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Health and Wellbeing Board

Date: Wednesday, 18 November 2026
Time: 2.00 pm
Venue: Meeting Room 1, County Hall, Dorchester, DT1 1XJ

Members (Quorum: 5)
Steve Robinson (Chair), Dean Spencer (Vice-Chair), Matt Bell, Gill Taylor, Mark Callaghan, Sam Crowe, Dawn Dawson, Paul Dempsey, Margaret Guy, Marc House, Julia Ingram, Martin Longley, Mike Murphy, Matthew Piles and Simone Yule

Chief Executive: Catherine Howe, County Hall, Dorchester, Dorset DT1 1XJ

For more information about this agenda please contact Democratic & Governance Services Meeting Contact 01305 224185 - george.dare@dorsetcouncil.gov.uk

Agenda

Item **Pages**

1. APOLOGIES

To receive any apologies for absence.

2. MINUTES 7 - 12

To confirm the minutes of the meeting held on 16 September 2026.

3. DECLARATIONS OF INTEREST

To disclose any pecuniary, other registrable or non-registrable interest as set out in the adopted Code of Conduct. In making their disclosure councillors are asked to state the agenda item, the nature of the interest and any action they propose to take as part of their declaration.

If required, further advice should be sought from the Monitoring Officer in advance of the meeting.

4. PUBLIC PARTICIPATION

Representatives of town or parish councils and members of the public who live, work, or represent an organisation within the Dorset Council area are welcome to submit either 1 question or

1 statement for each meeting. You are welcome to attend the meeting in person or via Microsoft Teams to read out your question and to receive the response. If you submit a statement for the committee this will be circulated to all members of the committee in advance of the meeting as a supplement to the agenda and appended to the minutes for the formal record but will not be read out at the meeting. The **first 8 questions and the first 8 statements received from members of the public or organisations for each meeting will be accepted on a first come first served basis in accordance with the deadline set out below.** For further information read Public Participation - Dorset Council

All submissions must be emailed in full to george.dare@dorsetcouncil.gov.uk by 8.30am on Friday, 13 November 2026.

When submitting your question or statement please note that:

- You can submit 1 question or 1 statement.
- a question may include a short pre-amble to set the context.
- It must be a single question and any sub-divided questions will not be permitted.
- Each question will consist of no more than 450 words, and you will be given up to 3 minutes to present your question.
- when submitting a question please indicate who the question is for (e.g., the name of the committee or Portfolio Holder)
- Include your name, address, and contact details. Only your name will be published but we may need your other details to contact you about your question or statement in advance of the meeting.
- questions and statements received in line with the council's rules for public participation will be published as a supplement to the agenda.
- all questions, statements and responses will be published in full within the minutes of the meeting.

5. COUNCILLOR QUESTIONS

To receive questions submitted by councillors.

Councillors can submit up to two valid questions at each meeting and sub divided questions count towards this total. Questions and statements received will be published as a supplement to the agenda and all questions, statements and responses will be published in full within the minutes of the meeting.

The submissions must be emailed in full to george.dare@dorsetcouncil.gov.uk by 8.30am on Friday, 13 November 2026.

Dorset Council Constitution – Procedure Rule 13

6. URGENT ITEMS

To consider any items of business which the Chairman has had prior notification and considers to be urgent pursuant to section 100B (4) b) of the Local Government Act 1972. The reason for the urgency shall be recorded in the minutes.

7. WORK PROGRAMME 13 - 16

To consider the Health and Wellbeing Board's work programme.

8. THRIVING COMMUNITIES PROGRAMME EVALUATION 17 - 96

To consider a report by Volunteer Centre Dorset, the Deputy Director of Public Health and Prevention, and the Business Partner – Communities and Partnerships.

9. DORSET SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2025-26 97 - 124

To receive and review the Dorset Safeguarding Adults Board Annual Report 2025-26.

10. HEALTH AND WELLBEING STRATEGY 125 - 160

To consider a report by the Executive Director for Housing, Prevention and Communities.

11. DORSET PLACE-BASED PARTNERSHIP FRAMEWORK

To discuss and support the Place-Based Partnership Framework implementation.

(Report to follow)

12. ROUGH SLEEPING PROGRAMME 161 - 168

To consider a report by the Corporate Director for Housing.

13. FUTURECARE CLOSE DOWN REPORT 169 - 202

To consider a report by the FutureCare Programme Director.

14. HEALTHY LIFE EXPECTANCY JOINT STRATEGIC NEEDS ASSESSMENT NARRATIVE 203 - 226

To consider a report by the Public Health Data Scientist and Public Health Intelligence Team Lead.

15. PHARMACEUTICAL NEEDS ASSESSMENT SUPPLEMENTARY STATEMENT 227 - 236

To consider a report by the Public Health Intelligence Team Lead.

16. STRATEGIC ALLIANCE FOR CHILDREN AND YOUNG PEOPLE - BABIES, CHILDREN, YOUNG PEOPLE AND FAMILIES' PLAN 2023-33 - ANNUAL REPORT 2026 237 - 290

To receive a report by the Corporate Director for Quality Assurance and Safeguarding.

17. EXEMPT BUSINESS

To move the exclusion of the press and the public for the following item in view of the likely disclosure of exempt information within the meaning of paragraph x of schedule 12 A to the Local Government Act 1972 (as amended). The public and the press will be asked to leave the meeting whilst the item of business is considered.

There are no exempt items scheduled for this meeting.

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Dorset Council

HEALTH AND WELLBEING BOARD

MINUTES OF MEETING HELD ON WEDNESDAY 16 SEPTEMBER 2026

Present: Cllr Steve Robinson (Chair), Dean Spencer (Vice-Chair), Cllr Matt Bell, Cllr Gill Taylor and Sam Crowe
Present remotely: Louise Bate (as substitute), Mark Callaghan and Simone Yule

Apologies: Paula Bennetts, Dawn Dawson, Paul Dempsey, Margaret Guy, Julia Ingram and Matthew Piles

Also present: Cllr Sally Holland

Officers present (for all or part of the meeting):
Rachel Partridge (Deputy Director of Public Health), George Dare (Senior Democratic and Governance Officer), Jen Furnell (Corporate Director for Education and Learning), Sarah Longdon (Head of Service Planning) and Amy-Jane White (Quality Assurance and Programme Lead)

Officers present remotely (for all or part of the meeting):
Stuart Burley (Head of Programmes) and Rachel Small (Chief Operating Officer)

14. **Apologies**

Apologies for absence were received from Julia Ingram, Paul Dempsey, Matthew Piles, Dawn Dawson, Margaret Guy and Paula Bennetts.

15. **Minutes**

The minutes of the meeting held on 17 June 2026 were confirmed and signed.

16. **Declarations of Interest**

No declarations of disclosable pecuniary interests were made at the meeting.

17. **Public Participation**

There was no public participation.

18. **Councillor Questions**

There were no questions from councillors.

19. **Urgent items**

There were no urgent items.

20. **Work Programme**

The Health and Wellbeing Board noted its work programme.

21. **Supporting a Smoke Free Dorset**

The Board received a report on the Smoke Free Dorset programme. The Cabinet Member for Public Health, Prevention and Communities introduced the item and highlighted both the scale of the public health challenge posed by smoking and the work being undertaken across Dorset to reduce smoking prevalence. The Head of Programmes, then gave a presentation on the programme's progress and priorities. The presentation is attached as an appendix to these minutes.

Board members discussed the report and raised the following points:

- A high proportion of people experiencing homelessness smoke, could be done to promote smoking cessation services to people as they moved into supported or sheltered accommodation. The Head of Programmes acknowledged that partnership working in this area had been effective but advised that there was scope to strengthen it further. He added that services had become more accessible in recent years, helping to remove barriers to support.
- There were concerns about youth vaping, that vaping had become fashionable among some young people and could act as a gateway to smoking and, in some cases, other substances. The charter appeared to be more focused on tobacco use. The Head of Programmes advised that Trading Standards had been actively targeting unregulated vape retailers and noted that further regulation was being introduced nationally. The Chairman referred to recent Government announcements regarding additional powers for councils to regulate vape shops.
- The potential of the programme to reduce health inequalities and improve life expectancy, particularly for people experiencing mental health difficulties, was welcomed.
- The success of the SmokeStop Van in North Dorset, which had engaged directly with employers and helped reach groups that are traditionally harder to engage, particularly middle-aged working men. However, the service was currently paused pending clarification about future funding.
- That Dorset aspired to become one of the first smoke-free places in England and whether the Board would find regular progress updates helpful. The Chairman supported this suggestion and commented that it would provide a useful measure of progress.
- The Deputy Director of Public Health highlighted the work taking place within maternity services to reduce smoking during pregnancy and reported that good progress was being made.

Following the discussion, the recommendations were proposed by Cllr S Robinson and seconded by Cllr M Bell.

Decision:
That:

a) The significant health, wellbeing, social care and economic burden arising from smoking in Dorset be noted.
b) The Board acknowledge progress made in expanding access to evidence-based smoking cessation support and treatment.
c) The South West Smoke-Free Charter and continued partnership action to reduce smoking prevalence and related health inequalities, be endorsed.
d) The forthcoming Stoptober campaign to increase the number of residents making successful quit attempts, be supported.

22. **Progress update for the refreshed Health and Wellbeing Strategy**

The Board received a presentation from the Executive Director of Housing, Communities and Prevention on the development of the Health and Wellbeing Strategy Outcomes Framework. He explained that the strategy was intended to provide a shared, prevention-focused framework for partners and outlined the draft strategic outcomes that would be delivered through a series of delivery groups. Members heard that the proposed outcomes aligned closely with the Government's Outcomes Framework and that further work would be undertaken to finalise the delivery arrangements before the strategy was brought forward for approval.

The Board discussed the report and raised the following points:

- The draft framework did not explicitly refer to factors within the home that affect health, such as damp, mould and indoor air quality. The Executive Director of Housing, Communities and Prevention responded that housing, homelessness and poverty were key areas of focus within the Healthy Places delivery group and agreed that these issues could be reflected within that workstream.
- The relatively small number of proposed outcomes were welcomed, as that this would help partners maintain focus on delivery. The opportunities the framework presented for developing more joint commissioning arrangements were highlighted.
- The importance of avoiding duplication of work already taking place across partner organisations. It would be important to understand the connections between existing programmes and identify where work was already being delivered.
- Clarification was sought on the purpose of the delivery groups and the organisations and stakeholders that would be represented within them.

The Chairman suggested that future Board meetings could include a standing item focused on the work of one of the delivery groups, enabling members to monitor

progress and understand delivery in greater detail. He also suggested that healthy life expectancy should be a core metric.

The recommendations were proposed by Cllr S Robinson, seconded by Cllr G Taylor and agreed by the Board.

Decision:

That:

1. The proposed outcomes framework, which will be a key component of the refreshed Health and Wellbeing strategy, be agreed.
2. The proposed delivery groups and life course structure be endorsed.
3. To responsibility be delegated to Sam Crowe (Dorset Council), Dean Spencer (NHS Dorset), and Dawn Dawson (Dorset Healthcare) to set up the delivery groups under the strategy.

23. **Neighbourhood Footprints**

The Board received a report from the Place Director - Dorset on the proposed Dorset neighbourhood footprints. Members heard that nine footprints had been identified, based on Primary Care Network geographies, with varying population sizes across the county.

Board members discussed the report and raised the following points:

- That community clusters should be considered alongside the neighbourhood footprints to help strengthen local partnership working and community engagement.
- Whether the larger population within the Weymouth and Portland footprint could present challenges, given that it exceeded the population range suggested in national guidance.
- How boundary overlaps would be managed. The Place Director - Dorset acknowledged that some cross-boundary issues would be unavoidable and noted that a number of GP practices already served populations across different geographical areas.
- Options would be explored for how potential duplication within policing arrangements could be addressed through a partnership approach.
- A series of workshops would be held by Dorset Healthcare until December to further develop the neighbourhood approach and stakeholders were encouraged to become involved in the process.

The recommendations were proposed by Dean Spencer, seconded by Sam Crowe and agreed by the Board.

Decision:

That a neighbourhood model be endorsed that:

- Retains PCN-aligned footprints as the core geography for Neighbourhoods.

- Recognises Dorset Council Community Clusters as a complementary geography for community engagement and local collaboration.
- Supports alignment between organisations where beneficial whilst acknowledging that different footprints may be required for different functions.
- Focuses on improving population health, reducing inequalities and strengthening neighbourhood partnerships rather than achieving complete geographical alignment.

24. **Exempt Business**

There was no exempt business.

Duration of meeting: 2.00 - 3.23 pm

Chairman

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Health and Wellbeing Board
Work Programme

Meeting Date: 18 November 2026

Report Title	Aims and Objectives	Lead Officers / Members	Other Information
FutureCare Programme Final Report	To review the final report on the FutureCare Programme	Julia Ingram – Director, Adult Social Care Cllr Steve Robinson – Cabinet Member for Adult Social Care & Health	
Thriving Communities – 1 year evaluation	Update on the progress on the Thriving Communities work, reviewing the results of the evaluation of the first year and agree next steps.	Cllr Matt Bell – Cabinet Member for Public Health Prevention and Communities Rachel Partridge – Deputy Director for Public Health and Prevention Lynita Harris, Volunteer Centre Dorset	
Strategic Alliance for Children and Young People Annual Report	To receive the annual report.	Michelle Pursall – Commissioning and Policy Lead Cllr Clare Sutton – Cabinet Member for Children's	

		Services, Education and Skills	
Health and Wellbeing Strategy	Approval of the Health and Wellbeing Strategy.	Sam Crowe – Executive Director for Housing, Prevention and Communities. Cllr Steve Robinson – Cabinet Member for Adult Social Care & Health	
Safeguarding Adults Board Annual Report	To receive the Dorset Safeguarding Adults Board Annual Report	Sian Walker-McAllister – Independent Chair, Safeguarding Adults Board Cllr Steve Robinson – Cabinet Member for Adult Social Care & Health	
JSNA Deep Dive – Healthy Life Expectancy	This Joint Strategic Needs Assessment (JSNA) deep dive focuses on Healthy Life Expectancy, a key measure of population health that reflects not only how long people live, but how many of those years are spent in good health. Following a request from the Health and Wellbeing Board in March 2026, this paper examines the factors that influence healthy life expectancy in Dorset and explores opportunities for prevention, early intervention and partnership action to help residents live healthier, more independent lives for longer.	Jane Horne – Consultant in Public Health Cllr Matt Bell – Cabinet Member for Public Health, Prevention and Communities	

Pharmaceutical Needs Assessment (PNA) Supplementary Statement	A supplementary statement to the 2025 Dorset and BCP councils' Pharmaceutical Needs Assessment that provides a factual update on pharmacy closures, consolidations and relocations, as well as opening of any new pharmacies, in line with The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.	Jane Horne – Consultant in Public Health Cllr Matt Bell – Cabinet Member for Public Health, Prevention and Communities	
Rough Sleeping Programme		Iain Sim – Corporate Director for Housing Cllr Gill Taylor – Cabinet Member for Housing and Homelessness	

Meeting Date: 17 March 2027

Report Title	**Aims and Objectives**	**Lead Officers / Members**	**Other Information**
Movement for Movement Strategy Update	To provide the Health & Wellbeing Board with an update on progress and a request to review opportunities for further action.	Rachel Partridge – Deputy Director, Public Health & Prevention Cllr Matt Bell – Cabinet Member for Public Health, Prevention and Communities	

Meeting Date: Unscheduled items

Potential Item	Description	Lead Officer	Cabinet Member(s)	Other Information
Dorset Intelligence and Insight Service				

Health and Wellbeing Board
18 November 2026
Thriving Communities Programme Evaluation
For Decision

Cabinet Member:
Cllr S Robinson, Adult Social Care & Health

Senior Leadership Team:
S Crowe - Executive Director, Housing, Prevention and Communities

Report author and job title: Lynita Harris Volunteer Centre Dorset**,** Rachel Partridge; Deputy Director Public Health and Laura Cornette Business Partner – Communities and Partnerships
Email: Rachel.partridge@dorsetcouncil.gov.uk Laura.cornette@dorsetcouncil.gov.uk

Statutory Authority:

Report status: Public Choose an item.

1. Executive summary

1.1 This report summarises the findings and achievements from Year One of the Thriving Communities programme delivered by Volunteer Centre Dorset (VCD). The programme was established to strengthen community resilience and support organisations that contribute to the health, wellbeing and independence of older residents across North Dorset, Purbeck and Weymouth.

1.2 The programme identified a wide range of community assets and demonstrated the significant contribution that voluntary and community organisations make in reducing social isolation, promoting wellbeing and supporting prevention. A key finding was that organisational resilience is influenced by more than funding alone. Many groups identified challenges relating to volunteer recruitment and retention, succession planning, governance, visibility and long-term sustainability. The programme also found that many valuable grassroots organisations operate outside formal networks and require proactive engagement to access support and opportunities.

1.3 In total 93 organisations engaged in nine locality-based networks and 40 network sessions, involving 331 participants. Learning from these activities informed the development of the Dorset Connect model, a neighbourhood-based approach that brings together community groups, councils, health

services and other partners to strengthen collaboration, share intelligence and address local challenges collectively.

1.4 The programme also introduced the ‘Try It, Do It, Grow It’ investment model, supporting community-led initiatives through flexible grant funding and practical organisational support. Overall, Year One has established strong foundations for a sustainable community infrastructure model, demonstrating the importance of trusted relationships, partnership working and targeted investment in achieving long-term community wellbeing and resilience.

1.5 Volunteer Centre Dorset (VCD) had a programme administration budget of £40,000 for year 1 and have spent £39,287. The grant award allowance was £132,000 and has spent £6,100. A breakdown of costs is provided in Item 7, while an explanation of the changes and the reason for the underspend is detailed in Item 6.

1.6 In light of the findings of this report, the Thriving Communities Reference Group (TCRG) has identified a strategic need to strengthen community capacity. Recognising that sustainable community development relies on trusted relationships, local knowledge, and practical support, as well as financial investment, the TCRG proposes the reallocation of £50,000 to provide additional staffing capacity (equivalent to 1 FTE) to support the expansion of these networks across the Dorset Council area. This would leave £75,500 available for allocation through support grants until the end of the current grant period.

2. Recommendation(s)

2.1 Members of the board review the year 1 report as detailed in appendix 1 and note the successful outcomes and achievements.

2.2 Support the proposal to reallocate some of the grant funds to build resource capacity for Volunteer Centre Dorset to roll out the programme to the other 3 localities for year 2. The amount proposed is £46,000 for additional resource and associated costings.

2.3 Explore mechanisms to identify and secure longer-term opportunities to develop the model of this pilot programme into a more sustainable VCS system.

3. Reason for the recommendation(s)

3.1 The Health and Wellbeing Board is the governance oversight for the Thriving Communities programme and sponsored the research and development work that led to this pilot programme being established.

3.2 Year One has established strong foundations for a community-led prevention model across Dorset. The programme has demonstrated that meaningful community development is rooted in trusted relationships, local knowledge and practical support rather than funding alone. Continued investment will enable the model will mature, strengthen community resilience and contribute to Dorset's wider health, wellbeing and prevention ambitions.

3.3 Ensure the pilot programme is included in the wider Dorset Council VCS commissioning transformation programme and considered as part of the community conversations currently being undertaken.

4. Programme Background

4.1 Under the Integrated Care Partnership strategy, in June 2023 a brief proposal was presented to the Dorset Health and Wellbeing Board to support place-based working in the Dorset Council area. The aim was to develop a plan to grow community support and capacity through the VCS, to support older people to remain living well and independently.

4.2 In June 2024, the Dorset Health and Wellbeing Board (DHWB) approved the development of a Project Delivery and Transition Plan for creation of a Voluntary and Community Sector (VCS) led Dorset Thriving Communities Network (DTCN) model to support place-based working in the Dorset Council area.

4.3 The Thriving Communities project, through which the report was developed, was provided support, direction, and guidance from a multi-agency Thriving Communities Reference Group (TCRG). That group included representatives from Dorset Council; NHS Dorset; the VCS and Dorset Fire and Rescue Service.

4.4 Following detailed research and engagement the multiagency TCRG recommended presentation of the Project Report and Forward Plan (April 2024) to the Dorset Health and Wellbeing Board. That report provided the Board with compelling evidence for the development of a Dorset Thriving Communities Network.

4.5 It was identified that, through the growth of a Dorset Thriving Communities Network led by the Voluntary and Community Sector and supported by a partnership of Dorset Council, NHS Dorset, Public Health Dorset, the VCS and other partners, the relevant VCS infrastructures could be strengthened and the local groups who support older people could become more resilient and effective. The DTCN would also create potential to support the VCS in some of its challenges around leadership, development, governance, and

administration. The Thriving Communities Reference Group identified the need for transformation in the way Dorset Council and other partners work with the VCS.

4.6 **Appendix 1** provides the DHWB with Volunteer Centre Dorset's evaluation report of the 12 months Foundation Phase.

1. Key Findings

1.1 Engagement with grassroots organisations revealed that many of Dorset's most valuable community assets operate largely outside established voluntary sector networks and formal support structures. These groups are often volunteer led, highly trusted within their communities, and focused on addressing social isolation, promoting wellbeing and maintaining independence among older people. However, they are frequently invisible to traditional funding and support mechanisms, making proactive outreach and relationship-building essential. The report highlights that community development, and resilience depends on significantly more than grant funding alone.

1.2 Volunteer Centre Dorset identifies that financial need is often not the primary challenge facing community groups. While funding can be beneficial, organisations more commonly identify issues relating to volunteer recruitment and retention, succession planning, governance, safeguarding, visibility, participation levels, transport barriers and long-term sustainability.

1.3 Many groups were operating successfully on modest incomes through donations, membership fees and local support arrangements. In these cases, practical advice, introductions to partners, improved referral pathways or organisational development support were often more valuable than financial investment.

1.4 The programme also found that community capacity can be both substantial and fragile. Numerous longstanding activities relied heavily on one or two committed volunteers, creating a significant risk where succession planning was absent. The sustainability of lunch clubs, friendship groups and social activities often depends upon a small number of individuals whose retirement, illness or changing circumstances could threaten the continuation of valued local services. This demonstrated the importance of investing in organisational resilience alongside service delivery.

1.5 Another important finding was that not all organisations aspire to growth. Some groups deliberately remain small and informal because this enables them to meet local needs effectively. It has been identified that support is most beneficial when focused on maintaining sustainability and community value rather than encouraging growth for its own sake.

1.6 The programme further demonstrated that engagement activities must offer clear and practical benefits. Smaller organisations often lacked capacity to attend additional meetings unless participation resulted in useful connections, problem-solving opportunities or access to support. This learning informed the development of the Dorset Connect model, replacing multiple network structures with a more inclusive and action-focused approach. Trust and relationship-building emerged as critical infrastructure in their own right, requiring time, sustained engagement and a commitment to working at the pace of individual communities.

2. Volunteer Centre Dorset Programme Achievements and Future Priorities

2.1 Throughout the foundation phase, the programme established nine local networks, delivered 40 network sessions and engaged 93 organisations involving 331 participants. Twenty individual conversations were undertaken with community groups and stakeholders to better understand local challenges and opportunities. Five grant applications were supported, enabling 67 community activities.

2.2 The programme evolved to create the Dorset Connect model, bringing together voluntary organisations, town and parish councils, health and care partners, businesses and community stakeholders. Dorset Connect acts as a neighbourhood-based infrastructure for collaboration, information sharing, problem solving and community action.

2.3 Alongside this, the Try It, Do It, Grow It grant model was developed to provide flexible investment for testing new ideas, sustaining successful activities and supporting growth where appropriate. Grant awards supported initiatives addressing social isolation, digital inclusion, community engagement and accessibility.

2.4 The report concludes that Thriving Communities should continue to develop as a broader community infrastructure model combining relationships, organisational support, community intelligence, collaboration and targeted investment.

2.5 Future priorities include increasing engagement with grassroots groups, embedding Dorset Connect across Dorset, strengthening links with neighbourhood health services, improving organisational resilience and enhancing the collection of community intelligence and outcome evidence.

2.6 In light of the findings of this report, the Thriving Communities Reference Group has identified a strategic need to strengthen community capacity. Recognising that sustainable community development relies on trusted

relationships, local knowledge, and practical support, as well as financial investment, the TCRG proposes the reallocation of £50,000 to provide additional staffing capacity (equivalent to 1 FTE) to support the expansion of these networks across the Dorset Council area. This would leave £75,500 available for allocation through support grants.

3. Programme Budget and Spend for year 1

Administration Grant	**Annual Budget £40,000**	**Actual £39,287**
Staff costs	£29,208	£28,641
Direct costs	£1,386	£1,440
Indirect Costs	£534	£333
Recharges	£7170	£8873
VCS Grant distribution (up to October 2026)	Annual Budget £132,000	Actual £6,100

4. Legal considerations

4.1 The Foundation Phase contract has been awarded through a competitive "Request for Quotes" process. Should the programme expand following evaluation there may be a requirement for a full commissioning process.

5. Financial implications

5.1 This evaluation relates to year 1 of a two-year funded programme. Consideration is needed for how to take the learning from this programme to establish a sustainable model beyond July 2027 when the current grant agreement ends.

6. Natural environment, climate & ecology implications

6.1 Supporting people to stay well and live independently by building strong community networks of support close to their homes should reduce travel and healthcare utilisation - both of which also have the benefits of reducing travel time and costs and in turn have a positive impact on the environment and reducing emissions.

7. Well-being and health implications

7.1 Collaborating with people to understand what keeps them well and healthy, and building capacity in the voluntary and community sector to offer support around these needs, should improve healthy life expectancy – keeping people living for longer in good health. Working in this way to develop person centred approaches should also have benefits for people's personal sense of wellbeing.

12. Risk implications

12.1 HAVING CONSIDERED: the risks associated with this decision; the level of risk has been identified as:

Current Risk: Low

Residual Risk: Low

13. Equalities

13.1 An Equality Impact Assessment with resultant action plan has been completed.

14. Appendices

14.1 Appendix 1 – Thriving Communities Evaluation Report by Volunteer Centre Dorset October 2026

15. Background papers

15.1 Thriving Communities Health and Wellbeing Board 26 June 2024

15.2 Thriving Communities Health and Wellbeing Board 24 September 2025

16. Report sign-off

16.1 Due to the nature of this report it did not need to go through the full internal Dorset Council internal governance sign off processes. It has been discussed and reviewed by the lead Cabinet Member as Chair of Health and Wellbeing Board and the Executive Director of Housing, Communities and Prevention.

Appendix 1 – Thriving Communities Evaluation report

Thriving Communities

Building the Foundations for Community-Led Prevention

Year One: Learning, Progress and Future Direction

1 August 2025 – 31 July 2026

Contents

PART ONE: WHAT WE LEARNED

PART TWO: WHAT WE BUILT

PART THREE: WHERE WE GO NEXT

APPENDIX

Produced by Michelle Rayner & Lynita Harris
Funded by

Volunteer Centre Dorset

Thriving Communities

Year One: Impact, Learning and the Case for Continued Investment

1. Executive Summary

Thriving Communities is developing a new approach to strengthening the grassroots community infrastructure that helps older people across Dorset remain active, connected, supported and independent.

Established as a Foundation Phase across North Dorset, Purbeck and Weymouth, the programme set out to test how local community activity could be identified, connected, supported and sustained. Year One has been a deliberate period of learning, testing assumptions and establishing and adapting the approach in response to what communities have told us.

One of the most significant findings is that community resilience depends on so much more than funding.

Across Dorset, valuable activities are often sustained by small, informal and volunteer-led groups that operate largely outside established networks. Many are financially self-sufficient, yet face challenges around volunteer succession, participation, governance, visibility, transport and sustainability. Some do not seek to grow or formalise; they simply want to continue providing something valued by their community.

The Foundation Phase has demonstrated that these groups cannot always be reached through traditional networks or funding opportunities. Building trust, spending time in communities and understanding the circumstances of individual organisations are essential. Sometimes a small grant can make a meaningful difference; at other times, an introduction, practical advice, stronger referral pathways or access to existing community resources can be more valuable.

This learning has fundamentally strengthened the Thriving Communities approach.

Rather than operating primarily as a network and grant programme, Thriving Communities has evolved into a connected model combining neighbourhood relationships, community intelligence, organisational development, improved access to local provision, collaboration and targeted investment.

At the centre of this approach is **Dorset Connect**, bringing together grassroots organisations, the wider voluntary and community sector, local councils, health and care partners, businesses and other stakeholders. The emphasis is not simply on bringing people together, but on what happens as a result: stronger relationships,

practical solutions, shared resources, improved referral pathways and opportunities for community-led action.

Alongside this, the **Try It, Do It, Grow It** grant model provides flexible, proportionate investment to test new ideas, sustain valuable existing activity and support organisations to develop where there is a clear need or opportunity. Year One has already provided practical examples of the value of this approach, from connecting community groups with health professionals and addressing barriers to organisational sustainability, to supporting established activities and enabling new opportunities for social connection.

The significance of the Foundation Phase lies not only in the activities supported, but in the community infrastructure and relationships now being developed around them.

For Dorset's health and care system, this creates an opportunity to strengthen the community foundations of prevention. Better connected, more visible and more resilient community provision can help residents access opportunities for friendship, participation, activity and support, while enabling local intelligence to inform wider planning and investment.

The next phase will focus on embedding this model, reaching more grassroots organisations, strengthening connections with neighbourhood health, making better use of existing community assets and developing clearer evidence of outcomes for organisations and residents.

Continued investment will enable Dorset to build on these foundations, and demonstrate the contribution of community infrastructure to prevention and develop a more sustainable, connected approach to supporting people and communities over the longer term.

What Has Changed in Year One?

The first year of Thriving Communities has already begun to make a practical difference to grassroots organisations, local partnerships and the people who benefit from community activity. Across the programme, we have established nine local networks, delivered 40 network sessions, engaged 93 organisations and recorded 331 participants, alongside 20 one-to-one conversations with community groups. These figures demonstrate the reach of the programme, but the more important evidence lies in what has happened as a result of those connections.

Community organisations are becoming better connected to the support and resources they need. For example, a volunteer-led singing group supporting people living with dementia and their carers had struggled to attract new members and was receiving no referrals from local GP practices. A conversation with an NHS

representative at a network meeting helped address this barrier. The group subsequently began receiving referrals, increasing attendance and enabling more people to access an existing source of companionship and support.

Practical intervention is helping organisations overcome barriers to their future development. A community organisation seeking to extend farm-based activities to older residents initially identified accessibility as its main challenge. Through further conversations, we uncovered an underlying issue with its land arrangements. Signposting to specialist legal support helped the organisation secure a formal lease, placing it in a stronger position to develop its activities and seek future investment.

Existing community provision is becoming more visible, supported and connected. Our work with volunteer-led lunch clubs, friendship groups and other informal activities has identified opportunities to strengthen links with social prescribing and primary care, improve how groups welcome new participants and address organisational challenges that may threaten their sustainability. Importantly, some of these groups have required no additional funding. The value has come from practical advice, introductions and helping them make better use of existing resources.

Small-scale investment is beginning to support locally identified opportunities. The Try It, Do It, Grow It approach has generated five grant applications totalling £6,100, responding to needs including improved visibility, accessible technology, transport and opportunities for social connection. These proposals demonstrate how modest, targeted investment can complement existing community assets and support activity that residents value.

Taken together, these examples show an emerging shift from simply bringing organisations together or offering grants towards identifying barriers, connecting resources and enabling practical change. We can already demonstrate improvements in referral pathways, organisational readiness and access to support. The next phase will build on these foundations by following organisations over time, measuring changes in participation and sustainability, and developing stronger evidence of the benefits experienced by residents.

The Foundation Phase has not yet demonstrated measurable reductions in demand for health or care services, and we would not claim that it has. What it has demonstrated is that targeted community development can address practical barriers, strengthen local provision and improve the connections through which people access community support. This provides a credible foundation for continued investment and a clearer focus for evaluating outcomes in Year Two.

PART ONE: WHAT WE LEARNED

2. The Opportunity: Strengthening the Community Foundations of Prevention

Across Dorset, a wealth of community activity already contributes to the health, wellbeing and independence of older residents. Lunch clubs, friendship groups, community cafés, walking groups, volunteer-led activities and informal networks provide opportunities for connection, participation, practical support and belonging.

These activities can also provide an important early connection to support when someone's circumstances begin to change. A volunteer noticing that a regular attendee has stopped coming, or a community group recognising that someone may need additional help, can create an opportunity for an early conversation, practical assistance or a connection to more formal services.

In this way, community organisations do more than bring people together. Through the relationships and trust they build, they can help people remain connected and supported, while providing an important bridge between individuals, their communities and wider health and care services.

Much of this activity operates quietly within communities, often sustained by a small number of dedicated volunteers and limited resources. These groups can be deeply embedded in local life, yet remain largely invisible to wider health and care systems, established voluntary sector networks and those who could benefit from their support.

The opportunity for Thriving Communities was not simply to create or fund more activity, but to better understand, connect and strengthen what already exists.

This meant looking beyond individual projects to the wider community infrastructure that enables local activity to thrive: the volunteers who sustain it, the organisations and spaces that support it, the relationships that connect people, and the knowledge and resources that communities already hold.

It also meant recognising that community capacity cannot be taken for granted. Valuable activities can be vulnerable to volunteer shortages, succession challenges, declining participation, limited visibility and practical barriers such as transport. Additional funding may help, but it does not necessarily address the underlying issues affecting an organisation's sustainability.

Thriving Communities was therefore established to explore a broader approach: identifying grassroots activity that might otherwise remain under the radar, understanding what organisations need, strengthening their capacity and

connections, and using targeted investment where it can make the greatest difference.

For Dorset's wider prevention ambitions, the potential lies in making community provision more visible, accessible, connected and resilient, while creating stronger relationships between communities and the services supporting residents.

Our ambition is not simply to fund more community activity. It is to strengthen the people, organisations and relationships that enable communities to support their residents and contribute to prevention.



3. What We Set Out to Test

Building a model around local communities

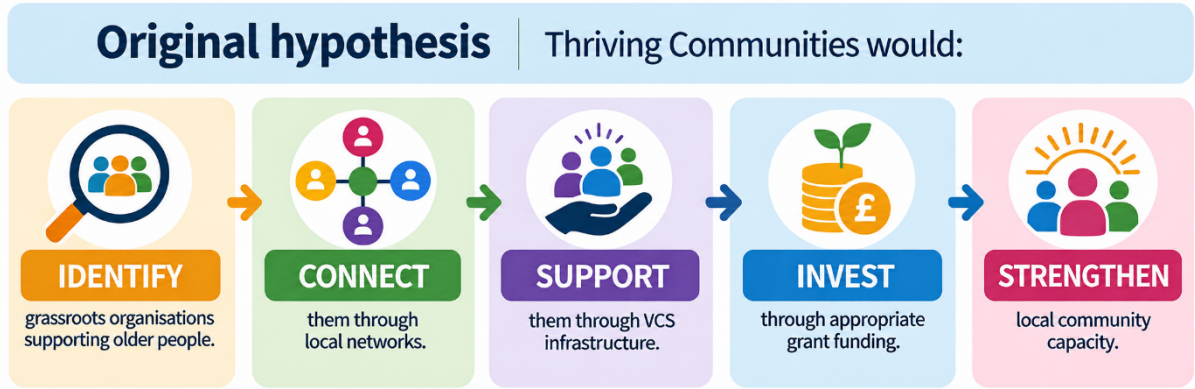
The Foundation Phase of Thriving Communities was established to explore how Dorset could better identify, connect and support grassroots, volunteer-led groups that contribute to the health, wellbeing and independence of older residents.

From the outset, the programme recognised that significant community activity was already taking place. The intention was not necessarily to create new services, but to understand how existing community assets could be better connected, strengthened, supported and expanded, and where relatively small amounts of investment could enable local activity to develop or become more sustainable.

The initial programme therefore focused on three areas – **North Dorset, Purbeck and Weymouth** – and sought to test a locally based approach to community development.

Our starting hypothesis

At the heart of the original model was a relatively simple proposition:



We wanted to understand whether, by creating stronger local connections between voluntary and community organisations, statutory partners and other community stakeholders, we could identify grassroots activity that might otherwise remain under the radar and then provide the right support to help it thrive.

The model was designed to test whether:

- **Local networks could help identify grassroots activity**, particularly smaller and volunteer-led groups supporting older people.
- **Bringing organisations and partners together locally would create stronger relationships**, enabling information, opportunities and community knowledge to be shared.

- **Community organisations would tell us what they needed**, allowing support to respond to local circumstances rather than being prescribed centrally.
- **Infrastructure support could strengthen community groups**, including help with governance, volunteering, safeguarding, communications and organisational development.
- **Small-scale grant investment could unlock or sustain community activity**, particularly where relatively modest resources could make a meaningful difference.
- **Local insight could inform programme development**, ensuring that investment was increasingly shaped by what communities themselves identified as important.

Creating local spaces for conversation

The original delivery model centred on establishing VCS Networks and Thriving Communities Working Groups within the programme areas.

Because North Dorset and Purbeck cover large geographical areas with distinct communities, a place-based approach was adopted rather than treating each as a single locality. Initial activity therefore focused on Weymouth, Sturminster Newton, Shaftesbury & Gillingham, Sherborne, Blandford, Swanage and Wareham.

To facilitate connection, VCD established locality-based VCS Networks to bring a range of people together from VCS organisations large and small, town & parish councils, health, care, education, and any local stakeholders interested in working with or supporting the local VCS to network, receive training, and learn about local services and support.

The Thriving Communities Working Groups were intended to work alongside, providing a focused space for discussion, collaboration and decision-making. They would bring together people with knowledge of their communities, help identify grassroots organisations and local needs, generate ideas and provide a route through which community voices could influence the developing programme.

Starting with relationships

A deliberate feature of the Foundation Phase was that the Thriving Communities grant opportunity was not initially promoted as a conventional open grant programme. Instead, the intention was to use local engagement and relationships to identify organisations and activities that could benefit from support. Conversations could then explore what an organisation was trying to achieve, what challenges it

faced and whether funding – or another form of support – would make the greatest difference. This was important because the programme was seeking to reach grassroots organisations that might not routinely respond to traditional funding opportunities.

The expectation was that local networks, introductions and existing community knowledge would help uncover these grassroots groups and create a pathway into wider support. The first year subsequently demonstrated that this assumption was only partially correct and that more proactive outreach into communities was required.

Testing assumptions, not delivering a fixed model

The Foundation Phase was therefore as much about learning how to support communities effectively as it was about delivering activity. Several assumptions sat behind the original model:

We wanted to test whether…	Why it mattered
Local networks could identify grassroots organisations	Many smaller groups are not visible through formal VCS structures
Groups would engage with a locality-based network	Networks could provide an efficient way to build relationships and share intelligence
Existing local knowledge could identify community assets	This could reduce the need for resource-intensive mapping and outreach
Funding would provide an incentive for organisations to engage	Small grants could enable activity to be tried, sustained or developed
Organisations would articulate their wider support needs	VCD could then provide proportionate infrastructure and development support
Local conversations could generate solutions	Communities themselves often hold the relationships, knowledge and assets needed to respond to local challenges

The importance of a Foundation Phase is that these assumptions could be tested in practice rather than accepted as fact.

A test-and-learn approach

We've been on a learning journey. That required us to listen to organisations, observe how different communities responded, understand what encouraged or

prevented engagement and be prepared to change the model when the evidence suggested a different approach was needed.

Some of our original assumptions were validated. Others were challenged. All were valuable.

The learning generated through this process has ultimately shaped our approach to Thriving Communities – one that places greater emphasis on relationships, community infrastructure, organisational capacity and collaboration, with funding as one of several tools available to support change.

4. What We Did

Turning the model into action

The first year of Thriving Communities focused on building the relationships, networks and delivery mechanisms needed to identify and support grassroots community activity across North Dorset, Purbeck and Weymouth.

Delivery combined locality-based engagement, direct conversations with community groups, partnership development, infrastructure support and the development of a flexible community grant programme.

Building local networks

The initial delivery model established VCS Networks and Thriving Communities Working Groups across the three programme areas. Recognising the size, rurality and different identities of communities within North Dorset and Purbeck, the programme adopted a more localised approach rather than expecting organisations to travel to, or work as, a single area-wide group.

Activity was therefore developed across:

North Dorset: Sturminster Newton, Shaftesbury & Gillingham, Sherborne, and Blandford

Purbeck: Swanage, and Wareham

Weymouth: Weymouth

The programme was initially launched through three webinars covering Weymouth, North Dorset and Purbeck. These introduced Thriving Communities, invited local organisations and partners to help identify grassroots activity, encouraged people to join the VCS Networks and began building the relationships required for delivery.

This was followed by a programme of in-person and online Working Groups, designed to provide regular opportunities for organisations and stakeholders to connect, discuss local issues, identify community activity and contribute to the development of Thriving Communities.

Creating opportunities for local conversation

The Working Groups were deliberately designed to be more than information-sharing meetings.

They provided a space to:

- **Connect** organisations and people working within the same communities.
- **Listen** to the experiences of grassroots organisations and volunteers.
- **Identify** activities and groups that may not otherwise be visible.
- **Understand** the barriers affecting local community activity.
- **Explore** opportunities for collaboration and practical support.
- **Inform** how Thriving Communities should develop.

Engagement varied considerably between areas. Weymouth established relatively strong engagement from the outset, benefiting from existing relationships, Volunteer Centre Dorset's other activity in the area and the foundations of Weymouth Town Council's established VCS network.

Across North Dorset, engagement was more varied. Separate activity in Blandford, Sherborne, Sturminster Newton and Shaftesbury & Gillingham enabled the programme to develop relationships across a large rural area, although awareness of VCD and our wider support offer, or engagement with other VCS infrastructure organisations was more dispersed.

In Purbeck, Wareham and Swanage were initially explored separately. Engagement with a standalone Thriving Communities Working Group was more limited, leading to conversations with existing local partners about how the programme could complement rather than duplicate established activity.

Going beyond the meetings

The networks were only one part of delivery. Alongside these meetings, the programme used one-to-one conversations, introductions, existing relationships and direct engagement to develop a better understanding of grassroots community activity. These conversations proved particularly valuable when engaging smaller volunteer-led groups. Forming trusted relationships with the volunteers delivering different provision has been foundational to then encourage further engagement.

They enabled the team to understand not simply what a group did, but:

- Who was keeping it going?
- Who participated?
- What challenges were emerging?
- Was the activity sustainable?
- What support would actually be useful?

These relationships also began to build a richer picture of community assets and challenges than could be obtained through organisational directories or formal datasets alone.

Providing support beyond funding

Although grant funding forms an important part of the overall programme, organisations engaging with Thriving Communities could also access Volunteer Centre Dorset's wider infrastructure support.

This meant that conversations could identify support around areas such as:

- Governance and organisational development
- Safeguarding
- Volunteer recruitment and development
- Communications and increasing visibility
- Referral pathways
- Training
- Partnership and collaboration
- Planning and sustainability

This became increasingly important as engagement progressed. The programme found that some organisations did not require additional funding at all, while others needed organisational support before funding could provide sustainable benefit.

This enabled Thriving Communities to begin moving away from a simple **"funding available → application → grant"** relationship towards a more developmental approach: **Conversation → Understand the need → Identify the right support → Connect, develop or invest.**

Developing a flexible community investment offer

Alongside community engagement and infrastructure support, the programme developed the **Thriving Communities Grant Fund** to enable appropriate investment in community-led activity.

The emerging **Try It, Do It, Grow It** model recognised that organisations may require investment for very different reasons:

- **Try It** – enabling a group to test a new idea or approach.
- **Do It** – helping sustain activity that is already working and making a difference.
- **Grow It** – supporting successful community activity to increase its reach or capacity.



Try It

To give VCS groups the confidence and resources to try something new and learn what works

Seeding activities to test a new idea or innovative way that address an identified local need, supporting older people.



Do It

Grant funding to continue doing something that is already working well and making a difference

Helping established community groups, clubs and wellbeing activities to deliver quality activities that improve health, wellbeing and social connection for older people.



Grow It

Building capacity and resilience within exisiting successful community projects and groups

Scaling successful project that have demonstrated positive outcomes into new areas or communities, or increasing capacity to reach more people.

As delivery progressed, eligibility was broadened to better reflect the diversity of community activity encountered through the programme. Rather than relying primarily on organisational structure, greater emphasis was placed on the activity being delivered, the community benefit created and its alignment with Thriving Communities objectives.

While initially, there was ambition to have a grant panel in each locality, due to practicalities, a central Thriving Communities Grant Panel has been developed. This has provided consistency in decision-making, access to a broader range of expertise, improved management of conflicts of interest and reduced administrative duplication between localities. Representatives of the panel are from across all areas, and a range of sectors.

A flexible, conversation-led approach to community investment

The Thriving Communities Grant Fund was deliberately designed to be different from a traditional grant-making process. Rather than beginning with an application form, the process begins with a conversation. This enables us to understand the idea in context – the need it is responding to, the organisation's capacity, the resources already available within the community, the outcomes it hopes to achieve and what support would make the greatest difference.

Where appropriate, applicants are then invited to bring their idea to their local **Dorset Connect** network. This is an opportunity to share the idea with people and organisations who know the area and ask a broader question: **“What could this community bring to make this idea stronger?”**

The conversation may uncover local knowledge, volunteers, venues, equipment, expertise, introductions, partnerships or other resources that the applicant did not

know were available. It may identify another organisation already doing something similar or create an opportunity for collaboration. In some cases, this could reduce the amount of funding required; in others, it could significantly increase the reach, sustainability or impact of the original idea.

The grant therefore becomes one part of a wider community response, rather than the response itself.

The aim is not simply to fund a good idea, but to surround that idea with the relationships, assets and support that give it the best opportunity to succeed and become sustainable.

This approach also helps ensure that decisions are informed by local knowledge and community insight, while creating greater connection, and emotional investment between the organisations receiving investment and the communities in which they operate.

Evolving the network model

As the year progressed, we recognised that operating separate Thriving Communities Working Groups alongside the wider VCS Networks was creating unnecessary duplication. We also found that the term 'VCS Networks' was not widely understood, even among some of the community organisations we were trying to reach, potentially limiting participation.

This learning led to the development of **Dorset Connect** – a broader, neighbourhood-based network bringing together grassroots and community organisations, Town and Parish Councils, health and care partners, businesses and other local stakeholders.

Rather than expecting organisations and volunteers to attend multiple meetings, Dorset Connect provides a shared space to build relationships, exchange local knowledge, identify challenges and opportunities, and develop practical solutions together.

Importantly, the approach extends beyond the meetings themselves. Through ongoing communication, introductions and locality-based relationships, connections and collaboration can continue between gatherings, helping turn conversations into meaningful action.

Building reach and visibility

The revised approach was supported by more proactive communications and engagement. Thriving Communities and Dorset Connect were promoted through newsletters, social media, direct engagement and wider sector events. This was particularly important in areas where awareness of Volunteer Centre Dorset's new broader infrastructure role had previously been limited.

