Notice of Health and Wellbeing Board

Date: Monday, 12 January 2026 at 2.00 pm

Venue: HMS Phoebe, BCP Civic Centre, Bournemouth BH2 6DY

Membership:

Chairman:

Cllr D Brown	Portfolio Holder for Health and Wellbeing
Vice-Chairman:	To be elected
Aidan Dunn	Chief Executive
Laura Ambler	Corporate Director for Wellbeing
Rob Carroll	Director of Public Health
Peter Browning	Dorset Police
Marc House	Dorset & Wiltshire Fire and Rescue Service
Glynn Barton	Chief Operations Officer
Cllr R Burton	Portfolio Holder for Children and Young People
Cllr K Wilson	Portfolio Holder for Housing and Regulatory Services
Cathi Hadley	Corporate Director for Children's Services
Matthew Bryant	Dorset HealthCare University NHS Foundation Trust
Dawn Dawson	Dorset Healthcare Foundation Trust
Louise Bate	Healthwatch
Karen Loftus	Community Action Network Bournemouth, Christchurch and Poole
David Freeman	NHS Dorset
Betty Butlin	Director of Adult Social Care
Siobhan Harrington	University Hospitals Dorset NHS Foundation Trust
Cllr S Moore	Portfolio Holder for Communities

All Members of the Health and Wellbeing Board are summoned to attend this meeting to consider the items of business set out on the agenda below.
The press and public are welcome to view the live stream of this meeting at the following link: https://democracy.bcpcouncil.gov.uk/ieListDocuments.aspx?MId=6208

If you would like any further information on the items to be considered at the meeting please contact: Louise Smith, louise.smith@bcpcouncil.gov.uk or
email democratic.services@bcpcouncil.gov.uk
Press enquiries should be directed to the Press Office: Tel: 01202 454668 or
email press.office@bcpcouncil.gov.uk

This notice and all the papers mentioned within it are available at democracy.bcpcouncil.gov.uk

AIDAN DUNN
CHIEF EXECUTIVE

2 January 2026

DEBATE NOT HATE

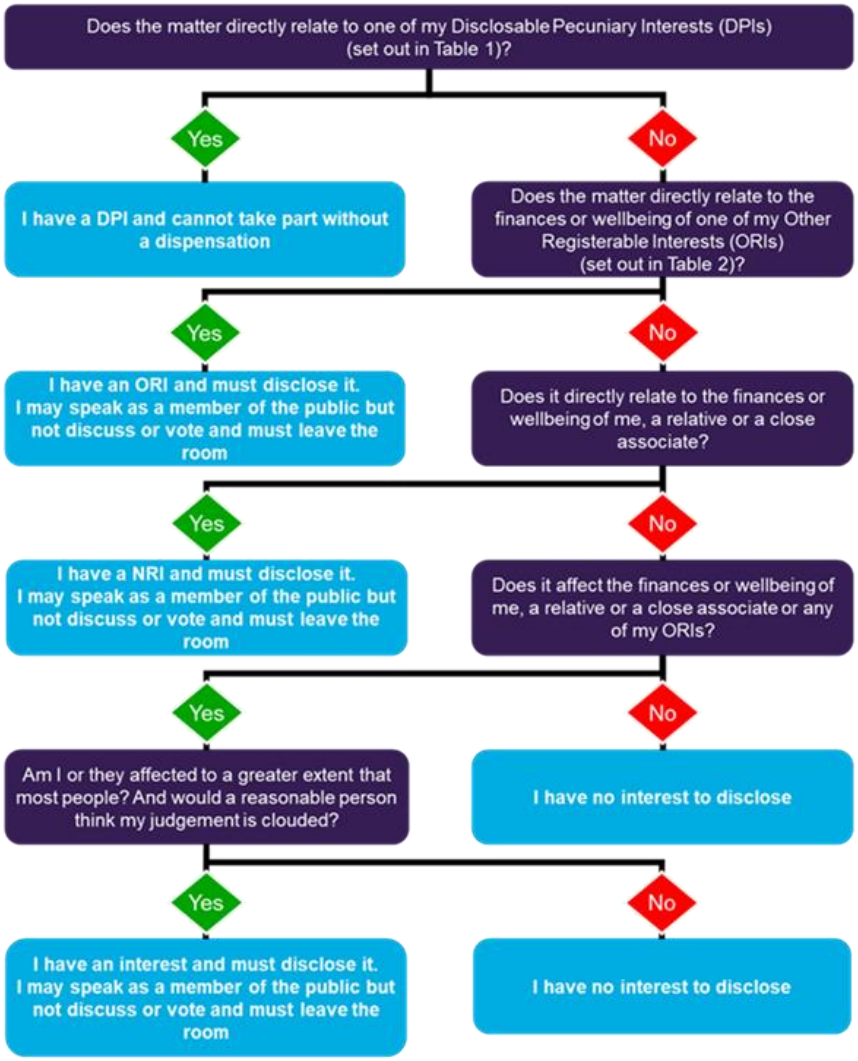
Available online and on the Mod.gov app

Maintaining and promoting high standards of conduct

Declaring interests at meetings

Familiarise yourself with the Councillor Code of Conduct which can be found in Part 6 of the Council's Constitution.

Before the meeting, read the agenda and reports to see if the matters to be discussed at the meeting concern your interests



What are the principles of bias and pre-determination and how do they affect my participation in the meeting?

Bias and predetermination are common law concepts. If they affect you, your participation in the meeting may call into question the decision arrived at on the item.

Bias Test	Predetermination Test
In all the circumstances, would it lead a fair minded and informed observer to conclude that there was a real possibility or a real danger that the decision maker was biased?	At the time of making the decision, did the decision maker have a closed mind?

If a councillor appears to be biased or to have predetermined their decision, they must NOT participate in the meeting.

For more information or advice please contact the Monitoring Officer

Selflessness

Councillors should act solely in terms of the public interest

Integrity

Councillors must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships

Objectivity

Councillors must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias

Accountability

Councillors are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this

Openness

Councillors should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing

Honesty & Integrity

Councillors should act with honesty and integrity and should not place themselves in situations where their honesty and integrity may be questioned

Leadership

Councillors should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs

AGENDA

Items to be considered while the meeting is open to the public

1. Apologies

To receive any apologies for absence from Councillors.

2. Substitute Members

To receive information on any changes in the membership of the Committee.

Note – When a member of a Committee is unable to attend a meeting of a Committee or Sub-Committee, the relevant Political Group Leader (or their nominated representative) may, by notice to the Monitoring Officer (or their nominated representative) prior to the meeting, appoint a substitute member from within the same Political Group. The contact details on the front of this agenda should be used for notifications.

3. Election of Vice Chair

To elect a Vice Chair of the Health and Wellbeing Board for the remainder of the 2025/2026 Municipal Year.

4. Confirmation of Minutes 7 - 14

To confirm and sign as a correct record the minutes of the Meeting held on 6 October 2025.

5. Declarations of Interests

Councillors are requested to declare any interests on items included in this agenda. Please refer to the workflow on the preceding page for guidance.

Declarations received will be reported at the meeting.

6. Public Issues

To receive any public questions, statements or petitions submitted in accordance with the Constitution. Further information on the requirements for submitting these is available to view at the following link:-

https://democracy.bcpcouncil.gov.uk/documents/s2305/Public%20Items%20-%20Meeting%20Procedure%20Rules.pdf

The deadline for the submission of public questions is midday on Tuesday 6 January 2026.

The deadline for the submission of a statement is midday on Friday 9 January 2026.

The deadline for the submission of a petition is Wednesday 24 December 2025.

ITEMS OF BUSINESS

7. FutureCare Programme – Mid-Programme Review 15 - 28

The FutureCare Programme is a Dorset-wide programme aimed at delivering better health and care outcomes for residents and reducing the time people spend in hospital waiting to be discharged, or in hospital if support can be provided at home.

Significant challenges still exist in increasing flow and reducing the no criteria average length of stay (NCTR ALOS) for residents in the East of the County. However, overall, the Futurecare Programme is on track to deliver its anticipated benefits, and robust plans are in place to address challenges in the East.

For BCP Council positive long-term benefits are now beginning to be delivered with positive operational and cumulative benefits delivered in November as home-based intermediate care effectiveness and throughput begins to increase.

8. Better Care Fund 2025-26 Quarter 2 Report 29 - 56

This report provides an overview of the Quarter 2 Report of the Better Care Fund (BCF) for 2025-26.

The BCF is a key delivery vehicle in providing person-centred integrated care with health, social care, housing, and other public services, which is fundamental to maintaining a strong and sustainable health and care system.

The report is a part of the requirements set y the Better Care Fund 2025-26 Policy Framework. The report must be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements.

9. Integrated Care Board (ICB) Medium Term Plan

To receive a verbal update.

10. Update on the Adult Social Care Prevention Strategy 57 - 98

The Adult Social Care Prevention Strategy (2025-2030) was approved at Cabinet on 29 October 2025 and sets out five key strategic priorities to reduce, delay or prevent the need for long term care and support for people living in Bournemouth, Christchurch and Poole.

The strategy has been shaped by the views and experiences of local people, carers, the voluntary and community sector and partners. It aims to develop a sustainable approach to prevention in adult social care. The strategy emphasises early intervention, the promotion of wellbeing, and collaboration with key partners, to not only prevent the development of long-term needs, but also to enhance the overall quality of life for people living in the BCP Council area.

11. BCP Joint Health and Wellbeing Strategy Draft for Consultation — 99 - 122

This report and associated documents provides;

- An update on the development of the BCP Joint Health and Wellbeing Strategy for the Bournemouth, Christchurch and Poole area
- An updated draft of the BCP Joint Health and Wellbeing Strategy (version 2) for public consultation
- A draft Joint Strategic Needs Assessment (JSNA) Forward Plan for 2026 and 2027 for additional comments

12. Health Literacy Update and Proposal — 123 - 132

The purpose of this report is to provide members of the BCP Health and Wellbeing Board with an overview of the activity delivered to date to increase 'organisational health literacy' across BCP and Dorset.

It seeks to confirm health literacy as a system priority and requests nominations for a co-design workshop to develop a proposal for scaling up 'organisational health literacy' across BCP and Dorset.

13. Work Plan — 133 - 136

The Board is asked to consider its Work Plan.

No other items of business can be considered unless the Chairman decides the matter is urgent for reasons that must be specified and recorded in the Minutes.

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, rBOURNEMOUTH, CHRISTCHURCH AND POOLE COUNCIL

HEALTH AND WELLBEING BOARD

Minutes of the Meeting held on 06 October 2025 at 2.00 pm

Present:-

Cllr D Brown – Chair

Present:	Rob Carroll, Cllr R Burton, Karen Loftus, Betty Butlin, Siobhan Harrington, Cllr S Moore, Rachel Gravett and Marc House
In attendance virtually:	Cllr Keiron Wilson, Louise Bates, Ellie Lindop and Pam O'Shea

14. Apologies

Apologies were received from Aidan Dunn, Cathi Hadley, Dawn Dawson and David Freeman.

The Chair advised the Board that Patricia Miller had left her role at NHS Dorset and thanked her for her contributions to the Board. The Board was advised that a new Vice Chair would need to be elected at the next meeting.

15. Substitute Members

Rachel Gravett substituted for Cathi Hadley, Ellie Lindop substituted for Dawn Dawson and Pam O'Shea substituted for David Freeman.

Cllr Kieron Wilson, Louise Bates, Ellie Lindop and Pam O'Shea joined the meeting virtually forgoing the ability to vote on any matters arising.

16. Confirmation of Minutes

RESOLVED that the minutes of the Health and Wellbeing Board held on 9 June 2025 be confirmed as an accurate record and signed by the Chair, subject to the addition of the following attendees: Rob Carroll, Tim Branson, Ellie Lindop and Lizzy Warrrington.

17. Declarations of Interests

There were no declarations of interest on this occasion.

18. Public Issues

There were no public issues on this occasion.

19. Bournemouth, Christchurch & Poole (BCP) Safeguarding Adults Board Annual Report 2024-2025

The Chair of the Safeguarding Adults Board presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'A' to these Minutes in the Minute Book.

The BCP Safeguarding Adults Board (SAB) published an Annual Report each year and was required, as set out in the Care Act 2014, to present this to the Council's Health & Wellbeing Board.

Many Councils also requested that the report be presented to Scrutiny as the report enabled a discussion on the work of the Safeguarding Adults Board.
The attached report was for the year April 2024 to March 2025. The report was agreed at the September meeting of the BCP Safeguarding Adults Board (SAB).

The BCP SAB had successfully worked together with the Dorset SAB with joint meetings over the year.

The Board was advised that the two separate Annual Reports were created, one for each of the Boards as they were separately constituted. Throughout 24-25, BCP SAB had delivered against all priorities which were set out in the annual work plan; the Annual Report summarised what the Board had achieved.

The Board discussed the report, including:

- The annual report detailing how the Safeguarding Adults Board fulfilled its responsibilities to prevent abuse, harm, and neglect of adults with care and support needs during 2024–25 was noted.
- Members highlighted the impact of including personal stories, such as a case that raised awareness of cuckooing, which was considered grounding and powerful.
- Assurance was given that working relationships between safeguarding and health colleagues across the system were strong.
- Two key achievements were commended: development and signing of a Memorandum of Understanding to address tensions between mental capacity and mental health legislation, and launch of training based on a safeguarding case study, which engaged hundreds of staff across the system.
- The comprehensive nature of the report was praised, including positive partner assurance, embedding of learning from Safeguarding Adult Reviews (SARs), and work on suicide prevention, hoarding, and violence against women and girls.
- Concerns were raised about safeguarding risks linked to increased digital access to health records and coercive control.
- Digital safeguarding risks were acknowledged, and it was suggested that this could be a focus for the next annual development day.

- The importance of community involvement and voluntary sector engagement in safeguarding, particularly in identifying cuckooing, was stressed.
- Commitment to community engagement and communication was reiterated, noting that increased safeguarding referrals indicated better public awareness.
- Observations were made regarding cuckooing not currently being illegal and the need for clarity on thresholds for coercive relationships, emphasising multi-agency communication.
- Board Members agreed that safeguarding was everyone's business and supported ongoing strategies for engagement and learning dissemination, including seven-minute learning tools.

RESOLVED that the Board Members note the report which informs how the SAB has carried out its responsibilities to prevent abuse, harm and neglect of adults with care and support needs during 2024-2025.

Voting: Nem. Con.

20. BCP Safeguarding Children Partnership Annual Report 2024/2025

The BCP Safeguarding Children Partnership Manager presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'B' to these Minutes in the Minute Book.

The report for the period April 2024-March 2025 set out that since the dissolution of the 'Pan-Dorset Safeguarding Children Partnership', the new BCP Safeguarding Children Partnership had focussed on implementing new arrangements to fulfil the statutory responsibilities of the three statutory safeguarding partners who had joint responsibility and accountability for the multi-agency safeguarding arrangements in the BCP geographical area.

The three statutory safeguarding partners were BCP Council, NHS Dorset ICB and Dorset Police. Within this period of significant change, partners had maintained a focus on safeguarding children and through the new arrangements had gained insights on the effectiveness of how well partners worked together to safeguard local children and young people, and areas to be developed. Full details of the multi-agency safeguarding arrangements could be seen here.

The report provided an account of:

- What had been done as part of our local arrangements, including any child safeguarding practice review
- Impact of learning from local and national reviews
- How we had applied independent scrutiny to review and challenge our safeguarding practice
- How education partners were engaged with
- Future improvements that could be made as to the effectiveness of local safeguarding arrangements.

The report would be submitted to the Child Safeguarding Practice Review Panel by 30 September 2025 and would be published on the BCP Safeguarding Children Partnership website.

The Board discussed the report, including:

- A Board Member highlighted that reading the report was emotionally challenging, with particular concern expressed over child deaths and the prevalence of domestic abuse and exploitation.
- The importance of community awareness was emphasised, and a personal experience of reporting suspected abuse was shared.
- The breadth of the report was appreciated, and a query was raised regarding the use of the Child Exploitation Risk Assessment Framework (CERAF) across NHS partners, with gaps identified.
- It was confirmed that CERAF was in use but not yet fully embedded. Plans for independent peer review were outlined to strengthen its application.
- The report was praised for being well-written, and the value of case reviews in making the content relatable was highlighted.
- The importance of self-awareness within the partnership was noted, and a question was raised about the benefits of transitioning to a localised BCP Safeguarding Children Partnership.
- It was explained that the localised approach allowed better focus on urban challenges such as neglect, exploitation, knife crime, and county lines. Plans for improved communication and resource allocation were described.
- Formal thanks were expressed for work undertaken during the transition from Pan-Dorset to BCP arrangements, with progress acknowledged under challenging circumstances.

RESOLVED that the establishment of the new BCP Safeguarding Children Partnership, the multi-agency safeguarding arrangements in place, identification of its effectiveness to date and areas to be developed are to be noted by the Board.

21. Better Care Fund 2025-2026 Quarter 1 Report:

The Commissioning Manager presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'C' to these Minutes in the Minute Book.

NHS England (NHSE) required the Health and Wellbeing Board (HWB) to approve all BCF plans, this was one of the national conditions within the Policy Framework. This included planning documents at the beginning of a funding period, and template returns reporting progress against the plans quarterly.

The report provided an overview of the Quarter 1 Report of the Better Care Fund (BCF) for 2025-26.

The BCF was a key delivery vehicle in providing person-centred integrated care with health, social care, housing, and other public services, which was fundamental to maintaining a strong and sustainable health and care system.

The report was a part of the requirements set by the Better Care Fund 2025-26 Policy Framework. The report must be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements.

The Board discussed the report, including:

- Members acknowledged the extensive work involved in delivering the Better Care Fund (BCF) across the system, covering over 50 schemes.
- The complexity of managing BCF funding was highlighted, along with expected national changes, including potential links to health neighbourhoods and alignment with the NHS 10-year plan.
- The importance of responding collectively to the forthcoming national consultation on BCF was stressed, particularly to protect key areas such as intermediate care.
- The inclusion of voluntary sector examples in the presentation was welcomed, and the need for objective data to track progress against targets for future reports was emphasised.
- Support was expressed for the point on data, and local charities and community groups were praised, with the Prama Walking Group cited as an example of impactful volunteering.
- It was shared that volunteering initiatives had saved the NHS nearly £500,000 by supporting safe hospital discharges and reducing readmissions.
- An offer was made to share a short film highlighting the value of volunteering, which had been shown at the Integrated Care Board. **ACTION.**
- Members noted the significant scale of BCF delivery, with approximately £80 million funding around 50 schemes, representing a major partnership effort between NHS, local authorities, and the voluntary sector.
- Positive examples were discussed, including: same day emergency care improvements, voluntary sector involvement in hospitals and transfer of care hubs, access wellbeing and its role in supporting health workers and social workers and lifeline technology service supporting hundreds of people weekly.

RESOLVED that the Health and Wellbeing Board retrospectively approve the Better Care Fund 2025-26 Quarter 1 Report.

Voting: Nem. Con.

22. Pharmaceutical Needs Assessment

The Director of Public Health, Specialist Registrar in Public Health and Senior Public Health Analyst presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'D' to these Minutes in the Minute Book.

The Bournemouth, Christchurch and Poole (BCP) Health and Wellbeing Board, and the Dorset Health and Wellbeing Board, were both required to publish a Pharmaceutical Needs Assessment (PNA) every three years. A new PNA had been developed as a single document covering both areas as agreed during transition and was scheduled for publication in October 2025.

The Steering Group reviewed current population needs, future population growth, and current pharmaceutical services. They concluded that, although there had been changes since the last PNA, these were unlikely to significantly affect access to, or the provision of, pharmaceutical services. Therefore, no gaps in pharmaceutical service provision had been identified.

The Steering Group now sought approval from the Health and Wellbeing Board to proceed with publication of the new PNA.

A statutory consultation was carried out to support the development of the PNA. Consultation responses were considered, and where appropriate, amendments were made to the PNA (see Appendix 1 to the report).

The Board discussed the report, including:

- Members reviewed the Pharmaceutical Needs Assessment (PNA) draft and acknowledged its comprehensive scope.
- The board noted the statutory requirement to publish the PNA every three years.
- It was highlighted that the PNA informed commissioning decisions and supported the provision of pharmaceutical services.
- The board discussed the engagement process, including consultation with stakeholders and the public.
- Members recognised the importance of aligning the PNA with local health priorities and population needs.
- The Board acknowledged the inclusion of data on access to pharmacies, opening hours, and service availability.
- It was confirmed that the draft PNA had undergone scrutiny and quality assurance processes.

RESOLVED that the Board:

- **Note the outcome of the consultation**
- **Approve the new Pharmaceutical Needs Assessment for publication by October 2025.**

Voting: Nem. Con.

23. BCP Health and Wellbeing Board Strategy (Draft)

The Director of Public Health & Communities, Deputy Director of Modernisation & Place, NHS Dorset and Head of Communities, Partnerships and Community Safety presented a report, a copy of which had been circulated to each Member and a copy of which appears as Appendix 'E' to these Minutes in the Minute Book.

The report and associated documents provided an update on the progress towards the development of the Health and Wellbeing Board Strategy for the Bournemouth, Christchurch and Poole area, a draft strategy for comments and considerations from the Board and proposals for further stakeholder engagement on the strategy prior to finalisation.

The Board discussed the Strategy, including:

- Members noted the timeliness of the draft strategy and acknowledged the absence of a timeline initially, which was later included.
- It was emphasised that a workshop and co-production were essential due to significant changes across the NHS and broader systems.
- The strategy was recognised as critical for guiding the Health and Wellbeing Board's role in future neighbourhood plans and collaborative working.
- The importance of sense-checking the strategy through the upcoming workshop was reiterated.
- The draft was generally well received, with minimal additional comments due to prior feedback opportunities.
- Members supported the principle of co-production and appreciated the inclusion of complementary current strategies.
- It was agreed that the strategy must remain flexible to adapt to evolving strategic directions.
- Support was expressed for the Poverty Truth Commission and its principles, acknowledging their relevance to the strategy.
- Members endorsed the draft strategy's ability to reflect broader systemic changes, including the national 10-year health plan.
- The previous workshop on health inequalities and access was referenced as a valuable foundation for ongoing strategy development.
- It was noted that not all Board Members were aware of the proposed date for the workshop and the Director of Public Health advised that he would ensure all members were given the details. **ACTION.**

RESOLVED that the Board:

1. **Note the progress made to date with the development of the draft strategy and approve further engagement with stakeholders.**
2. **Approve that the Strategy comes back to the Health & Wellbeing Board in January 2026 for approval.**

Voting: Nem. Con.

24. Work Plan

The Chair highlighted the items due to come to the Board at its next meeting.

A Board Member shared a lived experience regarding the Steps to Wellbeing service, where the individual was left without support and faced a seven-month waiting list. Following this, the individual contacted NHS Dorset, the commissioning body, to suggest improvements to the service's email communication. It was noted that the original email did not reference the Access Wellbeing hubs available across Dorset. NHS Dorset agreed to update the email to include information about local hubs in Poole, Boscombe, and other areas. The Chair and Board acknowledged the positive outcome resulting from the shared experience and the resulting improvement in service communication.

25. Dates of future meetings

The dates of future meetings were noted.

