HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Fulfilled Lives Programme Update**
Meeting date	20 July 2026
Status	Public Report
Executive summary	In July 2024, BCP Cabinet and Full Council agree to support a four-year transformation programme called Fulfilled Lives, approving a total investment of £2.9m spanning the first three years. The programme is made up of four inter-dependent projects: • How We Work • Short-Term Support • Self-Directed Support • Support At Home The programme entered its delivery phase in January 2025 and progress reports were presented to Committee in January, March, July and September. This report provides a further update for the programme overall to reflect the achievements to date, the current challenges, and the next steps to be taken over the following six months.
Recommendations	**It is RECOMMENDED that** Committee notes the current work-in-progress with the Adult Social care Fulfilled Lives Programme
Reason for recommendations	Delivery of the Fulfilled Lives programme will improve outcomes for adults and their families within the BCP Council area through enhanced person-centred practice, and the provision of effective and efficient support solutions. It will ensure that the Council continues to meet its statutory duties, despite ongoing demand pressures and economic uncertainty, leading to recurrent annual savings of c.£3.5m by the end of the programme in 2028

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Wards	Council-wide
Classification	For recommendation

Background

1. In July 2024, BCP Cabinet and Full Council approved the business case for an adult social care 'Fulfilled Lives' transformation programme which will address the risk to its ability to fulfil statutory responsibilities and maintain a balanced budget in the face of continually rising demographic and economic pressures.
2. This business case outlined the opportunities available to deliver true transformation and innovation within adult social care, whilst creating sustainable change to support future demand, and achieve financial and service quality benefits.
3. Total investment of £2.9m to support the Fulfilled Lives programme was agreed by Cabinet and Full Council in July 2024, with an initial investment of £1.79m to establish the programme and its governance structure, recruit to the project teams, complete the scoping, initiation and approve business cases for each project.
4. The programme moved into Delivery Phase from January 2025 with regular reporting to the Health and Adult Social Care Overview & Scrutiny Committee, and received approval of a further £1.11m to support its progress in July 2025.
5. The programme remains within budget with service quality improvements continuing to be achieved as planned, although some challenges have more recently impacted the timeline for the realisation of specific financial benefits, further details of which are outlined later in this paper.

Strategic case for change

6. The Fulfilled Lives Programme aligns with the Adult Social Care Strategy 2025-28 and our co-produced vision "*Supporting people to achieve a fulfilled life, in the way that they choose, and in a place where they feel safe*".

Summary of programme progress

7. The Fulfilled Lives Programme has four inter-dependent projects, as follows:

- **How We Work** – to implement the Three Conversations approach, embedding strengths and relational-based practice to connect and support residents, focusing on prevention. A second key workstream has a focus on making improvements to our First Response function.

- **Self-Directed Support** – ensuring more people are in control of their support by developing more community-based options via direct payments or Individual Service Funds, reducing the need for more traditional 'off the shelf' services at higher cost.
- **Short-Term Support** – improving access to reablement services directly from the community, ensuring that people can appropriately maximise their safety, wellbeing and independence, and reduce their need for long-term services.
- **Support At Home** – developing and implementing a new Support At Home provision, enabling people to keep well and remain in their own home, reducing the need for residential care home admission.

How We Work

8. The Three Conversations principles have been adopted across all operational teams with responsibility for assessment and care and support planning under the Care Act 2014.
9. The final stage of reconfiguring our First Response function, by reallocating staff from Long-Term Conditions teams to our Adult Social Care Hub, have been fully operational for almost six months, enhancing our prevention and early intervention approach. This ensures that people receive timely information and advice, and connection to community resources that will help them.
10. The ASC Hub's new ways of working have also ensured that more people have the benefit of short-term intermediate care by accessing the Community Reablement Service that is being piloted as part of the Short-Term Support project (see below). The percentage of new requests accessing short-term support has risen from an outturn of 15.3% for 2024/25 to 31.2% for 2025/26.
11. The combined impact of the workstreams within the How We Work project has reduced the number of new requests for support that result in long-term services. Adjusted for contacts relating to Safeguarding and Mental Health Act assessment, the conversion rate has fallen from 8.7% to 7.8%, realising the programme's £961k savings target for 2025/26
12. Our Care Quality Commission (CQC) Local Authority Assurance Report, published 18 June, recognised the improvements to our first contact arrangements.