By the later stages of Year One, this increased visibility was beginning to generate wider enquiries for organisational support, including training, governance, planning, marketing and engagement support, alongside increased participation in Dorset Connect.

Year One at a Glance

CONNECT	ENGAGE	INVEST
9 local networks	**93** organisations engaged	**£6,100** application value
40 network sessions	**331** participants	**5** grant applications
6 sectors represented	**20** 1:1 conversations	**67** activities enabled

Behind every number is a relationship: an organisation identified, a conversation started, a connection made, a challenge understood or an opportunity unlocked.

Year One: Our Reach, Activity and Early Outcomes

During Year One, Thriving Communities focused on establishing local relationships, identifying grassroots community activity and developing practical ways to strengthen the organisations supporting older residents across North Dorset, Purbeck and Weymouth.

The figures provide an overview of programme delivery and engagement. Importantly, they represent different types of activity, from establishing networks and engaging organisations to providing individual support and developing community investment opportunities. They should therefore be considered alongside the examples of change described throughout this report.

9 Local Networks – Building Connections Across Communities
Thriving Communities established and developed locality-based engagement across its three Foundation Phase areas. The localities identified in the original delivery

programme included Weymouth, Blandford, Sherborne, Sturminster Newton, Shaftesbury and Gillingham, Wareham and Swanage. These networks provided opportunities for voluntary and community organisations, local councils, health and care professionals and other stakeholders to meet each other, share knowledge, identify challenges and develop working relationships. Additional networks have been created in other areas, eg Dorchester and East Dorset, as part of wider VCS support provision, in preparation for potential Thriving Communities expansion.

93 Organisations Engaged – Increasing Awareness and Connections
Across Year One, 93 organisations engaged through programme activity, providing opportunities to share information, strengthen relationships and identify practical support needs. Engagement included voluntary and community organisations, statutory partners and other local stakeholders. Of particular importance was identifying smaller, volunteer-led and informal groups that may not previously have been connected to wider infrastructure support.

331 Participants – Bringing People and Organisations Together
Year One recorded 331 participants through network meetings and associated engagement activity. These opportunities brought together people working in or supporting local communities, enabling them to share information, develop connections, identify resources and explore practical solutions. The programme increasingly focused on ensuring that participation led to useful outcomes, rather than treating attendance alone as a measure of success.

20 One-to-One Conversations – Understanding Needs and Providing Practical Support
Alongside wider network engagement, VCD visited 20 community organisations and local stakeholders for one-to-one conversations. These conversations enabled a more detailed understanding of the circumstances of individual groups, including their strengths, ambitions, organisational challenges and sustainability. Issues explored included volunteer recruitment and succession, governance, financial arrangements, visibility, participation, referral pathways and opportunities for collaboration. Year Two will strengthen the recording of actions and follow-up outcomes so that the practical difference resulting from these conversations can be demonstrated.

5 Grant Applications – £6,100 Requested
The Try It, Do It, Grow It community investment model generated five grant applications with a combined requested value of £6,100. The applications included support for a community café in Wool, Bishops Caundle Community Shop and Hub, Love Dogs & the Environment West Dorset, Swanage Linking Lives and Vale Family Hub's Young at Heart Lunch Club. The proposals addressed a range of locally identified needs, including improving the visibility of community activities, supporting digital inclusion, replacing essential equipment, enabling accessible transport and developing new opportunities for social connection.

67 Activities Enabled – Supporting Community Participation
The programme recorded 67 activities associated with its community investment and support activity. These activities reflect the potential for relatively modest investment and practical assistance to sustain existing provision, test new ideas and create opportunities for social connection.

What These Figures Tell Us

The first year has established an important foundation of relationships, engagement and community investment opportunities. However, the value of Thriving Communities cannot be measured solely through the number of meetings, organisations, participants or grant applications.

The emerging evidence of change is found in the practical outcomes of those relationships: improved referral pathways, organisations overcoming barriers to development, existing community activities becoming more visible and groups accessing support that responds to their circumstances.

Year Two will build on this foundation by recording not only what the programme delivers, but what changes for organisations and residents as a result. This will provide a clearer understanding of the contribution Thriving Communities makes to stronger, more connected and sustainable community provision.

5. What We Learned

Listening to communities changed our understanding

The Foundation Phase was designed to test how grassroots community organisations could best be identified, connected, supported and strengthened. One of its most important outcomes has therefore been the learning generated through delivery.

Direct engagement challenged some of our original assumptions. It demonstrated that grassroots community activity is often less visible, less formal and yet more self-sufficient than traditional models of VCS engagement might suggest. It also showed that the challenges affecting sustainability are frequently more complex than a lack of funding.

Most importantly, the first year reinforced the need to start with the organisation and its community, rather than with a predetermined intervention.

1. Some of Dorset's most valuable community activity flies under the radar

Many of the grassroots groups encountered through Thriving Communities are invisible to ‘the system’, and they did not necessarily identify themselves as part of the voluntary and community sector (VCS). They were often operating independently, with no connection to infrastructure organisations or wider networks and limited or no awareness of the support available to them.

Some were small friendship, lunch, coffee or activity groups that had developed organically because local people recognised a need and decided to do something about it.

These groups can be difficult to identify through traditional databases, mailing lists or established networks. Indeed, one of the programme's original assumptions was that existing local knowledge and networks would naturally lead us to these groups. In practice, this was only partially achieved and greater one-to-one identification and outreach is still required in Phase Two.

What this means: If we want to understand community capacity, we cannot rely solely on the organisations already known to us. Effective community development requires active relationship-building and a willingness to seek out activity happening outside formal structures. This will require more considerable resources to spend time in communities.

2. Funding is important – but money is not always the answer

One of the clearest findings from Year One was that financial need was not always the primary challenge facing grassroots groups. Some groups operate with remarkably little money. Activities may be supported through small attendance charges, donations, raffles, low-cost venues or contributions from local businesses. Some groups we encountered were financially self-sufficient and had little interest in or need to apply for grant funding.

Their challenges were different. They included attracting volunteers, succession planning, declining participation, governance, safeguarding, increasing awareness of their activity, improving referral pathways and overcoming transport barriers. A short-term grant might help an organisation continue an activity for a period, but it would not necessarily address the underlying issue threatening its sustainability.

What this means: Community investment is most effective when funding sits alongside organisational development, connections, volunteer support, knowledge and practical assistance.

3. Community capacity can be both powerful and fragile

The programme encountered activities that have been sustained for many years through the commitment of a very small number of volunteers. This represents an enormous community asset – but also a vulnerability.

Where an activity depends on one or two people, the retirement, ill health or changing circumstances of those individuals can put the entire activity at risk. In many cases, there is no formal succession plan and limited capacity to recruit or develop the next generation of volunteers.

This is particularly important when considering preventative community infrastructure. A longstanding lunch club, friendship group or social activity may appear stable because it has existed for many years, while in reality its future may depend upon a handful of individuals.

What this means: Supporting community resilience requires attention not only to what exists today, but to the people, skills, governance and succession arrangements that will enable it to exist tomorrow. Engagement needs to be sensitive, in-person, and relationship-based.

4. Not every organisation wants to grow

Traditional funding and development models can sometimes assume that successful organisations should increase their reach, income, activities or geographical footprint. Our engagement demonstrated that this is not necessarily what grassroots groups want.

Some are intentionally small. They exist to serve a particular community or group of people and are content with their current scale. Some are self-financing and have no ambition to become more formalised or significantly increase their activity. Obviously, that does not make their contribution less valuable.

For a small friendship group, success may mean continuing to provide companionship to the same group of older residents. For another organisation, it may mean recruiting two new volunteers so that an existing activity can continue. Formalisation can create a barrier - most groups don't want to develop complex governance, open bank accounts, have policies and procedures or receive training. Support needs to be proportionate.

What this means: Our approach needs to recognise sustainability, resilience and community value alongside growth. Support should be proportionate to the ambitions and circumstances of the organisation.

5. Engagement has to offer a clear purpose

The original model anticipated separate Thriving Communities Working Groups operating alongside wider VCS networks. In practice, many organisations and partners were already being invited to multiple meetings, networks and advisory groups – or just have busy lives – or are simply not interested, and only want to deliver their service.

For smaller organisations in particular, attending another meeting places additional pressure on limited capacity and frontline delivery. A simple but important message emerged from our conversations: ***People are busy. They want to "do the doing" and only get further involved if there is a clear purpose.***

Engagement therefore needs to provide tangible value. People need to make useful connections, solve problems, discover opportunities, access support or contribute to something that matters to their community. This learning was a significant driver behind integrating Thriving Communities into Dorset Connect, thereby reducing duplication and creating a broader space for meaningful local engagement.

What this means: We should measure the success of community networks not simply by attendance, but by what happens because people attended. Dorset Connect engagement should ensure that people have something to contribute, as much as something to take away.

6. Different communities require different approaches

Delivery varied considerably between the programme areas. Weymouth established stronger engagement relatively quickly, supported by existing relationships, Volunteer Centre Dorset's presence through other programmes, a vibrant VCS, and an established local VCS network operated by Weymouth Town Council.

North Dorset presented different challenges. Its rural geography required activity across several distinct localities, while awareness of VCD as a wider infrastructure organisation, beyond volunteer support, was lower and relationships needed to be developed. Purbeck again required a different response, with limited engagement in a standalone Working Group leading to discussions about aligning with existing local activity that could modify, rather than creating duplication.

Across all areas, rurality matters - transport and geography affect participation, volunteering and access to activities.

What this means: A single delivery model cannot simply be replicated across Dorset. Effective neighbourhood working needs to recognise existing relationships, geography, identity, infrastructure and local capacity – building on what already exists rather than automatically creating something new.

7. Trust and relationships are infrastructure too

Grassroots community development depends upon trust. We have therefore established a position of “Moving at the pace of trust”. Some of the organisations encountered were cautious about “interference”, formal structures, external organisations and offers of support. Many had successfully operated independently for years and did not necessarily perceive a need for outside involvement. Engagement therefore required careful, sensitive, one-to-one conversations and reassurance that support would not mean imposing unnecessary processes or changing what already worked.

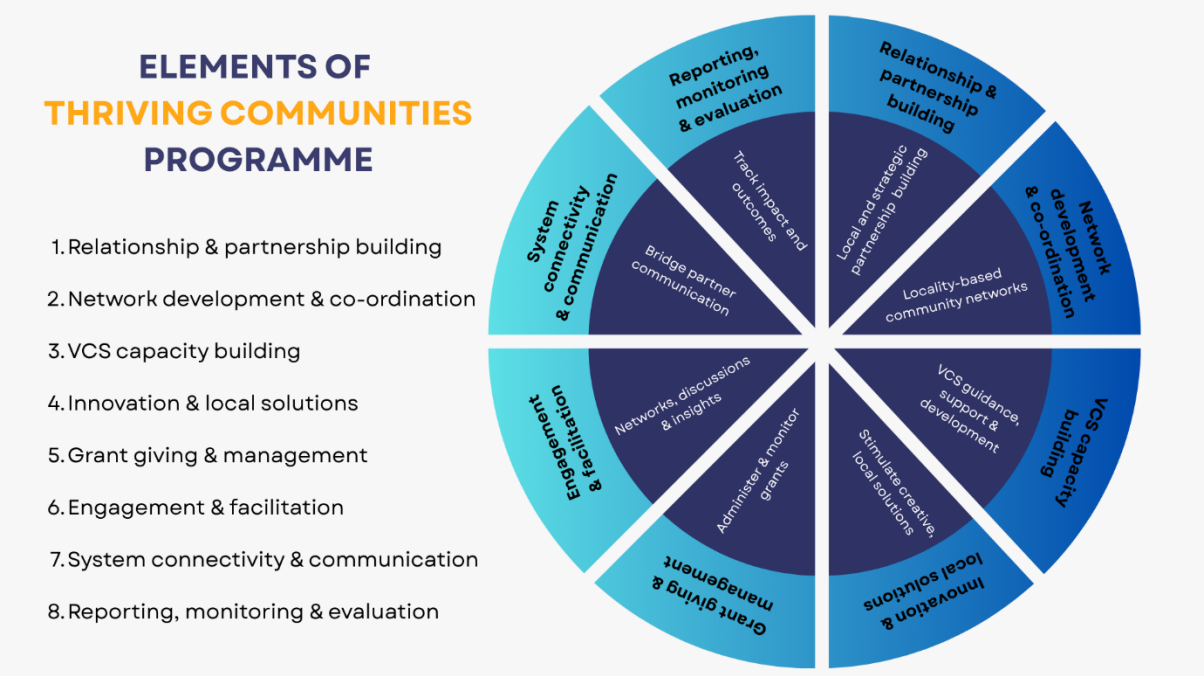
This takes time. Some groups require repeated conversations and reassurance before they will engage with any infrastructure support. We ensure we are ‘meeting groups where they are at’, and helping solve problems that matter to them. Building relationships this way has created something valuable beyond the infrastructure support: a connection through which organisations can ask for help, hear about opportunities, meet potential partners and contribute their knowledge of their community – identifying that they too have more to offer than they think.

What this means: Relationships should not simply be viewed as the route through which the programme delivers its work. Building trusted relationships is itself part of building community infrastructure, with extensive opportunities for wider community insight.

8. From learning to a stronger model

Taken together, these findings have clarified our understanding of what is required to build thriving communities. We started with a model that placed significant emphasis on networks and grant funding. What has emerged was a need for a broader programme – with equal emphasis on all parts:

Relationships + Connections + Organisational Support + Community Intelligence + Collaboration + Investment



Thriving Communities is evolving from a programme that primarily sought to identify groups and fund activity into one that seeks to identify, connect and strengthen community assets – and then use funding where investment can add the greatest value.

This is the foundation upon which the next phase of the programme can now build.

9. Testing Our Assumptions

The Foundation Phase gave us an opportunity to test original assumptions against the reality of voluntary and community activity across Dorset. Some assumptions were validated, while others were challenged or proved more complex than anticipated.

The most significant shift was recognising that grassroots community capacity cannot simply be identified and strengthened through networks and grant funding. It requires active outreach, trusted relationships, proportionate organisational support and an understanding of the different assets and challenges within each community.

What did we test?

Our original assumption	What we found	What this means for delivery
Local networks would naturally identify and	Partially. Existing networks provided a valuable starting	Networks need to be complemented by proactive

Our original assumption	What we found	What this means for delivery
connect grassroots organisations.	point, but many smaller volunteer-led groups remained outside them and were difficult to identify.	outreach, local relationships, introductions and one-to-one engagement.
Groups supporting older people would be attracted by grant funding.	Not always. Some groups were financially self-sufficient or had relatively modest financial needs. Funding was frequently not their greatest challenge.	Funding should be one tool within a wider support offer rather than the starting point for every conversation.
Grassroots organisations would engage with a formal network structure.	Engagement was mixed and varied considerably between localities. Smaller organisations in particular had limited capacity or appetite for additional meetings.	Engagement needs to be simple, accessible and clearly worthwhile. This directly informed the integration of Thriving Communities into Dorset Connect.
Existing local knowledge would enable us to identify priority groups.	Local knowledge was valuable but incomplete. Further direct engagement was required to find organisations operating outside established relationships.	Community mapping cannot be a one-off exercise. Identifying community assets needs to be an ongoing, relationship-led process.
Existing information sources would provide a good picture of community provision.	They provided a starting point, but there was no single reliable source identifying the breadth of informal and volunteer-led community activity.	Dorset Connect and ongoing community engagement can help build a richer and more current picture of local assets, needs and gaps.
Funding would strengthen community activity.	Yes – where finance was the barrier. However, sustainability was often influenced just as strongly by volunteers, succession, governance, participation, visibility and transport.	Investment needs to combine financial support with infrastructure support, connections and organisational development.

Our original assumption	What we found	What this means for delivery
A common approach could be applied across the programme areas.	Different localities responded differently depending on geography, existing infrastructure, relationships and awareness of VCD.	Delivery needs to remain place-based and adaptable, building on existing community infrastructure rather than imposing a uniform model.

PART TWO: WHAT WE BUILT

6. The Thriving Communities Model

Building the conditions in which communities can thrive

The Foundation Phase has developed Thriving Communities from its original focus on networks and grants into a broader community infrastructure model. It brings together relationships, local intelligence, organisational support, community assets, pathways into provision, collaboration and targeted investment. Rather than treating these as separate interventions, the model connects them around the needs and opportunities within each community.

At its heart is a simple principle: Start with the community, understand what already exists and what is needed, then bring together the relationships, resources, support and investment that can make the greatest difference.

The model recognises that communities already hold significant assets – people, organisations, volunteers, places, knowledge, skills, relationships and ideas. Thriving Communities provides the infrastructure to connect, strengthen and mobilise those assets, while investing where additional resources can unlock greater community benefit.

A connected model

Thriving Communities brings together six interconnected elements:

CONNECT — Building relationships and local networks

Dorset Connect provides the neighbourhood infrastructure through which organisations and partners can build relationships, understand what is happening

locally and identify opportunities to work together. It connects grassroots organisations with the wider VCS, health and care, Town and Parish Councils, public services, businesses and other community stakeholders – creating relationships through which information, resources, referrals, opportunities and collaborative solutions can flow.

UNDERSTAND — Building community intelligence

Relationships create a richer understanding of communities: what provision exists, where there are gaps, what organisations and residents are experiencing, where capacity may be vulnerable and what opportunities are emerging. Dorset Connect, direct engagement and one-to-one relationships create a two-way flow of community intelligence, enabling local insight to inform support, collaboration and investment while connecting communities with wider opportunities and developments.

STRENGTHEN — Building capacity and resilience

Support is proportionate to the organisation and what it is trying to achieve. This can range from a conversation or introduction through to support with governance, safeguarding, volunteering, organisational development, sustainability, communications or collaboration. The aim is not to make every organisation bigger or more formal, but to help valuable community provision become as strong and sustainable as it needs to be to fulfil its purpose.

REACH — Connecting people to community provision

Community provision achieves its greatest value when people can find and access it. Thriving Communities therefore strengthens the connections between community provision, residents and the professionals supporting them. Better visibility, communications and relationships with health, care and other services can create stronger pathways into local activity and support.

COLLABORATE — Mobilising community assets

Connecting people around local opportunities enables communities to make better use of the assets already available – including volunteers, venues, knowledge, expertise, equipment, communications channels and partnerships. Dorset Connect provides a mechanism for bringing these assets together, supporting collaboration and strengthening community-led responses before assuming that additional funding is the only solution.

INVEST — Targeted funding where it adds value

Investment remains an important part of Thriving Communities, but sits within this wider model.

The ‘Try It, Do It, Grow It’ grant model provides a flexible framework for testing new ideas, sustaining valuable existing activity and developing successful approaches

where there is further need or opportunity. Investment can therefore sit alongside community assets, connections and organisational support to strengthen its reach, value and sustainability.

One model, different routes in

The model is deliberately connected rather than linear. An organisation might first engage through Dorset Connect, a grant enquiry, an introduction, a governance question or a conversation with VCD. From there, different elements of the model can be brought together according to the organisation, opportunity or locality.



The strength of the model is in the relationship between these elements. Connections generate intelligence; intelligence informs support and investment; stronger organisations become more visible and accessible; collaboration mobilises additional assets; and targeted investment can unlock further community capacity.

Thriving Communities is a connected model for strengthening the infrastructure around community activity – enabling valuable provision to be found, connected, strengthened, accessed and sustained.

7. Dorset Connect: Creating the Connection Infrastructure

Connecting people, organisations and opportunities at neighbourhood level

The Foundation Phase reinforced that strong communities depend upon strong connections. Grassroots organisations can often operate in isolation – but their ability to thrive can depend upon relationships with other community groups, volunteers, Town and Parish Councils, health and care professionals, businesses, public services and the people who live within their communities.

Yet these connections do not always happen naturally. Dorset Connect provides the infrastructure to help make them happen. Developed from the learning of the original VCS Networks and Thriving Communities Working Groups, Dorset Connect creates a shared neighbourhood space where different sectors can come together around the communities they serve, with a membership that is deliberately broad and inclusive.

Its purpose is to:

- Connect people
- Surface community intelligence
- Connect organisations with support
- Create collaborations
- Connect statutory partners with communities
- Inform participants through news updates or micro-training
- Identify challenges
- Uncover opportunities
- Solve problems
- **Take action**



More than a VCS network

While we continue to primarily focus on bringing the voluntary and community organisations together, Dorset Connect deliberately widens the room. Depending on the locality, participants can include grassroots and volunteer-led groups, larger VCS organisations, Town and Parish Councils, health and care, education, housing, businesses, faith organisations, arts and culture, sports and leisure, community leaders and other local stakeholders.

This breadth matters because communities do not experience challenges according to organisational or sector boundaries. A community organisation may need volunteers – a local business may have employees looking for volunteering opportunities. A lunch club may need a venue – a local organisation may have underused space. A health professional may be supporting someone experiencing isolation – a community group nearby may provide exactly the social connection that person needs. A grassroots organisation may have an idea but lack equipment, expertise or communications capacity – another person in the room may be able to provide it.

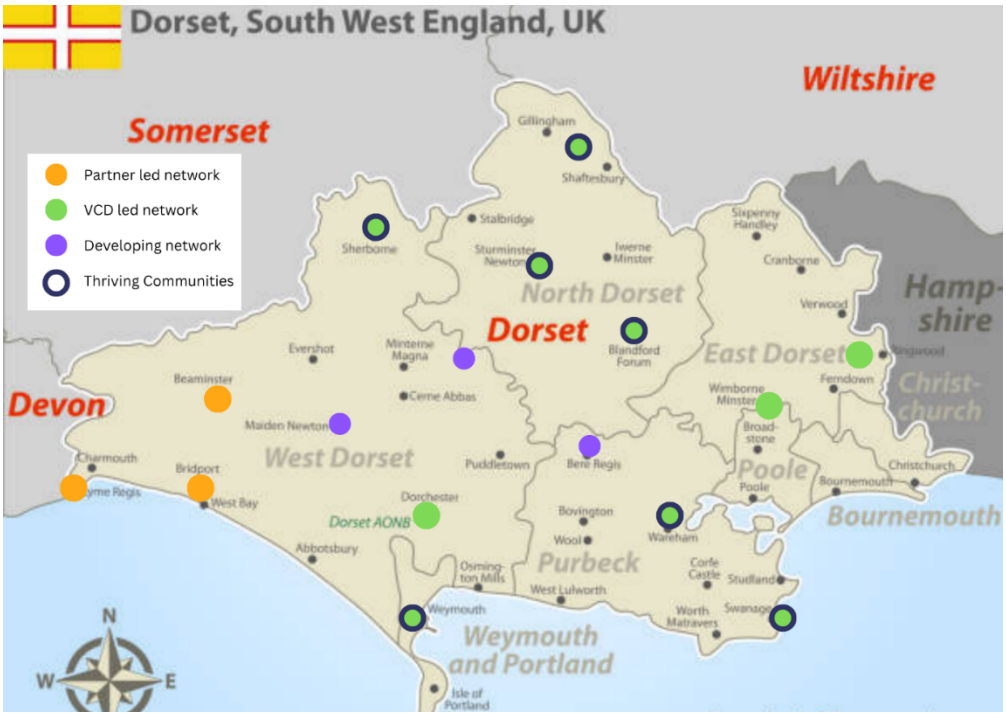
Dorset Connect creates the environment in which those connections are more likely to happen.

A neighbourhood approach

Dorset Connect operates at a locality level, recognising that Dorset is made up of distinct communities with different identities, assets, challenges and relationships. The network is therefore not intended to impose a standard agenda across the

county. Each locality can develop around the issues and opportunities that matter locally, while remaining connected to a wider Dorset infrastructure.

The network footprint is developed across North Dorset, Dorchester, Weymouth, Purbeck and East Dorset, with further locations being explored where there was a clear need and where new activity would complement rather than duplicate existing local arrangements. Where good local infrastructure already exists, we will connect with it. Where there is a gap, we can help build it.



What happens through Dorset Connect?

Dorset Connect meetings provide an opportunity to meet quarterly in-person to share, connect, explore, collaborate and act. Organisations can share what they are working on, identify challenges, ask for help, hear about local activity and discover opportunities that they may otherwise never encounter. But we don't want the value of Dorset Connect to be limited to the meeting itself.

Relationships continue through introductions, one-to-one conversations, ongoing communication and practical follow-up. The evolving model continues contact between the quarterly in-person meetings, with an online meeting, so that opportunities and collaboration are not dependent upon waiting for the next formal gathering, and others who cannot attend in person are welcomed online. Recently created Whatsapp groups, are another way that group members are staying connected and involved between meetings – reaching out to their community for support or with updates.

In both formats, news and updates are shared from statutory partners and the wider sector, along with developments that are important and specific to the locality. Micro-training is a feature which enables us to share quick wins to help improve social media engagement, volunteer recruitment, safeguarding procedures, business planning, etc – and this is used to whet the appetite of attendees to then enquire about further support, or book a full training session.

We have developed an 'Ask One', 'Give One' wall, where everyone adds post-it notes with contributions (see samples in Appendix). These are shared by email after the event giving everyone equal opportunity to follow up on opportunities that are valuable to them. During a post-event debrief, the VCD team identify opportunities and connections beyond the participants, and follow these through. The 'bring a challenge' segment incorporates Thriving Communities, enabling a group or individual to speak to the room. This can be because the group would like to apply for Thriving Communities funding, or just because they want the help and support of their community. This has raised some vibrant conversations, created ideas, connections, and opportunities, that would not have otherwise been identified.

By attending Dorset Connect, we want people to leave:

- **better connected** – knowing people and organisations they did not know before;
- **better informed** – understanding more about their community, local provision and opportunities; or
- **better equipped** – with a connection, resource, idea or next step that helps them take action.

Increasingly, the test of a successful network is not about how many people attended, but the quality of the participation and actions that follow.

Mobilising community assets

Dorset Connect and 'Ask One', Give One' are central to the programme's approach to community asset mobilisation. Every community contains assets that extend far beyond financial resources:

- **People** with skills, experience and enthusiasm.
- **Volunteers** willing to contribute time.
- **Places** where activity can happen.
- **Organisations** with knowledge, capacity and reach.
- **Businesses** with expertise, resources and networks.
- **Relationships** that enable things to happen.
- **Local knowledge** about what communities need and what already works.

The challenge is that these assets are not always visible or connected – therefore Dorset Connect provides a mechanism for bringing them together. This is particularly important within the Thriving Communities grant model where an organisation bringing an idea forward can share it with its local network, creating an opportunity to

identify support and resources before funding is considered in isolation. The result may be a new partnership, access to a venue, volunteers, equipment, specialist knowledge, greater visibility or an introduction to another organisation.

In this way, Dorset Connect can help increase the value of financial investment while strengthening local ownership and resilience.

See Samples of Ask One, Give One in Appendix.

Creating pathways into community support

Dorset Connect also has the potential to address another important challenge identified through the Foundation Phase: good community provision is only valuable if people know it exists and can access it. By bringing community organisations into closer contact with health, care and other professionals, the network can improve awareness of the activities and support available locally. This can help develop stronger informal and formal pathways between Health & Care, Community Provision, Residents – and is more impactful than a flyer, poster or email.

The relationship works in both directions, with professionals building confidence to connect people into community activity, while grassroots organisations can better understand wider services and know where to direct someone when their needs extend beyond what the organisation can provide.

For Thriving Communities, this is an important part of the prevention ambition: connecting people with appropriate community support earlier and making better use of the provision that already exists.

Creating a flow of community intelligence

Dorset Connect also creates a regular flow of community intelligence. Grassroots organisations and local leaders often see changes within communities before those changes appear in formal datasets. They hear when attendance is declining, when transport has become a barrier, when volunteers are becoming exhausted, when a new group of residents is struggling or when demand for a particular type of support is increasing.

Bringing those voices together provides an opportunity to identify: emerging needs and pressures; gaps in provision; vulnerable community activity; duplication; opportunities for collaboration; local assets that are underused; and ideas emerging directly from communities. It will also importantly shine a light on ‘what’s working well’, and help us all understand why.

This intelligence can inform not only Thriving Communities, but potentially wider conversations about prevention, neighbourhood working and community investment.

Equally, information can flow in the other direction – enabling local organisations to better understand wider strategies, services, funding opportunities and developments that may affect their communities. Dorset Connect therefore creates a two-way bridge between communities and the wider system.

From networking to action

Ultimately, the success of Dorset Connect should be judged by what happens because people are connected. The ambition has been to move beyond a regular network: **Meeting → Conversation → Meeting** and towards: **Connection → Opportunity → Collaboration → Action.**

This might mean two organisations developing something together, a professional discovering a community service they then refer into, a group finding volunteers, an organisation accessing infrastructure support, a local challenge being collectively addressed or an idea progressing into the Thriving Communities investment pathway.

Over time, these individual connections create something bigger: a stronger and more connected community infrastructure. Dorset Connect is an integral part of the infrastructure that enables Thriving Communities to happen.

Building the infrastructure for prevention

Prevention begins in communities – through friendship, activity, volunteering, practical support, information, self-activation, belonging and connection within a community. But those community assets need an infrastructure around them if they are to be visible, accessible, connected and sustainable.

Dorset Connect provides that connective infrastructure. It creates the relationships through which community assets can be identified and mobilised; the intelligence through which needs and gaps can be understood; the connections through which residents can reach local provision; and the partnerships through which communities can develop their own responses.

If Thriving Communities is the model, Dorset Connect is the connective tissue – linking people, organisations, resources and opportunities so that communities are better able to support their residents and contribute to prevention.

8. The ‘Try It. Do It. Grow It.’ Grant Model

Flexible investment for community-led solutions

Grant funding for grassroots VCS groups to be able to continue or expand their provision for older residents is an important part of the Thriving Communities model. Rather than operating a traditional grant programme in which organisations respond to a funding opportunity through a written application process, the **Try It, Do It, Grow It** approach provides a simple framework for investing in community activity at different stages of its development.

A simple framework with a wider purpose







TRY IT	DO IT	GROW IT
Test something new	**Sustain something valuable**	**Develop something proven**
Respond to an idea, gap or opportunity	Protect activity communities already value	Increase reach, accessibility, capacity or resilience
Test → Learn	**Continue → Strengthen**	**Develop → Sustain**

The funding is flexible, and the purpose is consistent. To help communities turn local ideas and existing assets into sustainable activity that strengthens connection, wellbeing and independence.

Further details of each funding element and governance are included in the Appendix.

The approach recognises that community groups need different things at different times. A new idea may need a small amount of funding to test whether it works. An established activity may simply need help to continue. Another may have demonstrated its value and be ready to reach more people.

More than three grant categories

A Try It, Do It, Grow It grant starts with a conversation. Rather than asking an organisation to immediately demonstrate how it fits predetermined funding criteria, completing forms and submitting documents, a conversation can help us first understand:

- What are they trying to achieve?
- What need or opportunity have they identified?
- What already exists within the community?
- Who could they work with?
- What resources or assets are already available?
- What is getting in the way?
- What would make the greatest difference?

That conversation might uncover a range of support needs – of which one may be funding. But it may also uncover a need for volunteers, communication support, a venue, governance advice, marketing, training; while opening the door to wider support opportunities including an introduction, partnerships, professional referrals or collaboration with another organisation or even donations.

This is why the Try It, Do It, Grow It model works most effectively, embedded within Dorset Connect and the wider Thriving Communities model, rather than as a standalone grant programme.

Bringing the community into the investment process

Where appropriate, potential applicants will bring their idea to **Dorset Connect** as part of the application process; and before taking an application to panel. This creates an opportunity to put local knowledge around the proposal. Rather than a focus on asking only: **“Should we fund this?”** the wider conversation can ask: **“What could we collectively bring to help make this work?”**

People in the room may identify a venue, volunteers, equipment, expertise, referral routes, communications channels, another funding source or an organisation interested in collaborating. This can strengthen the proposal, avoid unnecessary duplication and potentially reduce the amount of grant funding required. Importantly, it also begins building the relationships around an activity before the money is awarded, increasing the likelihood that those relationships and interest continue after the grant has been spent.

Making every pound work harder

This approach changes the role of the grant. Rather than funding being the beginning and end of the relationship, it becomes one resource amongst many that can be mobilised around a community idea. For example:

Traditional approach: Application → Assessment → Grant → Activity → End of grant

Thriving Communities approach: Conversation → Community insight → Connections & assets → Support + Investment → Activity → Relationships & sustainability

The ambition is to increase the value and longevity of the investment made. Where an organisation can combine a grant with volunteers, partnerships, local assets, in-kind support and stronger referral pathways, the resulting activity has the potential to become more resilient and less dependent upon repeated grant funding alone. Involving their Dorset Connect community, will organically create ongoing engagement, interest and buy in from wider community partners.

Investment that reflects community value

The Foundation Phase has also encouraged us to look beyond organisational labels when considering where community value is created. A charity, CIC, informal community group or other provider; like a sole trader; may deliver very similar activity to the same population. The distinction may lie only in governance, ownership and how income or surplus is ultimately used.

Our developing approach therefore considers not only what type of organisation is applying, but:

- What activity will be delivered?
- Who will benefit?
- What community need or opportunity does it address?
- Where will the benefit of the investment ultimately sit?
- How will public or charitable investment be appropriately protected?

This enables Thriving Communities to recognise valuable community provision while maintaining proportionate safeguards around the use of funding.

9. Bring It to Life

Meeting groups where they are

‘Meeting groups where they are’ has started to have meaning both in terms of geography, and where they are in their development journey. One of the most encouraging responses to Thriving Communities and Dorset Connect has been the appreciation expressed by organisations that we are taking the time to visit them in their own communities, rather than expecting them to come to us.

This has been particularly meaningful in rural areas such as North Dorset and Purbeck, where geographical isolation has contributed to strong, self-reliant communities with established local relationships and ways of working. By being present, listening and understanding local circumstances, we are building connections with groups that have often felt distant from wider systems and support networks.

The feedback has reinforced that being visible, accessible and willing to listen is valuable in itself. Organisations have welcomed the opportunity to share their experiences, challenges and ambitions with people who have made the effort to understand their community.

This relationship-led approach recognises that communities are different, local knowledge matters, and effective support must reflect the strengths and circumstances of each place. By meeting groups where they are, we are building the trust and relationships that enable more meaningful collaboration and lasting community connections.

Conversations in the Community

Dorset Connect is creating opportunities for conversations that lead to practical solutions and stronger partnerships. We have experienced that:

- Conversations often uncover underlying challenges that are not immediately visible.
- Bringing together different perspectives helps organisations explore solutions they may not have considered on their own.
- The first issue presented is not always the barrier that needs addressing most urgently.
- Early support and signposting can help organisations build stronger foundations for future growth.
- Sometimes progress is not about delivering a project immediately, but about removing obstacles that would prevent future development.
- Organisations are increasingly thinking about how existing community assets and services can evolve to meet changing needs within their communities.

During Phase One, we have been party to many conversations, both collectively and 1:1. Here is a flavour of what we are hearing:

Example Conversation 1: Conversations That Lead to Action

At a network meeting in North Dorset, a volunteer-led singing group supporting people living with dementia and their carers, highlighted a lack of new members

joining, and that they receive no referrals from local GP practices. An NHS representative present identified a barrier for people not yet formally diagnosed being signposted, and recognised the opportunity to strengthen referral pathways. Subsequent conversations resulted in the group then receiving referrals from local GP services, increasing attendance and helping more people access support earlier, even prior to diagnosis. The discussion also opened up opportunities to improve the group's visibility and longer-term sustainability, including promotional materials and potential support from local businesses and community partners. What began as a conversation about referrals became an opportunity to strengthen connections, increase access to community support and explore longer-term sustainability.

Example Conversation 2: Looking Beyond the Presenting Challenge

An organisation successfully delivering farm-based activities for young people wanted to explore extending its offer to older people, including those living with dementia or Parkinson's. Initial conversations through Dorset Connect focused on improving accessibility for people with reduced mobility. Local partners suggested practical solutions, including specialist advice and potential support from businesses. However, further discussions revealed a more fundamental barrier: the organisation did not have a formal lease for the land it occupied, and other foundational governance issues limiting its ability to secure funding for future development. Through signposting to specialist legal support, the organisation was able to formalise its land arrangements and secure a lease, putting it in a stronger position to pursue funding and develop its plans.

What began as a conversation about accessibility uncovered a more significant challenge. By looking beyond the presenting issue, we helped the organisation address a fundamental barrier to its future development.

Example Conversation 3: Understanding Informal Community Groups

One practical challenge identified through conversation with a bereavement support group, was managing small amounts of money raised through raffles and social activities, and the disproportionate burden of bank fees. They had been operating for over 15 years, without a formal constitution or charitable status, but have found accessing suitable banking arrangements to be difficult or disproportionately expensive. Conversations helped groups explore more proportionate approaches, for the small amounts of money, including operating activities on a largely cost-neutral basis. We helped them think differently about how they raise money, where they keep it, service user contributions, and a sustainable funding model that meant not asking for a grant to pay for bank fees. These conversations reinforce that community value is not determined by organisational size or structure. Sometimes the most appropriate support is simply practical advice, a trusted relationship and an understanding of what a group needs to continue doing what it does well.

Example Conversation 4: Recognising and Supporting What Already Works

A volunteer-led lunch club in Weymouth demonstrates how strong local partnerships can sustain valuable community activity, sometimes without external funding. Operating from a church venue provided free of charge, the club offers affordable meals and social connection, supported by volunteers and a local fish and chip supplier providing meals at cost price. The group also benefits from the church's existing governance, safeguarding and volunteer support arrangements. The club was not seeking funding or expansion, and its existing arrangements were working well. They just wanted some reassurance they were ‘getting it right’. Our conversations therefore focused on where

Thriving Communities could add value, particularly by raising awareness of the club among social prescribing teams, primary care and wider community networks. Sometimes the greatest value lies not in creating or changing provision, but in recognising what already works, offering reassurance, strengthening connections and helping more people benefit.

Example Conversation 5: Looking Beyond Funding Requests
A long-established community group in North Dorset initially approached Thriving Communities seeking funding support. However, conversations revealed that the group already had a sustainable financial model, supported by membership contributions and a local town council grant.
The more pressing concern was attracting and welcoming new members. While the group had strong, established friendships, organisers recognised that newcomers could find it difficult to feel included, potentially limiting the group's longer-term sustainability. Our discussions explored simple approaches to improve the experience of new attendees, including a buddy system to help people feel welcomed and supported from their first visit. We also highlighted wider resources, other examples from across the county and support available should it be needed. This example demonstrates that sustainability is not always about funding. Sometimes a conversation and a few practical ideas can help an organisation address barriers to participation and strengthen its future.

What These Examples Demonstrate

Lots of conversations happen, and sadly, we don't get to be party to all of them, we never get to know all the connections and outcomes, and we don't see when independently, people quietly go and act on things they have heard. But together, these examples illustrate how Thriving Communities is translating relationships and local knowledge into practical support and opportunities for stronger community provision.

We now know that:

- **Local presence builds trust.** Meeting organisations in their own communities helps us reach groups that may otherwise remain disconnected from wider networks and support.
- **The presenting issue is not always the underlying challenge.** Conversations can reveal barriers and opportunities that would not emerge through a funding application or standard support offer.
- **Sustainability is about more than funding.** Volunteer capacity, succession, participation, governance, visibility and partnerships can be just as important to an organisation's future.
- **Not every organisation needs to grow or formalise.** Small, informal groups make an important contribution to community wellbeing, and support should reflect their purpose, ambitions and capacity.
- **Existing community assets are a valuable starting point.** Volunteers, venues, local businesses and established partnerships can often provide solutions without additional financial investment.
- **Connections can lead to tangible outcomes.** Stronger referral pathways, greater visibility and practical collaboration can help more people access valuable community activity.
- **Small interventions can make a meaningful difference.** An introduction, specialist advice or a conversation can help organisations overcome barriers and strengthen their resilience.

The common thread is that Thriving Communities adds value by understanding what already exists, identifying what will make the greatest difference and connecting organisations with the people, resources and opportunities that can help them thrive.

Community Intelligence: What Dorset Is Telling Us

Beyond the individual conversations, connections and grants, Thriving Communities is beginning to build something equally valuable: a deeper understanding of what is happening within Dorset's communities. Through Dorset Connect, direct engagement and relationships with grassroots organisations, we are hearing about challenges, changes and opportunities that may not be visible through formal data or established networks.

Community groups and volunteers often have detailed knowledge of their local areas. They notice when attendance is changing, when volunteers are struggling, when residents are finding it harder to participate or when an activity is at risk. They also know what is working well, where there is untapped potential and what their communities already have to offer. This is community intelligence: local knowledge and experience that can help us understand not just what provision exists, but how well it is working, how resilient it is and what might make a difference.

The Foundation Phase has not undertaken a comprehensive assessment of community need. However, recurring themes are beginning to emerge from our conversations.

1. Valuable community activity can be vulnerable
Some longstanding activities depend upon a handful of committed volunteers, often with limited succession arrangements. Their continued existence can mask underlying fragility, with the potential loss of both the activity and the relationships built around it.

2. Participation is not always straightforward
Groups report difficulties attracting new members, reaching people who might benefit or helping newcomers feel comfortable. The existence of an activity does not guarantee that residents know about it or feel able to attend.

3. Transport can determine whether people participate
Particularly in rural areas, transport remains a significant practical barrier. Communities may have suitable provision, but residents cannot always reach it. Understanding accessibility is therefore as important as identifying what activities are available.

4. Informal groups face different organisational challenges
Some small groups operate successfully without formal structures, while others face difficulties around banking, governance, safeguarding or volunteer arrangements. The appropriate response depends on the activity, its risks and the circumstances of the group.

5. Communities often already hold part of the solution
Conversations reveal existing venues, volunteers, businesses, skills, relationships

and activities that could be better connected or utilised. Sometimes the opportunity lies in strengthening what already exists rather than creating something new.

6. Financial need and organisational vulnerability are not the same
Some financially sustainable groups face challenges around leadership, participation or succession. Others need modest financial support to sustain valuable activity. Understanding the underlying circumstances is essential before deciding what support will be most useful.

7. Local circumstances shape both challenges and opportunities
The experiences of organisations differ across Dorset. Geography, transport, established relationships, local infrastructure and community identity all influence what support is needed and how people engage.

Turning local knowledge into practical value

Individually, these observations help us respond to particular organisations and communities. Collectively, they begin to reveal patterns that could inform wider decisions about our approach, support, investment and prevention.

For example, recurring concerns about volunteer succession may indicate a need for more targeted volunteer development. Reports of low participation despite existing provision may point towards problems with visibility, confidence, accessibility or referral pathways rather than a need to create additional services. Similarly, understanding the resources and relationships already present within a locality can help partners identify opportunities for collaboration before committing further investment.

The value of this intelligence is not simply in what we hear, but in what we can do with it. As Thriving Communities develops, there is an opportunity to capture these insights more consistently, identify emerging patterns across localities and share relevant intelligence with partners who can help address challenges or inform wider decisions.

Importantly, this must remain a two-way relationship. Communities should not simply be a source of information for wider systems. They should also benefit from improved access to knowledge, resources, opportunities and feedback about decisions that affect them. By connecting population-level evidence with the knowledge held by communities themselves, Thriving Communities can help create a more informed, responsive and locally grounded approach to prevention.

Try It. Do It. Grow It. – What grants look like in practice

The following examples illustrate how relatively small, targeted grants have the potential to make a meaningful difference to community organisations and the

people they support. They demonstrate the flexibility of the *Try It, Do It, Grow It* approach, from sustaining valued activities and improving accessibility and visibility, to testing new ideas and creating opportunities for social connection. Each grant responds to a specific local need, recognising that meaningful community impact does not always require significant financial investment. Importantly, these grants form part of a wider approach that combines funding with practical support, relationships and connections to help community activity thrive.

Grant Application 1: Community Café, Wool (Purbeck)
Grant requested: £250 | Purpose: External promotional signage

Established in response to local consultation highlighting loneliness and a lack of informal meeting spaces, the Community Café in Wool provides a welcoming place for residents to meet, socialise and build friendships.

Based at the D'Urberville Centre, the café brings together older residents, young families and others seeking social connection. Founded and run by two experienced community volunteers, the café was largely self-funded and now generates sufficient income from refreshments to cover its day-to-day running costs. Support from the Parish Council also helped refurbish the space.

As the café became established, its organisers identified a need to improve visibility and attract more residents. A £250 Thriving Communities grant funded an external swing sign, helping people discover the café and understand when it is open.

Early feedback suggests the sign is already improving awareness and attracting additional visitors.

What this investment could unlock: A small, targeted grant has strengthened the visibility and reach of an existing, financially-sustainable community initiative, helping more residents access opportunities for companionship and social connection.

Grant Application 2: Bishops Caundle Community Shop and Hub (North Dorset)
Grant requested: £1,200 | Purpose: Accessible technology and community engagement activities

Bishops Caundle Community Shop is developing its role beyond a village shop into a welcoming community hub, helping to reduce rural isolation, improve access to essential services and bring residents of different generations together.

The project aims to create a community café and social space, supported by volunteers, where residents can build friendships, share skills and participate in activities. VCD will also provide support with volunteer recruitment, development and

training, helping to strengthen the sustainability of the shop and its Post Office services. A £1,200 Thriving Communities grant will support two elements:

- **£750 – Accessible community laptop:** Touchscreen and voice-recognition technology to help residents, particularly older people and those with additional needs, access online services, complete forms and navigate digital health services.
- **£450 – Community engagement:** Six sessions over three months to bring residents and volunteers together, encourage intergenerational connections and support the development of an ongoing companionship group.

What this investment could unlock: Greater digital inclusion, stronger volunteer capacity and new opportunities for social connection, helping an established rural community asset develop its role in supporting local residents.

Grant Application 3: Love Dogs & the Environment West Dorset (Weymouth)
Grant requested: £1,200 | Purpose: Replacement gazebo and promotional materials

Love Dogs & the Environment West Dorset is a volunteer-led community group bringing people together through dog walking, outdoor activities and a shared interest in the environment. Operating across Weymouth and Dorchester, the group encourages physical activity, friendship and social connection, welcoming both dog owners and those who simply enjoy the company of dogs. Through regular 'Waggy Walks', seasonal beach walks and community events, Love Dogs has developed a supportive social network while promoting responsible dog ownership and care for local environments. Here is a link to a video VCD has produced that brings this group to life.

Following storm damage to its existing gazebo, the group applied for a £1,200 Thriving Communities grant to purchase a replacement heavy-duty gazebo, branded panels and a promotional feather flag. These promotional resources will enable the group to maintain its presence at community events, improve visibility and reach more potential participants.

What this investment could unlock: Greater community engagement and participation, helping an established volunteer-led group strengthen its reach and continue providing opportunities for friendship, outdoor activity and improved wellbeing.

Grant Application 4: Swanage Linking Lives
Grant requested: £450 | Purpose: Accessible transport & subsidised lunches for six social outings

Swanage Linking Lives is an established befriending organisation supporting people experiencing loneliness and social isolation, particularly older residents in Swanage and surrounding villages. Through trained volunteers, it provides regular companionship and support, with referrals from local health services and community organisations.

