BCF Narrative

1. **Health and Wellbeing Board(s):**

Dorset

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

- Dorset Council
- NHS Dorset ICB
- 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, programmes and workstreams. This directly influences the Plan.

The Joint Commissioning Board, a Pan Dorset Group of Commissioners lead on planning as a collective and throughout the year are updated and referred to in relation to allocation and spending against the plan.

Stakeholders are involved in preparing the plan via specific discussions focussed on our joint priorities. Dorset Council and Dorset NHS leads are keen to begin to embed a different approach to BCF during 2023-2025 Plan, therefore joint working is progressing to identify how new investment will be added to the BCF to create new BCF schemes.

Joint working across DC, ICB and Dorset County Hospital has seen significant improvements in performance and resilience through the work towards the end of 2022/23. The ambition for this BCF is to progress this further, pulling funding into the schemes to continue work already underway.

2. **Governance**

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

In the event that submissions to the BCF National Team are required outside of HWB meeting dates, the HWB has delegated authority to approve and submit BCF plans to the Director of Adult Social Care (DASS) in consultation with the HWB Chair. In such scenarios retrospective approval is always sought formally from the Board. This is the case for submission of this plan, the HWB will receive documentation at its meeting on 20th September 2023, the National team will be informed once HWB has formally approved.

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, this is achieved via regular communication and contact.

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

The Council and NHS Dorset have their own internal mechanism for monitoring delivery of the Plan before submission to the Pan Dorset Joint Commissioning Board.

3. Executive Summary

a. Priorities for 2023-25

The 2023-25 allocation of the Better Care Fund (BCF) continues in-line with previous years, however, as a local system we are committed to demonstrating progress within this Plan term around adding new investment to create new BCF schemes and extending the remit of funding to include All Age Commissioning activity. We are making positive progress towards addressing some of the key challenges in Dorset, and our collaborative approaches, particularly in our Home First Programme (hospital discharge and avoidance workstreams) are enabling Dorset to evidence meeting of the core BCF objectives of enabling independence and providing the right care in the right place at the right time. New schemes for 2023-25 support the development of Intermediate Care Services via our Home First programme.

Our excel template details the scheme breakdowns and how investments have been allocated. Priority schemes continue to be:

- Maintaining Independence (this is where new investments have also been included)
- 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 challenges associated with high demand and higher acuity. Since the last plan we are pleased to be able to report that within the last three months, with the changes made within out of hospital pathways, along with an improving capacity in the local home care market, we are beginning to see a reduction in the length of time it takes to source appropriate care solutions.

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

These additional investments are directly supporting Dorset to meet National Condition 2 & 3.

The following areas are of focus for development during the next 2 years:

- **Development of Dorset's Intermediate Care Offer**; this includes further enhancement of Reablement, which is funded via BCF, development of Urgent Community Response and Enhanced Models of Care Delivery, e.g. Tele-medicine / e-medicine supporting independent care delivery. We will also continue to focus on integrated working approaches across Health and Social Care across the Dorset Council footprint, which includes implementation of an Out of Hospital model for Integrated Care with a focus on multidisciplinary teams across organisations linked to the health of older people.

  Our system funded 'Home First Accelerator' programme is a new line of investment we have added to the Plan, as well as our enhanced Home Care Service 'Recovery and Community Resilience'. These commissioning interventions are enabling us to build on performance last year around Admission Avoidance and Discharge to Usual Place of Residence. See narrative in National Condition 2& 3.

  A stream of priority work is improving our data and understanding around demand and capacity. Part of this work will include adding data feeds into systems that can be viewed by all partners in

Dorset, our DiiS (Dorset Information & Intelligence Service (DiiS).

- **All Age Commissioning**; our ambition is to increase investment in the BCF by adding our Birth to Settled Adulthood Programme as a new scheme by end of year 2. We have already began to expand Carers support for All Ages through BCF Funds. More narrative is included at section 8.

- **Preventative approaches via VSCE networks**– Strengthening links across VSCE networks to the local Health and Social Care Offer to further develop Dorset's Prevention Approach. Linking with Dorset's Place offer and Ageing Well Programme, and confirming our approach to capturing data to evidence how interventions through BCF are improving outcomes and reducing health inequalities.

  The HWB recently agreed to oversee progress and provide leadership to a project supporting place-based working in the Dorset Council area, that aims to develop a plan to grow community support and capacity through the community and voluntary sector, to support people to remain living well and independently. The project will contribute to the priorities of both Integrated Care Partnership Strategy, Thriving Communities, and BCF. Whilst a relatively small funding pot, we have included this as a new Scheme as additional investment this year in recognition of the opportunity the project offers to identify and unlock VSCE capacity.

- **Working collaboratively with the providers** to support workforce development in a number of areas including; Care Homes market to enable higher levels of care and support to be met, for example middle to later stage dementia and conditions that benefit from positive behaviour support planning; all markets around opportunities to utilise technology and equipment.

- **Development of whole market relationships**, working closely with Dorset Care Association, who also host our Trusted Assessor Service, both elements of which were initiated from pilots enabled by BCF funding. More information is at section 4b.

b. Key changes since previous planning document submitted 2022-23

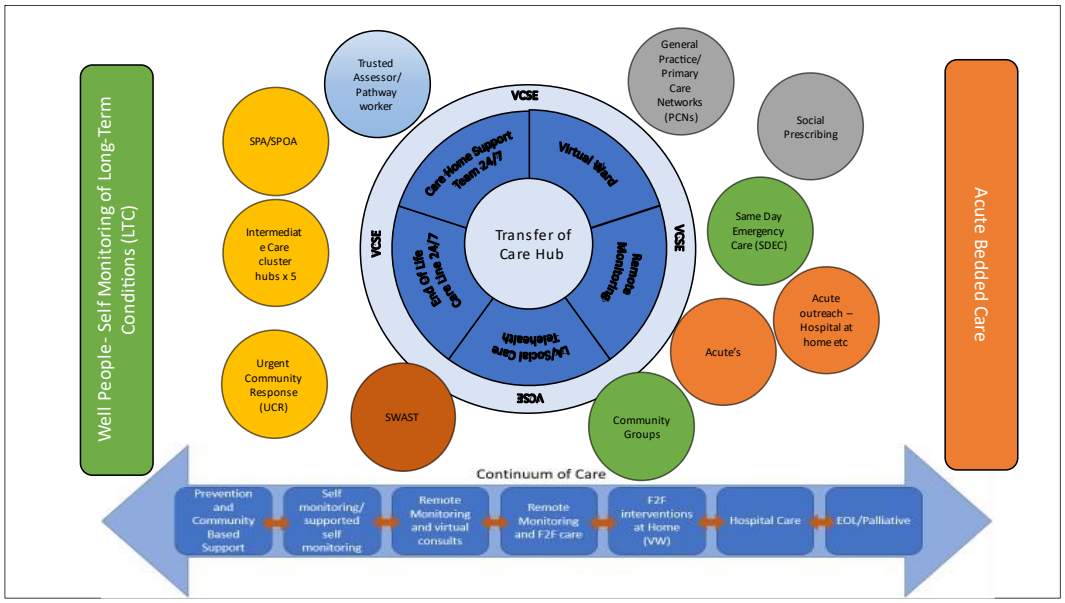
Since submission of the last plan, the Dorset Integrated Care Board has been established, along with new governance arrangements to which Dorset Council is a partner of. The Integrated Community and Neighbourhood Oversight Group is key governance whose priorities align to BCF Objectives. The group has oversight of the system transformation programme to deliver an integrated community care model that supports more people to remain safe and well in their own homes and which enables them to return home following a period of ill-health with the support they need to live well and independently in Dorset. Key areas of delivery include:

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

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

- NHS Dorset is leading on several primary care and community programmes, such as Virtual Wards, Care Home remote monitoring, urgent community response services and anticipatory care, all of which form part of our community continuum of care model. As we further develop this model, we will be bringing together these separate programmes of work into a single portfolio that will include

the work we are doing within Home First. This will ensure that we maximise the opportunity of the investment and can better understand how our model, incorporating our Better Care Funded services, can collectively be delivered at local place and neighbourhood levels.