The meeting ended at 4.05 pm

CHAIR

Health & Wellbeing Board

Report subject	**FutureCare Programme – Mid-Programme Review**
Meeting date	12 January 2026
Status	Public
Executive summary	The FutureCare Programme is a Dorset-wide programme aimed at delivering better health and care outcomes for residents and in particular reducing the time people spend in hospital waiting to be discharged, or in hospital if support can be provided at home. Significant challenges still exist in increasing flow and reducing the no criteria average length of stay (NCTR ALOS) for residents in the East of the County. However, overall, the Futurecare Programme is on track to deliver its anticipated benefits and robust plans are in place to address challenges in the East. For BCP Council positive long-term benefits are now beginning to be delivered with positive operational and cumulative benefits delivered in November as home-based intermediate care effectiveness and throughput begins to increase. A mid-programme review has been undertaken and this identified that significant benefits are being delivered for residents: • 80 more people per week, or more than 4000 per year are being referred to same day emergency services (SDEC) as an alternative to hospital admission; • The number of referrals into long term residential and nursing care placements from acute hospitals have reduced by 20% and from intermediate care beds by 30% since the beginning of the programme; • Each week at least 40 people, or more than 2000 per year are returning home from an intermediate care bed in Dorset at least one week sooner than at the beginning of

	the programme (ALOS reduced from 38.2 days at the beginning of the programme to 33.9 days at the beginning of December); • At Dorset County Hospital, patients waiting for a supported discharge are waiting 1.5 days less to receive a package of care than at the beginning of the programme. In addition to focusing on delivering improvements in the East of the County, work is now underway to prepare a business case to support the reduction of intermediate care beds. Advice and engagement remains ongoing with NHSE regarding the best approach to changes in this area, and a proposal for the process and configuration of beds will be presented to BCP Council, NHS Dorset and other partner organisations in the New Year. Overall, at the beginning of October the programme was on track against its operational benefits trajectory, delivering a projected £12.87m of annual operational benefits, against a target of £12.54m.
Recommendations	It is RECOMMENDED that the Health and Wellbeing Board: 1) Recognises the progress that the programme continues to make in respect of improved outcomes for people and the delivery of financial benefits to the Dorset Integrated Care System 2) Notes that more work is required to reduce the average length of time people spend in hospital waiting for a care package.
Reason for recommendations	To update the Health and Wellbeing Board on progress with the FutureCare Programme.
Portfolio Holder(s):	Cllr David Brown, Portfolio Holder for Health and Wellbeing
Director	Betty Butlin, Director of Adult Social Care
Report Authors	Dylan Champion, Programme Director - FutureCare Programme
Wards	Council-wide
Classification	Recommendation

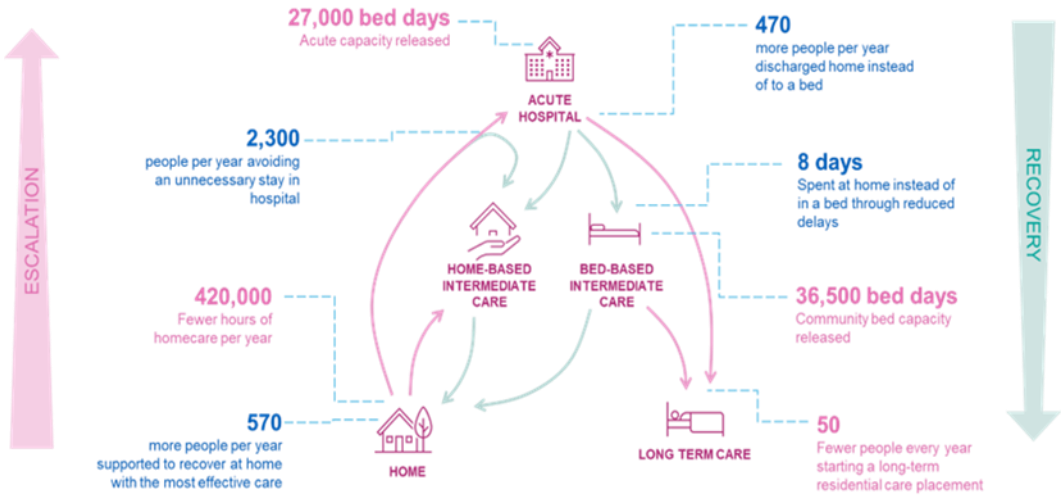
1.0 Background

1.1 Following completion of a diagnostic exercise in September 2024 and the subsequent agreement of health and care partners across Dorset to progress, work commenced on the FutureCare programme in January 2025. The aims of the programme are to:

1. Reduce the length of time people spend in hospital by speeding up joint working and decision-making across organisations and starting discharge planning earlier

2. Support more people to recover better at home following a hospital stay, reducing the requirement for long term care packages at home and the need to move from home into long term residential or nursing care.

1.2 The diagram below provides an overview of the anticipated people benefits and resource savings that will be delivered through the FutureCare Programme.



1.3 This report provides an update on progress in delivering the FutureCare Programme and contains details from the recently completed Mid Programme Review. In parallel, the Mid Programme Review is also being presented to other partner boards and committees.

1.4 As well as focusing on the operational and cumulative benefits delivered as part of the programme, it also focuses on the impact the programme has had on overall system flow and in contributing to system financial plans.

2.0 Workstream Updates

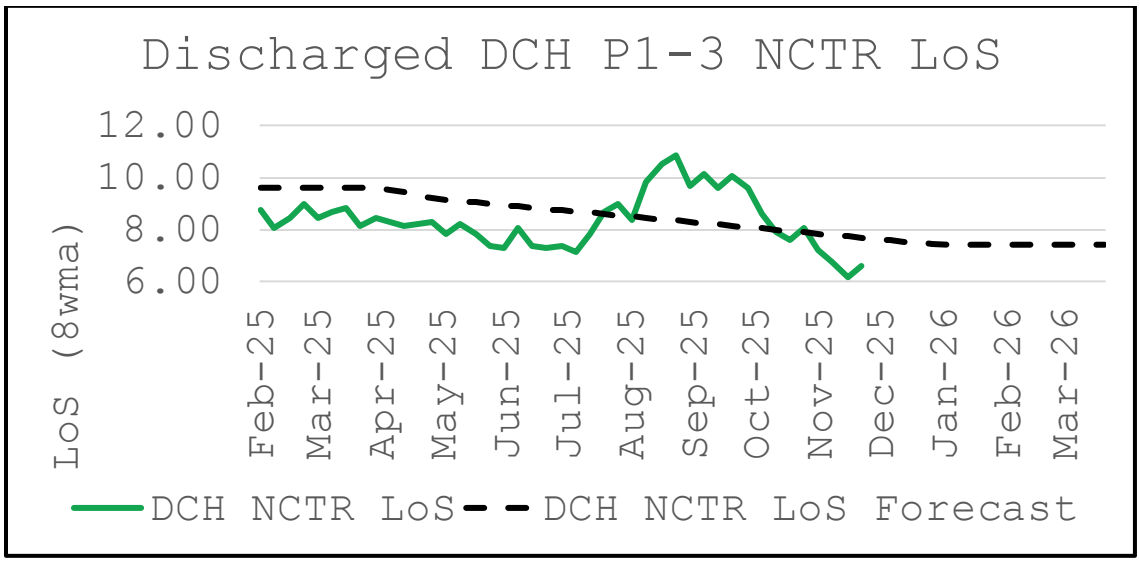
2.0.1 The Programme is structured around four key workstreams. Presented below is a brief update against each workstream.

2.1 Transfers of Care workstream

2.1.1 The transfer of care workstream aims to reduce the length of time people spend in hospital once they are medically fit and waiting for a care package. This will be achieved by establishing two new Transfer of Care (TOC) Hubs, one at Dorset County Hospital and one at the University Hospitals Dorset and by improving partnership working across hospital wards, councils, community and VCSE partners to support and deliver earlier discharge planning.

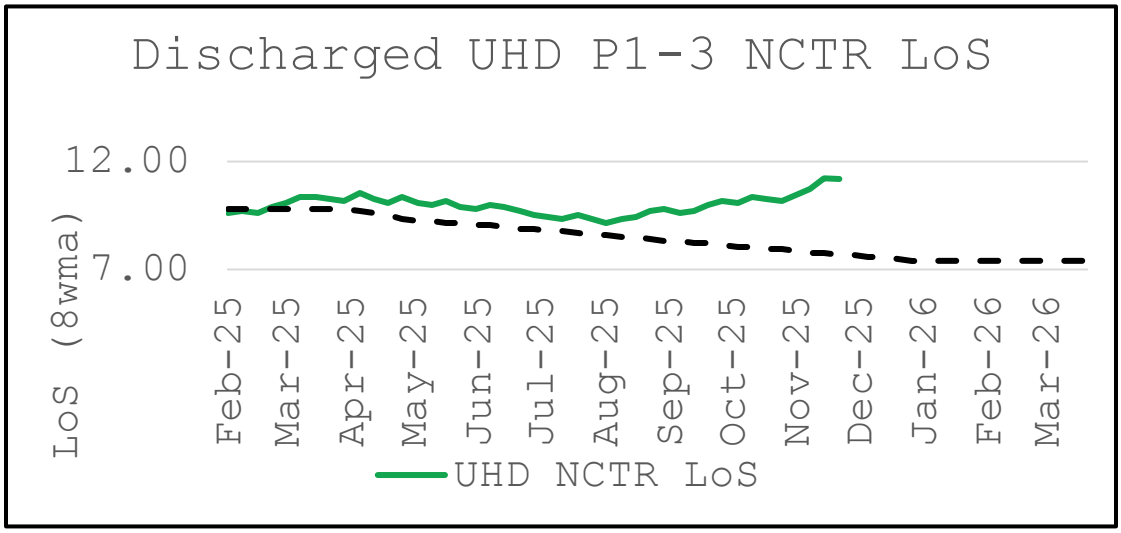
2.1.2 Both multi-agency TOC Hubs are now operational and intensive programmes of work are now underway to support system partners and hospital wards to achieve earlier hospital discharges.

2.1.3 At Dorset County Hospital there was early success with the average length of stay for people waiting to be discharged from hospital with a care package reducing from an 8-week average of 9.1 days on 24th of February 2025 to an 8-week average of 7.4 days at the end of June 2025. However, a combination of focussing on supporting people who had been in hospital for a long time to get home and increased hospital pressures meant that performance declined during the summer but has subsequently improved significantly, as shown in the graph below.



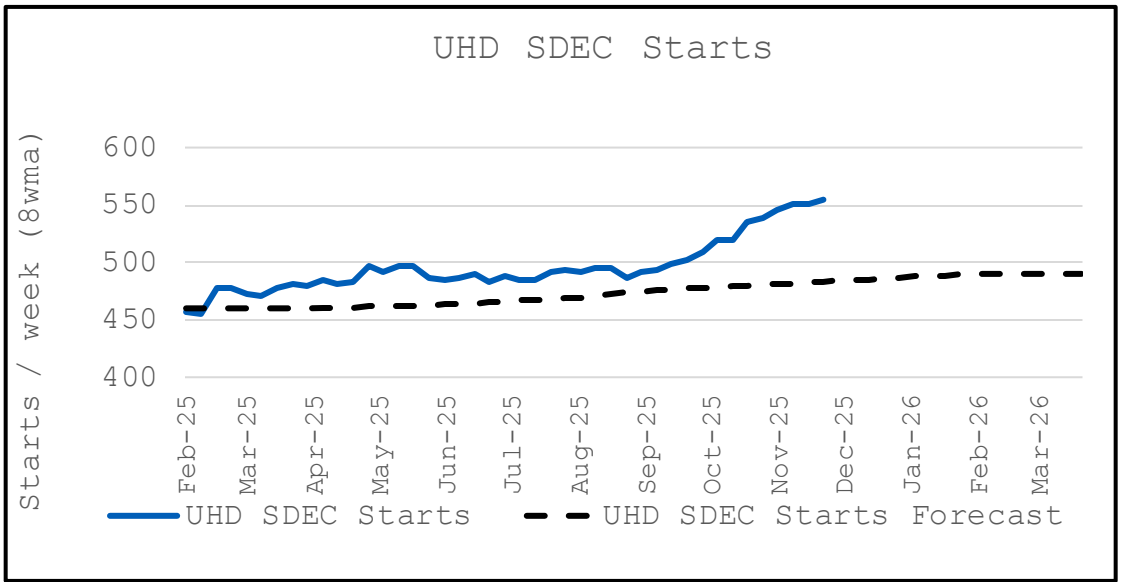
2.1.4 At UHD hospitals, it took longer to fully establish the East TOC hub but now this is complete, work has shifted to improving multi-agency working , additional home based intermediate care capacity has been commissioned

and steps have been taken to reduce the length of time takes to complete care act assessments and source long term care where required, it is anticipated that performance will improve significantly between January and March 2026.



2.2 Alternatives to Admission workstream

2.2.1 The Alternatives to Admissions (A2A) workstream primarily focuses on better utilising and referring more people to same day emergency care (SDEC) services as an alternative to admission into an acute hospital ward. Good progress has been made with this workstream specifically at UHD hospitals and this workstream is significantly outperforming its benefits trajectory with 65 more people per week being referred to SDEC than anticipated.

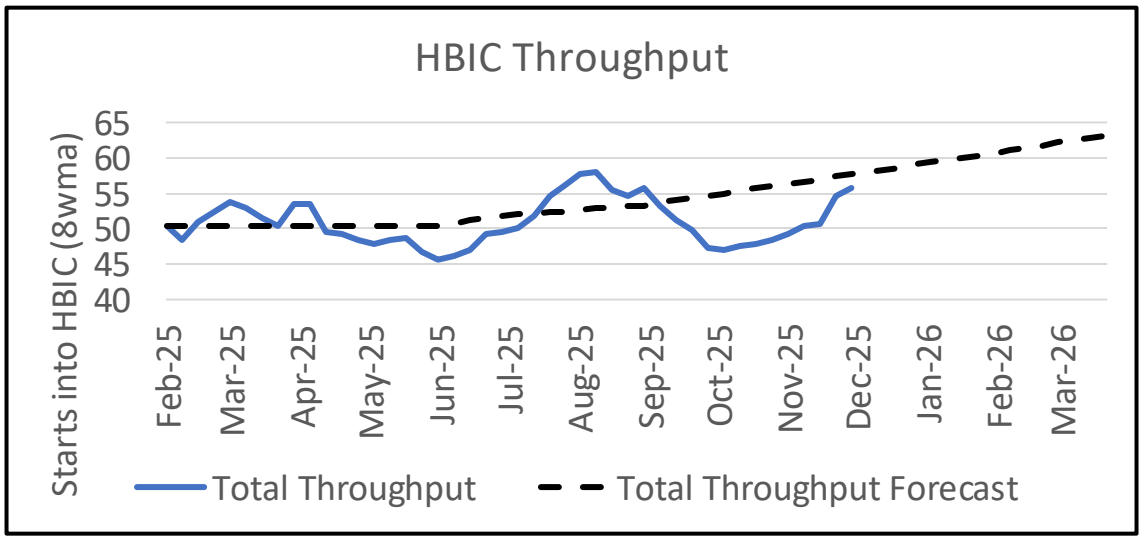


2.2.3 Focus is now shifting to working with community partners and in particular Dorset Healthcare to support more people to receive community support at home following a visit to an Emergency Department, rather than being referred to SDEC services or being admitted into hospital.

2.3 Home Based Intermediate Care (HBIC) workstream.

2.3.1 The HBIC workstream aims to increase the effectiveness of short-term care provided at home following a hospital stay, releasing more capacity to help more people and to improve the quality of the service.

2.3.2 Good progress was made with this workstream over the summer period. During September there were challenges, across both council areas due to staffing shortages in reablement providers and amongst those teams responsible for sourcing packages, which limited the number of people who could be supported. As actions have taken place to address this and capacity has increased, performance has begun to improve across both areas and this is anticipated to continue.



2.3.3 A key deliverable for the HBIC workstream is the launch of a new Reablement App. This allows residents to set personalised goals for their reablement programme and for reablement packages to be more tailored to individual needs. The App went live across Care Dorset and TRICURO reablement services during September and already positive feedback is being received.

What this is meaning for patients: Lewis

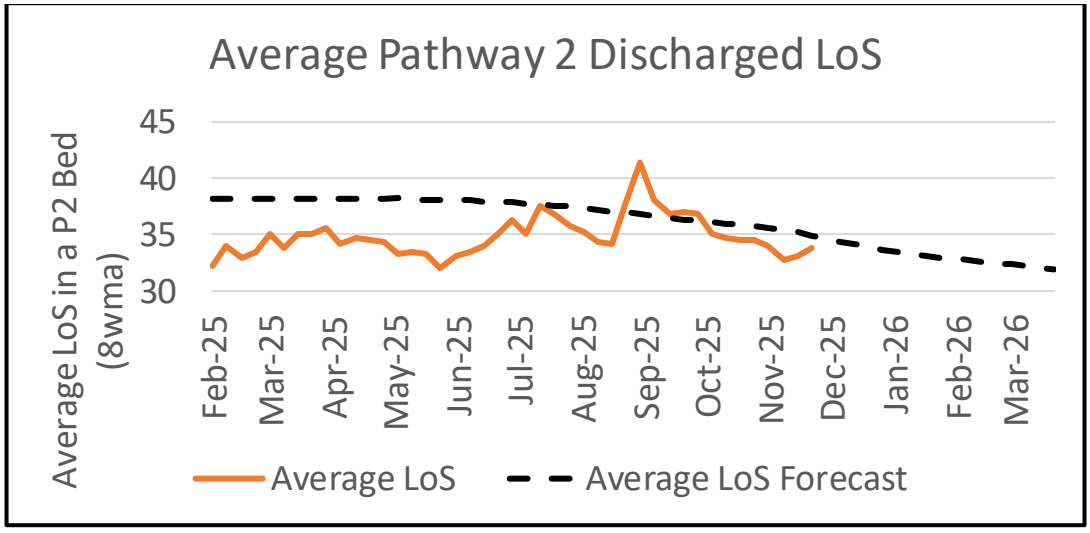
Lewis, a former doctor recovering from COVID-related complications, needed support preparing food and managing new medications. Using the reablement app his carers worked with him to focus on small, practical goals – like learning to use a bath board safely – while tracking progress over time. He now washes himself twice a week and is arranging to have handrails fitted to support further independence. The real-time updates through the app also meant his Reablement Officer could monitor progress and adjust support accordingly, allowing Lewis to regain confidence and reduce his reliance on care visits. It has also enabled them to step down two of Lewis's visits as soon as they're no longer required, which has freed capacity for someone else to join the service days earlier than they would have done previously.

2.4 Bed-based intermediate care workstream.

2.4.1 The aim of the Bed-Based Intermediate Care (BBIC) workstream is to deliver better patient outcomes for people receiving care in community hospital and local authority-provided intermediate care beds. In particular, the aim is to reduce the average length of stay from more than 39 days at the time of the diagnostic to 31 days or less.

2.4.2 Wave 1 improvement cycles focussing on community hospitals began in the middle of July and significant reductions in the length of stay were achieved across these sites. The average length of stay in a community hospital reduced from 36.7 days at the beginning of the programme to 31.9 days in the period up to 6 October.

2.4.3 In September and October, improvement cycles also began at TRICURO operated Coastal Lodge and at the Care Dorset Castleman site and significant progress is now also being made. At the beginning of October, the average length of stay at Coastal Lodge was 28 days, though this increased to 37 days through October and November as care packages were sourced for a number of long staying residents.



2.4.4 Consideration is now being given to how many and what type of intermediate care beds will be required in the future and a fuller update will be provided to a future meeting of the Health and Wellbeing Board.

2.5 Mid Programme Review and Transacting Benefits

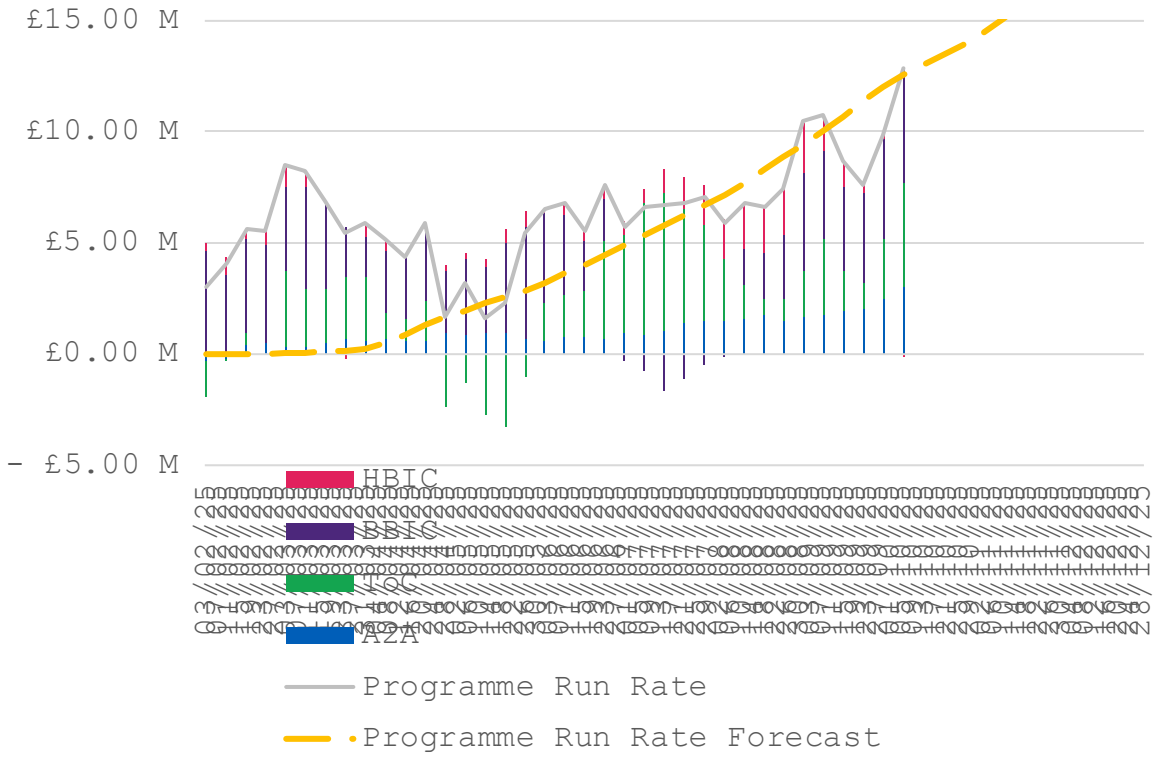
2.5.1 A mid programme review report has recently been considered by the FutureCare Steering Group and presented to partner committees and boards. As well as looking at the value of operational benefits delivered by the programme, it also considers the impact that the programme has had on reducing the number of people waiting to be discharged from hospital while an intermediate care package is sourced

2.6 Operational benefits

2.6.1 On 6 October 2025, the FutureCare Programme had achieved an operational run rate of £12.87m against a target of £12.54m and so at the mid-point was is slightly ahead of trajectory. The run rate target for the year is £28.4m and as can be seen in the graph below, rises steeply over the next six-month period.

2.6.2 While the programme is on track, week on week, performance is variable and subject to significant variation. During August, significant benefit was being delivered via the home-based intermediate care workstream, however due to capacity challenges this diminished in September, but now these have been addressed will increase. Similarly, there is still significant month on month variation with the amount of benefit delivered via the TOC workstream and significant under-performance against the anticipated trajectory. Progress continues to be tracked monthly and a further update will be provided to a

future meeting of the Health and Wellbeing Board.



Run rate or recurrent operational benefit is the financial value of the operational change that has been achieved if that level of performance is maintained for a year.

Example 1: During the diagnostic exercise it was agreed that the cost of a bed day at UHD hospital was £355. Under the agreed benefits model, if during a week a total of 50 people are discharged from hospital with a support package (P1-3) on average one day sooner than the 9.7 day baseline average agreed as part of the diagnostic, then this contributes £923,000 to the target run rate (£355 x 50 people x 52 weeks).

