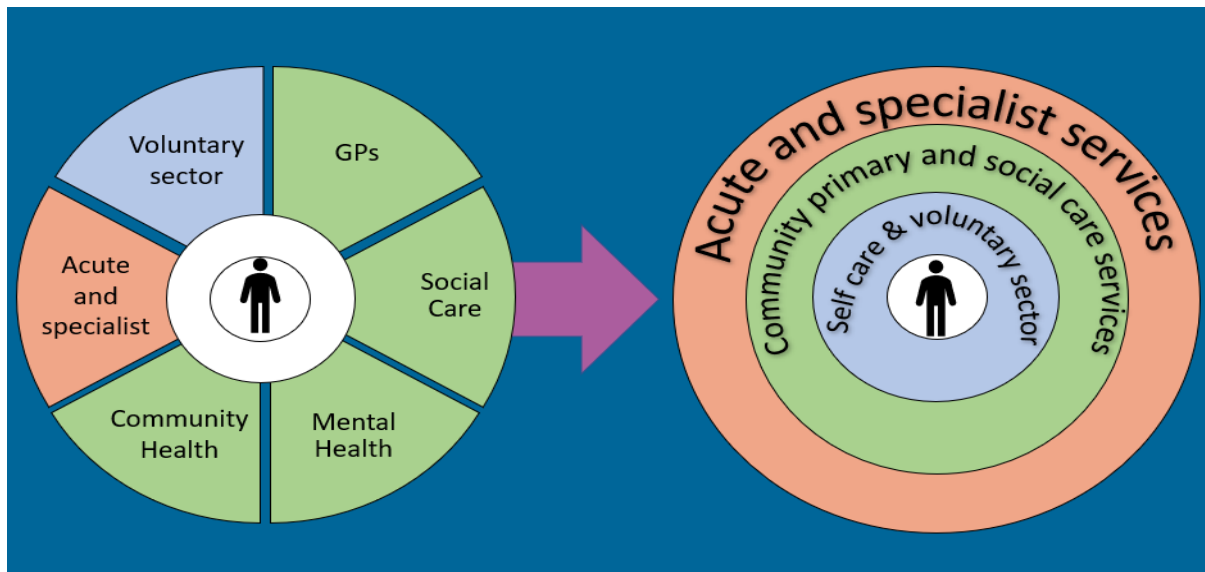
- i) Effectiveness of reablement
- ii) Discharge to normal place of residence
- iii) Avoidable Admissions
- iv) Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population

1.7 In addition, performance and contract activity of key funding streams, such as Disabled Facilities Grants, improving outcomes of people being discharged from hospital and Carers Services is included. Where the information is available at a local level this has been captured in the report, as have links to the HWB Board priorities.

2. Supporting delivery of the Health and Wellbeing Strategy

2.1 There are key links between the purpose of the BCF and the priorities of the HWB Strategy, fundamentally both share goals and requirements to work together across health, social care and wider partners to improve health and wellbeing outcomes for individuals, ensuring services for individuals are delivered closer to home.

2.2 A useful summary of the vision for the BCF is shown in the infographic on the following page; it shows how the BCF strives to enable co-ordination of health and social care services around the individual – a vision that will is hoped resonates with the HWB Strategy.



Moving from:

"I have to tell my story multiple times to different people"

"I'm left waiting for services whilst commissioners argue over who pays"

"I don't get a say in my treatment"

"When I'm discharged from a service, I'm not sure where to go next"

Moving to:

"I completed an integrated care plan, setting out who will provide care and support to me and when"

"I receive more care in or near my home, and haven't been to hospital for ages"

"I feel fully supported to manage my own conditions and live independently"

2.3 In order to clearly show the key links back to the HWB Strategy, the following sections align the BCF mandatory conditions, Schemes and other requirements to each of the three HWB priorities.

2.4 HWB Priority - Empowering Communities

Priority one - engaging with and empowering communities of highest need to improve healthy life expectancy

2.4.1 The BCF supports this priority within the mandatory conditions around investment in NHS community services to help people manage their health conditions at home. Furthermore, Maintaining Independence BCF funding streams that provide the following services and support this priority:

- Assistive Technology
- Dorset Accessible Homes (Disabled Facilities Grant)
- Dorset Integrated Community Equipment Service
- Moving on from hospital living – support for a Learning Disabilities cohort to live in the community
- Occupational Health support
- District Nursing Capacity
- Carers support; Case workers, carers mental health support, respite and short breaks, training.

Integrated working of locality-based health and social care teams e.g. Locality Cluster Teams delivers localised services to support to communities closer to home.

2.5 HWB Priority - Promoting healthy lives

Priority two - set priorities to accelerate work promoting healthy lives and wellbeing

2.5.1 Some of the examples above also meet this priority. However, the following services support the mandatory BCF condition to improve outcomes for those being discharged from hospital which supports promotion of healthy lives:

- Reablement Services
- Integrated Crisis and Rapid Response services
- Mental Health and dementia support

In addition, funding streams support domiciliary packages and residential placements, ensuring individuals live safely and as independently as possible in their local community.

2.6 HWB Priority - Support and challenge

Priority three - provide governance and support to our partners, prioritising the delivery of key partnership outcomes

2.6.1 The BCF sets a statutory requirement to integrate some areas of health and social care. For example, the Integrated Community Equipment Service is a true pooled budget with contributions from Dorset Council, Dorset CCG and BCP Council. The service is delivered by one provider, Nottingham Rehab Supplies Ltd (NRS), and can be accessed by both Health and Social Care professionals and Teams. This is a key enabler to support people to remain at home. Council and CCG Commissioners work together to commission and contract manage this service.

2.6.2 The Dorset Accessible Homes Service, funded through Disabled Facilities Grant element of the BCF, is also delivered by Millbrook Healthcare Ltd and again can be accessed by both Health and Social Care professional and Teams for minor works and social care for Major adaptations.

2.6.3 Furthermore, the membership arrangements of the HWB offers an excellent enabling opportunity to develop more joint commissioning approaches already being developed by both the Joint Commissioning Board and the Learning Disability and Autism Joint Commissioning Board.

