Dorset's Better Care Fund Narrative Plan 2022-2023

1. Cover

Health and Wellbeing Board(s):
Dorset
Bodies involved in preparing the plan: (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils:
- Dorset Council, - NHS Dorset - Dorset Joint Commissioning Board (JCB). Representatives from above have either directly input or been consulted on the content of the Plan. Wider consultation with Acute Trusts, Providers, VCS organisations takes place in other forums and settings in relation to specific contracts, priorities and workstreams. This directly influences the Plan. The Joint Commissioning Board, a Pan Dorset Group of Commissioners, has been consulted on the planning as a collective and throughout the year are updated and referred to in relation to allocation and spending. JCB at its meeting on the 23rd September approved the plan. The NHS Dorset and Dorset Council Chief Executive have approved the 2022/23 Plan submitted. The Health and Wellbeing Board (HWB) will receive the plan for approval at its next meeting on 9th November 2022. However, the documentation has been shared with the Chair of the Board. The 2022/23 Plan builds on the priorities previously agreed and overseen by the HWB and demonstrates the progress Dorset has made.
How have you gone about involving these stakeholders?
Via the forums referenced above plans are developed and agreed, whilst live projects and contracts are monitored and reported. The stakeholders are kept abreast of any evolving guidance and support development of current and new schemes.

2. Executive summary

Dorset Council and NHS Dorset Better Care Fund Plan (BCF) for 2022-23 seeks to deliver against the National Conditions including the Policy Objectives as set out in the BCF guidance published on 19th July 2022.

This document is to be read in conjunction with both BCF excel return templates, together they provide confidence and assurance that Dorset Council and Dorset NHS have:

- Jointly completed and agreed this Narrative Plan and Planning templates
- Ensured the NHS contribution to adult social care is being maintained in line with the uplift to NHS minimum contribution
- Invested in NHS out of hospital services
- Implemented BCF policy objectives

Note: The Health and Wellbeing Board will receive this Plan for approval on 9th November, however the submission has been shared with the Chair of the Board.

2.1 Priorities for 2022-23

The 2022-23 allocation of the Better Care Fund (BCF) continues in-line with previous years. Our ambitions for health and social care delivery have not changed from the previous years and we are making positive progress towards addressing some of the key challenges in Dorset.

Working collaboratively, Dorset Council and Dorset NHS alongside input from the local NHS providers, including Acute Trusts, the provider market and voluntary community sector have continued to invest BCF into the following schemes:

- Maintaining Independence
- High Impact Change – Hospital Discharge

- Integrated Health and Social Care Teams
- Strong & Sustainable Care Markets
- Carers
- Moving on from Hospital Living

We have applied the uplift to the NHS minimum contribution to the following key priority areas, as we continue to manage extreme challenges associated with high demand and reduced health and social care capacity.

The Schemes which have been prioritised for additional investment from 2022-23 uplift are as follows:

8 - High Impact Changes Implementation/ Supported Hospital – Reablement/ Rehabilitation
10 - Maintaining Independence – Residential Placements
12 - High Impact Changes Implementation/ Supported Hospital – Rapid/ Crisis Response

This investment, particularly into Schemes 8 and 12 is directly supporting Dorset to meet National Condition 3 - Agreement to invest in NHS-commissioned out of-hospital services, also BCF Policy Objective 1 - Enable people to stay well, safe and independent at home for longer

During this year we are keen to begin planning on how we can invest BCF funding into both new pilot initiatives but also include services that support All Age Commissioning. Over time we wish to align and arrange the funding into a small number of local schemes, that will still enable us to continue to deliver against the national conditions and policy objectives, but that will clearly link to local priorities. Our initial thinking is explored in section 4.

2.2 Key changes since previous planning document submitted 2021-22

No services have been decommissioned in the last year and we have increased funding to the schemes 8,10 and 12 by investing the uplift.

Due to the ongoing challenges and pressures in the Dorset Health and Social Care System, our focus has continued on similar areas as last year, however, we have developed planning of new services and improvements in key BCF funded Schemes such as Carers and Reablement. During the course of 2022/23 we will seek to review the application of the BCF and, where agreed by all partners, re-allocate funds to schemes and initiatives that might better support achievement of our shared goals. Our focus has been on the following key areas:

- Maintaining and supporting Hospital Discharge; much work has been progressed in the Dorset wide Home First Programme, several supported by BCF funding streams. A range of commissioned services continue to maintain capacity to support this key area.