Example 2: During the diagnostic the hourly homecare rate across BCP was agreed at £16.20. Under the agreed benefits model, if 10 people complete a reablement package during a week, and the average reduction in the size of the subsequent long term home care package required is one hour greater than the previous average reduction of 4.59 hrs (i.e. 5.59 hrs) then this contributed £8,424 (£16.20 x 10 people x 52 weeks) to the run rate.

2.7 Reducing the number of people waiting to be discharged from hospital(NCTR)

2.7.1 A second key measure for the mid programme review is success in releasing system pressures and reducing the number of people waiting in hospital with no criteria to reside. As indicated above, though reductions in the key NCTR ALOS indicator are now being achieved at Dorset County Hospital, the programme is currently behind trajectory across UHD hospitals.

2.8 Programme Reset

2.8.1 To address this challenge a programme reset has been undertaken. Moving forward, the focus of the programme will increasingly be focussed on bringing together workstreams to collectively improve system flow and to speed up decision-making across organisations. More Newton resources will also be invested in the programme at no extra cost to system partners and additional home-based intermediate care capacity has been commissioned to reduce waiting times at UHD hospitals.

2.8.2 Key appointments have also been made to the new Flow Team.

2.8.3 In combination, it is anticipated that these changes will ensure that system pressures will reduce in coming weeks and performance against the key NCTR ALOS indicator will improve and return to trajectory by March 2026.

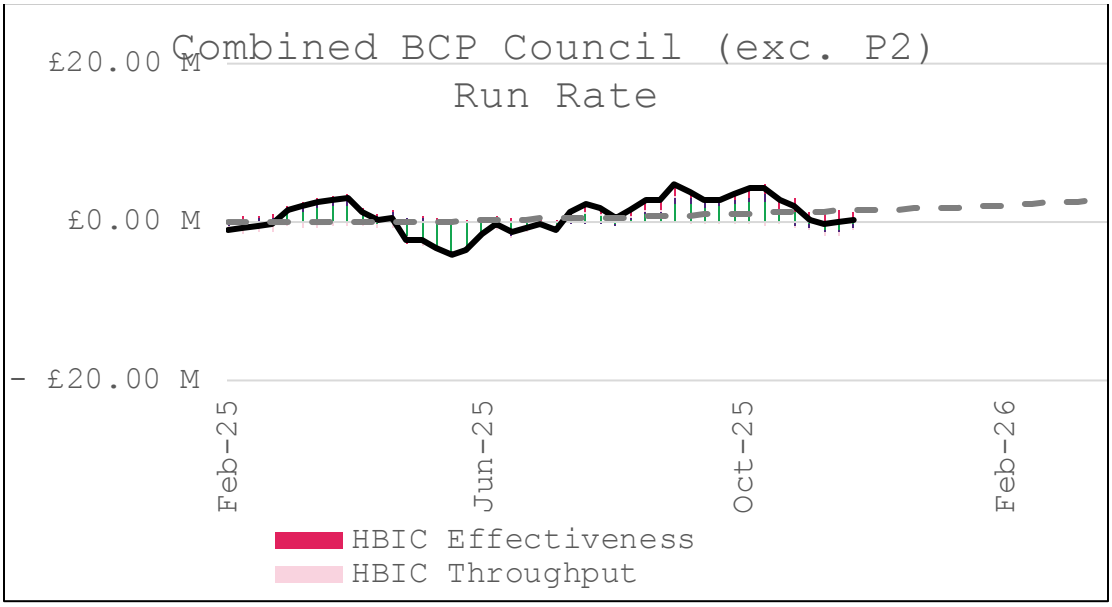
3 Options Appraisal

3.1 Not applicable

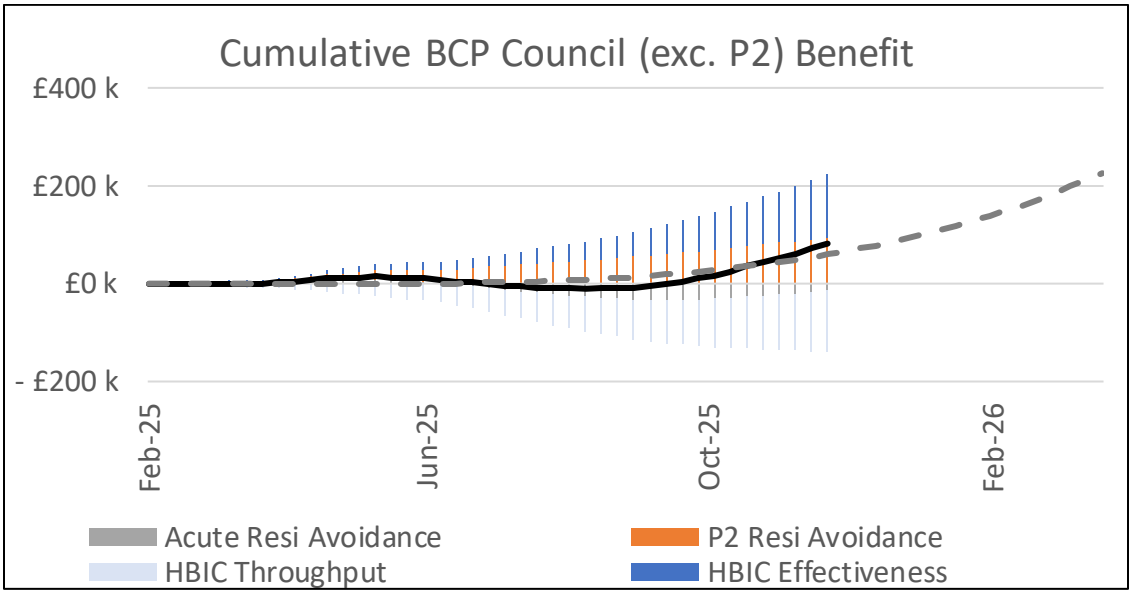
4 Summary of financial implications

4.1 A fee of £9m has been agreed to provide the transformation support and data and technology tools required to deliver the programme. For BCP Council this means a financial contribution of £912,000, with payments beginning in January 2026.

4.2 The graph below presents the benefits delivery trajectory for BCP Council up to 2 November 2025. As can be seen by November, though behind trajectory the Futurecare Programme was delivering positive operational benefits to BCP residents.



4.3 Savings delivered in-year are tracked as a cumulative benefit (below). By 2 November, the programme had delivered a cumulative benefit of £81,800 to BCP Council, marginally ahead of the anticipated trajectory for the programme at that time.



4.4 The table below sets out the anticipated benefits that will be delivered for BCP Council throughout the lifetime of the programme.

FY	Cumulative benefit	benefit in year
FY24/25	£0.0m	£0.0m
FY25/26	£0.3m	£0.3m
FY26/27	£2.4m	£2.1m
FY27/28	£6.1m	£3.7m
FY28/29	£10.5m	£4.4m
FY29/30	£15.2m	£4.7m

5 Summary of legal implications

5.1 Dorset Council is the lead organisation for managing the contract with Newton. To ensure that costs and benefits are shared equitably a Dorset Health and Care Partnership Agreement has been drafted and executed. This is legally binding between partner organisations and has been signed and circulated.

6 Summary of human resources implications

6.1 Adult Social Care staff and people employed in organisations contracted by BCP Council to deliver care services play an important part in the delivery of the services within the scope of this work programme. As a result of this programme, it is envisaged that many people will work differently but no substantial reorganisations to existing council structures or care organisations will take place.

6.2 Some changes in the delivery of home based reablement care services and intermediate bedded care services provided in care homes is envisaged but these will follow a co-design process and a subsequent re-commissioning of services if required. Where this is the case then an appropriate consultation and change process will be undertaken.

7 Summary of sustainability impact

7.1 The FutureCare Programme will have a positive impact on sustainability, reducing the length of time people spend in hospitals, optimising hospital assets and supporting more people to live independently at home for longer

8 Summary of public health implications

8.1 The quality and effectiveness of urgent and emergency care pathways has a substantial impact on public health. In particular, the diagnostic identifies that it is primarily older people, with one or more long term condition, that are most likely to be admitted into hospital unnecessarily or are likely to face delays in returning home following a hospital stay. There is a substantial body of evidence that suggests that each additional day that a person spends in a hospital bed leads to

physical deconditioning and that substantial hospital delays can be very detrimental to overall quality of life and can impact on whether a person is able to return home and live independently or will require long term residential care.

9 Summary of equality implications

9.1 Equality Impact Assessments have been undertaken at a workstream level. The diagnostic has identified some variation in the outcomes achieved from different services across Dorset and by geographical area. As key priority for the programme is ensuring equality, equity and consistency of services across the East and West of Dorset.

10 Summary of risk assessment

10.1 The greatest risk for the programme at the mid-point is failure to address the key no criteria to reside average length of stay indicator. Without sustained improvement in this area anticipated benefits for people – shorter lengths of hospital stay, once people are fit to be returned home will not be delivered. Following the programme reset there is increased confidence that anticipated improvements will be delivered.

Background papers

FutureCare Mid Programme Review.

Appendices

There are no appendices to this report.

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HEALTH AND WELLBEING BOARD

Report subject	**Better Care Fund 2025-26 Quarter 2 Report**
Meeting date	12 January 2026
Status	Public Report
Executive summary	This report provides an overview of the Quarter 2 Report of the Better Care Fund (BCF) for 2025-26. The BCF is a key delivery vehicle in providing person-centred integrated care with health, social care, housing, and other public services, which is fundamental to maintaining a strong and sustainable health and care system. The report is a part of the requirements set y the Better Care Fund 2025-26 Policy Framework. The report must be jointly agreed and signed off by the Health and Wellbeing Board as one of the planning requirements.
Recommendations	**It is RECOMMENDED that:** **The Health and Wellbeing Board retrospectively approve:** • **Better Care Fund 2025-2026 Quarter 2 Report**
Reason for recommendations	NHS England (NHSE) require the Health and Wellbeing Board (HWB) to approve all BCF plans, this is one of the national conditions within the Policy Framework. This includes planning documents at the beginning of a funding period, and template returns reporting progress against the plans quarterly.

Portfolio Holder(s):	Cllr David Brown, Portfolio Holder for Health and Wellbeing
Report Authors	Scott Saffin, Commissioning Manager – Better Care Fund and Market Management Becky Whale, Deputy Director, UEC and Flow - NHS Dorset
Wards	Not applicable
Classification	For Decision

Background

1. This report is a covering document for the content of the Better Care Fund Quarter 2 Report. The report is made up of a single document template. The template was provided by NHS England and completed collaboratively by officers from BCP Council and NHS Dorset.
2. The document details the following:
    - Confirmation of National Conditions agreed by partners
    - Q2 Performance of Better Care Fund metrics
    - Expenditure update
3. The BCF is a Programme spanning both the NHS and Local Government which seeks to join-up health and care services, to promote people's ability to manage their own health and wellbeing and live independently in their communities for as long as possible.
4. The BCF pooled resource is derived from existing funding within the health and social care system such as the Disabled Facilities Grant and additional contributions from Local Authority or NHS budgets. In addition, short-term grants from Government have been paid directly to Local Authorities i.e. Local Authority Better Care Grant, which is used for meeting adult social care needs, reducing pressures on the NHS, and ensuring that the social care provider market is supported. The Adult Social Care Discharge Fund is also now wrapped up as part of the BCF and is subject to quarterly reporting against spend and activity.
5. In Bournemouth, Christchurch, and Poole - the Better Care Fund totals £79,272,349 for the year 2025/26.
6. In November, Department of Health and Social Care shared details of allocations for the Minimum NHS Contribution of the Better Care Fund for 2026/27 and indictive allocation for 2027/28.
7. In 2026/27, the NHS minimum contribution to adult social care has been uplifted by 4.4% (in line with the Spending Review 2025 commitment of an increase to the NHS's minimum contribution to adult social care via the BCF in line with Department of Health and Social Care's Spending Review settlement), the Discharge Fund and remaining ICB contributions will have a 2.1% uplift in line with Community Services inflation growth.
8. Details on BCF objectives and conditions, allocations for the Local Authority Better Care Grant for 2026/27 will be set out shortly and shared with the Health & Wellbeing Board.

9. The planning requirements sheet dictate that this document is presented to the Health & Wellbeing Board on Monday 12 January 2026 for approval.

10. The Health and Social care landscape continues to present performance challenges; however, BCP Council are currently on track to meet the 2025/26 targets for:
    - Average length of discharge delay for all acute adult patients
    - Long-term support needs for people aged 65+ met by admission to residential and nursing care homes, per 100,000

    Performance is not on track for:

    - Emergency admissions to hospital for people aged 65+

11. All schemes are being implemented as outlined in the BCF Planning Template 25/26 that was approved at the 24 March 2025 Health & Wellbeing Board meeting.

Options Appraisal

12. Option 1: Approve the Better Care Fund 2025–26 Quarter 2 Report

    The report demonstrates that most performance targets are on track, and all schemes are being implemented as planned. Approval will provide assurance to NHS England and the Department of Health & Social, avoiding any delays in funding or governance processes.

13. Option 2: Do not approve the report

    This will risk non-compliance with national conditions and potential reputational impact.

14. **Recommended Option:**
    The recommendation is Option 1 and to approve the Better Care Fund 2025–26 Quarter 2 Report, as it ensures compliance, supports continued delivery of integrated care objectives, and maintains funding certainty for the Bournemouth, Christchurch, and Poole Health & Wellbeing Board.

Summary of financial implications

15. The Better Care Fund Group comprises of members from BCP Council and NHS Dorset who continue to monitor BCF budgets and activity for the 2025-26 Plan.

16. The previously approved plan provides a granular breakdown of the spending by scheme type, source of funding and expenditure (See Appendix 2).

A high-level view of this is detailed in the table below:

Source of Funding	2025-2026 Planned Income
DFG	£4,365,654
Minimum NHS Contribution	£40,466,631
Local Authority Better Care Grant	£16,578,901
Additional LA Contribution	£2,182,000
Additional NHS Contribution	£15,679,163
Total	**£79,272,349**

Summary of legal implications

17. Section 75 agreements, (in accordance with the 2006 National Health Service Act), are in place as prescribed in the planning guidance for each of the pooled budget components in the fund.

Summary of human resources implications

18. The services funded under the BCF are delivered by a wide range of partners some of whom are employed by BCP Council and many who are commissioned by BCP to deliver these services. There are no further human resources implications to note.

Summary of sustainability impact

19. Services are only sustainable if funding is available.

Summary of public health implications

20. The BCF is a key delivery vehicle in providing person-centred integrated care with health, social care, housing, and other public services and is fundamental to maintaining a strong and sustainable health and care system.

Summary of equality implications

21. An Equalities Impact Assessment was undertaken when the Better Care Fund schemes were implemented and there have been no changes. Additional Equality Impact Assessments (EIAs) will be undertaken if there are any proposed future changes to policy of service delivery.

Background papers

Better Care Fund policy framework 2025 to 2026 - GOV.UK – Published by Department of Health & Social Care.

Appendices

Appendix 1 - BCP Council BCF 2025-26 Q2 Report

Appendix 2 - BCP Council BCF 2025-26 Planning Template v1.5

Better Care Fund 2025-26 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).

https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.

3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing the objectives of the BCF

National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD): 1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.Populations are based on 2023 mid year estimates

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q2. If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Planned Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'Q2 Year-to-Date Actual Expenditure' should include total amount that has been spent in Q2, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan.

Please also use this section to provide the aggregate year-to-date spend at Q2. This tab will also display what percentage of planned income this constitutes; [if this is 50% exactly then please provide some context around how accurate this figure is or whether there are limitations.]

HM Government

NHS England

Better Care Fund 2025-26 Q2 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Bournemouth, Christchurch and Poole	
Completed by:	Scott Saffin	
E-mail:	scott.saffin@bcpcouncil.gov.uk	
Contact number:	01202 126204	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 12/01/2026	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Confirmation of Nation Conditions			Checklist Complete:
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,848.7	1,982.6	1,720.5	1,837.4	1,698.9	1,714.8	1,882.8	1,848.7	1,882.8	1,821.5	1,731.8	1,815.8
	Number of Admissions 65+	1,629	1,747	1,516	1,619	1,497	1,511	1,659	1,629	1,659	1,605	1,526	1,600
	Population of 65+	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0	88,115.0

		Checklist
		Complete:
Assessment of whether goal has been met in Q2:	Not on track to meet goal	Yes
If goal has not been met please provide a short explanation, including noting any key mitigating actions.	Emergency Admissions Actuals: April: 1,603 May: 1,734 June: 1,579 July: 1,701 August: 1,611 Sept (estimated) 1,646	Yes
You can also use this box to provide a very brief explanation of overall progress if you wish.	The FutureCare programme has a workstream focused on alternatives to admission. The key metrics are: 1. The number of Same Day Emergency Care (SDEC) starts per week 2. The number of patients referred to community services from the Emergency Department (ED) front door 3. The number of Hospital at Home (H@H) admissions per week To achieve this, the approach across Bournemouth, Christchurch, and Poole for admission avoidance is: Improving the number of patients pulled from the ED front door into SDECs Improving the flow from SDECs and ED to H@H Appointing a front door clinician to identify patients suitable for community services and refer them from ED An increase in SDEC referrals from ED has maintained the success rate, meaning more people are spending less time in hospital and avoiding admission. Our front door resource is showing early signs of success by directing patients to other out-of-hospital services. We hope this activity will increase admission avoidance.	Yes

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.88	0.85	1.14	1.17	0.88	0.92	1.08	0.99	0.93	0.97	1.01	1.01
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.4%	87.8%	87.3%	85.4%	87.5%	88.5%	86.5%	87.6%	88.4%	86.2%	87.4%	87.4%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.00	7.00	9.00	8.00	7.00	8.00	8.00	8.00	8.00	7.00	8.00	8.00

Assessment of whether goal has been met in Q2:	On track to meet goal	Yes
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	April: 86.39% May: 86.10% June: 85.71% July: 86.81% August: 84.23% Sept (estimated): 85.87%	Yes
You can also use this box to provide a very brief explanation of overall progress if you wish.	The FutureCare programme has a workstream focused on Transfer of Care (TOC). The TOC workstream has 2 key metrics: Reducing length of stay for those with no criteria to reside and increasing the number of people returning home. To achieve this TOC has 3 key area of focus: 1) Improving early discharge planning. 2) Bringing decision making into one place where multi agency teams work together to increase efficiency around discharge planning. 3) Improving how we record and track what is happening for people requiring care and support to leave hospital so we have greater clarity on next actions for people. In Q2, a change in the ICES provider from NRS to Medequip occurred. During the transition, Medequip has been prioritising discharge and admission avoidance, which has helped minimise disruption across the system. Colleagues monitoring the Single Point Of Access (SPOAs) have not identified any notable issues, and discharge-related concerns have not surfaced during system-wide ICES meetings. These twice-weekly meetings that took place during Q2 were an effective way to keep key stakeholders informed and address emerging issues. Regular newsletters have also been circulated to ensure colleagues across the system remain updated with the most important developments. While some challenges are likely to have occurred, operational teams have demonstrated strong resilience and adaptability. For example, there has been increased use of domiciliary care to support discharges during the provider changeover.	Yes

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	370.0	574.2	124.8	121.4	121.4	119.2
	Number of admissions	326.0	506.0	110.0	107.0	107.0	105.0
	Population of 65+*	88115.0	88115.0	88115.0	88115.0	88115.0	88115.0

Assessment of whether goal has been met in Q2:	On track to meet goal	Yes
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.		Yes
You can also use this box to provide a very brief explanation of overall progress if you wish.	Year to date, the actual rate of residential admissions stands at 254.3, slightly exceeding the target of 246.2. Q2 saw a notable increase in new admissions, with a greater than usual proportion from hospital referrals. This trend highlights ongoing pressures within the system. Additionally, BCP Council continues to experience a high number of people depleting their financial assets (capital depleters) and becoming eligible for local authority-funded care, which is placing further strain on finances. BCP Council is actively working to support people living independently, particularly those with disabilities or long-term conditions. In Q2 2025, 59 housing adaptations were completed through the Disabled Facilities Grant, enabling people to remain safely in their homes. These adaptations, including stairlifts, wetrooms, widened doorways etc are tailored to the needs of every person following assessments from an Occupational Therapist. In addition, BCP Council has launched a new community reablement pilot as part of its Fulfilled Lives Transformation Programme. This initiative provides short-term, therapy-led support to help regain independence after hospital discharge. Since the launch of the pilot in September, 15 people in the community has accessed the service. To further enhance support, BCP Council transitioned its Integrated Community Equipment Service to a new provider, Medequip, in August 2025 following our previous provider NRS going into administration. Medequip supplies and maintains essential equipment like mobility aids and hospital beds, with a focus on admission avoidance and hospital discharges during the transition period, but has recently launched a full catalogue to be able to provide better support in the community as well, which should reflect in the Q3 metrics.	Yes

Better Care Fund 2025-26 Q2 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Source of Funding	2025-26 Planned Income	2025-26 Updated Total Plan Income for 25-26	DFG Q2 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£4,365,654	£4,365,654	£1,836,181	Yes
Minimum NHS Contribution	£40,466,631	£40,466,631		Yes
Local Authority Better Care Grant	£16,578,901	£16,578,901		Yes
Additional LA Contribution	£2,182,000	£2,182,000		Yes
Additional NHS Contribution	£15,679,163	£15,679,163		Yes
Total	**£79,272,349**	**£79,272,349**		

	Original	Updated	% variance	
Planned Expenditure	**£79,272,349**	£79,272,349	**0%**	Yes

		% of Planned Income	
Q2 Year-to-Date Actual Expenditure	£39,239,527	**49%**	Yes

If Q2 year to date actual expenditure is exactly 50% of planned expenditure, please confirm this is accurate or if there are limitations with tracking expenditure.	Most schemes are spending on track. Any underspend reported has a plan in place to ensure budgets are exhausted by the end of Q4. As part of its ongoing commitment to support independent living, BCP Council Housing is expected to complete at least 52 housing adaptations in Q3, as approved by the Housing Panel in Q2.	Yes
If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	There have been no changes to planned expenditure since the original plan. However, updates will be reflected in the Q3 return, as 10 transitional beds have been repurposed into residential dementia placements, which will impact spending from October 2025 onwards. The recent change in provider for the Integrated Community Equipment Service is not expected to result in any significant financial implications, but updates will be provided in future reports.	Yes

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Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

		Complete:
Health and Wellbeing Board:	Bournemouth, Christchurch and Poole	Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes	Yes
If no indicate the reasons for the delay.		Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

Submitted by:	Scott Saffin	Yes
Role and organisation:	Better Care Fund Manager - BCP Council	Yes
E-mail:	scott.saffin@bcpcouncil.gov.uk	Yes
Contact number:	01202 126204	Yes
Documents Submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative	Yes
	C&D Local Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	David	Brown	David.Brown@bcpcouncil.gov.uk		Yes
	Health and Wellbeing Board Chair						
Named Accountable person	Local Authority Chief Executive	Mr	Graham	Farrant	graham.farrant@bcpcouncil.gov.uk		Yes
	ICB Chief Executive 1	Ms	Patricia	Miller	patricia.miller@nhsdorset.nhs.uk	NHS Dorset	Yes
	ICB Chief Executive 2 (where required)						
	ICB Chief Executive 3 (where required)						
Finance sign off	LA Section 151 Officer	Mr	Adam	Richens	adam.richens@bcpcouncil.gov.uk		Yes
	ICB Finance Director 1	Mr	Rob	Morgan	rob.morgan@nhsdorset.nhs.uk	NHS Dorset	Yes
	ICB Finance Director 2 (where required)						
	ICB Finance Director 3 (where required)						
Area assurance contacts	Local Authority Director of Adult Social Services	Ms	Zena	Dighton	zena.dighton@bcpcouncil.gov.uk		Yes
	DFG Lead	Ms	Kelly	Deane	kelly.deane@bcpcouncil.gov.uk		Yes
	ICB Place Director 1	Ms	Becky	Whale	becky.whale@nhsdorset.nhs.uk	NHS Dorset	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)						
	ICB Place Director 3 (where required)						