3. Dorset's Performance against Better Care Fund Metrics Performance

3.1 Potentially Avoidable Hospital Admissions – CCG led metric

3.1.1 One of the new metrics introduced this year is *unplanned hospitalisation for chronic ambulatory care sensitive conditions*. Ambulatory care sensitive conditions

(ACSCs) are conditions where effective community person-centred care can help prevent the need for hospital admission. This indicator indicates how successfully the health & care system manages long-term (LTCs) or chronic conditions (such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure) where optimum management can be achieved in the community.

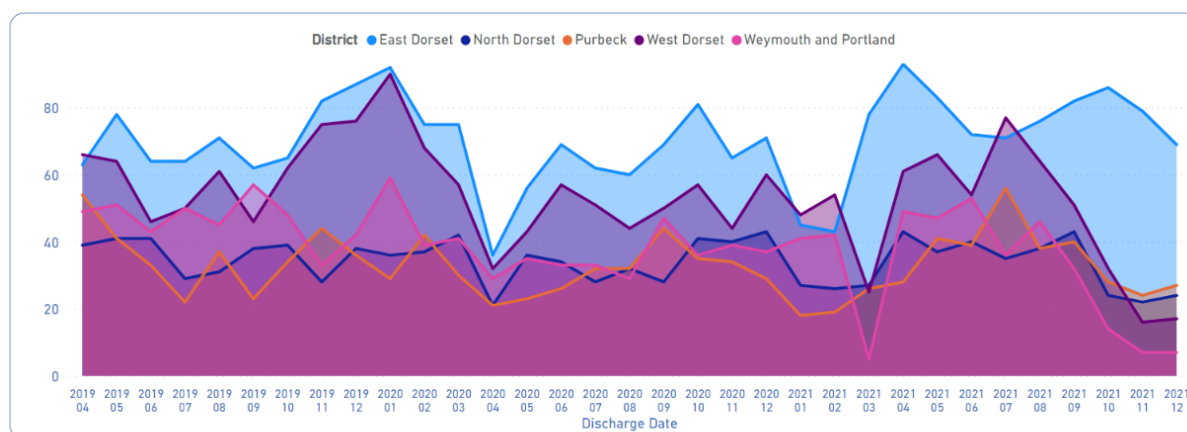
During the initial waves of COVID, people were less likely to consult medical services and, with continued pressure on primary care services potentially impacting also on the management of chronic conditions, we thought it was reasonable to enter the same indirect standardised rate (ISR) as 2019/20 for both 2020/21 and 2021/22.

2020-2021 Actual	2021-22 Plan
595.4	595.4

The metric is age and sex standardised, which happens at a national level. We can therefore not replicate this locally. It is also only undertaken annually and so we are currently unable to report against this metric on a quarterly basis.

We have, however, produced a report that shows actual ACSCs discharge numbers which provides us with a trend over time, as you will see below. We have broken this down to locality areas within Dorset.

Metric 8.1 Unplanned Hospitalisation for Chronic Ambulatory Care Sensitive Conditions - Locally Produced Data



Note: Incomplete diagnostic coding at Dorset County Hospital may have affected the counts of unplanned hospitalisations for Chronic Ambulatory Care Sensitive Conditions for March, October, November and December 2021.

Note that the nationally produced data is only available for 2019/20 at HWB level and the indicator value is the indirectly standardised rate (ISR) of admissions per 100,000 population. The data for the most recent three months will be subject to change when the local data is refreshed. This is largely due to the clinical coding issues at Dorset County Hospital.

3.2 Length of Stay – CCG led metric

3.2.1 The metric used reports on the percentage of in-patients, resident in the Dorset HWB catchment area, who have been an in-patient in an acute hospital for

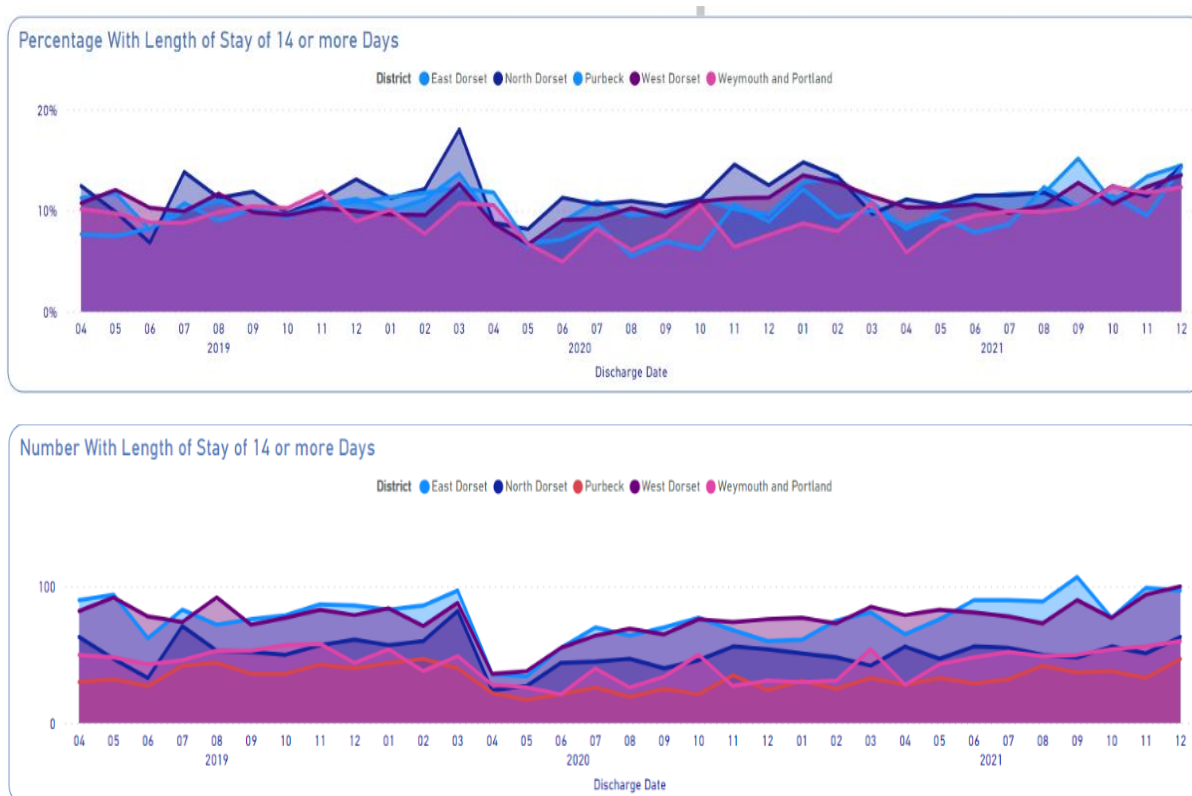
- i) 14 days or more, and
- ii) 21 days or more, as a percentage of all in-patients.