Building on its successful one-to-one befriending service, the organisation plans to pilot six social lunch outings over twelve months, enabling participants to develop wider friendships and enjoy shared experiences. Recognising that transport and cost can prevent older residents from participating, a £450 Thriving Communities grant, alongside an £80 contribution from the organisation's reserves, will help fund accessible minibus transport and subsidised lunches for up to eight participants per outing.

The pilot will allow Swanage Linking Lives to assess demand, gather feedback and explore whether group outings could become a sustainable addition to its existing service.

What this investment could unlock: New opportunities for friendship, confidence and social participation, while enabling an established organisation to test an approach that could strengthen its support for isolated older residents.

Grant Application 5: Vale Family Hub – Young at Heart Lunch Club
Grant requested: £3,000 | Purpose: One-year pilot of a community lunch club

Vale Family Hub, based in Sturminster Newton, is developing a new *Young at Heart Lunch Club* to address loneliness and social isolation, particularly among older residents with limited opportunities for social contact. Building on its established community services and existing kitchen facilities, the Hub plans to introduce a welcoming lunch club offering affordable, nutritious meals alongside opportunities for friendship, conversation and social activities.

A £3,000 Thriving Communities grant will support a one-year pilot, initially providing weekly sessions. Funding will contribute towards staffing (chef), volunteer expenses, coordination and activities. Modest participant contributions will help cover food costs and support longer-term sustainability.

Importantly, the pilot will remain flexible, with attendance and participant feedback informing whether weekly, fortnightly or monthly sessions offer the most effective and sustainable approach.

What this investment could unlock: A new opportunity for social connection and improved wellbeing, while enabling an established community organisation to test demand, refine its delivery model and build the foundations for a sustainable service.

PART THREE: WHERE WE GO NEXT

10. From Community Activity to Wider System Value

Building on the foundations of Year One

The first year of Thriving Communities has provided valuable evidence about how grassroots community activity can be better identified, supported and connected. The examples in Part Two demonstrate the practical difference that relationships, organisational support, community collaboration and modest financial investment can make.

The next challenge is to understand how these individual improvements can contribute to something wider: a more resilient community infrastructure that is better connected to Dorset's health and care system and better able to support residents before their needs escalate.

The opportunity is not simply to increase the amount of community activity, but to strengthen the connections between community capacity, residents and the wider services that support them.

Making better use of what already exists

Dorset has considerable community capacity, but its potential is not always fully recognised or utilised. Community organisations may be delivering valuable activities without being known to local health and care professionals. Professionals may be supporting people who could benefit from community provision but have limited awareness of what is available nearby. Groups facing similar challenges may be working independently, unaware of opportunities to share resources or collaborate. Thriving Communities can help bridge these gaps.

By strengthening relationships between community organisations and wider partners, the programme creates opportunities to make existing provision more visible, improve access and referrals, and connect organisations with the resources they need to remain sustainable.

This is particularly relevant to the development of neighbourhood health approaches, where understanding and connecting with the community assets available within a locality will be increasingly important.

Recognising the contribution to prevention

The contribution of grassroots community activity to prevention is often indirect and develops over time. A lunch club may provide regular social contact for someone who would otherwise spend much of their week alone. A volunteer-led activity may help an older resident maintain confidence and routine. A trusted relationship within a community group may create an opportunity to recognise when someone is not coping as they did and needs additional support.

These are important contributions, even where they cannot immediately be translated into measurable changes in demand for statutory services.

Thriving Communities does not claim that the Foundation Phase has demonstrated reductions in hospital admissions, GP appointments or care needs. Establishing that level of impact would require longer-term evidence and a more developed evaluation approach. What Year One has established is a practical model through which the community infrastructure supporting earlier intervention, participation and independence can be strengthened. The next phase must demonstrate not only what Thriving Communities delivers, but what changes because that infrastructure is stronger.

11. Community Intelligence: Connecting Local Experience with Wider Decisions

Understanding communities through relationships

One of the important opportunities emerging from Thriving Communities is the ability to develop a richer and more current understanding of community activity, capacity and challenges. Grassroots organisations and volunteers often hold knowledge that is difficult to capture through formal datasets. They understand who is attending activities, where participation is changing, which groups are struggling to recruit volunteers, what prevents people from getting involved and where local opportunities are emerging.

This intelligence is valuable because it provides context around the services and activities that exist within a community. It can also help identify vulnerabilities that may not otherwise be visible until an activity is at risk of closing or residents have lost access to support. Through Dorset Connect and direct engagement, Thriving Communities is beginning to create a mechanism for gathering and sharing this knowledge.

From listening to action

The value of community intelligence lies in what happens as a result. At a local level, it can inform practical responses: connecting organisations, addressing gaps in participation, identifying volunteer support needs or bringing partners together around a shared challenge. At a wider level, recurring themes across communities can help inform decisions about infrastructure support, investment, access to services and neighbourhood priorities.

The ambition is to develop a clear, two-way process:

Community experience → Local conversations and relationships → Shared intelligence → Partner decisions and action → Feedback to communities

This final step is particularly important. Community organisations need to see that the knowledge and experiences they share are valued and, where appropriate, have informed decisions or practical action.

Developing a more systematic approach

During the next phase, we intend to strengthen how community intelligence is captured, reviewed and shared. This will include identifying recurring themes across

Dorset Connect localities, recording emerging challenges and opportunities, and developing appropriate ways to share relevant insight with health, local authority and other partners.

We will also seek to distinguish between individual experiences, recurring observations and wider evidence, ensuring that local intelligence informs decision-making without being presented as a comprehensive assessment of community need.

Over time, this could provide Dorset with a valuable additional source of insight into the strengths, vulnerabilities and opportunities within its communities. Thriving Communities can help ensure that community knowledge does not remain within individual conversations, but contributes to better-informed local action and wider planning.

12. The Next Phase: Embedding and Strengthening the Model

From establishing the approach to demonstrating its value

The Foundation Phase has enabled us to test assumptions, develop relationships and establish a more connected model of community support. The next phase should focus on embedding that approach, addressing the gaps identified through Year One and developing stronger evidence of its contribution.

This is not simply a question of increasing the number of networks, organisations or grants. The learning has demonstrated that meaningful engagement takes time, different communities require different approaches and the support needed by grassroots organisations is often practical rather than financial. Our priorities for the next phase are therefore focused on strengthening the quality, reach and effectiveness of the model.

Our priorities

1. Reach further into grassroots communities
Develop a more proactive approach to identifying and engaging smaller, informal and volunteer-led groups, particularly those not currently connected to established networks or infrastructure support. This will require more time spent within communities, building trusted relationships and understanding what is already happening locally.

2. Embed Dorset Connect as a practical neighbourhood resource
Continue developing Dorset Connect around the needs and opportunities of

individual localities, with a clear emphasis on collaboration, shared resources and practical action. Strengthen communication and follow-up between meetings, and work alongside existing networks rather than creating unnecessary duplication.

3. Strengthen the sustainability of existing community provision
Provide proportionate support that responds to the circumstances of each organisation, including volunteering, succession planning, governance, safeguarding, visibility, participation and organisational development. Recognise that helping an existing activity continue successfully can be just as valuable as supporting a new initiative.

4. Improve connections with neighbourhood health and care
Develop stronger relationships between community organisations and the professionals supporting residents, including social prescribing, community health and other neighbourhood services. Increase our presence within the INT and Neighbourhood Health programmes. The aim is to improve mutual awareness, appropriate signposting and referral opportunities, while ensuring community organisations are not expected to take on responsibilities beyond their capacity or purpose.

5. Make better use of community assets and targeted investment
Continue developing the Try It, Do It, Grow It approach, using conversations and local knowledge to identify where funding can add value. Ensure that investment decisions reflect community need, knowledge and feedback. Alongside grants, place greater emphasis on mobilising existing resources, including volunteers, venues, equipment, expertise, business support and partnerships.

6. Develop stronger community intelligence and evidence
Introduce more consistent ways of recording connections, support provided, challenges identified, actions taken and outcomes achieved. Use selected longer-term case studies to understand how organisations and activities develop over time, and what contribution Thriving Communities has made.

Investing in the capacity to make the model work

One of the clearest implications of Year One, is that the effectiveness of Thriving Communities depends upon having sufficient capacity to work directly with communities.

Developing Thriving Communities during Phase One, has required considerable additional resources from VCD, well beyond the funding provided for this programme. The infrastructure to roll-out a programme of this scale and impact has required the resources of around eight members of the wider team at varying scale and stages. They have supported with skills, experience, resources and time around

co-ordination, administration, training, marketing, communications, engagement, management, oversight, and reporting, that has enabled significant progress.

The current funding envelope for the programme provides approximately 0.5 full-time equivalent staffing capacity, plus on-costs, some management, and overheads. While this has enabled important foundations to be established, the learning suggests that more dedicated community engagement and development capacity will be needed to reach organisations that remain outside established networks. This work takes time, and presence in communities – and it requires more manpower.

Identifying these groups, building trust, understanding their circumstances and providing appropriate support cannot be achieved through communications, meetings or grant administration alone.

This has implications for the balance of future investment. The next phase may deliver greater value by increasing the capacity for direct community engagement, organisational support and relationship-building, rather than increasing the amount available for grants.

Grant funding should remain available where it can unlock or sustain valuable activity. However, the Foundation Phase has demonstrated that funding is most effective when supported by the relationships, local knowledge and organisational capacity needed to make good use of it.

Any future investment model should therefore reflect the full cost of delivering Thriving Communities, including community development, coordination, infrastructure support, partnership working, intelligence gathering, management and evaluation.

Building towards longer-term sustainability

The remaining Foundation Phase provides an opportunity to establish a stronger evidence base and explore how the model could be sustained beyond the current funding period.

This should include considering how Thriving Communities can align with wider neighbourhood health and prevention priorities, where responsibilities and resources could be shared with partners, and how longer-term investment might support the infrastructure that enables community activity to thrive.

The intention is not to create a permanent dependency on programme funding for individual groups. It is to establish a sustainable approach through which communities can continue to access connections, support and appropriate investment as their needs evolve.

13. Demonstrating Impact: What We Will Measure Next

Moving beyond activity measures

Year One has provided useful information about engagement, participation, relationships and investment. These measures demonstrate programme activity and reach, but do not, on their own, tell us whether community organisations are becoming stronger or whether residents are experiencing meaningful benefits.

The next phase will therefore place greater emphasis on what is needed to understand what is changing over time. Our central evaluation question will be: **What changed, for whom, and what contribution did Thriving Communities make?**

To understand the longer-term value of Thriving Communities, we will evaluate more than the number of organisations engaged, meetings held or grants awarded. Our focus will increasingly be on what changes as a result of the relationships, support and investment provided.

The following framework identifies six connected areas through which we will assess progress, from reaching grassroots organisations and strengthening community capacity to understanding the experiences of residents and the programme's wider contribution to prevention.


REACH
Who are we connecting with?
Engaging with a diverse range of community organisations and activity across Dorset, including grassroots groups and those outside established networks.
CONNECTION
What happens because people are connected?
Building new relationships, collaboration, referrals and shared resources between community organisations and with wider partners.
CAPACITY
Is community infrastructure becoming stronger?
Supporting organisations to develop their people, governance, volunteering, visibility, partnership working and long-term resilience.
COMMUNITY ACTIVITY
What is being tested, sustained or developed?
Enabling new activities, sustaining valuable provision and developing existing activity through investment, collaboration and wider community assets.
PEOPLE
What difference is being experienced?
Supporting greater connection, participation, belonging, confidence, activity, access to support and independence for residents.
SYSTEM CONTRIBUTION
How is this contributing to prevention?
Strengthening pathways between community provision and health and care, informing action through community intelligence and contributing to a stronger, healthier and more resilient Dorset.

We propose to assess progress across six connected areas.

Area	What we want to understand
Reach	Are we identifying and engaging grassroots organisations that were previously outside established networks?
Connection	Are relationships leading to useful introductions, referrals, shared resources and collaborative action?
Capacity	Are organisations better equipped to sustain their activities, manage challenges and support volunteers?
Community activity	Has valued provision been sustained, improved, made more accessible or developed in response to local needs?
People	What evidence is emerging of increased participation, social connection, confidence and wellbeing among residents?
System contribution	Is community intelligence informing decisions, and are stronger links developing between community provision and wider services?

Combining data with lived experience

A meaningful evaluation will require both quantitative information and qualitative evidence. We will continue recording engagement, support provided, grants awarded and activity enabled, but will increasingly capture what happens afterwards. This could include whether an organisation recruited volunteers, addressed a sustainability challenge, developed a new partnership, increased participation or improved its connections with local services.

We also intend to develop a small number of longitudinal case studies, following organisations and activities over time to understand what changes, what contributes to those changes and what challenges remain. This is particularly important because the benefits of community development may emerge gradually and are not always attributable to a single intervention.

Being realistic about impact

We recognise that stronger community infrastructure is one contribution to prevention, rather than a direct or isolated solution to pressures within health and care.

The evaluation will therefore distinguish between:

- **Activity and outputs:** What the programme delivered.
- **Early outcomes:** What changed for organisations, relationships and community activities.
- **Longer-term outcomes:** What difference those changes may make to residents' participation, wellbeing, independence and access to support.

We will seek to understand the programme's contribution without attributing wider health outcomes to Thriving Communities where the evidence does not support that conclusion. This approach will enable us to build a more credible case for future investment, grounded in practical evidence of what works, for whom and in which circumstances.

14. Conclusions and Recommendations

A stronger foundation for community-led prevention

Thriving Communities began with a hypothesis: that stronger local networks and targeted funding could help identify and support grassroots activity contributing to older people's health, wellbeing and independence.

The Foundation Phase has shown that the opportunity is both greater and more complex than originally anticipated. Dorset already has a wealth of valuable community activity, but much of it operates with limited visibility, support or connection to wider services. Strengthening that capacity requires more than individual grants or opportunities to network. It requires the time, relationships, knowledge and practical infrastructure needed to help community organisations sustain what they do well and connect with the wider resources available to them.

Year One has enabled us to adapt the original approach and establish a model that responds more closely to those realities. The next phase is an opportunity to consolidate that progress, deepen engagement with grassroots organisations and demonstrate the value of a more connected approach to community development.

Recommendations to Dorset Council and the Dorset Health and Wellbeing Board

We invite you to:

1. Recognise the importance of grassroots community infrastructure as part of Dorset's wider approach to prevention, wellbeing and neighbourhood health,

including the value of small, informal and volunteer-led activities that may sit outside established systems.

2. Support the continued development of the Thriving Communities model through the remaining Foundation Phase, with an emphasis on embedding Dorset Connect, strengthening grassroots organisations and improving connections between community provision and health & care partners.

3. Endorse a stronger role for community intelligence in informing neighbourhood priorities, recognising the value of local knowledge alongside formal data and supporting opportunities for relevant insight to reach partners and decision-makers.

4. Support the development of a longer-term investment proposition that reflects the learning from Year One, including the importance of dedicated community engagement and development capacity alongside proportionate grant funding.

5. Support a clear approach to evaluating outcomes, enabling the programme to demonstrate changes in community capacity, connections, participation and sustainability, and to build a stronger evidence base for its contribution to prevention.

Specific Programme Development Actions Recommended

To progress Thriving Communities significantly in this phase, we are requesting these three specific developments:

1. To roll out the programme in a more targeted and significant way, we need more human resources working on the ground in communities. Currently, we have a 0.5 FTE dedicated to this work. Ideally, we would need 3.0 FTE to really make an impact across Dorset.
2. We are ready to roll out the programme across Dorset. As part of our wider work, we have been laying foundations for Thriving Communities in all localities. This includes creating Dorset Connect networks, connecting with health, town & parish councils, local VCS and other stakeholders.
3. Consider broadening the scope of grants to include sole traders who are not formally within the VCS, mirror some VCS provision. They are often confused as VCS because they are delivering low cost services, support or activities that bring community value, and improve the health and wellbeing of older people. This would increase the ability to be able to encourage wider provision, particularly in more remote areas, that is no/low risk for the provider.

This additional capacity presents these opportunities

Subject to further investment or additional resources, the programme could:

- Undertake more extensive grassroots identification and outreach.
- Provide more intensive support to vulnerable community organisations.
- Increase dedicated locality-based community development capacity.
- Develop more systematic community asset mapping and intelligence gathering.
- Strengthen formal links with neighbourhood health teams.
- Expand outcome monitoring and longer-term evaluation.

The Foundation Phase is intended to establish a model that can inform a more sustainable approach to community-led prevention. Year Two will therefore consider not only how the programme performs, but what would be required to maintain and develop the approach beyond the initial funding period.

This work will include:

- Identifying the elements of Thriving Communities that provide the greatest value.
- Understanding the level of community development and infrastructure capacity required.
- Considering how the model can align with Dorset's neighbourhood health and prevention priorities.
- Exploring opportunities for collaboration, shared delivery and potential future investment.
- Assessing the balance between direct community development, organisational support, grants and evaluation.
- Developing a longer-term proposition supported by Year One and Year Two evidence.

The intention is not to create ongoing grant dependency for individual groups, but to establish a sustainable infrastructure through which community organisations can access relationships, practical support and appropriate investment as needs change.

Looking ahead

The first year has demonstrated that meaningful community development is not simply about introducing new activities or distributing funding. It is about recognising the value of what communities already do, understanding what enables that activity to continue and creating the conditions for people and organisations to work more effectively together.

The foundations are now in place to develop this approach further.

Our ambition is for Dorset's community infrastructure to become better connected, more visible and more resilient – so that valuable local activity can continue to support people to live well, remain independent and feel part of their communities.

The next phase will be an important opportunity to turn the learning of Year One into stronger evidence, more sustainable community capacity and a clearer long-term contribution to Dorset's prevention ambitions.

15. Year Two Plan

Purpose of the Year Two Plan

In response to the development and learning in Year One, VCD has developed an inter-connected Thriving Communities model built around six elements:

CONNECT • UNDERSTAND • STRENGTHEN • REACH • COLLABORATE • INVEST

Dorset Connect networks provide the neighbourhood infrastructure through which these elements can be brought together, alongside the flexible Try It, Do It, Grow It community investment grants.

The purpose of Year Two is to move from establishing and testing this approach to embedding it in practice, strengthening delivery, demonstrating outcomes and developing a sustainable proposition for the future.

For the purposed of this plan, no presumption has been made about the adoption and implementation of the suggested programme developments.

This programme plan will therefore retain its focus on grassroots community activity contributing to the health, wellbeing, social connection and independence of older residents, within the three original Foundation Phase areas, within current funded resources.

Year Two Objectives

Year Two will focus on six interconnected objectives.

1. **Increase engagement with grassroots organisations**, particularly small, informal and volunteer-led groups that remain outside established networks and support structures.
2. **Embed Dorset Connect as an effective neighbourhood resource**, enabling practical collaboration, shared resources, local problem-solving and stronger relationships between communities and wider partners.

3. **Mobilise community assets and deliver targeted investment**, using the Try It, Do It, Grow It framework to support locally identified needs and opportunities.
4. **Strengthen the capacity and resilience of community organisations**, providing proportionate support that enables valuable existing activity to continue and develop where appropriate.
5. **Improve access and connections between community provision and health and care**, increasing awareness, signposting and appropriate referral opportunities.
6. **Develop community intelligence and gathering insights** resulting from the programme and informing a longer-term approach to community-led prevention.

Delivery Priorities and Activities

Priority 1: Increase engagement with Grassroots VCS

Objective: Continue to identify and engage smaller, informal and volunteer-led organisations that may not currently be visible through established VCS networks or directories.

Year Two activities

- Develop a resource-friendly and proactive approach to identifying grassroots activity within the three Foundation Phase areas.
- Build on local relationships with parish and town councils, village halls, community venues, libraries, faith organisations, health professionals and existing community groups.
- Undertake further targeted outreach and visits to organisations that may be unlikely to attend formal network meetings.
- Continue one-to-one conversations to understand organisational circumstances, challenges, strengths and aspirations.
- Identify and support organisations at risk of losing valuable activity through volunteer shortages, succession issues, declining participation or other pressures.
- Record emerging support needs and opportunities for further engagement.
- Continue raising awareness of Thriving Communities grant fund

Expected outcomes

- Growing awareness of previously unidentified grassroots community activity.
- Increased engagement with organisations outside established networks.
- Greater understanding of the strengths, vulnerabilities and opportunities within local community infrastructure.
- More organisations accessing appropriate support, connections or investment.

Priority 2: Embed Dorset Connect as a Practical Neighbourhood Resource

Objective: Strengthen Dorset Connect as a mechanism for collaboration, community intelligence, practical support and local action.

Year Two activities

- Continue developing Dorset Connect locality networks, with a focus on the original Foundation Phase areas.
- Maintain regular opportunities for both in-person and online engagement, reflecting local circumstances and participant preferences.
- Continue developing the Ask One / Give One approach to identify resources, challenges and opportunities.
- Provide opportunities for organisations to 'Bring a Challenge', including proposals seeking support through Thriving Communities grant funding.
- Maintain consistent recording and follow-up of actions, connections and collaborations generated through meetings.
- Continue to develop communication between meetings through introductions, updates and appropriate digital channels.
- Complement existing local networks and partnerships.
- Encourage participation from health, care, town and parish councils, businesses and other organisations able to contribute local knowledge or resources.

Expected outcomes

- Dorset Connect becomes increasingly recognised as a useful neighbourhood resource.
- More connections result in practical actions, partnerships and shared resources.
- Grassroots organisations have improved access to information, expertise and wider support.
- Local partners develop a better understanding of community provision and opportunities.

Success will be measured not simply by attendance, but by what happens because people are connected.

Priority 3: Mobilise and Invest in Community Assets and Priorities

Objective: Ensure that financial investment is informed by local knowledge and lived experience, complemented by the wider assets and resources available within communities.

Year Two activities

- Continue delivering the Try It, Do It, Grow It grant model.
- Maintain a conversation-led approach to understanding grant enquiries and organisational needs.
- Encourage applicants, where appropriate, to present ideas or challenges through Dorset Connect before grant decisions.
- Explore opportunities to mobilise volunteers, venues, equipment, expertise, business support, communications and partnerships alongside financial investment.
- Support organisations to develop proportionate and sustainable proposals.
- Maintain transparent grant assessment and decision-making through the central Thriving Communities Grant Panel.
- Follow up with grant recipients to understand progress, challenges and early outcomes.
- Capture examples where collaboration or in-kind support has strengthened an activity or reduced the need for financial investment.

Expected outcomes

- Targeted investment supports activities that respond to identified community needs and opportunities.
- Grant recipients benefit from wider connections and practical support.
- Community resources are better utilised.
- Funded activities have stronger foundations for sustainability.

The emphasis will remain on the value and sustainability of community activity, rather than maximising the number of grants awarded.

Priority 4: Strengthen the Sustainability of Existing Community Provision

Objective: Help grassroots organisations remain safe, resilient, accessible and sustainable, without imposing unnecessary formalisation or expectations of growth.

Year Two activities

- Provide proportionate infrastructure support according to each organisation's circumstances.
- Support groups with volunteer recruitment, retention and succession planning.
- Offer guidance on governance, safeguarding, organisational structures and financial arrangements where appropriate.
- Support communications, marketing and visibility to help organisations reach residents who could benefit from their activities.
- Help organisations explore sustainable approaches to participation, leadership, income and volunteer involvement.
- Identify where introductions, specialist advice, training or collaboration may resolve challenges without grant funding.
- Encourage organisations to consider their longer-term resilience while respecting their purpose and preferred scale.

Expected outcomes

- Community organisations are better equipped to address identified challenges.
- Valuable existing activities are supported to continue.
- Groups have stronger volunteer, governance or organisational arrangements where needed.
- Organisations gain greater confidence in accessing support and responding to changing circumstances.

Priority 5: Strengthen Connections with Neighbourhood Health and Care

Objective: Improve relationships between community provision and the professionals supporting older residents, helping existing activities become more visible and accessible.

Year Two activities

- Increase engagement with Integrated Neighbourhood Teams, Primary Care Networks, social prescribing teams and other relevant health and care partners.
- Invite more health and care partners to participate in their local Dorset Connect network.

- Improve mutual awareness of local community activities and wider health and care services.
- Support grassroots organisations to communicate what they offer, who they support and how people can access their activities.
- Explore practical ways to improve signposting and appropriate referrals into existing community provision.
- Identify barriers affecting access, including transport, accessibility, confidence and awareness.
- Share examples of effective community and health partnerships to encourage wider learning.

Expected outcomes

- Stronger relationships between community organisations and health and care professionals.
- Improved awareness of available community support.
- More opportunities for appropriate signposting and referral.
- Better understanding of the practical barriers affecting residents' access to community activity.

The programme will not assume that grassroots organisations can take on additional responsibilities or capacity. Connections must reflect the capacity, safeguarding arrangements and purpose of individual organisations.

Priority 6: Develop Community Intelligence and Demonstrate Outcomes

Objective: Establish more consistent approaches to capturing community intelligence, recording outcomes and demonstrating the programme's contribution to prevention.

Year Two activities

- Develop a proportionate system for recording engagement, organisational support, connections, referrals, collaborations and outcomes.
- Identify recurring themes emerging through Dorset Connect and direct community engagement.
- Distinguish between individual experiences, recurring observations and wider evidence.
- Produce periodic summaries of community intelligence, including emerging challenges, gaps, vulnerabilities, assets and opportunities.
- Explore appropriate ways to share relevant intelligence with commissioners, health and care partners and other decision-makers.
- Develop a two-way feedback approach so communities can understand how their insights have informed action.
- Select a small number of organisations or activities for longer-term case studies.
- Gather qualitative feedback from organisations, partners and, where practical, residents participating in supported activities.
- Develop a Year Two evaluation report assessing changes in community capacity, connection, activity and access to support.

Expected outcomes

- Improved evidence of the programme's contribution beyond activity and attendance figures.

- Better understanding of changes experienced by supported organisations.
- Stronger insight into the relationship between community infrastructure and residents' opportunities for participation and wellbeing.

Community intelligence becomes more useful in informing programme delivery and wider partnership discussions.

Monitoring, Evaluation and Reporting

Year One established useful measures of activity and engagement. Year Two will place greater emphasis on understanding what changes because of the support, relationships and investment provided. The central evaluation question will be: **What changed, for whom, and what contribution did Thriving Communities make?**

What Success Will Look Like at the End of Year Two

By the end of the Foundation Phase, we aim to demonstrate that:

1. **More grassroots organisations are visible and connected**, including groups previously outside established networks.
2. **Dorset Connect is producing practical value**, with examples of collaboration, shared resources, problem-solving and improved connections.
3. **Community organisations are becoming stronger**, with evidence of improvements in capacity, sustainability, participation or access to support.
4. **Existing community provision is being better utilised**, with stronger relationships between local groups and the professionals supporting residents.
5. **Targeted investment is being used effectively**, supported by local knowledge, collaboration and proportionate organisational development.
6. **Community intelligence is contributing to local action**, with a clearer mechanism for sharing insight and feeding information back to communities.
7. **A stronger evidence base is available**, demonstrating early outcomes for organisations, activities and residents, alongside the programme's contribution to prevention.
8. **A credible longer-term investment proposition has been developed**, identifying the resources, partnerships and delivery arrangements required to sustain and build upon the model.

APPENDIX

Funding Model – Try It. Do It. Grow It.

TRY IT - Testing ideas and responding to local need

Try It supports communities to test new ideas without requiring them to have everything fully developed before they begin, or risk their own funds. A conversation through Dorset Connect or with VCD might identify a gap, challenge or opportunity within a community. Rather than immediately developing a large programme or service, a small investment can enable local people to test an idea, learn from experience and understand whether there is demand.

This could support a new activity, a short pilot, consultation with residents, the purchase of equipment or resources, or the development of a new partnership.

The principle is: Start small. Learn quickly. Build from what works. This creates space for community-led innovation while reducing the risk of investing significant resources before an idea has been tested.

DO IT - Sustaining what communities already value

One of the strongest lessons from the Foundation Phase is that innovation does not always mean creating something new. Across Dorset, there are community groups and activities that have quietly supported residents for many years. Friendship groups, lunch clubs, social activities, community cafés and other volunteer-led provision can provide important opportunities for connection, participation, friendship, purpose and mutual support.

Do It recognises the value of what already works. Investment can help an established activity continue where relatively modest support could make a meaningful difference – for example through venue costs, equipment, transport, volunteer expenses, communications or other delivery costs.

This is particularly important where an activity is valued by its community but operates with very limited resources. Sometimes the most valuable investment is not creating something new – it is protecting something good that a community would miss if it disappeared.

GROW IT - Developing proven community activity

Grow It supports activity that is already working but where there is evidence of an opportunity to develop further. Growth does not have to mean becoming a larger organisation. It might mean reaching a neighbouring community, increasing the number of sessions available, recruiting additional volunteers, improving accessibility, strengthening organisational capacity or responding to increased demand.

For some organisations, it may also involve developing governance, leadership, partnerships or income generation so that successful activity becomes more sustainable. The important distinction is that growth should be purposeful rather than assumed.

The Foundation Phase demonstrated that not every grassroots organisation wants or needs to grow. Some groups are successful precisely because they are small and deeply rooted in a particular community. Therefore, Grow It is an opportunity, not an expectation.

THRIVING COMMUNITIES GRANTS

WHO CAN APPLY?

VCS Identity	Annual income	Maximum grant	What is grant for?	Governance
Unincorporated VCS group	Up to £2,000	£1,000	· New initiative · Existing activity · Building capacity	· Restricted for agreed project · Safeguarding policy & training · Nominated fund holder, eg Parish Council · Participate in Dorset Connect · End of term report · Case-by-case guidance on best practice (eg insurance, food handling)
Small incorporated VCS Group (eg charity, CIC, CIO)	Up to £10,000	£2,000	· New initiative · Existing activity · Building capacity	· Project or core costs · Safeguarding policy & training · Named bank account · Participate in Dorset Connect · End of term report · Case-by-case guidance on best practice (eg insurance, food handling)
Medium incorporated VCS Group (eg charity, CIC, CIO)	Up to £100,000	£4,000	· New initiative · Existing activity · Building capacity	· Restricted for agreed project · Safeguarding policy & training · Named bank account · Participate in Dorset Connect · End of term report · Case-by-case guidance on best practice (eg insurance, food handling)
Larger incorporated VCS Group (eg charity, CIC, CIO)	Over £100,000	£2,500	· Seeding new activity	· Restricted for agreed project · Safeguarding policy & training · Named bank account · Participate in Dorset Connect · End of term report · Case-by-case guidance on best practice (eg insurance, food handling)

Ask One / Give One

This is a new feature of Dorset Connect allowing all participants to give and receive. There is no limit to what can be written on the post-it notes and placed on the wall, so there are some brilliantly different contributions.

This list is distributed to everyone who attended, to become an ongoing resource and opportunity. VCD treats each contribution as a possible lead, and during a team debrief, team members are allocated work to follow up, connect, or help.

Dorset Connect: Ask One

Organisation	Ask One
Read Easy South Dorset	Publicity volunteer needed (and other roles available). Ideas for publicity for non-readers to access.
The Friendly Food Club	Groups with people with young children 0-5 to sign post early years sessions around weaning & fussy eating.
The Lantern Trust	Ideas to signpost older isolated people in Weymouth & Portland Area.
Weymouth Community Workshop	We are looking for space with ventilation to expand Weymouth Community Workshop
St Nicholas Church	Funding for an accessible toilet please!
Future Portland Community Benefit Society	Would like to have a more diverse membership, how?
The Parish of Wyke Regis	Volunteers to help with fellowship project by welcoming and serving teas & coffees.
Age UK North, South and West Dorset	Reasonably priced large rooms to hire in Weymouth with good access, parking and near bus stops if possible too.
Ridgewater	How can we reach residents facing fuel poverty in Weymouth & Portland who would benefit from our services?
Weymouth Area Development Trust CIC	Needs – Board Members (pro bono), Account/Treasurers and a Charity Lawyer
Elevate Employment Services	Local partners able to offer referrals, volunteering, site visits, employer talks, mock interviews, short taster, work experience, apprenticeships, entry level jobs – particularly opportunities accessible to young people with little or no work history.
Weymouth Town Council	Tell me about what you need, what you do, & challenges faced – let's see how we can work together.

Organisation	Ask One
Westham Methodist Church	We always need new volunteers for a range of activities.
Age UK North, South and West Dorset	Volunteers, Visitor needed in Weymouth & Dorchester and fundraising/admin support
Dorchester Community Plays Association	Help / advice with GDPR regulations Social media help, Fundraising opportunities Rehearsal/workshop space
Dorchester Bike Park Community Project	Advice on legal structures & fundraising.
LiveWell Dorset	Appreciate connections to communities & leads for better access to our services.
Dorchester Library and Learning Centre	Build new partnerships with different organisations.
Help Dorset	Community creative social group –awareness and support for residents with disabilities
Money Ready	Space to run courses/drop-ins on financial education for People aged 7 – 40 Ideas of what people could do with financial education on, or support with.
South West Dorset Multicultural Network	Space to hold events in the future Advice & guidance around fraud, crime and anti-social behaviour/hate crimes.
Dorset Youth Association	All organisations to do more with young people.
Home-Start Wessex	Volunteers, Charity shop items, Paper & card (coloured) for craft. Opportunity for corporate fundraising and events to join in.
Dorchester Chaplains	More town Chaplains – need to be sponsored by their church.
Mid Dorset Primary Care Network	Mid-Dorset Primary Care Network (PCN) are organising a Diabetes information event at the Dorford Centre on Friday 20th November from 9am-12pm. They would love about 6 volunteers to

Organisation	Ask One
	help on the day for things such as welcoming guests, helping with refreshments and floating support. For more information and to offer support please contact Sharon

Dorset Connect: Give One

Organisation	Give One
Weymouth & Portland PCN	More than happy to chat / support and showcase services at Health & Wellbeing Fairs throughout the year.
Weymouth Area Development Trust CIC	Shared space. Connections with businesses. Project support.
Dorset Council – Community Transport	Information on community transport schemes in Dorset – Type community transport directory on the Dorset Council website to bring up the interactive map. Community Transport Grants – Available on the DC website – applications close 20/10/26 – 3 groups to apply: - Up to 5K capital grant - Up to 2.5K revenue grant - Up to 20K longer revenue grant
The Friendly Food Club	Intro demo session – opportunity to learn about running cooking sessions for your group/ community.
The Lantern Trust	Support older people with benefits checks (Attendance Allowance etc.) and over 55's.
Elevate Employment Services	Supported progression route for 16–18-year-olds, English & Maths, employability, CV/applications, interview support, confidence, work experience, named contact for referrals. Can also bring employers/partners in for talks, mock interviews or site visits.
The Parish of Wyke Regis	Hire space, volunteering opportunities and fellowship activities.
St Nicholas Church	Happy to help and organize fundraising events and to hold them at St Nicholas Church, Broadwey.

Organisation	Give One
Age UK North, South and West Dorset	Did you know that Age UK NSWD runs a volunteer led 'Good Neighbour' scheme in Weymouth area doing 'one-off' tasks for older people in their homes (e.g. change a lightbulb).
Ridgewater	Share your projects & opportunities in our Newsletter & Social media.
Dorset Council – Public Health & Protection	Public Health – data on population health if you need it. Information on public health services locally (smoking cessation, alcohol reduction, physical activity, weight management).
Home-start Wessex	Family support and fund-raising ideas.
Weymouth Town Council	Support local organisations, linking up with each other. Information on Weymouth Town Council Grants. Linking up with Primary Care Network. Promoting what you do.
Weymouth Vehicle Preservation Society	Expertise and resources
Westham Methodist Church	We have Space for use
Age UK North, South and West Dorset	Talks on our services, welfare benefits, fraud & scams. Potential space for groups to meet.
Dorchester Community Plays Association	Workshops/talks & activities Collaboration & opportunities for everyone Social events
Dorchester Bike Park Community Project	New community space for all ages to be active
LiveWell Dorset	Resources & Health MOT's (blood pressure, BMI checks) & NHS checks, all free. Health & wellbeing training for professionals who support other people - free
Dorchester Library and Learning Centre	Library space for use by groups.

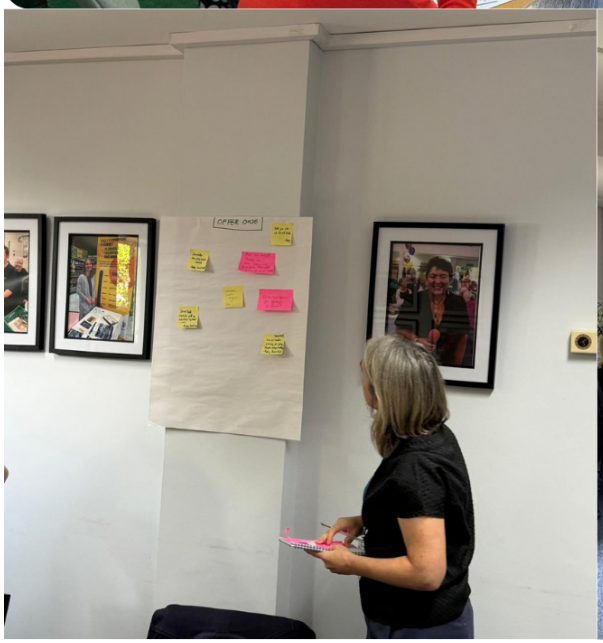
Organisation	Give One
Money Ready	I can offer free financial education support to people in Dorset (Focus aged 4-40)
South West Dorset Multicultural Network	Collaboration within wider Dorchester / Dorset community. Advice for individuals and groups, as well as other organisaitons.
Dorset Youth Association	Hall for use at Dorset Youth Advertise – Social media filming for young people projects/organisations. Dorset Youth Website full of activities & groups to join. Newsletter – Young people related. Core memories funding - £140.000 for youth organisations – APPLY! DBS / Safeguarding
Home-Start Wessex	Fundraising advice.
Volunteer Center Dorset	Connection in community, health, councils Support with engagement - market services Lots of in-person & online training on a range of subjects.

Photos from Dorset Connect

Below on the following pages are a sample of photos from Dorset Connect networks in different localities.











DSAB
Dorset Safeguarding Adults Board

Dorset Safeguarding Adults Board

Annual Report

2025-26

Safeguarding is everybody's business

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Dorset Safeguarding Adults Reviews (SARs) published 2025-2026 There were no Dorset SAB SARs published in 2025/ 2026. The Dorset Safeguarding Adults Board is currently working on 4 commissioned SARs, and if approved by the SAB within this current year, may be published in 2026-2027. All previous published SARs can be found on our website **Dorset SAB published SARs**	
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Foreword

I'm delighted to introduce the Dorset Safeguarding Adults Board (SAB) Annual Report 2025/2026.

Over the last year, we have continued to strengthen our commitment to safeguard adults with care and support needs from abuse, harm and neglect in Dorset.

Our Board meets jointly with the Bournemouth, Christchurch & Poole Safeguarding Adults Board and shares all its subgroups. This enables us to work efficiently with our statutory partners across the NHS and the Police and also with many other public, voluntary and community sector organisations.

It has been a busy and challenging year for many of our partners with increasing pressure across the system, but we have continued to work closely together to progress the priorities set out in our 2023-26 Strategic Plan to keep people safe. This has included:

- the launch of new independent SAB website enabling partner organisations and the public to access current safeguarding information and local learning
- sharing best practice and embedding learning through our annual multi-agency Safeguarding Adult Review (SAR) learning event
- hosting events with our partner housing providers and the voluntary and community sector to support them in building their networks and developing their understanding of safeguarding issues

In addition to assurance through Board meetings and subgroups, our partners completed an annual audit, providing assurance to the Board that safeguarding arrangements are effective, and that learning from Safeguarding Adult Reviews is being embedded in practice throughout their organisations.

This year, BCP Safeguarding Adults Board published 2 Safeguarding Adult Reviews (SARs) SAR Matthew, highlighting key learning points around mental capacity and executive function, trauma-informed care and risk management; and SAR Peter, highlighting the need



for interagency collaboration and information sharing between healthcare providers, adult social care services, and other agencies to manage support for people with complex needs effectively. SAR Peter includes references to his management of diabetes, a theme that is being noted more frequently nationally. Although these are BCP SARs, the learning has been shared with agencies across both local authority areas.

I remain committed to ensuring that people's voices and their lived experience are reflected in our learning and approach to safeguarding with every Board meeting featuring a personal safeguarding story and every review focussed on the person and their choices.

Within this 2025/2026 reporting year we reflect on the achievements and progress against objectives set out in our strategic plan, in this Annual Report and look forward to working with partners on our new 2026/2029 3-year plan in the coming years.

I would like to thank our members and the Board support team for their continued commitment, leadership and hard work.



Siân Walker McAllister
Independent Chair
Dorset Safeguarding Adults Boards

The role of a Safeguarding Adults Board

A Safeguarding Adults Board (SAB) plays a crucial role in protecting adults with care and support needs who are at risk of abuse, harm and neglect by providing multi-agency strategic oversight of adult safeguarding.

A SAB oversees and seeks assurance on the effectiveness of the safeguarding work of its members and partner agencies which includes our statutory partners in the Local Authority, NHS, and Police as well as other public sector organisations, such as Prison & Probation, Fire & Rescue Service and importantly housing providers and the voluntary and community sector.

The SAB's functions and responsibilities are outlined in the Care Act 2014. Bournemouth, Christchurch and Poole Safeguarding Adults Board has three core duties:

- developing and publishing a **strategic plan** detailing how we will meet our objectives and how our partner agencies will contribute to delivering our strategic priorities
- publishing an **annual report** to report on progress against our strategic priorities and how effective we have been which includes what each partner has done to implement our strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action
- commissioning and publishing **Safeguarding Adult Reviews** (s.44 of the Care Act) when an adult in our area dies as a result of abuse, harm and neglect, whether it is known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult.

SABs must arrange a Safeguarding Adult Review if an adult in its area has not died but the SAB knows or suspects that the adult has suffered serious abuse or neglect and must ensure partners demonstrate how they work together so that lessons learned impact the future delivery of services to those with care and support needs.



Our partners

The Dorset and BCP Safeguarding Adults Boards are made up of senior representatives from the following agencies:

Our statutory partners:

Dorset Council

BCP Council

DORSET POLICE

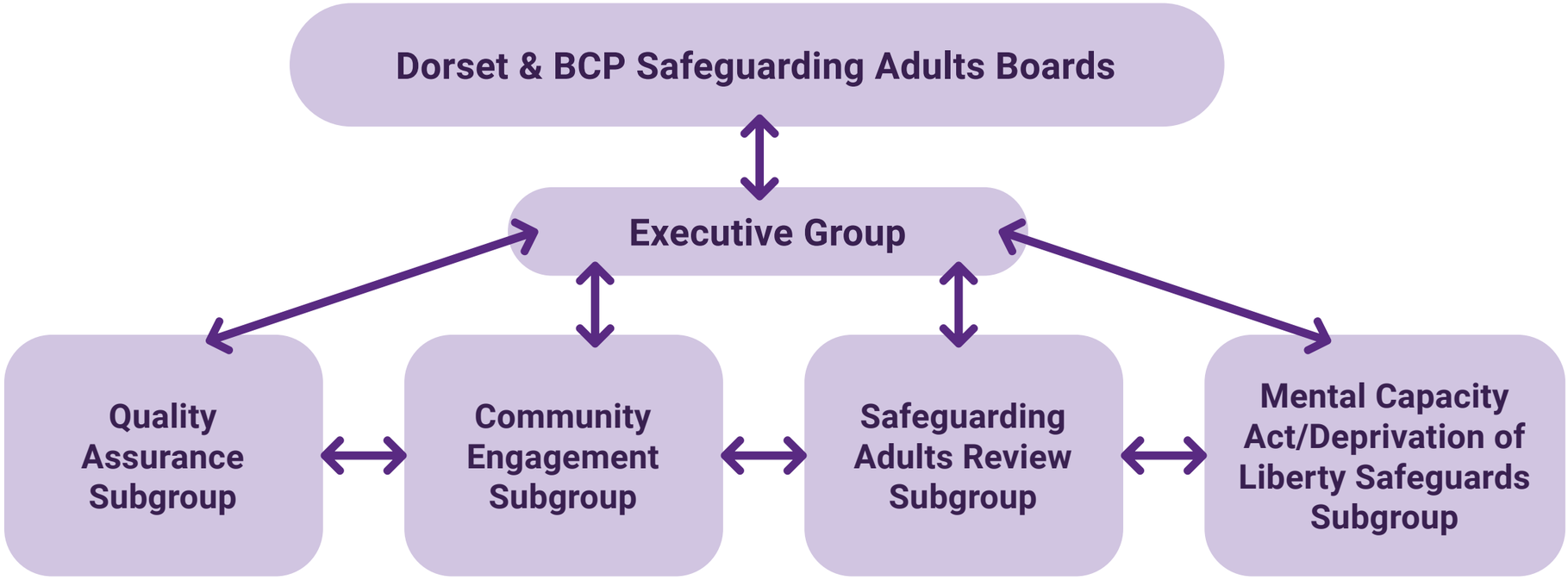
NHS Dorset

Our board member organisations:

Local Authority representatives from Dorset and BCP Council include senior officers from Adult Social Care and Housing as well as Cabinet Members for Adult Social Care.

- **NHS Dorset HealthCare University** (NHS Foundation Trust)
- **NHS Dorset County Hospital** (NHS Foundation Trust)
- **NHS University Hospitals Dorset** (NHS Foundation Trust)
- **NHS South Western Ambulance Service** (NHS Foundation Trust)
- **NHS England**
- **Dorset & Wiltshire Fire and Rescue**
- **Volunteer Centre Dorset**
- **Probation Service**
- **CAN Community Action Network**
- **Department of for Work & Pensions**
- **HM Prison Service**
- **HMP Guys Marsh**
- **HMP Portland**
- **HMP The Verne**

Structure of the Dorset & BCP Safeguarding Adults Boards



Budget for 2025-26

Dorset & BCP SABs maintain a working budget to enable us to undertake our work, and the priorities identified in the strategy and business plan. Each year, contributions are received from statutory partners to support this work.

The Dorset & BCP SABs are grateful for the financial support of partners which enables us to carry out our work.