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

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. Additional funding has been included (schemes 41 and 42) which are key investments that support BCF objectives and National Conditions – 'Home First Accelerator Programme' and ' Recovery and Community Resilience'

Our focus has continued on similar areas as last year; however, we have made good progress with the planned development of new services and improvements in key BCF funded Schemes such as Carers and Reablement. As a local ICS area good progress has been made in our Home First Programme with implementation of a Discharge to Assess approach, with the new schemes referenced above enhancing pathways out of hospital, and supporting people to remain at home. Several elements such as Reablement, District Nursing, Integrated Community Rehabilitation are services funded from BCF. Further information about this can be found in National Conditional 3 section.

The Carers Strategy has been finalised since the last year, and through collaborative work through Joint Commissioning Board we are working pan Dorset to ensure we have an aligned offer across both LA areas to avoid creation of an inequality in offer. More information is provided in section 8.

The Council's new Local Authority Trading Company launched successfully in October 2022 as planned, and progress has been made in respect of enhanced reablement offer; this is explained further in the National Condition 3 section.

We are pleased to report that, particularly in the home care market, providers are having successes with recruitment and capacity is in an improved position compared with last year. The successes are largely due to successful overseas recruitment, but local recruitment is also contributing to local capacity. There are several approaches the council has set out in the Commissioning Strategies and within the Market Sustainability Plan, that provide more information.

4. National Condition 1: Overall BCF plan and approach to integration

a. Joint priorities for 2022-23

As set out in the Executive Summary, the 2023-25 allocation of the Better Care Fund (BCF) continues in-line with previous years, however, as a local system we are committed to demonstrating progress within this Plan term around adding new investment to create new BCF schemes and extending the remit of funding to include All Age Commissioning activity. We want to build flexibility into the 2-year plan, so we can begin to implement changes as we progress into year 2 (24/25).

We are making positive progress towards addressing some of the key challenges in Dorset, and our collaborative approaches, particularly in our Home First Programme (hospital discharge and avoidance workstreams) are enabling Dorset to evidence meeting of the core BCF objectives of enabling independence and providing the right care in the right place at the right time. Further development of Dorset's Intermediate Care Offer is a key priority for all Dorset Partners – this is explained further in National Condition 3 section.

Other priority areas are explained in section 3a above.

b. Approaches to joint/collaborative commissioning

Since the last planning round Dorset Council and NHS Commissioners have begun planning how we can invest BCF funding into both new pilot initiatives but also include services that support All Age Commissioning. We have identified 2 areas initially to prioritise; further development of Carers offer to enhance all age offer, also to introduce a new scheme, to which additional funding would be invested into the BCF for Birth to Settled Adulthood (BTSA). For BTSA this will begin with joint commissioning arrangements to deliver the programme of work, in terms of contractual mechanism and commissioning personnel.

In addition, working collaboratively, we have agreed to include additional funding lines into this plan for:

- Home First Accelerator Programme
- Recovery and Community Resilience – Enhanced Home Care
- Thriving Communities

These initiatives are explained later in this narrative.

- **Palliative and End of Life Care**

Our ICS Strategy for Palliative and End of Life Care is all age and whilst the section for children and young people is still in development the sections that cover adult and transitions have been agreed with a view to implementation during this next two-year period. There are seven key priorities, as follows.

1. Achieve timely, personalised care planning for people at end of life taking into account what matters most to them and their individual preferences.
2. Co-ordinated care across services with effective joint working and improving continuity of care at end of life.
3. Supporting people to live and die in their preferred care setting with timely symptom relief, personal care, support of and for carers and healthcare professional support.
4. Supporting education, training, resilience and well-being across Dorset for all staff involved in end-of-life care.
5. Ensuring effective, consistent and timely bereavement care for people in Dorset.
6. Helping to develop caring, inclusive communities with openness about death and dying and willingness to help in emotional and practical ways.

7. Ensuring continued feedback and involvement of people at end of life, those people important to them, carers and healthcare professionals in Dorset.

For those who are unable to die at home and need some additional support that is not acute, we will be exploring how we can provide some community provision that is appropriate to need and inclusive of families. In addition, we are exploring new contracting models to address the homecare deficit creating stronger links with local voluntary and community sector organisations.

We have continued our collaborative commissioning approach and made progress on our 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

We continue to develop services together across Dorset, including with Primary Care Networks. Significant investment continues in out of hospital and admission avoidance pathways, via our Home First Programme and Urgent Community Response model, and multidisciplinary working in our Health and Social Care Cluster Teams is a key element. New commissions in respect of enhanced recovery focussed homecare, 'Recovery and Community Resilience' and Trusted Assessor Service is providing greater integrated working between health and social care staff and independent sector providers.

Maintaining Independence – Integrated Community Equipment Service (ICES)
The ICES is jointly commissioned, via a pooled budget, BCP Council are the lead commissioner, with Dorset Council and NHS Dorset as partners. The contract has just been retendered, with the incumbent provider being successful in their tender bid. The service has continued to respond well to increasing demand; numbers are increasing compared to the pandemic number in 2019-20. However, the pressures are still on hospital discharges demand, prioritising same and next day deliveries with 88% of these requests delivered within the times requested.

The new contract will allow better customer access to their online records, improved ordering system and work is ongoing to support practice of subscribers with a proposal to employ an OT by the provider to support training, recycling of equipment and overview of special equipment purchasing.

This is an area, along with assistive technology, we invested some of the additional Adult Social Care Discharge Funding to last year, in the reporting period 1439 people were supported to leave hospital.

Carers
Some Carers services continue to be commissioned in partnership between both LAs in Dorset and NHS Dorset. There is a Pan-Dorset Carers Steering Group developing a Vision document which is signed up to by all partners and approved at Joint Commissioning Board. The Vision's objectives challenge partners to deliver, improving services for Carers across Dorset. The Dorset Council Adult Social Care Carers Strategy aligns to this vision.

Several contracts remain in place to support Carers across the Dorset area. These include; preventative early help support of information, advice and guidance services; befriending, training, peer support services; Carers Reference Group, and counselling support service.

Partnership working with Dorset HealthCare, NHS Hospital Trusts, and voluntary and community sector continues through the Dorset Carers Partnership Group and Dorset Council Carers Provider Forum.

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.