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes		Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£4,365,654	£4,365,600	£54
NHS Minimum Contribution	£40,466,631	£14,758,031	£25,708,600
Local Authority Better Care Grant	£16,578,901	£16,578,901	£0
Additional LA Contribution	£2,182,000	£2,182,000	£0
Additional ICB Contribution	£0	£0	£0
Total	**£63,593,186**	**£37,884,532**	**£25,708,654**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26	
Minimum required spend	£14,759,838	
Planned spend	£12,440,858	Planned spend is less than the minimum required spend

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,849	1,983	1,720	1,837	1,699	1,715	1,883	1,849	1,883	1,821	1,732	1,816

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.88	0.85	1.14	1.17	0.88	0.92	1.08	0.99	0.93	0.97	1.01	1.01

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	499.3	124.8	121.4	121.4	119.2

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

Complete:

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Bournemouth, Christchurch and Poole	£4,365,654
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£4,365,654**

Local Authority Better Care Grant	Contribution
Bournemouth, Christchurch and Poole	£16,578,901
Total Local Authority Better Care Grant	**£16,578,901**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	Yes

Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Bournemouth, Christchurch and Poole	£2,182,000	Moving on From Hospital Living Campus
Total Additional Local Authority Contribution	**£2,182,000**	

Yes

NHS Minimum Contribution	Contribution
NHS Dorset ICB	£40,466,631
Total NHS Minimum Contribution	**£40,466,631**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	<Please Select>

No

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£40,466,631**	

Yes

	2025-26
Total BCF Pooled Budget	**£63,593,186**

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£4,365,654	£4,365,600	£54
NHS Minimum Contribution	£40,466,631	£14,758,031	£25,708,600
Local Authority Better Care Grant	£16,578,901	£16,578,901	£0
Additional LA contribution	£2,182,000	£2,182,000	£0
Additional NHS contribution	£0	£0	£0
Total	**£63,593,186**	**£37,884,532**	**£25,708,654**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£14,759,838	£12,440,858	£2,318,980

Checklist

Column complete:

No	Yes	No	Yes	Yes	Yes	No

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Long-term residential/nursing home care	Moving on From Hospital Living	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution		24/25 £7,428,193
2		*Community based schemes Needs updating*		Community Health	NHS Community Provider	NHS Minimum Contribution		24/25 £10,480,335
3	Assistive technologies and equipment	Integrated Community Equipment Service	2. Home adaptations and tech	Community Health	Private Sector	NHS Minimum Contribution		24/25 £2,906,542
4	Wider local support to promote prevention and independence	Advocacy, information, and front door.	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 241,338	
5	Wider local support to promote prevention and independence	Voluntary Organisation Schemes	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 199,841	
6	Long-term residential/nursing home care	High Cost Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 618,686	
7	Long-term residential/nursing home care	Dementia Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 2,622,374	
8	Long-term home-based social care services	Home Care	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 1,656,604	
9	Evaluation and enabling integration	Support to Self Funders *combine Scheme 9 + 18*	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 165,989	Wrapped 2 previous Self funder schemes together
10	Long-term residential/nursing home care	Dementia Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 838,192	
11	Long-term residential/nursing home care	Residential, Dementia, and Mental Health Placements	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 2,166,277	
12	Long-term residential/nursing home care	Residential, and Dementia Placements	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 62,245	

13	Discharge support and infrastructure	Hospital Discharge and CHC Teams	5. Timely discharge from hospital	Continuing Care	Local Authority	NHS Minimum Contribution	£ 2,273,764	
14	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Apex Rapid Response	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 132,136	
15	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Reablement at Home (Step Up and Step Down Users) - Tricuro	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 1,639,953	
16	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Bed Based Intermediate Care - Coastal Lodge *Combine schemes 16 & 17*	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 634,999	Wrapped 2 Coastal Lodge schemes
17	Support to carers, including unpaid carers	Support to Carers - Officers	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 168,172	
18	Support to carers, including unpaid carers	Support to Carers - Activities, Respite. *Combine schemes 20 + 21*	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 1,294,052	Wrapped 2 Carer schemes
19	Other	Community Therapy	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution		24/25 £1,256,334
20	Other	District Nursing	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	Additional NHS Contribution		24/25 £5,292,192
21	End of life care	Pallative Care - District Nurse	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	Additional NHS Contribution		24/25 £43,165
22	End of life care	Generalist Pallative Care	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	Additional NHS Contribution		24/25 £1,483,828
23	Home-based intermediate care (short-term home-based rehabilitation, reablement and	General Intermediate Care	6. Reducing the need for long term residential care	Community Health	NHS Community Provider	Additional NHS Contribution		24/25 £6,230,515
24	Evaluation and enabling integration	BCP Council Better Care Fund Manager	6. Reducing the need for long term residential care	Other	Local Authority	NHS Minimum Contribution	£ 43,409	
25	Disabled Facilities Grant related schemes	Integrated Community Equipment Service	2. Home adaptations and tech	Community Health	Private Sector	DFG	£ 1,971,000	
26	Disabled Facilities Grant related schemes	Housing Adaptations - Disabled Facilities Grant	2. Home adaptations and tech	Social Care	Private Sector	DFG	£ 2,394,600	
27	Long-term residential/nursing home care	Moving on From Hospital Living	1. Proactive care to those with complex needs	Social Care	Private Sector	Additional LA Contribution	£ 2,182,000	
28	Assistive technologies and equipment	Lifeline	2. Home adaptations and tech	Social Care	Local Authority	Local Authority Better Care Grant	£ 35,000	
29	Long-term residential/nursing home care	Residential Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 4,143,748	
30	Long-term home-based social care services	Home Care	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 6,049,000	
31	Evaluation and enabling integration	Targeted Community Social Workers	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 189,000	
32	Evaluation and enabling integration	Occupational Therapists	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 68,000	
33	Discharge support and infrastructure	DOLS Best Interest Assessors *Combine schemes 36 & 55*	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 375,000	Wrapped 2 DoLS schemes
34	Discharge support and infrastructure	Brokerage Services	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 58,000	
35	Discharge support and infrastructure	Hospital Discharge and CHC Teams	5. Timely discharge from hospital	Continuing Care	Local Authority	Local Authority Better Care Grant	£ 288,000	
36	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	D2A Beds	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 550,000	
37	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Tricuro Reablement at Home	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 210,000	
38	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Step Down Beds - Figbury	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 21,000	
39	Long-term residential/nursing home care	High Cost Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 1,195,000	
40	Discharge support and infrastructure	Rapid Financial Assessments	5. Timely discharge from hospital	Social Care	NHS	Local Authority Better Care Grant	£ 72,000	
41	Evaluation and enabling integration	Social Workers	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 235,000	
42	Discharge support and infrastructure	7 Days a Week - Brokerage Services	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 57,000	
43	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Apex Rapid Response	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution		24/25 £1,006,940
44	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Coastal Lodge	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution		24/25 £1,988,379
45	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Intermediate Care Schemes	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution		24/25 £505,454
46	Discharge support and infrastructure	Support to Self Funders	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 251,000	
47	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Figbury Lodge - Residential and Intermediate Beds	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 2,782,153	

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Bournemouth, Christchurch and Poole

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,884	2,020	1,753	1,873	1,731	1,748	1,918	1,884	n/a	n/a	n/a	n/a	Using Data from 2023 - 2025 we have calculated an average rate of admissions and factored a reduction. The calculations include seasonal variation and the FutureCare expected benefit assumptions from alternatives to admission workstreams.	Yes
	Number of Admissions 65+	1660	1,780	1,545	1,650	1,525	1,540	1,690	1,660	n/a	n/a	n/a	n/a		
	Population of 65+*	88,115	88,115	88,115	88,115	88,115	88,115	88,115	88,115	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
	Rate	1,849	1,983	1,720	1,837	1,699	1,715	1,883	1,849	1,883	1,821	1,732	1,816		
	Number of Admissions 65+	1629	1747	1516	1619	1497	1511	1659	1629	1659	1605	1526	1600		Yes
	Population of 65+	88,115	88,115	88,115	88,115	88,115	88,115	88,115	88,115	88,115	88,115	88,115	88,115		

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	1.16	0.99	1.06	n/a	n/a	n/a	n/a	Calculations are based on national DRD data. National data differs to local data with the local data showing a slightly lower average number of days between DRD date and discharge.	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	86.7%	85.6%	87.3%	n/a	n/a	n/a	n/a	We have chosen to use national data as this forms the basis of BCF reporting. The year end position links to the expected benefits from the FutureCare programme. Please note FutureCare benefits have been calculated using local data for DRD and local reporting will show a greater benefit.	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	8.7	6.9	8.3	n/a	n/a	n/a	n/a		
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
Average length of discharge delay for all acute adult patients	0.88	0.85	1.14	1.17	0.88	0.92	1.08	0.99	0.93	0.97	1.01	1.01		
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.4%	87.8%	87.3%	85.4%	87.5%	88.5%	86.5%	87.6%	88.4%	86.2%	87.4%	87.4%		Yes
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.00	7.00	9.00	8.00	7.00	8.00	8.00	8.00	8.00	7.00	8.00	8.00		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	370.0	422.2	499.3	124.8	121.4	121.4	119.2		The projected figures for 2025-26 incorporate lessons learned from the previous year, especially the shift from SALT to Client Level Data, which resulted in higher-than-expected figures. The adult social care sector and the demand for residential care have faced significant challenges. Many people who were self-funding their care have exhausted their savings, and broader economic pressures have exacerbated the situation. We anticipate these challenges will persist throughout 2025/26. However, we remain committed to investing in initiatives that promote independence, enabling people to stay in their homes longer. Some of these initiatives include BCP Council's Transformation Programme, which aims to modernise and enhance service delivery, focusing on the holistic needs of individuals, reducing the reliance on residential care. The Disabled Facilities Grant provides more home adaptations to support independent living, giving the opportunity for people to stay in their own home for longer. Home Care Packages offer support within people's homes. Financial Assessments by the Local Authority help self-funding people ensure their care remains sustainable.	Yes
	Number of admissions	326	372	440	110	107	107	105			Yes
	Population of 65+*	88,115	88,115	88,115	88,115	88,115	88,115	88,115			

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Bournemouth, Christchurch and Poole

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes		
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes		
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes		
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes		
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes		
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes		
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes		
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes		
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care				
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes		
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes		

HEALTH AND WELLBEING BOARD

Report subject	**Update on the Adult Social Care Prevention Strategy**
Meeting date	12 January 2026
Status	Public Report
Executive summary	The Adult Social Care Prevention Strategy (2025-2030) was approved at Cabinet on 29 October 2025 and sets out five key strategic priorities to reduce, delay or prevent the need for long term care and support for people living in Bournemouth, Christchurch and Poole. The strategy has been shaped by the views and experiences of local people, carers, the voluntary and community sector and partners. It aims to develop a sustainable approach to prevention in adult social care. The strategy emphasises early intervention, the promotion of wellbeing, and collaboration with key partners, to not only prevent the development of long-term needs, but also to enhance the overall quality of life for people living in the BCP Council area.
Recommendations	**It is RECOMMENDED that:** a) Members note the content of this report
Reason for recommendations	The Strategy: i) Delivers a sustainable, preventative approach to delaying, reducing, or preventing the need for long-term care and support services. It contributes to improved outcomes for people while generating financial benefits for adult social care through more effective demand management ii) Meets the requirements of the Care Act (2014) iii) Supports the priorities of the Corporate Strategy and Adult Social Care Strategy; and iv) Supports the Fulfilled Lives transformation programme

Portfolio Holder(s):	Councillor David Brown – Health and Wellbeing
Corporate Director	Laura Ambler, Corporate Director for Wellbeing
Report Authors	Emma Senior, Strategic Commissioning Manager for Prevention and Wellbeing
Wards	Council-wide
Classification	For Update

Background

1. BCP Council is facing increasing demand for adult social care services. There was an increase in new requests of support of 28% from 2022/23 to 2023/24 for people aged 18-64, and an increase of 7% for older people aged 65+.
2. The number of residents aged 65 and over is set to increase by 15% between 2018 and 2028. By 2028, 24% of the local population will be aged 65+. Living longer does not always equate to living healthier lives. While healthy life expectancy in the BCP area is better for both males and females compared to nationally, the difference between life expectancy and healthy life expectancy shows that locally, people may live between 15 to 18 years in ill health.
3. Mental health conditions such as depression and anxiety are the leading cause of disability in those aged 15-49, accounting for around a fifth of disability in this age group in the BCP Council area.
4. In order to manage this increase in demand, we need to shift the focus from crisis management to prevention and enable people to live happier, healthier and independently for longer.
5. In February 2025 we began engagement with local communities, the voluntary and community sector, the local market and the adult social care workforce, to understand their needs, preferences, aspirations and ideas for a new adult social care approach to prevention.
6. We delivered 30 presentations at community events, team meetings and conferences and met with over 30 different Voluntary and Community Sector organisations to hear their views.
7. We produced a series of surveys and offered 1:1 support and easy read copies, to which we received 180 responses.
8. We held a multi partner prevention event which brought together 117 key partners and stakeholders. We shared insights from public health and our adult social care fulfilled lives programme, celebrated best practice from voluntary and community sector organisations and hosted workshops to explore key questions about prevention and our developing priorities.
9. Overall, we had a combination of over 400 attendees at various events who collaboratively shaped the priorities of the adult social care prevention strategy.

10. The five key strategic priorities for the Adult Social Care Prevention Strategy are:

Priority 1: A change in culture

- Strengths based and holistic approaches
- Equality and diversity
- Co-production
- Language and listening

Priority 2: Living and ageing well

- Falls prevention, strength and balance
- Better physical health
- Financial stability and security
- Age friendly communities

Priority 3: Individual resilience to build on wellbeing

- Information, advice, guidance and self-education
- Supporting people with sight and/or hearing loss and impairment
- Hoarding and self-neglect
- Self-funders and people on the cusp of eligibility
- Supporting Carers
- Occupational Therapy and Care Technology

Priority 4: Supporting the Workforce

- Workforce wellbeing
- Staff development and training
- Leadership commitment
- First, think prevention
- Integration, collaboration and communication

Priority 5: Connecting Communities

- Connection and a sense of belonging
- Addressing health and social inequalities
- Community first
- Safety and security
- Supporting the voluntary and community sector

11. The ASC Prevention Strategy was approved at Cabinet on 29 October 2025.

12. The ASC Prevention Strategy is provided in Appendix 1 and a detailed action plan with timescales is provided in Appendix 2.

13. Since Cabinet approval of the Adult Social Care Prevention Strategy, we have taken forward a range of actions to progress our priorities. We have been meeting regularly with Public Health colleagues to explore how the Public Health Grant can be most effectively utilised, ensuring that investment is targeted towards initiatives with the greatest potential impact. In particular, we will be focusing on developing pilot projects for Priority 2, which aims to promote better physical health and prevent falls. These ongoing discussions will enable us to identify innovative approaches and potential areas for collaboration that will support residents to live and age well.

14. We have also engaged with the Dorset Intelligence and Insight Service (DiiS) to explore participation in a pilot as part of their targeted prevention hub work, which will enhance our ability to deliver data-driven, targeted interventions.

15. We are also working closely with procurement colleagues to review and remodel existing preventative contracts. This comprehensive review will ensure that our commissioned services are aligned with the evolving needs of our communities, supporting the delivery of effective and sustainable prevention across adult social care.

Summary of financial implications

16. A total commitment of £817,000 was approved by Cabinet for the ASC Prevention Strategy. This includes an identified £317,000 in base revenue budget resources, an investment of £203,000 to protect current levels of service delivery, £150,000 of public health funding and an additional investment of £147,000 per year for 3 years as proof of concept.

17. The table below outlines the demand reduction savings to be realised, in absolute figures and an incremental format.

ASCPrevention Strategy - current funding, additional investment and demand avoidance savings

	2025/26 £000s	2026/27 £000s	2027/28 £000s	2028/29 £000s
Current ASC Prevention Strategy - Absolute Values				
Base revenue budget resources	317	317	317	317
Public Health Funding	150	150	150	150
Temporary Funding (ends 31 March 2026)	203	0	0	0
Total Current Resources for ASC Prevention Strategy	670	467	467	467
Growth Bid to maintain current business as usual prevention strategy		203	203	203
Total Current Resources for ASC Prevention Strategy	670	670	670	670
Growth Bid - MTFP - Incremental Basis		203	0	0
Demand Reduction Savings	(1,537)	(3,074)	(4,611)	(6,148)
Incremental Demand Reduction Savings (already factored into in MTFP)		(1,537)	(1,537)	(1,537)

	2026/27 £000s	2027/28 £000s	2028/29 £000s	2029/30 £000s	Total £000s
Additional ASC Prevention Strategy - Absolute Values					
3 Year - **Invest to Save** - Time limited one-off revenue budget resources (proof of concept)	147	147	147	0	441
Total Additional Resources for ASC Prevention Strategy	147	147	147	0	441
Additional Demand Reduction Savings	0	(330)	(680)	(1,050)	(2,060)
Incremental Demand Reduction Savings (MTFP Format)	0	(330)	(350)	(370)	

18. Using best practice and tools that have been developed by other Local Authorities to measure the benefits of preventative services, we are working with our data analytics

and management information colleagues to create our own BCP Council bespoke benefits realisation methodology. This will evaluate both the financial impact and the broader societal value of preventative initiatives within the ASC Prevention Strategy. The tool will enable ongoing measurement of effectiveness and success, ensuring that the strategy delivers its intended outcomes and achieves the additional savings target.

Summary of legal implications

19. Under The Care Act (2014) and associated statutory guidance, the first two general duties placed on local authorities are to promote individual wellbeing and to prevent, reduce or delay the development of needs for care and support, for people and carers.

20. The strategy supports and encompasses the statutory duties placed on the local authority to people and carers living in Bournemouth, Christchurch and Poole.

Summary of human resources implications

21. To ensure the successful delivery of the Adult Social Care Prevention Strategy, it is essential that the senior commissioning officer for prevention and wellbeing post is extended beyond its current funding period, which ends on 30 April 2026 and is currently funded by transformation funding. Continued investment in this role will maintain the strategic capacity to implement the strategy and embed prevention across adult social care.

Summary of sustainability impact

22. A decision impact assessment report has been produced and is showing a positive impact on:

    - Communities and culture
    - Economy
    - Health and Wellbeing
    - Learning and Skills
    - Transport and Accessibility

Summary of public health implications

23. The Adult Social Care Prevention Strategy will improve the health and wellbeing of people living in Bournemouth, Christchurch and Poole. Priority 2 focuses on enabling people to live and age well and priority 3 supports individual resilience to build on wellbeing.

Summary of equality implications

24. An Equality Impact Assessment (EIA) screening tool was completed and reviewed by the EIA Panel.

25. The priorities of the Adult Social Care Prevention Strategy will have positive equality implications. Throughout its implementation, the experiences of people with different needs will continue to be considered to ensure that everyone can access preventative support to remain as independent as possible and live healthier happier lives.

Summary of risk assessment

26. A new risk assessment will be developed in the forthcoming months which will be linked to the Strategy implementation as any new risks will then be identified.

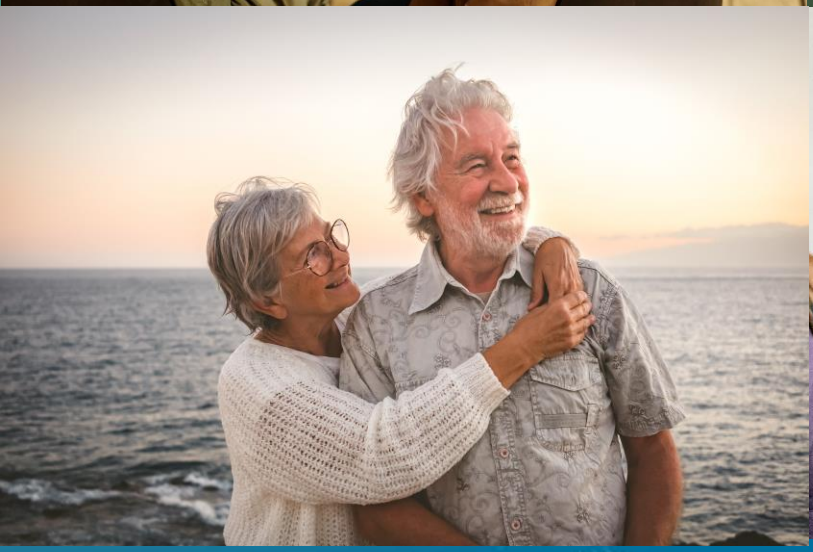
Background papers

None

Appendices

1. The Adult Social Care Prevention Strategy
2. The Adult Social Care Prevention Strategy Action Plan

Our Adult Social Care Prevention Strategy



2025-2030

Content

Foreword

As Interim Director of Adult Social Care Commissioning, I am proud to introduce our Adult Social Care Prevention Strategy for 2025–2030. This strategy marks a pivotal moment in our journey to embed prevention at the heart of everything we do, ensuring that people across Bournemouth, Christchurch and Poole can live healthier, happier, and more independent lives.

Prevention is not a single intervention, it is a mindset, a commitment to act early, to listen deeply, and to work collaboratively. It means recognising the strengths of individuals and communities and investing in the support that helps people thrive before crisis occurs. This strategy reflects that ethos, shaped by the voices of over 400 residents, carers, professionals and partners who shared their experiences and aspirations with us.

Adult Social Care Commissioning are deeply committed to delivering the ambitions set out in this strategy. It aligns with our wider commissioning principles and the Adult Social Care Strategy and will guide how we work with our partners the community and voluntary sector, health, and beyond. Together, we will build a system that is proactive, inclusive and person-centred.

I would like to thank everyone who contributed to this strategy. Your insights have helped us define what good looks like and how we will measure success. Prevention is everyone's business, and with this strategy, we take a bold step forward in making it a reality.

Zena Dighton
Interim Director of Adult Social Care Commissioning
BCP Council

Introduction

Preventative services delay, reduce or prevent the need for long term care and support, enabling people to stay healthier, happier, and independent for longer. This, in turn, reduces demand on health and adult social care services. Prevention is also more cost-effective than crisis management: the Department of Health & Social Care's 2018 paper "*Prevention is Better than Cure"* found that every £1 spent on prevention delivers around £14 in social value.

This strategy outlines BCP Council's plan to developing a sustainable preventative approach in adult social care. It emphasises early intervention, the promotion of wellbeing, and collaboration with key partners to not only prevent the development of long-term needs, but also to reduce health and social inequalities and enhance the overall quality of life for people living in Bournemouth, Christchurch, and Poole.

To shape this strategy, we actively engaged with residents and stakeholders to gather their valuable insights. Through a series of engagement events, we collaboratively developed the vision, areas of focus, and ambitions of the strategy.

Our collective definition of Prevention in Adult Social Care

Throughout our engagement, we asked local people, carers, communities and partners: 'What does Prevention mean to you?'. It was clear that everyone shared the same vision for a future where people can live happier, healthier and more independent lives. We combined over 400 responses to develop a shared definition of prevention:

"Prevention in adult social care means taking early, proactive steps to help people stay healthy, independent, and safe for as long as possible. It focuses on supporting wellbeing, reducing risks, and avoiding crises by providing timely information, practical support, and community-based services. By working together with individuals, carers, and partners, adult social care helps people make informed choices, stay connected, and live well at home, reducing the need for hospital stays or long-term /care."