Where we receive our money from:

BCP Council	£70,000
Dorset Council	£70,000
NHS Dorset	£38,745
Dorset Police	£19,404
HM Prison & Probation Service	£1,500
Total	**£199,649**

Dorset Council Safeguarding Activity in 2025-2026

7,624

Total safeguarding concerns

→ **received**

Care Act s.42.1

1,141

Total safeguarding concerns

→ **progressed**

Care Act s.42.2

0

Total safeguarding concerns

→ **progressed to other query**

top four locations of abuse

49% own home

27% Care Home Residential

6% In the community

excluding community services

13% Care Home Nursing

concluded enquiries

Source of Risk

41% Service Provider

58% Known to individual

1% Unknown to individual

gender & age

15% of Safeguarding concerns **progressed** to a s.42 enquiry

Of those s.42 enquiries,

58% related to **females**

41% to **males** and **1%** **gender unknown**

73% of s.42 enquiries related to **people aged 65** and over

Outcome when risk identified

risk **removed** **20%**

risk **reduced** **73%**

risk **remains** **7%**

top four types of abuse

40% Neglect and Acts of Omission

15% Self Neglect

11% Physical Abuse

10% Domestic Abuse (including coercion)

Strategic Plan 2023-26

The work of the Boards is focused on delivering 4 strategic aims which are effective prevention, effective protection, effective learning and effective governance.

Preventative work in safeguarding	Seeking assurance on safeguarding practices	Assurance on delivery of 'Making Safeguarding Personal' (MSP)
Prevention Aim Continued development with partners of preventative work in safeguarding	**Accountability Aim** Continuing to seek assurance on safeguarding practice across system partners	**Partnership working Aim** Assurance on delivery of 'MSP' using a whole family approach
We will → Review learning from SARs from DBCPSAB & other Boards and revisit thematic learning from reviews to inform preventative work with adults with care and support needs. → Ensure we always take account of the experiences of people who use services or receive safeguarding interventions. → Seek assurance on an annual basis from partners that learning is embedded in the work of all frontline staff in all services in line with our Training & Development strategy. → Ensure that the Boards' subgroups are able to provide evidence of system learning and working to deliver preventative work. → Ensure there is good multi-agency working with a contextual safeguarding approach to preventative work with people who are homeless. → Improve use of data from all partners to enable us to identify trends which influence preventative work across all agencies.	**We will** → Continuously develop how we receive assurance as governance frameworks evolve across every statutory partner. → Ensure data is understood/ used to identify themes for every partner to progress in their safeguarding work; that information and learning is shared across the system. → Work in partnership across the safeguarding children and community safety partnerships to ensure that complexities of 'Transitional Safeguarding' are understood well. → Seek assurance on delivery of safe and person-centred practice in private mental health hospitals and for all placements of people outside our area. → Seek assurance that 'Think Family' practice across all agencies is embedded. → Continue to seek assurance on health & social care practice and provider care quality. → Seek assurance that the system is working to safeguard people via the new national policing initiative, 'Right Person, Right Care'.	**We will** → Seek assurance from all partners that Making Safeguarding Personal (MSP) is embedded throughout all agencies' safeguarding work. Seeking evidence that people have opportunity to express their outcomes at every stage in their safeguarding journey. → Involve people in the work we do – review how we communicate more widely with people and listen to and act upon the voices of those who have experienced safeguarding interventions. → Deliver our communication/ engagement strategy to the widest audience with the support of the voluntary and community sector through our Community Engagement Subgroup. → Ensure that the Quality Assurance subgroup continues to audit application of MSP and provides data which evidences that application of MSP is embedded.

Key achievements in 2025-2026

In our strategy we said...

Continued development with partners of preventative work in safeguarding

This is what we achieved…

- Shared learning and invited practitioner reflections through an annual SAR Learning Event with over 200 attendees.
- Continued partnership working with Probation & Prison Services to highlight safeguarding issues within prisons and as part of planning for prisoner release. At our meeting in January 2026, progress updates were shared as well as relevant national learning relevant e.g. SAR X (Norfolk SAB), which addressed the challenges of releasing an aging prisoner with history of sexual offending.
- Continued collaboration with the Housing sector through quarterly meetings and an annual in-person event to focus on safeguarding issues including cuckooing, anti-social behaviour and vulnerability.
- Continued strategic links with Higher & Further Education safeguarding leads to embed learning from Safeguarding Adult Reviews and discuss emerging safeguarding issues in their sector.
- Continued engagement with safeguarding leads and safeguarding practitioners from the Voluntary & Community sector. An in-person conference was held for the wider sector to increase understanding of safeguarding and the support available to volunteers and the public.
- Delivered a new independent SABs website to enable partner organisations and the public to access current safeguarding information and local learning.

  dbcpsafeguardingadults.org.uk

Continuing to seek assurance on safeguarding practice across system partners

This is what we achieved…

- Updated multi-agencies policies and procedures to share best practice with partners and support the implementation of recommendations from SARs (including; Safeguarding Adult Review (SAR) Policy; Multi-Agency Risk Management (MARM) Guidance; Safeguarding Policy, and the Boards' Training Strategy).
- Developed a Memorandum of Understanding (MOU) across local authorities and NHS partners to guide practitioners about the escalation process for adult patients in an Acute Hospital where there is disagreement as to whether a patient should be detained under the Deprivation of Liberty Safeguards or Mental Health Act.
- Produced and circulated a range of '7-Minute' Learning Reviews related to published SARs **SAR 'Matthew', SAR Peter, '7-Minute Learning on MAPPA** and sought assurance from partners that learning was cascaded to support change in practice.
- Continued connections with safeguarding children's partnerships and community safety partnerships to ensure common understanding and focus on shared risks and concerns as well as issues and ongoing reviews.
- Sought assurance that the system is working to safeguard people via the new national policing initiative, 'Right Care, Right Person' through presentations to our Board.

Assurance on delivery of 'Making Safeguarding Personal' (MSP) using a whole family approach

This is what we achieved…

- Local authorities shared data relating to their MSP practice at quarterly Quality Assurance subgroup meetings including how people involved in safeguarding interventions felt about the process and their desired outcomes.
- Partners reflected on their MSP practice in our annual audit questionnaire and detailed what they were doing to ensure every interaction takes a personalised approach.
- Continued focus on MSP through presentations from partners of personal safeguarding stories' at each Board Meeting.
- Engagement with families to gather insights about what the person was like to make the Safeguarding Adult Review personal.

Subgroup Chairs Reports 2025-2026

Safeguarding Adult Review (SAR) Subgroup

The Safeguarding Adult Review (SAR) subgroup met on 5 occasions throughout 2025-2026.

- During 2025-2026 the SAR subgroup provided the governance leading to the delivery and publication of two BCP Safeguarding Adult Reviews – SAR Peter & SAR Matthew.
- Reviewed 13 referrals during the year where 9 of these met the criteria for commissioning a SAR. 3 referrals were included in a Self-Neglect Thematic Review). A further 3 referrals were grouped into a thematic SAR to explore issues of women who have taken their own lives when their children had been removed due to child protection proceedings and 3 referrals were commissioned as individual SARs.

The SAR Policy was reviewed and approved in November 2025 to provide additional clarity for partners when making referrals.

Quality Assurance (QA) Subgroup

The Quality Assurance Subgroup met on 4 occasions during 2025-26.

- Considered and agreed a Safeguarding Supervision Framework to ensure that safeguarding supervision is offered to all colleagues in partner organisations which were then able to provide assurance that their staff are supported in this important work.
- Undertook Data analysis which showed low volumes of safeguarding advocacy uptake; then followed up working with the commissioned advocacy service which produced a short video for the SAB website
- The local authorities and a healthcare provider engaged in audit work on Making Safeguarding Personal, aligned with one of the key areas of focus in the Strategic Plan.
- Focussed on the care provider market and the challenges of international recruitment in the sector and how quality of care provision and safeguarding can be impacted.
- Regularly reviewed SAR Action Plans and tracked relevant recommendations Contributed to updated Multi-Agency
- Risk Management (MARM) guidance arising from recommendations within SAR Simon and SAR Edward.
- Continued to work with partners to encourage improved system-wide data recording, particularly in respect of protected characteristics which help evidence how actions and outcomes of safeguarding interventions impact our communities.

Mental Capacity Act/ Deprivation of Liberty Safeguards (MCA/ DoLS) Subgroup

The Mental Capacity Act & Deprivation of Liberty Safeguards (MCA & DoLS) Subgroup met on 4 occasions during 2025-26.

- Discussed the need for a Memorandum of Understanding (MoU) across local authorities and NHS partners to guide practitioners about the escalation process for adult patients in an acute hospital where there is disagreement as to whether a patient should be detained under the Deprivation of Liberty.
- Safeguards or Mental Health Act Undertook in-depth analysis of a thematic review of SARs in our region featuring mental capacity – partner agencies in Dorset and BCP reviewed the recommendations and provide assurance as to how they were being implemented.
- Reviewed SARs from other areas to consider whether the issues arising could happen in Dorset and BCP and what further preventative work would be of benefit locally.
- Reviewed local SARs to ensure that specific actions and learning relating to mental capacity are effectively tracked and learning implemented. Shared training resources from organisations in order to create a suite of learning materials to assist with understanding of executive functioning and fluctuating capacity.

Community Engagement Group (CEG)

A Safeguarding Adults Conference with the Voluntary & Community Sector (VCS) was held in November 2025 during National Safeguarding Adults week which was well-attended with 88 people from across the sector.

- Speakers included the SAB Independent Chair, professionals from the Dorset & BCP Adult Social Care Safeguarding teams and an informative session on dementia.
- The aim of the conference was to help engage the wider VCS better with the Safeguarding Adults Board, improve understanding and enable learning.
- The SAB website was promoted, along with resources available to the sector.

Partner assurance

This section highlights the achievements and progress of each of our partners, as described by them, to implement the SAB strategy in 2025-26 as well as the work they have done to embed learning from Safeguarding Adults Reviews, strengthen safeguarding practice and protect adults with care and support needs.

We asked all the Board partners a number of questions to provide the Board with assurance that they were delivering against our Strategic Plan. Questions were in relation to learning from SARs, which have taken place over the previous 3 years, delivering a strong preventative focus in practice and delivery of services appropriate to people's protected characteristics. Partners' responses follow.

Dorset Council

Dorset Council Adult Social Care

Learning from SARs

Dorset Council embeds learning from SARs through a variety of formats including safeguarding webinars, 'National Adult Safeguarding Week' programme delivery, and supervision. Resources for learning developed by the SAB are cascaded across the organisation.

Mandatory annual updates for all Dorset Council staff complement the wider safeguarding training offer which aims to build staff confidence and knowledge of current practice; prevent harm occurring and support adults at risk.

Dorset Council has a passionate and committed workforce promoting a culture of learning, professional curiosity and innovation to drive forward improvements underpinned by a strengths-based approach to practice.

Key initiatives to support risk management, learning, practice and governance included:

- Safeguarding Practice Forum for practitioners
- High Risk Domestic Abuse (HRDA & HRDAP) meetings (4/week) attended by the Adult Safeguarding Service
- A self-neglect toolkit work on substance misuse guidance
- Risk enablement forum – supportive environment for frontline practitioners and managers to discuss individuals with complex and high-risk needs, with senior managers and subject experts
- Meetings e.g. Partnership Coordination Group and eSocial Care Provider intelligence sharing as well as local Multi-Disciplinary Team/ virtual ward meetings
- Community Events – working with Community Groups and Faith Groups
- Adverse incidents dashboard monitors data to identify changes or trends.

An external audit of our Safeguarding service was commissioned in 2023, producing an action plan and providing assurance going into the 2025 CQC inspection that our Safeguarding model meets a high standard.

The Quality Assurance Programme Lead and Manager maintain a strong connection with the Safeguarding Service in Dorset Council as well as attending SAB events.

Learning from Dorset SAB 'SAR Simon' (published 23/24)

Changes to our Out-of-Area contract monitoring processes have been implemented as a result of learning from SAR Simon to ensure that additional checks are in place and a robust handover process followed when people move across county or country boundaries. Dorset Council instigates a formal handover, with both the host and receiving authority having an obligation to complete details of commissioning arrangements, restrictions, quality concerns, financial viability, and recent safeguarding activity. If there are concerns about the setting's occupancy or CQC rating these are considered at an early stage and risks assessed, service quality is noted and investigated. Dorset Council maintains high quality records of steps taken during placement processes.

Learning from BCP SAR Edward (published by BCP SAB during 2024-25)

Practice and understanding in relation to self-neglect, hoarding and the exploitation of vulnerable adults is a continued focus for Dorset Council. Two new posts were developed in the safeguarding service to enable enhanced practice knowledge development and support to the wider service. Postholders liaise directly with NHS colleagues, housing providers, our

commissioned drug and alcohol support service (REACH) and Dorset Police to ensure that we respond to risk as a partnership. Both roles are operationally focused and lead on Section 42 enquires and support community workers to navigate often complex and challenging situations to support the person to achieve positive outcomes as a result of the safeguarding intervention.

Dorset Council Housing has also developed a cuckooing protocol with social housing landlords and there are a number of resources linked to cuckooing available to all staff.

Learning from BCP SAR Peter (published by BCP SAB during 2025-26)

Implemented learning by strengthening practice in several areas, including:

- Improved consistency of documentation – routine Quality Assurance audits of care plans, escalation, safeguarding referrals and capacity assessments
- Strong supervision and governance structures
- Clinical audit of essential care tasks, especially in care homes and supported living.

Evidence of a strong preventative focus

- Developing our organisational improvement approach highlighting reports focusing on areas of learning such as audit, SARs, adverse incidents, complaints, commissioning and Domestic Homicide Reviews (DHRs). These will be analysed to identify emerging themes and priority improvement areas to be monitored.
- Launched our Prevention, Early Intervention and Assessment Guidance to support adults in Dorset to live their best lives as independently and as well as possible by taking a proactive approach aiming to help avoid longer term support.
- A new Prevention and Early Intervention Team launched in October 2025, leading and working collaboratively across services to identify and respond to emerging need by taking a proactive approach to supporting individuals before challenges become crises; by supporting people to remain independent in the homes and communities they love; and by helping individuals stay connected to the relationships that matter most.

By working holistically and integrating technology-enabled care, equipment, digital inclusion, community assets, reablement, and strengths-based practice, we're building a model that supports independence and fosters resilience.

We launched our transitional safeguarding pathway in November 2024, working closely with Children's Services to create a clear pathway for young people to access safeguarding support if they are at risk of harm and avoid them being 'screened out' as their care and support need may not be immediately obvious. This approach complements the Birth to Settled Adulthood (B2SA) pathway.

The Safeguarding service continues to attend community events to raise awareness of safeguarding and how people can seek support.

Delivery of services appropriate to people's protected characteristics

Care and Support assessments consider a person's cultural identity, heritage and preferences. Checks are made to ensure that a person's individual needs and protected characteristics are captured in individual assessment and support plans.

- October 2025 – Corporate Director delivered vlog focusing on Black History Month and a round table discussion took place focused on Culturally Competent Practice.
- November 2025 – Adult Social Care Roadshow presentation focusing on cultural competency.
- We are reviewing recording mechanisms on Mosaic to ensure that we improve capture of EDI and protected characteristics to better understand our communities and identify gaps in accessing support to inform service design.
- Learning from complaints and adverse incidents also supports improvements in inclusive practice.
- A focused workstream ensures that individuals known to Multi Agency Public Protection Arrangements (MAPPA) who have a care and support need are supported positively and their protected characteristics are recorded.

Case study X:

A safeguarding concern was raised about an older adult's (X) lack of access to gas and electricity and associated risks of self-neglect. X was not engaging with health services, who were also unable to make contact. After several attempted visits, adult social care eventually made contact. 3 visits have now taken place, with X starting to open up about their financial situation; their significant debts to utility companies and their refusal to accept referrals to debt support services.

...continued on the next page

X is secretive and anxious about possible repercussions and fear that many letters are scams, choosing not to pay energy providers resulting in urgent warning letters.

X's home is very cold in the winter and in a poor state of repair, causing them to use multiple blankets for warmth, battery operated lights, and a gas camping stove for cooking. X does not have a phone, limiting communication to letters or in-person visits and the back door does not lock, increasing safety concerns.

The team explored X's wishes, asking what makes them feel safe, and whether they want support with actions. The team worked with X to review water debt and with their permission, statements were requested. Home security was discussed and X agreed to consider a new locking back door, and a quote has been arranged. X has now provided permission for their recent financial statements to be reviewed to check benefit entitlement and potential income maximisation.

X has significant trust barriers and was reluctant/ fearful to engage with services. An increasingly positive relationship has been built enabling access to their home and sharing of financial information. Longer term engagement is important to prevent escalating concerns.

Dorset Police

Learning from SARs

The main development is the creation of Safeguarding Hubs within each of our two Local Policing Areas (LPAs). These are aligned with BCP and Dorset which means consistency in resourcing, allowing partnership working to improve.

Greater consistency of investigators, supervisors and heads of department has made it easier for partner agencies to know who to link in with, allowing better collaboration around investigations. This has enabled partners to know who to contact regarding more strategic issues and how to escalate any concerns.

Dorset Police has worked hard on the quality of the Public Protection Notices (PPNs) submitted by our staff. The Multi-agency Safeguarding Hub (MASH) will provide direct feedback to Officers when they identify any issues. Frequent systemic issues are highlighted and tackled through any necessary process, change and training. The MASH Detective Inspector also has a monthly meeting with local authority colleagues where PPNs are reviewed.

Within the MASH, we have a dedicated Adult Safeguarding Detective Sergeant. This gives consistency in approach and a point of expertise.

Multi-Agency Risk Management meeting (MARM) attendance is something that at times we have struggled with, particularly in the BCP command area. The benefits of having the officer in the case attend are well known but due to shift patterns and other demands, this has not always been possible. Plans are now in place to improve how MARM attendance is allocated.

Evidence of a strong preventative focus

Dorset Police has processes that aim to identify vulnerabilities at points of contact with us. For example, risk assessments within the Force Command Centre will ask a number of questions and if the caller is identified as vulnerable, it can help determine how we respond.

Throughout the year, Dorset Police has run communication campaigns around particular themes. For example, there has been considerable work around Violence Against Women and Girls (VAWG), an area where sadly, we know that perpetrators will often target those with vulnerabilities.

One of Dorset Police's priorities is a pledge to put victims first, to prevent and reduce victimisation and to meet an individual's needs.

Delivery of services appropriate to people's protected characteristics

Officers and staff should always consider Equality, Diversity, Inclusion (EDI) and receive training.

1. The Paedophile Online Investigation Team (POLIT) has dealt with individuals who are neurodivergent and have offended without properly understanding their behaviour. Opportunities to support and educate the individual have been taken rather than a criminal justice route.

2. Within Multi-agency Public Protection Arrangements (MAPPA), EDI is considered when dealing with every case – ensuring that the risk management plans put in place take account of any protected characteristics.

3. An example of considering the protected characteristics of victims was in a Honour-Based Abuse (HBA) case. A domestic Grievous Bodily Harm (GBH) between uncles and father or son (victim). Domestic Abuse Act (DAA) support given to the victim and his family and then discussed through Multi-Agency Risk Assessment Conference (MARAC).

This resulted in the family being moved to Southampton whilst the three suspects were charged with GBH. This case required cultural understanding due to the complexities of the criminal aspect of the family business, the shame it would bring to some family members, and ultimately the victim's refusal to deal drugs in line with the family business being the apparent reason for the sustained attack from family members.

Dorset

NHS Dorset

Learning from SARs

NHS Dorset Integrated Care Board (ICB) fully recognises the importance of Safeguarding Adults Reviews (SARs) under Section 44 of the Care Act 2014. Learning from SARs is a core component of our safeguarding governance, and we remain committed to ensuring that learning is embedded across commissioning, quality assurance, and frontline practice.

Over the last three years, learning from SARs including Aziza, Matthew, Billy, Peter, Edward, and Simon has directly informed several developments within NHS Dorset. These have strengthened practice in key areas such as self-neglect, trauma-informed care, mental capacity, domestic abuse, and multi-agency working.

Strengthened self-neglect and complex risk practice (Linked to SARs: Aziza, Billy, Peter, Edward, Simon)

Learning from SARs has highlighted the need for consistent and coordinated responses to self-neglect and chronic risk. NHS Dorset has implemented:

- The Boards' MARM (Multi-Agency Risk Management) approach and improved guidance for practitioners, which included specific training sessions on MARM and is incorporated into Adult Safeguarding update training (level 3).
- Increased oversight of high-risk cases through the NHS Dorset Safeguarding Team, including case consultation and supervision for All Age Continuing Care (AACC) practitioners.
- A self-neglect dashboard to identify themes, emerging risks, and patterns requiring system attention has been developed and now incorporated in the Health Inequalities Dashboard on the Dorset Insights and Intelligence Service (DiiS).
- An audit into the MARM process completed with recommendations shared.

These changes have improved shared understanding, promoted earlier intervention, and strengthened multi-agency coordination.

Stronger trauma-Informed and person-centred approaches (Linked to SARs: Aziza, Matthew, Edward)

Learning highlighted the importance of engaging individuals with compassion, understanding and a trauma-informed approach. In response, NHS Dorset has incorporated trauma-informed principles into Level 3 safeguarding training to strengthen practitioner confidence and promote more person-centred practice.

Focus on domestic abuse, coercive control, and exploitation (Linked to SARs: Aziza, Edward)

Domestic abuse and exploitation remain key risks identified in SARs. NHS Dorset has responded by:

- Delivering specialist domestic abuse training to NHS Dorset staff, including coercive control awareness.
- Ensuring NHS providers incorporate domestic abuse pathways into staff training and clinical policies.

These actions have improved practitioner awareness and response to complex domestic abuse dynamics.

Evidence of a strong preventative focus

NHS Dorset ICB maintains a strong preventative safeguarding focus through system-wide collaboration, community engagement, and proactive initiatives designed to reduce harm before it occurs. Prevention is embedded across commissioning, quality assurance, training, and partnership work. Below is evidence demonstrating this commitment.

NHS Dorset works closely with partners and local communities to promote early identification of risk and support wellbeing. Evidence includes:

- Active participation in the Dorset & BCP Safeguarding Adults Board (SAB) Strategy, ensuring a shared, system-wide approach to early help and early intervention.
- Named GPs and Designated Professionals advising and supporting primary care to identify early indicators of self-neglect, domestic abuse, mental health decline and health inequalities.

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This reinforces that prevention is led across the system – not only within specialist safeguarding teams. Health inequalities programmes focused on prevention (e.g. targeted vaccination programmes, enhanced access to mental health care, and outreach to marginalised groups).

Delivery of service appropriate to people's protected characteristics

NHS Dorset ICB is committed to delivering safeguarding practice that actively considers and responds to people's protected characteristics under the Equality Act 2010. Our approach ensures that safeguarding interventions are personalised, rights-based, and inclusive, with reasonable adjustments made to meet diverse needs.

Staff are trained to recognise how characteristics such as disability, age, race, sex, gender identity, religion, and sexual orientation may influence risk, engagement, accessibility, and the person's experience of safeguarding.

We embed these considerations through:

- Trauma-informed and culturally competent practice.
- Mental Capacity Act–compliant decision-making and advocacy referrals.
- Accessible communication and reasonable adjustments.
- Outcome-focused approaches aligned with Making Safeguarding Personal (MSP).
- Multi-agency working to address inequalities and barriers to access.

NHS
Dorset HealthCare University
NHS Foundation Trust

Dorset HealthCare

Learning from SARs

Over the last three years, all but one published Safeguarding Adult Reviews (SARs) have involved Dorset HealthCare (DHC) services. DHC employs over 7,000 staff across mental health, learning disabilities, children and families, community services and community hospitals. Learning from SARs is actively shared and embedded into practice.

The Safeguarding team leads the dissemination and implementation of SAR recommendations, working closely with operational colleagues. In the past year, the team has aligned with the Patient Safety Team under the Patient Safety Incident Response Framework (PSIRF), strengthening the Trust-wide learning and response framework.

Governance and Learning Structures

DHC has monthly learning & review groups which include Integrated Care Services, Mental Health, Learning Disabilities, and Children & Young Families which take a "Think Family" approach.

There is a bi-monthly DHC Safeguarding Group that oversees progress of SAR actions, and shares learning from the SAB (e.g. 7-minute briefings). This is supported by DHC Communications for wider dissemination.

Training: Core safeguarding levels 1 & 2 are being reviewed. Staff are offered bespoke SAR-related sessions and staff feedback on the impact of learning and is collected through training evaluations.

Embedding learning and assurance: The Safeguarding team collaborates with operational colleagues to audit practice once learning has had time to embed. The Clinical Audit & Effectiveness team supports ongoing audits and quality improvement.

DHC's Safeguarding workplan includes regular auditing aligned to SAB priorities and key learning themes from statutory reviews which include:

SAR Peter: Key learning and actions have been implemented including rolling out a Mental Capacity Act (MCA)

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leaflet across DHC, implementing recommendations in psychiatric liaison services and encouraging practitioners to take stronger consideration of social circumstances and caring responsibilities. This is evidenced through training feedback, completed MCA assessments, hospital discharge planning records and carers assessments documentation.

SAR Edward: Key learning and actions have been implemented including updating DHC MARM guidance (2025) reflecting SAB updates, updating SAB documents shared on intranet, embedding trauma-informed practice in partnership with Dorset Mental Health Forum (DMHF), rolling out of a Mental Health Training Programme led by lived experience and trauma specialists. This is evidenced through training attendance and feedback, and a MARM audit is planned for 2026/27.

SAR Simon: Key learning and actions have been implemented including improving transition planning between services and geographical areas, sharing care/support plans between placing and host authorities, learning for MCA, greater involvement of family/friends and post-Mental Health Act (MHA) assessment planning using multi-agency approaches.

This is evidenced through training attendance and feedback, MCA assessment audits, contingency planning recorded in patient electronic records and Approved Mental Health Professional (AMHP) reports.

SAR Billy: Key learning and actions have been implemented including improved risk assessment and management planning, greater use of MARM, engaging with people who decline services, MCA assessments with attention to executive functioning and strengthening the family/social network approach.

This is evidenced through team audits of risk assessment, management planning, and wellbeing plans and MARM audits and use of family network form in electronic record are planned for 2026/27 and 2027/28.

SAR Aziza: Key learning and actions have been implemented sharing risk assessments and crisis plans with all agencies, confirming communication preferences, greater use of advocacy, financial support for students, information sharing with family and greater use of MARM meetings.

This is evidenced through policy and guidance review, team audits of risk assessment, management planning, and wellbeing plans and MARM audits and use of family network form in electronic record are planned for 2026/27 and 2027/28.

Evidence of a strong preventative focus

DHC evidences a strong preventative focus through training compliance, recording of advice given on safeguarding advice line, supervision arrangements and documentation as well as team engagement across DHC in multi-agency forums to plan service delivery, with input from people who use those services.

DHC is a partner and engages in all multi agency work for adult safeguarding, children's safeguarding, Community Safety Partnership, Health & Wellbeing Boards; Prevent and Multi Agency Public Protection Arrangements (MAPPA).

Delivery of services appropriate to people's protected characteristics

Equality Impact Assessments (EIA) completed for all policies and procedures across all services - including all safeguarding policies and procedures.

1. Equality, diversity and inclusion work with set standards and adherence to legislation in recruitment processes.

2. Act in response to complaints; whistleblowing (Freedom to Speak up Guardians); allegations against staff if having a safeguarding element.

3. Have a good network and inclusion of people with lived experience in Trust-wide business.

Dorset County Hospital NHS Foundation Trust

Learning from SARs

In response to learning from recent SARs including 'Aziza', 'Billy', and 'Simon', Dorset County Hospital (DCH) has implemented significant changes in policy, training, and clinical practice to strengthen safeguarding and patient care.

Key achievements include:

- Enhanced communication policy: Clear processes for patient and carer communication preferences, including consent for email and alternative methods.
- Return to face-to-face care: Majority of appointments are now in person, with robust guidance for virtual consultations and adoption of the NHS Patient-Initiated Follow-Up (PIFU) programme.
- Learning Disability & Autism work plan: Addressing diagnostic overshadowing through practitioner-led initiatives, pain management, and reasonable adjustments.
- Mental Capacity Act training: Targeted and supplementary training for staff to ensure compliance with MCA principles, including consideration of 'unwise' decisions.
- Embedding key themes: Application of MCA, 'Think Family' approach, domestic abuse awareness, and recognition of executive dysfunction in care planning.

DCH remains committed to continuous improvement, aligning local practice with national programmes while addressing safeguarding priorities.

Evidence of a strong preventative focus

Safeguarding is supported through DCH's Safeguarding Quality Improvement Plan, which prioritises prevention and community involvement and is overseen through quarterly board-level safeguarding reports. Mandatory safeguarding policies and training for all staff and volunteers' emphasis early identification and prevention.

DCH works in partnership with the Safeguarding Adults Board and Safeguarding Children's Partnership, and delivers targeted community awareness activity within DCH departments, such as domestic abuse and neglect prevention campaigns. Preventative practice is embedded through early identification tools for issues such as domestic abuse and self-neglect, proactive discharge planning with safeguarding considerations, and the support of Safeguarding Leads and Named Professionals. Safeguarding data and trends, including frequent attenders and adults at risk, are monitored to inform action.

A strong safeguarding culture is promoted through high training compliance, visible safeguarding messaging across DCH, onsite support from the safeguarding team, and shared learning from safeguarding reviews via newsletters and training.

Delivery of services appropriate to people's protected characteristics

DCH recognises that the NHS has a core role to play in reducing health inequalities by improving access to services and tailoring services around the needs of the local population in an inclusive way.

DCH is committed to delivering on its statutory obligations under the Equality Act (2010) and uses data intelligently to assess for any disproportionate safety risk to patients from across the range of protected characteristics. Our updated incident management system will allow for the details of patients to be directly drawn from the healthcare record, and incidents can be analysed with protected characteristics to give insight into any inequalities.

Within our patient safety response toolkit, we directly address any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we consider inequalities, and this is built into our documentation and governance processes.

Engagement of patients, families and staff following a patient safety incident is critical to any review of patient safety incidents and their response. We ensure that we use available tools such as Easy Read, translation and interpretation services and other methods (as appropriate) to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

University Hospitals Dorset NHS Foundation Trust (UHD)

Learning from SARs

There has been significant transformation in adult safeguarding at UHD over the last 3 years.

Level 3 safeguarding training has been introduced to all appropriate staff, previously only L1 and L3 training was offered. Importantly, all Safeguarding L3 training includes a face-to-face element where specific cases involving UHD and learning from local SARs is included. UHD align to the Intercollegiate document for training purposes, as well as the Essential Core Skills Framework and Oliver McGowan training has been introduced.

Our Mental Capacity Act (MCA) policy and supporting information has been updated to include Executive Functioning when considering a person's mental capacity. This is included within our Safeguarding Training. Our MCA training is being reviewed. UHD engage with partners and subgroups including the MCA subgroup.

UHD was pivotal in producing a Memorandum Of Understanding (MOU) for ensuring a person lacking capacity is protected (Article 5 Human rights Act) where there is professional disagreement between whether the MCA (and DOLS) or MHA are best applied to support the person remaining in an acute hospital.

Understanding of exploitation including cuckooing is strengthened within training and we have started seeing an upward trend on referrals regarding exploitation.

The Specialist Learning Disability and Autism (LD&A) practitioners (which includes MCA) provision at UHD has doubled and been banded at a higher grade to create more visibility of specialist staff as well as more development of all working for UHD.

An audit and subsequent review of UHD referral forms now specifically includes capture of the person's wishes as part of the Making Safeguarding Personal agenda. The updated referral form is shared with our GP colleagues as well as Adult Social Care. The updated referral prompts staff to consider that when a crime has potentially been committed contact with the police should be made.

The safeguarding team has strengthened our lines of communication at UHD with the student team (who support student nurses and midwives, amongst other roles) The student team work closely with Bournemouth University to support students.

We have engaged with our discharge team at UHD specifically around hoarding and forging close links with Fire & Rescue services. Our discharge team now make referrals direct to the team to ensure patients are supported home safely. UHD staff have attended SAR learning events.

MARMs are now regularly called by UHD where there are ongoing or emerging concerns about an adult at risk to ensure information is shared across partners in a safe and proportionate manner.

Specialist Domestic Abuse Advocates have delivered regular training events to increase staff awareness of stalking, coercion and control and identify people who may previously have been 'hidden' from services, such as older people. Within the training they discuss a trauma aware approach, staff can access trauma aware supporting videos via the staff intranet.

Delivery of services appropriate to people's protected characteristics

Dedicated teams to support patients including patient experience and LD&A practitioners. We have produced story boards to support patients with their hospital journey.

We invited a family to share their loved one's story at Senior Nurse and 'Grand Round' meetings (medical staff), staff signed pledges. Our patient experience team support with patient stories which are shared for Board and for ward staff to learn from.

A UHD consultant has been working with Bournemouth University to produce a Health ability passport to ensure patients' needs can be captured pre-admission/ attendance and they can be better supported.

Charity support helps provide sensory boxes and tools to support patients in hospital.

Dorset & Wiltshire Fire and Rescue Service

Learning from SARs

When local SARs are published, they are made accessible via our Learning Hub, ensuring that all staff have the opportunity to review the findings and learning points.

Looking back at the Safeguarding Adult Reviews (SARs) published over the last three years, we have reviewed the recommendations from recent SARs to identify any implications for Fire and Rescue Service (FRS) practice.

Overall, many of the recommendations were not directly applicable to FRS operational responsibilities. However, where relevant, the following changes or developments in practice have been identified:

SAR Billy

A recommendation referred to welfare calls being directed to the Police. These calls are now more commonly directed to the Ambulance Service, with FRS providing support where entry is required.

SAR Edward

Practice developments have been implemented in response to learning relating to cuckooing:

- Cuckooing has been incorporated into safeguarding training. This has been reinforced through awareness campaigns and posters displayed at stations and offices.
- Training has been completed with 'Escapeline' to strengthen awareness of County Lines and cuckooing.
- Guidance has been updated following the launch of the SaferBCP 'cuckooing referral form', and the form has been used in practice following a recent incident.

SAR Matthew

- The referral form has recently been reviewed and updated to improve clarity and effectiveness.
- A continued issue regarding limited feedback from partner agencies has been noted. Where feedback is received, this is shared with the original referrer and/or watch to support organisational learning.

Evidence of a strong preventative focus

FRS demonstrates a strong preventative focus through its data-led targeting of vulnerability, robust safeguarding governance, and active participation in multi-agency partnerships. Prevention is embedded in strategic planning, operational delivery, and performance management. Staff are trained and empowered to identify and report safeguarding concerns.

Our Community Safety Plan 2024-2028 outlines a four-year strategic framework focused on saving lives, reducing risk through prevention and protection, and improving service delivery. It is designed to ensure resources are in the right place, with the right skills, to meet community risks.

Delivery of services appropriate to people's protected characteristics

Fire does not discriminate and nor do we.

- We dynamically monitor development and compliance with the Equality Act and Public Sector Equality Duty by staying abreast of legislative changes such as the Worker Protection Act, Supreme Court ruling on biological sex, Employment Rights Act – accounting for protected characteristics.
- Our Community Safety Plan is informed by widespread public consultation – during consultation, we approach various community groups to reflect as many voices as possible. This and our strategic assessment of risk informs our strategies and plans – so that the identified needs of people consider their protected characteristics.
- We complete People Impact Assessments for procedures and significant changes – ensuring that changes and decisions are assessed for impact on people who share characteristics and that any negative impacts are reduced, removed or justified with a legitimate aim.
- Staff Networks – members offer support for each other, but concerns are also heard and considered for organisational improvement at our Culture Development Committee. These drive changes such as better accessibility for neurodivergent staff, better support for new parents etc.

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The needs of our staff and our service users are considered throughout various functions and processes such as:

- Translation services for written and verbal communication e.g. Home Fire Safety (HFS) visits, hot strikes (fire safety checks carried out in the surrounding area following a fire), business safety checks, legal proceedings for people who don't have English as their first language (mostly supporting people from different ethnic backgrounds), HFS materials are translated into 26 languages. To assist Afghan resettled families, we created comprehensive translated videos in Dari and Pashto along with children's booklets.
- Customs and expectations at community events e.g. targeted safety campaigns, religious celebrations (mostly supporting people based on their race and Religion/Belief). Following the summer riots in 2024 we increased our outreach to faith groups to provide public reassurance and encourage better communication.
- Reasonable adjustments or other accommodations at recruitment, interview, have a go days etc. for disability, race, religion/belief
- Safeguarding Team were part of a Personal Safety Workshop, considering protected characteristics that might make people more vulnerable to violence such as women, disabled people, LGBT+.

NHS
South Western Ambulance Service
NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust (SWAST)

Learning from SARs

Themes identified from SARs for SWAST include:

- **Professional curiosity** – We recognised there was a need to develop the professional curiosity of our workforce, primarily because internal documentation did not evidence this. Action was taken to include professional curiosity in the mandated level 3 safeguarding training, in respect of applying professional curiosity (what are you seeing, hearing, smelling; the context of the situation; what is not being said or is missing; who else may be in the property, at risk etc.) and in documenting what has been observed.

The revised safeguarding forms include prompts to encourage sharing holistic information.

- **Sharing of information** – SWAST safeguarding team has reviewed how we share information, aligned with the review of our safeguarding forms. Operational staff can share information with GPs via the electronic Patient Care Record (ePCR), however safeguarding referrals are not shared routinely with GPs. Safeguarding forms encourage staff to contact police if there is a concern.
- **Mental Capacity** – Mental capacity does not sit in the safeguarding portfolio but learning from SARs is shared across the organisation and the Trust's position on the application of the Mental Capacity Act is being reviewed. National guidance is available to paramedics in relation to how to apply the Mental Capacity Act in pre-hospital urgent care on the 'Joint Royal Colleges Ambulance Liaison Committee' and this is reflected in the new SWAST MCA policy. Mental capacity is included in safeguarding training with topics such as executive function, impact of coercion and fluctuating capacity. SWAST is in the process of identifying a Mental Capacity Lead.

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- **MARM (Flags and Care plans)** – The safeguarding team has increased in capacity, appointing a safeguarding specialist for each county. Referrals to the fire service are made using our electronic safeguarding referrals. Where a person at risk is conveyed to a hospital the safeguarding referral can be shared to support decisions around safe discharge planning within the SWAST footprint. This enables specialists to participate in MARM meetings, and to raise concerns or facilitate a MARM meeting as required.

Evidence of a strong preventative focus

Our operational crews highlight concerns which amount to care and welfare, but do not reach safeguarding thresholds and share these with our social care colleagues. Work is underway to refine crews' understanding of safeguarding versus care and welfare and our new safeguarding referral forms support this process.

Delivery of services appropriate to people's protected characteristics

SWAST appointed a 'Learning Disability and Vulnerability Lead' in November 2024 who has co-developed the Trust learning disability strategy and is in the process of developing dementia-friendly resources.

SWAST has developed a new Quality, Equality Impact Assessment policy and Panel to ensure any service development and policies are duly considering those with protected characteristics.

SWAST has created a mental health team, which works with colleagues in partner organisations across our footprint to provide urgent mental health response in a specialist mental health vehicle.

Probation Service

Learning from SARs

Over the past 18 months, Dorset Probation has implemented significant changes to embedding learning from SARs (Aziza, Matthew, Billy, Peter, Edward, Simon) into everyday practice. A key focus has been strengthening professional curiosity and risk management which has also been prompted from learning from MAPPA Serious Case Reviews (SCRs) and internal Serious Case Reviews. Reflective Supervision Panels were introduced for complex safeguarding cases, enabling staff to challenge assumptions and improve decision-making. Enhanced use of practitioner dashboards has supported timely safeguarding checks and risk reviews, with compliance improving from 44% to 48% in the past three months. These measures directly address SAR findings on missed warning signs and inadequate oversight.

Multi-agency collaboration has also been prioritised. South West Probation established a dedicated safeguarding hub with direct access to Dorset Police systems, allowing real-time information sharing and better coordination with social care and the MASH. It is hoped that the hub will gain access to other systems where safeguarding information is stored. The Safeguarding Families Together project embedded probation service officers within multi-disciplinary teams to address domestic abuse and whole-family safeguarding needs in a non-statutory context, reflecting SAR learning on holistic interventions. Additionally, annual SAR learning events and practice development days have reinforced joint working and continuous improvement across partner agencies.

Workforce development and targeted support for vulnerable cohorts have been central to change. Mandatory adult safeguarding training is in place for all Probation staff, complemented by trauma-informed practice sessions and SEEDS2 leadership programmes for managers promoting reflective practice. Specialist training on autism and ADHD in women was commissioned locally and supports SAR insights into missed vulnerabilities. Policy improvements include mandatory gatekeeping of all Pre-Sentence Reports,

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raising compliance to 81%, and the Probation Reset initiative to prioritise engagement at critical sentence points.

Gender-specific strategies, such as women-only reporting times and wellbeing activities, and a dedicated pod for 18-25-year-olds with trauma-informed approaches, demonstrate Dorset Probation's commitment to embedding SAR learning and improving safeguarding outcomes.

Impact statement: These changes have strengthened safeguarding practice, improved risk management, and enhanced multi-agency collaboration, ensuring that vulnerable individuals receive timely, person-centred support. For service users, this means safer transitions, better engagement, and access to tailored interventions. For staff, the improvements have fostered a culture of professional curiosity, reflective practice, and wellbeing, equipping teams with the tools and confidence to manage complex cases effectively and reduce the likelihood of serious harm.

Evidence of a strong preventative focus

We are active partners in the Pan-Dorset Reducing Reoffending Strategy, which prioritises early intervention, holistic support, and restorative approaches. This includes working not only with individuals on probation but also with their families and local communities to reduce risk and prevent harm. For example, our involvement in Safeguarding Families Together places probation officers within multi-disciplinary teams alongside social care, health, and domestic abuse specialists, ensuring whole-family safeguarding and early help for those at risk of harm.

Probation practitioners support community resolutions and Outcome 22 interventions, helping to steer individuals away from formal criminal justice processes and towards constructive support. These efforts are complemented by our engagement in Community Safety Partnerships, where we collaborate on campaigns like 'Just Don't' to challenge harmful behaviours and raise awareness of safeguarding responsibilities across the wider community.

Delivery of services appropriate to people's protected characteristics

Overview

Dorset Probation recognises the challenges of engaging individuals with complex needs or those who find it difficult to access mainstream services. Over the past three years, we have implemented a range of measures to equip staff with the skills, resources, and multi-agency support required to manage these cases effectively.

Training and professional development

All practitioners receive mandatory safeguarding and trauma-informed practice training, alongside specialist development on neurodiversity, mental health, and substance misuse. Recent training on autism and ADHD in women has helped staff tailor interventions for those who struggle with traditional service models. The Management Oversight and Quality Assurance Framework ensures reflective supervision and coaching, enabling staff to explore barriers to engagement and adopt person-centred approaches.

Specialist support and multi-agency collaboration

Dorset Probation utilises Complex Case Support Panels, bringing together senior probation officers, psychologists, and multi-agency partners to provide guidance and formulate bespoke plans. Specialist services such as the Offender Personality Disorder (OPD) Pathway and Pathways Enhanced Resettlement Service (PERS) provide structured interventions and emotional support for individuals with entrenched behavioural issues. Staff benefit from consultation and formulation processes, improving confidence and competence in managing these cases.

Gender-responsive practice and Women's Strategy

The Women's Pod offers a dedicated space for women under supervision, with tailored interventions and wellbeing activities that reduce barriers to engagement. Staff receive specialist training in trauma-informed practice and motivational interviewing. Dorset also participates in pre-release panels for women at HMP Eastwood Park, ensuring sentence planning and resettlement support are coordinated before release. Partnerships with local women's centres and specialist agencies provide wraparound support for women with multiple needs, including substance misuse, mental health, and domestic abuse. Gender-specific reporting times, wellbeing activities, and peer support groups further demonstrate our commitment to reducing barriers and supporting family stability.

Practical adaptations

Dedicated pods for the 18–25 cohort and co-location with partner agencies, including mental health and housing services, ensure staff can quickly link individuals to specialist support. For those with neurodivergent needs, probation practitioners use easy-read licence conditions and adapted communication techniques to improve understanding and compliance.

HMP The Verne

Learning from SARs

Within the HMP Prison Service (HMPSS) resettlement is a significant focus and we work with partner agencies for prisoners who are highlighted as high risk when due for release. We collaborate with multi-agency partners to manage these individuals, ensuring they have the appropriate support available to them.

Whilst in prison those highlighted as a risk upon release are supported via Assessment, Care in Custody Teams (ACCTs) and/or Challenge, Support & Intervention Plan (CSIPs) alongside mental health and resettlement referrals. These teams liaise with outside agencies, identifying and putting in place essential support for when the person is released with the aim of helping the person live a crime-free life.

Evidence of a strong preventative focus

We can evidence a strong preventative approach to safeguarding by demonstrating that safeguarding is embedded into everyday practice, informed by early identification of risk, and delivered through collaborative working with internal departments and external community partners. Safeguarding is clearly understood as everyone's responsibility, not solely the role of specialist teams.

Delivery of services appropriate to people's protected characteristics

The delivery of our services actively considers and responds to individuals' protected characteristics as defined under the Equality Act 2010. Safeguarding interventions are risk-assessed on an individual basis, with adjustments made to ensure prisoners are treated fairly, safely, and with dignity. Staff work collaboratively with Health, Safer Custody, Equality teams, and external partners to ensure vulnerabilities linked to disability, age, mental health, ethnicity, religion, or other protected characteristics are identified and addressed.

Equality monitoring, multidisciplinary decision-making, and reasonable adjustments are embedded within daily operational practice to reduce the risk of discrimination and harm.

1. Age and vulnerability – support for older prisoners

An older prisoner presented with mobility issues and increased vulnerability following a change to their regime, raising safeguarding concerns around isolation and access to essential services. Reasonable adjustments were made to work allocation and daily movement to accommodate mobility needs. Wing staff increased welfare checks and coordinated with safer custody and healthcare to monitor wellbeing. The prisoner was supported to access age-appropriate activities and peer support, reducing social isolation.

The intervention reduced the risk of neglect, falls, and deterioration in physical and emotional wellbeing, ensuring the service remained accessible and safe.

A safeguarding concern arose involving a prisoner whose religious beliefs impacted engagement with staff and healthcare, particularly during periods of religious observance.

Staff liaised with Chaplaincy and Equality representatives to better understand religious requirements. Safeguarding meetings and welfare checks were arranged to avoid key religious observance times where possible. Dietary, regime, and appointment flexibility were applied to prevent disengagement or escalation of distress. Respecting religious and cultural needs, improved cooperation, reduced tension, and ensured safeguarding concerns were addressed without discrimination.

Disability and mental health – adjustments to disciplinary and regime processes

A prisoner with a recognised mental health condition and cognitive impairment was involved in a safeguarding concern linked to behavioural incidents on the wing.

Healthcare and Mental Health teams were consulted before any action was taken. Communication methods were adapted, including simplified explanations, additional time, and staff support to ensure the prisoner fully understood proceedings.

Where sanctions were considered, the prisoner's mental health condition was explicitly documented, and alternative management options were used in place of punishments that could exacerbate distress.

This approach prevented disproportionate outcomes, ensured procedural fairness, and reduced the risk of further deterioration in mental health, while still addressing risk and behaviour.