Joint work has continued the prescription pads in the GP surgeries to enable individuals to register themselves as a carer with their GP. Information is also shared via Carers Support Dorset and Council contact to ensure GP records are updated. GP surgeries continue to be key point of access for Carers,

and Carers Week activities are always publicised through this route. Carer's Week offers a shared calendar of Dorset events for Carers and joint activities that are held in local venues.

BCF funding is also invested into Carers Case Workers, enhancing integrated working approaches across localities and linked to some hospital sites. This provides a small team to support where there is complexity or safeguarding concerns. We have introduced an Area Practice Manager role to develop the team, drive performance and consistency of practice.

Further work in partnership with Children's Services is planned to improve the transition of young carers to young adult carers being supported by commissioned services and Dorset Council Adult Social Care.

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. Formal reporting is via the Joint Commissioning Board.

iBCF Winter monies allocations
This plan's allocations continue to focus on supporting provider resilience and addressing the workforce capacity challenges we are facing, such as:

- Supporting the re-launch and implementation of our local Care Provider Association. Re-launched in 2022, the Association supports all market areas in Dorset and hosts the Trusted Assessor Service. We have agreed a programme of work linked to our Commissioning Strategies, an example is Cost of Care Engagement with the market to increase take up and support providers, in conjunction with the independent consultants running the exercise. Other priorities the DCA will support include; Market Sustainability Plan, workforce development and winter pressures planning.

- 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.

- A portion of funding has been invested into supporting provider fee uplifts in 2023/24 – supporting BCF scheme 'strong and sustainable markets'. Particularly in home care and supported living at present, we are seeing an increase in providers keen to work with us at published rates. Our rates since 22/23 have been set by the results of cost of care and followed best practice in terms of applying and accounting for inflation. As a result we have seen a reduction in the time it takes to find home care and we have reduced the number of people waiting for care by 70% (as at May 2023). This will increase confidence heading into times of increased system pressure that there will be additional capacity in the market to call upon to respond.

c. Additional Collaborative Working

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

Developing Strong and Sustainable Markets
Since the last Plan we have progressed the following initiatives:

Dorset Care Framework (DCF)
This 10 year framework was launched in 2022 and is a shared approach to the Care Markets for Health and Social Care Commissioners in the Dorset Council area. This enables 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. We have received positive feedback from providers joining the framework particularly in relation to the flexibility the open framework approach offers. The new framework is now live

and providers have begun joining in advance of specific Lot competitions. The first round of procurements was conducted in early 2023 for Home Care and Advocacy.

Defining types and levels of care in a care home
We continue to experience challenges in the sourcing of placements for higher levels of need and greater complexity. We have progressed our work to develop clear definitions around the care and support requirements and are in the process of engaging and seeking feedback from the care homes market. We will incorporate the definitions into the DCF to embed clarity and transparency.

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. At the time of writing this plan we are concluding a restructuring of the Brokerage Service to enhance the approach of the function. Brokers will be upskilled to develop more effective relationship management and negotiation with providers, they will also adopt a case management approach to reduce hand-offs and delays.

Provider engagement
Our joint contract with BCP Council and Dorset NHS continues to support provider engagement, via Partners in Care – 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.

As referenced above, in 2022 we supported the re-launch of the Dorset Care Association and this is already supporting the further improvement of our provider engagement, and we have a programme of work the association with support.

d. Continued integration of health and social care and support improvement of outcomes for people with care and support needs

- Since the last plan integrated approaches have developed particularly well in initiatives linked to the Home First Programme. Closer working around Carers as detailed in section 8 is another area of improved integrated working, along with our continued approaches around DFGs and Integrated Community Equipment Service as described in section 9. Examples of Home First integration include:
    - Implementation of Discharge to Assess Model; this is covered in detail at section 6. This approach, of which Reablement and Rehabilitation support are funded from BCF schemes, and some of the short-term home care, has created a ‘Core Offer’ that all health and social care practitioners can refer into to support discharge and avoidance. This has increased the number of people being supported via a recovery and independence approach before consideration to long term care needs is made. More integrated working between health, social care and providers is also reducing wait times and reducing hand-offs in decision making.

    - Multi-Disciplinary Teams (MDTs); our well-established integrated working approach via MDTs continues and across Dorset (Dorset and BCP Council) we manage activity on a local ‘Cluster’ approach, 5 across the county. This approach is enabled by BCF funding. In addition, social care and health demonstrate their MDT approach in Primary care Networks with arrangements for GP MDT

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:

- **Embedding Trusted Practice into Intermediate Community Rehabilitation (ICRT)**

At section 6 we explain the Trusted Practice approach we have embedded with Reablement and enhanced home care provision that support hospital discharge. NHS Dorset continue to commission ICRT from the BCF, but we have enhanced the service by including Trusted Practice. ICRT colleagues can refer people requiring long term care via Care Act eligibility, directly to the Council. This is reducing duplication of work required by social care, as integrated working is supporting sharing of information. In turn this is increasing flow through ICRT services as resources can be recycled more quickly. We continue to blend care (where providers share care visits) across our Core Pathway 1 offer. This is explained further in section xx. 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.

- **Trusted Assessor Service**

  Since the last plan, the successful pilot, that was funded from in 2021/22 and 2022/23 from BCF funding has been commissioned as an expanded service with System funding through to end of 22/24. TAs support Acute and Community Hospitals in the Dorset area, supporting all care markets and all age adults. TAs support admission avoidance, with an on-call approach 7 days per week supporting Emergency Department. Providers are also able to call TAs if an individual they are supporting is on their way to ED so that the TAs can meet the induvial, support them and where appropriate enable their return home without admission (whatever the care setting) as soon as possible.

  The TAs have recently completed recruitment up to their full quota of five staff. From 1 July 2023 a 7 day per week on site service across hospital settings will be available.

  In the last quarter of 2022/23 the TA service assessed 233 individuals in hospital, all of whom were discharged. There are 86 providers signed up to the service. With their growing skillset the assessors have reduced the assessment time from approx. 2 hours to just over 30 minutes.

5. National Condition 2: Meeting BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

a. Enabling independence

Much of the work we are doing in Dorset overlaps in evidencing how we are meeting both National Condition 2 and 3; ‘Enabling people to stay well, safe and independent at home for longer’, and ‘Provide the right care in the right place at the right time’. This section explains the range of initiatives and support available, many of which are enabling Dorset to meet targets around the metric of Discharge to Usual Place of Residence and Avoidable Admission.

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

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

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

These teams provide both proactive and reactive care and are a key to the development of our out of hospital care model, aligned with both anticipatory care and hospital flow. NHS Dorset's community work programme includes the further development of our urgent community response service linked to virtual wards, enhanced health in Care Homes work, which has been further expanded this year with remote monitoring commissioned as a proof of concept for winter last year and anticipatory care, all linked to our integrated locality teams.

Our joint approach support options for unpaid carers is explained at section 8 and enables longer term independence to be maintained at home for those individuals being cared for.

Voluntary and Community Sector (VCSE) networks offer a vital link and support network for individuals in need of support, and this is a key element of our infrastructure. Dorset's Community Prevention Offer is made up of many streams, funded from a range of budgets outside of BCF, with many contracts managed outside of Adult Health and Social Care, but provide key resources. These include Citizens Advice, Housing Related Support, Domestic Violence Against Women.

