Equality Impact Assessment: Conversation Screening Tool	
What is being reviewed?	Adult Social Care (ASC) Prevention Strategy
What changes are being made?	The creation of an ASC Prevention strategy for individuals over the age of 18. It is aimed at people before they use ASC services or during early interactions with Adult Social Care, enabling people to live independently for longer, delaying, reducing or preventing the development of longer-term needs for support. The strategy could affect anyone who may be at a higher risk of developing care and support needs such as older adults who may be at a higher risk of loneliness and isolation. A separate EIA will be completed for implementation of the strategy and any potential equality impacts.
Service Unit:	Adult Social Care
Participants in the conversation:	Eliza Atyeo, Senior Commissioning Officer - Prevention and Wellbeing Mike Lynton, Policy Officer and ASC EIA Champion Emma Senior, Commissioning Manager – Prevention and Wellbeing
Conversation date/s:	05/12/2025 12/02/2025 05/08/2025
Do you know your current or potential client base? Who are the key stakeholders?	The Adult Social Care Prevention Strategy will apply to all residents over the age of 18 living in the BCP conurbation. The strategy impacts people with low level needs for support who engage with Adult Social Care Services, including unpaid carers, now or in the future. It also includes individual who may not be in contact with Adult Social Care but are at a higher risk of developing support needs. The Adult Social Care and Commissioning workforce are key stakeholders. The Voluntary and Community sector, NHS, public health and Dorset Healthcare are also key stakeholders as they will be key to the delivery of the strategy.
Do different groups have different needs or experiences?	Yes. The creation of the strategy is to ensure people that are provided with preventative support and interventions at the earliest opportunity. The engagement process for the strategy has included surveys, focus groups, workshops, discussion panels and engagement events to obtain feedback on the proposed strategy. The engagement aims to be inclusive for all BCP residents, local communities, business and services, the provider market, commissioned services, health colleagues and BCP staff to ensure that feedback is received from as broad a range of needs and experiences as possible.

Surveys and presentations were also developed in easy read with the support from the Service Improvement Team and People First Forum. Consideration will be given to providing future information in easy read, accessible formats and translated versions of the consultation and strategy documentation.

The Department of Health and Social Care Paper Prevention is better than cure (2018) outlines a vision for public health focused on prevention. It emphasises creating conditions for good health to reduce the need for intensive social care. By addressing root causes and promoting early intervention, it aims to keep people healthier 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.'

General Population of BCP:

The ONS 2021 Census results for BCP give a resident population of **400,300**. This is an increase of **5.6%** compared with the 2011 Census and is **0.8%** higher than the mid-2020 population estimates.

Table 1 - Usual Resident Population[3]

	1981	1991	2001	2011	2021	Change 2011-21	% 2011-21
BCP	294,634	325,247	346,546	378,888	400,300	21,412	5.7%
SW	4,252,005	4,609,424	4,928,434	5,288,935	5,701,200	412,265	7.8%
SE	7,029,680	7,500,054	8,000,645	8,634,750	9,278,100	643,350	7.5%
England	45,771,917	47,055,204	49,138,831	53,012,456	56,489,800	3,477,344	6.6%

Census-2021-First-Release-Briefing-Paper

The ASC Prevention Strategy is aimed at all adults over the age of 18. The strategy seeks to ensure that local residents are supported at the earliest point to prevent them from going on to develop longer-term support needs. The estimated target population cannot be quantified due to the diversity and variety of circumstances that lead to an individual having contact with social care services or the voluntary and community sector.

The BCP areas population is expected to reach **403,600 by 2028, a growth of 2% since 2018**. This growth rate is slower than previously predicted and will be driven mainly by migration, including internal, international and cross-border moves.

Impact on protected characteristics:

Age

BCP has an older age profile with more residents over 65 and fewer under 16 compared to the national average. Specifically, 16% of the local population are aged 0-15 versus 18% for England and 22% of residents over 65 compared to the national figure of 19%.

Further to this, over two fifths of the current BCP population is aged 50 and over (41%); and 3.4% are aged 85 and over. This compares to 38% and 2.5% respectively for England.

In the BCP area there are:

Age	Number
0-15	65,903
16-64	250,032
65+	88,115

There is significant variation in numbers of older people within the older age bands. There are:

- A large cohort in their mid 70s born in the post war baby boom;
- Higher numbers in their mid to late-50s - the 60s baby boomers;
- A higher proportion of women, particularly from age 85 onwards. 53% of the population aged 65-84 are female, compared to 61% of those aged 85+.

This variation has implications for current needs and demand for services as well as an impact on future population trends.

Projections

Due to rising life expectancy and the transition into retirement of the 60s Baby Boom cohort, we have a growing number of older people. The number of over 50s could increase by around 17,000 people over the next decade – a 10% increase.

- By 2028, residents over 65 will make up 24% of the population, increasing by 12,400 people or 15%. Those over 85, currently 3.5% of the population will also increase.
- The number of residents aged 0-15 will drop by 4,500 (-7%)
- the working age population (16-64) will remain mostly unchanged, decreasing by just 106 people.

This shift in age distribution, especially the rise in older adults, will impact council services in the coming decade, particularly Adult Social Care.

Relationship between age and wellbeing

Previous research has shown the relationship between age and personal well-being to be U-shaped. That is, our sense of personal well-being is highest among younger people and older people and is lowest among people in their middle years. This is reflected in the ONS Annual personal well-being estimates for 2022 - 2023.