HMP Portland

Learning from SARs

HMP Portland remains committed to learning from local and national Safeguarding Adult Reviews (SARs) and incorporating relevant learning into practice. Particular focus is given to improving awareness and understanding of issues that can affect vulnerable adults, including exploitation, coercion, county lines activity, self-neglect, mental health deterioration and barriers to accessing support. The prison recognises the importance of effective multi-agency working, information sharing and early intervention in safeguarding vulnerable adults.

Evidence of a strong preventative focus

HMP Portland demonstrates a strong preventative approach to safeguarding through robust identification, management and review processes designed to identify vulnerabilities early and reduce the risk of harm.

- All new receptions are screened twice within the first 24 hours of arrival to identify safeguarding concerns, vulnerabilities, support needs and risks relating to self-harm, bullying, disability, first-time custody and other factors.
- The prison's online change of circumstances forms provide an additional route for staff to raise concerns, automatically notifying the Safety Team and relevant departments.
- Safeguarding concerns can be raised through the Prison Family Support Line, safeguarding referral forms and Challenge, Support, and Intervention Plan referrals, ensuring concerns can be identified from multiple sources.
- The weekly Safety Intervention Meeting provides multi-disciplinary oversight of the establishment's most vulnerable and complex prisoners, with referrals accepted from any member of staff.
- The Inter-Departmental Risk Management Meeting (IRMM) brings together Offender Management, Security, Residential, Psychology, Healthcare, Substance Misuse and Safer Custody teams to review MAPPA-eligible prisoners and other complex public protection cases, enabling coordinated risk management and safeguarding planning.

Delivery of services appropriate to people's protected characteristics

HMP Portland delivers safeguarding services that recognise and respond to the diverse needs of prisoners protected under the Equality Act 2010. Safeguarding interventions are individually assessed and adjusted where necessary to ensure prisoners can access support fairly, safely and with dignity.

- All safeguarding referrals are considered alongside individual vulnerabilities, including age, disability, mental health, protected characteristics and social care needs.
- Where prisoners have mobility, physical health or social care needs, established referral pathways exist with local authority social care teams to secure assessments, specialist equipment and appropriate support.
- Residential units have designated Safety and Equalities Representatives who provide peer support, help identify concerns and assist prisoners who may require additional practical support.
- The Samaritans Listener Scheme operates 24/7, providing confidential peer support for vulnerable prisoners.
- Healthcare, Safer Custody, Equality and Residential teams work collaboratively to ensure reasonable adjustments are implemented where required and that support plans reflect individual needs.

Multi-Agency Working and Community Safeguarding

Effective safeguarding at HMP Portland is supported through strong partnership working and information sharing both within the prison and with external agencies such as Probation, Police, Local Authorities, Dorset Combined Partnership Board (DCPB), Healthcare providers, Housing Services, Social Care Teams and Community Outreach organisations.

Prior to release, identified vulnerabilities, safeguarding concerns and support needs are communicated to relevant agencies to support continuity of care, effective risk management and safer outcomes within the community. This collaborative approach assists in identifying and protecting vulnerable adults, reducing the risk of serious harm to self or others, and ensuring safeguarding responsibilities continue beyond the prison gate.

HMP Guys Marsh

Learning from SARs

Having reviewed the SARs over the last 3 years, none of them had custodial elements and so no areas of change in practice could be identified, however, we will as a prison look to raise awareness around 'Cuckooing' and 'County Lines' as these do affect us.

Evidence of a strong preventative focus

Safeguarding concerns are raised through our well-attended weekly Safety Intervention Meeting so that all departments are aware.

Healthcare also liaises with all relevant departments when concerns are raised.

Delivery of services appropriate to people's protected characteristics

There are quarterly prisoner forums held for each protected characteristic.

- Weekly cell cleans have been implemented for Mr. M who was not able to do this activity for himself due to his age and mobility. This is supported by staff and training bio cleaner prisoners.
- Before lock down, young adults are given extra gym time to support them through the period of lock up later in the day.
- Mr. A wanted to work in the kitchen and uses a wheelchair so reasonable adjustments are being made to support him in working in that area.

Board attendance

We would like to thank our Partners for continued commitment to attending our Board meetings.

	June 2025	Sept 2025	Dec 2025	March 2026 Dev. event	March 2026
BCP Council	✔	✔	✔	✔	✔
Dorset Council	✔	✔	✔	✔	✔
Dorset Police	✔	✔	✔	✔	✔
NHS Dorset	✔	✔	✔	✔	✔
Dorset HealthCare	✔	✔	✔	✔	✔
University Hospital Dorset	✘	✔	✔	✔	✔
Dorset County Hospital	✔	✔	✔	✔	✔
Dorset & Wiltshire Fire Service	✔	✘	✔	✔	✔
SW Ambulance Service	✔	✔	✘	✔	✔
Prisons & Probation	✔	✔	✔	✔	✔
VCS	✘	✔	✔	✔	✔

Story of difference

Albert's Personal Safeguarding Story

'Albert' is a 57-year-old white British man who has significant health needs, a cognitive impairment and history of substance misuse.

A safeguarding concern was received from a pharmacy and REACH (Drug and Alcohol Service) raising concerns of financial abuse and coercive controlling behaviour by a 'live in carer'.

A Section 42.2 enquiry was initiated.

Albert initially appeared fearful, withdrawn, and unable to speak freely. The carer was reported to be controlling finances, access to his home, and communication with others.

An Enquiry Planning Meeting (EPM) was held with multi-agency partners. Albert did not wish to attend the meeting, but his views and wishes were shared by the safeguarding practitioner.

His expressed outcomes were for the Police and housing to visit his home as he was scared.

Information shared indicated that Albert may be cuckooed and the Police were to lead an investigation with Dorset ASC & Housing to support.

The Police and Housing visited Albert and identified further risks, including;

- Criminal exploitation (cannabis farm, weapons and large sums of money)
- Confirmed Cuckooing of home

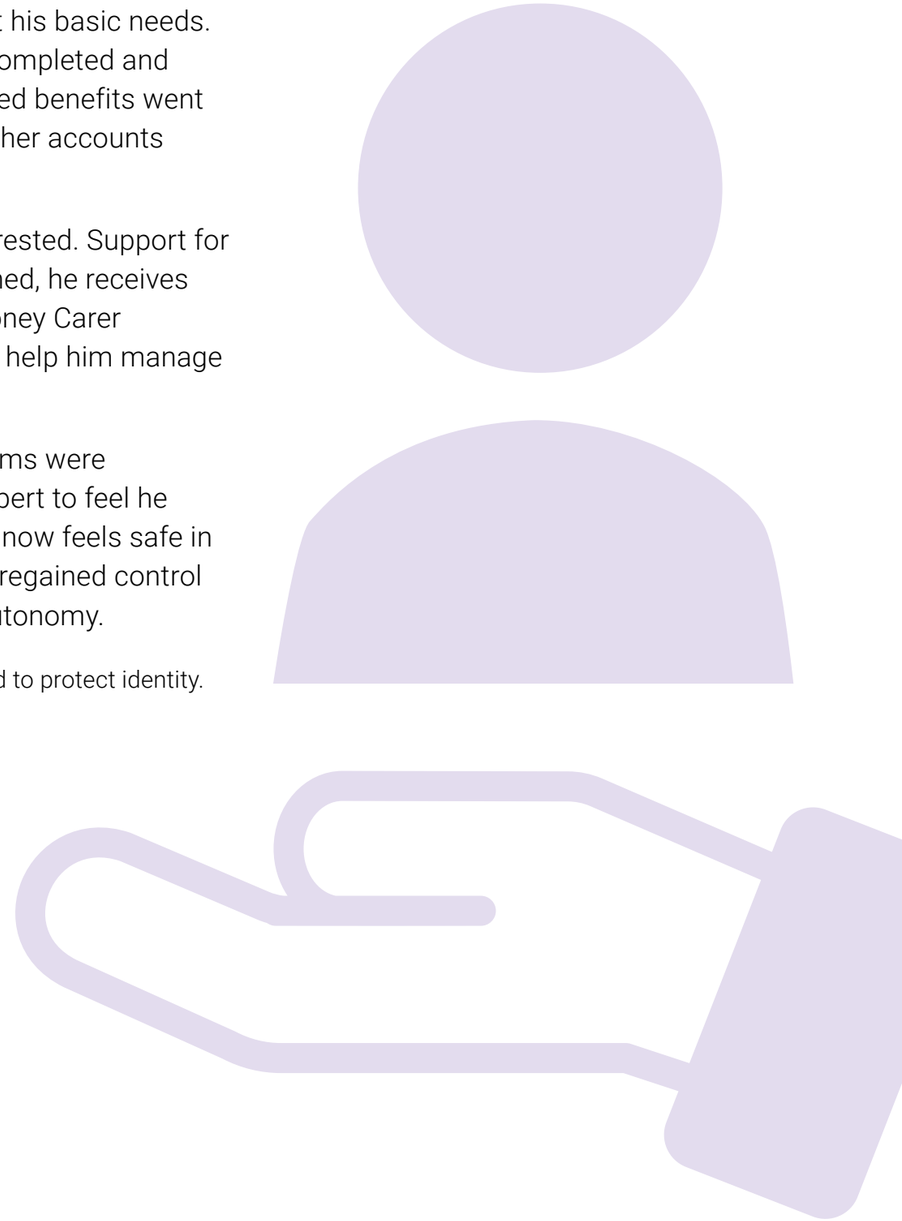
The Police and Housing took immediate action, the 'live in carer' was evicted, their belongings removed from the Property. locks were changed, key safe installed and a mobile phone was provided to Albert.

Albert disclosed to safeguarding he had no access to money and was scared to ask for support to meet his basic needs. A benefits check was completed and liaison with DWP ensured benefits went directly to Albert and other accounts were terminated.

The perpetrator was arrested. Support for Albert was commissioned, he receives 2 visits per day, and Money Carer Foundation engaged to help him manage his finances safely.

Essential household items were purchased to enable Albert to feel he had his home back. He now feels safe in his own home and has regained control restoring dignity and autonomy.

*Names have been changed to protect identity.



Safeguarding Adults

Safeguarding adults is about protecting the rights of people with care and support needs to live in safety, free from abuse, harm and neglect.

If you are concerned about a person who is over the age of 18 years, who has care and support needs, and you feel they are being abused or at risk of abuse from another person, you should seek help for them.

To report a safeguarding concern in the Dorset Council area contact 01305 221016

During evenings and weekends, call 01305 858250

Thank you for reading our Dorset Safeguarding Adults Board Annual Report 2025-2026

If you would like to get in touch, please do so by the following contact details:

dbcpsafeguardingadultsboard@bcpcouncil.gov.uk

DSAB
Dorset Safeguarding Adults Board

dbcpsafeguardingadults.org.uk

Health and Wellbeing Board
18 November 2026
Health and Wellbeing Strategy
For Decision

Cabinet Member:
Cllr S Robinson, Adult Social Care & Health

Local Councillor(s): **All**

Senior Leadership Team:
S Crowe - Executive Director, Housing, Prevention and Communities

Report author and job title: Sam Crowe, Executive Director, Housing, Prevention and Communities
Email: sam.crowe@dorsetcouncil.gov.uk

Statutory Authority:

Report status: Public Choose an item.

1. **Executive summary (maximum of 500 words)**

1.1 A new strategy for the Health and Wellbeing Board has been developed this year, following agreement of the approach and aims of the strategy at the March meeting. Development has been carried out with the engagement of partners and stakeholders, and updating this Board with regular progress.

1.2 The strategy is framed around four strategic outcomes which are based on Start Well, Live Well, Age Well and Healthy Places. This structure allows the Board to focus on broad strategic priorities relevant to residents and partners.

1.3 Delivery of the strategy will be overseen by delivery groups and a joint commissioning partnership, aligned to these strategic outcomes, where the detailed programmes can be managed, and partners come together at a place-based level. There is a separate paper on the partnership being considered by this Board meeting.

1.4 The Board will review progress at its quarterly meetings. It will review and update the strategy and outcomes annually to reflect changing priorities and local need.

1.5 The final draft of this strategy was presented to the People and Health Overview Committee on 2nd November, a summary of their feedback will be provided verbally at the meeting because this report was submitted for clearance before the committee took place.

2. Recommendation(s)

2.1 That the Board approves the strategy, supports the approach of four strategic outcomes as the framework, and the mechanism of delivery groups and joint commissioning partnership to oversee programmes and progress towards the outcomes.

2.2 That the Board confirms the appointment of chairs of the delivery groups and that they start work as set out in the strategy.

3. Reason for the recommendation(s)

3.1 Having an approved strategy will enable the Health and Wellbeing Board to act effectively as the partnership space for prevention focused integrated health and care in Dorset. The outcomes framework provides a structure and focus to manage priorities and coordination of effort across the partner organisations. The delivery groups will manage the detailed programmes making sure that delivery supports the outcomes, work is coordinated and priorities are aligned.

3.2 Final publication of the strategy will incorporate feedback from the board.

4. The report

Introduction

4.1 The Health and Wellbeing Board is a statutory partnership board, responsible for promoting prevention focused integrated care in Dorset. Statutory functions include undertaking a joint strategic needs assessment, developing a strategy, undertaking a needs assessment for pharmacy services, oversight of the Better Care Fund, and ensuring the work of the Safeguarding boards is considered.

4.2 The strategy for the Dorset Health and Wellbeing Board was due to be refreshed earlier this year. This comes at a time when the Integrated Care Board (ICB) is changing to a cluster arrangement covering six unitary authority places, and Dorset Council is focusing heavily on prevention and working more closely with communities. This provided an opportunity to update the approach and priorities for the Health and Wellbeing Board to improve place-based partnership working and

support the left shift on prevention, including from hospital to communities. It supports the council plan priorities of Communities for All in line with partnership working.

4.3 The strategy reinforces the principle of the Health and Wellbeing board incorporating the emerging neighbourhood health work, with NHS partners. The NHS is developing clear plans for supporting the 20% of the population most in need of health care services. The focus for the health and wellbeing strategy is broader, supporting the remaining 80% of the population to live well and independently. The two plans overseen together allows connectivity and alignment of priorities and partnerships.

4.4 This refresh of the strategy and the work of the Board comes at a time when there is an opportunity to look at joint commissioning with partners, especially the ICB and Dorset Council. There is a separate paper to this Board meeting proposing a partnership approach including a new joint commissioning forum. This will oversee the main commissioning fund of the Board, the Better Care Fund, and provide opportunities for a more effective partnership as it takes on responsibility for devolved funding from the ICB.

Timeline

4.5 The emerging strategy has been developed through these meetings for input and approval:

- December 2025 Green Paper to Dorset Council Senior Leadership Team setting out the opportunity for the Health and Wellbeing Board to work collaboratively within the partnership.
- 2nd February 2026 People & Health Overview Committee. Set out the approach to building the strategy with full engagement of partners and stakeholders.
- 18th March 2026 Health and Wellbeing Board. Setting out the approach and timeline for refreshing the strategy and developing an outcomes framework.
- 17th June 2026 Health and Wellbeing Board. Presentation on developing the board and its purpose under the emerging strategy, with delivery groups overseeing the programmes.
- 16th September 2026 Health and Wellbeing Board. Progress update for the refreshed strategy and outcomes framework.
- 2nd November 2026 People and Health Overview Committee. Review of final draft strategy.

Engagement sessions

4.6 Four stakeholder engagement sessions were planned as part of the development of the strategy. Attendees included representatives for Dorset Council, health services, voluntary and community sector and wider system partners.

4.7 The sessions held were:

- 24th February 2026 – developing an outcomes based strategy
- 21st May 2026 – developing a vision for Dorset
- 16th July 2026 – delivering the priorities
- 15th October 2026 – adding value with meaning and purpose

4.8 There was a clear and consistent message from stakeholders, that improving health and wellbeing in Dorset requires a greater focus on prevention, early intervention and the wider determinants of health (such as housing, employment and access to green space). Stakeholders highlighted the importance of designing services around what matters most to residents, strengthening communities and the voluntary sector, and creating simpler, more integrated systems with shared outcomes and accountability.

Overall, there was a clear message that delivery should build on existing programmes that share common characteristics: prevention, community-based support, holistic approaches and trusted local relationships. Participants also highlighted the need for stronger governance, better data sharing, improved collaboration across organisations, and success measures that focus on outcomes such as quality of life, belonging, purpose and community connection.

Development of the strategy

4.9 The approach taken in developing this strategy was to focus on priorities and strategic outcomes, with the aim of enabling the Board to work at a strategic level across the partnership. This will be an evolving strategy that will reflect progress and emerging priorities and is relevant to residents.

4.10 An internal officer group for Dorset Council was established to ensure a whole council approach was taken, with directorates working together on prevention, avoiding silos and duplication. The engagement with partners and stakeholders, together with progress updates to the Board during development, supported an iterative process with feedback being incorporated during the process.

4.11 Refreshing the strategy allowed the Board to consider its purpose driving integration, prevention and place-based leadership. This means a strategic focus on priorities and outcomes at Board, and detailed oversight of programmes through the delivery groups.

Outcomes Framework

4.12 An outcomes framework provides a structured approach to cover broad outcomes across multiple partners. It focuses on the real-world impact for Dorset residents and provides a common language and structure for measuring progress. It

is better to focus on a few priority outcomes well, instead of trying to track lots of outcomes ineffectively.

It focuses on top priorities at a strategic level, with measures that are already available to monitor progress. It allows detailed delivery work to be organised under the strategic outcomes where place-based delivery can happen.

4.13 The strategic outcomes in the strategy are as follows:

- **Start Well**: Children, young people and their families are healthy, thriving and resilient. They feel safe and connected to their community.
- **Live Well**: People can live healthy, fulfilling and independent lives, with support in the community to improve wellbeing.
- **Age Well**: Older people live independently, with dignity and choice, supported to stay well in their own homes and communities
- **Healthy Places**: Our neighbourhoods are safe, inclusive and connected, with access to nature, making healthy living easier for everyone.

Delivery groups

4.14 The concept of delivery groups led by senior officers and partners enables strong leadership of the work and will provide assurance back to the board. They will provide clear updates to the Board on progress and issues for escalation.

4.15 Major programmes will be grouped by outcome, to manage the connections and shared achievements. This will show the added value of aligning partnership work, connection to related work managed elsewhere in the system and will help see the bigger picture. An example of this would be the Healthy Places delivery group overseeing a new partnership programme for rough sleeping, reflecting national policy direction for partnerships and providers to work together.

4.16 Focusing on the detail here will allow the Health and Wellbeing board to remain strategic. The delivery groups will have space to focus on the main programmes linked with outcomes in the strategy. It helps simplify where the work in the partnership happens. The groups will advocate for the move to prevention, to avoid demand, and prevent ill health. They will review and develop detailed metrics as programmes develop

4.17 The establishment of these delivery groups will facilitate connections with the Dorset Council delivery boards and will strengthen their shared purpose. This alignment will make the Health and Wellbeing Board stronger by strengthening the focus on partnership working which adds more value than organisations working in silos.

4.18 This table show the initial view of current programmes aligned to the strategic outcomes

	Start well	Live well	Age well	Healthy places
Best start in life	✓	✓	✓	✓
LiveWell Dorset		✓	✓	✓
Neighbourhood Health	✓	✓	✓	✓
Age Friendly Dorset	✓	✓	✓	✓
Future Care		✓	✓	✓
Better Care Fund		✓	✓	✓
Thriving Communities		✓	✓	✓
Physical Activity	✓	✓	✓	✓
Rough sleeping		✓		✓

4.19 The delivery programmes, overseen by the delivery groups, will provide some proxy measures as an additional way of checking progress towards the strategic outcomes. There will not necessarily be a one-to-one map of measure to outcome, rather a mix of measures to outcomes as illustrated in the table above.

4.20 The Health and Wellbeing Board will hold an annual review of the strategy and outcomes, which will allow assessment of progress, celebrate success and identify where further attention is needed for the following year. The annual review process

will also enable the strategic outcomes to be adapted to meet changes in context and goals.

The review process will include learning and innovating from good practice elsewhere to enhance the target outcomes and continue to improve the means of achieving them for Dorset residents.

Next Steps

4.21 Work is underway to appoint chairs of the delivery groups and core members. They will define the full membership of the individual groups based on the initial work programmes, and agree the scope of these programmes. They will clarify relationships and connections with the other delivery groups as well as other relevant boards to ensure effective coordination of plans, focus on partnership work coming under the remit of the Health and Wellbeing Board, and alignment of work to strategic outcomes.

5. Alternative options considered

5.1 Not having a strategy – this option is dismissed as it is a statutory requirement of the board.

5.2 Using a previous approach of drafting by professionals, sharing with the board for consultation. Discounted as experience shows this is not an effective way of building engagement around the importance of the work.

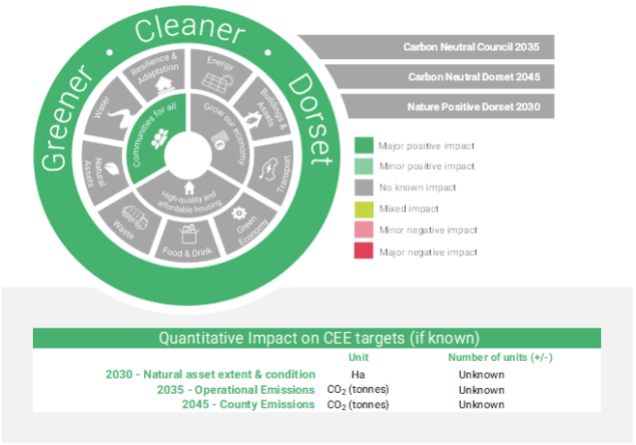
6. Legal considerations

6.1 Developing a local Health and Wellbeing Strategy is a legal requirement for the board under the 2012 and 2022 Health and Social Care Acts.

7. Financial implications

7.1 The strategy and supporting work on community needs and the outcomes framework will be essential in the ambitions of Dorset Council to develop its prevention approach, working with communities. An effective prevention approach at scale, through this strategy, should support the council to be financially sustainable, through meeting needs earlier.

8. Natural environment, climate & ecology implications

8.1 

9. Wellbeing and health implications

9.1 Having a clear strategy that is owned and supported by partners and communities will be essential in focusing work to improve wellbeing and health of residents and continue to tackle inequalities in health.

10. Other implications

10.1 The approach may need to evolve as the Neighbourhood health plan and the ICB Cluster further develops in 2027, and the Health Bill is passed.

11. Risk implications

11.1 HAVING CONSIDERED: the risks associated with this decision; the level of risk has been identified as:

Current Risk: Low

Residual Risk: Low

12. Equalities

12.1 Equality impact assessments are provided for individual programmes within the emerging delivery groups.

13. Appendices

13.1 The draft strategy is circulated as a separate document

14. Background papers

14.1 Health and Wellbeing board reports 18th March, 17th June, 16th September 2026

15. Report sign-off

15.1 This report has been through the internal report clearance process and has been signed off by the Director for Assurance & Governance (Monitoring

Officer), the Director for Resources (Section 151 Officer) and the appropriate Cabinet Member(s)

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Dorset

Health & Wellbeing Strategy

Supporting the people of Dorset to start well, live well and age well in healthy places



Dorset Council

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Foreword

Cllr. Steve Robinson, Chair, Dorset Health and Wellbeing Board

Health and wellbeing are shaped by far more than the services we receive when we become unwell. They are influenced by our relationships, our communities, our opportunities, our sense of belonging and purpose, and the strengths we build throughout our lives. This strategy is founded on the belief that every person in Dorset should have the opportunity not only to be healthy, but to thrive.

In developing this strategy, we have been inspired by a simple but powerful idea: people achieve better outcomes when they are surrounded by supportive relationships, meaningful opportunities, clear expectations and environments that help them develop confidence, resilience and a positive sense of identity. These principles apply not only to children and young people, but to people of all ages and stages of life.

Communities are strongest when individuals feel connected, valued, and empowered. Whether it is a child benefiting from a positive start in life, an adult maintaining their health and independence, or an older person remaining active and involved in their community, the conditions that support wellbeing are remarkably consistent. Strong families, supportive neighbourhoods, trusted services, opportunities to contribute, and a sense of belonging all help people live healthier, happier and more fulfilling lives.

This Health and Wellbeing Strategy sets out our shared ambition for Dorset. It is a commitment from partners across local government, the NHS, the voluntary and community sector, emergency services and our residents to work together to create those conditions for success. Through prevention, early intervention, integrated neighbourhood working and community-led approaches, we will focus on building the strengths and assets that already exist within Dorset's people and places.

Together, we can create a Dorset where everyone has the opportunity to start well, live well, age well and enjoy healthy, thriving communities. This strategy is our shared roadmap towards that vision.

Introduction

Purpose Statement

This Health and Wellbeing strategy aims to establish the conditions for everyone in Dorset to live well by improving prevention-focused integrated care, strengthening communities, and supporting people to thrive at every stage of life. It focuses on the wider population to support healthier lifestyles, prevent future ill health, and remain independent. This strategy will complement the emerging NHS Neighbourhood Health Plan, which will focus on residents already dependent on health services and will support our shared commitment to working together to lead improvements in health and wellbeing in Dorset.

The national direction of travel, through devolution and the health bill, points towards local places working together with communities, making decisions on how best to commission services for local populations. This decision making is anticipated to be devolved to local health leaders, i.e. the Health and Wellbeing Board.

Ambition

The ambition set out in this strategy is to:

- ensure that every child has the best start in life through strong family support and high-quality early education,
- support people to live healthier and longer lives while reducing health inequalities,
- deliver integrated health and social care at a neighbourhood level.
- allow people to feel safe and included in their local community, and to take pride in their local area as a place where they can live well and thrive,
- enable everyone to achieve their full potential.

Health and Wellbeing Board

The board is a statutory partnership bringing together councillors and leaders from health and care agencies and the voluntary and community sector to address health priorities in a coordinated and integrated way.

It has statutory responsibilities to produce a Joint Strategic Needs Assessment, enable integrated health and care working, and produce a Joint Local Health and Wellbeing Strategy.

The partners on the board are: Dorset Council, NHS Dorset, Dorset Healthcare and Dorset County Hospital (NHS), Dorset Voluntary and Community Assembly, Dorset Police, Dorset and Wiltshire Fire and Rescue Service, Dorset Healthwatch, GP representatives.

Health and Wellbeing in Dorset

The Joint Strategic Needs Assessment (JSNA) brings together evidence on the health, wellbeing and wider needs of Dorset's population. It provides the evidence base for this strategy, ensuring that priorities, ambitions and actions are guided by evidence and responsive to the needs of local people.

The following diagram shows a snapshot of the picture in Dorset using data from the JSNA.

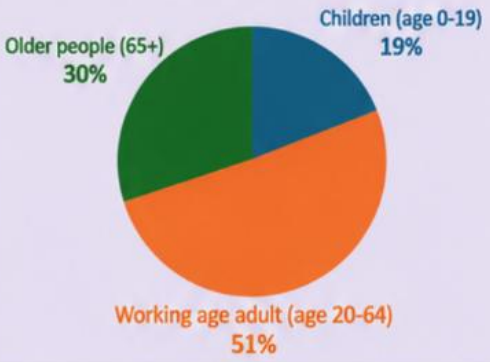
Dorset Data (from the published 2026 JSNA)

Dorset Council

GENERAL DATA

Population:
389,947 (2024)
increasing by **4%**
over the past decade.

POPULATION DISTRIBUTION



Dorset is less diverse than urban areas but is becoming more ethnically diverse. **6%** of residents are from minority ethnic backgrounds.

Over **1 in 25** residents in Dorset (around **14,300** people) live in areas ranked among the 20% most deprived in England. In contrast, **1 in 6** residents (approximately **62,500** people) live in areas among the 20% least deprived nationally.

START WELL

Childhood obesity is a persistent concern. In 2023/24, **24.7%** of Reception age children and **31.8%** of Year 6 pupils were overweight or obese.

Breastfeeding rates are above the national average: **75.8%** of babies in Dorset receive a first breast milk feed compared to **71.9%** nationally.

School readiness. In 2023/24, **71%** of children aged 2-2.5 years achieved a good level of development which is below the England average. Areas of lower achievement include fine motor skills and personal social skills.

LIVE WELL

In Dorset the percentage of patients with a depression diagnosis has been increasing since 2012 to **12.9%** in 2022/23 (similar to England) however new diagnoses appear to be declining.

The percentage of adults who are overweight or obese in Dorset is similar to the England average. However, at **62.4%** this is still high and has changed little over time.

Smoking is one of the main causes of health inequalities, with the harm concentrated in disadvantaged communities and groups. Smoking prevalence has been reducing in Dorset – currently **9.9%**. However, prevalence is higher among adults in routine and manual occupations (19.5%), adults with long-term mental health conditions (20.9%) and adults in substance use treatment.

Economically inactivity is **18%** of the working age population, and among them **32%** are classified as long term sick (highlighting major barriers to workforce participation). Financial stress is linked to poor mental health and lower engagement with preventative healthcare services.

Around **1 in 6 (67,000)** residents live with a disability that limits daily activity (5% aged 35-49 and 16% aged 75-84, over a third aged over 85).

AGE WELL

In Dorset people are generally healthier and live longer than the England average. Latest life expectancy data shows women live to approximately **84.5 years** and men **81.1**. The difference of life expectancy of **4.9 years** for men and **3.2 years** for women between the most and least deprived areas (2021-23).

Healthy life expectancy is an important measure of health and inequality. Men in Dorset will experience poor health for around **17 years** and women **20 years**. We know from national data that people in more deprived areas experience ill health at an earlier age.

Of Dorset's 60+ population, **10%** are frail. Of these **59%** are classed as having high frailty. Hip fracture numbers are similar to the national average, however the rate of hip fracture in ages 65+ are significantly higher in the most deprived area.

HEALTHY PLACES

Access to green space and nature is known to benefit physical, mental, and social health. Local analysis estimates that **51%** of people live within walking distance of space that is likely to provide access to nature.

The Local Environment score **(4.95)** in the Thriving Places Index for the Dorset area is close to the England average. Data used in the score include air and noise pollution, outdoor space access and flood risk. The Transport score **(3.74)** for Dorset is below average, reflecting challenges in active travel and car relance, collisions and travel time to services.

Fuel poverty affects an estimated **10%** of households **(around 18,000)** particularly those living in older properties with poor energy efficiency. Cold, inefficient homes common in rural Dorset contribute to respiratory and cardiovascular illness, frailty, and falls, particularly among older adults and those with long-term conditions.

Building the strategy with stakeholder engagement

To ensure this strategy reflects the priorities of Dorset's communities and partners, a series of stakeholder engagement workshops were held with representatives from Dorset Council, health services, the voluntary and community sector and wider system partners. The engagement process was designed to shape the strategy from the outset, helping to develop a collective vision for health and wellbeing.

There was a clear and consistent message from stakeholders that improving health and wellbeing in Dorset requires a greater focus on prevention, early intervention and the wider determinants of health (such as housing, employment and access to green space). Stakeholders highlighted the importance of designing services around what matters most to residents, strengthening communities and the voluntary sector, and creating simpler, more integrated systems with shared outcomes and accountability. Collectively, the engagement has reinforced the need for a person-centred, community-enabled approach that supports people to live well, age well and feel valued, while tackling inequalities and improving the quality of life for all Dorset residents.

This strategy and outcomes framework incorporate council objectives, NHS goals and the aims of the community and voluntary sector, reinforcing the shared commitment to integrated support in the partnership.

National Context - Changes in Health Policy and Legislation

The strategy is influenced by the changing national policy relating to health and wellbeing. An important part of this is the Health Bill currently going through Parliament. At the time of writing (October 2026);

- The Health Bill proposes to abolish NHS England (NHSE), transferring its functions to the Department of Health and Social Care and the Secretary of State. This represents a significant restructuring of NHS governance, intended to simplify accountability, strengthen national oversight and support the Government's neighbourhood-based model of care.
- A major policy theme is place-based care, with Integrated Care Partnerships (ICPs) and their integrated care strategies being abolished and replaced by a new Neighbourhood Health Plan framework.
- The Bill also aims to strengthen collaboration between health and care partners, improve data sharing, and support efforts to reduce health inequalities.
- It intends to devolve decision making to local health leaders, i.e. the Health and Wellbeing Board

The bill's provisions align with the NHS 10 Year Health Plan (2025), which sets out a vision for a more preventative, community-based and person-centred health system. It

emphasises a shift from hospital-based, reactive care to local, neighbourhood health models and the importance of co-production, partnership working, and valuing community insight.

The national plan provides a clear framework to support Dorset in delivering a more integrated, sustainable, and person-centred Health and Wellbeing Strategy. The emphasis on partnership working, shared accountability, and the role of the voluntary and community sector (VCSE) as equal partners also reflects Dorset's approach to moving resources upstream into prevention and building stronger, more resilient communities.

Local context – system partners' priorities

Dorset Council's priorities include making prevention a defining principle of how Dorset Council operates, reducing future demand and achieving better outcomes, as well as recognising the need to work differently with partners and communities.

NHS Dorset's priorities include targeting prevention, proactive care and earlier intervention in neighbourhoods to deliver radically different models of care and support, and ensuring delivery is through neighbourhood care, with high-functioning Integrated Neighbourhood Teams.

Vision, Mission and Aims

Vision

Strong communities, healthy lives

Dorset will be a county where people can live well - for longer: independent, connected, healthy and active within their communities; where support is available before crisis occurs; where care is delivered locally and personally when needed; and where more people are enabled to remain in their own homes and communities throughout later life.

Mission

Dorset will take a whole-system, long term approach to supporting health and wellbeing, rooted in homes, places, relationships, health, care, income, transport, technology, information and community life. This will help people live well, maintain independence, prevent future ill health, and delay or reduce the need for formal care.

Overarching aims

To achieve our vision, partners across Dorset will work together to:

- **Improve the health of the population:** Support people to stay physically, mentally and socially well through prevention, early intervention and community-based support. Including addressing the wider determinants of health such as housing, education and social support.
- **Reduce health inequalities:** Address the unequal factors that affect health and wellbeing, ensuring everyone has the opportunity to live a healthy and fulfilling life.
- **Integrate health and care services:** Create joined-up, person-centred services that are easier to access and closer to home, improve experiences of care and support people to remain independent. Prioritise community-led approaches central to the design of services.

This vision, mission and aims are supported by the following principles of working together as an integrated system:

1. **People First-** Focus on what matters to people, not just what is the matter. Meet basic needs first and recognise lived experience.
2. **Communities as Equal Partners-** Communities lead, shape, and co-design solutions. Build on local strengths, relationships, and assets.
3. **Local by Default-** Decisions and priorities shaped at neighbourhood level. Solutions tailored to Dorset's diverse places
4. **Simple & Joined-Up-** No wrong door. People are guided, not passed around. Clear, accessible information and seamless support
5. **Prevention & Wellbeing-** Act early to keep people well. Prioritise connection, belonging, and independence.
6. **Inclusion & Equity-** Actively reduce inequalities and remove barriers. Ensure everyone can access and benefit from support.
7. **Collaboration & Shared Responsibility-** One system, one purpose, shared accountability. Organisations, communities, and individuals working together
8. **Sustainable & Long-Term-** Invest in what works over time. Value both large-scale change and small, meaningful impact.

Strategic Outcomes Framework

The strategy is framed around four strategic outcomes based on life stages. This provides a structured approach to cover outcomes and priorities across multiple partners and allows for a common language and structure for measuring progress. It is better to focus on a few strategic priority outcomes well, than tracking lots of outcomes ineffectively.

1



Start Well

Children, young people and their families are healthy, thriving and resilient. They feel safe and connected to their community.

We support the development, wellbeing and physical and mental health of young people, from early childhood to adulthood, supported by strong, confident families.

2



Live Well

People can live healthy, fulfilling and independent lives, with support in the community to improve wellbeing.

We work to reduce health inequalities across Dorset, making it easier for adults to stay physically and mentally well, prevent long-term illness and get help early when they need it

3



Age Well

Older people live independently, with dignity and choice, supported to stay well in their own homes and communities.

We help older adults to maintain their independence for as long as possible, preventing unnecessary hospital stays and ensuring care is centred around what matters to them.

4



Healthy Places

Our neighbourhoods are safe, inclusive and connected, with access to nature, making healthy living easier for everyone.

We create and look after local environments that support health, ensuring safe streets, accessible green and blue spaces and strong community connections.

Start Well

Outcome:

Children, young people and their families are healthy, thriving and resilient. They feel safe and connected to their community.

We support the development, wellbeing and physical and mental health of young people, from early childhood to adulthood, supported by strong, confident families.

Ambition:

Strengthen early child development and health through improved family support, supportive friendships, role models and achievement at school to give children in every part of the county the best start in life.

Strategic Focus:

- Early years development
- Youth mental health
- Family resilience
- Making healthier choices

Measures:

- School readiness
- Rates of childhood obesity
- Children's mental health wait times and outcomes

Delivery group programmes:

- Best start in life
- Neighbourhood Health

Relevant policies and strategies:

- Dorset's Best Start Local Plan 2026 to 2029 - Dorset Council
- Dorset SEND strategy 2024 to 2027 - Dorset Council
- Placement Sufficiency Strategy for Children in Care and Care Leavers 2024 to 2027 - Dorset Council
- Birth to Settled Adulthood (B2SA) - Dorset Council

JSNA Evidence

- **Childhood Health:** Dorset's children generally have good health outcomes, but significant inequalities emerge early in life. The JSNA highlights that in 2023/24, only 71% of children aged 2 to 2.5 years achieved a good level of development, which is below the England average, while 67.4% of children achieve a good level of development by the end of Reception, matching the national average. Childhood health challenges include 24.7% of Reception-aged children being overweight or obese, 14.4% of 5-year-olds experiencing visible dental decay, and declining childhood vaccination rates, with only 67.4% of children in care up to date with immunisations.
- **Education, Skills & Learning:** While overall school readiness in Dorset is 67.4%, achievement falls to just 46% for children eligible for Free School Meals (FSM), demonstrating a substantial disadvantage gap. School attendance also remains a concern, with 7.9% of half-day school sessions missed in 2023/24, significantly higher than pre-pandemic levels and above national trends.
- **Childhood Vaccinations:** Vaccination uptake in Dorset has been declining, with coverage for school-age children at or below the England average, and immunisation rates for children in care notably low, with only 67.4% up to date in 2023/24.
- **Oral health and obesity:** 24.7% of Reception children are overweight or obese, with the prevalence remaining persistently higher in more deprived areas. Furthermore, 14.4% of 5-year-olds had visually obvious dental decay in 2023/24, and hospital admissions for dental decay and gum disease have been increasing.
- **Maternal and infant health:** On a positive note, infant mortality is similar to the national average, and Dorset performs well in early nutrition, with 75.8% of babies receiving a first breast milk feed compared to the national average of 71.9%.

Live Well

Outcome:

People can live healthy, fulfilling and independent lives, with support in the community to improve wellbeing.

We work to reduce health inequalities across Dorset, making it easier for adults to stay physically and mentally well, prevent long-term illness and get help early when they need it

Ambition:

People live healthier lives for longer, and health inequalities are reduced.

Strategic Focus:

- Adults' prevention
- Reducing health inequality gaps
- Healthy lifestyles
- Learning disabilities

Measures:

- Making healthy life choices (smoking, physical activity, alcohol harm rates)
- Rates of preventable long-term conditions
- Adult mental health wellbeing scores
- Improved community cohesion

Delivery group programmes:

- LiveWell Dorset
- Neighbourhood Health
- Physical Activity

Relevant policies and strategies:

- Public health vaping position statement
- Physical Activity Strategy

JSNA Evidence:

- **Life expectancy gaps:** Although Dorset generally has high life expectancy, there is a clear social gradient. There is a life expectancy gap of 4.9 years for men and 3.2 years for women between the most and least deprived areas, driven heavily by heart disease, cancer, and circulatory diseases. Furthermore, men in Dorset experience poor health for around 17 years of their lives, and women for 20 years.
- **Preventable lifestyle factors:** Across Dorset, 62.4% of adults are overweight or obese, and 22% are physically inactive. While smoking prevalence is 9.9% overall, it is disproportionately higher among adults in routine and manual occupations (19.5%) and those with long-term mental health conditions (20.9%). Social isolation and loneliness also remain significant factors affecting wellbeing, particularly in rural communities.
- **Rising multiple long-term conditions (LTCs):** Over 150,000 residents live with two or more long-term conditions. For example, 19% of patients have hypertension (with many more undiagnosed), which often presents alongside comorbidities like depression and diabetes.

Age Well

Outcome:

Older people live independently, with dignity and choice, supported to stay well in their own homes and communities.

We help older adults to maintain their independence for as long as possible, preventing unnecessary hospital stays and ensuring care is centred around what matters to them.

Ambition:

Residents experience joined-up health and social care services at a neighbourhood level.

Strategic Focus:

- Ageing at home
- Dignity
- Frailty prevention

Measures:

- Healthy life expectancy
- People remaining independent in their community for longer, reducing engagement with NHS and social care
- Social isolation and loneliness metrics for older adults
- Dementia diagnosis rates and support quality
- Trips and falls avoidance

Delivery group programmes:

- Neighbourhood Health
- LiveWell Dorset
- Age Friendly Dorset
- Future Care
- Better Care Fund
- Thriving Communities

Relevant policies and strategies:

- A Better Life for Adults in Dorset 2023 to 2028
- A Better Life for Carers in Dorset 2023 to 2028
- Nutritional Care Strategy
- Dorset's Extra Care Housing Strategic Statement 2024 to 2039

JSNA Evidence:

- **Our Population:** Dorset has one of the oldest populations in the country and is ageing further. By 2028, around 33% of residents will be aged 65 and over. Currently, approximately 10% of people aged over 60 are frail, meaning they are less able to cope with illness or everyday challenges due to declining physical, mental or social resilience. Over a third of those aged 85+ experience significant ill health or disability that restricts daily living.
- **Reliance on unpaid carers:** Nearly 10% of the population (35,505 people) provide unpaid care. Current pressures on public services mean reliance on these carers is growing, yet people providing high levels of unpaid care are more likely to report poor health themselves.

Healthy Places

Outcome:

Our neighbourhoods are safe, inclusive and connected, with access to nature, making healthy living easier for everyone.

We create and look after local environments that support health,

ensuring safe streets, accessible green and blue spaces and strong

community connections.

Ambition:

People feel safe and included in their local community and are satisfied with their local area as a place to live.

Strategic Focus:

- Environment and setting
- Air quality
- Access to green/blue spaces
- Active travel
- Physical activity
- Community safety

Measures:

- Residents with easy access to quality outdoor, community, recreation and leisure spaces, within a 15-minute walk
- Perceptions of safety and local community strength
- Physical activity groups
- Fuel poverty rate

Delivery group programmes:

- Thriving Communities

- Active 4 Health
- Movement for Movement
- Live Well Dorset

Relevant policies and strategies:

- Community Safety Plan (CSIP) 2020 to 2026 (2024 refresh)
- Bournemouth, Poole and Dorset Local Transport Plan 3
- Natural Environment, Climate and Ecology Strategy 2023 to 25 Refresh
- Housing Strategy January 2024 to January 2029 - Dorset Council

JSNA Evidence:

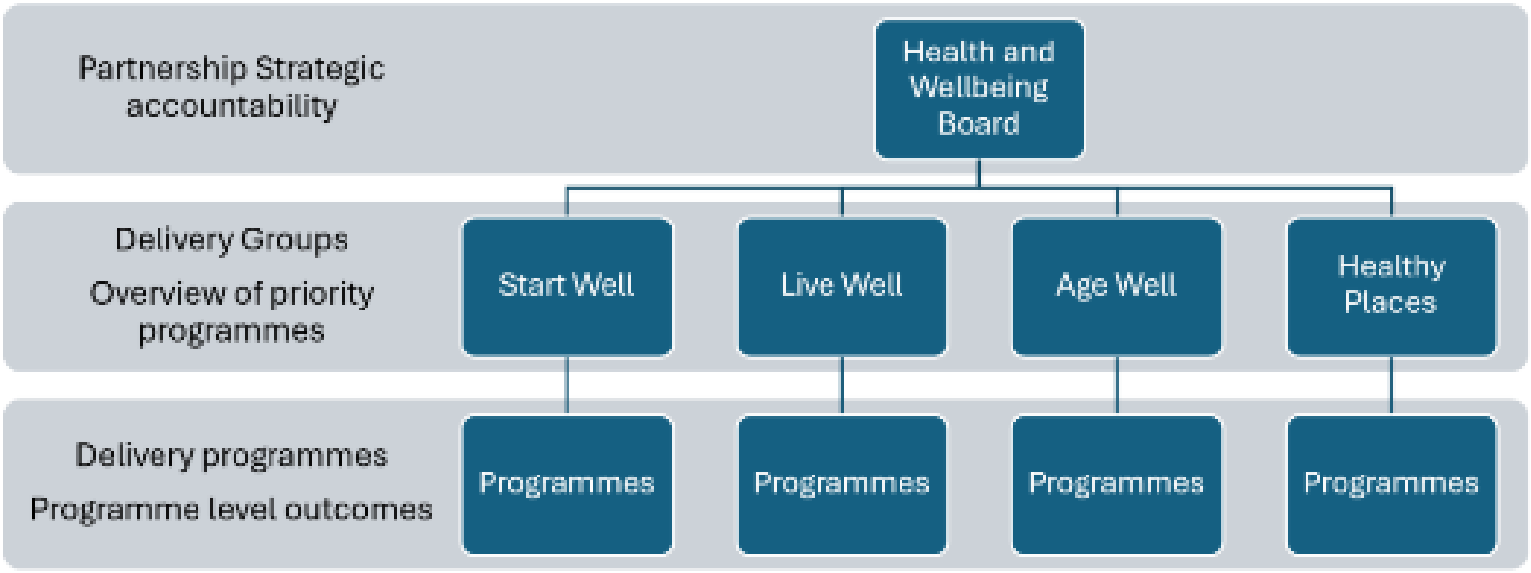
- **Environment:** Rurality presents a significant challenge for Dorset residents. The county has 51 Lower Layer Super Output Areas (LSOAs) that fall within the 20% most deprived areas nationally for access to housing and essential services. Dorset's transport score in the Thriving Places Index is below average due to this car reliance and long travel times to services. Long travel distances, limited public transport and reliance on private vehicles can restrict access to healthcare, employment and community support.
- **Deprivation:** Around 10% of Dorset households (approximately 17,800 households) experience fuel poverty, while the cost-of-living crisis is increasing financial hardship, reliance on foodbanks and health inequalities. Deprivation is strongly associated with poorer physical health, lower educational attainment and reduced life expectancy. For instance, cold, inefficient homes contribute to respiratory illness, frailty, and falls, particularly among older adults.
- **Social isolation:** The JSNA highlights that social isolation and loneliness have detrimental effects on physical and mental wellbeing. Due to rural barriers, residents have expressed a strong need for localised access to services through community hubs and outreach clinics, as long travel distances negatively impact those without transport.

Leadership and Accountability

The Health and Wellbeing Board is responsible for providing strategic oversight and accountability for the outcomes and overarching aims. It will do this by strengthening the partnership, committing to working more closely with our communities, and using data and insights in planning and decision making. The board will ensure that its business supports the achievement of the outcomes.