- Supporting providers with significant workforce shortages; Commissioners have continued to work collaboratively with partners to try and manage the significant shortage of care capacity in the local market, particularly home care, due to a range of ongoing factors leading to staff leaving the sector, including; 'Burn out' due to the pandemic, overseas workers not returning either due to pandemic-related decisions or immigration status, staff finding more attractive terms and conditions in other industry sectors, including tourism and logistics, and more recently, the cost of living rises, particularly fuel costs.

Note – since the last Plan, Dorset has progressed a 'Dorset NHS & Care Vocational Scholarship' which is a joint recruitment programme that launched in early September. This offers a pathway from education into health and social care, along with a career pathway of progression.

- The development of new Reablement model; due to launch from October, this will provide greater community prevention opportunities and continue to support System demands, including admission avoidance and discharge.

- Carers Strategy: this has been jointly developed and includes a clear plan by which we will introduce Personal Budgets for carers, along with other new services. The Personal Budgets will be implemented during 2022/23 and will include support for Carers' Wellbeing.

3. Governance

Dorset Health & Wellbeing Board govern the Dorset Better Care Fund, signing off and monitoring the local Plan.

In advance of sign off at the HWB, Dorset Council Chief Executive and DASS approve the Plan, as does the NHS Dorset Chief Executive Officer.

Dorset Council, BCP Council and NHS Dorset have in place a Pan Dorset Joint Commissioning Board – this Board is responsible for development and agreement of the Plan before it is submitted for approval from the Chief Executives in advance of submission to the HWB.

Senior Commissioning Leads in NHS Dorset and the Council are responsible for supporting the implementation, monitoring and reporting on the delivery of the agreed targets.

Voluntary sector organisations and other statutory and non-statutory partners feed into the Plan through various forums.

The Council has an internal mechanism for monitoring delivery of the Plan before submission to the Pan Dorset Joint Commissioning Board.

4. Overall BCF plan and approach to integration

4.1 Joint priorities for 2022-23

As set out in the Executive Summary the 2022-23 allocation of the Better Care Fund (BCF) continues in-line with previous years. Our ambitions for health and social care delivery have not changed from the previous years and we are making positive progress towards addressing some of the key challenges in Dorset.

Working collaboratively Dorset Council and NHS Dorset alongside input from the local NHS providers, including Acute Trusts, the provider market and voluntary community sector have continued to invest BCF into the following schemes:

- Maintaining Independence
- High Impact Changes – Hospital Discharge
- Integrated Health and Social Care Teams
- Strong & Sustainable Care Markets
- Carers
- Moving on from Hospital Living

4.2 Approaches to joint/collaborative commissioning

As mentioned, during this year Dorset Council and NHS Commissioners are keen to begin planning on how we can invest BCF funding into both new pilot initiatives but also include services that support All Age Commissioning. Over time we wish to align and arrange the funding into a small number of local schemes, that will still enable us to deliver against the national conditions and policy objectives, but that will clearly link to local priorities too.

Pilot initiatives being explored include interventions to support the End of Life and Palliative Care Strategy and also new contracting models to address the homecare deficit creating stronger links with local voluntary and community sector organisations.

Our initial thinking around All Age Commissioning is to include Birth to Settled Adulthood, and the development of Supported Living; both these areas are in line with the BCF national condition 4, and both Policy Objectives. We have much work to plan how alignment would take place over time as all current available funding is committed. Other local priorities we will consider how we can link to the BCF Plan include; Demand Management, Digital and Technology, Care Optimisation and Care Provider Development. Much joint work is needed to further this thinking and develop our approach.

Since the last Plan we have continued our collaborative commissioning approach and made progress on integrated working. Our approaches across the local System, are outlined below, linked to specific named BCF Schemes for ease of Assurance:

- **Integrated Health and Social Care**

The integrated health and care partnerships across Dorset are continuing to further develop services in conjunction with our Primary Care Networks. Significant investment is being directed in developing rapid response services in order to deploy rapid intervention, treatment and monitoring of patients that have an immediate and/or escalating need.