- A greater proportion of adults aged 50 to 54 and 55 to 59 years reported low levels of life satisfaction (7.9% for both groups) and low levels of happiness (10.3% and 10.9%, respectively).
- The greatest proportion reporting high levels of anxiety (25.1%) were also those aged 50 to 54 years. Anxiety remains fairly high until the ages of 65 to 69 when it begins to dip.

	• While the highest proportion reporting low levels of feeling things done in life are worthwhile (6.8%) were those aged 85 to 89 years. **Married or in a civil partnership** in 2022, there were 1,844 opposite-sex marriages and 70 same-sex marriages in the BCP Council area. Both figures were higher compared to 2021 when it is likely that pandemic restrictions impacted the number of ceremonies. There were 15 same-sex civil partnerships and 47 opposite-sex civil partnerships in 2022 in the BCP Council area. Legal partnership status The 2021 Census showed that in the BCP area, the largest percentage of usual residents ages 16+ are married or in a registered civil partnership (43%) with 37.5% never married and never in a civil partnership and 11% divorced or having had a civil partnership dissolved. 2% were separated but still legally married or in a civil partnership and 7% were widowed or a surviving civil partner. No different needs have been identified at this time in relation to the ASC Prevention Strategy. **Pregnant or maternity** Modifiable risk factors in pregnancy can have health impacts on both mother and child. Smoking, alcohol and substance misuse, poor nutrition, and obesity, both before and during pregnancy, are all associated with adverse child health outcomes, and are more common in deprived areas. Breastfeeding is a protective factor for infant survival, particularly for infants born preterm. • Rates of obesity and smoking in pregnancy and smoking at delivery in BCP are similar or better than for England overall, however, significant social inequalities exist. National data suggest women living within the three most deprived deciles experience significantly higher rates of obesity and smoking in pregnancy and at delivery. . • Rates of alcohol related admissions for females under 40 in BCP is significantly worse than the national average, and the highest in the Southwest. Rates have been rising since 2015/16. Social inequalities are also evident with Index of Multiple Deprivation (IMD) deciles 1, 2 & 4 having significantly worse rates nationally.

Maternal lifestyle risks and behaviour PIs and inequalities, BCP 2018-19[21]

	BCP	England	South West	Inequalities maternal deprivation	Inequalities ethnicity	Inequalities age of mother
Folic acid supplements before pregnancy (2018/19)	34.7%	27.3%	32.0%	IMD deciles 1-4 sig worse	Mixed, Asian & Black sig worse	Age <40 sig worse
Obesity in early pregnancy (2018/19)	19.6%	22.1%	21.0%	IMD deciles 1-3 sig worse	White & Black sig worse	-
Smoking in early pregnancy (208/19)	12.4%	12.8%	13.3%	IMD deciles 1-3 sig worse	White sig worse	-
Smoking status at time of delivery (2018/19)	10.5%	10.4%	11.0%	NA	NA	NA
Alcohol-related admissions for females <40 rate per 100,000 (2018/19)	435.4	261.7	323.4	IMD deciles 1, 2, 4 sig worse		
Babies first feed breastmilk (2018/19)	79.7%	67.4%	75.3%	IMD deciles 1-3 sig worse	White sig worse	Age <30 sig worse

Compared with England	Better	Similar	Worse

Late booking and poor attendance at antenatal care are associated with poor outcomes for mothers and babies. NICE recommends antenatal booking by 10 weeks of pregnancy, but significant inequalities exist in timely access to care.

• The proportion of women who access antenatal care within 10 weeks of pregnancy in BCP is significantly below the national and Southwest average:

BCP	55.4%
Southwest	63.5%
England	57.8%

Risk factors for late initiation of antenatal care include mothers living in the more deprived areas, ethnic minority groups (Mixed, Asian and Black ethnic groups in particular), high parity, age of mother especially <20, and living in temporary accommodation.

REF:
Commissioning - Long Term Conditions & Disabilities - Health inequalities in BCP Nov 2021.pdf - All Documents

Disability

The Equality Act defines disability as a physical or mental impairment that has a "substantial and long-term adverse effect" on the ability to carry out normal day-to-day activities.

BCP Census 2021 - Number of disabled people in household		
Category	**Number**	**Percentage %**
Total / All households	173,842	100%
No people disabled under the Equality Act in household	117,229	67.4%
1 person disabled under the Equality Act in household	45,244	26.1%

2 or more people disabled under the Equality Act in household	11,180	6.4%

Throughout our engagement during the development of our Prevention Strategy, we heard that people with disabilities experience:

Barriers to Access

- Physical and communication barriers in healthcare settings can prevent disabled people from receiving timely and appropriate care.
- Digital exclusion and inaccessible information make it harder to navigate services or book appointments.

Cultural and Attitudinal Challenges

- An outdated "what can't you do" mindset in services can lead to disempowerment and dependency.
- The 3 Conversations Model and similar approaches aim to shift this to a "what can you do" culture, focusing on strengths and potential.

Lack of Involvement in Service Design

- Disabled people are often feel excluded from shaping the services they use, leading to care that doesn't reflect their needs or lived experiences.

National data and research tells us that health and wellbeing outcomes are often poorer for disabled people when compared to the general population:

Health Inequalities

- Disabled people often experience poorer health outcomes and higher rates of avoidable deaths. For example, people with learning disabilities are significantly more likely to die from preventable causes
- Disabled people aged 16 to 64 years had poorer ratings than non-disabled people on all four personal well-being measures; average anxiety levels were higher for disabled people at 4.6 out of 10, compared with 3.0 out of 10 for non-disabled people (year ending June 2021).
- The proportion of disabled people (15.1%) aged 16 years and over in England who reported feeling lonely "often or always" was over four times that of non-disabled people (3.6%) (year ending March 2021).