The board will hold itself to account through an annual review and refresh process, assessing and measuring progress towards the strategic outcomes and updating the direction for the following year. There will be ongoing engagement sessions at least annually to ensure the outcomes reflect the needs of residents and partners.

While the Health and Wellbeing Board will provide strategic leadership and oversight, delivery of the strategy will be overseen by delivery groups aligned with the four outcomes. The delivery groups will be responsible for coordinating priority programmes and will report progress to the Health and Wellbeing Board to prompt discussion and development, allowing reflection and learning so the strategic outcomes can be refined over time.



Implementation

The four delivery groups aligned to the outcomes Start Well, Live Well, Age Well and Healthy Places will be the main mechanism for coordinating implementation of the major delivery programmes. They will report progress and risks back to the Board at each meeting. These groups are effectively the place-based partnership where the work will get done.

The groups will provide a structure for joining up activity, identifying opportunities for collaboration and ensuring delivery contributes to shared outcomes. Working together, Dorset Council, NHS partners, VCSE organisations and communities will support integrated care and neighbourhood-based models of delivery, creating a collaborative system focused on prevention and improved outcomes for residents.

The delivery groups will be led by senior officers in the partnership. Membership will be dependent on the scope of the programmes within them and will evolve as the work progresses. The groups are expected to be partnership based, representing the health and care system.

The delivery groups will be responsible for overseeing the main programmes and developing detailed performance measures, avoiding duplication of work.

These groups do not necessarily own the work of the delivery programmes but provide a clear reference point to join up related work, understand the added value of aligning partnership work and focus on the most important programmes that contribute to achieving strategic outcomes. Where there is a strong connection with work managed elsewhere, it helps to have awareness and understanding so that the Health and Wellbeing Board can support, advocate and champion relevant programmes.

Delivery model

The delivery groups will incorporate these key features in how the delivery will be managed (developed in the engagement sessions):

- Data-Informed but Community-Shaped
- Community-led and co-produced
- Services closer to home
- Local decision-making
- Neighbourhood health models
- Community hubs and local access points
- Integrated Neighbourhood Teams as a key delivery mechanism
- Coordinated, not duplicated, efforts
- Align and join up, so everyone works towards shared outcomes

A living strategy (Test, Learn, and Grow)

The strategy is intended to be a living document, providing a framework for the board to use a test, learn and adapt approach to assess impact, success, and identify areas for improvement. This includes building evidence as work develops, improving measures, and learning from good practice in other places. The board will promote discussion and development, allowing reflection and learning from good practice elsewhere so the strategic outcomes can be refined over time.

The strategy is not intended to cover everything we do across the partnership but will focus on key strategic priorities that deliver the agreed outcomes, with an awareness and connection to related work overseen elsewhere in the system.

The strategic outcomes reflect broad long-term measures while the delivery groups will develop more specific and short-term measures. These will reflect both health outcomes and wider community outcomes.

The Health and Wellbeing board will hold an annual review of the strategy and the outcomes, which will allow assessment of progress, celebrate success and identify where further attention is needed for the following year. The annual review process will also enable the strategic outcomes to be adapted to meet changes in context and goals.

The conditions for success are to maintain engagement, keep partners on track, and include all relevant programmes from constituent organisations in the delivery groups' scope of work.

Opportunities for system work

The strategy provides an opportunity to align activity and join up efforts, recognising that organisations in the system are already working in the same themes. The health and wellbeing board, with its coordinated delivery groups, will help prevent duplication and ensure everyone is working towards shared outcomes, coming together through the board to discuss and debate progress.

Some key opportunities for joined-up system working can be achieved through this strategy, these have been identified by system leaders and are as follows:

- **Community Data and Intelligence:** Consolidate community data and insights from various sources, including JSNA, DiiS, and community conversations, to inform commissioning and support local decision-making. Include new needs assessments from housing and supported housing in our system planning to help prioritise housing for those who will benefit most.
- **Align outcomes to key system programmes** through an updated

Health and Wellbeing Strategy. Stand up delivery groups for starting well, living well, ageing well and healthy places.

- **Develop an integrated commissioning strategy** that aligns Dorset Council changes with joint commissioning opportunities with health (children's, Better Care Fund, person-centred frameworks). This will include how we maximise return on spend to build community wealth and increase social value as anchors.
- **Physical Assets and Estates:** Strategic importance of reviewing and repurposing physical assets, including releasing underused buildings for housing or other community uses, and coordinating asset management between Dorset Council and NHS partners. Develop high-quality third spaces for work with our communities.
- **Develop a clear prevention offer** that can wrap around the Neighbourhood Health developments. This includes provision of effective voluntary sector support, through Thriving Communities, and council services to build health improvement capacity, like LiveWell Dorset.
- **Join up the learning from Future Care, Better Care Fund schemes, and Neighbourhood Health** into a place operational model that embeds prevention approaches, keeps people away from high-cost services, and living well in communities for longer. Address the future workforce needs of this model through change programmes like the Weymouth Multiversity proposal.

Appendix

Stakeholder Engagement and Insights

We took a deliberative approach to developing the strategy with input from partners and stakeholders. We held four sessions to discuss the key elements and gain insights that formed the basis for this strategy. We also looked at previous insights from residents and stakeholders in relation to health and care services, to avoid duplication of engagement.

Across the stakeholder workshops, there was consistent support for a strategy that:

- **Focuses on what matters to residents:** quality of life, independence and wellbeing.
- **Prioritises prevention and early intervention,** helping people stay well for longer and building resilience.
- **Strengthens communities,** investing in local capacity and VCSE partners.
- **Addresses the wider determinants of health,** including housing, employment, transport, environment and social inclusion.
- **Creates simpler, more joined-up services,** with shared outcomes, clear accountability and a "No Wrong Door" approach.

Overall, there was a clear message that delivery should build on existing programmes that share common characteristics: prevention, community-based support, holistic approaches and trusted local relationships. Participants also highlighted the need for stronger governance, better data sharing, improved collaboration across organisations, and success measures that focus on outcomes such as quality of life, belonging, purpose and community connection.

NHS Dorset Insight review

NHS Dorset carried out a review in 2025 of recent engagement reports to consolidate findings of what people are telling us in the health and care system. It is important not to duplicate engagement already done, provided it is still relevant, and it is important to reflect the views and priorities of our communities in the strategy. The overall themes were identified as follows:

- Integration and joined-up working
- Voluntary and community sector and social connection
- Prevention and early help
- Inequalities and inclusion

- Digital inclusion and choice
- Mental health and wellbeing
- Access and barriers to services
- Communication and information
- Workforce and relationships
- Wider determinants of health

JSNA forward plan (agreed at HWB March 26)

- **26/27:**

1. Work and Health
2. Healthy Life Expectancy
3. Annual Narrative update

- **27/28:**

4. Prevention across the life course
5. Community voices and local insight
6. Annual Narrative update Notes

- **Longer term:**

7. Integration and service transformation
8. Community wellbeing

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Health & Wellbeing Board
18 November 2026
Rough Sleeping Programme
For Review and Consultation

Cabinet Member:
Cllr G Taylor, Housing & Homelessness

Local Councillor(s):

Senior Leadership Team:
S Crowe - Executive Director, Housing, Prevention and Communities

Report author and job title:
Email: Iain Sim, Interim Corporate Director for Housing

Statutory Authority: Dorset Council

Report status: Public Choose an item.

1. Executive summary

1.1 The Government has recently launched the national **Rough Sleeping Programme**, delivering the Prime Minister's commitment to end rough sleeping and ensuring that everyone sleeping rough has access to a route off the streets before Christmas 2026.

1.2 The programme combines immediate interventions with a longer-term commitment to settled accommodation and intensive wraparound support for people experiencing the most entrenched forms of rough sleeping.

1.3 Dorset Council has already established a multi-agency response involving housing services, voluntary and community organisations, outreach providers, substance misuse services, and mental health services.

1.4 This partnership approach recognises that rough sleeping is not, just, a housing issue as individuals often have a range of complex needs, poor physical and mental health outcomes, social exclusion, and reduced life expectancy.

1.5 The immediate priority is to ensure that anyone sleeping rough in Dorset can access appropriate accommodation and support this winter, whilst developing sustainable pathways into longer-term housing solutions. Alongside this, work is underway to review the level of local need,

strengthen partnership arrangements, and explore opportunities for additional accommodation and support provision through future programme funding.

1.6 We believe that The Health and Wellbeing Board has a key role in supporting this agenda through system leadership, promoting collaboration across agencies, and ensuring rough sleeping remains a shared priority across, housing, social care, and health services.

1.7 This report provides an overview of the Government programme, outlines work undertaken by Dorset Council and its partners to date, and seeks the Board's support in promoting a coordinated, whole-system response to rough sleeping across Dorset.

2. **Recommendation(s)**

The Health and Wellbeing Board is asked to:

2.1 Note the Government's national Rough Sleeping Programme and its ambitions to provide an immediate route off the streets and longer-term settled accommodation for people experiencing rough sleeping.

2.2 Note the work already underway across Dorset Council and partner organisations to develop a coordinated local response.

2.3 Recognise rough sleeping as a significant health and wellbeing issue requiring sustained multi-agency collaboration.

2.4 Support partnership working across housing, health, social care, voluntary and community sector organisations to maximise opportunities arising from the programme.

2.5 Champion a prevention-focused approach that seeks to address the root causes of rough sleeping and homelessness.

2.6 Consider whether this Board should form part of an active governance structure, in particular, this initiative could sit very well as part of the role of the Healthy Places Subgroup, which could receive regular updates on progress and partner involvement.

3. Reason for the recommendation(s)

3.1 Rough sleeping has significant impacts on health, wellbeing, community safety, and wider public services. Individuals who sleep rough frequently experience multiple disadvantages, including poor physical health, mental ill-health, substance dependency, trauma, and social isolation.

3.2 The national Rough Sleeping Programme presents an opportunity for Dorset to strengthen existing partnership arrangements, improve outcomes for residents experiencing rough sleeping and secure additional investment to support both immediate and long-term solutions. Endorsement from the Health and Wellbeing Board will help reinforce the importance of a joined-up system response and ensure that health inequalities associated with rough sleeping remain a strategic priority

4. The report

4.1 Local Position

4.2 Dorset Council has a strong track record of partnership working to prevent and reduce homelessness and rough sleeping. Through commissioned outreach services, voluntary sector provision, housing advice and support services, the Council and its partners have continued to engage with people experiencing rough sleeping across the county.

4.3 Whilst overall numbers remain relatively low compared with many urban authorities, individuals sleeping rough in Dorset often present with complex and multiple needs requiring coordinated intervention from a range of services. Access to affordable homes, mental health support, substance misuse treatment, and community-based support remain key challenges. It is also important to note that the pathway may not always be about the provision of a general affordable home, but, instead, a range of different types of accommodation as needs change.

4.4 Multi-Agency Partnership Response

4.5 In response to the national Rough Sleeping Programme, Dorset Council and partners have already undertaken significant preparatory work to establish our approach to the Governments stated policy objective.

4.6 The work has focused on increasing assessment, outreach, prevention, and accommodation capacity to ensure that people sleeping rough can be identified quickly and supported into suitable accommodation.

4.7 Key elements of the Dorset response developed to date include:

4.8 Establishment of a multi-agency Rough Sleeper Taskforce bringing together housing, outreach, and voluntary sector partners.

4.9 Development of a Night Assessment Centre model, supported through additional staffing and accommodation resources, based at “The Bus Shelter” in Weymouth.

4.10 Expansion of outreach and navigator capacity through partnership working with Alongside and other commissioned services.

4.11 Creation of specialist rough sleeper housing casework capacity within Dorset Council to go beyond traditional homeless case management, focusing on securing and sustaining permanent accommodation outcomes and supporting move-on arrangements.

4.12 Investment in prevention activity, including dedicated prevention worker capacity through the Lantern Trust.

4.13 Enhanced partnership arrangement with The Bus Shelter to strengthen emergency accommodation and out of hours support provision.

4.14 Provision of rent in advance and personal budgets to increase access to accommodation within the private rented sector.

4.15 Identification of accommodation capacity, staffing requirements and funding proposals to support delivery of the programme.

4.16 In September Dorset was allocated £1.1m of Government funding over three years to implement the programme. £703k in revenue and £438k in capital. The initial Dorset proposal outlines, initially, c£252,000 of revenue investment requirements across staffing, accommodation, and prevention activity, together with contingency provision to respond to emerging needs. The Government has now announced via a letter from the Deputy Prime Minister to Local Authorities, that the National Allocation will be doubled, with a clear expectation that a range of key partners are required to work together to provide long term solutions to Rough Sleeping. This additional funding will be made available from 2027/28. Dorset, has not, at the time of writing this report, been made aware of the revised funding.

4.17 We are working closely with MHCLG and are required to submit out final proposals for the initial phase (Routes off the street by Christmas) by 1st December.

4.18 This work provides a strong foundation for Dorset’s participation in the national programme and demonstrates the commitment of local partners to a coordinated housing-led approach.

5. **Accommodation Options currently being considered** A range of accommodation options will form part of the response.

5.1

Accommodation Type	Purpose	
Night Assessment Centre (The Bus Shelter, Weymouth)	Immediate assessment, stabilisation, and support planning	6
Bed & Breakfast Accommodation (Weymouth)	Emergency temporary accommodation	10
Spot Purchase Accommodation (Lyme Regis & Swanage)	Flexible emergency accommodation provision	3*
Private Rented Sector Tenancies	Settled accommodation supported by Rent in Advance and personal budgets	4
Direct Lets through Housing Register	Permanent accommodation solutions	9
Total Planned Capacity		**32**

*Subject to confirmation

6. Legal considerations

6.1 The final programme will be subject to MHCLG grant conditions.

7. Financial implications

7.1 The Government has indicated that funding will be made available to support delivery of the Rough Sleeping Programme, including immediate "route off the streets" provision and longer-term settled accommodation with intensive wrap around support. Dorset Council will continue to assess opportunities for external funding and will bring forward any specific financial implications as programme guidance and allocation arrangements become clearer.

8. Natural environment, climate & ecology implications

8.1 Not applicable

9. Well-being and health implications

9.1 People experiencing rough sleeping face some of the poorest health outcomes in society and often experience barriers to accessing mainstream healthcare services. Improving access to accommodation, healthcare, mental health support, and substance misuse services can significantly improve individual wellbeing outcomes, reduce health inequalities, and lessen demand on emergency and crisis services. The programme provides an opportunity to strengthen integrated support arrangements across Dorset.

9.2 Bringing this programme to the Health and Wellbeing Board is an excellent opportunity to raise awareness of the programme, but more importantly to seek the assistance and buy in of key partners in tackling this very complex and multifaceted client group. In this respect the support and involvement of partners outside of Dorset Council is a key requirement if we are to meet the long-term commitment to ending Rough Sleeping.

9.3 We are asking the Board, not just to note this report, but to consider how partners can get meaningfully involved and help plan what happens after Christmas, and the long-term wrap around support envisaged by the Government's guidance.

9.4 In addition, and to strengthen the partnership approach does the Board feel that it can form part of an active reporting and governance arrangement to ensure we do not lose sight of our objectives?

10. Other implications

10.1 Not applicable

11. Risk implications

11.1 HAVING CONSIDERED: the risks associated with this decision; the level of risk has been identified as:

Current Risk: Medium
Without effective partnership coordination there is a risk that opportunities presented through the national programme may not be fully realised, leading to poorer outcomes for individuals experiencing rough sleeping.

Residual Risk: Low-Medium
Risks can be mitigated through strong governance, effective partnership working, robust needs assessment and continued focus on prevention and early intervention. This version should fit well within Dorset Council's committee report format and position the Health and Wellbeing Board as a key strategic partner rather than the operational lead.

12. Equalities

12.1 The Government's Rough Sleeper Programme is designed to meet the short and long term needs of all people sleeping rough, irrespective of any characteristic that person may present as. The response in Dorset is geared towards a system which reflects those values and objectives. Due to the speed and changing nature of the funding and guidance Dorset has had to respond quickly to phase one of the programme and ensure partners are in

place to deliver this phase and seek approval from MHCLG by the 1st of December. A full EQIA will be produced as we fully develop our response and will be submitted in support of the wider programme.

13. Appendices

13.1 None

14. Background papers

14.1 The Rough Sleeping Programme - from the Government's GOV.uk website

15. Report sign-off

15.1 This report has been through the internal report clearance process and has been signed off by the Director for Assurance & Governance (Monitoring Officer), the Director for Resources (Section 151 Officer) and the appropriate Cabinet Member(s)

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Health and Wellbeing Board
18 November 2026
FutureCare Close Down Report
For Review and Consultation

Cabinet Member:
Cllr S Robinson, Adult Social Care & Health

Local Councillor(s):

Senior Leadership Team:
J Ingram - Director, Adult Social Care

Report author and job title: Dylan Champion FutureCare Programme Director

Email:

Statutory Authority:

Report status: Public Choose an item.

1. **Executive summary (maximum of 500 words)**

1.1 This paper presents the FutureCare Closedown Report for formal approval by partner boards across the Dorset Health and Care System. It summarises the outcomes of the eighteen-month transformation programme that concluded on 30 June 2026, designed to help more people avoid unnecessary hospital stays and regain independence sooner.

The report confirms that FutureCare has delivered measurable improvements in urgent and emergency care productivity, achieving £11.9 million in cumulative benefit and embedding annual operational savings of £26.4m at 30 June 2026. This follows a period of four months since February 2026 where operational savings have consistently been within a £4m variance of the achieved sum and within the £21m to £28m range set for the programme during the diagnostic but below the upper £28.4m stretch target set in the business case. It also highlights remaining challenges—particularly the high number of patients with no criteria to reside and gaps in commissioned intermediate-care capacity—and sets out four priorities for completion by March 2027:

- Establish and sustain a **Discharge to Assess Partnership**, which provides a mechanism for senior system leaders to continue working together, shape on-going change and ensure benefits are delivered;

- **Focus on securing the benefits that have already been delivered**, effective governance, processes and insight tools are in place to support this. Amongst competing priorities and pressures, focus will be required to ensure success;
- Use the resources that have been allocated to deliver an innovative and long-term solution to the **identified intermediate care commissioning gaps** which in turn will deliver better outcomes and fewer discharge delays for people, as part of a wider, agreed Intermediate Care strategy that also enables point 4 below, and further changes to bed based landscape;
- Address the **outstanding challenges with home-based intermediate care**, releasing and optimising core capacity in East Dorset and developing and resourcing an enhanced home-based intermediate care offer across both East and West Dorset.

The paper seeks board endorsement of these recommendations and recognition of the programme's contribution to system-wide improvement.

2. **Recommendation(s)**

- Approve the Closedown Report and its recommendations.
- Endorse continuation of Horizon 1 improvements through March 2027.
- Support commissioning of intermediate-care capacity to close identified gaps.
- Note the financial and operational benefits achieved to date.
- Recognise the need for sustained leadership focus and governance continuity.

3. **Reason for the recommendation(s)**

3.1 This report makes reference to a concluded piece of work. The work undertaken was delivered by partnership arrangements across the NHS in Dorset and Local Authorities in Dorset, Bournemouth Poole and Christchurch alongside Newton. This report therefore covers risks across those partnerships and at that time and does not cover the action, risks or activities that have taken place since the 30th June 2026.

3.2 Quality and Resource impact

- **Quality:** Average hospital stay reduced by one day; 10 % more people discharged home; 25 % higher reablement impact.
- **Resources:** £10 million cost removal across NHS and LA budgets.
- **Workforce:** Established transfer of care hubs and upskilled workforce through service improvement programme undertaken.
- **Data:** Single shared system-wide data view now enables real-time operation al insight.

4. The report

4.1 See attached Appendix1

5. Alternative options considered

5.1 N/A

6. Legal considerations

6.1 No direct legal implications. Future commissioning decisions regarding intermediate care and bed-based provision will require statutory consultation led by the ICB in line with NHS engagement duties.

7. Financial implications

7.1 Financial risk: Delivery of additional benefits inhibited by insufficient P1 capacity as understand at the time of the programme conclusion. Delivery of longer term

benefits may vary over time.

8. Natural environment, climate & ecology implications

8.1

9. Well-being and health implications

9.1 See report

10. Other implications

10.1

11. Risk implications

11.1 Having considered the risk associated with this decision, the assessment undertaken in accordance with Dorset Council's Enterprise Risk Management Framework is as follows:

The inherent risk position (before implementation of the decision) is Tolerance (Medium)

The inherent risk position (after implementation of the decision) is Tolerance (Medium)

As understood at the time of the conclusion of the work at 30th June 2026

- Sustainability risk: Reduction in ICB data-analytics capacity may undermine shared visibility tools.
- Commissioning risk: Lack of an agreed intermediate-care strategy delays bed-based reconfiguration.

- Operational risk: Persistently high NCTR levels at UHD and DCH indicate ongoing discharge delays.

Leadership risk: Organisational changes across partner bodies could weaken programme continuity

12. Equalities

12.1 An EQIAA has been completed and reviewed to inform the establishment of the Discharge to Assess Partnership – the next stage of the planned work.

13. Appendices

13.1 Appendix1 Full Report

14. Background papers

14.1 N/A

15. Report sign-off

15.1 This report has been through the internal report clearance process and has been signed off by the Director for Assurance & Governance (Monitoring Officer), the Director for Resources (Section 151 Officer) and the appropriate Cabinet Member(s)



FutureCare Closedown Report

July 26

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1. Executive Summary

The FutureCare programme set out, over eighteen months from January 2025, to help more people in Dorset avoid an unnecessary hospital stay or return home and regain independence more quickly, and in doing so to release bedded capacity, improve outcomes and deliver financial benefit across the system. This followed a diagnostic activity completed by Newton in the summer of 2024. It has delivered real and measurable improvement in the productivity of the urgent and emergency care system. It has not, on its own, yet delivered improvement of the scale Dorset needs to deliver the outcomes it aspires to for its residents, nor enough to enable the planned reconfiguration of hospital services at UHD. As the programme closes there is as much still to do as has been done, and this report summarises both what has happened, and what needs to happen next.

What was delivered

At the end of June 2026, the programme has delivered £11.9m of cumulative benefit and embedded the changes to achieve annual operational benefits of £26.4m. This follows a period since February 2026, when operational benefits have consistently been in the £21m to £28m range identified during the diagnostic, though below the £28.4m target set within the business case.

Improvement has been seen in each of the 11 tracked KPIs by which benefit is measured compared with the 2024 baseline, and approximately £10m of cost has been removed from the system across NHS and LA budgets. However, the anticipated reduction in NCTR ALOS across UHD hospitals has not been achieved and while the target NCTR ALOS reduction at DCH has been achieved this has been insufficient to consistently deliver the reduction in demand required to enable the current stock of beds to be sufficient without the regular use of escalation beds. Overall, the impact has therefore been that while some costs have been removed, the impact on system pressures has been less than anticipated.

Operationally two co-located Transfer of Care hubs and a system-wide Flow Team are established and operating. Across DCH and UHD, patients are spending a day less on average before being discharged. In UHD, SDECs are seeing 12% more patients every day, 3000 more each year. As a result of improved reablement capacity 10% more people are being discharged home following a stay in hospital in both East and West, and the impact of those reablement services is 25% higher, mitigating the need to commission more long-term home care hours for Local Authorities.

Most significantly for the long term, the system now has a single, shared view of its own data for the first time, replacing fragmented and incompatible local records. The programme SROs are unanimous that this shared picture, and use of it by their teams, is the programme's most important gain, and unanimous too that, against rising demand, the system would be in a materially worse position without the programme.

Challenges remaining, and why

The number of people in hospital and community beds with no criteria to reside remains high, higher than in neighbouring systems, and has risen since February across UHD. This is the programme's most consequential shortfall and reflects a structural gap that has not been possible to address solely through targeting efficiency improvements to existing services. The right community services, in particular specialist discharge to assess and home-based intermediate care capacity with the capability to deal with more complex needs, are not yet commissioned, so too many long-term care assessments still take place in a hospital bed and result in extended hospital stays, poor outcomes for patients and increased costs for LAs and the ICB as people's potential to regain their independence diminish.

Three further factors shape the perception of the success of the programme: the programme's targets were set to deliver an amount of benefits by a point in time, as part of a longer journey; they were not set to achieve a final level of ambition or to deliver a strategic milestone for the system such as to deliver the capacity for UHD's hospital move. There was also a decision not to reinvest benefit released in one part of the system in another part of the system to deliver additional benefits and this has limited the overall level of benefits that could be delivered. Finally, the volume and disruption of leadership change across the system has impacted on perceptions of the programme and its delivery momentum throughout it's duration.

What happens next

The system's senior leaders have agreed that the immediate priority for discharge within UEC is not a new transformation programme but the completion of what Horizon 1 began: a focused continuation to embed discharge to assess, finish the operational improvements, and recommission intermediate care to match need.

Section 11 sets out four key priorities for delivering the remainder of the Horizon 1 improvements which the system should aim to deliver by March 2027. They are:

1. Establish and sustain a **Discharge to Assess Partnership**, which provides a mechanism for senior system leaders to continue working together, shape on-going change and ensure benefits are delivered;
2. **Focus on securing the benefits that have already been delivered**, effective governance, processes and insight tools are in place to support this. Amongst competing priorities and pressures, focus will be required to ensure success;
3. Use the resources that have been allocated to deliver an innovative and long-term solution to the **identified intermediate care commissioning gaps** which in turn will deliver better outcomes and fewer discharge delays for people, as part of a wider, agreed Intermediate Care strategy that also enables point 4, and further changes to bed based landscape;
4. Address the **outstanding challenges with home-based intermediate care**, releasing and optimising core capacity in East Dorset and developing and resourcing an enhanced home-based intermediate care offer across both East and West Dorset.

2. Purpose of document

The purpose of this Closedown report is to provide an evaluation of the progress achieved through completion of the commissioned phase of the FutureCare Programme, which ended on 30 June 2026.

Producing a Closedown Report is a key deliverable for the Programme and identified in the Partnership Agreement which underpins the programme which was considered and agreed by Partner Boards in December 2024 and January 2025

Once agreed by the FutureCare Steering Group and presented to System Chief Executives for review, it will be presented in July and August 2026 to Partner Boards across the Dorset Health and Care System.

3. Programme summary

The FutureCare programme is a system wide end to end transformation programme with the aim of supporting more people to avoid a hospital stay, or to return home more quickly and to live more independently following a hospital stay.

The objectives of the programme are to improve people's lives by:

- Supporting more people to live independently at home
- Improving patient safety
- Deliver better, more person-centred care; and
- Deliver financial efficiencies.

The programme aims to reduce the requirement for bedded capacity across the Dorset health and care system to reduce system pressure, support the delivery of the ICS Operating Plan and to assist with achieving the reconfiguration of hospital services at UHD.

The programme also aims to deliver financial benefits to local authorities and healthcare partners and assist with reducing demand for long term care.

4. Background and strategic fit

The aims of the programme were agreed following a diagnostic review which was undertaken in July 2024. It was to improve outcomes for people and in particular people like Nancy, who interact with the Dorset health and care system and who with better processes and decision-making could have been supported to return home and regain her independence more quickly.



Nancy's Story

Nancy lived at home, independently, with informal support from her sons, John and Stuart.

One Saturday morning, Nancy's son, John, visited her house and found Nancy suffering from breathlessness and a runny nose. As Nancy's local GP was closed due to the weekend, John phoned 111 and was advised to phone 999 so that paramedics could assess Nancy in her home. Services such as UCR and Virtual Wards weren't considered by 111.

Worrying that waiting for the ambulance was a waste of resources as he was able to transport Nancy, John chose to drive Nancy to hospital. John wasn't made aware during his interactions with 111 and 999 that there were services available in the community to diagnose and treat Nancy at home.

Nancy was assessed in ED and even though it was decided that only a period of observation and a prescription of antibiotics was required, ED chose to admit Nancy onto a specialty ward. Services such as Virtual Wards/AHAH and SDEC were not consulted about whether Nancy would be suitable for referral.

Nancy was deemed medically fit for discharge after 7 days and returned home.

> **This lady could have been turned around before even reaching A&E and instead she's had a week-long stay in hospital.**
>
> – Consultant Practitioner during case reviews

As well as providing an evidence base to support the design of the programme the diagnostic also identified that Dorset pathways and services have evolved to create a complex system for people and staff to navigate and that with greater insight and through collaborative working outcomes for people could be improved. It also identified:

- Too many people spend more time in hospital than they need to;
- Short-term care in the community is provided across many different services with too many handoffs;
- A high use of bed-based care with varying levels of support;
- Many older people could reduce or avoid the deconditioning that has an impact on their independence and long-term care needs if better processes and joint working was in place.

5. Vision and objectives

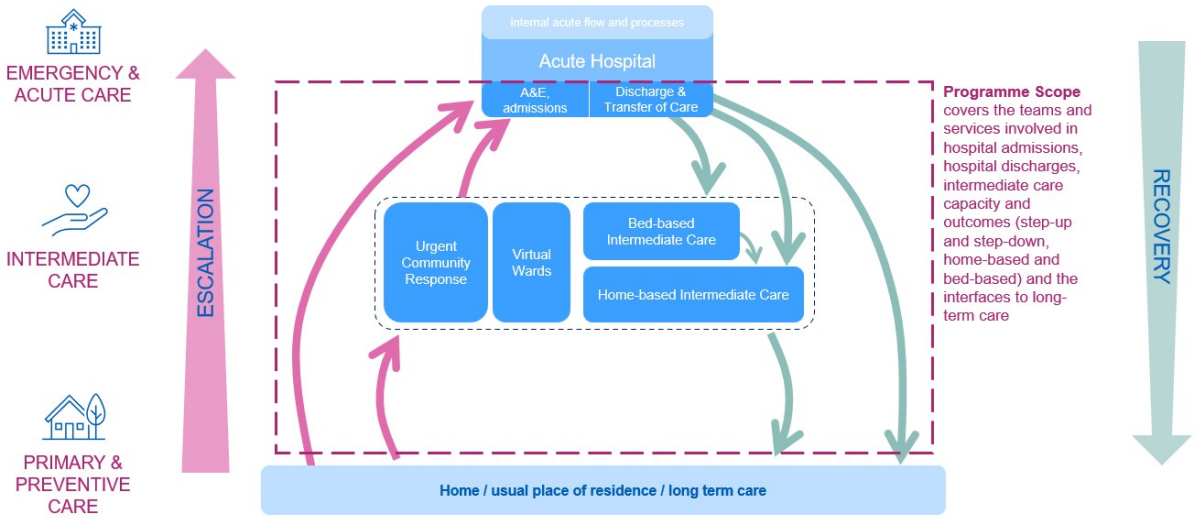
The vision set for the FutureCare programme was to achieve the best possible improvements in people's health and wellbeing; and to create strong partnerships, integration and shared goals across our health and social care organisations, voluntary organisations as well as with education, local businesses and crucially, with our local communities.

The objectives set for the programme were to improve people's lives by:

- Supporting more people to live independently at home
- Improving patient safety
- Delivering better, more person-centred care;
- Providing more reablement support for Dorset residents
- Releasing hospital bedded capacity and reducing unnecessary hospital stays
- Delivering financial benefits

6. Programme scope

The diagram below sets out the agreed scope of the programme. It was to undertake several inter-related workstreams which focused on improving urgent and emergency care pathways across Dorset, simplifying and accelerating patient journeys and using data and technology, different ways of working and learning and experience from elsewhere to deliver a step change in UEC pathways across Dorset.



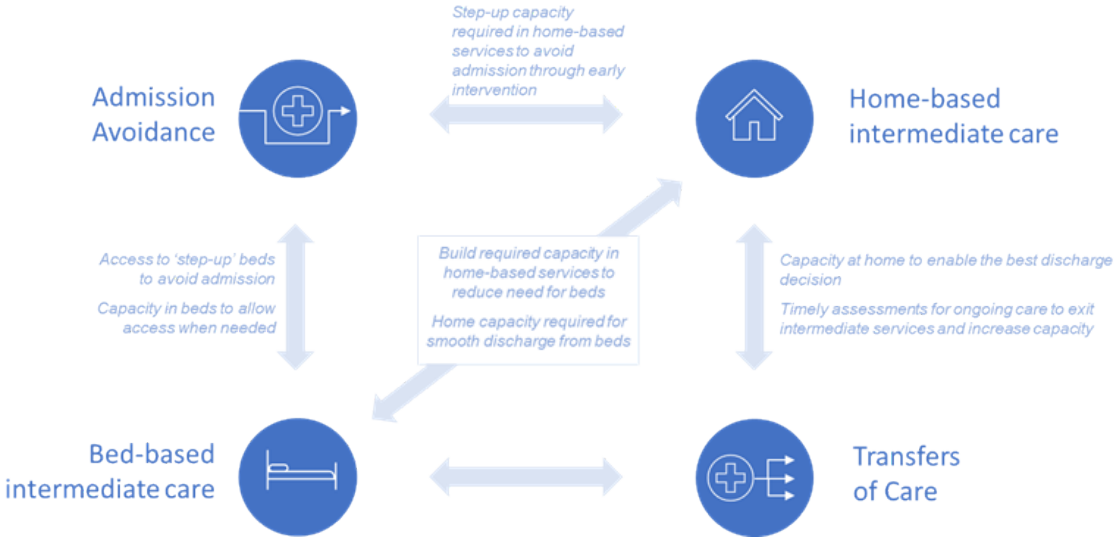
It was a time limited programme where a large amount of transformation support was provided over an eighteen-month period to deliver an agreed amount of operational benefit. From the outset it was recognised that the planned improvements would represent the first step in a longer journey and to achieve long term ambitions would require further work and a more fundamental reallocation of capacity and resources.

The transformation journey was driven by people's experience of health and care in Dorset and developing a clear understanding of those experiences will underpin the design and transformation process.

It was anticipated that 153 beds, across acute and intermediate care beds, would be released as a result of the programme by September 2026 and that this would enable health partners to remove this resource from the system without the requirement for an additional investment.

It was also anticipated that annual financial benefits of £11.2m per year would be released for local authorities by 2029/30, primarily by making home-based intermediate care services more effective, mitigating long term homecare hours, and delivering more benefit from the same amount of investment.

While there was some flexibility in the scope of the programme it was focussed around four key workstreams as set out below.



To support the overall change programme, two further enabling workstreams were set-up. These were:

- **System visibility and active system leadership.** This focussed on developing better data systems and business intelligence to identify where people are getting stuck in the system and to speed up decision-making. Data will also be shared so all partners can see a single version of the truth.
- **Change capability**. This focussed on creating the teams to support the change programme and providing the insight to support culture change and a different way of working across the health and care system.

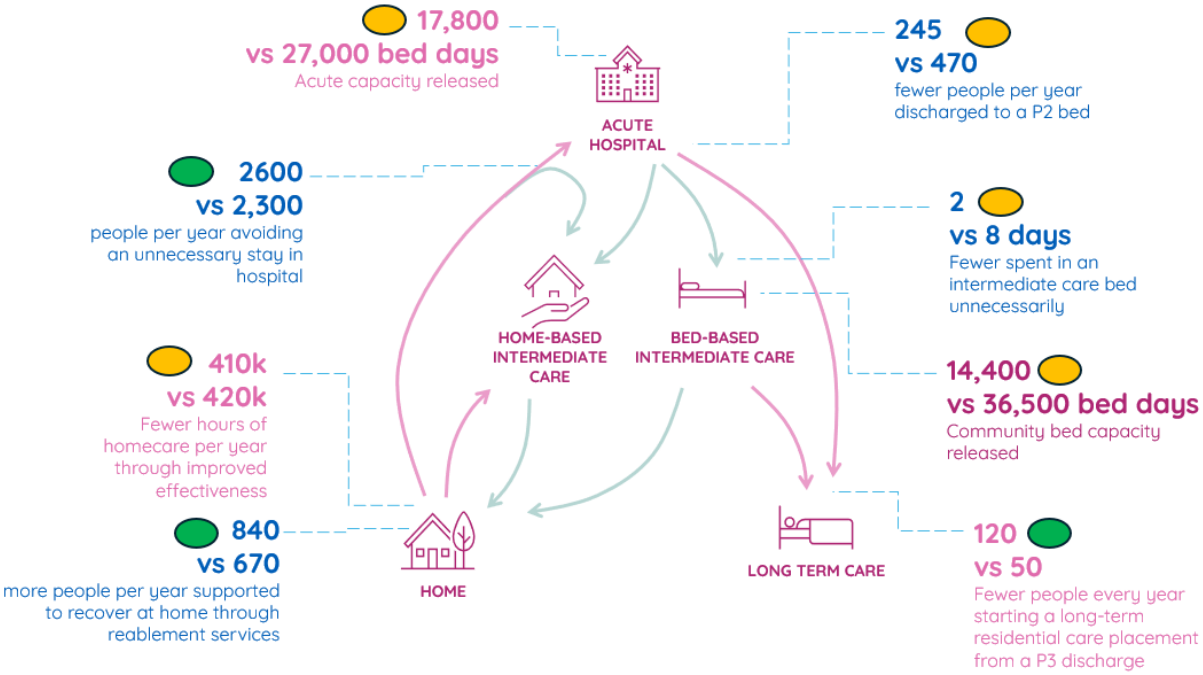
7. Delivery review

Overview

The FutureCare programme ran from January 2025 through to June 2026, a period of approximately eighteen months. At the point of close-out, all six workstreams had been completed and signed-off, though in some workstreams not all intended outcomes have been delivered, a workstream-by-workstream summary is provided here, and programme challenges are summarised in section 8. Consideration and options for sustaining improvement and ensuring the continued utilisation of the data and insight tools developed had also been provided.

While substantial and genuine improvement in the productivity of the Dorset urgent and emergency care system has been delivered, so far this has not been of a quantum to meet the ambitions of all partner organisations expected from the business case. In addition, compared to neighbouring systems, levels of NCTR and the number of long waiters across the system remains high. The journey to that outcome has also been more complex and taken longer than had originally been anticipated.

The diagram below provides an overview of benefits delivered. The first number presented against each outcome is the aggregate amount of operational benefit delivered over the first six months if 2026 (January to June), the second number is the amount of operational benefit anticipated at the end of the programme in the diagnostic exercise undertaken at the beginning of the programme. The financial benefits of this impact are described in detail in section 9.



Comparison of annual operational impact of changes, as of 2026 averages, compared to target business case impact.

Alternatives to Admission

Work across the admission avoidance workstream focused on improving the utilisation of existing step-up and same-day services, improving awareness of community alternatives among ED staff and wider system partners, and redesigning referral processes to make it easier to access the right service at the right time. Improvements were made to SDEC ways of working and efforts were made to shift the decision-making culture at the front door. While progress was made in redirecting more people away from unnecessary acute admissions, it struggled to set-up pathways to redirect to community services in DCH after patients had arrived at ED, one of the ambitions of the workstream, though a new triage function was set-up in UHD and has been successfully redirecting patients since going live last Autumn.

In UHD, there has been a 1% reduction in the number of patients being admitted to hospital despite a 7% increase in year-on-year demand in the past two years – see section 9. Along with re-design to SDEC services delivered by UHD, improvements to productivity in these services has contributed to a 12% increase in throughput – in excess of the 7% originally targeted. This means that, each year, 2-3,000 patients are being treated and discharged back to their own home on the same day – avoiding an unnecessary stay in hospital.

In DCH, a sustained 10% rise in attendances resulted in high pressures within ED, and over winter frequent bedding of the SDEC spaces available. These have reopened post peak winter pressures, and are performing above their baseline volumes, but the SDEC model remains an area of focus as DCH continues with their ED reconfiguration, which will be a critical enabler of maximising SDEC capacity and capability.

Transfer of Care

The transfers of care workstream tackled the delays that were keeping patients in acute hospital beds well beyond the point at which they were medically ready to leave. Work included implementing earlier discharge planning across acute sites, improving patient-level tracking, reducing triage and handover points in the discharge process.

A big success for the programme and the system was establishing two co-located Transfer of Care (TOC) Hubs and a system-wide Flow Team. In addition, trials have demonstrated a reduction in length of stay and increased discharges through optimising and standardising ward processes. This has been implemented and sustained within Specialist Medicine in UHD, with plans to roll this out across the rest of the Trust through its Clinical Vision of Flow programme.

Now the TOC hubs are fully operational and supported by tailored insight tools, the Dorset system is now ready for the next stage of transformation, looking fundamentally at related functions – discharge coordination, care allocation, brokerage, case management – to create a single system-wide approach, delivering faster and better discharges, with a more efficient and effective use of resources.

Progress was made in a number of these areas, and improvements to discharge processes and decision making contributed to the overall benefits position. However, this was also the area of most notable underperformance relative to expectations, namely in a sustained reduction in the NCTR number at both DCH and UHD. In DCH a significant reduction in NCTR LoS has been delivered, exceeding the target level (a 3 day NCTR LoS reduction from the baseline of 9.6 days, vs a target of a 2.2 day reduction), mostly driven by significantly reductions in the core P1 and P2 length of stays, and a 10-15% increase in the proportion of P1 discharges. P3 length of stay for the most complex patients remains too high in DCH (over 30 days on average). However, despite patients spending less time waiting to be discharged once medically fit, over the course of the programme DCH has seen a sustained 10% demand growth, which has largely offset any capacity created through NCTR LoS improvements and prevented realisation of capacity through bed closures.

The programme has not managed to sustainably decrease the NCTR LoS within UHD as seen in DCH, despite dropping below 9 days (from a baseline of 9.7) for 3 months at the start of 2026, it has since risen again and remains relatively close to baseline. This has stemmed primarily from a reduction in the available pathways for patients to be discharged to in the East, off-setting capacity created through LoS improvements to core provision. A key example was in P1, where an additional 400 hours of capacity was temporarily made available, which, combined with efficiency improvements within the rest of the provision saw a 50% reduction to P1 LoS and queue in UHD for a period. However, at the end of April the temporary capacity was removed, and a further 200 hours was removed due to lack of sufficient BCF funding, leading to a subsequent deterioration in performance.

Consequently in UHD, the NCTR number remains stubbornly high. Historically in each calendar year, the number of patients NCTR in UHD has averaged c. 200, with peaks in Winter which decrease through the year. In 2024, the average NCTR was 201 with a peak of 263. In 2025, the average NCTR was 198 with a peak of 250. Through 2025, this pattern again repeated, but the peak came sooner, averaging 210 in October 2025. This has remained higher for longer through 2026, with NCTR patients still at c.230 in June 2026. See the appendix for a full time series.

To achieve the target level of NCTR (<12% in Acute, <27.5% in intermediate care beds) across Dorset hospitals, the key challenge remaining is that commissioned solutions for all elements of intermediate care are not in place. In particular, assessment beds for people with complex discharge needs and the right specialist capacity (including night support) for people discharged home. The consequence of this is that for substantial numbers of people a long-term care assessment is taking place in hospital and this is delaying discharges and having a substantial impact on overall system flow. Late in the programme resources have been identified to address this but these are unlikely to have a significant impact until August/September 2026.

Bed-based Intermediate Care

Cross system working, co-designed solutions, and multiple waves of roll-out through summer 2025 has implemented new ways of working in BBIC. This includes formalised multidisciplinary team governance, SMART therapy goals, patient self-administration of medication, live ward visibility, weekly improvement cycles and a dedicated P2 Flow Lead. This resulted in open length of stay across all P2 sites held at or below 30 days from July to December 2025. Closed length of stay fell to below 32 days, against a 38.2-day baseline. However, since September 2025 there has been consistent deterioration of both Open and Closed LoS measures across the whole system average to around the baseline position. Primarily this has been due to social rather than clinical issues - the time taken to complete Care Act Assessments (CAAs), wait times for adaptations and equipment and housing issues – but also due to the timeliness of early discharge planning. NCTR, whilst not an original targeted measure for the programme, has also stayed above the 27.5% metric set out in the 26/27 operating plan with current performance around 40% for the last month.

In the last 3 months system partners have agreed discharge targets and initiated actions to reduce discharge delays caused by social issues. Commitment to move towards a discharge to assess approach should also reduce the number of CAAs being undertaken in intermediate care beds and thereby reduce average lengths of stay.

The longer-term position is constrained by a sequencing dependency: further P2 bed closures require additional P1 capacity to be in place first, and P1 investment depends on confirmed commissioning decisions from the LAs and the ICB. P1 starts in both East and West are currently below the level required to maintain sufficient flow, and recent decommissioning of P1 hours in the East has reduced flow further. Without addressing these gaps, diverting more patients from P2 into P1 is not viable, and the original ambition to decommission the full number of P2 beds cannot be delivered.

Making changes to the bed-based provision in a joined-up way across system partners – either to release savings or repurpose capacity - namely across the ICB, Local Authorities and DHC, has proven challenging, exacerbated by the lack of agreement up front in the business case on exactly how the workstream benefits would be realised across the 5 different providers offering P2 discharge services in 2024.

The consequence of this is that while 28 local authority provided beds have been decommissioned and 16 community hospital beds temporarily closed for safety reasons, the original target of releasing 80 beds worth of capacity has not been achieved. A decision on further or permanent bed closures remains outstanding and capacity is required from the ICB to facilitate a consultation process to support this in line with their statutory engagement duties It is recognised that a formal engagement or consultation process was outside of the scope of the BBIC workstream or the role of the provider to lead.

Mid programme, an intermediate commissioning group was established outside of the BBIC workstream, however ICB changes have meant this group has not concluded the work intended to be in scope. This includes development of an intermediate care strategy, which would be critical to addressing commissioned gaps, and forming the basis of any change and engagement programme with the public. It is likely that the any further intermediate care commissioning will be continued within West and East placed based partnerships, but while these are not in place, and a comprehensive intermediate care strategy is not agreed, further changes to the bed-based provision within Dorset will be difficult.

Home-based Intermediate Care

The home-based intermediate care (HBIC) workstream has delivered some of the most tangible operational improvements of the programme. The diagnostic highlighted improvements within three main reablement providers - Tricuro, Care Dorset and RCR – where new ways of working were embedded including SMART goal-based care supported by a Progression Tracker, structured MDT meetings with named accountability for actions, daily huddles supported by scheduling tools, and active leadership and improvement groups supported by performance dashboards. In addition, development of a digital P1 caseload list now enables full oversight of the live caseload.

In the West, process improvements have increased the pace of P1 discharges; including the introduction of daily meetings to better align capacity, set up of a hybrid push/pull P1 discharge model, alongside streamlined ways of working supported by a new digital tool. Through FutureCare, the time to complete reviews at the back-door of West P1 has halved after the process was fully automated. Some work remains to consistently stay above the target for reablement throughput sustainably. Across Care Dorset and RCR reablement services, 15% more people are being supported each week (and more in terms of total hours, as the average needs of individuals supported by these services has increased), utilising additional capacity created by reduced length of stay. Furthermore, the impact of the services has improved, with a further 1.5 hours of care mitigation (against a 4.5-hour baseline) for each person starting with reablement.