3.2.2 A national dataset is available, however, as there is a time delay, locally validated data has been used for monitoring purposes. For both subset groups, we have also looked at a more granular/locality level and provided, in addition to the percentage graph, the comparative numbers.

All graphs shown below show a trend over time and, as you will see, correlate to the first wave of the Covid-19 pandemic and the change in NHS policy to release capacity in our hospitals.

The variation at the local level will be multi-factorial and would require further in-depth analysis and, even then, will likely be difficult to determine direct cause and effect.

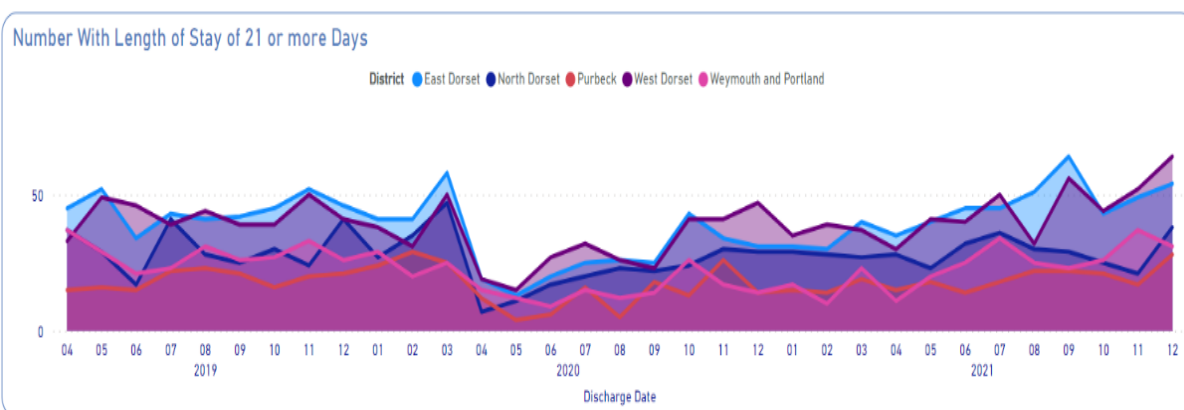
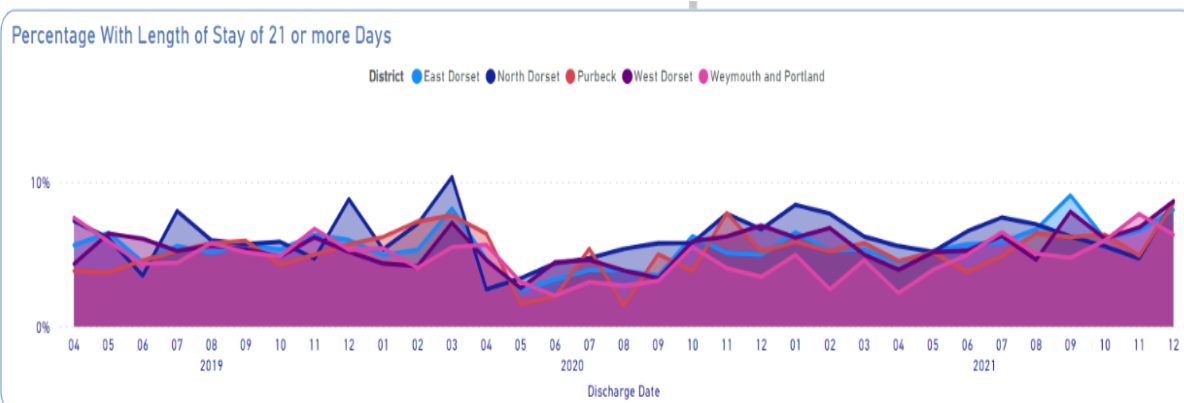
Metric 8.2 Length of Stay 14+ Days - Locally Produced Data



3.2.3 Please note that the stays of fourteen plus days will include those staying twenty-one or more days. In order to enable examination at this geographical level the data has been prepared locally and therefore will not provide an exact match to

the nationally supplied trend data. The data for the most recent month may also be subject to change when the data is refreshed.

Metric 8.2 Length of Stay 21+ Days - Locally Produced Data



	21-22 Q3 Plan	21-22 Q4 Plan	End of Q3 1 Oct 2022	As at Dec 2022
Proportion of inpatients resident for 14 days or more	10.8%	10.8%	11.9%	14%
Proportion of inpatients resident for 21 days or more	5.7%	5.7%	6.3%	8.4%

3.2.4 Working as a local system, greater integrated and partnership working is enabling people to leave hospital to go home more quickly in their recovery period. Examples include, our focussing of BCF funded Reablement Services into short-term interventions to support people to be at home, also closer integrated working in Cluster Teams at a local level to support and plan initial and longer term care and support.

3.2.5 The CCG with agreement from 'system partners' have commissioned, via HDP funding, significant blocked home care hour contracts in order to guarantee resources to support pathways home. Furthermore, BCF scheme maintaining independence has continued the roll out at assistive technology and the use of community equipment to aid discharge and promote re-gaining and maintaining of independence, reducing risks of re-admissions.

3.2.5 Our Plan targets were set on an average of the April-August 2021 national dataset, on the basis that previous lengths of stay showed an upward trend. As you will see from our local information, we are above both targets. Dorset ICS is facing significant challenges in relation to availability of care due to workforce shortages, particularly care at home, which is causing delays to discharge. However, there is joint commitment to continue to work together to seek improvements and solutions.