Ref:
Outcomes for disabled people in the UK - Office for National Statistics
Mortality Among Adults With Intellectual Disability in England: Comparisons With the General Population - PMC

When services are inaccessible or unresponsive and individuals are already experiencing poorer health and wellbeing outcomes, preventative care is missed, leading to crises that could have been avoided.

This is also made clear in the CQC's State of Care report 2023/24, which highlights that people with disabilities face significant challenges accessing health and social care services, including long waits, physical and communication barriers, and insufficient capacity in adult social care. The report also emphasises that people with protected characteristics—including

disabilities—struggle to get timely care, often resorting to emergency services or delaying help until conditions worsen.

NICE also reports that people with learning disabilities often miss out on routine health checks and preventative care, contributing to poorer health outcomes.

Disability and age

There are around 16,000 people aged 50 or over in BCP whose health status is bad or very bad. The proportion in bad or very bad health increases to 15% for those aged 75 years and over, from 8% at age 65 to 74.

As the older population increases, the number of people living with ill health and multiple long-term conditions will increase too, generating significant additional demand for future care and support.

Older people are more likely to have multiple long-term conditions (LTC), which may compromise their quality of life. LTCs can present challenges in their social lives, psychological health, and activities related to self-care, domestic lives and mobility. These present difficulties not just for individuals but also for families, and care and support services

In BCP 115 thousand (80%) people aged 55 or over have at least one LTC. The proportion of people with 3 or more LTC increases from 29% aged 55-64 to 82% aged 85+. These can present significant challenges to people's lives. Supporting people to delay the onset and manage their LTCs is vital to maintaining health and independence.

Number of long-term conditions by age group:

Age	0 LTC	1 LTC	2 LTC	3+ LTC
55-64	31%	22%	17%	29%
65-74	19%	17%	18%	46%
75-84	9%	11%	15%	66%
85+	4%	5%	9%	82%

Top 10 long-term conditions 55+ age group

Condition	Number
Hypertension	55,696
Depression	30,265
Cancer	22.832
CKD Stage 3-5	19,924
Diabetes	19,773
Asthma	17,628
Coronary Heart Disease	14,977
Arterial Fibrillation	11,149
Osteoporosis	9,753
COPD	7,745

Race & Ethnicity

BCP's population has become increasingly diverse, 82% of the population were White British and 18% from an ethnic minority background, including white minorities.

In 2021 there were approximately 30,100 (5.3%) people born in the EU living in the BCP council area. This is a 60% increase from the 2011 census which showed an EU population of 18,800, equating approximately 5% of the population at the time.

Over 80 languages are spoken in the area with the top 10 being:

Language	Number
Polish	6,563
Portuguese	3,869
Romanian	3,066
Spanish	3,003
Hungarian	1,340
Italian	1,078
Arabic	865
Turkish	864
Russian	785
East Asian Language: All other Chinese	700

The 2021 Census also shows that our older population is becoming more diverse:

- 6% of older people aged 65+ identified as a minority ethnic group, compared to 12% aged 50-64.
- The majority identify as White: Other White (43%), followed by Asian, Asian British or Asian Welsh (19%).
- There is significant variation in the number and proportion of older people from minority ethnic groups between wards, from just over 1,000 (40%) in East Cliff & Springbourne to around 150 (8%) in Creekmoor.

Throughout our engagement into the ASC Prevention Strategy, and through local and national research, we have heard that people who come from an ethnic minority background have different experiences in their overall health and wellbeing, and access to services:

Ethnic minority groups are more likely to live in deprived areas, which are associated with poorer health outcomes.

- Deprivation affects access to nutritious food, safe housing, education, and employment—all of which influence health.

Experiences of racism, discrimination or a lack of cultural awareness can impact how services are designed and delivered, leading to unequal treatment or barriers to access.

- Language differences, cultural misunderstandings, and lack of culturally appropriate services can make it harder for some ethnic groups to engage with health and social care.
- Some may delay seeking care due to mistrust of the system or previous negative experiences.

Certain ethnic groups are more likely to experience specific health conditions. For example:

- Black African and Caribbean populations have higher rates of hypertension and stroke.

Some conditions may be underdiagnosed in ethnic minority groups due to lack of awareness among healthcare providers or biases in diagnostic tools. This can lead to delayed treatment and worse outcomes.

Furthermore, refugees often face higher levels of trauma and stress that can stem from experiences in their home countries and can be worsened during the asylum process, by media publications, negative reactions on an international scale (such as riots or racism) or concern and fear for the welfare of loved ones.

Ref:
The Health Of People From Ethnic Minority Groups In England | The King's Fund
Inequalities by ethnicity | The Health Foundation.
MHF Mental health of asylum seekers and refugees - 2025 report V2.pdf

Religion or belief

In the ONS National Census 2021 the question regarding religion is voluntary, 94% of national population answered the question.

The Southwest is the least religiously diverse region with only 3.2% of usual residents selecting a religion other Christian, not including those that select "no religion".