This Prevention Strategy is a key component of BCP Council's broader vision, alligning with our Corporate Strategy and the Adult Social Care Strategy, by focusing on helping people and carers stay healthy and independent for longer. Throughout the delivery of our approach, we are committed to continue working closely with partners across public health, housing, the voluntary sector, the NHS, care providers, and local communities.

BCP Council's Corporate Strategy sets out the council's direction and vision to create a place "where people, nature, coast and towns come together in sustainable, safe and healthy communities" with two key priorities:

Our People and Communities: everyone leads a fulfilled life, maximising opportunity for all.

Our Place and Environment: vibrant places where people and nature flourish, with a thriving economy in a healthy, natural environment.

Putting people, carers and families first

We will listen and build good relationships with people, so we understand what matters to them.

Living in a place called home

We will help people to connect with their family, friends and community, in a place where they feel safe and at home.

Developing how we work.

We are creative and innovative with solutions and resources. We understand and measure the impact we are having.

BCP Council's Adult Social Care Strategy sets out our four-year plan to transform services, focusing on prevention and wellbeing.

Our Vision: Supporting people to achieve a fulfilled life, in the way that they choose, and in a place where they feel safe.

A fulfilled life looks different for everyone—whether it's living independently, building social connections, or accessing care. Our teams use a strength-based approach to understand what matters most to each person and how best to support them.

BCP Council has also signed up to the Social Care Future mission statement:

"We all want to live in the place we call home, with the people and things we love, in communities where we look out for each other, doing the things that matter to us."

This reflects our commitment to supporting people to live fulfilled lives. It aligns with our strategic priorities, shifting away from process-driven systems towards compassionate, strengths-based practice. The vision helps us focus on what truly matters to individuals: living in the place they call home, surrounded by what they love, and connected to their communities

National Context

Our Adult Social Care Prevention Strategy, influenced by national changes, applies to all adults. With an ageing population and rising disability rates, the UK must shift from reactive to proactive care to ensure sustainability and better outcomes for people, carers and communities

With people living longer, the 85+ population is set to grow by 75% in 20 years, and care demand for over-65s could rise by 80%. However, longer life often means living with complex conditions. Disability is also rising among working-age adults, and unpaid carers face growing pressures. Without a shift toward prevention, this trend is unsustainable for adult social care.

The Association of Directors of Adult Social Services (ADASS) Spring Survey 2025 found that in 2024/25, 80% of councils overspent on adult social care and most directors lack confidence in meeting legal duties for prevention and wellbeing.

£774m
Total overspend by councils on their adult social care budgets in 24/25

74%
of directors have partial or no confidence budgets are sufficient to meet legal duties for prevention and wellbeing.

The Local Government Association (LGA) report – "Earlier action and support: The case for prevention in adult social care and beyond" shows how investing in prevention is both ethical and cost-effective by highlighting that early support could save councils £3.17 for every £1 spent, with potential national savings of £7.6 billion.

The Care Act 2014 imposes a statutory duty on local authorities to promote wellbeing, prevent or reduce care needs, and offer clear information and support to adults and carers – ensuring care is fair, person-centred, and focused on helping people achieve what matters most to them

Prevention is better than cure (2018) focuses on promoting good health to reduce the need for intensive social care. By addressing root causes and promoting early intervention, it aims to keep people healthier for longer, reduce health inequalities, and use social care resources more effectively.

'Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention is as important at seventy years old as it is at age seven.'

Fit for the future: 10 Year Health Plan for England is part of the government's health mission to build a health service fit for the future. It sets out how the government will reinvent the NHS through 3 radical shifts:

- hospital to community
- analogue to digital
- sickness to prevention

Local and Strategic Context

The 3 Conversations and Fulfilled Lives programme

Since 2022, we've been using the 3 Conversations (3Cs) approach in adult social care, with support from Partners 4 Change, to shift from traditional care management to a more person-centred, strengths-based way of working.

3Cs seeks to enable us to think more preventatively and creatively in our work with people, focusing on building relationships, understanding what matters to people, and supporting them to live fulfilling lives – moving away from simply assessing for services – and aligning with our Care Act duties.

> *"The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life." – Care Act guidance 1.1*

Adult social care plays a key part in the **Dorset Integrated Care System (ICS)**, a partnership of health, care, and community organisations working together to improve wellbeing and outcomes across the region.

Integrated Neighbourhood Teams (INTs) in Dorset brings together professionals from health, adult social care, housing, and the voluntary sector to deliver joined-up, person-centred support in local communities. Their goal is to improve experiences and create a more equitable, integrated care system.

The FutureCare Programme aims to transform urgent and intermediate care in Dorset by 2027, creating a more integrated, people-centred system. It focuses on reducing unnecessary hospital admissions and helping people recover at home or in community care more quickly.

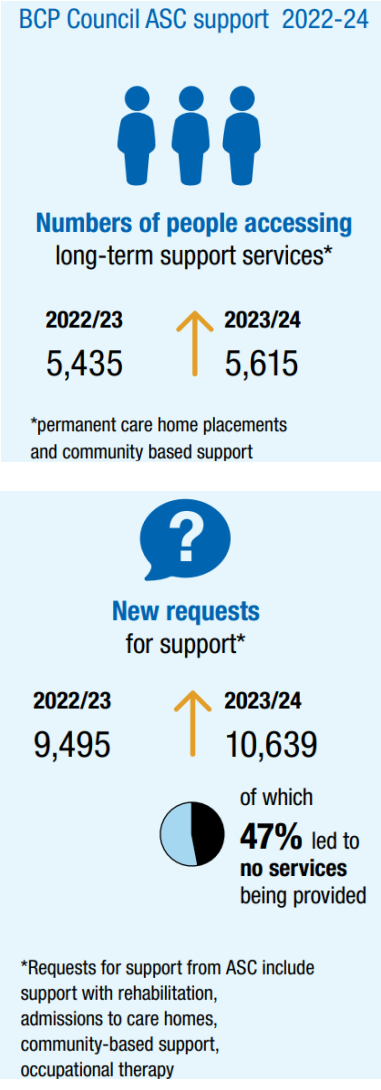
Our Population

Formed in April 2019 as part of Local Government Re-organisation, Bournemouth Christchurch and Poole Council is the tenth largest urban local authority. The area is home to just over 400,000 residents, which is predicted to grow to 403,600 by 2028. Alongside this growth, the area has one of the highest proportions of older people with high levels of care needs in the country and some of the most deprived areas, emphasising a need to prevent, reduce or delay the onset on long-term needs developing.

Overall, however, people living in Bournemouth, Christchurch and Poole generally live for longer than the national average. The area also has a strong and independent voluntary sector.

This strategy has been supported by data from various sources including the Dorset Insight and Intelligence Service (DiiS), the State of Ageing in Bournemouth, Christchurch and Poole (2024) report and BCP Council's Joint Strategic Needs Assessment (JSNA). These highlight key health and wellbeing priorities, such as health inequalities, economic inactivity, and mental health, guiding targeted strategic action.

- Life expectancy at birth is **83.5 years** for **females** and **79.4 years** for **men** in the BCP Council area, which is higher than the national average
- **1,315** people are registered as **blind** or **sight impaired**. Over **half** are **over 75** and **555** have an **additional disability**
- There are **2474** people with a **learning disability** and **3660 autistic people** in the BCP Council area
- **22%** of the population are **over 65** years old, **4% higher** than the **national average**
- There are **33,352** unpaid carers in BCP Council area, with **2.5%** of residents providing **50 hours or more** of care **per week**
- There are **1050 serving armed forces personnel** and **15,894 veterans**
- Over **80 languages** are spoken in the BCP Council area
- Around **12%** of BCP Council residents say they **feel isolated**
- There is a projected increase of **17%** of people living alone in the BCP Council area by **2043**
- Admissions to hospital for **alcohol related conditions** are **higher in BCP (890 per 100,000 population)** compared to England **(626 per 100,000)**
- The BCP Council area has **657 registered charities** and over **2,600 Voluntary and Community Sector** groups



Introducing our Priorities for Prevention

"All of these priorities are important areas. Some areas already having strong development work in progress which will be a benefit. This is a strong strategic approach that will complement, support and further strengthen what is already happening across Adult Social Care" – VCSE Member

Priority 1: A change in culture

Focus Area	Objective
Strengths based and Holistic approaches	Leverage the skills and talents of individuals and communities to promote independence, resilience and sustainable positive outcomes.
Equality and Diversity	Promote equal opportunities to create a more inclusive and supportive environment for all individuals.
Co-production	Support the implementation of BCP Adult Social Care's Co-production Strategy and create opportunities for people to support the development of preventative initiatives.
Language and listening	Foster a more inclusive and supportive environment by using empowering language and addressing key issues that create barriers in access.

Priority 2: Living and ageing well

Focus Area	Objective
Falls Prevention, strength and balance	Reduce the risk of falls and improve physical health and independence among older people and adults with physical conditions and mobility limitations through targeted interventions.
Better physical health	Promote physical activity in adult social care to improve health and wellbeing.
Financial stability and security	Work alongside our Communities Team and partners to ensure adults and families have access to financial assistance and advice to maintain a dignified standard of living.
Age friendly communities	Continue to work in partnership with the Age Friendly Network to support the development of Age Friendly Communities across Bournemouth, Christchurch and Poole.

Priority 3: Individual resilience to build wellbeing

Focus Area	Objective
Information, advice, guidance and self-education	Empower individuals and the provider market to prevent, delay or reduce the need for long-term care by providing accessible, timely, and inclusive information, advice, and self-education resources that promote healthy behaviours, early intervention, and informed decision-making.
Supporting people with sight and/or hearing loss and impairment	To promote independence, inclusion, and wellbeing for individuals with sight and/or hearing impairments by ensuring timely access to preventative support, accessible services, and inclusive community opportunities.
Hoarding and self-neglect	Work with partners to identify and co-ordinate multi-agency approaches to identify, engage, and support individuals who hoard or self-neglect, reducing risk and promoting safety, wellbeing, and independence.
Self-funders and people on the cusp of eligibility	Enhance support for self-funders and individuals near the eligibility threshold by improving access to information, advice, and community resources that promote independence, financial resilience, and wellbeing.
Supporting Carers	Strengthen early identification and support for unpaid carers by improving access to information, advice, direct payments and wellbeing services, enabling them to maintain their caring role, avoid crisis, and live well alongside caring.
Occupational Therapy and Care Technology	Promote independence and prevent the escalation of care needs by expanding access to Occupational Therapy and Care Technology that supports daily living, enhances safety, and empowers individuals to manage their health and wellbeing at home.

Priority 4: Supporting the workforce

Focus Area	Objective
Workforce wellbeing	To strengthen workforce wellbeing in adult social care, ensuring a resilient, motivated, and high-performing workforce capable of delivering preventative, high-quality support.
Staff development and training	Empower the adult social care workforce through accessible, high-quality learning and development opportunities that embed preventative approaches and promote continuous improvement.
Leadership commitment	Cultivate strong, compassionate leadership that prioritises workforce wellbeing, fosters a culture of continuous learning, and drives the delivery of preventative, person-centred support.
First, think prevention	Embed a prevention-first mindset across the adult social care workforce by strengthening access to community-based knowledge, training, and leadership support that empowers practitioners to act early and innovatively.
Integration, collaboration and communication	To strengthen workforce capacity for prevention by fostering integrated, collaborative, and communicative partnerships across health, social care, and community sectors.

Priority 5: Connecting Communities

Focus Area	Objective
Connection and a sense of belonging	Strengthen community cohesion and social connectedness to reduce loneliness and isolation, enhance mental and physical wellbeing, and build resilient, inclusive communities
Addressing health and social inequalities	To reduce health and social inequalities by strengthening community connections, improving access to inclusive and person-centred care, and building trust with underserved groups - ensuring that all individuals, regardless of background or circumstance, can access the support they need to live healthier, more independent lives.
Community first	Enable people to live independently at home for longer by prioritising community-based, person-centred support to reduce avoidable admissions, delayed discharges, and reliance on long-term residential care through integrated, localised, and accessible services
Safety and security	Promote safer, more secure communities by raising awareness of personal and digital safety, strengthening partnerships with key stakeholders, and empowering residents to maintain their safety and security through community-led safety initiatives.
Supporting the voluntary and community sector	Support and strengthen the sustainability, diversity, and capacity of the voluntary, community, and social enterprise (VCSE) sector by embedding supportive commissioning practices and promoting collaborative relationships - ensuring the sector can thrive as a key partner in prevention and wellbeing.

Strategy Coproduction and Engagement

From November 2024 to May 2025, we engaged with residents, carers, professionals, and partners to shape this strategy. By exploring prevention from multiple perspectives, we gained valuable insights into people's experiences and the vital role of communities, the VCSE sector, and care teams in preventing and reducing long-term support needs.

We produced a series of surveys and offered 1-1 support and easy read copies, to hear the experiences and views of local communities, residents, carers, workforces and local organisations that support people to live well.

We attended various events and held in depth discussions to share our vision which enabled us to identify gaps and opportunities and gain valuable feedback.

Our ASC multi-partner prevention event

On 23 May 2025, we celebrated our first ASC multi-partner engagement event that brought together 113 key partners and stakeholders to collaboratively shape our ASC Prevention Strategy. On the day, 17 stall holders joined us to share the work they do, and we heard insights from Public Health and the Fulfilled lives programme. We also celebrated best practice in engaging ways and hosted table-top and open space workshops to explore key questions about prevention and our priorities.

The event gave us the opportunity to share the priorities and areas of focus we have identified throughout our engagement, and we have received strong support for our vision.

- 95% agreed or strongly agreed with the priority: A change in culture
- 96% agreed or strongly agreed with the priority: Individual resilience to build wellbeing
- 96% agreed or strongly agreed with the priority: Living and ageing well
- 100% agreed or strongly agreed with the priority: Supporting the workforce
- 100% agreed or strongly agreed with the priority: Connecting communities

Comments we received about our approach included:

"Looks a great strategy and priorities. Looking forward to working with you on it"

"Fabulous aspirational approach."

"I think it's hugely positive and moving in the right direction, maybe it's also about giving people the tools to swim…rather than rescue them."

"All important areas. Some areas already having strong development work in progress, which will hopefully benefit from a strong strategy"

Positive responses on the event with strong support for more like this:

"Fantastic event, great workshops and networking opportunities. Thank you."

"Perfect length of event, kept me captivated throughout, more should be like this"

180 responses to our combined surveys

Met with over 30 VCSE organisations and community groups

Gave over 30 talks and presentations at events, team meetings and conferences

A combination of over 400 attendees from various events

113 attendees at our Multi-Partner Prevention event

Measures of success

What does good look like?

INCREASE
The proportion of adults who say they find it easy to access information and advice

INCREASE
The proportion of people who report they have as much social contact as they would like

INCREASE
The number of people offered care technology

INCREASE
The proportion of people who use services who say those services have made them feel safe and secure

INCREASE
The proportion of new clients who receive short term support to maintain their independence, develop skills and continue living at home for longer.

INCREASE
Engagement and partnership working with the VCSE sector, health and other partners

INCREASE
Co-production with local people, carers and communities from all backgrounds

INCREASE
The overall satisfaction of people and carers with social services

INCREASE
The proportion of people who feel their health and wellbeing has improved because of the support from preventative services

INCREASE
The awareness of community resources and services that can support people

INCREASE
Investment into preventative services and interventions

INCREASE
Workforce confidence and satisfaction in their roles and ASC culture

INCREASE
Awareness and confidence from people in underserved groups, to find and use local services and support that meet their individual needs

REDUCE
The proportion of people referred to LTC locality teams for a care act assessment

REDUCE
The spend on long-term traditional services

From strategy to action

What will we do?

2025-26

Celebrate success by recognising the achievement of preventative outcomes through ‘our stories of difference’.

Create focus groups with local people, carers, and stakeholders to co-produce preventative interventions and form a strategic steering group to monitor preventative outcomes.

Support the Age Friendly Network to align initiatives with the WHO Age Friendly Communities Framework.

2026-27

Create a framework for measuring preventative outcomes consistently

Raise awareness of support for people who hoard or self-neglect to reduce stigma and work with cross sector partners to identify opportunities.

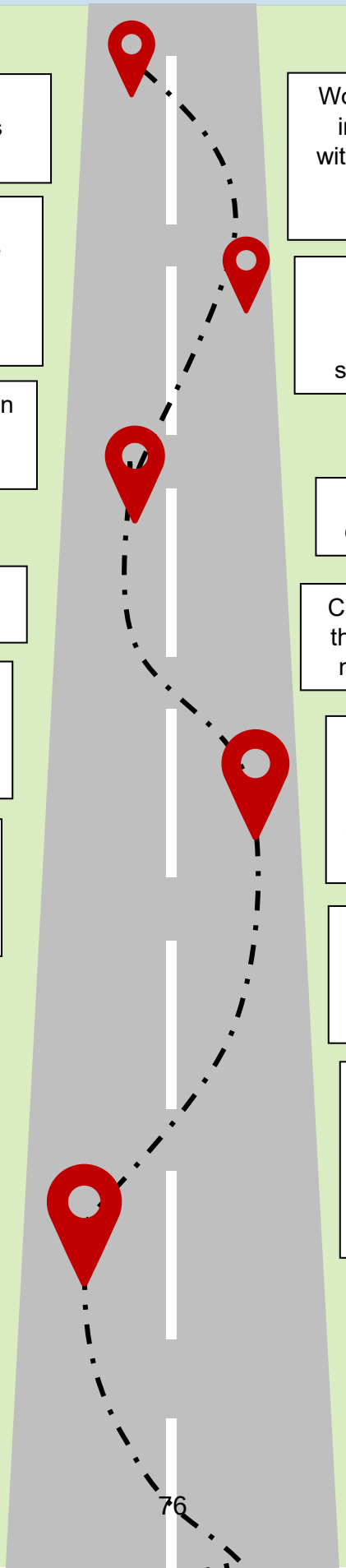
Enhance workforce and public knowledge of community assets through joint campaigns, awareness raising and regular prevention updates.

Use the ASC Research Champions network and work with partners to identify research opportunities and funding.

Collaborate with ongoing preventative programmes and projects, such as Integrated Neighbourhood Teams

Partner with public health, communities and housing teams to ensure consistent messaging and raise public awareness

Promote information, advice, and self-education through targeted campaigns in various formats, using relatable and empowering language



2027-28

Work with partners and the local market to increase opportunities for peer support within communities and tackle barriers that prevent people from accessing their communities (i.e. Transport)

Boost ASC workforce knowledge of community assets by developing a prevention area on our ASC Intranet, sharing resources and hosting webinars

2028-29

Utilise data to identify at risk adults and collaboratively provide targeted support.

Create connect and collaborate forums for the ASC workforce and VCSE Partners to network, collaborate and share learning.

Review the information, advice and guidance provided to self-funders to ensure people have access to clear and effective resources to help them manage their own care and support.

Work with our learning and development team to identify learning opportunities for the workforce as well as the VCSE, provider market and communities.

Embed Occupational Therapy and Care Technology into early intervention pathways and equip staff, individuals, carers and communities with the knowledge and tools to use these services confidently and effectively.

2029-30

Collaborate with communities and local markets to enhance local assets for wellbeing, offering alternatives to traditional care services like micro-enterprises

From strategy to action

What outcomes do we want to achieve?

People stay at home safely for longer and have access to home adaptions, small works, reablement and care technology

Unpaid carers feel recognised and are supported to take a break from their caring role

Relationship focussed wellbeing support is available to prevent hospital admissions and support safe discharges

Professionals have the tools to connect people to community support and can collaborate effectively with partners

People with sight and/or hearing loss are connected to community services and offered solutions that can support them to live fulfilled lives

People at a higher risk of loneliness and isolation are identified and connected back into their communities

People can regain, build, and maintain skills to stay independent for longer with less support from, or without the need for, long term services

People at a greater risk of addiction are identified in communities, hospitals and primary care and are connected to specialist and community support

Peer support networks and long-term relationship-focussed support is available for people who hoard or self-neglect to reduce risk, prevent hospital admission, support safe discharge and enable people to stay at home for longer.

Our ASC Prevention Strategy will be supported by a robust action plan to monitor, track and measure progress in our focus areas.

It will detail how each service area prioritises prevention and ensures consistent outcome reporting, allowing us to track changes over time

The action plan will also clarify the roles of different professionals, departments, and programmes and how they link in with Adult Social Care, reinforcing the ethos that 'prevention is everyone's business'

With thanks…

Prevention is everybody's business, and we recognise that prevention cannot be delivered in isolation. Successful delivery of this strategy will only be achieved through collaborative working to provide a joined-up approach for our residents and communities across Bournemouth, Christchurch and Poole.

In developing this strategy, we have shared our aspirations with many key stakeholders to understand their thoughts and hear their feedback. This has helped shape our areas of focus which we feel will have the greatest impact and improve outcomes for local people, carers and communities.

Throughout the implementation of this strategy, we are committed to continue working in equal partnership with our partners and local residents to ensure their voices are central to everything we do.

We would therefore like to extend our thanks everyone who has contributed, supported and acted as a critical friend in the development of this strategy.

We hope you find the Adult Social Care Prevention Strategy useful, interesting and informative and would welcome and questions or comments that you may have.

We would also be interested to hear about your experience of services or what you would like to see improved.