3.3 Discharge to normal place of residence – CCG led metric

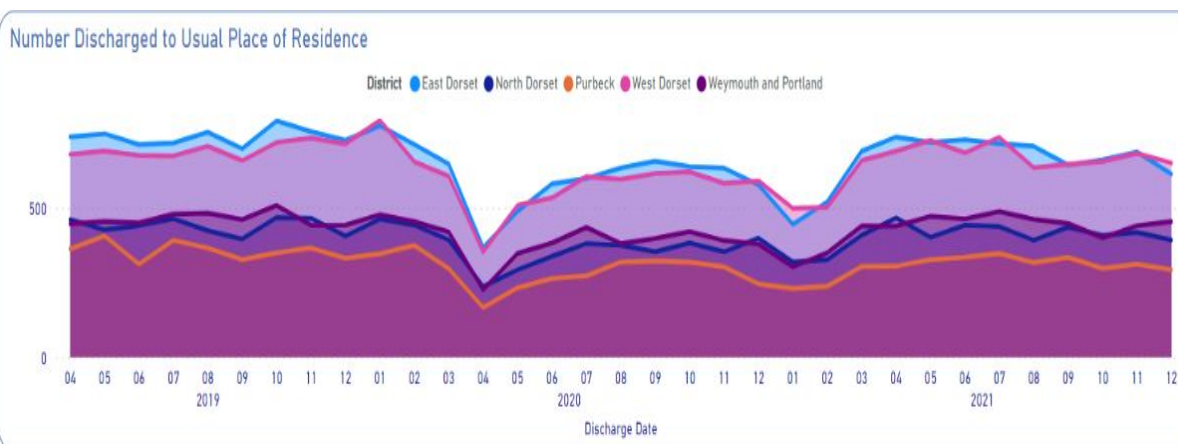
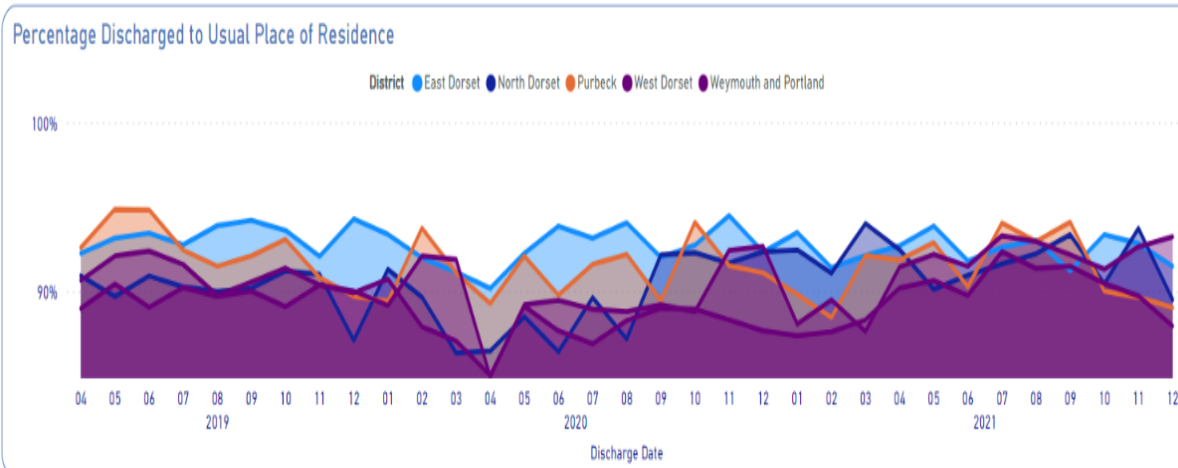
3.3.1 This metric records the percentage of people, resident in the Council's HWB catchment area, who are discharged from an acute hospital to their normal place of residence.

3.3.2 Note that usual place of residence can include accommodation such as a nursing home if that is appropriate. As illustrated for the two metrics above, the two graphs below have been prepared using local data and therefore will not provide an exact match to the nationally supplied trend data. The data for the most recent month may also be subject to change when the data is refreshed.

Planned Target

	21-22 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)	91.6%

Metric 8.3 Discharge to Normal Place of Residence - Locally Produced Data



At the end of Quarter 3, the percentage recorded 1 October was 91.15%.

3.4 Residential Admissions – Council led metric

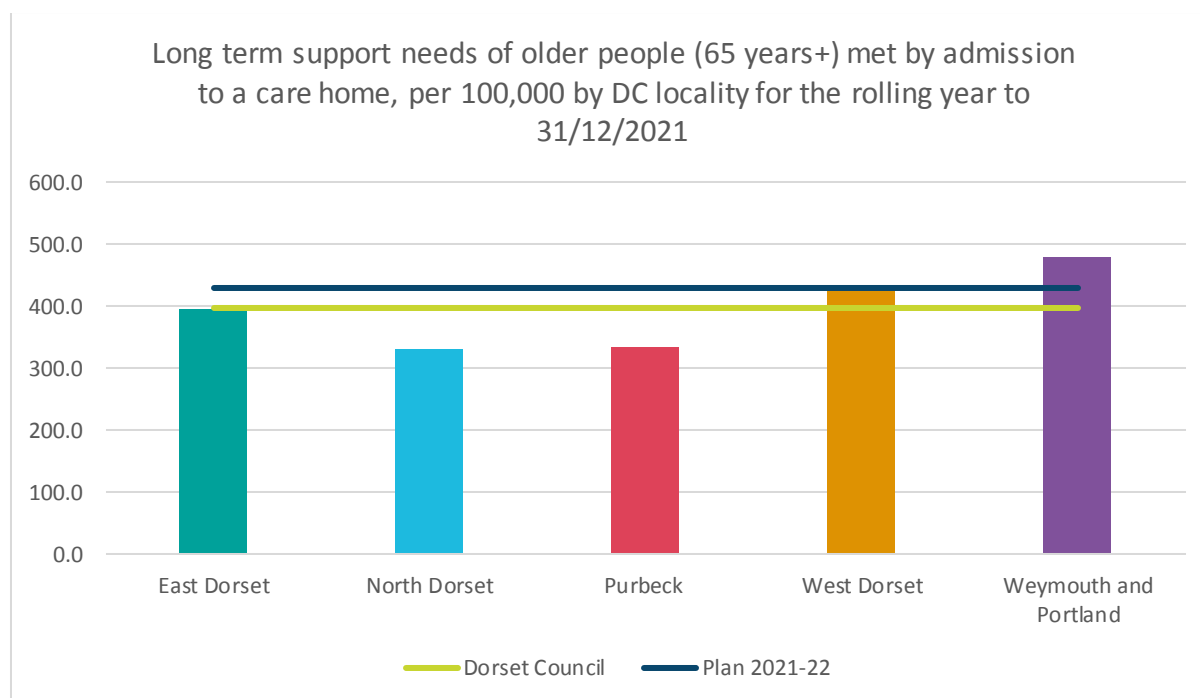
3.4.1 This measures the long term support needs of older people (65 years+) met by admission to a care home, per 100,000.