Within Adult Social Care, the following arrangements offer wide ranging support to promote and maintain independence:

- **Dorset Integrated Prevention Services (DIPS)**

We commission, via the Dorset Integrated Prevention Services (DIPS) Contract, a range of services including:

- Central Point of Access for triage assessment and signposting into the most appropriate intervention including housing, homelessness, mental health and addiction
- Volunteer led response – including same or next day support where quick response is needed. 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. This response offers 7 day per week support which includes enhancing weekend capacity to enable hospital admission avoidance and discharge.
- Home from hospital and Crisis support, this provides short term support for a wide range of matters including financial support with budgeting, benefits and unaffordable rents, accommodation issues such as eviction and court action; abusive/violent situations and offering welfare checks. There are also services covering a handyperson offer (furniture moving, waste disposal, decluttering, cleaning etc) and 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 in supporting discharges.
- Emergency Local Assistance where people with no other access to funds for essential items
- Social Reablement and Recovery, and Housing First – longer term support to maintain housing tenancies, domestic violence support, development of personal resilience and wellbeing.
- Micro-Provider Network

Via DIPS all contracted organisations are linked closely together to create a 'no wrong front door' for people needing support; this reduces the risk of falling between any 'cracks'.

Through Home First development activity there is closer working between Adult Social Care, Housing and the DIPS organisations to identify those most at risk of homelessness and to develop robust plans to support individuals where needed.

- **Adult Social Care Community Prevention Offer**

In addition to the DIPS contract, there is a specific ASC Community Prevention Offer in Dorset, commissioned via Help & Kindness. Via triage and signposting it assists people in finding statutory and non-statutory support. Referrals can be made by anyone; professionals and members of the public. Access to this approach is promoting and enabling longer term resilience for individuals and reducing impact for ongoing formal support, and includes urgent responses for crisis situations, and to support hospital discharges.

Other programmes and approaches that evidence our approach to maintaining independence include:

- **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. With 3 key workstreams for Urgent Community Response, Anticipatory care and Enhancing health in care homes., where many new initiatives are being trialled such a Tele / e- medicine and remote monitoring approach for care homes.

We have seen positive outcomes, and heard much positive feedback from providers, who have been party to the telemedicine approach, which enables a clinical first call assessment for acute episodes delivered by NHS staff. We are now in the process of exploring how the pilot can be extended to all care homes, but also be used by homecare providers. This is an area we would like to prioritise for inclusion into future years BCF plans; this is a key enabler to meeting Avoidable Admissions and Discharge to Usual Place of Residence metrics.

The programme is also developing community Link workers to support locality teams and prevention of admission. Linking with Place to create age friendly communities with supportive services and to enable people to age well in place.

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

- **Technology Enabled Care (TEC)**

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, the TEC team have established an Independent Living centre specifically for TEC. This TEC Lounge is open to Dorset residents who may wish to explore TEC options available including how modern available technology such as Alexas can work to enhance their independence.

The TEC referrals are increasing (from about 20-30 per month to over 103 in March 2023) and numbers of connected carelines have gone up from 980 to 1220, supporting 1263 service users despite a turnover of 220 individuals. The number of referrals are now averaging about 56 per month with a total of 683 deliveries alone during 2022-23.

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 across acute and community hospitals.

Our plans around implementation of Trusted Practice amongst Home Care Providers (see section 6) will also include TEC and the first round of initial training has already been held.

Other NHS Dorset led programmes that work Pan Dorset, are also exploring how TEC can support the development of Virtual Wards, as well as in line with Ageing Well plans, especially in relation to anticipatory care.

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

Explained in detail in section 4b, ICES capacity and resources continue to support hospital and community referrals, which can be made from health and social care workers to enable people to remain at home, and get home from hospital, wherever home is. e.g., own home, a care setting. The service continues to respond well but there remain pressures from rising costs associated with inflationary open market pressures. We are working hard to recycle equipment as much as possible.

Housing adaptations enable individuals to remain at home and promote and maintain independent living. Our work in this space is explained at section 9.

b. Step Up Support and Discharge Pathways

Where formal care and support is needed, we have further developed the services we commission to ensure there is focus on recovery, promotion and maintenance of independence. Like many other ICB areas, Dorset was challenged in 22/23 in meeting the metric for the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population. This was due to the need to utilise care home placements on discharge due to lack of homecare, particularly during quarters one to three. Homecare availability is now improving, and the schemes and initiatives outlined in this section will also contribute to improving performance against this metric.

The majority of the resources support hospital discharge, however, re-commissioning of some contracts has enabled greater equity of access, and extended access to support community crisis and step up requirements. As described at section 6, we have implemented a Discharge to Assess approach in Dorset, which is enabling more people to leave hospital much earlier in their recovery:

- **Reablement**

Dorset's Reablement offer is fully funded by the BCF. In October 2022, Dorset Council successfully launched a new Local Authority Trading Company through which to deliver, and further enhance the Reablement offer in Dorset. The Council also transferred a number of other services to the new care company, Care Dorset, which included six Care Homes.

The intention is to develop a therapy led Reablement offer, however, recruitment challenges have initially limited this opportunity, although close working with health and social care is supporting some support in this respect. Despite this Reablement is providing good outcomes for people, Care Dorset are consistently reducing care and support needs, since January 2023 there has been a reduction in care from start point to exit of over 70%.

Reablement representatives are a partner in the MDT approach, and continue to work closely with health and social care colleagues to plan and manage discharges, and to avoid admission where possible. Reablement colleagues continue to operate via a Trusted Practice approach, and we have further enhanced since the last Plan. Care Dorset provide a Trusted Practice approach at the end of the period of reablement if long term care needs are required, or if no care needed are able to end the care without waiting for approval from Health or Social Care, in order to make care available for others waiting. Further details about how we have enhanced our Trusted Practice approach is explained in on the next page within the Recovery and Community Resilience Offer.

In response to system pressures in Winter 2022/23, with the support of additional System funding, Care Dorset were able to re-purpose 20 of their existing care home beds to Reablement Beds. This offered a more intensive reablement offer to individuals with higher levels of care and support, enabling them to leave hospital more quickly and focus on regaining greater independence. The Community Reablement Team then oversee the individuals progress and plan their discharge home, often with a reduced care package initially, further reducing once the individual has settled. Since opening the beds in December 2022, 66 people have been supported across the 20 beds, with the average length of stay being 29 days.

Our longer term plans for bedded Reablement are explained in section 6 'Home First Accelerator Programme'.

- **Recovery and Community Resilience (RCR) Offer**

This is an enhanced homecare offer that was re-commissioned in November 2022 to focus support on recovery and regaining / maintaining independence, which has supported implementation of Discharge to Assess and enabled us to expand the Core Offer. Providers have been supported to further enhance workforce skills via a development programme delivered by Adult Social Care Practitioners which included refreshers on Strengths Based Approach, Equipment and Assistive Technology. This has provided the ability for providers to adopt a Trusted Practice approach (TP) completing assessments for long term care needs at end of recovery period, enabling people to end support, or move onto long term care swiftly where needed, freeing capacity more quickly for others ready to leave / needing support. The TP also includes recommending of alternative care solutions such as equipment and TEC, and links to VSCE resources and networks where appropriate. We are in the process of further improvements which include authorising RCR providers (and Reablement) to prescribe equipment direct from our Integrated Community Equipment Store.