To let us know e-mail comments.adultsocialcare@bcpcouncil.gov.uk

ASC Prevention Strategy Action Plan

Key	New action
	Strengthening current practices
	Finer detail

Priority 1: A change in culture action plan				
Focus Area & Objective	**Action**	**Start**	**Outcomes**	**Measures**
Strengths-based and holistic approaches Leverage the skills and talents of individuals and communities to foster independence, resilience and sustainable positive outcomes.	Support the implementation of the 3 Conversations model across Adult Social Care and approaches that consider the whole person, focusing on individuals' abilities, resources, and potential. Increase awareness of preventative services for practitioners by: Creating an ASC Intranet Prevention Page Sharing blogs and good news stories from preventative services through the ASC news pages Holding quarterly connect and collaborate forums with the VCSE sector and ASC colleagues to share details of commissioning updates, funding opportunities and showcase stories of difference Hosting 2 x yearly webinars that educate practitioners about preventative interventions and services	2025 2026 2025 2026 2026	Reduce the proportion of people referred to LTC locality teams for a care act assessment	ASC intranet prevention page live and available to all ASC practitioners Number of page hits on the ASC intranet prevention page Number of views of preventative news updates and blogs Connect and collaborate forums running on a quarterly basis Attendance rates and repeat participation at quarterly connect and collaborate forums Feedback from attendees at connect and collaborate forums via survey to measure the effectiveness of communication and understanding of services available Attendance rates at prevention webinars Feedback from attendees at prevention webinars via survey to measure their awareness and confidence in using preventative services

ASC Prevention Strategy Action Plan

Equality and diversity Promote equal opportunities to create a more inclusive and supportive environment for all individuals	Ensure service specifications and tenders outline how our commissioned services are flexible, personalised and adapt to individual needs and preferences Regularly monitor Equality, Diversity and Inclusion (EDI) data within our commissioned services through quarterly monitoring meetings. Collaborate with VCSE services that are connected to underserved communities by attending existing meetings and events. The aim will be to raise awareness of available services, listen to people's experiences and perspectives, and identify any barriers they face in accessing support. Raise awareness of forums and co-production groups within underserved communities to increase diversity of membership through targeted campaigns and attendance at existing meetings and events.	2025 2025 2026 2026	Increase awareness and confidence among people, especially those from underserved groups, in finding and using local services and support that meet their individual needs	Quarterly monitoring reports from commissioned services, including EDI data, case studies and evidence of how they are flexible, personalised and adapt to individual needs and preferences Number of meetings and events attended with underserved communities Number of people reporting increased awareness of and trust in services via survey after engagement Number of people reporting they feel more confident in accessing services via survey after engagement Increased diversity of membership of forums and co-production groups
Co-production Support the implementation of BCP Adult Social Care's Co-production Strategy and create opportunities for people to support	Create focus groups with local people, carers, and stakeholders to co-produce preventative interventions and form a strategic steering group to monitor preventative outcomes. Promote co-production opportunities through our networks and channels (ASC Your Voice forum, PIER Network, Age friendly network, People First Forum etc) to	2025 2026	Increase co-production with local people, carers and communities from all backgrounds	Number of focus group meetings held annually Attendance rates at focus group meetings Number of Prevention Strategic Steering Group meetings

the development of preventative initiatives.	ensure everyone has an equal opportunity to be involved.			Membership of the Prevention Strategic Steering Group Number of co-production opportunities created and promoted People attending groups and forums reporting that they feel their views were listened to in surveys following engagement People attending groups and forums reporting that they feel included in shaping services in surveys following engagement
The language we use and how we listen Foster a more inclusive and supportive environment by using empowering language and addressing key issues that create barriers for individuals accessing services	Promote information, advice, and self-education through targeted campaigns in various formats, using relatable and empowering language Raise awareness of health literacy through the ASC intranet news page, the connect and collaborate forums with the VCSE sector and ASC colleagues, and the Prevention webinars.	2027 2026	Increase the overall satisfaction of people and carers with social services	Number of targeted campaigns promoted through ASC intranet news page, the connect and collaborate forums with the VCSE sector and ASC colleagues and the Prevention webinars. Number of people reached through campaigns, events, and digital platforms

ASC Prevention Strategy Action Plan

Priority 2: Living and ageing well action plan				
Focus Area and Objective	**Actions**	**Start**	**Outcome**	**Measures**
Falls prevention, strength and balance Reduce the risk of falls and improve the physical health and independence among older adults and adults with physical conditions and mobility limitations through targeted interventions.	Link in with falls prevention programmes across BCP and relevant sectors and share knowledge with ASC practitioners (Communities, public health, health, VCSE etc) Promote self-help mechanisms specifically designed to prevent falls, including balance and stability exercises and raise awareness about the benefits of falls prevention and strength training through: • System and partner networks • News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars. Work with partners to identify innovative solutions for preventing falls, such as Bournemouth University research project – DIALOR – with Help and Care Continue to commission a community Handyvan service that reduces the risk of falls by providing small household jobs and repairs that enable people to live safely in their own homes for longer Utilise care technology, reablement, occupational therapy and housing	2028 2026 2027 2026 2025	Increase the proportion of people who feel their health and wellbeing has improved because of the support from preventative services	Number of falls prevention programmes identified and shared with ASC practitioners Number of people presenting at A&E after a fall Number of views on falls prevention related information pages for both the ASC Intranet Prevention page and VCSE Prevention information hub Number of people supported through: • Care technology • Reablement • Occupational Therapy • Lifeline • Equipment services • Housing adaptions Quarterly contract monitoring reports showing case studies relating to falls prevention Proportion of people who respond to the ASCOF survey to say services have made them feel safe and secure

	adaptions in innovative ways to reduce the risk of falls			
Better physical health Promote physical activity in adult social care to improve health and wellbeing.	Work with the VCSE sector and internal departments and teams to identify, support and promote physical health programmes across BCP and relevant sectors (Communities, public health, health, VCSE etc) through: • System and partner networks • News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars.	2027	Increase the proportion of people who feel their health and wellbeing has improved because of the support from preventative services	Quarterly monitoring reports of commissioned preventative services showing that people feel their health and wellbeing has improved because of the support Number of physical health programmes identified and shared Number of views on physical health related promotion on the ASC Intranet prevention pages and the VCSE Prevention information hub
Financial stability and security To work alongside our Communities Team and partners to ensure adults and families have access to financial assistance and advice and maintain a dignified standard of living.	Utilise data to identify at risk adults and collaboratively provide targeted support. Continue to collaborate with stakeholders and monitor the prevalence of older adults who are financially vulnerable through the DiiS system partnership group. Work with the Communities team to promote information, advice and guidance to support people who may be struggling financially through: • System and partner networks • News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues	2028 2025 2028	Increase the awareness of community resources and services that can support people	Number of DiiS financially vulnerable pensioners working group meetings Number of views of cost-of-living support pages on the ASC intranet

	• Prevention webinars.			
Age friendly communities Continue to work in partnership with the Age Friendly Network to support the development of Age Friendly Communities across Bournemouth, Christchurch and Poole.	Support the Age Friendly Network to align initiatives with the WHO Age Friendly Communities Framework by: Attendance at Age Friendly Steering Group Meetings and Age Friendly Forums and feedback at team meetings Aligning initiatives through collaborative projects that achieve mutual aims. Promoting Age Friendly updates and training opportunities through the ASC Intranet page and VCSE prevention information hub.	2025 2025 2025 2026	Increase engagement and partnership working with the VCSE sector, health and other partners Increase the proportion of people who report they have as much social contact as they would like	Number of Age Friendly steering group meetings attended Number of Age friendly Forums attended Number of joint projects and initiatives ASC Attendance at age friendly training Proportion of people who respond to the ASCOF survey to say they have as much social contact as they would like
Priority 3: Individual resilience to build wellbeing action plan				
Focus Area and Objective	**Actions**	**Start**	**Outcome**	**Measures**
Information, advice, guidance and self-education Empower individuals and the provider market to prevent or delay the onset of long-term conditions by providing accessible, timely, and inclusive	Promote information, advice, and self-education through targeted campaigns in various formats, using relatable and empowering language Partner with public health, communities and housing teams to ensure consistent messaging and raise public awareness Utilise both physical and digital platforms and social media to reach wider audiences with preventative messages, services and opportunities for self-education, and work	2027 2026 2025	Increase the awareness of community resources and services that can support people	Proportion of people who use services responding to the ASCOF survey to say they find it easy to find information about services Proportion of carers who respond to the ASCOF survey to say they find it easy to find information about services

information, advice, and self-education resources that promote healthy behaviours, early intervention, and informed decision-making.	with partner organisations that specialise in these areas, such as our commissioned service providers, LiveWell Dorset and ICS partners. Support the integration of the ASC directory into CAN's Service Finder database to develop a shared dataset of local assets, services, and support networks.	2026		Number of people reporting increased awareness of, and trust in, services via survey after engagement Number of people reached through campaigns, events and digital platforms Successful integration of the ASC directory with the CAN Service Finder
Supporting people with sight and/or hearing loss and impairment To promote independence, inclusion, and wellbeing for individuals with sight and/or hearing impairments by ensuring timely access to preventative support, accessible services, and inclusive community opportunities.	Provide tailored preventative support, such as assistive technology, skills training, and community navigation by: • Implementing the innovation phase of the care technology transformation • Commissioning a service that offers community navigation support and training for people with sight and/or hearing loss and impairment and access to resources. Raise awareness and understanding among staff and the public to reduce stigma and promote inclusion through: • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars. Ensure commissioned services are accessible, including physical spaces, communication formats, and digital platforms by monitoring efforts to improve	2025 2027 2025	Increase the proportion of people who feel their health and wellbeing has improved because of the support from preventative services	Number of people supported by the sight and hearing team annually Quarterly monitoring reports from the service that provides community navigation, training, and resources for individuals with sight and/or hearing loss or impairment, highlighting impact through case studies and people's feedback and the number of people supported Quarterly monitoring reports from preventative commissioned services, including case studies and evidence of how they are accessible, personalised and adapt to individual needs and preferences

	accessibility through quarterly monitoring meetings.			
Hoarding and Self-Neglect Work with partners to identify and co-ordinate multi-agency approaches to identify, engage, and support individuals who hoard or self-neglect, reducing risk and promoting safety, wellbeing, and independence.	Raise awareness of support for people who hoard or self-neglect to reduce stigma and work with cross sector partners to identify opportunities Conduct a needs analysis for people that hoard or self-neglect to determine whether there is a gap in provision that needs to be met Collaboratively identify practices and evidence-based approaches, explore opportunities, review policies and procedures across services and promote a consistent, joined-up response with a multidisciplinary working group. Support practitioners and partner sector workforces to gain a better understanding of identifying and supporting those who hoard or self-neglect by promoting training and guidance through: • System and partner networks • ASC News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars.	2026 2026 2026 2028	Increase the proportion of people who feel their health and wellbeing has improved because of the support from preventative services	Number of ASC practitioners hoarding drop ins held annually Attendance at ASC practitioner hoarding drop ins Needs analysis completed to determine if there is a gap in service provision that needs to be met Number of views on the hoarding support pages and guidance on the ASC intranet and VCSE Prevention Information Hub

ASC Prevention Strategy Action Plan

Self-Funders and people on the cusp of eligibility Enhance support for self-funders and individuals near the eligibility threshold by improving access to information, advice, and community resources that promote independence, financial resilience, and wellbeing.	Review the information, advice and guidance provided to self-funders to ensure people have access to clear and effective resources to help them manage their own care and support. Collaborate with independent living advisors, system partners and the VCSE Sector to identify and explore opportunities to support self-funders at the connect and collaborate forums Provide clear and consistent information and advice to guide self-funders on the BCP Council webpages Work with partners to review research on self funders and those with reducing assets to inform a more timely and preventative approach	2028 2027 2027 2025	Increase the proportion of adults who say they find it easy to access information and advice	Number of people supported by independent living advisors Number of views on public facing information pages for self-funders Proportion of people and carers responding to the ASCOF survey to say they find it easy to find information about services
Supporting carers Strengthen early identification and support for unpaid carers by improving access to information, advice, and wellbeing services—enabling them to maintain their caring role, avoid crisis, and live well alongside caring.	Implement the BCP Carers Strategy 2022-2027 and support the implementation of the Pan Dorset Carers Vision – Together with Carers Supporting Carers Week and Carers Rights Day campaigns through co-producing campaigns and events with carers and partners Attendance and involvement in the Dorset Carers Partnership Group and Pan Dorset Carers Steering Group Jointly raising awareness of preventative carers services through:	2025 2025 2025 2027	Increase the overall satisfaction of people and carers with social services	Number of carers identified by the BCP Carers Support Service Attendance rates and repeat participation at the Dorset Carers Partnership Group meetings Attendance rates and repeat participation at the Pan Dorset Carers Steering Group meetings Proportion of carers responding to the ASCOF survey to say they are satisfied with social services

	• System and partner networks • News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars.			Proportion of carers responding to the ASCOF survey to say they find it easy to find information about services
Occupational therapy and care technology Promote independence and prevent the escalation of care needs by expanding access to Occupational Therapy and Care Technology that supports daily living, enhances safety, and empowers individuals to manage their health and wellbeing at home.	Embed Occupational Therapy and Care Technology into early intervention pathways and equip staff, individuals, carers and communities with the knowledge and tools to use these services confidently and effectively. Collaborate with Occupational Therapy teams by attending OT colleague events and the ASC Research Champions network meetings and feedback in team meetings Use data and lived experience to evaluate impact of occupational therapy and care technology, and share stories of difference Implement the innovation phase of the care technology transformation to increase pathways into the service and support more people to access it	2029 2026 2026 2026	Increase in number of people offered care technology Increase the proportion of new clients who receive short term support to maintain their independence, develop skills and continue living at home for longer.	Number of visits to the ASC intranet Care Technology Information Hub Number of referrals to the care technology service from different teams Number of people supported through Occupational Therapy Case studies showing the impact and outcomes for people who have used care technology or who have received occupational therapy Evidence the impact of care technology in delaying, reducing or preventing long-term care and support needs via PowerBI reporting

ASC Prevention Strategy Action Plan

Priority 4: Supporting the workforce action plan				
Focus Area and objective	**Objective and actions**	**Start**	**Outcome**	**Measures**
Workforce wellbeing To strengthen workforce wellbeing in adult social care to ensure a resilient, motivated, and high-performing workforce capable of delivering preventative, high-quality care.	Enhance workforce and public knowledge of community assets through joint campaigns, awareness raising and regular prevention updates Celebrate success by recognising the achievement of preventative outcomes through 'Our Stories of Difference'. Improve internal communication channels to the ASC workforce related to wellbeing by: • Sharing regular news updates and blogs • Hosting commissioning drop-in sessions • Hosting connect and collaborate forums • Hosting prevention webinars Promote Cross-Team Collaboration and encourage inter-team projects through connect and collaborate forums and commissioning drop ins to build relationships and reduce silos. Create or strengthen staff-led wellbeing and interest groups (e.g., carers network, mental health champions) Work with the Staff Involvement Group (SIG) to listen and respond to feedback	2026 2026 2026 2026 2025 2026	Increase workforce confidence and satisfaction in their roles and ASC culture	Attendance rates and repeat participation at quarterly connect and collaborate forums Feedback from attendees at connect and collaborate forums via survey to measure their awareness of community assets Attendance rates and repeat participation at the monthly commissioning drop-in sessions Feedback from the ASC Workforce on the ASC Intranet prevention page Number of visits to the ASC Intranet Prevention Page ASC Colleagues reporting they are aware of preventative services via annual workforce survey Number of submitted 'stories of difference' relating to preventative outcomes Number of staff-led wellbeing and interest groups Number of SIG Meetings held annually

	and engage staff in co-designing service improvements			
Staff development and training Empower the adult social care workforce through accessible, high-quality learning and development opportunities that embed preventative approaches and promote continuous improvement in care delivery.	Work with our learning and development team to identify learning opportunities for the workforce as well as the VCSE, provider market and communities. Equip practitioners with tools and frameworks to identify early signs of need (case studies and scenario-based learning) that highlight early intervention as part of the 3 Conversations Model roll out Attend the ASC Research champions network to encourage experimentation with new evidence-approaches and grow research capacity by encouraging more people to become ASC Research Champions Encourage staff to explore personal and professional development courses, including those focussed on staff wellbeing, prevention and early intervention through: • System and partner networks • News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars.	2028 2025 2028 2026	Increase the awareness of community resources and services that can support people Increase workforce confidence and satisfaction in their roles and ASC culture	ASC Colleagues reporting they have access to learning opportunities via annual workforce survey Number of ASC Research champion meetings held annually and membership of the ASC Research Champions Network Stories of difference, and good news articles highlighting innovation Number of staff accessing optional learning and development opportunities

ASC Prevention Strategy Action Plan

Leadership commitment To cultivate strong, compassionate leadership that prioritises workforce wellbeing, fosters a culture of continuous learning, and drives the delivery of preventative, person-centred care.	Create a framework for measuring preventative outcomes consistently Use the ASC Research Champions network and work with partners to identify research opportunities and funding. Strengthen place-based and cross-sector collaboration by continuing to have regular meetings with health, housing, voluntary sector, and community groups Empower leaders to build cross-sector relationships and champion holistic prevention by embedding it into strategic and commissioning priorities, collaborative forums, and everyday decision-making	2027 2026 2026 2025	Increase investment into preventative services and interventions Reduce the spend on long-term traditional services	A long-term budget in place for preventative services The creation of a framework for measuring preventative outcomes Number of ASC Research champion meetings held annually and membership of the ASC Research Champions Network Staff have an awareness and understanding of our collective definition of prevention via feedback after engagement ASC Colleagues reporting they are aware of preventative services via feedback after engagement Number of commissioned services that prevent, reduce or delay the need for long term care and support
First, think PREVENTION To embed a prevention-first mindset across the adult social care workforce by strengthening access to community-based	Boost ASC workforce knowledge of community assets by developing a prevention area on our ASC Intranet, sharing resources and hosting webinars Enhance workforce and public knowledge of community assets through joint campaigns, awareness raising and regular prevention updates	2027 2026 2026	Increase the proportion of new clients who receive short term services to maintain their independence, develop skills and continue living at home for longer. Reduce the proportion of people referred to LTC locality teams for a care act assessment	ASC intranet prevention page live and available to all ASC practitioners Number of visits to the ASC Intranet Prevention page Attendance rates and repeat participation at quarterly connect and collaborate forums Feedback from attendees at connect and collaborate forums via survey to

knowledge, training, and leadership support that empowers practitioners to act early and innovatively.	Gather and use feedback, case studies, and data to promote preventative practices through: • News updates • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars.			measure their awareness of community assets ASC colleagues reporting they are aware of preventative services via feedback after engagement Number of people reached through campaigns, events, and digital platforms
Integration, collaboration and communication To strengthen workforce capacity for prevention by fostering integrated, collaborative, and communicative partnerships across health, social care, and community sectors.	Create connect and collaborate forums for the ASC workforce and VCSE Partners to network, collaborate and share learning. Identify and collaborate with ongoing preventative programmes and projects, such as Integrated Neighbourhood Teams Boost ASC workforce knowledge of community assets by developing a prevention area on our ASC Intranet, sharing resources and hosting webinars in partnership with stakeholders Raise awareness of roles and services that bridge sectors (e.g. link workers, community connectors) through: • The ASC Intranet Prevention page • The VCSE Prevention Information hub • connect and collaborate forums with the VCSE sector and ASC colleagues • Prevention webinars.	2028 2026 2027 2028	Increase engagement and partnership working with the VCSE sector, health and other partners	The creation of quarterly connect and collaborate forums for the ASC workforce and VCSE Partners. Attendance rates and repeat participation at quarterly connect and collaborate forums Feedback from attendees at connect and collaborate forums via survey to measure the effectiveness of how well they support collaboration, communication, and shared understanding of commissioning priorities Number of preventative programmes the Prevention Steering Group are engaged with (representative attendance) Feedback from the ASC Workforce on the ASC Intranet prevention page via survey

	Use feedback, case studies, and data to assess the effectiveness of integrated approaches and share learning across teams and partners to drive continuous improvement	2025		Number of visits to the ASC Intranet Prevention Page Stories of Difference relating to integrated working and joint commissioning
Priority 5: Connecting communities action plan				
Focus Area	**Objective and actions**	**Start**	**Outcomes**	**Measures**
Connection and a sense of belonging Strengthen community cohesion and social connectedness to reduce loneliness and isolation, enhance mental and physical wellbeing, and build resilient, inclusive communities	Promote co-produced local groups, peer support circles, interest-based clubs, community events and intergenerational activities that build trust and shared identity. Hold quarterly connect and collaborate forums with the VCSE sector and ASC colleagues to showcase stories of difference and promote community services Collaborative with organisations and networks to reach groups at a higher risk of loneliness (e.g. carers, young adults, LGBTQ+ individuals, older people) and provide targeted outreach to promote awareness of services Commission services that support people at a higher risk of loneliness and isolation and connect them back into their communities	2027 2027 2027 2026	Increase the proportion of people who report they have as much social contact as they would like	Proportion of people who respond to the ASCOF survey to say they have as much social contact as they would like Number of meetings and events attended with groups at a higher risk of loneliness Quarterly monitoring reports from commissioned services including case studies and feedback about how people have been supported to connect back into their communities

ASC Prevention Strategy Action Plan

Community first Enable people to live independently at home for longer by prioritising community-based, person-centred support following hospital discharge—reducing avoidable admissions, delayed discharges, and reliance on long-term residential care through integrated, localised, and accessible services.	Work with partners and the local market to increase opportunities for peer support within communities and tackle barriers that prevent people from accessing their communities (i.e. Transport) Embed Occupational Therapy and Care Technology into early intervention pathways and equip staff, individuals, carers and communities with the knowledge and tools to use these services confidently and effectively Collaborate with communities and local markets to enhance local assets for wellbeing, offering alternatives to traditional care services like micro-enterprises Support the integration of the ASC directory into CAN's Service Finder database to develop a shared dataset of local assets, services, and support networks. Commission services that connect people into community support following hospital discharge and to prevent hospital admission Commission community services that reduce the risk of hospital admission by enabling people to live safely in their own homes for longer and reduce the risk of falls	2027 2029 2029 2026 2026 2026	Increase the awareness of community resources and services that can support people	Number of referrals made by hospital staff into the Care Technology service Successful integration of the ASC directory with the CAN Service Finder Quarterly contract monitoring reports from commissioned services detailing outcomes that show a reduced risk of admission to hospital Quarterly contract monitoring reports from commissioned services detailing outcomes that facilitate discharge from hospital

	Create a referral pathway into the Care Technology service for hospital staff	2026		
Safety and security Promote safer, more secure communities by raising awareness of personal and digital safety, strengthening partnerships with key stakeholders, and empowering residents to maintain their safety and security through community-led safety initiatives.	Collaborate and strengthen links with the BCP Safeguarding Adults Board and key partners such as Dorset Police, BCP Safer Communities, health, housing, communities team and voluntary and private sector organisations. Promote, raise awareness and support personal and digital safety alerts, community-led safety initiatives, resources, events and local and national campaigns ('Just Don't', Friends Against Scams and Take Five to Stop Fraud), to empower residents and give them confidence and a raised awareness through provider networks, community hubs, libraries, and digital platforms.	2027 2026	Increase the proportion of people who use services who say those services have made them feel safe and secure Increase the awareness of community resources and services that can support people	Number of people reached through campaigns, events, and digital platforms Proportion of people who respond to the ASCOF survey to say services have made them feel safe and secure
Addressing health and social inequalities To reduce health and social inequalities by strengthening community connections, improving access to inclusive and person-centred care, and building trust with underserved	Utilise data to identify at risk adults and collaboratively provide targeted support. Analyse data from the Dorset Intelligence and Insight Service (DiiS), Public Health, State of Ageing Report and the Census to identify where people are who need targeted support due to barriers in accessing care, social isolation, or unmet health and wellbeing needs. Create safe spaces within those communities for dialogue, such as in café's, community hubs, faith and cultural spaces and local clubs to obtain feedback,	2028 2028 2028	Increase awareness and confidence among people, especially those from underserved groups, in finding and using local services and support that meet their individual needs	Number of people engaged through community spaces Geographic coverage of engagement activities mapped against areas of identified need Number of people reporting increased awareness of and trust in services via survey after engagement Improvement of self-reported wellbeing scores via survey after engagement

groups—ensuring that all individuals, regardless of background or circumstance, can access the support they need to live healthier, more independent lives.	raise awareness of services and rebuild trust with communities that have experienced discrimination or exclusion.			
Supporting the VCSE sector To support and strengthen the sustainability, diversity, and capacity of the voluntary, community, and social enterprise (VCSE) sector by embedding supportive commissioning practices and fostering collaborative relationships - ensuring the sector can thrive as a key partner in prevention and wellbeing.	Create connect and collaborate forums for the ASC workforce and VCSE Partners to network, collaborate and share learning. Hold quarterly connect and collaborate forums with the VCSE sector and ASC colleagues to share details of commissioning updates, funding opportunities and showcase stories of difference Develop a VCSE information hub to share updates, opportunities, and changes in policy or commissioning. Involve VCSE partners in strategic planning, service design, and evaluation through co-production and advisory roles when designing new resources, projects and services, via task and finish groups.	2028 2028 2025 2025	Increase engagement and partnership working with the VCSE sector, health and other partners	Annual partnership surveys to measure satisfaction, trust and impact Attendance rates and repeat participation at quarterly connect and collaborate forums Feedback from attendees at connect and collaborate forums via survey to measure the effectiveness of how well they support collaboration, communication, and shared understanding of commissioning priorities Number of page hits on VCSE Information hub

How we will measure success

Success comes in many forms and looks different to all individuals being supported by, working with or working within Adult Social Care. We measure our success using a variety of resources to ensure that we are meeting our legislative duty as well as ensuring the people we support, their carers, our stakeholders and our staff are satisfied with the way we work.

The Care Quality Commission assess adult social care against their duties under the Care Act (2014), this includes how the local authority works with people, partners and the local community to promote independence and support people to prevent, reduce or delay the need for care and support.