3.4.2 Investment from the BCF into Care Home placements includes a minimum CCG contribution of £2,158,317, Improved Better Care Fund contribution of £4,155,848 and additional Local Authority contribution of £55,058,800. A total of £61,372,965.

3.4.3 The lower the rate of admission the better our performance as people are able to remain at home and independent for longer. In the following table the annual rate and numerator are calculated for a whole year.

	2019-2020 Actual	2020-2021 Actual	2021-2022 Plan	Qtr 3 2021- 2022 Actual
Annual Rate ⁶	491	460	429	396
Numerator ⁷	540	514	488	443
South West Annual Rate	519	455		
England Annual Rate	584	498		
CIPFA / nearest neighbour	576	487 ⁸		

3.4.4 In 2020-21, Dorset ranked 69 for this indicator. In the South West, the rankings ranged from 26 (BCP) to 150 (Isles of Scilly) with the annual rate ranging from 327 to 2107 per 100,000 population aged 65+. In the CIPFA / nearest neighbour group, the rankings ranged from 25 (Central Bedfordshire) to 148 (Stockport) with the annual rate ranging from 321 to 1368.



3.4.5 As of Quarter 3 of 2021/22, performance is currently better than planned. Dorset's annual rate is 396 per 100,000 population, numerator, as a count of all permanent admissions, is 443.

⁶ Annual Rate – takes the data for each locality and scales it to show the number of admissions out of a population of 100,000. This makes the rate comparable for each of the localities

⁷ Numerator –in this example, the number of people aged 65+ who became permanent residents in a care home in the year to 31/12/2021. The denominator, for this example, is the 65+ population of Dorset

⁸ CIPFA nearest neighbour average calculated to minimise the impact of outlier result from Stockport by using England average as a proxy for the Stockport annual rate

- People in West Dorset and Weymouth and Portland are more likely to need and be placed in residential care when compared to the whole Dorset Council area. However, West Dorset remains below the Plan target.
- Weymouth and Portland have a higher rate of permanent admissions than other localities and this is consistent with data for Quarter 1 and 2. This warrants further monitoring to fully determine the factors involved; relative higher deprivation or other more nuanced influences.
- Quarter 3 performance is better than all three comparator rates from last year. Dorset's England ranking of 69 sits us toward the bottom of the middle area of the performance table. Given Dorset's older than average population it is unlikely to move to top of the performance table.

3.4.6 This metric is aligned to a number of the HWB and Adult Social Care strategic priorities – Promoting Independence, supporting people to remain independent for as long as possible. In addition, the ethos of Home First has emphasised the already established focus to reduce residential admission. Partnership working to increase provision of reablement, therapy and rehabilitation support to promote independence is a priority for the Home First Programme in Dorset and will further support maintaining achievement of this metric.

3.4.7 Whilst performance is improving there have been challenges from the ongoing pressure and lack of home care provision, like many other areas in the country, particularly to maintain discharges from hospital (to reduce infection risks and manage the demand for acute hospital beds). This had led to the increase in the need for more interim placements in residential care, whilst ongoing care at home is found. Therefore, performance could have been better still and we strive to improve our England ranked position. Good established working relationships with BCP Commissioners offers the opportunity to understand how they have achieved good performance.

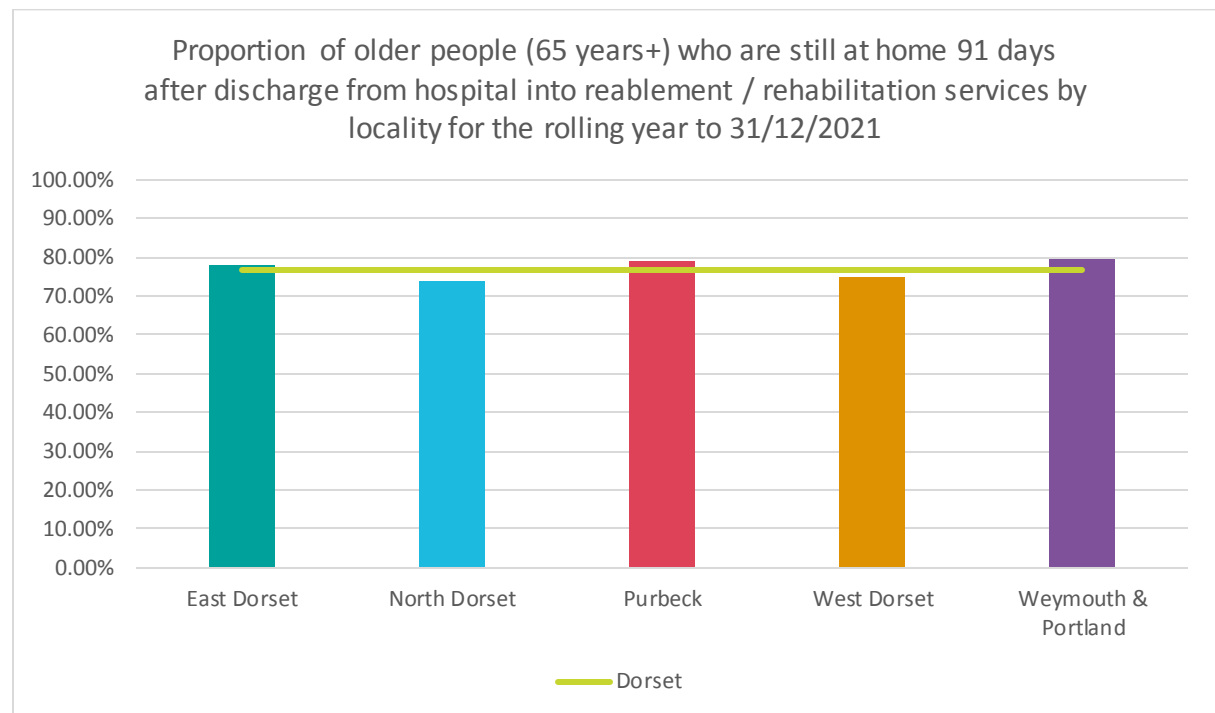
3.4.8 Commissioners continue to work closely with the local provider market to support workforce growth, ensuring Government funding is allocated in the best way to support retention and recruitment into social care. In addition, pilot schemes, funded from iBCF, to further develop the role of Trusted Assessors and embedding Strengths Based approaches will further support maintaining of independence.