Multidisciplinary working, virtual wards, home visiting and risk profiling tools ensure that the right support is provided at the right time and in the right place.

Under the Home First and the Ageing Well programmes we are bringing together System partners and taking a population health management approach which will support teams to be proactive at a neighbourhood level, that will also link into our urgent community response service when needs escalate

- **Maintaining Independence – Integrated Community Equipment Service (ICES)**

The ICES is jointly commissioned, via a pooled budget, by Dorset and BCP Councils and NHS Dorset, a single provider delivers the service. It has continued to respond well to demand, despite some driver recruitment challenges, prioritising same and next day deliveries usually required to support hospital admission avoidance and discharge, with 88% of these requests delivered within the times requested. The contract is currently being jointly re-tendered in order to comply with procurement regulations.

- **Carers**

Carers services are commissioned in partnership between both LAs in Dorset and NHS Dorset. There is a Pan-Dorset Carers Steering Group to support achievement of the Strategy objectives and agreed joint priorities over the next five years. Several contracts remain in place to support Carers across the Dorset area. These include information, advice and guidance services; befriending and peer support services; counselling support service and short breaks services. In addition, initiatives remain in place such as My Carers Card and other types of engagement and promotion materials are available to offer different forms of support. These services, in partnership with care technology and support in GP surgeries support the carer to enable them to continue caring and helps to maintain their wellbeing reducing the need for more formal long-term commissioned care options.

The Council hosted Carers Week earlier in 2022, planned collaboratively with Partners including third sector, working together to create a calendar of events to celebrate and promote Carers, and raise the profile of what support is available.

BCF funding is also utilised for Carers Case Workers across localities and linked to some hospital sites. This provides resilience in both ongoing support for carers but also at times of crisis response and hospital discharge planning. The number of workers has been increased this year to enable more complex scenarios to be supported.

- **Moving on from Hospital Living**

A pooled budget continues from the BCF to support a small number of adults with learning disabilities who moved out of long stay hospitals to live at home in the community. Work continues to look at the historic agreement and to review people where their needs have changed. NHS Dorset and Dorset Council meet regularly to ensure oversight and governance over this work

- **iBCF Winter monies allocations**

This year's allocations focus on supporting provider resilience and addressing the workforce capacity challenges we are facing, such as:

- Our Trusted Assessor pilot for Care Homes has been extended due to the positive results including much swifter discharges of individuals and improved communication and relationships with care providers and Acute staff. Work is underway within Home First to explore opportunities to fund and expand the service on a longer-term basis

- Additional resources deployed to support integrated locality working and MDT approaches, including Safeguarding capacity. Also, to provide extended working hours to support weekend hospital discharge and admission avoidance via Home First approach.

- Several pilots have been commissioned to support development of strong and sustainable markets. Including focussing on unmet home care demand and working more closely between regulated providers and voluntary and community sector organisations at a local level. Also, resources to introduce Trusted Practice into home care provision and support provider recruitment

4.3 Additional Collaborative Working

Aligned to the BCF schemes we undertake additional and complimentary joint work; including but not limited to:

- **Supporting the Home First Programme**

Dorset is making progress in embedding greater integrated working via Dorset Home First, this has been elaborated on within section 5.

- **Developing Strong and Sustainable Markets**

Since the last Plan we have progressed the following initiatives:

  - **Dorset Care Framework**

This is a shared approach to the Care Markets for Health and Social Care Commissioners in the Dorset Council area. This will enable all commissioning activity to funnel through this single contracting mechanism, creating greater efficiency for the market, commissioners and stakeholders across the local System. iBCF and BCF schemes will be procured through the Framework going forward. The new framework is now live and providers have begun joining. The first round of procurements will commence in October for Home Care services, as described in Section 5.2.

o Quality monitoring and assurance of Care

Whilst there isn't funding from the BCF to support this work, it is important to note the strong collaborative working approach of NHS Dorset and Dorset & BCP Councils. Both Councils are planning to move to a new digital System to enable them and providers, a more efficient and consistent approach to gathering information to meet quality standards. This is a joint programme with 11 other southwest authorities and a regional stakeholder forum is in place, along with local plans. Dorset will begin pilot implementation of the new approach in October with a small number of providers from across the market before a wider system rollout can be progressed.

o Joint Brokerage

Our joint Care Brokerage Service remains in place and continues to assist social care and health practitioners find the most appropriate care and support for individuals. This offer is monitored to ensure there is a consistent approach to arranging personalised care and support choices across the system that places the individual at the centre of their support planning journey. We intend to implement an e-Brokerage System, that will be a joint venture with Children's Services colleagues, to streamline our processes and seek greater efficiencies for all Partners, including providers.

o Provider engagement

In Dorset, we have a joint contract in place to support provider engagement – again supporting the development and maintaining market relationships. This contract enables regular joint provider communications to be issued on behalf of both LAs in the county of Dorset and the NHS.