> *'Skilled practitioners completed more work at first contact, which reduced handoffs and helped people avoid repeating their story. For instance, some people told us the new hub had arranged urgent therapy within a week and had coordinated rapid support with other agencies where risks to people's wellbeing and safety were high. Staff said joint work with occupational therapists early in the assessment reduced delays and enabled proportionate, person-centered problem solving. The pathway from first contact aimed to build a team around people and provided information and advice before transferring to the most suitable team when needed.'*

13. The CQC report also noted how the Three Conversations approach *'supported clearer planning and safer decisions.'*

14. That said, our own practice audits have shown that not all teams are applying the approach consistently, a point also recognised in the CQC's report. Our focus has now switched from implementation to embedding the approach to promote consistency, recognising the large scale cultural and mindset shift that is necessary for the full benefits of the approach to be widely realised.

15. Further enhancements to our first response function are currently focused on how we can fully leverage the potential efficiency benefits from our telephony system to further improve call wait times during busy periods and creating easier ways for other health and care professionals to refer safeguarding concerns or request Mental Health Act assessments.

Self-Directed Support

16. Our partnership with Community Catalysts has now established eleven Community Micro Enterprises (CMEs), and work is continuing to promote these businesses with people who have chosen to receive their personal budget in the form of a direct payment.

17. A further seventeen CMEs are currently progressing through the Community Catalysts accreditation programme.

18. An example of how CMEs support people with more person-centred solutions to their care and support can be found at **Appendix Two**.

19. Following a period of consultation with frontline practitioners and people and carers in receipt of a direct payment, the outputs have been analysed to establish a clear improvement plan, designed to make access and administration easier for recipients understand and to simplify processes that helps practitioners more confidently discuss the benefits of direct payments with people they are supporting. This workstream launched in June and is anticipated to take six-to-twelve months to complete.

20. Work is continuing to encourage framework care providers to begin offering the option of Individual Service Funds to broaden people's personal budget options and opportunities for enhanced person-centred support.

Short-Term Support

21. The Community Reablement Pilot is approaching the three-quarter stage when evaluation will commence to inform the longer-term commissioning intentions. Uptake has improved since the full implementation of the changes at the ASC Hub (see above)

22. Most recent data (June 2026) 137 people have received reablement support, our data shows:

    - 69 people regained full independence
    - 44 people required long term care

- 3 people needed residential care
- 21 people were either admitted to hospital; family support took over or other reasons.

23. Of the 44 people who needed long-term care:
    - Fifteen people (34%) needed fewer hours of support than they did at the start of their reablement
    - Eighteen people (41%) needed the same level of support
    - Eleven people (25%) needed more support
24. Practitioner guidance has been produced to ensure that the most appropriate candidates for reablement are referred for support
25. Ongoing promotion of the pilot will continue, highlighting examples of the positive outcomes achieved for individuals and the wider health and care system. The next phase will focus on completing a full evaluation to inform future commissioning requirements.
26. Tricuro reablement services are tracked separately with an average weekly reduction of 6.1 hours domiciliary care per person (equivalent to a 50% reduction in hours at the end of reablement compared to the start).

Support At Home

27. The Support At Home project is a commissioning-led project to replace expiring legacy council domiciliary care contracts with a new all-age domiciliary care framework that encompasses long-term conditions, mental health, learning disability and autism support.
28. The project is founded on the Care and Support at Home Strategic Plan which has been fully developed and completed its path through the governance process. This plan sets out a clear long-term vision for how home-based care and support will be commissioned, delivered, and monitored across the locality. It provides a structured framework for achieving person-centred, outcome-focused services that support adults to live independently in their own homes for as long as possible.
29. A new combined Care and Support at Home Framework (Lot 1) has been developed and formally approved, marking a significant step forward in standardising and strengthening the commissioning of home care services for adults aged eighteen and above. The framework also includes a waking-night assessment service (Lot 2).
30. Minimum Criteria for Care and Support at Home providers included The requirement to have a local office registered within the BCP conurbation or no further than 10 miles from BCP and providers who submit a tender must be rated as Good or Outstanding by the Care Quality Commission.
31. The project remains on target with the Care and Support At Home procurement tender having closed on 7 April, resulting in a total of 83 bids for Lot One and 34 bids for Lot Two.

32. The evaluation of all bids took place throughout May and June, with the final moderation stage due to complete by the end of June. Contract awards will be made in July with contract mobilisation in October 2026.