In the BCP Council area:

Religion	Percentage
Christian	46.8%
Buddhist	0.5%
Hindu	0.7%
Jewish	0.4%
Muslim	1.7%
Sikh	0.1%
Other	0.7%
No religion	42.2%
Not answered	6.9%

Experiences for people of certain religions and cultures can differ and influence their overall health and wellbeing:

Religious beliefs can influence diet, alcohol use, sexual health practices, and attitudes toward medical treatment (e.g. blood transfusions or end-of-life care). These beliefs may affect how individuals engage with health services or adhere to medical advice

- Some groups may struggle to identify caring roles as it is an expectations of the religion or culture.

People from some religious groups, especially people of the Muslim and Jewish religion, report experiencing discrimination in their communities, which can lead to mistrust and reduced engagement with services.

- Further to this, with growing conflict between countries and religions, the UK has seen an increase in antisemitism and religious hate crime.

Ref:
Antisemitic Incidents Report January-June 2024 – CST Publications – CST – Protecting Our Jewish Community

A lack of cultural or religious sensitivity in service provision (e.g. gender-specific care, prayer space, dietary needs) can discourage people from seeking support and engaging with services.

- Faith can be a source of resilience, but also a barrier if physical or mental health issues are stigmatised within a religious community.
- Some groups may prefer faith-based support over health and social care services.

Faith communities, however, often play a positive role in promoting health, especially during crises like COVID-19, by disseminating information, hosting clinics, and supporting vulnerable members.

Sex at birth

According to WHO research, sex and gender both impact health outcomes in different ways. Gender affects health throughout life, influencing experiences in crises, disease exposure, and access to healthcare, water, hygiene, and sanitation.

A study by Manual, a wellbeing platform for men, found that in many countries, men are more likely to face greater health risks. However, the UK does not follow this trend. It was found to have the largest female health gap in the G20 and the 12th largest globally.

Gender Health Inequalities

Women's Health:

- Women often face misdiagnosis and longer wait times for treatment. Research shows that women with abdominal pain wait 65 minutes in A&E, while men wait 49 minutes. Women are also less likely to get painkillers.
- Women's health concerns are often not taken as seriously. They are 13% less likely to receive pain relief or life-saving drugs after heart attacks.
- Alzheimer's is diagnosed later in women due to better verbal memory.
- Medical research has historically excluded women, leading to knowledge gaps.
- Women with dementia receive less care and support and have worse outcomes.

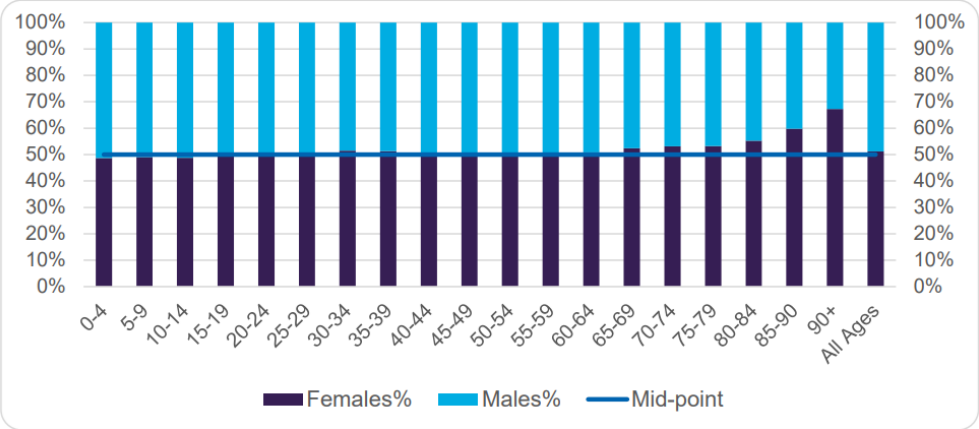
Impact of Gender Norms:

- Rigid gender roles harm both men and women.
- Women and girls more likely to take on domestic and caregiving roles.

- Men are more likely to take up risky behaviours and habits and avoid seeking help.
- The pressure to be a breadwinner is linked to stress-related illnesses in men.
- Men are also at a higher risk of suicide and are less likely to show symptoms of depression or anxiety or talk about how they feel.

Ref:
https://pubmed.ncbi.nlm.nih.gov/18439195/
https://pmc.ncbi.nlm.nih.gov/articles/PMC4831033/
https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002805
https://pmc.ncbi.nlm.nih.gov/articles/PMC4800017/
https://www.ucl.ac.uk/news/2016/dec/women-dementia-receive-less-medical-attention
https://pubmed.ncbi.nlm.nih.gov/17522133/
https://hal.science/hal-00477883/document

BCP 2021 Census – Gender:
The population in BCP Council is split by 51% female and 49% male as shown in the chart below. The chart illustrates that while in the younger age groups the percentage of males generally exceeds females, in the older age groups this pattern is reversed.



Census-2021-First-Release-Briefing-Paper

LGBQTQ+ Communities

Sexual orientation

BCP 2021 General Population Census Data:
309,329 (92.4%) people aged 16 years and over in BCP answered this question:

- Straight or Heterosexual: **88.5% (296,257)**
- Gay or Lesbian: **1.9% (6,494)**
- Bisexual: **1.6% (5,358)**
- Pansexual: **0.2% (829)**
- Asexual: **0.1% (251)**
- Queer: **0.0% (75)**
- All other sexual orientations: **0.0% (65)**
- Not Answered: **7.6% (25,580)**