The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people. The ASCOF is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

People's views and feedback are integral in understanding how we are performing, and we use several methods to obtain these. Further to this, we welcome any compliments and complaints and use these as a means to better understand quality and strive for positive change.

We are committed to **equality, diversity and inclusion** within adult social care. We will continue to actively seek feedback during the duration of the strategy from a diverse range of people, including people of all ages, people with sight and hearing impairment, people with disabilities, and carers. This will ensure everybody is fairly represented.

We use **internal performance data and analytics** to give real time information on our performance, identify potential issues and put measures in place to rectify them, as well as work on continuous improvement.

We conduct regular **contract monitoring reviews** with commissioned service providers to analyse the impact services have on people's lives.

Workforce data and staff satisfaction measures enable us to better understand our workforce and colleagues and ensure they are effectively supported in their line of work.

Monitoring collaboration and partnerships between stakeholders will enable us to strengthen relationships and continuously improve our means of communication.

It is well evidenced that early intervention is more cost effective than crisis management and understanding our **expenditure** on long-term services versus preventive efforts (capital and revenue) will enable us to gain a clearer understanding of what works well.

Further to this, monitoring the **funding sources** for preventative services will enable us to have a better understanding of investment into prevention, along with the measurement of outcomes.

Care Quality Commission

ASCOF

Peoples Views

Compliments & Complaints

Performance Data

Workforce Data / Feedback

Partnerships / collaboration

Cost Analysis / funding sources

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HEALTH AND WELLBEING BOARD

Report subject	**BCP Joint Health and Wellbeing Strategy Draft for Consultation**
Meeting date	12 January 2026
Status	Public Report
Executive summary	This report and associated documents provides; • An update on the development of the BCP Joint Health and Wellbeing Strategy for the Bournemouth, Christchurch and Poole area • An updated draft of the BCP Joint Health and Wellbeing Strategy (version 2) for public consultation • A draft Joint Strategic Needs Assessment (JSNA) Forward Plan for 2026 and 2027 for additional comments
Recommendations	**It is RECOMMENDED that:** 1. The Board note the progress made to date with the development of the draft Strategy. 2. The Board approve the draft Strategy for public consultation. 3. The Board note a new requirement to develop a Neighbourhood Health Plan by the end of March 2026. 4. The Board note the suggested priority topics for the BCP Joint Strategic Needs Assessment (JSNA) Forward Plan and provide any additional comments.
Reason for recommendations	1. To ensure that appropriate engagement has been undertaken with stakeholders to inform the development of the Strategy. 2. To ensure that the Board meets its statutory requirements under the Health and Social Care Act 2022 to develop a Joint Local Health & Wellbeing Strategy.

Portfolio Holder(s):	Cllr David Brown, Portfolio holder for Health and Wellbeing
Corporate Director	Laura Ambler, Corporate Director for Wellbeing
Report Authors	Rob Carroll, Director of Public Health and Communities. Paul Iggulden, Public Health Consultant. Cat McMillan, Head of Communities, Partnerships and Community Safety. Amy Lloyd, Head of Programmes. Mark Harris, Deputy Director of Modernisation and Place, NHS Dorset.
Wards	Council-wide
Classification	For Decision

1. Background

It is a statutory requirement in England under the Health and Social Care Act 2022 for Health and Wellbeing Boards to produce a Local Joint Health and Wellbeing Strategy.

2. Progress to date

During December 2024 Board Members were asked to give their views of the priorities for the BCP Joint Health and Wellbeing Strategy following a review of the latest data contained within the Joint Strategic Needs Assessment (JSNA). This was then presented to the Health and Wellbeing Board in January 2025, where the following priorities themes were agreed:

- Children and Young People
- Community Mental Health Transformation
- Supporting Adults to Live Well and Independently
- Housing
- Cost of Living and Poverty

These have subsequently been refined as:

- Starting Well
- Mental Wellbeing
- Living & Ageing Well
- Healthy Places & Communities

In addition, the Board wanted to have a better understanding of the work taking place around these priorities across the system, with a view to ensuring that the function of the Board brings additional benefits, rather than increasing reporting or duplicating effort where it is not needed. To facilitate this, Board members were asked to complete a mapping exercise over the summer of 2025 to capture the current or emerging activity, and a good response was received.

A draft BCP Health & Wellbeing Strategy was presented to the Health & Wellbeing Board on the 6th of October 2025. The report and associated documents provided an update on the progress towards the development of the Health and Wellbeing Strategy for the Bournemouth, Christchurch and Poole area, a draft strategy for comments and considerations from the Board and proposals for further stakeholder engagement on the strategy prior to finalisation.

A BCP Health & Wellbeing Board Workshop took place on the 24th of November 2025. The workshop included a presentation on the latest 2025 Joint Strategic Needs Assessment (JSNA) and the development of priority topics for a BCP JSNA Forward Plan. Board members were then asked to review and agree the draft BCP Health & Wellbeing Strategy strategic priorities and proposed actions, prior to a potential public consultation.

The feedback and outputs and from the BCP Health & Wellbeing Board workshop have now been reviewed and a second version of draft BCP Health & Wellbeing Strategy has been produced in response to the feedback received.

The Health & Wellbeing Board is now asked to approve the second version of the draft BCP Health & Wellbeing Strategy for public consultation (Appendix 1) with a view to a final draft being presented to the Health & Wellbeing Board, following a public consultation.

The Health & Wellbeing Board is also asked to note the suggested priority topics for the BCP Joint Strategic Needs Assessment (JSNA) Forward Plan (Appendix 2) and provide any additional comments.

The Health & Wellbeing Board is also asked to note a new requirement for the Board to produce a Neighbourhood Health Plan by the end of March 2026. This will be an additional plan to the BCP Health & Wellbeing Strategy.

3. Summary of Key Changes

This section details some of the key changes that have been made to the draft Strategy (V1) following the Health & Wellbeing Board Workshop on the 24th of November 2025:

The draft strategy dates have been changed from 2025-2030 to 2026-2031, recognising that the strategy will now be approved and published in 2026.

Strategic Priority 1 - Starting Well. This section has been rewritten, and the proposed actions have been changed to provide greater connection to the BCP Children & Young People's Partnership Plan, Families First Programme, the SEND Improvement Plan and a greater focus on reducing inequalities through neighbourhood approaches.

Strategic Priority 2 – Mental Wellbeing. This section has been rewritten to provide greater connection to the development of Integrated Neighbourhood Teams and Neighbourhood Health Services and the opportunities these present to tackle physical, mental and social wellbeing together.

Strategic Priority 3 – Living & Ageing Well. This section has been rewritten for the proposed action on hospital admissions to have a specific focus on falls. It also has an added proposed action to support the development of creative heath approaches in supporting people to live and age well. Anew proposed action to support the Support the development of an adult social care and housing strategy that supports people to live and age well has been added. Finally, a new proposed action to support the delivery of the Dorset Palliative and End of Life Strategy has been added.

Strategic Priority 4 - Healthy Places and Communities has been renamed Healthy Neighbourhoods and Communities, recognising the central importance of neighbourhoods in the 10 Year Health Plan for England. The proposed actions have been reduced and consolidated and include actions to improve health literacy and community resilience.

Measuring Impact – the proposed measures have been updated to better reflect the updated strategic priorities and proposed actions.

4. Neighbourhood Health Plan

The 10 Year Health Plan for England, published in July 2025, and subsequent NHS planning guidance, includes a new requirement for Health & Wellbeing Boards to produce a neighbourhood health plan, setting out how the NHS, local authority and other organisations, will work together to design and deliver neighbourhood health services. Further guidance to support the development of neighbourhood health plans is expected in January 2026 with a view to the development of a neighbourhood health plan by the end of March 2026. It is envisaged that this plan will build on the Health & Wellbeing Strategy.

5. Proposed next steps

The draft BCP Health & Wellbeing Strategy is attached as Appendix 1 and has been developed based upon the work outlined in sections 1 to 5. Board members are asked to approve the draft strategy for public consultation with a view to a final draft being presented to the Health & Wellbeing Board, following public consultation.

The Health & Wellbeing Board is also asked to note the suggested priority topics for the BCP Joint Strategic Needs Assessment (JSNA) Forward Plan (Appendix 2) and provide any additional comments, noting that this forward plan is flexible and will be kept under review.

6. Options Appraisal

Option 1- proceed with the next steps detailed above to ensure we meet our statutory requirements.

Option 2- do nothing- this is not an option as it is a statutory requirement to produce a Health & Wellbeing strategy.

7. Summary of financial implications

None.

8. Summary of legal implications

It is a statutory requirement for Health & Wellbeing Boards to produce a Joint Local Health & Wellbeing Strategy.

9. Summary of human resources implications

None

10. Summary of sustainability impact

The Sustainability Impact assessment will be undertaken once the strategy has been finalised.

11. Summary of public health implications

The purpose of the strategy is to address local health and social care needs, improve health outcomes, and reduce health inequalities in line with Public Health functions.

12. Summary of equality implications

The Equality Impact Assessment will be undertaken once the strategy has been finalised using the latest data from the Joint Strategic Needs Assessment.

13. Summary of risk assessment

The current recommendations are low risk.

14. Background papers

None.

Appendices

Appendix 1- Draft BCP Health and Wellbeing Strategy December 2026 (Draft Version 2)

Appendix 2 – Draft JSNA Forward Plan for 2026 and 2027

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Bournemouth, Christchurch and Poole's Joint Health and Wellbeing Strategy 2026-2031 V2 December 2025

Contents

1. Background

BCP Health & Wellbeing Board

The BCP Health and Wellbeing Board is a statutory partnership and formal committee of the Council where political, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities.

The Health and Wellbeing Board is made up of elected members and council officers, local NHS representatives, representatives from the voluntary and community sector and representatives from the police and the fire and rescue service. The Board holds regular meetings which can be observed by the public. The Health and Wellbeing Board also works closely with the BCP Community Safety Partnership, Safeguarding Adults Board and the Safeguarding Children's Partnership. The Health and Wellbeing Board uses development sessions, workshops and formal business meetings to identify strategic priorities and to drive work forward.

The Health & Wellbeing Board has a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy to improve the health & wellbeing of the local population and to reduce health inequalities.

In January 2025, the Health and Wellbeing Board agreed a three-layered approach to the development of a new Health and Wellbeing Strategy:

- Adopt the Dorset Integrated Care Partnership Strategy – 'Working Better Together' as the framework for a Bournemouth, Christchurch and Poole Health and Wellbeing Strategy
- Ensure that the Health and Wellbeing Strategy contributes to the delivery of the Council's Corporate Strategy to deliver the corporate vision and ambitions for our local communities
- Ensure that the Health and Wellbeing Strategy contributes to the delivery of the NHS Joint Forward Plan

Health and Wellbeing Board members re-affirmed the following role of the Health and Wellbeing Board:

- Identify strategic priorities that we can champion, monitor and drive forward
- Convene system partners to share work programmes that progress and contribute to local health & wellbeing
- Support the inclusion of health and wellbeing in all policies
- Consider relevant data and metrics to monitor progress
- Focus on working together and co-production
- Sponsor the work of a Place Based Partnership and champion integration of services in local neighbourhoods

1.1 BCP Placed Based Partnership

BCP started establishing a Place Based Partnership in October 2024 to drive strategy into action. The partnership confirmed its intention to act as an officer executive delivery group to drive delivery of the Health and Wellbeing Board's priorities. A workshop was held in February 2025 to shape the partnership and obtain a commitment to finalise membership and set up monthly partnership meetings by the end of the calendar year.

At the workshop it was agreed that the Place Based Partnership should:

- Add value and not duplicate existing governance
- Help to shape the forward plan for the Health and Wellbeing Board alongside the statutory functions
- Connect the Health and Wellbeing Board to neighbourhoods and communities
- Support a 'wellbeing' in all policies approach
- Work towards becoming a formal partnership which can receive and allocate delegated funding, shape integrated commissioning strategies and drive action

2. Strategic Context

The Health and Wellbeing Strategy sits alongside a number of accompanying strategies, action plans and evolving workstreams that are being delivered across the BCP area to improve health and wellbeing.

Key strategies and plans this Health and Wellbeing Strategy compliments and builds upon include:

2.1 Dorset Integrated Care Strategy

The Dorset Integrated Care Strategy – 'Working Better Together' is a collaborative plan to improve the health and wellbeing of the county's residents by integrating health and care services and provides the foundation for our place based Health and Wellbeing Strategy. Guided by the three overarching principles of prevention and early help, thriving communities, and working better together, the integrated strategy emphasises co-designing services with people and communities, building on community assets, reducing inequalities, and strengthening partnerships between the NHS, local government and the voluntary sector. The overarching goal is to enable people to live healthier lives by providing more accessible, personalised, and equitable care.

2.2 BCP Corporate Strategy - A Shared Vision for Bournemouth Christchurch and Poole 2024-28

The BCP corporate strategy sets out the Councils vision to create a BCP area *'Where people, nature, coast and towns come together in sustainable safe and healthy communities'*. It provides a single set of priorities for the whole council and sets the

direction for the Council's policy and strategy development, service planning, budget setting and service delivery.

The strategy includes two priorities:

- Our place and environment: Vibrant places, where people and nature flourish, with a thriving economy in a healthy, natural environment.
- Our people and communities: Everyone leads a fulfilled life, maximising opportunity for all.

These priorities are underpinned by a series of ambitions, focus areas and progress measures which are reported on a performance dashboard A shared vision for Bournemouth, Christchurch and Poole | BCP

2.3 NHS Joint Forward Plan

Dorset's NHS Joint Forward Plan sets out the key health priorities that local health partners are working together to achieve. It is framed around five strategic pillars that provide a framework for making Dorset the healthiest place to live:

- Improve the lives of 100,000 people impacted by poor mental health
- Prevent 55,000 children from becoming overweight by 2040
- Reduce the gap in healthy life expectancy between the most and least deprived areas from 19 years to 15 years by 2043
- Increase the percentage of older people living well independently in Dorset
- Add 100,000 healthy life years to the people of Dorset by 2033

2.4 BCP Children & Young People's Partnership Plan

The BCP Children & Young People's Partnership Plan sets out a vision where Bournemouth, Christchurch and Poole are great places to live, where all children and young people have the best possible opportunities in life and are supported by the community to flourish and grow in order to succeed.

This plan outlines how partners will work together to help children and young people have the best chances in life and be supported by the community to grow and succeed in living their best lives.

The plan contains five main priorities for our children and young people:

- Feeling happy – Feeling at your best mentally, physically and emotionally
- Being safe - Having a safe place to live, study, work and play
- Feeling supported - Having people to turn to for help
- Being included - Being actively involved in the world and activities around you
- Feeling fulfilled - Being proud of yourself and feeling really happy with what you are doing in life

2.5 BCP Adult Social Care Strategy 2025-2028

The BCP Adult Social Care Strategy sets out BCP Council's direction for Adult Social Care over the next four years, outlining an ambitious plan where we will work to transform the services we provide, working in collaboration with partner organisations including health, housing, the voluntary and community sector and independent care providers, as well as people and carers who currently use services, their families and communities. The strategy sets out a vision of 'supporting people to achieve a fulfilled life, in the way that they choose, and in a place where they feel safe'.

The BCP Adult Social Care Strategy outlines 3 key areas of focus:

- Putting people, carers and families first - We will listen and build good relationships with people, so we understand what matters to them
- Living in a place called home - We will help people to connect with their family, friends and community, in a place where they feel safe and at home
- Developing how we work - We are creative and innovative with solutions and resources. We understand and measure the impact we are having

2.6 BCP Adult Social Care Prevention Strategy 2025-2030

This strategy outlines BCP Council's plan for developing a sustainable preventative approach in adult social care. It emphasises early intervention, the promotion of wellbeing, and collaboration with key partners to not only prevent the development of long-term needs, but also to enhance the overall quality of life for people living in Bournemouth, Christchurch, and Poole. The strategy includes 5 strategic priorities:

1. A change in culture
2. Living and ageing well
3. Individual resilience to build wellbeing
4. Supporting the workforce
5. Connecting Communities

2.7 Adult Social Care Transformation- Fulfilled Lives

The Fulfilled Lives programme has four priority projects aimed at improving outcomes for adults and their families within the BCP area through enhanced person-centered practice, and the provision of effective and efficient support solutions.

1. **How We Work** - To embed strengths and relational-based practice by implementing and embedding the 3 Conversations (3C's) approach, building on recent innovation sites and focusing on prevention. 3C's supports practitioners to think more preventatively and creatively in our work with people, moving from a mindset of 'assessing for services' towards a deeper understanding what matters most to people for them to lead a fulfilled life.
2. **Better short-term support** – Improving community access to reablement services, ensuring that anyone with reablement goals has the best possible

chance to achieve them and maximise their independence- reducing their need for long-term support services.

3. **Self-directed support** - We will ensure more people have control of their own support by increasing the range of options for them to access their personal budget, including the creative use of Direct Payments or Individual Service Funds, reducing the need for more costly traditional services.
4. **Care and Support at Home** - Develop and implement a new 'Support at Home' provider framework, enabling people to stay as independent for as long as possible in their own home and reducing the need for admission to a residential care home.

2.8 BCP Community Safety Partnership Strategy

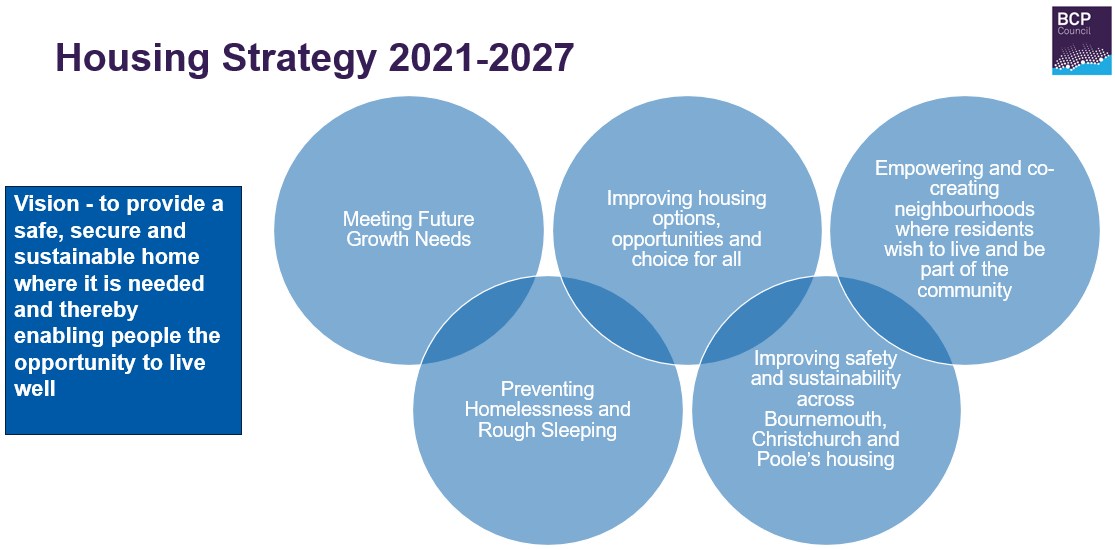
Safer BCP is the statutory Community Safety Partnership (CSP) for the BCP area. The Community Safety Partnership Strategy sets out the strategic priorities for the partnership using an evidence-based approach. These are:

a. To reduce serious violence
b. To reduce Violence Against Women and Girls (VAWG)
c. To reduce Anti-Social Behaviour (ASB), drug related ASB and crime hotspots

The CSP also leads on the duties under the Serious Violence Act, Domestic Abuse Act and Contest (Counter terrorism strategy), with associated strategies and partnership plans outlining roles and responsibilities.

2.9 BCP Housing Strategy 2021-2027

The BCP Council Housing Strategy (2021–2026) sets out a clear vision to make Bournemouth, Christchurch and Poole one of the best coastal places to live, work, invest, and play. It focuses on delivering affordable, high-quality homes, promoting equality, and ensuring housing services meet the diverse needs of local communities. Central to this strategy is a commitment to improving health and wellbeing by addressing the wider determinants of health through safe, secure, and sustainable housing. This aligns closely to the Health and Wellbeing Strategy.



2.10 Homelessness and Rough Sleeping Strategy 2021-2025

The BCP Council Homelessness and Rough Sleeping Strategy (2021–2025), developed in collaboration with the Homelessness Partnership, sets out a bold vision to end homelessness across Bournemouth, Christchurch, and Poole by ensuring everyone has a safe and secure place to call home. The strategy emphasises prevention, rapid rehousing and person-centred support, recognising that homelessness is a complex issue intertwined with health, wellbeing, and social care. Through multi-agency collaboration—including health services, housing providers, and voluntary organisations—the strategy promotes early intervention and trauma-informed approaches to help individuals rebuild their lives. Health and wellbeing are central to its delivery, with initiatives such as supported emergency accommodation, multidisciplinary teams and lived experience groups ensuring that services are responsive, inclusive, and focused on long-term recovery and resilience. The Strategy is currently under review and will be complete by March 2026.

2.11 Homewards

BCP Council is one of six trailblazer regions participating in *Homewards*, a transformative five-year programme led by Prince William and The Royal Foundation, aimed at ending homelessness by making it rare, brief and unrepeated. Locally led and rooted in collaboration, the BCP Homewards Coalition brings together over 90 organisations- including businesses, charities, and educational institutions- to co-design and deliver innovative solutions. The initiative complements BCP's Homelessness and Rough Sleeping Strategy by enhancing prevention, expanding access to housing, and supporting employability, particularly for young people and those with care experience. It also aligns with the Council's Health and Wellbeing Strategy by addressing the social

determinants of health, promoting stability, and fostering resilience through secure housing, meaningful employment, and community engagement.

2.12 NHS 10 Year Plan

Our Health & Wellbeing Strategy reflects the recent publication of 'Fit for the Future' – the government's 10 Year Health Plan for England which sets out an ambition to reinvent the NHS through 3 radical shifts:

- hospital to community
- analogue to digital
- sickness to prevention

Development and implementation of neighbourhood health services lies at the heart of the plan that embodies prevention as a primary principle and promotes care in settings as close to home as can be.

2.13 Principles of working

The Health and Wellbeing Board has agreed to adopt the following Poverty Truth Commission Access to Services Principles to underpin its work:

- Consistent and connected services from cradle to grave
- A whole person and a whole community approach
- Services when and where people need them that everyone can access
- Dependable and supportive relationships
- Everyone is treated with dignity and humanity.

3. BCP's Health and Wellbeing Strategy 2026-2031

BCP's Health and Wellbeing Strategy sets out how the Health and Wellbeing Board will work together to promote wellbeing, prevent ill health and reduce health inequalities across the BCP Council area. The strategy has been informed by the Joint Strategic Needs Assessment (JSNA) and shaped by consultation and engagement activity.

3.1 Vision

The Health & Wellbeing Board agreed to adopt the Dorset Integrated Care Partnership Strategy – 'Working Better Together' as the framework for a Bournemouth, Christchurch and Poole Health and Wellbeing Strategy. This includes the following vision:

"Dorset Integrated Care System works together to deliver the best possible improvements in health and wellbeing".

3.2 Strategic Priorities

Following a survey of members, the Health and Wellbeing Board identified five themed areas of focus for the strategy:

- Children and Young People
- Community Mental Health Transformation
- Supporting Adults to Live Well and Independently
- Housing
- Cost of Living and Poverty

These themed areas of focus have subsequently been developed into four Strategic Priorities:

1. Starting Well
2. Mental Wellbeing
3. Living and Ageing Well
4. Healthy Neighbourhoods and Communities

Our strategic priorities are high-level and informed by local data and evidence. These priorities seek to improve health and wellbeing for everybody but with a focus on narrowing inequalities for those with greatest need.