33. To ensure that individuals with more complex, high need, or specialist conditions receive tailored and expert provision, specialist and complex care will be commissioned separately through a dedicated Disabilities Framework.

Summary of financial implications

34. The total investment over a 3-year period is £2.9m to achieve recurring savings of approx. £3.5m. Whilst there has been some in-year delays within certain elements of the programme delivery, the £961k savings target for 2025/26 was achieved in full, and we remain confident that the combined impact of all projects will achieve the projected cumulative savings by the time the programme concludes in 2028.

35. The savings attributed to the Fulfilled Lives programme are in addition to those that have been identified via the FutureCare programme, which focuses on Urgent and Emergency Care in the acute hospitals across Dorset. Whilst both programmes of work have dependencies and will naturally complement each other, they will seek to achieve separate savings.

Summary of legal implications

36. Statutory roles are required to be held by the Council, including a Director of Adult Social Services (DASS) and a Principal Social Worker (PSW).

37. The Council is required by law to provide and hold direct accountability for the effectiveness, availability and value for money of Adult Social Care services. The statutory functions are set out in legislation, including the Care Act 2014.

38. Para 1.1 of the Care Act 2014 Statutory Guidance states "*The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life*".

39. In particular, the Care Act 2014 imposes a general duty to promote the wellbeing of individuals when carrying out their care and support functions, and to safeguard adults with care and support needs from experiencing or being at risk of abuse or neglect. At the same time, the Act requires that care and support is tailored to a person's individual needs and preferences, and local authorities are encouraged to support individuals in making their own choices and taking risks that are part of everyday life. This approach aims to empower individuals and enhance their independence and quality of life.

40. Local authorities also have statutory responsibilities regarding market shaping to create a responsive and stable care market that can adapt to the needs of the local population. This includes ensuring a diverse, sustainable, and high-quality market for adult care and support services. The Care Act stresses the importance of giving individuals and their carers choice and control over how their needs are met. This includes stimulating a range of care and support services to meet diverse needs.

41. The quality of Adult Social Care services is inspected by the Care Quality Commission (CQC) against a quality assurance framework.

42. The recommendations of the Fulfilled Lives Programme business case will improve the Council's ability to discharge all these duties more effectively.

Summary of human resources implications

43. Human Resources processes will be followed, as required, during recruitment around resources for delivery.

44. Introducing different ways of working could result in minor reorganisation of existing Adult Social Care team structures. Where this is the case, the corporate change process and policies will be applied, including the appropriate level of employee consultation, with support from the assigned HR Business Partner.

Summary of sustainability impact

45. There are no sustainability implications within this report.

Summary of public health implications

46. Relationships with Public Health partners will be enhanced and improved with transformed ways of operating Adult Social Care services, particularly linked to prevention and population health management.

Summary of equality implications

47. Full EIA documentation will be completed and reviewed (as required) during implementation of transformation plans e.g., policy change or development, service change or development.

48. The Adult Social Care strategic approach to Equality, Diversity and Inclusion supports transformation work with improved data and workforce support.

Summary of risk assessment

49. It has already been acknowledged in earlier reports and the preceding business case that, by doing nothing, the Council is holding significant risk, against a backdrop of continually rising demographic and economic pressures, in its ability to fulfil its statutory responsibilities towards adults and their families within the available budget. These risks are mitigated by the Fulfilled Lives Business Case and Transformation Programme.

50. Programme risks have been identified and mitigations put in place, with robust monitoring, an established formal governance structure and clear escalation processes for each workstream. There is regular reporting to the Corporate Management Board and scrutiny by the Health and Adult Social Care Overview and Scrutiny Committee.

Recommendations

51. It is recommended that Committee:

Notes the current work-in-progress with the Adult Social Care Fulfilled Lives Programme

Background papers

52. Cabinet 17 July 2024 – Adult Social Care Transformation Business Case

53. Cabinet 17 July 2024 – Adult Social Care Transformation Delivery Plan

Appendices

Appendix One

A) Three Conversations Approach – Miss P

(Note: Personal details have been changed to protect confidentiality)

Miss P was in her early fifties, facing multiple health and social challenges, including scoliosis, an eating disorder, mental health and addiction issues.

She had been admitted to hospital with serious spinal conditions and was living in a third-floor flat in a state of disrepair, with no heating, hot water, or lighting. She was also vulnerable to exploitation and cuckooing due to limited mobility and reliance on neighbours for support. After self-discharging herself from hospital, Miss P returned to the unsafe flat where exploitation worsened.