We have seen improved relationships and closer working between RCR providers and discharge leads via increased contact via MDTs. The RCR providers are supporting more complex care via this pathway now. There are opportunities to develop more integrated approaches to increase clinical support for the RCR providers and the individuals they support by learning from the benefits of remote telemedicine support such as Immedicare in Care Homes.

The commissioning approach has made for more attractive contracts for providers that have enabled greater supply. This has allowed hard to reach and high demand areas to be increased in capacity (Purbeck & East), which has created a more equitable offer across the Dorset area. The contracts are also flexible, so Commissioners can move capacity to meet demand, an example of this is recently moving capacity from West to East Dorset & Purbeck in order to address high demand, particularly for larger care packages (April 23).

The recommission in November 2022 added 770 hours per week to the scheme, an increase of 25% in capacity. However, performance has increased further with 80% more people being supported when comparing Apr 22 to Apr 23.

Whilst not a long term and fully funding stream in the BCF, additional Discharge monies supported this scheme in 22/23, and continue to do so in 23/24.

- **Trusted Assessor Service**

The TA service has enabled greater collaboration between the social care providers and acute hospital setting professionals, by improving communication, using creative problem solving and supporting providers and health professionals to better understand each others pressures, challenges and risks. This is breaking down barriers and speeding up discharges, enabling people to get home (whatever the setting) more quickly.

Specifically in relation to how this commissioned service supports people to remain at home, the TA service supports providers in circumstances where individuals are conveyed to the Emergency Department. The TA can meet the person in ED and working with ED staff establish treatment plans, keeping provider up to date and seeking any additional information about the persons history/baseline etc. Particularly for adults

of working age with more complex and specialised care and support needs, where the ED environment exasperates their presentation, this is enabling better outcomes for individuals and reducing the needs to admit to wards. This is improving collaboration and understanding between providers and ED staff, with TAs able to support ED staff to understand what the individual may need, arranging more appropriate environments clinical assessment and treatment.

c. Further information in relation to activity to support meeting of Metrics:

- **Unplanned admissions to hospital for chronic ambulatory care sensitive conditions**

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

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

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

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

An example of one of the initiatives implemented is a Carousel Clinic in North Dorset that takes a population health approach to address this challenge.

d. Demand and Capacity for Intermediate Care to support people in the community.

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

Step up capacity, and broadening our Preventative Approach, is an area of priority we have outlined. We have evidenced in section 5 and 6 where we have expanded services to support people to remain at home, and promote longer term independence that will reduce, delay and the need for long term care. We intend to refocus further step-down capacity to meet step-up demand in line with this ambition.

Further narrative on our demand and capacity is in section 6.

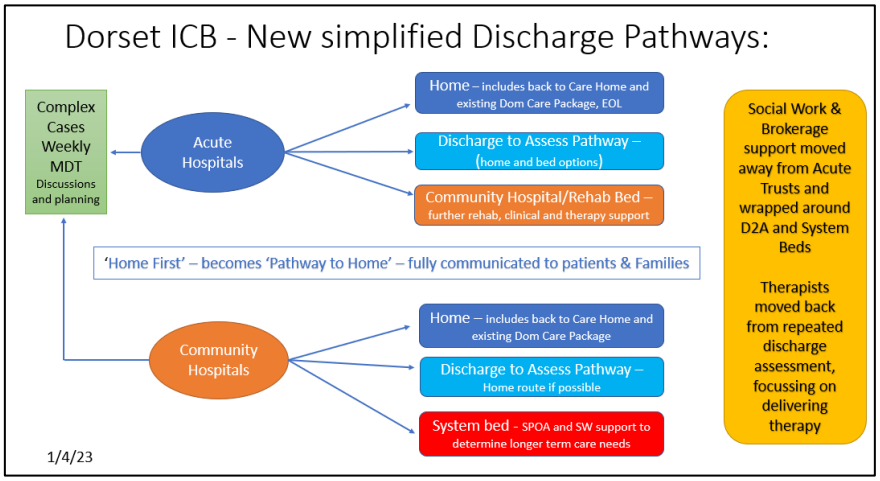
6. National Condition 3: Meeting BCF objective 2: Provide the right care in the right place at the right time

In addition to the Schemes explained in Section 5, the following approaches evidence our meeting of Objective 2 which includes longer term, and additional investment into new Schemes in this plan. We have embedded the High Impact Changes as core principles in our Home First programme. Adopting a universal Discharge to Assess (D2A) approach for hospital discharge, improving early engagement and discharge planning and increasing the efficacy of our MDT working are all key tenets of our improvement focus. Our 23/24 plans reflect our commitment to expand trusted assessment capabilities, improve our relationships and support to care providers and achieve a more consistent response over 7 days. Key

areas for further work this year will focus on further developing our demand and capacity capabilities as key to strengthening our longer-term strategy and commissioning plans and targeted work to source better and more timely solutions for people for whom housing and/or accommodation issues are a key factor in their discharge delay.

a. Discharge to Assess in Dorset & Addressing Immediate Pressures

The Dorset system has re-committed to implementing an at scale D2A approach for all hospital discharges and this has been in place since April 2023. Our approach, supported by all health and care partners, builds on the learning from the past three years and is grounded in the principle of supporting more people with a 'pathway to home' approach that maximises their opportunity for recovery out of hospital and a return to independent living. Through the Home First programme, we have set an ambitious roadmap for 2023/24 which takes account of the High Impact Changes and is collectively focused on:



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

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

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

- Further development of a pan-Dorset demand and capacity model to inform right-sizing of intermediate care capacity and skills at place level. We know that we do not currently have all the skills and capabilities in the right places or necessarily in the right quantum. Building on our BCF planning process, our plan is to evolve our demand and capacity modelling capabilities across health and social care to help us better understand where there are gaps in our intermediate care

model and how we can best optimise the skills and capacity we do have to meet people's needs. This includes but is not limited to:

- Scoping where we can extend our intermediate care offer to support more people and reduce reliance on one-off brokered solutions. Areas of focus include people with delirium, advanced dementia as well as solutions for younger people and those with LD who are often not easily support with core services
- Developing a joint approach to workforce development across health and social care, particularly around use of therapists. We are committed to delivering a therapy-led reablement model as part of our intermediate care offer and are scoping how we can increase investment in non-registered roles that enable us to target our limited therapy resource at the most effective places. This includes use of therapy/rehab assistants, discharge co-ordinators and expansion of trusted assessment capabilities

As we move forward, our ambition is to shift our focus from step-down (supported discharge) to step-up (admission prevention) which brings together our intermediate care capabilities with those being developed via virtual wards and UCR services and which will enable us to better target our collective resource to supporting people in their own homes. This requires us to continue to reduce the backlog of delays in hospital in order to create the necessary headroom to shift resources further upstream.

The following provides more detail on how our Home First Pathways, 0-3, are arranged:

- **Pathway 0**

This includes a well established VSCE offer, as referenced in section 5, with a range of support available 7 days per week to support discharge. Support ranges from help with housing issues, finances or benefits, cleaning, meal preparation to form filling and paperwork. A link worker is present on site at our Acute Hospital to act as a key link to support individuals and signpost onto other services and networks of support.