3.5 Reablement – Council led metric

3.5.1 This measures the Proportion of older people (65 years+) who are still at home 91 days after discharge from hospital into reablement / rehabilitation services. The total investment into Reablement through BCF is £3,466,585.

	2019-2020 Actual	2020-21 Actual	2021-2022 Plan	Qtr 3 2021- 2022 Actual
Annual Rate	81.2%	78.6%	77%	76.6%
South West	83.8%	78.2%		
England	82.0%	79.1%		
CIPFA / nearest neighbour	80.8%	76.1%		

3.5.2 In 2020-21, Dorset ranked 94 for this indicator. In the South West, the rankings ranged from 12 (BCP) to 145 (N Somerset) with the range of results from 91.9% to 42.1%, 6 of the 15 South West councils (including Dorset) had results between 76.6% and 79.2%. In the CIPFA / nearest neighbour group, the rankings ranged from 21 (Stockport) to 145 (N Somerset) with the range of results from 89.3% to 42.1%, 6 of the 15 councils had results between 83.2% and 86.1%.



3.5.3 As of Quarter 3 of 2021/22 performance is currently as planned, with Dorset's average annual rate is 76.6%. In the localities the annual rate is in the range 74.2% (North Dorset) and 79.6% (Weymouth and Portland). Performance against this measure has been monitored closely; there had been concern that we may see performance drop due to the changes in Hospital Discharge Policy in 2020, which essentially discharged people from hospital much earlier in their recovery, therefore, potentially increasing the numbers of re-admissions. However, the Reablement Service are managing and supporting recovery at home, and we will continue close monitoring and working with the Provider to seek further improvements. The capacity of the service does not however meet the 'System' demand.

3.5.4 Improving performance is a key priority, in order to improve individuals' outcomes and based on comparators there is much to learn from others to support this. At present the Reablement Service does not employ any therapists and this would enhance the offer. In addition, the service is holding a number of vacancies as it is unable to recruit in line with wider market workforce challenges. There have also been a number of home care provider who have handed back packages as they can not provide the workforce; these packages are being partly covered by the

reablement service until a permanent arrangement is made – this adversely impacts on capacity and performance of the reablement service.

4. Key funding streams and associated performance of Maintaining Independence Schemes

4.1 Disabled Facilities Grant

4.1.2 Disabled Facilities Grants (DFGs) were included in the Better Care Fund spending plans from April 2015 and is a statutory function under the Housing Regulation Act 1996. There has been growth in DFG allocations over the life of the BCF policy as Government have recognised the important part DFGs can play in enabling independent living.

4.1.3 The current budget for the Dorset Accessible Homes Service contract, which is commissioned as a complete service, Millbrook Healthcare Ltd for the management and delivery of both major and minor Adaptations, is £4.152 million.

4.1.4 Adaptations, whether minor or major, promote independence and enables people to remain in their own homes, a BCF mandatory condition. In addition, the service is improving outcomes for those being discharged from hospital, and helping people manage their health conditions at home.

4.1.5 The infographic on the following page shows the type of installations and equipment provided through the Service, both in 2020/21 and first six months of 2021/22. Major adaptations activity this year is lower than last, this is due to Covid related impacts (eg, lock downs, people not wanting contractors in their homes), and Brexit related, building supplies delays – e.g., shower trays due to plastic supplies, cost of timber and construction materials.

4.1.6 Minor adaptations data for first six months of 2021/22 reports higher turnover; 331 adaptations. The majority were ramps/half steps and external handrails, and this service is accessed by health and social care colleagues to help facilitate Hospital discharges, also helping to prevent accidents and enable people to remain independent in their own homes. Additional activity is linked to changes in Hospital Discharge Policy and greater pressure on hospitals as more people are being discharged early back to their homes.

4.1.7 There is currently no national benchmarking data. However, Foundations, which is the overarching organisation for Home Improvement Agencies, reports key measures around timeframes for completing works – within 26 working weeks, and this is a KPI in the contract. This stands at currently 73% which is lower than previous years and some of the delays reasons are as follows: Awaiting Planning permission, a very long delay due to utility company (gas), Delays with family finding funding to top up cost of works and awaiting permission with Registered Providers to start the grant process and we have been working specifically with one Housing Association to address this.

Dorset Accessible Homes Service (DFGs) - £4.152m

Major adaptations completed

2020-21 - 476 adaptations



Curved Stairlift

36



Straight Stairlift

36



Large external ramp

49



Through floor lift

5



Level access shower

218



Extension

5

2021-22 (6 months) 143 adaptations



Curved Stairlift

15



Straight Stairlift

5



Heating replacement

2



Kitchen adaptation

3



Level access shower

76



Extension

5

Minor adaptations completed

2020-21 - 453 adaptations



Ramps, external handrails etc.

453

2021-22 (6 months) – 331 adaptations



Ramps, external handrails etc.

331

4.2 Integrated Community Equipment Service (ICES)

4.2.1 Funded by BCF, the ICES for Dorset has a budget of £1.23m. The contract is held by NRS and supplies equipment that ranges from small items such as, toilet seat frames, walking frame, commodes, chair risers and bed risers to more complex equipment such as hoists, patient turners, hospital beds, pressure relieving equipment and riser recliner chairs.