In the East, a package restart process and digital functionality have been established, speeding up discharges for those who have previously had packages of care, and a trusted provider e-form has been updated and launched to improve P1 back-door process time. Tricuro, the reablement provider run as a Local Authority Trading company, has seen a consistent reduction across the course of the programme, from around 30 days to below 22 days today, combined with additional improvements in utilisation and improved staffing, the service is supporting 50% more starts each week compared to in 2024. Effectiveness has also seen a 40% increase, driven by Tricuro supporting residents with more complex needs to maximise their independence, combined with changes to ways of working to use a new app-based progression tracker to ensure all individuals have the best chance at reablement.

Creation of an oversight forum of all P1 capacity in both West and East to continue to hold this reduction in length of stay was also overseen by the workstream, which is now run in joint partnership between the P1 flow team and senior commissioners from Dorset Council and BCP. Consequently the end-to-end length of stay on P1 dropped significantly across both East and West from above 26 days, to below 21 days – which is in line with national benchmarking for a well performing reablement service. However this model represents a considerable ongoing investment from these LA commissioners outside of their core responsibilities and over time should be handed over fully to the new Flow Team described in the Transfer of Care summary.

System Visibility and Active System Leadership

The system visibility workstream made important progress in building a shared data infrastructure across the system, drawing on the existing DiiS platform and working with BI and digital leads across partner organisations. A system-wide visibility tool, and operational visibility reporting suite were developed to provide a single source of truth for operations and performance, replacing the previous picture of fragmented spreadsheets, manual data collation and incompatible organisational systems and pulling them all together into a coherent suite of tools shared across organisations, and used to support all of the 4 delivery workstreams.

Governance structures were established around that data, or surfacing the right data into existing forums, to identify and take the right action rather than simply report on numbers. This workstream was foundational to the delivery of improvements in every other area, and its outputs represented a lasting change in how the system was able to see and manage itself. That said, the ambition of full real-time data sharing across all partner organisations proved difficult to achieve within the programme timescale, and the sustainability of the data infrastructure, and the analytical capability to support teams to take corrective action against the data, beyond the programme period remains an important consideration at close-out.

A particular risk to sustaining system visibility and delivering insight are planned changes to the ICB and the reduction in system DiiS capacity. Without continued support to the tools developed, and oversight of tool usage, there is a risk that the value of data and insight tools developed as part of the programme will deteriorate quickly.

Change Capability

The change capability workstream ran in the first 6 months of the programme, to support delivery workstreams to set-up and engage teams effectively, and to provide a lasting upskilling of the Dorset system's ability to manage and deliver system-wide change in the future. This included leadership development activity, change champion upskilling, coaching support for operational teams, and a dedicated programme academy delivered to all senior managers who were involved in the delivery workstreams as part of workstream engagement. After 6 months and initial deliverables met, the workstream was closed, with ongoing change activity with teams to be managed within the remaining delivery workstreams.

8. Key challenges faced

Full delivery of anticipated benefits, both in operational KPI improvement and financially, has been impacted by a number of factors:

Implementing Discharge to Assess

In Dorset a number of a factors combine to result in more than 50% of Care Act Assessments (CAA) resulting from a hospital admission taking place in an acute hospital or community hospital ward environment. This is contrary to national discharge to assess guidelines, results in poor outcomes for people and contributes significantly to levels of NCTR in acute and community hospitals.

	UHD	DCH	Intermediate Care Beds	At home (during reablement)	Total
%	**30%**	**10%**	**15%**	**45%**	**100%**
BCP	14	0	5	16	35
Dorset Council	4	10	5	16	35
Total	**18**	**10**	**10**	**32**	**70**

For those people where a CAA is undertaken in hospital, lengths of stay are much longer than where this is not the case. Over the last 3 months, if a person is on the core P1 pathway and does not require a CAA they will be discharged on average after 6.9 days, if a person is on the P1 non-core discharge pathway a CAA process is undertaken the NCTR ALOS was 21.8 days. Where a person requires a (P2) core intermediate care bed, the NCTR ALOS was 8.7 days. If it was identified that a P2 non-core bed was required and a CAA should be undertaken then the NCTR ALOS was 39.1 days.

As well as impacting on patient outcomes and on levels of NCTR, the number of CAAs undertaken and the length of time it takes also means that there are more long stayers in Dorset hospitals than other health systems. The table overleaf compares current Dorset performance with other systems in the South-West.

Feb 26	% NCTR after discharge	7+ LOS	14+ LOS	21+ LOS
South-West	18.6%	48%	28%	17%
Cornwall & IoS	15%	47%	26%	17%
Devon	13%	45%	24%	13%
Dorset	**22%**	**53%**	**33%**	**23%**
Gloucestershire	17%	49%	28%	16%
Somerset	25%	48%	29%	18%

Discharge Standards

Recently, as part of the FutureCare Programme, systemwide Discharge Standards have been agreed which when parters meet their agreed commitments will reduce the number of CAAs required and speed up the length of time it takes but four other issues also need to be addressed:

- P1 capacity in the east of the County
- ASC Productivity
- P2 ALOS
- Intermediate Care Commissioning Gaps

P1 capacity in East of County

Programme operational benefits peaked at the end of March but have since reduced following the removal of 400 hours of temporary P1 capacity in the East of the County, which, combined with efficiency improvements within the rest of the provision had resulted in a 50% reduction to P1 LoS and queue in UHD during the first three months of 2026. The deterioration in performance was compounded by the removal of a further 200 hours of temporary P1 capacity at the end of April.

The operational consequence of this is that the number of P1 discharges from UHD each week is between 8 and 15 below the weekly target of 68. This has contributed to NCTR levels at UHD increasing from a low of 125 at the end of February to more than 200 at the end of May. There are two options for addressing the shortfall of capacity in the East of the County:

- In the short term, additional capacity could be commissioned. £200,000 would provide sufficient capacity for a 12-week period to increase the number of P1 discharges per week by 8. This would enable the UHD position to stabilise and improve and also provide more time for required improvements in BCP ASC assessment processes to improve
- Medium term, there is an urgent need for BCP Council to release the substantial amount of P1 capacity with the provider Apex which is being utilised while long term care assessments are being undertaken.

Pathway 2 bed length of stay deterioration

Four key issues have led to 34-40% of total bed days being occupied by patients with NCTR in the first half of 2026, and subsequent increases in the ALOS across intermediate care beds:

1. Limited Social Care and Brokerage capacity. BCP CAA completion times have doubled from 16 to 33 days, and the team is operating at around 60% of full capacity. With 25% of P2 patients requiring ASC support, this group is now spending around 50 days in P2 beds at minimum.

2. Insufficient Housing provision. Around 10% of P2 patients require housing support, with average waits of 1–3 months. The impact is concentrated in LA P2 sites - at Coastal Lodge, current patients with housing delays have an average open length of stay of over 100 days.
3. Poor early discharge planning. Case reviews show that discharge requirements are frequently identified too late in the patient journey. Early referral work has been established in the acutes to address this.
4. Mismatch between current provision and patient need. Acute queues for un-commissioned P2 are growing despite reduced P2 occupancy, driven by gaps in bed type, clinical capability, and weekend admission flow. A clearer specification of what a Dorset P2 bed should deliver is needed, and any required commissioning follow – see section 11.

Intermediate Care Commissioning Gaps

Intermediate care commissioning gaps are currently resulting in very long stays for a significant cohort of patients and specifically, very long stays for people with delirium or dementia. Delays occur partly because short term support is not available but then because of the length of time it takes to complete a CAA in order to source long term care.

Focussing on the impact of the commissioning gaps on acute hospitals around 58 beds are occupied by people with no criteria to reside waiting for non-core services and subsequently requiring a CAA to be undertaken within hospital. The annual cost of operating these beds for the acutes is £7.4m.

Discharge Pathway	Beds occupied	NCTR ALOS (last 2 months)	No of patients/ year	Annual Cost	Cost per patient
P1 non-core	13	21.8	146	£1,660,750	£11,406
P2 non-core	24	39.1	224	£3,066,000	£13,712
P3	21	42.9	182	£2,682,750	£14,740
Total	**58**		**551**	**£7,409,500**	

Recently a £1.8m Business Case has been agreed by the ICB Cluster Investment Panel to address this challenge, and work is now underway to implement the proposed changes. It is anticipated that within a 3-month period there will be a significant reduction in the number of people waiting in hospital to be discharged with additional care needs.

Commissioning the necessary and appropriate short term care will deliver the triple benefit of delivering better outcomes for people, reducing lengths of stay in hospital and reducing the requirement for CAAs to take place in hospital. Freeing up ASC

resource should also speed up the completion of CAAs where they are required, in turn releasing P1 and P2 capacity.

ASC Productivity

Currently system flow and the release of P1 capacity to deliver reablement is heavily constrained by the length of time it is taking to allocate social work capacity to undertake Care Act Assessments and subsequently to complete them. This is particularly for the people who have completed their P1 reablement but are waiting for a social worker to be allocated. The table below provides a snapshot of the BCP Hospital Social Work caseload. Data in the same format is currently being built by Dorset Council, where similar challenges are recognised, and the timescales are indicative.

		Allocation	CAA	Brokerage
Service standard		3-3.5 days	7-21 days	2-5 days
UHD	# ongoing	5	43	8
	Ongoing time	7 days	31 days	10 days
	# completed/ week (4WMA)	13	27	7
	Avg. completion time (4WMA)	4 days	37 days	8 days
P2	# ongoing	5	19	1
	Ongoing time	9 days	38 days	132 days* (data skewed by 1 complex case)
	# completed/ week (4WMA)	5	7	2
	Avg. completion time (4WMA)	10 days	46 days	15 days
P1	# ongoing	25	30	4
	Ongoing time	10 days	18 days	19 days
	# completed/ week (4WMA)	12	21	7
	Avg. completion time (4WMA)	13 days	20 days	5 days

Recognising that improvements are required, both local authorities have committed to **allocating a social worker to undertake a CAA within 3.5 calendar days of referral** and to **complete the assessment in no more than 21 calendar days**. However, this will only be achieved when the overall requirement for CAAs is reduced and ASC resources can be released from acute hospitals in order to accelerate the completion of CAAs in P2/Intermediate Care beds and following a P1 reablement package, when a CAA is required.

Stakeholder turnover disrupted governance and momentum

One of the most disruptive and least predictable challenges of the programme was the degree of stakeholder change that occurred during delivery. Over the course of the eighteen months, most of the SROs and senior leaders, with the exception of the NHS Provider Trusts, who had been involved in commissioning, scoping and shaping the programme changed roles or responsibilities. The scale of that turnover had a material impact on governance, grip and the overall narrative around the programme in several ways.

Incoming leaders were not always fully sighted on the origins, rationale and agreed parameters of the programme. Relationships that had been built during the diagnostic and scoping phases had to be rebuilt. The shared understanding of what the programme was for and what it had agreed to deliver was less consistent than it had been at the outset, and momentum was consequently disrupted as key individuals moved on and their successors found their footing.

9. Provider performance wider performance context

The wider system performance is important to contextualise the challenges and benefits of the programme, so the three tables below summarise the overall high-level changes in activity level which have occurred during the lifetime of the FutureCare programme within DCH, UHD and DHC. The 8 weeks leading up to the end of June in 2026 are compared with the same period in 2024 (during the programme baseline period), to enable like for like comparison of the same period – though there are notable variances across the year. The detailed time series charts for UHD and DCH are presented in the appendix for reference.

In DCH, the number of attendances and admissions has risen by approximately 10%, with a 15% rise in the number of complex (P1-3) discharges. In spite of that, the number of patients NCTR on Pathways 1-3 has remained stable.

Variable	Current 8WMA 22/06/26	Same time period 2024 (8WMA at w/c 24/06/24)	Variance
ED attendances	1247	1106	13%
Non-elective admissions	445	408	9%
Number of complex discharges (P1-P3)	49	42	16%
P1-3 NCTR levels	53	56	-5%
Occupancy	308	302	2%

In UHD, admissions have stayed flat, despite a 14% rise in attendances, and a 12% increase in complex (P1-3) discharges is observed, contributing to a significant rise in the number of patients NCTR (24%) – as described in the Transfer of Care overview in section 7.

Variable	Current 8WMA 22/06/26	Same time period 2024 (8WMA at w/c 24/06/24)	Variance
ED attendances	3620	3165	14%
Non-elective admissions	962	946	2%
Number of complex discharges (P1-P3)	137	122	12%
P1-3 NCTR levels	229	184	24%
Occupancy	1015	961	5%

In DHC, overall LoS has decreased since 2024, enabling more weekly starts with fewer beds – with more starts on average occurring despite the temporary closure of 16 beds as described earlier. However, compared with 2024, the number of beds with a NCTR status has significantly increased, by 37%. This is a critical factor to resolve to further reduce length of stay within these beds, freeing up further capacity and to improve patient outcomes.

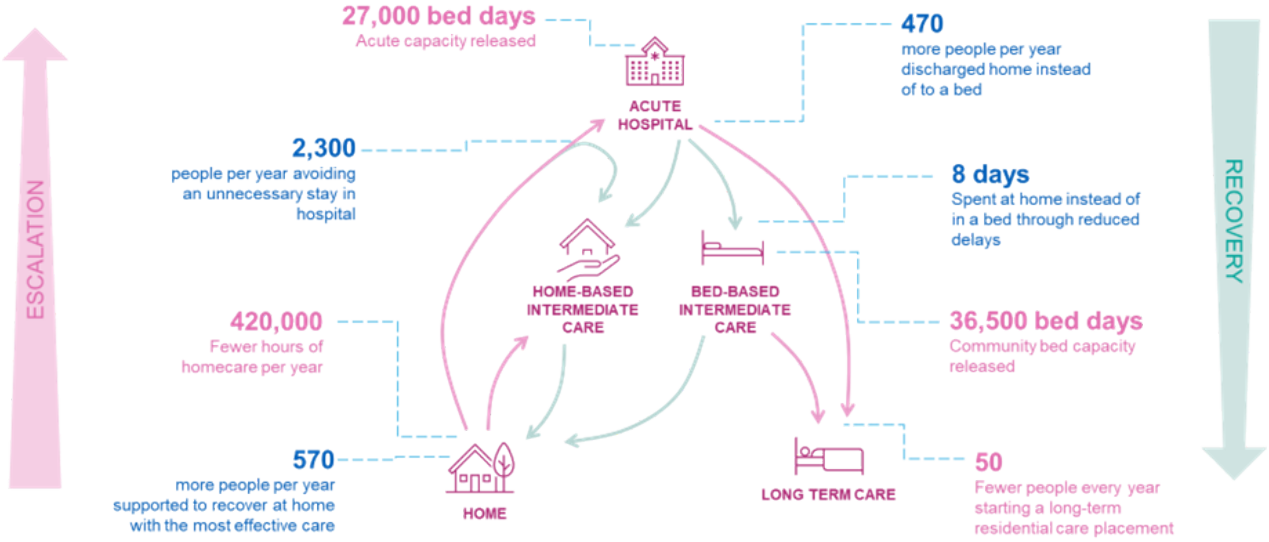
Variable	Current 8WMA 06/26	Same time period 2024 (8wma at w/c 06/24 2024)	Variance
# Beds	192	208	-8%
# Starts pw	37	35	6%
# Discharges pw	38	34	12%
Closed LoS (days)	31.0	37.7	-18%
Bed Occupancy %	93.2%	91.5%	2%
NCTR %	35.4%	25.8%	37%

10. Assessment against benefits plan

At the beginning of the programme a comprehensive Benefits Plan was agreed and this was reviewed and endorsed by Finance and Performance Leads across the system. A Partnership Agreement, which incorporated the Benefits Plan was also presented to Partner Boards for endorsement prior to the beginning of the Delivery Phase of the programme

The diagram and table below set out the anticipated benefits that would be achieved by the programme, first defined in terms of the impact on people and activity and secondly with an operational value attached. The agreed benefits plan committed partners and Newton to delivering a minimum of £17m of

operational benefits and targeting the stretch target from the diagnostic of £28.4m.

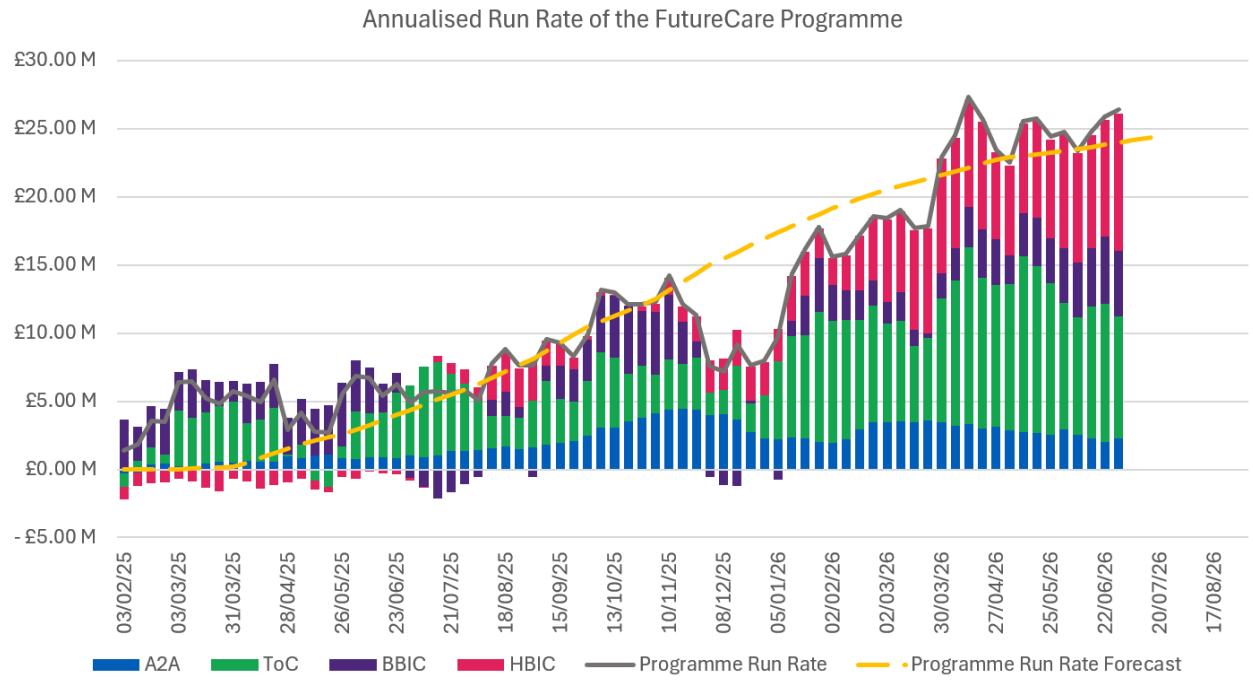


Project	Opportunity	UHD	DCH	DHC	BCP	DC	Total
Home-based Intermediate Care	Reablement Throughput				£ 2.03m	£ 0.78m	£ 2.81m
	Reablement Effectiveness				£ 0.37m	£ 3.30m	£ 3.67m
	Reablement Overlap				£ 0.06m	£ 0.33m	£ 0.39m
	Project Total:	-	-	-	£ 2.46m	£ 4.41m	£ 6.87m
Bed Based Intermediate Care	BBIC Length of Stay			£ 3.13m	£ 0.24m	£ 0.50m	£ 3.87m
	BBIC Outcomes (Nursing and Residential Placement Avoidance)				£ 0.15m	£ 0.19m	£ 0.34m
	Project Total:	-	-	£ 3.13m	£ 0.40m	£ 0.69m	£ 4.21m
Flow and Discharge	Hospital NCTR Length of Stay	£ 4.39m	£ 1.52m				£ 5.91m
	Discharge Outcomes (Nursing and Residential Placement Avoidance)				£ 1.66m	£ 0.71m	£ 2.37m
	Pathway 2 Reduction			£ 3.27m	£ 0.21m	£ 0.40m	£ 3.89m
	Project Total:	£ 4.39m	£ 1.52m	£ 3.27m	£ 1.87m	£ 1.12m	£ 12.18m
Admission Avoidance	Virtual Ward Starts	£ 1.11m	£ 0.51m				£ 1.62m
	SDEC Activity	£ 2.08m	£ 1.52m				£ 3.60m
	Project Total:	£ 3.19m	£ 2.02m	-	-	-	£ 5.22m
	Programme Target:	£ 7.59m	£ 3.54m	£ 6.40m	£ 4.73m	£ 6.22m	£ 28.48m

Run-rate

The graph below provides an overview of operational benefits delivered up until the end of June. At 30 June 2026, the Programme had delivered £26.4m of recurrent operational benefit, having consistently delivered, within a £4m variance, a similar amount of benefit since February 2026. This is significantly above the minimum £17m of operational benefits that Newton and partners committed to delivering but below the upper stretch target of £28.4m.

Following the roll out of the specialist discharge to assess pathway and when progress is made in releasing or increasing P1 capacity in the East of the County it is anticipated that the upper stretch target would be exceeded in the coming months.



Performance against key performance indicators

The table below provided an assessment of performance against key performance targets at the end of April 2026. Although all KPIs have moved positively against baseline, and the average for 2026 remains below the 2024 baseline, in some areas the target KPI movement has not been achieved, crucially P2 LoS and UHD NCTR LoS.

Workstreams	Forecast Run-rate	Current Run-Rate	KPIs Measured	RAG	Baseline	Target	Current Position
Alternatives to Admission	£2.0m	£2.3m	UHD - # Patients Starting in SDEC /Week		460	490	502
			DCH - # Patients Starting in FSDEC /Week		6.5	14	9.0
			UHD - # Patients Starting Community Services /Week		0	12	4
Transfers of Care	£11.2m	£9.0m	UHD - Average NCTR Discharged Length of Stay for Complex Discharge (P1-3)		9.8	7.4	9.9
			DCH - Average NCTR Discharged Length of Stay for Complex Discharge (P1-3)		9.6	7.4	6.5
			# Resi/Nursing Starts /Week from an Acute Discharge		6.1	5.1	4.1
			# P2 Starts /Week from Acute Discharge		47	39	43
Bed-based Intermediate Care	£3.7m	£4.8m	Average P2 Bed Discharged Length of Stay		38.2	31.0	36.3
			# Resi/Nursing Starts /Week following a P2 Discharge		1.8	1.6	0.6
Home-based Intermediate Care	£5.6m	£10.4m	Reablement Throughput *(Number of starts into HBIC)*		50	65	64
			Reablement Effectiveness *(Reduction in weekly hours between incoming and outgoing homecare package size to the service)*		4.6	5.8	5.9

Benefits delivered by organisation

The table below provides an overview of benefits delivered by organisation

		FY25/26		FY26/27 – Forecast position as of 21/04/26 *FY26/27 Cashable Savings contingent on final bed closure/MTFP plans*	
Organisation / Area		In-year Plan (Q2)	Forecast Outturn	Planned Saving *CIP for providers MTFS for Las*	Beds Closed *(target)*
DCH		£1.7m	£0.1m	£0m	0 *(30)*
UHD		£2.1m	£1.7m	£6.5m	35 *(59)*
Pathway 2	DHC	£1m	-	£0m	44 *(80)*
	(LA/ NHSD)	£0.8m	£0.3m	£1.2m*	
Dorset Council Exc. P2		£0.3m	£0.3m	£2.9m	N/A
BCP Council Exc. P2		£0.3m	£0.2m	£1.0m *(£1.8m inc. programme fee)*	N/A
Total		**£6.2m**	**£2.6m**	**£11.6m**	***79 (169)***

While no specific cashable savings plans were outlined within the business case, all organisations included tangible savings in their 2526 and 2627 CIP planning (for providers) or MTFS (for Local Authorities), attributed to FutureCare.

Despite the total benefits from the programme delivered to the system landing within the diagnostic range, this outcome did not meet benefit expectations across system partners. Five important qualifications sit alongside the headline delivery of operational benefits, relating to specific benefits transaction across organisation.

First, it took longer for significant benefits to begin flowing from improved discharge processes across UHD hospitals and in Home Based Intermediate Care with the complexity of the Dorset system - the volume of stakeholders, the interdependencies between organisations, and the time required to make change happen across that

landscape were all significantly greater than the diagnostic surfaced in its eight-week timeframe.

Second, although the responsibility for benefit realisation sat outside of the programme, the business case did not make sufficient allowance for greater amounts of activity growth than planned. In particular, the Business Case assumed that System Operational Plans would accurately model anticipated activity growth and that available resources would be aligned to this. Where this was not the case benefit delivered through FutureCare has been offset by additional capacity required to meet demand. As well as demand pressure on providers, both DC and BCP have seen significant growth to their Older Adults budgets, considerably in excess of any savings expected from the FutureCare programme. This has been exacerbated by changes in the UEC space, for examples from changes to how CHC has been managed, or how some benefits have been realised resulting in an unforeseen cost pressure.

Thirdly, it was assumed that at the beginning of the process activity was matched to capacity. While this was the case at UHD where bed occupancy levels of 92-95% in the first half of the programme meant there was opportunity to close beds, at DCH, where bed occupancy levels were consistently in excess of 100% from the start of the programme, there was less opportunity to reduce capacity on a permanent basis – made more challenging by the increases in attendances and admissions observed.

Fourth, the Business Case KPI improvements and targets were quantified in terms of delivering an indicative operational value as part of phase 1 of a longer-term programme and not the level of performance required to 'balance' the system or meet system goals such as the UHD hospital move. This has meant that the programme success criteria are not in line with what the system, and system partners, require to deliver the outcomes desired by the system, be that system-wide NCTR numbers, outcomes for residents, or capacity reductions.

Finally, the delivery of the maximum amount of benefit has been inhibited by the aim not to re-invest benefits delivered in other areas of the system. At a system level, the overall impact of this is that despite the benefits that have been delivered, too many hospital beds are occupied by people who should be discharged from hospital. In addition, because of gaps in specialist provision, too much adult social care resources is being utilised to undertake long term assessments in hospital and insufficient home based intermediate care capacity means there is an over-reliance and backlog on bed based intermediate care capacity.

11. Agreed priorities for the future

In order to deliver better outcomes for Dorset residents, reduce pressure on hospital capacity and on long term adult social care budgets the improvements made so far need to be maintained, more home-based intermediate care capacity needs to be released or additional capacity commissioned and partners need to utilise the

additional resources allocated to address the commissioning gaps in the intermediate care offer effectively.

Set out below are key actions for the period from July 2026 to March 2027, which have been informed by the discussions at the FutureCare SRO Development Session on Tuesday 9 June and the subsequent one-to-one discussions that have taken place to inform the drafting of the closedown report.

Action 1: Establish Discharge to Assess Partnership

A key strength of the FutureCare Programme has been to provide an environment and an agreed purpose for working together to deliver system-wide benefits. With the change in role for the ICB, leadership of the Partnership needs to shift to NHS providers and local authority partners.

Deliberate effort should be invested in rebuilding and then maintaining leadership alignment across the partner organisations.

Following the allocation of resources to address the specialist discharge to assess commissioning gaps a draft Partnership Agreement has been produced. This should be signed off as soon as possible and a monthly cycle of Partnership Group meetings for the remainder of the year diarised to ensure continued momentum and focus.

To support the Partnership Group some programme support capacity should be identified to track progress and deliver priorities.

Action 2: Securing what has already been delivered

The operational improvements delivered across the workstreams - in reablement effectiveness and capacity, discharge planning, system visibility, community bed productivity and admission avoidance, are not yet fully secure. Several of them depend on new ways of working and teams in some cases that are still relatively recent in formation, on governance structures that need continued active leadership, and on data tools that require ongoing maintenance and adoption. Without deliberate effort to sustain them, there is a risk that performance drifts back towards the pre-programme baseline as the external support and programme discipline that held them in place is withdrawn.

Sustaining the gains requires three things in the near term.

1. The operational leaders who now own each area of improvement need clear accountability for maintaining performance, with the metrics and dashboards put in place during the programme used actively and consistently in governance forums.

2. The data infrastructure, hosted on the DiiS platform, that supports WIG and supporting improvement cycles needs to be fully embedded as business as

usual - owned, maintained and acted upon by Dorset teams rather than dependent on Newton resource.

3. System governance – likely UEC Delivery Group - to support WIG to resolve issues and hold attendees to account needs to be reinvigorated to ensure that escalations and issues from WIG have a forum to be resolved, and the programme KPIs continue to be monitored and built upon, not reinventing new changes or losing the focus on the KPIs and service standards that have been agreed through the FutureCare Steering group and WIG.

As part of the transformation contract with Newton the Dorset system will receive two Programme Sustainability Reviews, or Health Checks – one in October 2026 and a second in March 2027.

These will examine whether benefits are still being delivered, improvement cycles are still underway and whether data insight tools are being utilised. Experience and insight from SROs and other system partners will also be collated in order to assist the system in agreeing actions to sustain improvement.

Action 3: Addressing specialist intermediate care commissioning gaps

Following the allocation of £1.8m of additional resources by the Cluster Investment Panel on Tuesday 7 July the resources are now secured to deliver better outcomes for those people for whom the core intermediate care offer is not sufficient.

Clear operational arrangements for identifying people who could be supported with the funding and for providing specialist support and case management for them once discharged into the community have been devised.

The focus now needs to shift to implementing these arrangements. The System TOC Lead will have overall responsibility for this but the system will need to recruit quickly a Clinical Case Manager to embed the new arrangements and to manage the caseload so that good progress can be demonstrated in time for the planned Gateway Review in October 2026.

In the medium term a long-term commissioning plan will be required and this will require Dorset Council, BCP Council and Dorset ICB commissioners to work together under the oversight of the Discharge to Assess Partnership to deliver a long term and sustainable solution from April 2027.

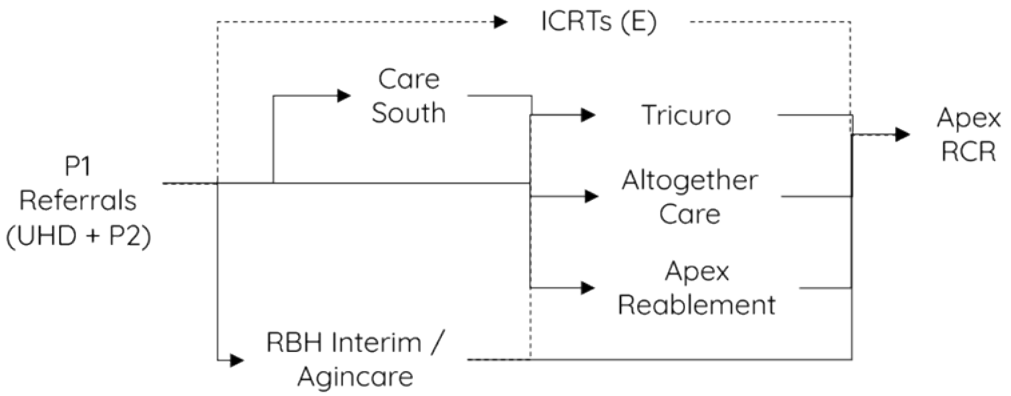
Action 4: Home Based Intermediate Care capacity

Despite considerable improvement to the existing home-based intermediate care provision, there is currently insufficient home-based intermediate care capacity available to meet core needs, meet the needs of people with more specialist requirements and to support the number of referrals to reablement providers from ASC teams for people living at home but who need support to maintain their independence.

In the East of the County, a large amount of HBIC capacity could be released if CAA assessments could be undertaken while reablement is being delivered and large amounts of available capacity were not being used to provide bridging care while CAA assessments are undertaken. Apex is the largest HBIC provider in the East delivering 1800 hours out of a total of 2700 commissioned hours per week. Of this,1800 hours, currently less than 400 hours are being utilised to provide reablement as more than 1400 hours per week are utilised to provide interim support after a reablement package has been completed because social worker capacity is not been allocated and CAA assessments completed within agreed discharge targets.

To address this challenge changes are required in how BCP ASC capacity is allocated and utilised. In the short term, addressing this issue is proving challenging and so as an interim measure commissioning additional HBIC capacity is recommended.

Substantial work remains outstanding to simplify and optimise the P1 pathway in the East. Developed tactically and as a response to hospital pressures it is delivering poor outcomes for people with several unnecessary pass offs from one provider to another before a reablement package is completed.



As well as being complex to navigate for patients and staff, the pathway is a mix of BCP, UHD and ICB Commissioning, making accountability and responsibility of performance difficult to understand and manage.

Linked to this challenge, there is currently insufficient recurrent resource allocated within the BCF to provide the amount of capacity required and so the system relies on non-recurrent funding sources and the direct commissioning of capacity from UHD. This is unsustainable in the long term and needs to be addressed.

In both East and West Dorset there is a requirement to build on the improvements in the effectiveness of HBIC services that have been delivered and to increase capacity and expertise in order to deliver an enhanced offer for HBIC, to support higher

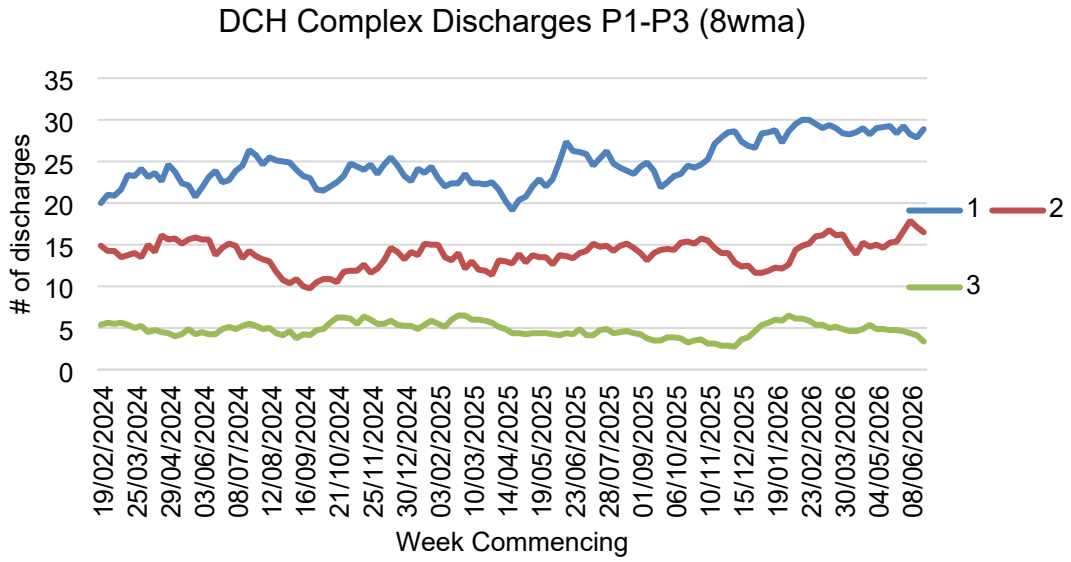
complexity at home. Initially this is a commissioning challenge and will require close working between both local authorities and Dorset Healthcare.

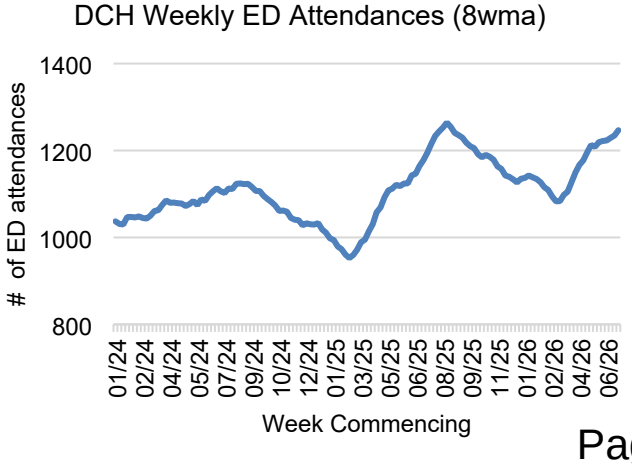
12. Conclusion

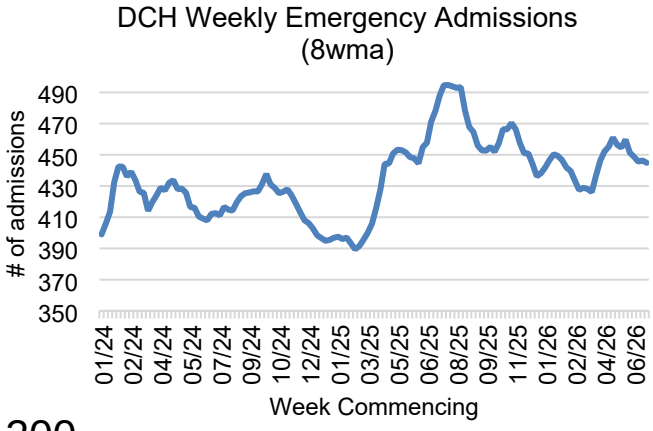
The FutureCare programme has delivered a meaningful and measurable improvement in the productivity of the Dorset urgent and emergency care system. But as described in this report, there is as much about what remains to be done as it is about what has been achieved. The diagnostic and work to date has demonstrated that the targeted value and substantially more is available, the challenge for Dorset is to continue the process to meet its full ambitions. As the first phase of the programme closes, continuing with further improvements is a practical necessity. Without further action, some of what has been gained is at risk, and structural challenges will continue to constrain the system.

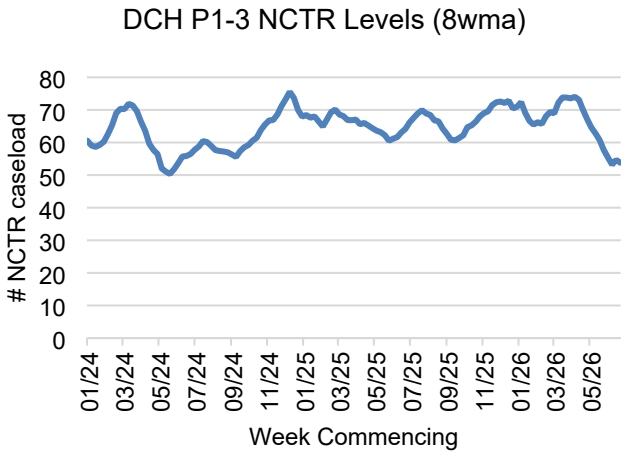
13. Appendices

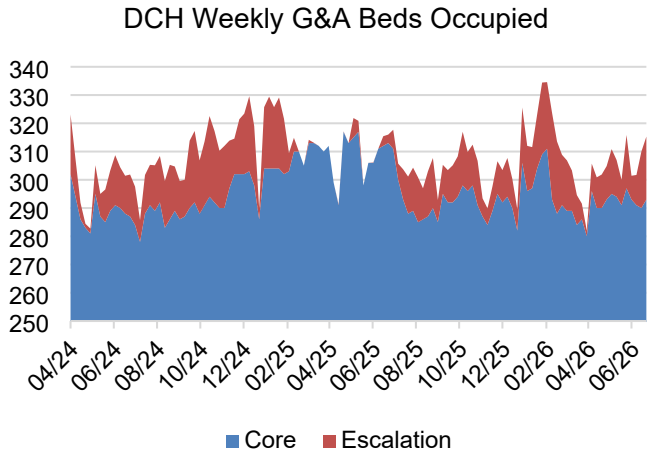
DCH performance time series from May 2024 to June 2026. All charts present a rolling 8 week moving average, for ease of observing trends in the volatile UEC environment.



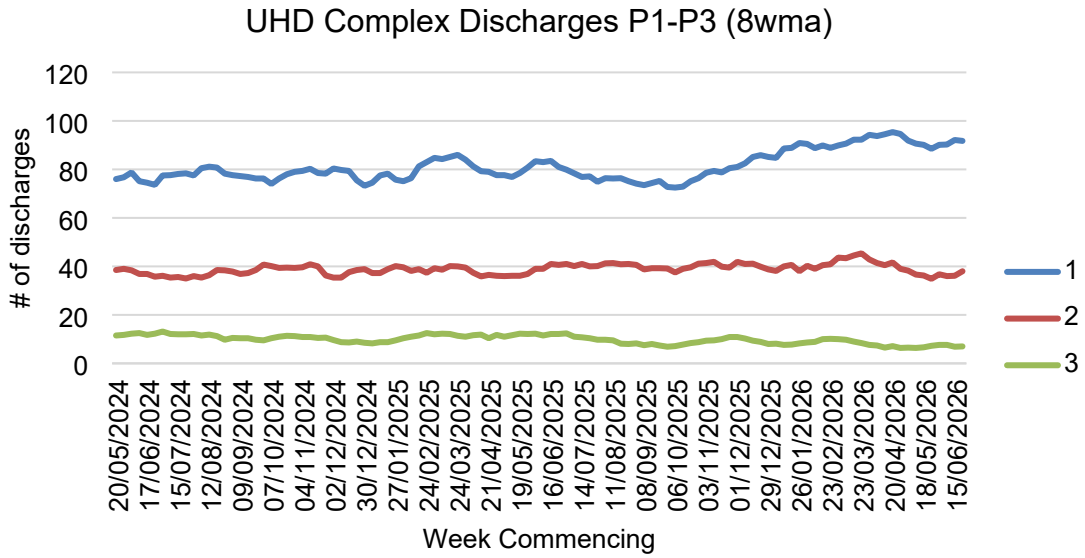


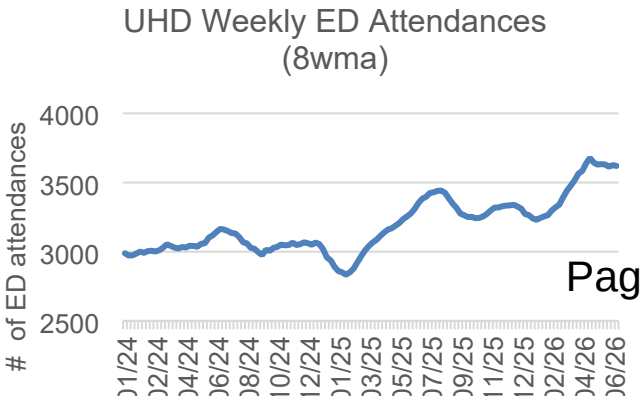


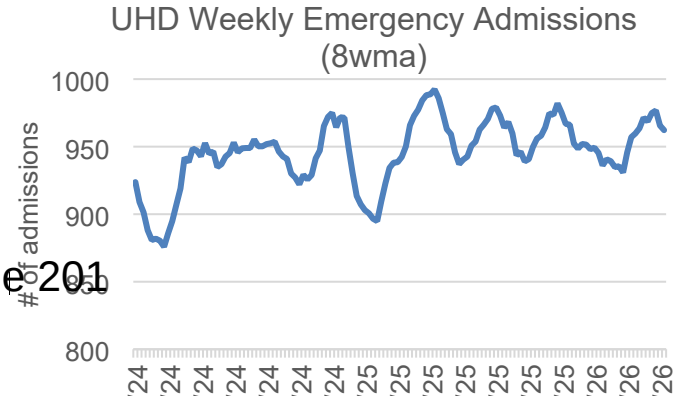




UHD performance time series from May 2024 to June 2026. All charts present a rolling 8 week moving average, for ease of observing trends in the volatile UEC environment.







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Health and Wellbeing Board
18 November 2026
Healthy Life Expectancy JSNA Narrative
For Review and Consultation

Cabinet Member:
Cllr M Bell, Public Health, Prevention & Communities

Local Councillor(s):

Senior Leadership Team:
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Statutory Authority: Local Government and Public Involvement in Health Act 2007 (Sections 116 and 116A), as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

Report status: Public (the exemption paragraph is N/A)

1. **Executive summary (maximum of 500 words)**

1.1 Each Health and Wellbeing Board must have a process for Joint Strategic Needs Assessment (JSNA). The Local Government and Public Involvement in Health Act (2007) sets out the role and responsibility of the Health and Wellbeing Board for this work. The current JSNA process is co-ordinated by the Public Health team and involves annual strategic narrative updates alongside deep dives into specific topic and cohort areas.

1.2 This JSNA was commissioned following a Health and Wellbeing Board development session in November 2025; as part of the approved JSNA Forward Plan for 2026/27, the Board requested further understanding of the drivers behind the gap between life expectancy and healthy life expectancy and the implications for future planning and service delivery.

1.3 Healthy Life Expectancy (HLE) measures how long people can expect to live in good health and is an important indicator of population health and health

inequality. While Dorset residents generally experience higher life expectancy than the England average, significant variation exists between communities, and residents spend many years living with ill health, disability or long-term conditions. The 2025 JSNA narrative update highlighted that Dorset men spend around 16 years and women around 19 years of their lives in poorer health.

1.4 The assessment explores the factors contributing to these outcomes, including deprivation, long-term conditions, health behaviours, mental wellbeing and wider determinants such as housing, employment, social connection and access to services. The report highlights the importance of maintaining independence, mobility and wellbeing throughout life, recognising the significant contribution that musculoskeletal health, physical activity and healthy ageing make to healthy life expectancy.

1.5 The report identifies several strategic opportunities for Dorset, including promoting active ageing, preventing and managing long-term conditions, encouraging physical activity and active travel, supporting mental wellbeing, improving the conditions in which people live, and reducing inequalities experienced by more disadvantaged communities. It also highlights how existing programmes, including Age Friendly Dorset, Healthy Homes Dorset, Thriving Communities and LiveWell Dorset provide practical mechanisms to support longer and healthier lives.

2. Recommendation(s)

2.1 The Health and Wellbeing Board is asked to:

- Note the findings of the Healthy Life Expectancy JSNA
- Approve publication of the Healthy Life Expectancy JSNA report in Appendix 1

3. Reason for the recommendation(s)

3.1 To update the Board on progress in the JSNA programme and provide an overview of the key findings relating to healthy life expectancy and health inequalities in Dorset.

4. The report

4.1 This report presents the findings of the Joint Strategic Needs Assessment (JSNA) on Healthy Life Expectancy (HLE) in Dorset. Healthy Life Expectancy measures the average number of years a person can expect to live in good health and is a key indicator of population wellbeing and health inequality.

4.2 The assessment shows that people in Dorset generally live longer than the England average. However, many residents spend a substantial proportion of

their lives living with ill health, disability or long-term health conditions. On average, Dorset men spend around 16 years and Dorset women around 19 years of their lives in poorer health, highlighting a significant gap between life expectancy and healthy life expectancy.

4.3 Whilst Dorset performs well overall compared with national averages, county-level figures mask considerable inequalities between communities. Residents living in more deprived areas experience poorer health outcomes, develop long-term conditions at younger ages and are more likely to spend a greater proportion of their lives in poor health than residents in less deprived areas. The report demonstrates the strong relationship between healthy life expectancy and wider determinants of health, including income, employment, education, housing, transport and access to services.

4.4 Long-term conditions are a major contributor to reduced healthy life expectancy. Cardiovascular disease, cancer, respiratory disease, diabetes, musculoskeletal conditions and poor mental health all impact the number of years people can live independently and in good health. The report also highlights the increasing challenge of multimorbidity, where people live with multiple long-term conditions simultaneously, often resulting in reduced quality of life and increased demand for health and care services.