3.3 A Targeted Approach

If we are to reduce health inequalities, the actions we take must be implemented proportionately to the needs of different neighbourhoods and communities, with those most in need receiving the greatest support. In doing this, we recognise that these communities are at risk of poorer outcomes because of unfair social systems and the circumstances in which they live, rather than due to who they are or individual biological and/or lifestyle factors.

Inequality also exists between people with different characteristics (including those protected by law) such as people of minority ethnicities, people with disabilities and between men and women. Some groups of people experience significant disadvantage, due to the circumstances that they are facing, such as people experiencing homelessness.

One mechanism for supporting proportionate delivery is Core20PLUS5, an NHS approach to reducing healthcare inequalities. The approach defines a target population, with the “Core20” being the most disadvantaged 20% of the population and “PLUS” groups being defined according to local need.

3.4 Strategic Priority 1 – Starting Well

Ensuring that Children and Young People up to the age of 25 have the best start in life and are supported to have good physical health and emotional wellbeing to go on and achieve their potential and live well into adulthood.

Proposed Actions:

- Support the delivery of BCP Children & Young People's Partnership Plan and Families First Programme, so that children and young people are supported by the community to flourish, giving them the best possible opportunities in life, and ensuring they grow and succeed
- Support the delivery of the BCP Special Educational Needs and Disabilities (SEND) Improvement Plan so that all children and young people with SEND have bright futures, fulfilled lives and are part of their local communities
- Promote good mental wellbeing in children, young people and families and reduce self-harm
- Work with priority neighbourhoods and communities to reduce health inequalities by:
    - Supporting mothers who smoke to give up during and after pregnancy
    - Improving the uptake of child and adolescent vaccinations
    - Improving oral health and hygiene in young children
    - Improving healthy nutrition and physical activity in young children
- To maximise opportunities to support children and young people at the earliest possible point, to prevent harm and encourage positive health behaviours and choices, including promoting positive sexual health and social media use, averting knife and weapon crime and supporting the prevention of harms from tobacco, vaping, drugs, alcohol and gambling

3.5 Strategic Priority 2 – Mental Wellbeing

Helping people to stay mentally well, improving access to services and reducing rates of suicide and self-harm.

Proposed Actions:

- Support Integrated Neighbourhood Teams (INTs) to jointly tackle physical, mental and social wellbeing in partnership with local organisations and communities
- Support improvements in access to, and uptake of, community mental health support services
- Work with key partners to reduce rates of suicide and self-harm
- Support mental health promoting communities, making mental wellbeing everyone's business through community development, training and peer support

- Health and Wellbeing Board members to ensure mental wellbeing, including tackling stigma around this agenda, are addressed through workplace wellbeing offers
- Support people with poor mental health to connect to paid and unpaid activities.

3.6 Strategic Priority 3 – Living & Ageing Well

Adults and older people will be supported to live and age well and to stay connected and independent for as long as possible.

Proposed Actions:

- Increase the number of BCP residents in our priority neighbourhoods and communities accessing LiveWell support services and increase the uptake of NHS Health Checks
- Reduce the harm caused by tobacco, drugs, alcohol & harmful gambling in priority neighbourhoods and communities
- Reduce inequalities in the uptake of NHS screening & immunisation programmes
- Reduce hospital admissions due to falls in people aged 65 and over through increased primary and secondary prevention activities
- Champion and monitor the delivery of the Fulfilled Lives & Future Care Programmes to reform urgent and community care, provide more person-centred and home-based recovery services and promote independence
- Champion the delivery of the Adult Social Care Prevention Strategy to prevent the development of long-term social care needs
- Support the development of creative health approaches in supporting people to live and age well
- Create more Age-friendly communities and spaces, where people are supported and enabled to age well and live a good later life
- Support the development of an adult social care and housing strategy that supports people to live and age well
- Support the delivery of the Dorset Palliative and End of Life Strategy

3.7 Strategic Priority 4 – Healthy Neighbourhoods & Communities

Our neighbourhoods and workplaces will make it easy for everyone to live well, with shared opportunities for health and happiness across our communities.

Proposed Actions

- Support the development of Integrated Neighbourhood Teams and Neighbourhood Health Services, improving local access to joined-up care and support
- Strengthen the voluntary and community sector to deliver impactful programmes that reduce health inequalities, alleviate poverty, improve health literacy and improve access to nutritious food
- Foster connected communities to combat social isolation, build community resilience and enhance overall wellbeing
- Embed health and wellbeing practices in workplaces, with Board Members actively championing initiatives that improve staff wellbeing and productivity
- Reduce rates of serious violence, including violence against women and girls, and enhance perceptions of safety across all neighbourhoods
- Reduce homelessness and increase the availability of good quality homes and environments that promote health and wellbeing
- Cut carbon emissions, reduce air pollution and increase active travel uptake

4. Measuring Impact

The Public Health Outcomes Framework, the proposed new Local Government Outcomes Framework and the BCP Corporate Strategy provide a comprehensive list of desired outcomes and indicators that can help to measure how well public health and wellbeing is being improved and protected in the BCP area. The Health and Wellbeing Board will focus on a selection of these indicators that a) require the most improvement and b) will best indicate progress towards the strategic priorities in this strategy. Progress against these measures will be reported to the Health & Wellbeing Board on an annual basis.

Strategic Priority	Measures			
Overarching	Healthy Life Expectancy at birth	Slope index of inequality in life expectancy at birth		
Starting Well	Breastfeeding prevalence at 6-8 weeks	Population vaccination coverage – MMR for	Child health: Percentage achieving good level of	Oral health: Percentage of 5-year-olds with

		one dose (2 years old)	development at 2-2.5 year review (Fingertips)	experience of visually obvious dental decay
	Obesity: Year 6 obesity prevalence	Percentage of physically active children and young people	Under 18 conception rate	Hospital admissions as a result of self-harm age 15-19 years, crude rate per 100,000 (persons)
Mental Wellbeing	Depression recorded prevalence	Hospital admissions as a result of self-harm age 15-19 years, crude rate per 100,000 (persons)	Emergency hospital admissions for intentional self-harm	
	Suicide Rate (persons)			
Living & Ageing Well	Smoking prevalence in adults in routine and manual occupations (aged 18 to 64)	Physical inactivity: Percentage of adults who are physically inactive	Drugs and alcohol: Rate of alcohol specific mortality (per 100,000)	
	Alcohol related hospital admissions (per 100,000)	The proportion of new clients accessing the Live Well Service who live in the most deprived areas (BCP	Hospital admissions due to falls in those aged 65 and over	

		Corporate Strategy)		
Healthy Neighbourhoods & Communities	The number and value of grants/contracts awarded to the voluntary and community sector to reduce health inequalities	Percentage of residents who have a good satisfaction with life	Percentage of physically active adults	Reduce levels of police recorded serious violent crime
	Percentage of people who feel safe in their local area after dark/during the day	The number of people rough sleeping	The number of homeless households in bed and breakfast accommodation	Total number of sustainable passenger trips in the BCP area per year

5. Making it happen

The Health and Wellbeing Board will be responsible for assuring delivery of the actions set out within the strategy, connecting to other existing partnerships and delivery boards where relevant. The Health and Wellbeing Board will provide additional focus and offer strategic direction to ensure that **Drive Actions** are co-ordinated and driven forward, with delivery co-ordinated by a BCP Place Based Partnership. Owners of these drive actions will be required to give more regular updates to allow the Board to monitor progress and shape delivery

Accountability for the delivery of the strategy sits across all members of the Health & Wellbeing Board which will:

- Meet regularly as a board, holding each other and wider partners to account
- Develop a forward plan to ensure all elements of the strategy are progressed and reported on
- Receive reports on progress in delivering against the strategic priorities outlined in the strategy
- Constructively challenge and support each other in relation to delivery, ensuring that all opportunities to improve health and wellbeing are maximised
- Ensure a performance monitoring framework is in place to enable the board to assure itself of delivery
- Produce a JSNA Annual Report, which will focus on progress against our key priorities, measures and inequalities across the BCP area
- Review progress, emerging needs and strategic priorities on an annual basis

Draft JSNA Forward Workplan 2026-2027

Introduction

At the BCP JSNA & HWB Strategy Workshop on the 24th November 2025, Health & Wellbeing Board members and workshop attendees were divided in breakout discussion groups to reflect on the presented 2025 JSNA Annual Narrative for BCP Council. The table discussions generated a list of priority topics and areas of interest as follows:

JSNA topics of interest

1. **Children & Young People**
   - Prevention of harmful behaviours (vaping, drug misuse, gambling, poor diet).
   - Education and early intervention of healthy lives.

2. **Mental Health**
   - High suicide rates, self-harm, influences on mental health.
   - Links with substance misuse, gambling and suicide.

3. **Substance Misuse**
   - Alcohol and drugs—targeted interventions and links to suicidality.

4. **Healthy Homes**
   - Improve quality and affordability of housing both social and private.
   - Address homelessness and inequality.

5. **Deprivation & Cost of Living**
   - Socioeconomic driven health behaviours.
   - Financial barriers to healthy living
   - Focus on most deprived areas, community development work, digital exclusion.

6. **Physical Environment**
   - Access to green/blue spaces, transport barriers.
   - Perceptions of community safety and how this may influence behaviour

7. **Healthy Ageing**
   - Reduce falls and hip fractures.
   - Support healthy ageing and reduce the number of years spent in poor health
   - Prevention of people getting ill earlier in life.

JSNA areas of focus

There is capacity in the BCP Public Health and Communities team to undertake two deep dive JSNA topics in 2026 and two deep dive JSNA topics in 2027.

The following four areas of JSNA focus have been identified:

1. **Prevention and Early Intervention**
   - Focus on children and young people: reduce harmful behaviours (vaping, drug misuse, gambling, poor diet).
   - Promote healthy behaviours and education to prevent long-term health issues.
   - Support and encourage physical activity across all ages.

2. **Mental Health and Wellbeing**
   - Reduce high suicide rates, self-harm, and mental health challenges.
   - Tackle the connections between mental health, substance misuse, and harmful gambling through support and prevention.

3. **Healthy Life Expectancy**
   - Reduce health inequalities driven by deprivation, cost of living and understanding local place variations.
   - Support healthy ageing, understanding the years spent in poor health, focusing on effective prevention.

4. **Healthy Homes and Neighbourhoods**
   - Housing quality and affordability across social and private sectors, reducing homelessness.
   - Enhance access to green/blue spaces and perceptions of community safety to enable active, heathy lives.

HEALTH AND WELLBEING BOARD

Report subject	**Health Literacy Update and Proposal**
Meeting date	12 January 2026
Status	Public Report
Executive summary	The purpose of this report is to provide members of the BCP Health and Wellbeing Board with an overview of the activity delivered to date to increase 'organisational health literacy' across BCP and Dorset. It seeks to confirm health literacy as a system priority and requests nominations for a co-design workshop to develop a proposal for scaling up 'organisational health literacy' across BCP and Dorset.
Recommendations	**It is RECOMMENDED that:** BCP Health and Wellbeing Board members: • Confirm health literacy as a system priority. • Nominate leads to participate in a workshop to co-design a proposal for a BCP and Dorset wide approach to scaling up 'organisational health literacy' for the Neighbourhood Health Programme Board to consider, or an alternative decision-making body.
Reason for recommendations	1. Organisational Health Literacy forms part of the foundation to the development of neighbourhood health models. 2. Partners will need to scale up the work to date on this agenda to create effective and equitable integrated neighbourhood health teams and services.

Portfolio Holder(s):	Cllr David Brown, Portfolio holder for Health and Wellbeing
Corporate Director	Laura Ambler, Corporate Director for Wellbeing
Report Authors	Rob Carroll, Director for Public Health and Communities; Paul Iggulden, Public Health Consultant; Rupert Lloyd, Programme Advisor, Dorset Council
Wards	Council-wide
Classification	For Decision

1. Background

36% of BCP residents aged 16-65 and 35% of Dorset residents aged 16-65 are estimated to have low health literacy or low health numeracy (Source: NHS-E & University of Southampton). Health literacy forms part of the foundation for success in delivering shared system goals including reducing health inequalities and the ambitions of the 10 Year Health Plan for England, including the shift from treatment to prevention, analogue to digital and the delivery of more integrated neighbourhood health services. Our local efforts to deliver a shift to prevention, digital care, neighbourhood health and patient activation will be less effective if organisations do not adopt health literacy principles as the foundation of communication with people.

The language of health is not everyone's language. Recognising and acting on this is key to 'organisational health literacy' and this video illustrates why: The Language of Health. Local training delivered to date has improved awareness and initiated changes in practice. See Appendix 1 for local examples.

System-wide leadership is needed to increase scale and sustainability. A co-produced, coordinated approach is recommended to embed a health literate culture across organisations and align with system priorities.

For people to engage meaningfully with their health, they must be able to understand and act on the information provided to them. If they don't understand it, then we have failed in our responsibility to empower people to take control of their own health and we are more likely to fail in our wider strategic goals that are built on this foundation, especially reducing health inequalities.

This paper sets out why increasing 'organisational health literacy' is fundamental to the system's objectives in Dorset, how a 'bottom up' approach has made progress to date and a proposal for how the system can capitalise on that success.

Personal health literacy is an individual's ability to understand and act on health information. Organisational Health Literacy is the degree to which organisations equitably enable people to find, understand and act on health information (source).

Increasing organisational health literacy is the system's response to varying levels of personal health literacy. It involves tailoring communication and checking understanding (e.g. using techniques like "chunk and check" or "teach back") to ensure information is accessible and actionable.

2. Progress to date

Activity to date originated from the Dorset ICS Health Inequalities Programme following the COVID-19 pandemic in 2022. It began with a series of webinars featuring external speakers, including Dr. Mike Oliver from Health Literacy UK. It culminated in a symposium in February 2023 with over 100 participants which included interactive workshops and pledge cards. Feedback from these events informed the development of two training pathways: introductory health literacy awareness and Champion level training. A community of practice was established alongside online resources and masterclasses to support Champions' ongoing learning.

The programme has transitioned from using external trainers to a locally delivered training model. More than 400 individuals have been trained across BCP and Dorset, including 52 champions, half of whom actively contribute to the community of practice (see Appendix 1 for an overview of participating organisations). This activity has been delivered with a small amount of staff capacity from Public Health Dorset prior to its disaggregation as a shared service.

3. How has the training benefitted participants?

Evaluation of awareness raising has focused on how successful training has been in increasing participants awareness of health literacy, their ability to communicate to patients and the change they intend to make as a result:

4. Where Are We Now in Dorset?

The disaggregation of Public Health Dorset in April 2025 invites us to seek wider system-level engagement in the goal of creating a more health literate system. Effective 'organisational health literacy' underpins the ambitions of the 10 Year Health Plan and the changes it seeks to bring about. Our local efforts to deliver a shift to prevention, digital care, neighbourhood health and patient activation will be less effective if organisations do not adopt health literacy principles as the foundation of communication with people. Failing to address organisational heath literacy may exacerbate existing health inequalities.

In essence, without health literacy our initiatives will primarily benefit those who are most equipped to identify, comprehend, and leverage the opportunities presented, leaving behind those who lack the means to do so. The system now stands at a juncture, requiring strategic decisions to scale and sustain the progress made.

5. Proposed next steps

Health and Wellbeing Board partners are asked to nominate People Leads and Inequality Leads to participate in a workshop (approximately 3 hours). The workshop will revisit our health literacy journey, before exploring the five elements of a Health Literate Organisation. Equipped with this background, participants will then co-produce an approach for how we scale up across BCP and Dorset. The scope of this discussion will include consideration of activity at different levels:

- System: Consider the benefits of having resource operating across the system to coordinate and grow the community of practice and facilitate knowledge transfer between organisations.
- Place: Consider the advantages of embedding ‘organisational health literacy’ in the neighbourhood health agenda. This could include collaboration with the Integrated Neighbourhood Team (INT) co-production working group or other options.
- Organisational: Consider how organisations can build health literacy understanding and skills in their workforce e.g. embedding health literacy in mandatory training programmes, internal communication and promotion, formal allocation of capacity for Health Literacy Champions.

6. Recommendations

It is recommended that BCP Health and Wellbeing Board members:

- Confirm health literacy as a system priority.
- Nominate health inequalities and People leads to participate in a workshop to co-design a proposal for a BCP and Dorset wide approach to scaling up ‘organisational health literacy’ for the Neighbourhood Health Programme Board to consider, or an alternative decision-making body.

7. Summary of financial implications

Subject to agreed options for scaling up, this will require additional resources to be confirmed depending on the option chosen and pace of delivery.

8. Summary of legal implications

None.

9. Summary of human resources implications

Capacity in the two Council Public Health teams has led activity to date. There are benefits to some time-limited continuation of this to support knowledge transfer and support for health literacy training. It is important to note that there is not currently capacity to deliver at scale within the two Public Health teams.

However, committing training capacity (e.g. up to 1 FTE per large organisation) within organisations to deliver health literacy awareness training could make significant progress in upskilling the local workforce. Further capacity could be required, but this will be an issue for consideration in the workshop.

10. Summary of sustainability impact

None.

11. Summary of public health implications

Health literacy is foundational for success in achieving the ambitions of the 10 Year Health Plan and delivering shared system goals including reducing health inequalities, shifting from treatment to prevention and neighbourhood health.

12. Summary of equality implications

NHS England states that *"Health literacy is a two-sided issue, comprising both an individual's ability to understand and use information to make decisions about their health and care, and a 'systems issue', reflecting the complexity of health information and the health care system. There is a strong social gradient in the population, with lower levels of health literacy much more common among the socially and economically disadvantaged. In other words, if we don't address health literacy, we run the risk of inadvertently widening health inequalities by developing information and services which do not meet the needs of those people who would benefit most from accessing them"*.

By adopting this approach to health literacy in BCP we will be directly removing barriers to enable more of our residents to access health care and therefore increasing the likelihood of earlier intervention, particularly for those at higher risk. This proposal has positive equality implications and seeks to ensure equitable access to our health care system.

Summary of risk assessment

The recommendations are low risk.

13. Background papers

None.

14. Appendices

Appendix 1- Case studies of local health literacy activity

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Appendix 1- Case studies of local health literacy activity

Our Dorset Health Literacy Champions Celebration

BEFORE

AFTER

STORY

Following health literacy training we started reviewing our patient information leaflet. We used the PDSA cycle to continue editing the new leaflet with feedback from patients, family and colleagues. We were then able to create leaflet a draft for more feedback. Eventually that led to a final version that was reviewed by the DCH health literacy team. This document will continue to be reviewed by colleagues and patients for further improvement.

QUOTES FROM PATIENTS

"It's good, describes it well"
"Would help me know what to expect"
"Has all the info you need"
"Don't always remember everything that has been told to you, nice to have a leaflet to refer to"

Dorset County Hospital NHS Foundation Trust Pulmonary Rehabilitation

Our Dorset Health Literacy Champions Celebration

How have you used your learning about health literacy?

- Re-written service leaflet focusing on the following;
- Ensuring use of unambiguous language (non-'specialist'/medical jargon
- Use of short sentences where possible
- Ensuring the pitch is inclusive in terms of reader age by running through the 'Grammarly' programme' resulting in reader age decreasing from university level to 'high school' level
- Conversation/discussion sparked re: the title of the service; 'Vocational'= ? does not accurately reflect the remit of the service

What are your plans/goals for the future?

- Consider changing the title of the service to reflect how service users are supported more accurately
- Re-write website information , both to update information and to ensure language used is unambiguous and pitched for accessibility in terms of reader age
- Include service users' opinions in the redesign
- Moving forwards looking at how assessment/treatment plans are written to ensure accessibility/optimal engagement of service users including the 'chunk and check'/'teachback' techniques

What could help you achieve your plans/goals or help organisations in Dorset become health literate?

- Time to train other partner services to streamline/reinforce health literacy
- Having the 'buy'-in/support of managers to reinforce the importance/benefit of health literacy and help it to become a shared concept not left to a 'champion' to 'own'

Vocational Services, Dorset Healthcare NHS Foundation Trust

Community Action Network Health Literacy

COMMUNITY ACTION NETWORK

OUR COMMITMENT TO ACCESSIBLE HEALTH AND WELLBEING INFORMATION FOR ALL

First steps

Members of the Community Action Network team attended Mike's training to become Health Literacy Champions. CAN Senior Leadership Team agreed this was too good not to share, and we were given time to produce and lead Awareness Raising sessions for the rest of the CAN team.

Getting to know our audience

We sent a questionnaire to the team to gauge their understanding of Health Literacy, to gather examples of their work using Health Literacy principles, and to share times when it had been hard to help people understand messages.

Support and advice

We used this information to design a 2-hour training session for our team including good examples from CAN of spoken and written communications and common problems. The sessions included a mixture of group work and paired work, role play of Teach Back techniques and the chance to rewrite written communications in a more Health Literate style.

We held in person and online sessions which staff and trustees attended. Feedback showed a growth in understanding Health Literacy and why it is important and an appreciation of the chance to take part in practical activities during the sessions.

Next steps

CAN staff have expressed an interest in more awareness sessions. The two main areas being co-production and the use of Artificial Intelligence (AI) so watch this space as we keep on learning and growing together!

Feedback

Health literacy is key to ensuring health equality and equity is reached across experiences with and access to healthcare.

I feel much more confident. In my work I did not use enough chunk and check before.

It was a great session, including role play, the email exercise and video example.

www.can100.org

hannah.rees@can100.org

Overview of some of the organisations that have participated

This is not a complete picture but includes organisations with high number of participants.

BCP Health and Wellbeing Board - Work Plan

Updated: 29 December 2025

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
12 January 2026					
	Health and well-being strategy into action place based partnership work		Committee Report	Rob Carroll and Cat McMillan	
	Better Care Fund Q2 Report		Committee Report	Scott Saffin, Commissioning Manager – Better Care Fund and Market Management	
	Update on the Prevention Strategy		Committee Report	Emma Senior	Added in agreement with the Chair
	Update on Future Care		Committee Report	Dylan Champion	Added in agreement with the Chair

	Subject and background	Anticipated benefits and value to be added by HWB engagement	How will the scrutiny be done?	Lead Officer	Report Information
	Health literacy update & proposal		Committee Report	Paul Iggulden	Added in agreement with the Chair
	Integrated Care Board (ICB) Medium Term Plan		Covering Report and presentation	Mark Harris, Deputy Director of Modernisation & Place, NHS Dorset	Added by MH on 24/12 and in agreement with the Chair
9 March 2026					
	Health and well-being strategy into action place based partnership work		TBC	Rob Carroll and Cat McMillan	
	Annual Report of the Community Safety Partnership		TBC	TBC	
	Better Care Fund Q3 and 26/27 plan		Committee Report	Scott Saffin, Commissioning Manager – Better Care Fund and Market Management	

Future items to be allocated to meeting dates				
Changes to hospitals, role of hospitals and responding to the needs of Communities	To consider the changes going on in local hospitals to include significant changes in mental health provision.		TBC – highlighted by Richard Renaut	Consider whether update to Board or possible Council wide briefing?
Fuel Poverty due to withdrawal of allowance	To monitor this issue	Committee Report	TBC	Suggested by SC Update – date tbc
Better Care Fund	To receive a mid year progress update	Committee Report	TBC	TBC
Update from the Urgent Emergency Care Board	To receive an update	Committee report	TBC	Requested at meeting on 13/1/25
Community Safety Partnership work	To receive an update	Committee report	TBC	Suggested at meeting on 13/1/25
ASC Prevention Strategy	TBC	Committee report	TBC	Suggested at meeting on 9 6 25

Dates for the 2026/27 Municipal Year

- 29 June 2026 at 2pm
- 12 October 2026 at 2pm
- 11 January 2027 at 2pm
- 5 April 2027 at 2pm