4.2.2 This is the only CCG, Dorset Council and BCP Council pooled budget, it is managed by BCP Council. Like minor adaptations – ICES experiences huge demand from hospital discharges coupled with supply chain issues relating to Brexit and Suez Canal blockages, which continue to experience some port delays.

4.2.3 The table below reports number of deliveries up to end of December 2021 (Quarter 3), across localities and into other Council areas. The total 2836 deliveries provided 6030 items (there could be multiple deliveries to one person, but it is reasonable to assume more than 2500 people have been supported via the service).

Ordering Team	Deliveries
North Dorset	220
West Dorset	330
Purbeck	354
Weymouth & Portland	402
East Dorset	375
Adult Access Team	525
Education & Children's Services	284
Other ⁹	346
TOTAL	2836

It is key to highlight that the service is supporting prevention. In addition, many deliveries result from contact with Council's Adult Access Team, who are the first point of contact for individuals / public access; this provides swifter support and negates the need for referral to the locality team enabling quicker resolution of individuals requirements.

It appears there are more deliveries supporting Weymouth and Portland, a community of priority as highlighted in the Health and Wellbeing Strategy.

4.2.4 Performance information and associated benchmarking will be provided in the November report.

4.3 Assistive Technology and Equipment

4.3.1 This contract has an annual spend of £538,668.

4.3.2 This is different from the above equipment as it is supported by live monitoring which can trigger a response. The technology and equipment, which is free at the

⁹ This data is being cleansed to allow specific area teams to be identified

point of issue, is installed to support individuals includes 24/7 careline support services and linked devices such as, falls detectors/smoke and Carbon Monoxide sensors that alert the careline service if help is needed. In addition, GPS tracker and falls technology can be linked to the care lines. These activate if someone falls or walks beyond their property or safe zone. Other devices are classed as standalone devices i.e. they link to a pager if the person lives with a family member or has live-in carers.

Some installations are for long term use predominantly the careline and tracker technology, and some are for short term to support the individual to recover from a period of illness or crisis such as standalone devices to support hospital discharges. Health colleagues can access short-term use devices by making referrals.

4.3.3 There has been a change in contracted provider during Quarter 3 of 2021/22 with the new contract tendered to bring both cost and working practice efficiencies. 2020/21 performance delivered by the outgoing provider was 932 installs for Adult Social Care and 223 short term referrals. However, the provider was unable to maintain this number of installations within the set contract price, which led to the contract termination and re-tender.

4.3.4 During 2021-22 there have been 439 installations up to the end of February 2022 and a further 190 devices installed as a short-term intervention. The reduced number of installations is within the financial envelope of the total contract. The re-contracting has focused on best value such as delivery and repair costs as well as equipment being purchased at cost price direct from the manufacturer. Therefore, this significantly improve the number of people who have access to this service in the next financial year, also enabling health staff to have direct access to the service.

4.3.5 The preventative measures and ability to promote independence is a key benefit offered by this service. Additional one-off funding has been added to the BCF allocation for Assistive Tech in order to support demand, particularly from hospital discharges, but there is further work required to reach a more sustainable solution for longer term System wide funding. This would increase the robustness and responsiveness of the offer and ultimately improve outcomes and wellbeing for more individuals.

4.3.6 As the new service is developed, we will improve knowledge and awareness of how other areas are utilising Technology and Equipment so as to share learning and make enhancements where possible.

5. Key funding streams and associated performance of Carers funded BCF Schemes

5.1 These services are jointly commissioned by the Council and CCG, with the Council lead commissioning. Any carer regardless of the care and support or health needs can access these services. Unpaid carers have a pivotal role in preventing the need for more formal, long term care and support.

5.2 Total funding from BCF for Carers Services is £1,112,941

5.3 Support for Carers in Dorset

5.3.1 A range of contracts are in place to support unpaid carers:

- Carers Support Dorset offer information, advice and guidance and register the Carer – Contract value is £334,000.
- Rethink, support carers who are caring for someone living with mental health illness - – Contract value is £107,355.

5.3.2 Due to varying definitions, and most likely, that many people who have a caring role do not recognise themselves as a carer, figures on the number of carers in Dorset varies greatly between sources. For example, from the 2011 Census there were 83,000 carers in Dorset (including BCP Council area), however, local records as held by Carers Support Dorset indicate 3,597 at Q3 2021 and Dorset Council social care records show 7,689. Further work is needed to raise awareness of carers and is one of the priorities in the forthcoming Carers Strategy, and this will include better definition of targets and measures. The latest Census information is expected at the time of writing this report.

5.3.3 Adult Social Care Outcomes Framework (ASCOF) indicators for Carers are focussed on:

Target	Dorset	South West	England
The proportion of carers who receive self-directed support (1C1B)	98.3% Rank ¹⁰ : 110	81.7%	87.1%
The proportion of carers who receive a direct payment (1C2B)	15.5% Rank: 136	70.8%	75.3%

5.3.4 Many Authorities have achieved 100% for both indicators, hence Dorset's performance appears low. However, the proportion of carers who receive self-directed support is very high and this indicates there is control and choice over how they access support.

5.3.5 Performance around direct payments is not where the Council want it to be and this is being addressed. Funding allocated via DPs to carers account for just £116,099, 10% of the total budget. However, this has already been identified as a key area for transformation for Dorset, for all care types. This will improve choice and control over how both carers and others eligible for care and support arrange, access and fund it. Direct Payments for all care groups is low and workstreams are in train to address this.