Ref:
Sexual-Orientation-Gender-Identity-Briefing-Paper

	LGBTQIA+ individuals—including those who identify as gay, lesbian, bisexual, pansexual, asexual, queer, and other sexual orientations—experience distinct challenges in their health wellbeing, and access to health and social care services: • Mental Health: Higher rates of depression, anxiety, and suicide due to discrimination and stress. • Chronic Illness & Substance Use: More chronic conditions and higher tobacco, alcohol, and drug use. • Healthcare Access: Many face discrimination and lack of LGBTQ+ competent care. • Preventive Care: Lower use of some services (e.g., gynaecological exams), but higher sexual health screening. • Financial Barriers: More likely to face poverty, housing issues, and trouble affording care. • Progress: More LGBTQ+-focused mental health support and calls for inclusive healthcare policies. *Ref:* *KFF Report on LGBT+ Health and Access to Care* *Frontiers in Public Health: Health Inequalities in LGBTI+ Populations* *The Hospitalist: Disparities in LGBTQIA+ Healthcare* A report from the House of Commons Women and Equalities Committee highlights several disparities in equality and experiences faced by LGBTQ+ people in health and social care *Ref:* *LGBT Health and Social Care:* LGBTQ+ individuals often experience worse health outcomes compared to the general population. This includes higher rates of mental health issues, substance abuse, and certain chronic conditions: **Mental Health**: 3% of gay/bisexual men attempted suicide (vs. 0.4% of men overall); 80% of trans youth have self-harmed (vs. 10% of youth generally). **Physical Health**: Lesbian/bisexual women face higher risks of obesity and heart disease; bisexual women are 4× more likely to have long-term mental health issues. **Sexual Health**: Men who engage in sexual activity with other men (MSM) account for 80% of new syphilis cases. **Lifestyle**: Gay/bisexual men are less likely to meet dietary guidelines. **Access to Health and Social Care**: Many LGBTQ+ people face barriers to care due to discrimination, lack of provider understanding, and fear of being outed. Discrimination from professionals can deter individuals from seeking help. **Data Collection**: Lack of comprehensive data on LGBTQ+ health needs makes targeted support difficult **Gender Identity Gender Reassignment**

	BCP 2021 Census - Gender Identity: 1,588 (0.5%) indicated that their gender identity was different from their sex registered at birth: • **549 (0.16%)** answered "No" but did not provide a write-in response • **330 (0.10%)** identified as a trans man • **291 (0.09%)** identified as a trans woman • **259 (0.08%)** identified as non-binary • **159 (0.05%)** wrote in a different gender identity Ref: *Sexual-Orientation-Gender-Identity-Briefing-Paper* Experiences of trans, non-binary, and gender-diverse people across the UK are varied. This may be due to individual services experience and understanding: Experiences in Health and Social Care • Discrimination: 70% of trans and 55% of non-binary people report poor treatment or lack of understanding from healthcare staff. Nearly half say their GP doesn't understand their needs. • Delays: 90% of trans people face delays in accessing gender-affirming care, with even greater barriers for trans people of colour. • Fear of Disclosure: Many avoid sharing their identity in care settings due to fear of mistreatment. Social Care and Community Impact • Invisibility: Gender-diverse people are often excluded from data, leading to gaps in service design. • Isolation: Discrimination contributes to mistrust and social isolation. • Workplace Barriers: 37% of non-binary people hide their identity at work due to fear of discrimination. *Ref:* *National LGBT Survey: Summary report* *LGBTQ+ facts and figures | Stonewall* *Trans People And The NHS: The Heat Of The Debate Needs The Light Of Evidence | The King's Fund* **Socio-economic** Levels of deprivation play a significant role in health inequalities. Deprivation is a measure that assesses areas based on how they fare on multiple fields, including income, employment, quality of environment, health, education, and housing. BCP is an area of significant disparity with neighbouring areas among the most and least deprived within England. LSOA's (Lower-layer Super Output Area) refer to the level of deprivation experienced by residents within a specific small area in England, as measured by the English Indices of Deprivation (IMD). In the BCP area 45,400 people (12% of the population) in BCP live in areas that are among the most deprived 20% nationally, including 8,900 0-16 year olds and 6,200 over 65s.

There is a social gradient to people's health, and the length of time people live is closely related to the extent of disadvantage and deprivation they experience. The difference in life expectancy between the most and least deprived quantiles of LSOAs in the BCP area in 2021 was:

- 6.9 years for males
- 6.4 years for females

Ref:
An overview of health inequalities in BCP – November 2021

In addition to the above, we have also adopted several local characteristics that must also be considered when developing equality impact assessments. These are:

Military veterans

Veterans are defined as anyone over the age of 16 who has served for at least 1 day in His Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations. Not everyone will define themselves as a veteran. The term 'service leaver or ex-armed forces' can often be used instead.

The 2021 Census shows that there are 1.85 million veterans in England and Wales (3.8% of the over 16 population), with around 2 million estimated across the whole of the UK.

In April 2024, the BCP are was home to 1,070 Ministry of Defence personnel. This included 960 military (UK regular forces) and 100 civilians (full-time equivalent).

It is estimated that 74% of all military personnel national are married or have a long-term partner and that 48% have children they support financially. This equates to around 710 partners and around 460 service personnel with children in the BCP area based of the military figures.

BCP 2021 Census – Military veterans:
BCP is home to both serving military personnel and veterans. There are **15,894 (4.7%)** residents aged 16+ have previously served in the UK armed forces:

- Previously served in regular UK armed forces: **12,743**
- Previously served in reserve UK armed forces: **2,443**
- Previously served in both UK armed forces: **708**
- Total: **15,894**
- Has not previously served in any UK armed forces: **319,015**

Ref:
Armed Forces - Our people our place - Equality and Diversity - Power BI

Each veteran's service experience is unique. While many have positive memories, others face challenges that affect their transition to civilian life. Some may not identify as veterans, especially if their experience was negative.