- **Pathway 1, our Core Offer includes:**
  - Home based Reablement (BCF funded)
  - Recovery focussed, enhanced Home Care known as 'Recovery & Community Resilience', plus Roaming Night support
  - Integrated Community Rehabilitation and Therapy (BCF funded)
  - Acute Hospital to Home services

Through the recent recommissioning activity for enhanced homecare referenced in section 5, this has enabled us to broaden access to the core offer ensuring more individuals can be supported home. The implementation of Trusted Practice means we are able to recycle care more quickly when individuals are ready to leave short term support, or when any long-term care needs have been identified.

- **Pathway 2:**

We have a range of options for people needing more recovery time before being ready for home. Community hospitals offer rehabilitation, with integrated working via MDTs enabling ongoing assessment to take place as recovery progresses. In addition, we have number of discharge to assess beds and reablement beds across a number of care homes. As referenced earlier, we have further work to do as a System to ensure we have an equitable offer of wraparound therapy support into these homes to ensure people are supported to achieve their best outcomes.

- **Pathway 3:**

We are working hard to reduce the number of people who are supported via Pathway 3 as we believe most people should have the opportunity for further recovery time before making long term care and support decisions. However, this is appropriate for some people, particularly where a further move would be detrimental and the LA Brokerage function, with support from Trusted Assessors, lead placement searches.

There is a separate funding arrangement in place for people who require bespoke commissioning to support a discharge from hospital. This is where health, care and support needs are complex and the long-term responsible commissioner is unclear.

b. Integrated Working to support timely discharges

We have several forums that enable a collaborative approach to managing risk around hospital and community care. Building on the governance and 'battle rhythm' built up during Covid, we have multiple scheduled Tactical Resilience Groups each week where all System representative across Urgent, Primary and Community Health and Social Care are represented to understand system pressures and challenges and agree measures to address. At times of escalation Strategic Resilience Group is stood up to provide additional senior oversight and direction where required.

A 'Discharge & Flow' group meet weekly to address current challenges and work through pathway improvements.

The Home First Programme has recently launched several workstreams, that will develop the longer-term planning, design and embed longer term Home First model for Dorset. There is work to do to clearly define the project/workstream deliverable for each workstream but progress is growing in the programme.

c. New investment into BCF to bring medium term improvement.

We have added a new Scheme to the BCF this year 'Home First Accelerator'. This is a two-year NHS Dorset funded programme, being commissioned by Dorset Council, and its focus is aligned to National Condition 3. This will support primary, intermediate, community and social care services and support safe and timely discharge, along with offering step up / admission avoidance options. The programme has three workstreams:

- Reablement
- Community
- Trusted Assessor

The purpose of the programme is to re-balance demand to create a more sustainable landscape that sees care available when needed that is affordable for the local system budgets. This will allow for funding to be re-used to invest into the prevention agenda, including VSCE offers. This programme will

This is additional investment that we are including into our BCF due to its alignment with objectives, but also to ensure transparency, good governance and the correct partnership arrangements.

- **Reablement Workstream**

We will develop new bedded reablement services that offer rapid step down and step-up capacity to support hospital demand:

- 30 additional, therapy led, reablement beds, which will be supported through multi-disciplinary teams and utilising the Dorset Care Record.
- During the 2-year investment period, work will be undertaken to build a sustainable long-term solution alongside a new, larger, community based reablement model.
- When fully operational the reablement beds will enable an additional c.260 discharges/admission avoidance for Dorset Council area System.

- The service will work alongside the existing community reablement teams to try and minimise the ongoing (long-term) use of home care.

- **Community Workstream**

This is creating capacity across the community to support long-term care through homecare. The initial pilot areas has eliminated the waiting list of home care in one area, and drastically reduced waits in another. This has also enabled a reduction in reliance on off-framework (high cost) homecare options.

This will deliver:

- Additional brokerage capacity, and improved processes, to work with the market in geographic clusters to optimise existing capacity. This alongside moving from spot purchasing to blocks will enable providers to make better use of existing resources, reducing transaction costs and, based on experience from a similar SW Council, could yield around 20% capacity improvement. In addition, evidence from experience elsewhere has shown that home care providers are able to increase their profitability without price increases. It also improves relations and partnership working with the market.

- This will help to reduce the need for expensive alternatives such as care home beds, where there is well documented evidence of poorer outcomes for people.

- **Trusted Assessor / Provider Led Reviews**

A model of trusted assessment which will minimise hospital assessment for on-going care needs and speed up the discharge process:

- A new model that assesses people in the right setting (ideally their own home) with the right care and a therapy-led approach will improve the speed of discharge and ensure people who do have ongoing support needs have the right support.

- Undertaking assessments in the community allows for a strengths-based approach and a view of long-term recovery. Research in another south-west area with a super ageing demographic showed that over 40% of the decisions made in hospital about people's long-term care were sub-optimal.

- This approach will also help to ensure that best use is made of ASC resources whilst maximising people's recovery options. This in turn can allow more time to be spend reviewing decisions and help recycle care faster.

The workstreams began in April 2023, we are seeing positive early benefits that we will be recording and monitoring closely. In terms of progress, an additional 10 reablement beds, in a purpose-built setting opened in early June, 6 of which were filled in the first week of opening. In addition to the reductions in community waiting times, TEC kits are being piloted in with 10 individuals to replace a face to face visit, and initial provider led assessment reviews are meeting quality assurance measures.

d. Investment of Additional Discharge Funding

The ICB element of funding has been invested to allow extension of the Recovery and Community Resilience (RCR) Scheme, as described in section 5b. The LA element of the discharge funded has been invested into securing home care capacity in the long term / community care market. This support system flow, freeing up acute, hospital and community beds as when individuals are ready to leave any short term intervention, e.g. reablement or rehab at home, support from RCR provider, or in a bedded setting, and long term care is needed in order to stay or get home, care capacity in the community will be available.

e. Demand and capacity for intermediate care to support discharge from hospital

Demand and capacity profile for 2023/24

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

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

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

Pathway 0 (VCSE offer)

- Demand and capacity in both step-up and step-down support is largely aligned with approximately 70% of activity (358 referrals per month) focused on a step-up response.
- There is ambition to continue to grow and evolve this offer with our VCSE partners to identify further gaps and opportunities to support people to return home as part of their recovery journey either as an alternative to, or in conjunction with, P1 support.

Pathway 1: Rehab and Reablement offer

- In the last 6 months we have invested into Reablement capacity and created additional capacity. Annualised demand and capacity figures across rehab and reablement at home services are largely aligned but there is disparity between the different service offers whereby there is more reablement capacity than demand and vice-versa for rehabilitation services.
- This will be compounded by geographic disparities between the different service offers in the Dorset area, recognising the challenged of finding home care in our more rural localities. This contributes to delays in both accessing and exiting intermediate care services and the persistence of a backlog that will not necessarily be reflected in these numbers.
- In the last 6 months we have seen acuity of conditions rising, and therefore greater care and support needs on discharge. This utilises more care per individual. This is a trend we expect to continue, particularly given Dorset's ageing demographic. Again, the Home First programme will address this in planning capacity required longer term.
- We have identified that as we have several services offering Rehab and Reablement, this can hamper efficient navigation of the pathway. The Home First programme is seeking to address this through developing an integrated operating model for intermediate care that bring together P1 services and is delivered at place level underpinned by a more granular demand and capacity analysis at 'cluster' level to better understand and respond to our service offer gaps.
- We will then need to optimise use resources and re-run our demand and capacity modelling to inform how we need to focus our resources. There should then be opportunity to re-align to focus more on step up and preventative approaches.
- This should offer more resilience and agility in our current P1 offers and help us to share future commissioning plans to address gaps