¹⁰ The rank is out of the total number of councils, appears to be 151 for 2020-21 but not all councils have submitted for every indicator

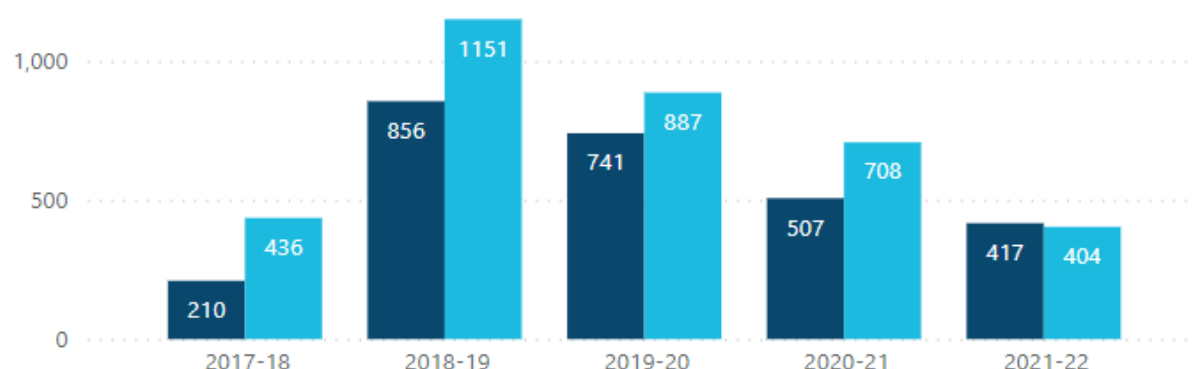
5.4 Carers Case Workers

5.4.1 Of the Carers funding, £240,000 is allocated to provide case workers. These locality-based workers support Carers with the more complex situations, including safeguarding concerns and when the home situation is particularly challenging, for example where there is conflict within relationships, safeguarding, complexity of care or where there is an immediate risk of carer breakdown without intense support. Some workers are also based at some hospital sites. This preventative intervention reduces the need for more formal care and support.

5.4.2 All locality and specialist teams undertake Carers Assessments. The graph below shows a decline in Carers Assessments taking place by workers with the launch of Carer Support Dorset November 2019 providing improved quality information, advice and guidance negating the need for an immediate or unnecessary Carers Assessment. The dark blue bars are completed Assessments and the light blue reviews. This is being addressed through targeted work.

Carers Assessment & Reviews Completed

Event Type ● Carer Assessment ● Review of Carer Support Plan



5.3 Additional support for Carers

5.3.1 The remaining carers funds, £431,586 are allocated across a number of areas, examples include:

- Short Breaks service – this gives Carers time away from their caring responsibilities. There is work to do to develop this offer. Often this support is provided by home care providers, but with recent market pressures some carers have not been able to access the support when they need it. Where possible support from voluntary and community sector organisations is accessed but further work is needed to improve the support available.

- Carer communications, befriending, engagement and training to provide support, guidance and enhance wellbeing are offered via counselling services, training opportunities, local magazine (of which 14,300 copies are circulated) and an identity and discount card
- GP practice carers support accreditations scheme to enable carers to access services from local access points.

These services offer the flexibility for the carer to access as much, or little, as is needed, when it's needed; this may change as their personal circumstances change. Sometimes, Carers begin with support via registration for the My Carers Card and then they choose access further services as needed.

5.3.2 Work is currently underway to review all carers offers and a longer-term Carers Strategy is being developed by Commissioners. Current work in train with carers and pan-Dorset partners is launching with a new ICS (Integrated Care System) leaflet advising people who have a caring role to register as a Carer with their GP and Lead Carer Organisation (Carer Support Dorset for Dorset Council) and CRISP for BCP Council).

6. Reducing Inequality and Prevention at Scale

6.1 Under the Care Act 2014, local authorities have a duty to prevent, reduce or delay needs for care and support. Prevention and preventative services form a critical foundation in supporting peoples' Health and Wellbeing, and not only have a positive impact on peoples' independence and quality of life, but there is a significant evidence base of the financial benefits through reducing demand on more formal health and care interventions.

We are working closely with our voluntary and community sector (VCSE) partners and local communities to develop inclusive, community-led offers, which also offer great potential to support the future Integrated Care System (ICS), providing a non-clinical, non-care pathway in Dorset. Whilst BCF monies are not specifically funding these activities, there are links between the projects and areas of focus that all contribute to the key priorities of both BCF and HWB Strategy; prevention, promoting and maintain independence locally, at community level. Examples of work underway include:

- Dorset's Community Response pilot - a pan Dorset Community Front Door enabling residents to easily identify and access support within their local communities
- Developing the micro-provider market in Dorset to provide outcomes-based approaches for Direct Payment holders, self-funders and direct commissioning where suitably accredited, by providing a range of support from setup to ongoing development

- A local 'community front door' for Weymouth and Portland providing a better link between the locality team and resources available within the community to support people to remain safe, well and independent
- Integrated Prevention Services working with individuals to resolve a range of issues in relation to housing, health and wellbeing, mental health recovery and crisis intervention. This also includes working with Dorset County Hospital as part of their discharge team to identify community support to support people home from hospital, and a Community Navigator pilot, where our Adult Access Team can refer people whose outcomes could be met through an intervention outside of a Care and Support Assessment.
- Supporting local businesses to implement a sustainable framework of inclusivity and accessibility across Dorset, focusing on reducing isolation and supporting inclusion of marginalised groups in Dorset communities
- Working with local communities to be inclusive of all diverse groups and people, reducing isolation and inequalities

It is anticipated that through the Social Care Reforms more emphasis will be placed on the BCF in relation to outcomes from prevention services. We wait for further information on this.

7. Better Care Fund 2022/23 – Next steps

7.1 There are opportunities to utilise the BCF differently in Dorset; to work differently at scale, but to keep impacts and outcomes local. The HWB are asked to identify specific measures in addition to those above, which will help demonstrate improved outcomes for Dorset. However, before any re-purposing work can be done we must ensure there is sufficient time to review current services, fully understand interdependencies and risks with other funding streams. We must also include time to review the learning from other areas.

7.2 Creating a more joined up approach across health and social care is not just about contracts but the whole commissioning cycle; from working with communities to establish need, looking at the evidence of what works and working with communities to plan how to respond to need, working to target our resources to deliver those plans and reviewing and measuring to check the impact.

7.3 We need to make the most of opportunities to work differently as our new Integrated Care System is implemented over the coming year and begin to explore further joint commissioning opportunities. The Social Care Reforms are explicit about increasing pooled budgets. The HWB provides an ideal place to discuss this.

7.4 The November 2022 report will contain more detailed information on both the health commissioned schemes funded through the BCF and will provide information on how mental health and dementia are supported.

At the time of writing this report, allocations, and guidance for BCF 2022/23 is awaited.