- **Diverse Experiences**: Female and LGBTQ+ veterans may face unique challenges, including the legacy of exclusion.
- **Family Impact**: Frequent moves, disrupted careers for spouses, and complex family dynamics are common.
- **Transition Challenges**: Leaving service can be sudden, and adjusting to civilian life often requires tailored support and guidance.
- **Pride and Self-Reliance**: Veterans may downplay their needs, focusing on others and avoiding asking for help.
- **Access to Services**: Many are unfamiliar with civilian systems, expect faster responses, and may face barriers or confusion about what's available.
- **Barriers to Support**:
    - Stigma around mental health
    - Lack of military-aware professionals
    - Difficulty finding purpose post-service
    - Financial pressures and undervaluing transferable skills
    - Misunderstandings from the public and media

Minority veterans face the same barriers as the majority, but these are often intensified due to their minority status and experiences.

Despite these challenges, veterans bring valuable skills and resilience that can benefit communities.

REF:
Personalising veteran healthcare: recognising barriers to access for minority and under-represented groups of veterans
10 things to know about veterans and their families: desk aid - GOV.UK

Unpaid Carers

A carer is a person of any age who provides or intends to provide on-going, unpaid support to a partner, child, relative or friend. Without this help, the health and wellbeing of the cared for person could deteriorate due to frailty, disability, a serious health condition, mental ill health or substance misuse.

- The carer may live with or apart from the cared for person
- Professional care may also be in place
- The cared for person could be in residential care, however the carer should still be recognised and may still need support

The 2021 Census shows that an estimated 5.0 million usual residents aged 5 years and over provided unpaid care in 2021 in England and Wales.

In BCP, the census found that **33,352** (**8.8%**) of usual residents aged 5 and over were providing unpaid care.

Number of Carers in BCP

- Total: **33,352**
- 1 to 19 hours unpaid care a week: **17,394**
- 20 to 49 hours unpaid care a week: **6,334**
- 50 or more hours unpaid care a week: **9624**

- Provides No Unpaid Care: **347,966**

Ref:
HOME - Our people our place - Health & Wellbeing - Power BI

The impact on carers' lives varies depending on the amount of care they provide, their age, and the length of time they have been providing that care. The needs of the individual receiving care and the relationship between the carer and cared for person will also have an impact on the caring experience.

Caring can impact on:
- The ability to access and stay in employment
- Financial resources
- The health and emotional well-being of the family unit
- The ability to access social and recreational activities
- Wider relationships with family and friends

For young carers it can also impact on their:
- Experiences of childhood
- Health and well-being
- Education and career opportunities
- Family and peer relationships
- Sense of identity

We also recognise that being a carer can impact on life after caring:
- Adjusting to changing relationships when caring at home is no longer viable
- Social isolation and lack of confidence after a bereavement
- Redefining their identity and purpose
- Having a higher risk of needing care services themselves

Children in care and care experienced young people

In 2025, there are approximately 516 children being looked after by BCP Council.

Data from the Sufficiency strategy for children in care and care experienced young people 2021-2024 tells us that on 31 March 2020 there were:
- **526 children in care** (CiC) within the BCP area
- **252 care experienced young people** (CEYP) within the BCP area

Further analysis from 2020 shows that of this cohort:
- 59% were boys
- 31% were aged 16+
- 24% were from BAME background
- 7% were Unaccompanied Asylum-Seeking Children (UASC)
- 5% had disabilities
- 14% of children were placed more than 20 miles from home address
- 8% came into care through police protection powers
- 71% were in foster care
- 4% were in semi-independent placements
- 88% had their annual health assessment

- 17% left care through adoption
- 9% moved more than three times in the year 2019-2020
- 70% were in education, employment or training
- 3% were in higher education (7 at university)

Children in care and care leavers can experience a multitude of challenges, including mental health difficulties, social isolation, difficulties with housing and employment, and limited access to support services. These challenges are often exacerbated by past trauma, lack of stability, and inadequate preparation for independent living.

Health and Wellbeing

- **Mental Health:** Care-experienced young people are more likely to face mental health challenges, including anxiety, depression, and trauma-related conditions. A more integrated and responsive mental health system is needed to support them effectively
- **General Wellbeing:** By the teenage years, 1 in 6 reported low overall wellbeing.
- **Social Relationships:** Compared to peers, fewer children in care report having close friendships or feeling able to talk to carers about important matters

Access to Health and Social Care

- **Barriers to Support:** Children in care often face fragmented services and inconsistent support. There are gaps in continuity of care, especially during transitions (e.g., moving placements or leaving care).
- **Inequality of Entry and Experience:** Children from the most deprived areas are significantly more likely to enter care.
- **Kinship and Informal Care (cared for by relatives / informally arranged care without social care involvement):** Many children in such arrangements are not formally registered, limiting access to services

REF:

Exploring the Lives of Care Experienced Children and Young People | National Centre for Social Research
10,000 Voices: The views of children in care on their well-being report - Coram Voice
Care experienced children and young people's mental health | Iriss

<u>local business or community organisations</u>

There are nearly **15,400 businesses** in the BCP Council area with around **89% considered micro-businesses** employing less that 10 staff, similar to the national average. Around **50 businesses are considered large**, (employing 250 or more people).