Dorset Council is currently planning to support the county's Provider Association to relaunch in order to further enhance provider engagement to support the market with the many new initiatives being introduced particularly via the Adult Social Care Reforms, e.g. Cost of Care Capping and Care Accounts, new digital care records etc.

5. How BCF funded services are supporting integration in Dorset and Implementation of the BCF Policy Objectives (national condition four)

We have outlined below how collaborative working approaches across primary, community and social care services is supporting greater integrated working. Particularly in the Home First Programme, this collaborative approach is informing commissioned services including those being led by the Local Authority as Lead Commissioner for the Dorset System. Ultimately these services are supporting people to remain at home or return home following an episode of inpatient hospital care.

Like many areas of the country, Dorset continues to experience a deficit in care, particularly for home care. It can also be a challenge to source care home placements where higher acuity or complex conditions require support. This presents a challenge in meeting the BCF Objectives for all individuals, however, we have developed several plans, outlined below that we believe will enable positive outcomes to be achieved:

BCF Policy Objectives:

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

5.1 Improved Integrated Working

- We have well-established integrated working through Multi-Disciplinary Teams (MDTs) both in locality areas who focus on community support, but also to facilitate and monitor discharges, both through a single point of access and

out to localised cluster teams. This approach is enabled by BCF funding and within integrated health and social care locality team Schemes reported in the BCF Planning Template. This activity is managed at local 'Cluster' levels, split into 5 areas across the county.

- To support Acute partners, BCF Funding enables social work staffing capacity to be present at the hospital front door including ED, medical assessment and rapid access clinics with a model of putting patients at the centre throughout all hospital pathways.

- As part of the Dorset ICS, Dorset and BCP Councils continue to work collaboratively in supporting the Home First model, striving where it is right to do so, to commission the same services across the footprint of Dorset to gain maximum impact to support people ready to be discharged.

- A key area of improved integration since the last Plan is via the Home First Programme, several Pathways of which are supported by BCF funding streams.

  Over the summer, development of Integrated Intermediate Care Teams has been progressed and mobilisation is planned in order to support, and respond to, winter pressures. Whilst this is not a formal integration, it is the first marked step towards clearly aligning resources and processes that reduces hand-offs and enables us to manage the collective resource as one, particularly heading into winter 2022/23. A System wide 'Sit Rep' will be launched to support this approach and continued focus on improving performance will be a priority.

  We expect this will drive up utilisation and efficiency in the capacity we have. We plan to arrange this in two footprints in the first instance -West and East. This approach will further support discharge and reduce length of stay in short term services.

- Closer working around Carers as detailed in Section 6 is another area of improved integrated working, along with our continued approaches around DFGs and Integrated Community Equipment Service as described in Section 7.

5.2 Changes to commissioned services

We are progressing several interventions, that are funded from the BCF to further support and enable delivery of the BCF objectives:

- **Remodelling of Reablement Service**
  (BCF Scheme - High Impact Changes Implementation/ Supported Hospital – Reablement/ Rehabilitation)

Whilst the existing Service is strengths based and recovery focussed, it has been unable to respond to all demand, both from hospital and community. This is due to workforce capacity, and lack of therapy led support.

The Council will award a new contract, to a new Provider, in October, who will remodel Dorset's Reablement offer. It will be therapy led and recovery focussed. This will enable more individuals to regain and maintain their independence and provide a greater response to System pressures and improve our community prevention offer. This will improve flow and reduce delayed discharges.