Pathway 2: Rehab and Reablement offer

- Headline analysis indicates that we have more community bedded capacity than is required to meet current demand and this is an area which we have invested in over the last winter to provide us with additional capacity to support our roll-out of the D2A model.
- This was necessary to provide us with the headroom needed to respond quickly to in-month peaks in demand as well as deal with the persistent backlog of people waiting for large packages of care or who needed a period of further assessment.
- Our plan is retain this additional capacity during 2023/24 as we seek to embed our D2A approach and move forward with our integrated P1 offer, both of which will enable us to have less reliance on bedded solutions. Our goals for 2024/25 would be reduce this commitment to bedded care.
- In 2023/24 we are planning to use this capacity in a more agile and recovery-focused way to support better outcomes for people that would otherwise be delayed in hospital. This includes:
    - People waiting for large packages of care. We know that there is insufficient capacity available to meet this level and intensity of demand and therefore are looking to use our bedded capacity as part of a 'pathway to home' approach that enables us to more intensive support in the early stages of a person's recover that reduces ongoing care need. This has the triple benefit of reducing their stay in hospital (and the associated risks of this), improving their longer-term outcome and increasing the likelihood of finding ongoing care if the care demands are reduced.
    - Enhancing our exiting health and care bedded capacity with additional therapy and discharge co-ordinator resource to ensure every community bed environment is recovery focused, can take a higher complexity of need in some areas and centred on returning someone home at the earliest opportunity.
    - Linking our P0, P1 and P2 offer as part of a transitional approach that enables people to be 'pulled' from their bed to home to continue their recovery at the earliest opportunity. This is linked into our single operating model approach for intermediate care.
    - Scoping how we can use our bedded capacity more for step-up care. Currently only about 7% of total bedded capacity is used for steps (against demand of 11%). There is scope to increase this through earlier identification and intervention as part of our step-up responses.

Pathway 3: Care Home placements

- We currently discharge approximately 4% of total intermediate care demand on P3 (circa 16 referrals per month). However, the journey for these individuals can often be protracted due to the multiplicity of their needs and the requirement for a brokered solution.
- Our plan for 23/24 is to put in place plans that expand our core intermediate care offer to accommodate some of this demand by looking at how we can enhance the wraparound support to our current offers to enable people to be supported safely in this environment. Challenging behaviours (associated with delirium/dementia) are key factors that reduce options and this is a target area of focus for this year.

Overall system flow

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

- Review of transfer of care process, and the resources that are assigned to Pathways to enable this, between acute and community to ensure this based on a minimal, proportionate assessment in hospital that facilitates a swift transfer to the most appropriate community setting to continue a person's recovery. This will be supported by an evolved Transfer of Care hub over 7 days (building on our current SPA model)

- Enhanced MDT model in the community that brings together therapists, social workers, discharge coordinators, VCSE partners and trusted assessors at place-level with clear leadership and accountability for decisions and robust follow-up of individuals on a D2A pathway. Additional investment in workforce is planned to support this
- Single integrated operating model for place-based intermediate care that removed unnecessary hand-offs and decision-points that do not add value to a person's journey and enable full system oversight of home and bedded capacity and how it's used.

7. How BCF support the delivery of Care Act Duties

The Schemes commissioned and our integrated working arrangements described in previous sections are evidence of how we use BCF funding to deliver duties under the Care Act. Several examples are repeated below:

Our Reablement, ICRT and recovery focus approach in our developing intermediate care offers rapid support that promotes recovery and independence. We utilise VSCE networks where appropriate to support individuals and to reduce, where appropriate formal care and support needs. This promotes individual's links with their local networks, an example of which is a successful pilot where a shared LA and Age UK post was employed to focus on promoting local opportunities to access VSCE support, this is now rolling out to other localities across the LA. This demonstrates our duties within both the prevention and wellbeing element of the Care Act.

We have clear information and advice offers, and well established sign posting that enable individuals to seek support in order to avoid, reduce or delay the need for formal care and support. The Council's Adult Access Team is our 'Front Door' to provide advice and guidance via phone, email, which includes referrals from Partners.

Our DIPS contract, (section 5) is an example of how we support and refer people, reducing the chances of people 'falling between the cracks' of services. We do know that we need to develop a more robust IAG approach in hospital settings do individuals and their families understand the discharge and recovery pathways post acute hospital treatment.

Schemes assigned to Strong and Sustainable Markets evidence our meeting of market shaping requirements. Some BCF funding supports care packages and placements for people who are eligible for support with funding their care and support needs. The Discharge fund money is invested into securing capacity in homecare market, and our new Home First Accelerator Programme is support greater efficiency for providers to create capacity longer term.

8. 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 continued to work in partnership with System Partners to improve ease of referrals for Carers from Primary Care to these services

The Cares Strategy has clear objectives and action plan for delivery over the next 5 years. The Better Care Fund will be invested to implement these plans concentrating on further developing the preventative services already in place and introducing more breaks for Carers, and expanding the offer to younger carers.

Since the last plan we have conducted co-production sessions in order to understand what is important to, and needed by, carers. They told us they need a more flexible Short Breaks offer, with more choice, that supports both their wellbeing and ability to remain independent. We are now continuing to review the Short Breaks Service and Personal Budgets offer in order to take account of carers input.

Our ambition is to introduce a range of opportunities for carers. This may include supporting activities with the person they care for, so they can spend quality time together, reconnecting with the person they care for in the primary relationship. Enabling a complete break, a distraction from the stresses of Caring and do something for themselves. The new offer will need to continue to provide replacement care for the person they care for and be offered with choice and support for those who need it. This links to work funded by other streams to develop Individual Service Funds (ISF).

As previously referenced, we intend to broaden the carers offer via the BCF to include all age carers offer, ensuring contracts better support younger carers. Joint work is underway with Children's Services to develop the Young Carer pathways as part of the Young and Thriving Strategy. A Young Carers Strategy is being developed which will be linked to Adult Social Care services via the Birth to Settled Adulthood programme.

To support the Carers Strategy outcomes to improve information advice and guidance and access to a meaningful assessment we are developing digital responses with the Bridgit Care platform, working in partnership with our Health colleagues and Digital networks. We have plans in place to further develop our use of technology to make the caring role easier, for example via 'Digital Doorway' where Carers can access IT equipment and training. We are also planning Robopets pilots where robotic pets can be used to support the person they are caring for to provide some respite to the Carer.

Supporting Carers better to prepare and plan for hospital admittance/discharge is being undertaken. Since the last plan, the Carers Area Practice Manager, funded from BCF, is now in post to lead the Carers Case Workers, , and will drive practice changes in this area to ensure we improving our approach to integrated working with Hospital Carer leads.

We continue to commission Rethink Dorset Carers Service, which supports Carers who are caring for someone living with mental health illness. This offer is connecting with more Carers than ever before and doing joint work with Live Well Dorset to deliver holistic services, training, and advice to Carers to support them to keep themselves healthy. Rethink are also embedding themselves within the mental health hospitals to improve integrated working with health based staff, and to provide information directly to Carers visiting. Rethink continue to offer the respite fund to carers to achieve their outcomes. They have also developed walking groups, increased their peer support groups and introduced a regular newsletter.