The number of businesses in the BCP area increased year on year with the exception of 2019-20 and 2022-23. This is comparison to both national and regional figures where nationally the number increased year on year until 2022 before decline during 2023 and 2024. Regionally, numbers have declined across the southwest from 2022.

In 2023 there were **1,910 new businesses** set up in the BCP area and **1690 business failures.**

	Ref: *HOME - Our people our place - Economy - Power BI* As of April 2021, there were **657 general registered charities** in the BCP Council area and 2,600+ voluntary and community sector groups. *Ref:* *Empowering Communities - Summary of VCS and Volunteer Strategy* Covid.19 had a significant impact on our economy and the ways in which organisations conduct their businesses. However the positive responses from many organisations throughout the pandemic saw communities coming together to support each other. Our Prevention Strategy seeks to strengthen this community support and enable people to live a fulfilled and meaningful life in a place they call home. During our engagement with the VCSE (Voluntary, Community and Social Enterprise), market providers and commissioned services we heard that the commissioning process is overly complex and rigid. Smaller organisations who are less versed in completing bids and applying for tenders feel they are missing out of opportunities as they are competing against larger organisations who have the resources and tools to bid for contracts. Smaller organisations can sometimes provide a more flexible and personalised service. They will be placing more focus into commissioned contracts due to it likely being their largest source of income. Larger organisations will be providing a variety of services and therefore may not be nurturing a commissioned service as closely. Our prevention strategy recognises that the VCSE sector and local market needs to be supported to thrive, therefore we will be reflecting on our own practices and working with the market to identify ways to make commissioning work for everyone. We do not see the prevention strategy having any negative impacts on local businesses or community organisations.
Will this change affect any service users?	Yes. The strategy would affect any BCP residents regardless of eligibility for care and support from Adult Social Care. Feedback received during the engagement may affect the content of the strategy and therefore the direction and focus of the ASC Prevention Strategy.
What are the benefits or positive impacts of the change on current or potential users?	The positive impact of a broad consultation and feedback from a wide range of people with different needs, experiences and opinions will ensure that this is reflected in the focus and approach of the new ASC Prevention strategy. The strategy aims to recognise services across the BCP Council area (both internal and external) that help to prevent, reduce or delay the development of longer term care needs. This will provide clarity for staff and BCP residents around providing more preventative interventions, reducing the need for longer term care and support, which in turn will improve the person's wellbeing, reduce reliance on carers, and reduce the need for ASC to provide longer term care and support.

	The strategy aims to secure longer-term funding for preventative services and interventions, ensuring continuity of service for local residents and security for the VCSE sector. The strategy may result in new services being commissioned that help to prevent the development of longer-term care needs. The strategy may result in changes being made to current services to improve provision. The strategy aims to promote partnership working and collaboration with the VCSE sector, market and partners in health sectors to improve communication between the local authority and key stakeholders. This will help to streamline peoples' experiences of support and the pathways they may encounter. **Benefits relating to our priorities and focus areas:** A change in culture • Strength based approaches helping people to develop more independence and resilience creating sustainable positive outcomes. • Wider promotion of equal opportunities to create a more inclusive and supportive environment for individuals • Greater co-production through the implementation of BCP Adult Social Care's Co-production Strategy • People feeling better able to engage with social care and navigate pathways by ensuring the use of empowering language and addressing key issues that create barriers in access. Living and ageing well • A reduced risk of falls and improved physical health and independence among older people and adults with physical conditions and mobility limitations through targeted interventions. • Wider promotion of physical activity in adult social care to improve health and wellbeing. • Better access to financial assistance and advice to maintain a dignified standard of living • Strengthened age friendly communities work through continued collaboration and development Individual resilience to build wellbeing • Better access to timely, and inclusive information, advice, and self-education resources that promote healthy lifestyles, early intervention, and informed decision-making. • Services exist that 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. • Enhanced support for individuals who hoard or self-neglect, reducing risk and promoting safety, wellbeing, and independence. • Enhanced 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.

	• Increased identification of unpaid carers with improved access to information, advice, direct payments and wellbeing services, enabling them to maintain their caring role, avoid crisis, and live well alongside caring. • Preventing the escalation of care needs by expanding access to Occupational Therapy and Care Technology that supports daily living, to enhance safety, and empower individuals to manage their health and wellbeing at home. Supporting the workforce • Improved workforce wellbeing in adult social care • Greater use and access of learning and development opportunities that embed preventative approaches and promote continuous improvement. • Compassionate leadership that prioritises workforce wellbeing, fosters a culture of continuous learning, and drives the delivery of preventative, person-centred support. • A prevention-first mindset embedded across the adult social care workforce with better access to community-based knowledge, training, and leadership support that empowers practitioners to act early and innovatively. • Greater capacity for prevention with integrated, collaborative, and communicative partnerships across health, social care, and community sectors. Connecting Communities • reduced loneliness and isolation and reduced health and social inequalities with more community connections, improved access to inclusive and person-centred support, and increased trust with underserved groups ensuring all individuals can access the support they need to live healthier, more independent lives. • People are able to live independently at home for longer through community-based, person-centred support that reduces avoidable admissions, delayed discharges, and reliance on long-term residential care through integrated, localised, and accessible services • safer, more secure communities with awareness of personal and digital safety, and community-led safety initiatives. • Better partnership working and collaboration with the voluntary, community, and social enterprise (VCSE) sector by embedding supportive commissioning practices and promoting collaborative relationships.
What are the negative impacts of the change on current or potential users?	There are no negative equality impacts identified from the introduction of an ASC prevention strategy. The engagement has a limited timescale and limited resources meaning that feedback (and therefore the outcome) of the engagement is reliant upon utilising the feedback from people who have chosen to engage in the consultation and may not reflect the views and opinions of all BCP residents. To ensure representation from all groups we will be working closely with the VCSE sector and cohort specific teams and organisations to engage with local residents from different protected characteristic groups during the development of the prevention strategy actions plan and it's implementation.