- '**Blended' approach with Intermediate Community Rehabilitation and Reablement**

A key approach to meeting the objectives is that of the System funded Care Allocation Team who co-ordinate discharges for people needing rehabilitation, reablement or home care by allocating to pre-commissioned capacity. Due to scale of demand, BCF funded schemes of Rehabilitation and Reablement have been unable to meet all referrals, so we have jointly commissioned additional homecare, that is focussed on strength-based approaches, that is deployed in a number of ways, including to 'blend' care resources. Blending care involves the care plan being led by Rehab and Reablement, but visits are shared with home care providers. Visits are shared across the day in order to make care hours spread further. This enables more individuals to leave hospital more quickly, and an MDT approach is used to maintain sight of the individual supported via these schemes.

- **Remodelling of Home Care Services**
  (BCF Scheme – Strong and Sustainable Markets)

Through the new Dorset Care Framework, we will re-commission the Council's Home Care contracts later in the Autumn. This will further enhance the ability to personalise care and deliver asset / strengths-based approaches, which are key priorities within the Council's Home Care Commissioning Strategy. In addition, we anticipate that this will improve provider resilience and begin to address the care deficit, importantly including:

- Greater focus on promoting and maintaining independence

- Introduce trusted practice, to enable providers to be more responsive and flexible in provision of care and support needs
- Working in clearly defined geographic local zones
- Closer links to voluntary and community sector organisations in order to enable opportunities for care and support needs to be met by non-regulated, and more individualised approaches
- New contracting models.

- **End of Life Care Pathways**

Led by NHS Dorset Commissioners, End of Life Pathways have been re-commissioned and streamlined since the last Plan was submitted, taking a proof-of-concept approach. This has enabled individuals in the end stages of life to be discharged more rapidly to the place they wish to be. This has increased the number of individuals who have been supported home, and this work clearly aligns to Objective 2.

- **Trusted Assessor Pilot**
  (BCF Scheme – iBCF winter pressures)

BCF funding enabled us to pilot this approach at Dorset County Hospital from 1 April 2021. Since then, more than 50% of care homes in Dorset have begun working with the service, which is enabling care home residents to return home from hospital more quickly. Communications and relationships between homes and wards has improved too. We are exploring how funding could be accessed to expand this service further to support Emergency Departments to avoid admissions, also new care home placements from hospital and home care referrals. We would also like to make this available to Community Hospitals. This is another example of a commissioned service that is promoting achievement of both objectives.

Learning from Dorset's pilot, BCP Commissioners intend to pilot this approach at the Acute hospitals in their council footprint.

- **Defining types and levels of care in a care home**
  (BCF Scheme – Strong and Sustainable Markets)

As referenced brokerage teams often report difficulties in the sourcing of placements for higher levels of need and greater complexity. This is an area of the market that needs further development, and we plan to work with providers to develop clear definitions around the four levels of complexity of care (residential, complex residential, nursing, complex nursing) and where needed develop a plan to embed these.

We will then establish the agreed set of definitions on the levels of complexity in care contracting.

5.4 Maintaining Independence Schemes

There are well embedded approaches via Maintaining Independence Schemes that contribute to both objectives; this includes jointly commissioned contract, with a pooled budget, for Integrated Community Equipment Service and also the Technology Enabled Care (TEC) (Assistive Technology) contract.

- **Integrated Community Equipment Service (ICES)**

Over the past year, ICES capacity and resources have been rebalanced from hospital to community as Covid pressures have subsided. Referrals can be made from health and social care workers to enable people to remain at home, and get home from hospital, wherever home is in the community, e.g. own home, a care home etc. The service continues to respond well but there remain pressures from rising cost of commodities and transport infrastructure which is increasing the costs of all equipment but particularly the specialist equipment. We are working hard to recycle equipment as much as possible.

- **Technology Enabled Care**

Funded from BCF, Dorset Council's TEC team continue to support people to remain in their own homes for as long as possible, an enabling and preventative service. Recently use of TEC has been expanded to support several supported living schemes to enable young adults with Learning Disabilities and Mental health to move into more independent living and minimising the size of the care package to give them more choice and control – evidencing our work towards Objective 2. The team are working with several Housing providers to trial different technologies as part of increasing innovation in Dorset.

In addition, we have invested iBCF winter funding to increase availability of TEC to support hospital discharges and we are working with our VCSE hospital coordinator to offer TEC via Pathway 0 as a key longer term preventative approach.

Our plans around implementation of Trusted Practice amongst Home Care Providers will also include TEC.