Carer Support Dorset, which is our Commissioned lead carer organisation, registered 1,000 carers in the past year. They continue to develop their services in a range of approaches; working with other organisations, providing pop up information opportunities, basing themselves in GP clinics, leading on the Carers Reference Group, coordinating training and befriending. They are also working with Children's Services to develop their young carer and young adult care service offer working closely with the Children's Services team. They have developed with MYTIME Charity a video of young carers which has been used in a training programme for Health, Social Care and Children's Services employees to raise awareness and support a change in culture that supports carers to be recognised, respected and listened to. This was feedback that was collected via the Carers engagement sessions.

9. Disabled Facilities Grant (DFG) and wider services

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

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. We continue to consider how smart technologies could support people to further independence and daily living tasks such as turning up the heating, lighting etc. This will complement the health offer from the Environment Control service team to widen the offer to more people living alone. 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. Last year we completed works to 372 individuals some of which had more than one type of adaptation e.g. they could have had a stairlift and a level access shower, so 489 types of adaptations were completed.

The DAHs 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 to allow for minor adaptations such as ramping/handrailing to be fitted under the minor works offer to avoid admissions to hospital/long term care. 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 increased the minor works limit to enable more people to access support in a timely way. 100 service users have accessed a minor adaptation that would have previously been classified as a major adaptation route. There have been over 778 minor works referrals completed in 2022-23. 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.

10. Additional information (not assured)

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

DFG maximum grant extended to £45K (£15K extra) as described above; this covered 5 major adaptations completed last financial year.

In addition, we have DFG Eligibility Criteria amended in October 2022 for works up to a value of £10,000 for the following:

- Loft and cavity wall insulation.
- Solid wall insulation
- Boiler replacement or repair.
- Night storage heater replacement or upgrade to more efficient model.
- First time gas central heating installation,
- The provision of a sustainable form of heating such as air or ground source heating or similar
- Any improvement or ancillary works associated with the installation of the above works.

These improvement works are specifically aimed at anyone with a disability and /or elderly and require the works due to the cost-of-living crisis up to end of March 2024 and £320,000 has been allocated this year 2023-24 to help with this scheme. Dorset Council is a unitary council and therefore applies across the whole council, however it is likely to remain as part of our DFG offer beyond March 2024 if funding allows.

11. Equality and Health inequalities

Since the last plan Dorset's Integrated Care Board has published the Integrated Care Partnership Strategy (ICPS), the priorities of which are intrinsically linked to BCF objectives. The key priorities of ICPS are:

- Prevention and early help
- Thriving communities
- Working better together

On 15 March 2023, we reported to our Health and Wellbeing Board the approach we would take to assess and develop our programme to deploy a new, and different approach to 2023-2025 BCF investment. This included Commissioners from across Adult Social Care, Public Health and NHS Dorset working with recently agreed ICPS and recognition that we need to link the BCF more closely to Population Health and Health Inequalities work.

We have identified in section 3 that one of our priority areas for this 2 year plan, is development Prevention approach within VSCE networks, and this includes better tools to measure for both improving outcomes and reduction of health inequalities. 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, and measure the impact of interventions designed to help. Further work to strengthen our information and analyst capacity, capability and data platforms is happening as separate organisations, as well as collective work to improve how the different teams work together. The current collective focus is on inequalities and place-based data, information and insights.

NHS Dorset have developed a draft Joint Forward Plan in response to the ICP Strategy. Ambitions cover five outcome areas, including a focus on health inequalities focused in three geographical areas including Portland & Weymouth, as well as a focus on older people living well and independently. As this develops we will continue to look for opportunities to connect tis and the BCF work more closely together.

At the time of writing, initial planning work is underway to develop a place-based programme to support development of ICPS priority 'Thriving Communities' work. Collaborative work through the Joint Public Health Board has identified funding outside of BCF to invest into the 2023-25 Plan that will enable development and growth of the VSCE infrastructure. Increasing capacity to focus support for people to stay well, living in their own homes should reduce health and care utilisation, as well as improve healthy life expectancy and wellbeing. As the programme develops, we will work closely to identify opportunities to link BCF longer term.

NHS Dorset has designed and delivered a system wide training programme for population health management (PHM) and health inequalities, with an ambition to raise awareness, build will and transfer skill across the ICS. The principles for PHM projects are led by data insights, leading to co-design of services that are personalised, consider the wider determinants of health, include multiple stakeholders, and deliver outcomes that are meaningful to the population, with specific consideration for people who may have poorer outcomes. A PHM ambassador programme has also supported individuals to lead projects to improve population health and reduce health inequalities via action learning sets, with an ambition to create a community of practice.

An area of development, where data insights are supporting specific groups of people is the Ageing Well Programme who have developed a falls prediction tool, which scores all over 65's for their risk of falling in the next 12 months. On testing, the 5% highest risk population of the over 65's contributed to 31% of people who fell in Dorset.

This indicates that this tool could be used to proactively target populations for falls prevention activities. There has been a lot of interest across ICB partners, and work is in train to develop how this tool can support targeted proactive care as well as measure outcomes across the population.

Specific examples of BCF funded services where inequalities are being addressed, in this current plan include:

- **Discharge to Assess Improvements**

As described in section 3, changes to the hospital discharge pathways have led to greater equality in access to core 1 services, increasing the number of people, many of whom have long term health conditions, access to Reablement and recovery based service to enhance their independence following a

stay in hospital. These services can also be access from the community, so people in crisis, including those experiencing a decline in health, can be supported via these services to remain at home.

In addition, a bespoke commissioning pathway has been developed that enables people with more complex needs, that cannot be met by the Core Offers, to leave hospital more quickly, via a specific commissioned response. Individuals on this pathway will have long term health and social care needs, and until this change was implemented would likely have spent more time in hospital awaiting discharge than now.

- **Carers**

The Pan-Dorset Carers Vision has an objective regarding Diversity and Equality which will create a focus for all partners to improve how they identify and support all Carers from all backgrounds.

To help us understand who our Carers are the Census records are analysed to inform areas to target. Carer Support Dorset have begun monitoring if Registered Carers have a disability, gender identification or whether they have a military connection.

Our commissioned service, Carer Support Dorset, have continued to analyse and support raising awareness to Equality, Diversity and Inclusion for Carers, working to raise awareness and reach vulnerable/marginalised groups from a range of diverse backgrounds. They continue to engage with Carers and have led targeted work with organisations who are supporting hard to reach Carers, for example the Veterans Hub at Wyke Regis. They have promoted projects such as the warm space initiative and cost of living challenges including food bank information. They held a Carer Friendly Conference inviting Carers to tell them what is important to them. They hold pop up information stations on a regular basis across the County to meet Carers in their local area and to develop trust.

We know that Carers who care for someone with mental health illness are likely to develop mental health illness themselves and the BCF enables support. We offer signposting to local services but Carers can also seek bespoke mental health support from Rethink.

- **Disabled Facilities Grant**

Our approach to DFG and minor works continues, as outlined in section 9 and 10. In October we introduced an approach specifically to support individuals with a disability and /or elderly, who require the works due to the cost-of-living crisis.