Will the change affect employees?	Once implemented, the Prevention strategy would support BCP employees with providing earlier preventative support before a person develops longer term needs. This will mean more preventative interventions but reduce the need for longer term care and support requirements. The strategy aims to improve communication with the workforce to support them in their roles. This includes regular updates about any changes being made to current services. Staff will be involved in the development of the prevention strategy action plan to ensure any changes account for the needs of the ASC workforce. The strategy may result in changes being made to current preventative services, new services being commissioned or existing service being decommissioned – any changes to provision as a result of strategy implementation will have a separate equality impact assessment completed to ensure there is consideration to making content of the strategy accessible and non-discriminatory and that the implemented strategy is inclusive.
Will the change affect the wider community?	Yes. The strategy would affect any BCP residents eligible for care and support from Adult Social Care and also have a positive impact on reducing the need for longer term care and pressure on unpaid carers and use of community resources and services if preventative measures are implemented before becoming longer term enduring care and support needs. The VCSE Sector is well placed to support a better understanding of need and will be involved in the development of the prevention strategy action plan The strategy recognises the importance of the VCSE Sector and aims to secure long-term funding for commission services, clarify funding opportunities available for communities and raise awareness to the support available in communities. The strategy will also impact the wider market and VCSE organisations and may result in an increase in referrals to community based support - we will work closely to identify what services are receiving high demand to gain an understanding of what services are needed locally.
What mitigating actions are planned or already in place for those negatively affected by this change?	**We have not identified any negative impacts of the Prevention Strategy, however, to ensure it is fully inclusive and accessible we will:** **Inclusivity:** • **Easy Read and Large Print Formats:** We will work with partners to ensure the prevention strategy can be available in easy read and large print format. • **Translations:** we will work with partners to ensure translations into other languages would be available upon request. • **Audible Option for Visually Impaired:** We will work with partners to ensure audible and visual options are available upon request. **Engagement and Consultation of the Strategy:**

	• The majority of engagement will be through mail shots, ensuring that information reaches a broad audience, including those who may not have internet access. • There will be opportunities to be involved in focus groups throughout the strategies implementation. • We will engage with key organisations/teams and community groups that's represent people from protected characteristic groups to ensure they can share their views. **Communication:** • We will provide regular updates throughout the prevention strategy implementation to ensure the workforce, wider market and communities are informed about any changes being made. • We will utilise existing communication channels with the VCSE sector to ensure effective partnership working and work with leading VCSE organisations to reach a wider audience. • We will look to have regular meetings and collaborative forums with the VCSE sector to share, learn and ensure the sector is aware of any planned changes. • We will work closely with the communities team to maintain an awareness of, and share information about ongoing schemes, opportunities and funding. • We will explore options for improving communication within the workforce via the ASC intranet, webinars and forums. Future strategy implementation will have a separate equality impact assessment completed to ensure there is consideration to making content of the strategy accessible and non-discriminatory and that the implemented strategy is inclusive.

Summary of Equality Implications:	The strategy will have positive impact and all experiences will continue to be considered to ensure that everyone can access preventative support to remain independent and live healthier happier lives.
	
	Impact on Service Users:
	• The strategy will affect all BCP residents, not just those eligible for Adult Social Care (ASC).
	• Feedback from public engagement may shape the strategy's direction and action plan.
	• The strategy may result in new services being developed – in line with local people's needs
	• The strategy may result in current services being re-tendered, adapted to meet needs, or decommissioned
	
	Positive Impacts:
	• Broad consultation ensures diverse needs and experiences are reflected.
	• Focus on preventative services aims to:
	  • Delay or reduce long-term care needs.
	  • Improve individual wellbeing.
	  • Reduce pressure on carers and ASC services.
	  • Supporting staff and residents to identify preventative solutions

	• Secure long-term funding for preventative services and support the VCSE sector. **Negative Impacts:** • No negative equality impacts identified currently. • Limited engagement resources may mean not all resident views are captured. • Efforts will be made to engage underrepresented groups through VCSE partnerships. **Impact on Employees:** • Strategy will guide staff to provide earlier, preventative support. • Aims to shift focus from long-term care to early interventions. • ASC Workforce wellbeing is recognised within the strategy. **Impact on the Wider Community:** • Benefits all BCP residents by reducing long-term care needs and supporting community resources. • VCSE Organisations are key stakeholders and will be involved in the development of the prevention strategy action plan • The strategy aims to secure long-term funding for commission services, clarify funding opportunities available for communities and raise awareness to the support available in communities. • An increase in referrals for preventative support may impact VCSE organisations – we will work closely to identify what services are receiving high demand to gain an understanding of what services are needed locally. **Mitigating Actions:** • Accessibility measures include to ensure inclusivity when publishing the prevention strategy and co-developing the action plan • Wider engagement with communities and organisations that have trusted relationships with groups from protected characteristics • Engagement via mail shots and through existing networks • Opportunities to be involved in focus groups • Future implementation will include an equality impact assessment to ensure inclusivity. • Use of the ASC intranet page to reach the workforce with regular updates relating to the strategy implementation