In addition, NHS Dorset is also working alongside both Dorset and BCP Councils in relation to the development of Virtual Wards, as well as in line with Ageing Well plans, especially in relation to anticipatory care.

5.5 Further embedding links with VSCE organisations

Other key work to further support BCF funded schemes that maintain independence and focus on an asset-based approach is the raft of projects underway with VSCE organisations and networks, these ultimately support both Objectives:

- **Dorset Community Response**

Following the successful pilot, Dorset Community Response model continues to match requests for support with people and groups in the community, such as befriending, moving / removing furniture, help with daily activities such as cleaning and meal preparation. Referrals can be made from across the health and social care system, from social work teams, social prescribers, Carers Support Dorset as well as Acute Hospitals. As part of this there is an urgent same day, short term service provided by the Volunteer Centre, which also operates at weekends, supporting hospital admission avoidance and discharge.

- **VSCE Pilot schemes**

There are several pilots underway that involve lead VSCE organisations such as Age UK and Volunteer Centre, supporting discharge and intervening to support admission avoidance. The services range from handyperson offer (furniture moving, waste disposal, decluttering, cleaning etc) to link workers being onsite in Acute hospitals as part of MDT approach to identify opportunities for community support to facilitate discharge. In this example the worker works directly with the patients – these are often complex including health, housing and environmental issues. The approach has allowed for speed and flexibility supporting 72 discharges to the end of August, and we are developing a business case to expand the approach to other local hospitals.

Working in partnership with BCP Council and the VSCE we are developing a pilot for one-off personal health budgets to support people living in the community as part of Ageing Well. In addition, the development of micro providers and routes to increase Direct Payments and Individual Service Funds are also increasing person centred local care and support options.

5.6 Ageing Well Programme

A key programme, that is separately funded but intrinsically linked to Intermediate Care, and the BCF Objectives, is the Ageing Well Programme. The Ageing Well Steering Group consists of representatives from across the Dorset System including primary, acute, community and social care services. A key workstream is Anticipatory Care, where many new initiatives are being planned such as Virtual Wards, where Dorset has a target to provide 360 beds by December 2023 providing higher acuity hospital care at home. Also, a programme of falls detection and prevention across care homes, and a greater emphasis on remote monitoring to prevent escalations and admission to hospital.

As this programme develops, we will continue to work closely together to ensure interdependencies are mapped across all programmes of work.

6. Supporting unpaid carers.

6.1 BCF funded services that are supporting unpaid carers

Dorset Council and NHS Dorset have joint arrangements in place to support Carers, with the Council leading the commissioning and contract monitoring activity, including measuring of outcomes. The BCF Planning Template evidences that the NHS minimum contribution is being invested to fund the contracts. There are large range of services available to support unpaid carers that includes breaks. We have worked in partnership with System Partners to improve ease of referrals for Carers from GPs to these services.

The services are outlined below, and there are case studies within the Appendices section that describes how carer outcomes have been improved:

- **Commissioned lead carer organisation;** A 'one-stop-shop' to provide information, advice, guidance and emotional support through a befriending service 'Here to Talk, peer support groups, regular newsletters, pop-up information points across Dorset including GP surgeries and signposting to services. They make referrals for Carer breaks, holidays, grant funding, counselling, Carers Assessments and Care Act Assessments for the Cared for Person. They also provide an extensive training offer to include a range of topics from legal and financial advice to physical, mental health and wellbeing. Young carers are also supported through this contract, particularly those who are in transition to adulthood.

  From contract performance data we know that carers who are already known to the service are returning for more support, information, advice and guidance concerning a different need, and that the provider is proactive in signposting carers to opportunities and support. We have included Case Studies 1,3 and 4 at the Appendices section.

- **A commissioned bespoke Mental Health service to support Carers who are caring for someone living with mental health illness**; This service offers 1:1 support, peer support groups, walking group therapy, training on mental health, Triangle of Care and Carers Rights, holistic and therapeutic activities. Carers to Counselling is also available. The service offers a respite funding offer to Carers to support their wellbeing which enables access to a range of activities and resources from gym membership to hypnotherapy, a family day out, to a bicycle or laptop to connect with friends and family. Please refer to Case study 2.