Adopting a Three Conversations approach, Miss P's social worker listened closely to her to understand what she felt was most important for her to move forward in her life (Conversation One). The immediate focus was on getting urgent short-term support in the shape of basic repairs and deep cleaning. She had not recognised the exploitation that was occurring.

The social worker arranged for the urgent repairs and a deep clean was conducted, with a package of care provided to reduce the risk of exploitation. Coordination involved housing, social care, health services, and specialized teams addressing cuckooing. Multi-agency meetings and safeguarding enquiries were also conducted.

As circumstances began to improve, focus could turn to longer-term solutions and Miss P later acknowledged that a move to a more accessible property was necessary. She was eventually rehoused to a ground-floor property with daily care support, medication delivery, and safety measures to prevent exploitation.

This means that she is no longer house bound and can go out whenever she chooses. Her daily care visits and weekly medication deliveries help her to stay safe and well. She has had no further hospital admissions, her alcohol and substance use has reduced significantly, and she is no longer being subjected to exploitation. She is much happier in her new home and said "*You and John* (Housing) *have saved my life. I will never forget what you have done for me. I was dying in there* [old flat]; *thank you for giving me a chance"*

B) Three Conversations Approach – Mrs T

(Note: Personal details have been changed to protect confidentiality)

Mrs T is the main carer for her adult son who has autism. During a telephone feedback interview, she described how the practitioner, using the 3 Conversations approach, completely changed her experience of Adult Social Care and how a Carer's Direct Payment has been reinstated which she can now use in a way that "*will change my life phenomenally*".

"It's always been my practice in any meeting to ask the person to repeat what I've said to make sure they have understood. This time, the practitioner did that automatically which impressed me, that this was her practice, it gives you confidence. I had assurance she was listening"

"Previously I had been in a very deep crisis and didn't feel I was getting the help I needed. I read about the 3 Conversations style and thought I would see how it goes - I thought it was excellent - it allows me to say what I need to say".

"Previously the forms didn't encourage the social worker to recorded what was important to me. At the start I told practitioner there would be some criticisms, and she said "go for it" which I was pleased about. In the past I felt ignored or I was told "I'm sorry you feel that way" which is different, I didn't feel I was being listened to".

"She ensured communications were dyslexic friendly, noted everything that hadn't worked before, and noted we needed to be listened to. Understanding that I retire in a few years' time, she talked me through my options which allowed me to put my thinking in place"

"It has allowed me to feel calm. I was in turmoil before and I felt BCP was going to force me to be a carer until I dropped. I now know I am going to be listened to. I feel I have peace of mind about the future".

"Once I have my direct payment, I will be able to have a respite break and be with my family in Wales"**.**

"The Three Conversation style is really good. The previous style didn't allow us to have a conversation; it was always based on the form. With my dyslexia, the problem was it wasn't noted on the form so no one was addressing this. With 3Cs it means you are now recording this which is important to me".

"I love the 3Cs style – I think it's fantastic, I'm now at the centre not the IT system. I really felt the carers assessment was about me, not the IT system. Before I didn't have the assurance that what I had said was recorded. It is for me to decide what I what to talk about - and that is brilliant".

Appendix Two

Community Micro-Enterprise – feedback from Mrs Y

Mrs Y had been living with her husband, who was also her main carer. After he sadly passed away, a care package was commissioned by the Council to provide Mrs Y with the care and support that her husband used to provide.

About 18 months ago, however, Mrs Y decided that she would prefer the greater freedom that receiving her personal budget in the form of a Direct Payment would provide. The direct payment meant that she could buy support from a Personal Assistant and one of our local Community Micro-Enterprise, Dawns Companion Support.

Mrs Y said the support from her CME had been much better for her in comparison to her previous commissioned care package. She now has consistency in staff and choice every week in what they do for her.

Mrs Y's CME support provides her with five hours a week which can be used flexibly according to what her needs are each week, for instance to go to the hairdressers, help to attend medical appointments, watering the garden and help walking her dog. Fridays are a fixed regular visit as this is the day when her shopping is delivered and Dawns Companion Support will help her unpack this.

Mrs Y says having a Direct Payment so she can arrange and buy her own support with a Personal Assistant and a Community Micro Enterprise has been "terrific" and "life changing". She added, "I could not have stayed in my own home without my PA and Dawns Companion Support"

Details of all currently available CMEs serving the BCP Council area can be found here.