- **Carers Case Workers**; Based across Dorset in Adult Social Care localities and linked to hospital settings, they undertake Carers Assessments where the situation is complex or includes Safeguarding. They also connect Carers to services, and provide 1:1 support, advice, and counselling referrals. There are plans underway to create a new Advanced Practitioner manager to provide greater dedicated support to the Workers, as well as a team approach.

- **Other initiatives**; include Carers Card; which enables the carers to access local discounts, free entry etc. Also 'Digital Doorway' that support carers to access digital devices, training and support.

- **Personal Budgets** are under development with plans to launch this financial year. This will award a personal budget to a Carer following a Carers Assessment to those with Care Act eligible needs. This will enable greater choice and take control over how their care and support needs. This includes their wellbeing; anything which the Carer feels will meet their need is acceptable.

6.2 Carers breaks

Carers breaks are currently available as respite (replacement care) and breaks away and are detailed below. Keen to develop the offer, Commissioners have been engaging with Carers to understand what a break means to them. This has revealed it is not necessarily a holiday, or a mini-break overnight stay, or a break from the person they are caring for. It is a break from the caring responsibilities and routine. In some cases, this will include a break from the person they are caring for, but not in all cases. A break can form many things including an activity, a new hobby or a task which distracts them from their caring routine/thoughts/pressures/stress and responsibilities. We are working on ways to develop more breaks for Carers for 2022/2023 and have already started offering some holistic activities and art activities.

- Short Breaks is our current replacement care, respite offer to Carers. Following a Carers Assessment if eligible they can access up to 120 hours of replacement care by a CQC regulated provider. This service has recently been reviewed and work is underway to enhance the offer to Carers with a wider range of providers including non-regulated where this would be appropriate.

- The commissioned services and Adult Social Care can make referrals for Carers to access breaks via a local and national voluntary sector charity too.

- A pilot called 'Memorable Moments' could offer a break together, offering opportunity to reconnect with carer and carer for person in their primary relationship and enhance their wellbeing. Barriers such as transport, lack of time to organise etc are being included as part of the project to ensure it is as easy as possible to take that break together.

7. Disabled Facilities Grant (DFG) and wider services

Dorset Council's Dorset Accessible Homes (DAH) contract covers the statutory duties for the local authority to assess for and deliver Disabled Facilities Grants (DFGs).

Adult Social Care and Housing colleagues have a well embedded joint working approach to support the administration, monitoring of spend and quality assurance of the work undertaken via the DFG. Housing colleagues have specialist technical skills that support the ongoing development of services. At present, the impact of the government's white paper

'Putting People at the Heart of Adult Social Care' is being assessed, as we understand it will include introduction of Smart Assistive technologies to further promote independence and daily living tasks such as turning up the heating, lighting etc. Work is needed to link these requirements to the ongoing Assistive Technology and Equipment offer.

As referred to in last year's plan, there are good working relationships with Registered Social Landlords who also undertake adaptations, as well providing the right level of intervention with Private Sector Landlords who may have reservations about homes being adapted. Ongoing work seeks to support housing options for those whose needs may be better met by a positive move to more suitable accommodation.

The DAH contract promotes independence in a strength-based approach to maximise individual's ability to carry out activities of daily living in their home which can enhance their health and well-being and reduce their reliance on formal care services. Adaptations can also assist carers to continue to care for longer by reducing the physical barriers to caring and make day to day caring activities easier. Health partners can access this arrangement in order to allow equipment such as overhead ceiling hoists to be installed to support people to remain at home. A recent re-tendering of the contract has enabled a refresh of requirements to ensure the contract remains fit for purpose and the appropriate vehicle to deliver statutory duties.

Since the last plan we have introduced a discretionary DFG Top Up grant in addition to the mandatory limit. This will enable more people to receive adaptations due to the increasing costs of building materials which risked people withdrawing from much needed adaptations as they were required to contribute.

In addition, we have increased the minor works limit to enable more people to access support. This has supported an increase in referrals, 30% of which are from health colleagues supporting hospital discharges or as an intervention that avoids hospital admission. This is not means tested so this change enables adaptations to be progressed more quickly, and the increased cost cap means a greater range of adaptations is accessible resulting in more people being able to access support. This will result in individuals having more opportunities to improve and maintain their independence; this contributes to meeting both BCF national condition and policy objectives

8. Equality and health inequalities

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

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

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

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

There are specific examples of BCF funded services where inequalities are being addressed, such as:

- Carers

The commissioned service for Carers has been proactively working with minority groups and Carers more difficult to reach. Engagement plans have been developed for the most recent period included targeting identified ethnic minority groups, people from the LGBT+ community, refugee groups and collaborating with key partners to help identify and reach male carers of all ages. Representatives are engaging with local organisations such as Dorset Race Equality Council, Community Health Ambassadors LGBT+ Voices Dorset Forum and Dorset Disability Equality Forum to raise awareness and improve networks of support.

As part of Carers Week, feedback we received was that male carers face individual challenges, depending on their circumstances but having a break and opportunity to take time out for themselves was a recurring theme. Therefore, we have planned focussed engagement for Quarters 2 and 3 for male carers.

- Disabled Facilities Grant

The changes described in section 7 in relation to the increasing the minor works limit is contributing to reducing inequality. This is not a means tested service and has created faster access to a greater number of adaptations, so now supporting people with more complex needs, a service that is available across all ages.

APPENDICES - Carers Case Studies – evidence of improved outcomes for unpaid carers

Case Study 1 –Lead Carer Organisation, Befriending Service:

Joy, carer

My family don't get what caring does to me, it's huge manging my life, Mum's and my business affairs. I have very time to relax. Any friends I did have in Wiltshire from growing up here, have passed away, I don't know or have the opportunity make new friends. I unable to talk to locals as I want to respect my mum's privacy.

I'm very careful to whom I confined in. My family often call mum and say 'give love to Joy', but they don't talk to me. It's assumed as I don't have children or a husband it's okay for me to give my life up for caring. Other family members unable to and unwilling to compromise.

Talking to the volunteer befriender has been wonderful, as I can talk about my concerns, and I feel no one else will take this. Caring for my mum is extremely isolating, I don't regret giving up my life but I do have needs and appreciate the time to talk.
The befriending calls are wonderful because the volunteer is a great listener, empathetic and I can explain things to her, and she understands. I have a feeling of self-worth to have this space. It stops me expressing myself as I don't want to take things out on my family and it takes my worries away, just an opportunity to chat and offload

Case Study 2

Recovery Case Study

Title of case study	Support Resistant Carer
Author	Rethink – Dorset Carers Service
Activity details	
What we wanted to achieve	
To reduce carer stress and frustration	
What we did	
X is an elderly man who cares for his wife with clinical depression. He was resistant to accessing the Service because he thinks he should just "get on with it". However, his wife's support worker asked us to give him a call to see if he would accept support as she was concerned about his levels of stress. I phoned him and talked to him about the Service, and what we could provide. I listened to him and spoke to him about resources available to him. He refused to access the respite fund, though eligible to do so, but did want phone support, and a full referral was made as a result. I signposted X to information on depression and talked to him about what this diagnosis meant to improve his understanding of what his wife was experiencing to try and reduce his frustration with her and her inability to get out of bed. I used Rethink fact sheets for this and signposted to the Recovery Education Centre and our online courses.	

In our second session we spent some time talking about the things X enjoyed doing and that he still did. We also discussed the things he used to do but feels he cannot anymore because of his wife's illness: we then explored ways he could adapt so he could still do those things – and we have set this as his goal. X is keen to engage in goal focussed work, which really surprised me given his initial resistance. His current goal is to invite a friend round for a drink to enjoy in his beautiful garden, and to explain briefly to his friend why his wife would not join them in the garden. X has not felt able to invite his friends round because he feels his wife should be present and feels awkward that she is not. His wife does not mind people coming round, she just doesn't want to engage with them herself.
What worked well
Having a short chat with X before he was referred to reassure him. Really listening to x about his frustrations and allowing him to let off steam. Expanding X's understanding of mental illness. X realising he could still do things he enjoyed.
Key messages
The need to take things at the carer's pace and, if appropriate, work with resistance sensitively. But never to underestimate a willingness to adapt and learn even in the elderly. The importance of taking time to establish trust.
Outcomes
X feels more positive. He is enjoying working with me and says: "I do feel better for having talked to you. I now realise I need to look after myself too."

Case Study 3 :

BCF case study template 2022-23 v1

Case Study 4

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