4.5 Health behaviours play an important role in determining healthy life expectancy. Smoking, inactivity, obesity, poor diet and alcohol-related harm continue to contribute to preventable illness and reduced quality of life. Conversely, maintaining an active lifestyle, supporting good mental wellbeing, preventing disease and enabling early diagnosis can help people remain healthier for longer.

4.6 The report identifies opportunities to improve healthy life expectancy through a whole-system approach that combines prevention, early intervention and action on the wider determinants of health. Existing initiatives across Dorset provide strong foundations on which to build, including programmes that support healthy lifestyles, early identification and management of long-term conditions, mental wellbeing and community resilience.

4.7 Also highlighting the importance of healthy ageing within Dorset's population. Dorset has a larger proportion of older residents than England as a whole and ensuring people can remain active, independent and connected to their communities for longer is central to improving healthy life expectancy. Evidence presented in the report demonstrates the benefits of physical activity, active travel, social participation and supportive environments in helping residents maintain good health throughout later life. Initiatives such as Age Friendly Dorset and Thriving Communities provide a framework for

creating communities that enable people to age well and continue participating in community life.

4.8 The findings provide an important evidence base for partners across Dorset. They reinforce the importance of reducing health inequalities, supporting healthy ageing and improving opportunities for people to live longer, healthier and more independent lives. The report will inform strategic planning, commissioning and partnership working across the health and care system and contribute to the delivery of the Dorset Health and Wellbeing Strategy.

5. Alternative options considered

5.1 Not Applicable

6. Legal considerations

6.1 Under the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Social Care Act 2012 and 2022, Health and Wellbeing Boards have a duty to prepare a JSNA as part of assessing the health and social care needs of the local population.

7. Financial implications

7.1 There are no direct financial implications arising from publication of this JSNA deep dive.

8. Natural environment, climate & ecology implications

8.1 Joint Strategic Needs Assessment includes consideration of the wider determinants impact on health and wellbeing in the local area.

9. Well-being and health implications

9.1 A comprehensive Joint Strategic Needs Assessment process identifies key health and wellbeing issues, to which services provided by Health and Wellbeing Board representative organisations can contribute.

10. Other implications

10.1 The requirement for the Health and Wellbeing Board to have a process of Joint Strategic Needs Assessment is set out in Local Government and Public Involvement in Health Act 2007.

11. Risk Implications

11.1 Having considered the risks associated with this decision, the level of risk has been identified as:
Current Risk: Low
Residual Risk: Low

12. Equalities

12.1 A JSNA should consider the impact of health inequalities and cohorts of the population who may experience poor health and wellbeing outcomes.

13. Appendices

13.1 Appendix 1 – Healthy Life Expectancy JSNA

14. Background papers

14.1 Dorset Joint Strategic Needs Assessment

15. Report sign-off

15.1 This report has been through the internal report clearance process and has been signed off by the Director for Assurance & Governance (Monitoring Officer), the Director for Resources (Section 151 Officer) and the appropriate Cabinet Member(s)

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Healthy Life Expectancy (HLE) in Dorset

October 2026

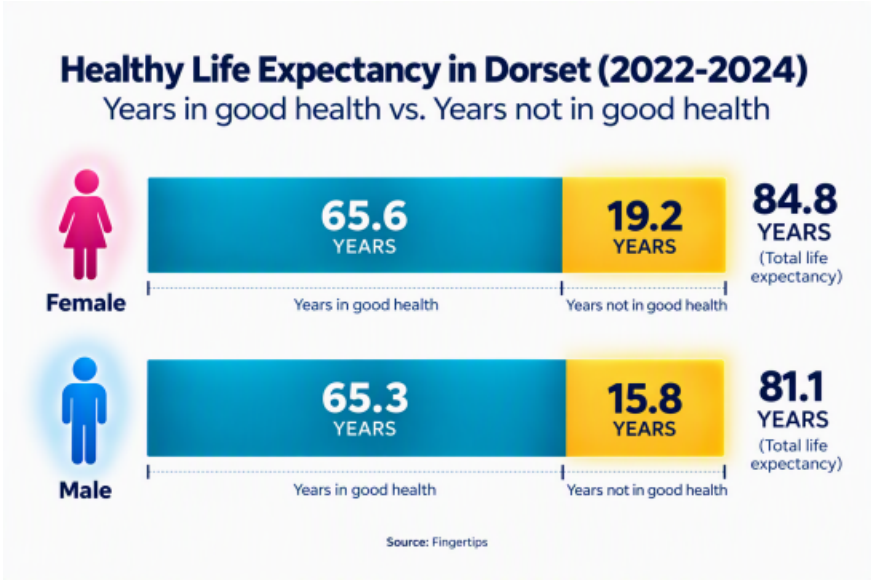
Summary

Healthy life expectancy (HLE) is a key measure of how long people can expect to live in good health and provides an important indicator of population wellbeing and inequality.

While Dorset residents generally live longer and enjoy more years in good health than the England average, 2022-2024 evidence suggests that many still spend around 16 to 19 years of their lives in poorer health.

Nationally, HLE has fallen to its lowest recorded level, but significant inequalities persist, with people in the most deprived communities experiencing around 20 fewer years of good health than those in the least deprived areas. In Dorset, pockets of deprivation, particularly in Weymouth and Portland, highlight the need for targeted action. Evidence shows that long-term conditions, multimorbidity and wider determinants of health are the main drivers of reduced HLE.

Dorset already has a strong foundation of prevention programmes and partnerships; including NHS Health Checks, LiveWell Dorset, Active Dorset and neighbourhood health initiatives. The key strategic challenge is not simply extending life, but also to increase the number of years people live in good health, reduce the years spent in poor health, and narrow the gap between communities.



What is healthy life expectancy and why is it important?

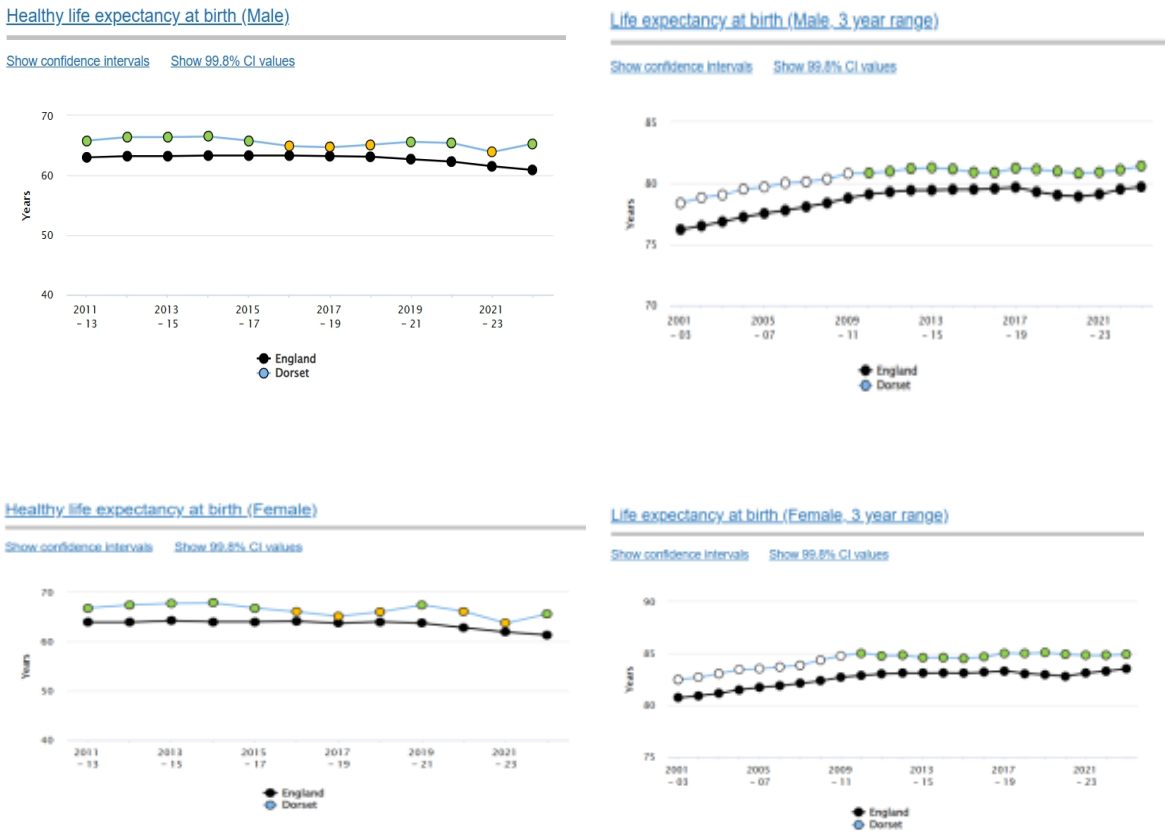
Life Expectancy (LE) estimates the average number of years a person would live if the age-specific death rates of a particular period continued. Healthy Life Expectancy (HLE) estimates how many of those years would be spent in good self-reported health. Measuring both helps distinguish living longer from the number of years lived well. [1, 2]

HLE is not the age at which a person becomes ill. People can move between better and poorer health throughout their lives. Nor does it mean being free of every condition or disability: someone living with a well-managed condition may still describe their health as good. The gap between LE and HLE is not a count of years with multiple conditions or a need for care. [1]

The distinction matters because living longer and living well are related but different outcomes. For a resident, poorer health may mean difficulty working, caring for someone, getting out or managing everyday activities. HLE does not measure those experiences directly, but it prompts us to consider them alongside deaths and diagnoses.

National OHID analysis identifies long-term conditions and multimorbidity as important influences on poor self-rated health. Musculoskeletal conditions are particularly relevant because they are common and associated with poorer reported health. Income, education, smoking and physical activity also matter. These factors interact, so no single service or behaviour explains the whole picture. [3]

Recent ONS releases show recovery in LE after the COVID-19 pandemic, but an uneven one as many local areas remain below their 2017–2019 levels. Although Dorset HLE shows improvement in 2022–2024, the England HLE was the lowest in the series beginning in 2011–2013. In England it was 60.9 years compared to 63 years for males and 61.3 compared to 63.9 years for females. [1, 2]



Source: Fingertips indicators 90366 and 90362, accessed 26 September 2026. [3]

The Chief Medical Officer's 2025 report (Health trends and variation in England, 2025) provides a wider account of these trends and differences in health across England.

Dorset picture and variation

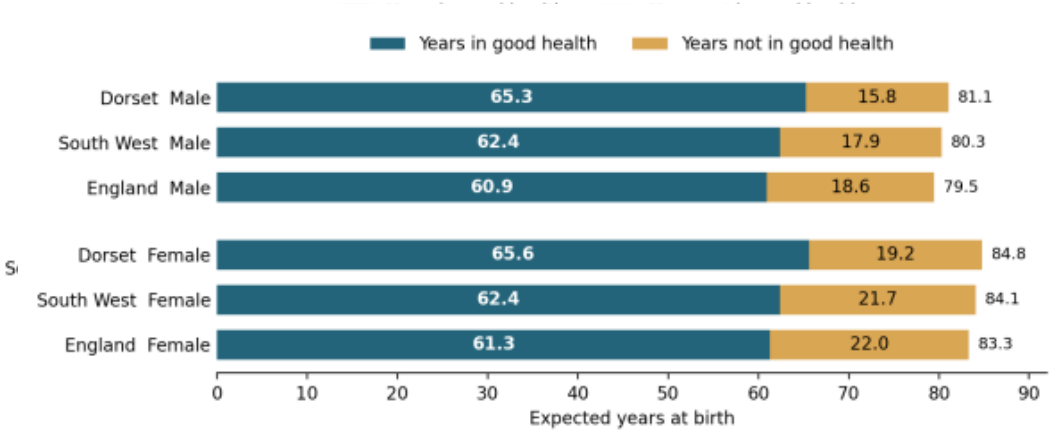
In 2022–2024, Dorset has higher LE and HLE estimates than the South-West and England. Yet the Dorset gap is 15.8 years for males and 19.2 for females: roughly 16 to 19 years outside good health. For England, the corresponding gaps are 18.6 and 22.0 years. For residents, poorer health can mean difficulty staying in work, managing daily tasks or taking part in activities they value. [4]

Women's longer life expectancy is also not matched by an equally large advantage in healthy years. Dorset female life expectancy is 3.7 years higher than male life expectancy, while the difference in HLE is only 0.3 years on the point estimates. The HLE estimates are uncertain, so this should not be read as a precise difference between the sexes.

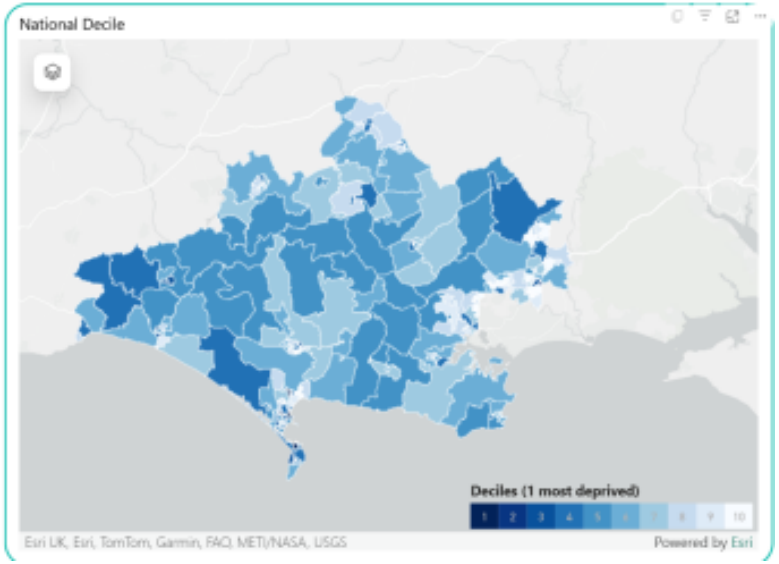
Deprivation and the years spent in poorer health

Nationally, the most deprived tenth of areas in England had HLE of 49.8 years for males and 48.2 for females in 2022–2024, compared with 69.2 and 68.5 in the least deprived tenth. Subtracting HLE from life expectancy gives approximately 23 and 30 years outside good health in the most deprived areas, compared with 14 and 18 in the least deprived. People in more deprived areas therefore face both shorter lives and more years in poorer health. [5]

The Dorset average can hide differences between communities. Dorset's 2025 deprivation data identify nine of its 223 small neighbourhoods in the most deprived 20% nationally for multiple deprivation: seven in Weymouth and Portland, one in Bridport and one in Ferndown. A different pattern appears for barriers to housing and services, where 88 neighbourhoods fall within the most deprived 20%. This matters because an overall measure of relative affluence can conceal difficulties reaching services or finding suitable housing. [6]



All values are years at birth. Years not in good health are calculated as LE minus HLE from the rounded published estimates; they are not separate estimates of disability or care need. Source: Fingertips indicators 90366 and 90362, accessed 26 September 2026. [4]



Dorset's Index of Multiple Deprivation (IMD) LSOA map.

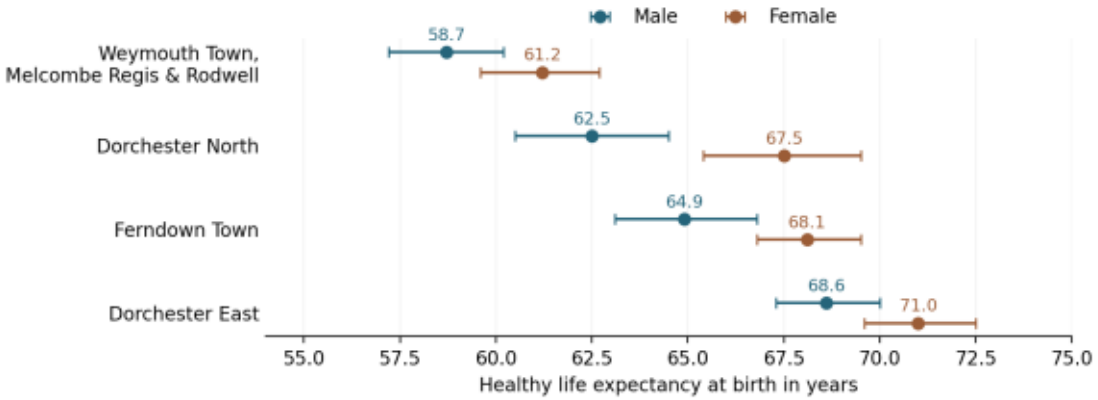
Dorset picture and variation

Differences within Dorset

The Census-based HLE series allows comparisons between middle layer super output areas (MSOAs), It combines the 2021 Census health information with mortality data for 2019–2023. [7, 8]

Dorset is generally viewed as an affluent area, where average HLE looks better that the South-West and England average, but further drip down paints a different picture. For example, the gap between Weymouth Town, Melcombe Regis & Rodwell and Dorchester East is 9.9 healthy years for males and 9.8 for females, which shows a significantly different outcome for residents from both MSOAs. The estimates describe place-based inequality. [5]

These findings suggest starting conversations where poorer health coincides with barriers to support. Geography is only part of the picture: disability, mental ill health, caring responsibilities or difficulty travelling may affect people in otherwise affluent areas. Local partners and residents can help identify these needs; area HLE figures cannot describe each group's experience.



HLE at birth, 2019–2023 Census-based series. Points show estimates; lines show 95% confidence intervals. These four MSOAs illustrate variation and are not a ranking of every Dorset area. Source: OHID Fingertips indicator 94359, extracted 14 September 2026. [5]

Dorset picture and variation

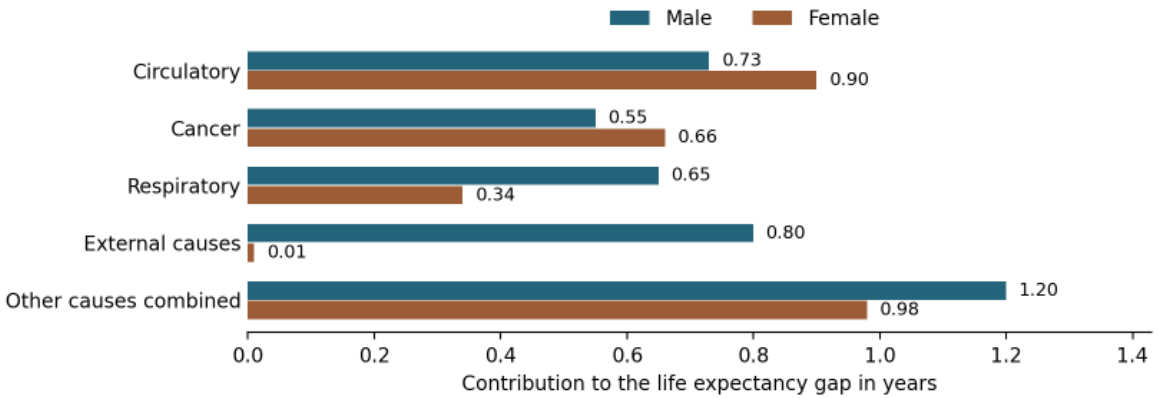
Which conditions matter

The OHID Segment tool helps explain inequalities in life expectancy through differences in causes of death. For Dorset in 2022–2023, life expectancy was 78.7 years for males in the most deprived local fifth of areas and 82.6 in the least deprived fifth, a 3.9-year gap. The female figures were 83.6 and 86.5, a 2.9-year gap. [9]

Circulatory disease contributes 0.73 years to the male gap and 0.90 to the female gap; cancer and respiratory disease also contribute a major contributor to the gap.

External causes contribute 0.80 years for males, including 0.57 years from accidental poisoning in the detailed breakdown. This supports looking beyond cardiovascular prevention alone. However, two years of deaths can produce unstable cause-specific estimates, especially for smaller categories. [9]

Causes of death tell only part of the HLE story. OHID's national review found strong associations between poorer self-reported health and long-term conditions, particularly when several occur together. Its analysis also draws attention to musculoskeletal conditions, and mental ill health. Pain, breathlessness or depression may limit daily life without appearing prominently in a mortality chart. Considering these other conditions alongside cardiovascular disease, cancer and respiratory disease can help better understand HLE. [10]



Most versus least deprived fifth of areas within Dorset Council, 2022–2023. Redrawn from the Segment tool data tables, November 2025, broad causes worksheet. Other causes combined sums digestive, mental and behavioural, COVID-19, neonatal and remaining causes. Rounded components may not sum exactly to the published overall gaps. This is a life expectancy chart, not an HLE decomposition. [9]

Dorset picture and variation

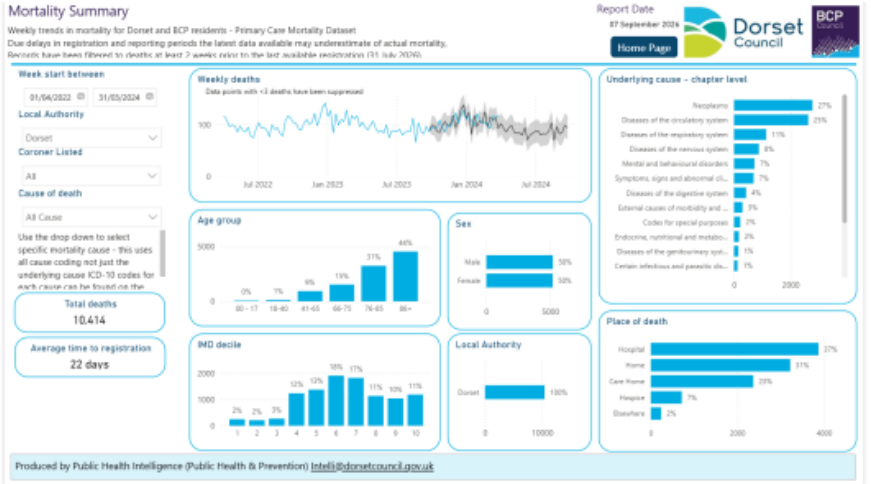
Local insight – Causes of Death

Dorset Public Health analysis of all-cause mortality between April 2022 to March 2024 shows that cancer (27%) and circulatory diseases (25%) account for more than half of all deaths. While three quarters of mortality occurs among those aged over 76 years, almost one quarter of deaths occur before age 76 and represent a significant source of preventable loss of healthy life years.

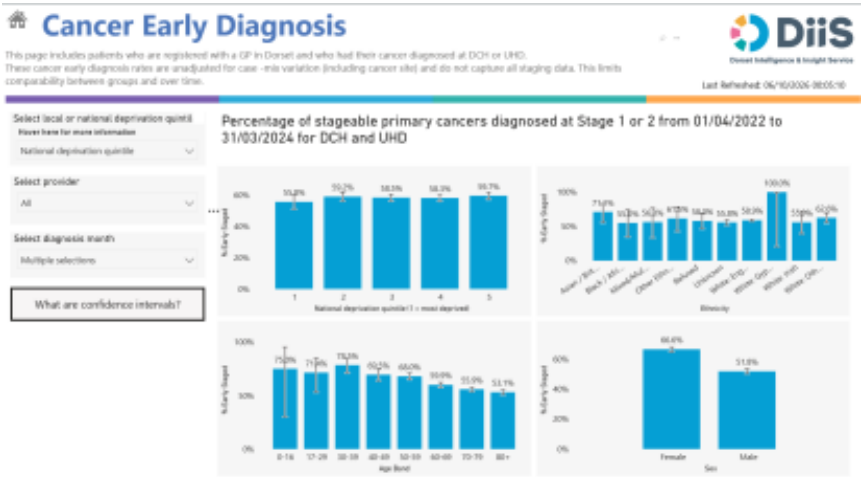
Cancer is the largest cause of death and is particularly important because deaths occur proportionately younger than for all causes combined, with 38% of cancer deaths occurring before age 76 compared with 24% for all-cause mortality. Men accounted for a larger share of cancer deaths than women, and variations across deprivation groups suggest ongoing inequalities in cancer outcomes. Weekly mortality levels remain persistently high, indicating continuing opportunities to improve survival through earlier diagnosis. Increasing uptake of screening programmes, reducing diagnostic delays, and targeting populations at highest risk could reduce premature cancer mortality and contribute significantly to improvements in HLE.

Dorset Intelligence and Insight Service (DiiS) brings together millions of data records from health and social care, providing Population Health Management (PHM) information for delivering better outcomes for residents across Dorset.

Insights from DiiS showed between April 2022 till March 2024, Dorset achieves early diagnosis (Stage 1 or 2) in approximately 59% of stageable cancers; however, around 40% are still diagnosed at later stages. Early diagnosis rates are substantially lower among men (52%) compared with women (67%) and decline progressively with age from 79% among people aged 30–39 years to 53% among those aged 80 years and over. These findings align closely with mortality data showing higher cancer mortality among men and older residents. Increasing the proportion of cancers diagnosed at Stage 1 or Stage 2, particularly among men, older adults and more deprived communities, represents a key opportunity to reduce premature cancer mortality and improve HLE.



Dorset Public Health report - Mortality Summary



DiiS report - Cancer Early Diagnosis

Dorset picture and variation

Local insight – Long Term Conditions

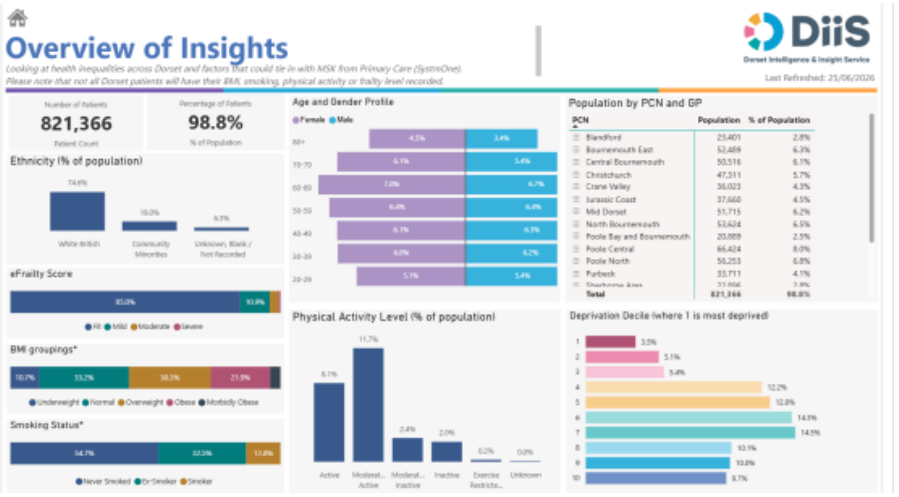
A key condition identified by OHID to have a huge impact on HLE is Musculoskeletal (MSK) conditions. Local insights from DiiS analysis showed that it is a significant contributor to reduced Healthy Life Expectancy in Dorset. MSK conditions refer to a broad group of disorders that impair the body's locomotor system; including muscles, bones, joints, and connective tissues, which commonly causes pain, stiffness, reduced mobility, and functional limitations.

The MSK population in Dorset is characterised by an ageing demographic, high levels of overweight and obesity, physical inactivity and increasing frailty. More than half of residents are overweight or obese, increasing the risk of chronic joint disease, pain and mobility limitations. Around one in nine residents already show signs of mild frailty, highlighting the importance of preventative interventions that maintain independence and functional health.

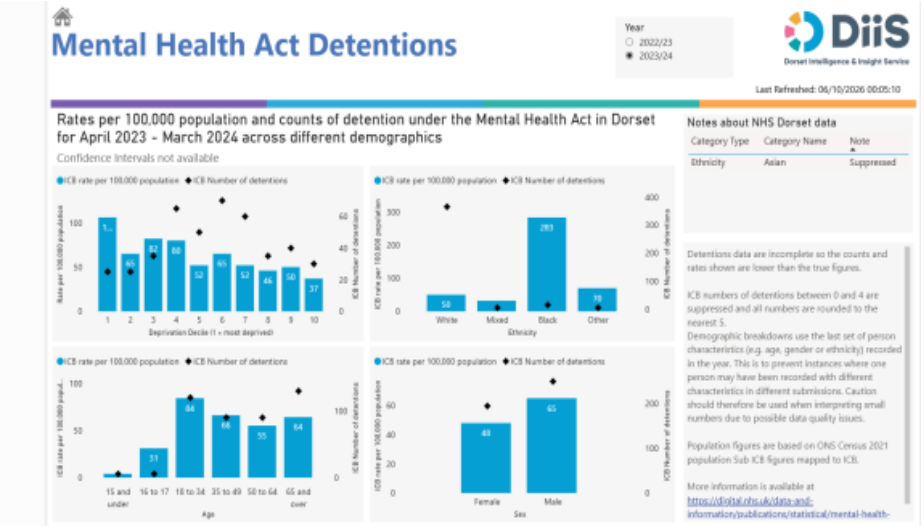
As musculoskeletal conditions are a major cause of disability rather than mortality, interventions that increase physical activity, reduce obesity, prevent frailty and support self-management have the potential to increase the number of years residents spend in good health, thereby improving HLE.

Mental health is also an important determinant of HLE. Analysis of DiiS data on Mental Health Act detentions demonstrates inequalities, with detention rates almost three times higher in the most deprived communities than in the least deprived communities. Young adults aged 18–34 years experience the highest detention rates, while men have rates approximately 35% higher than women. Black residents experience substantially higher detention rates than other ethnic groups, indicating significant inequalities in severe mental health outcomes.

Mental ill health can affect HLE through its impact on wellbeing, employment, social participation and management of physical health conditions. Interventions that improve access to mental health support, reduce inequalities and promote early intervention may therefore contribute significantly to increasing HLE and reducing health inequalities across Dorset.



DiiS report - MSK Overview



DiiS report - Mental Health Act Detentions

Dorset picture and variation

Local insight – Long Term Conditions

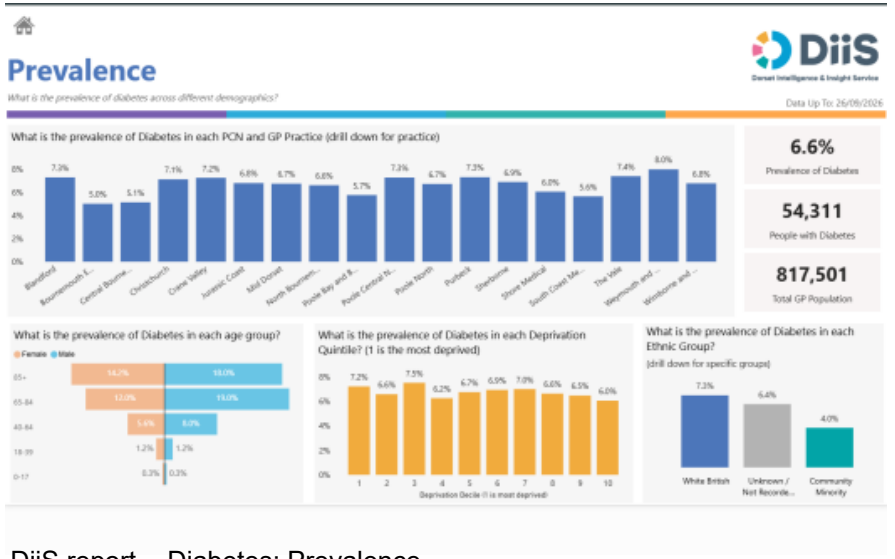
Dorset's published JSNA identifies possible undiagnosed hypertension particularly in Weymouth and Portland and Crane Valley primary care networks.

It also highlights higher diabetes prevalence in Weymouth and Portland, Blandford and the Vale with 8.0%, 7.3% and 7.4% respectively.

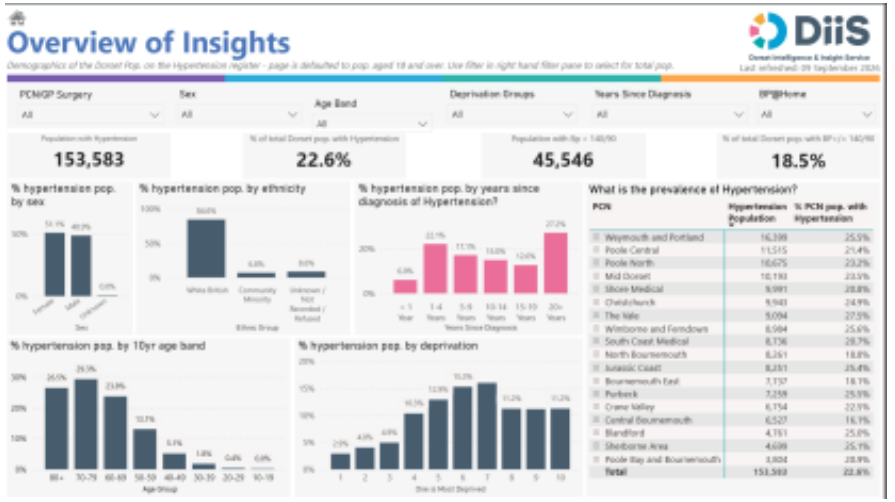
Further insights from DiiS shows that Diabetes prevalence rises with age, with men consistently having a higher prevalence than women. It is most prevalent in male aged 65-84 affecting around 19% of the GP registered population. This is consistent with known risk profile driven by obesity, cardiovascular risk factors, lifestyle behaviours and increasing insulin resistance with age.

Hypertension is around three times more common than diabetes and represent a large number of long-term conditions managed in primary care. It is similarly distributed amongst male and female with 49% and 51% respectively. Over 27% of people have been living with hypertension for over 20 years which indicates a significant ongoing demand for monitoring and medication management. Over 80% of all cases happens among people aged 60 and over, with fewer cases occurring below 40

Both conditions increase with age , show notable geographic variation, and demonstrates links with older adults and more deprived communities. They are major contributors to reduced HLE. While these conditions contribute to premature mortality through cardiovascular disease, their greatest impact is often through prolonged periods of poor health, they increase the risk of stroke, heart disease, kidney disease, visual impairment, frailty and disability, leading to many years lived with reduced quality of life. Interventions supporting prevention, early diagnosis, effective management and behavioural risk factor reduction could therefore deliver substantial improvements in HLE while reducing inequalities in health outcomes.



DiiS report - Diabetes: Prevalence



DiiS report – Hypertension: Overview of Insights

Dorset picture and variation

Local insight – Falls in later life

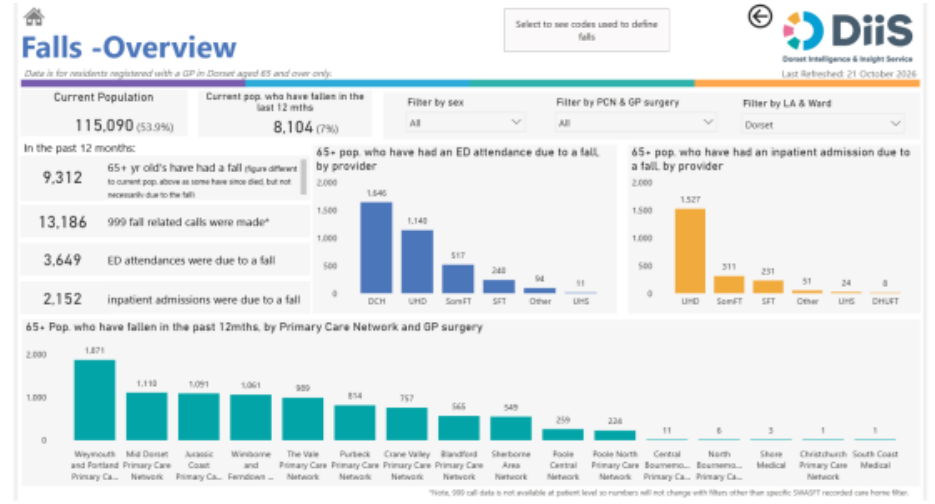
As of October 2026, in the last 12 months, of the approximately 115,090 residents aged 65+ are registered with Dorset GP, about 7% are registered as fallen. The data also shows almost 13,200 fall related 999 calls were made, about 3600 emergency attendances and 2,200 inpatient admissions was recorded, indicating fall affects around 1 in 14 residents aged 65+.

DiiS risk stratification model identified about 3787 residents;1362 residents at very high risk and 2425 residents at high risk, which is approximately about 3.3% of the 65+ population as at a very high or high risk of falling.

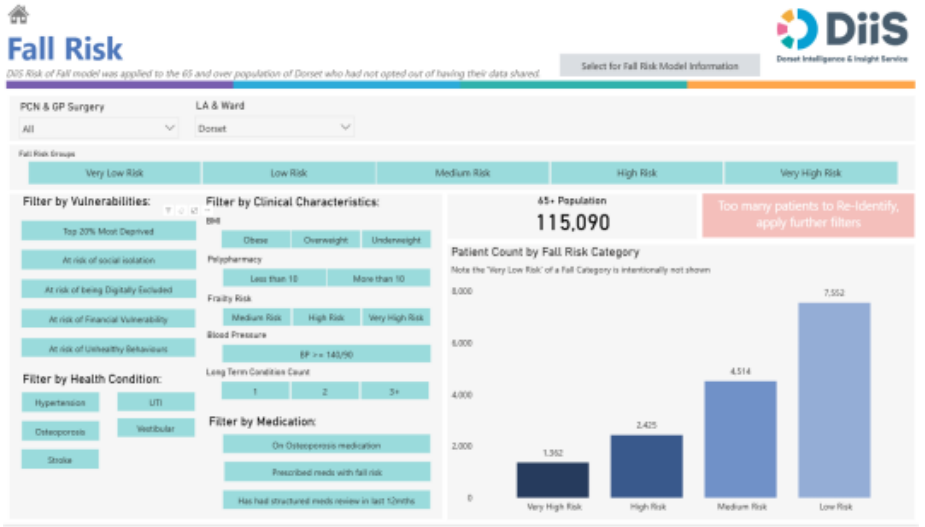
Around 4 PCNs in Dorset; Weymouth and Portland, Mid Dorset, Jurassic Coast, Wimborne and Ferndown have had over a 1000 falls and the Vale having just under 1000 falls over the last 12 months, accounting for around two thirds of recorded falls with Weymouth and Portland accounting for 1 in 5 falls.

Falls sit at the intersection of several factors associated with shorter HLE such as; frailty and reduced mobility, long term conditions such as hypertension, stroke, osteoporosis and vestibular conditions, social isolation, and reduced access to preventive support and community activity.

Falls can lead to injury, hospital admissions, reduced mobility, fear of falling, social isolation and loss of independence which can significantly impact healthy aging. Falls prevention should be considered not only as an injury-prevention programme, but also as part of a broader approach to maintain functional ability, independence and good health in later life. Early prevention and intervention such as identifying residents before crisis, providing targeted solutions amongst high-risk residents, reducing inequalities and applying a placed based approach could help Dorset's residents remain active and independent.



DiiS report - Falls Overview



DiiS report – Falls Risk

What this means

Healthy life expectancy is influenced by a wide range of factors including health behaviours, long-term conditions, access to services, social connections and the environments in which people live. Improving outcomes requires coordinated action across organisations, services and communities, with a particular focus on prevention and reducing inequalities.

The messages shown summarise the most relevant opportunities for key partners across our health and care system, not forgetting of course our supporting and empowering our residents in being able to enjoy longer, healthier and more independent lives.

Strategic opportunities for improving healthy life expectancy

1. Promote active ageing and independent living.
2. Reduce the impact of musculoskeletal conditions.
3. Expand falls prevention approaches.
4. Increase active travel and everyday movement.
5. Improve uptake of screening and early diagnosis.
6. Strengthen neighbourhood prevention through hypertension case finding, NHS Health Checks and integrated community delivery.

Dorset Health and Wellbeing Board
- Strategic leadership
- Reducing inequalities
- Partnership working
- Prioritisation of prevention investment

NHS and Primary Care
- Hypertension detection
- NHS Health Checks
- Early cancer diagnosis
- Long-term condition management

Community and Volunteer Sector
- Social connectedness
- Physical activity opportunities
- Falls prevention activities
- Support healthy aging

Residents
- Stay active
- Attend screening appointments
- Take up NHS Health Checks
- Maintain strength and balance

What can be done

Partners across Dorset bring different but complementary contributions that can support improvements in HLE. Dorset Council, through the Housing, Communities and Prevention Directorate provides several existing programmes driven by Public Health to support the health and wellbeing of local residents, as well as a focus on prevention and maintaining independence through Adult Social Care. The NHS is strengthening its focus on prevention through the 10-year Health Plan, neighbourhood health approaches and delivery of the Cardiovascular Disease (CVD) Modern Service Framework.

What a healthier long life could look like

A healthier long life might mean being able to get to the shops, continue a valued job or caring role, and manage a condition without it taking over everyday life. These are outcomes to discuss with residents, recognising that living well is possible with a condition or disability.

The Chief Medical Officer's 2023 annual report on health in an ageing society describes the aim as delaying illness and reducing the time spent with ill health or dependence. It also stresses adapting homes and neighbourhoods so that people can remain independent when their health changes. [12] The government's 2025 Ten Years Health Plan makes prevention and care closer to home central priorities. [13] For Dorset, this points towards preventing avoidable illness while helping people maintain function and wellbeing after diagnosis.

Housing, income and access to services shape what people can do to protect their health. One existing local connection is Healthy Homes Dorset, which provides energy advice and helps residents access insulation and heating support. [14] Prevention conversations should therefore include practical barriers such as a cold home, transport costs or an inaccessible activity, as well as advice about individual behaviour.

An important local opportunity Age Friendly Dorset [25], which brings together partners to create communities where people can age well. Its focus on staying connected, maintaining independence, having access to suitable services and environments, and supporting participation in community life reflects many of the factors that influence healthy life expectancy. Age-friendly approaches provide a valuable framework for helping residents enjoy more years in good health and reducing inequalities in later life.

As well as Thriving Communities with Volunteer Centre Dorset [26], helping people and places across Dorset become stronger, more connected and resilient. By reducing social isolation, strengthening community support networks and increasing access to local opportunities, Thriving Communities helps address some of the wider factors that influence health, such as loneliness, wellbeing, social participation and access to support.

What can be done

Active Aging

Dorset's older population represents one of the county's greatest strengths but also highlights the importance of helping people remain healthy, independent and connected throughout later life. Healthy ageing is about maintaining the physical, mental and social capabilities that enable people to do the things they value, reducing the impact of ill health and disability as they age. Supporting people to remain active for longer can help increase the number of years spent in good health and reduce inequalities in healthy life expectancy. [22]

Maintaining movement, strength and balance is particularly important in later life. Regular physical activity can help prevent or delay frailty, support musculoskeletal health, maintain independence and reduce the risk of falls. Falls are a major cause of injury, loss of confidence and reduced independence among older adults, making strength and balance activities an important component of healthy ageing. [23]

Dorset is well placed to support active ageing. The local area benefits from extensive access to green and blue spaces, a network of rights of way, coast and countryside locations, and communities where opportunities exist to incorporate physical activity into everyday life. Walking, cycling and other forms of active travel can contribute to physical, mental and social wellbeing while helping people build movement into their daily routines. Evidence shows that environments which support walking and cycling can increase overall physical activity levels and contribute to better health outcomes.

Dorset also benefits from established programmes that promote prevention and healthy lifestyles. LiveWell Dorset supports residents to make positive changes to improve their health and wellbeing, while Active Dorset works with partners and communities to increase physical activity and reduce inequalities in access to active lifestyles. Together with a strong voluntary and community sector, these assets provide a foundation for supporting healthy ageing and enabling more residents to remain active, independent and connected throughout later life.

What can be done

Making physical activity part of everyday life

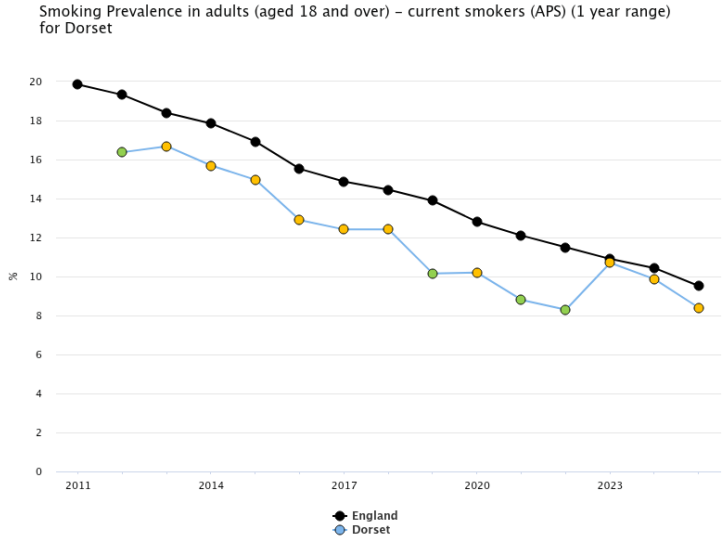
Physical activity is particularly relevant because it can help prevent disease and maintain independence after a diagnosis. The UK Chief Medical Officers' updated guidance recommends at least 150 minutes of moderate activity a week for adults, or an equivalent amount of more vigorous activity, with strengthening activity on at least two days. Older adults should also work on balance and flexibility. The guidance is clear that smaller increases still help, especially for people who are currently inactive. [17]

Active Dorset's A Movement for Movement provides an existing framework across Dorset and BCP. [18] The board could explore how its organisations make everyday movement easier: accessible walking and wheeling routes, affordable local sessions, strength and balance opportunities, and support that people with pain or breathlessness feel able to use.

LiveWell Dorset already offers support with movement, weight, smoking and alcohol. [19] Connecting a Health Check or clinical appointment to this support is one possible route; checking whether the person can access it is equally important. Evaluation should consider sustained participation and residents' ability to do the things that matter to them, alongside the number of referrals.

Building on progress while reaching people with greater need

Smoking has fallen over time, although individual annual estimates fluctuate. Dorset's JSNA also reports higher smoking prevalence among people in routine and manual occupations and those with long-term mental health conditions. [11] A favourable Dorset average should therefore prompt a closer look at who has benefited and who still needs more accessible support.



Estimates of current smoking among adults aged 18 and over, Annual Population Survey. Blue is Dorset Council; black is England. [11]

What can be done

Prevention-focused neighbourhood health

Neighbourhood health provides an emerging opportunity to bring these prevention pathways together around local population need. Residents may experience several interconnected risks; including hypertension, diabetes, physical inactivity, chronic pain, social isolation and difficulties accessing services, which individual programmes may not address collectively. Existing health intelligence could help in identifying Dorset communities where risks and barriers overlap, for example: lower screening uptake, lower Health Check participation, possible undiagnosed hypertension, higher cardiovascular risk and barriers to accessing services [24].

Dorset's existing assets; including primary care, community pharmacy, Public Health, LiveWell Dorset, Adult Social Care, community services and voluntary and community organisations could be brought together around a more coordinated local prevention offer. Neighbourhood health remains an emerging delivery model and provides an opportunity to make prevention more proactive, targeted, accessible and coordinated, with evaluation built into delivery.

For Dorset, early prevention is about making every contact count: identifying risk earlier, acting sooner, completing the pathway and focusing additional effort where residents face the greatest risk or barriers to prevention.

What can be done

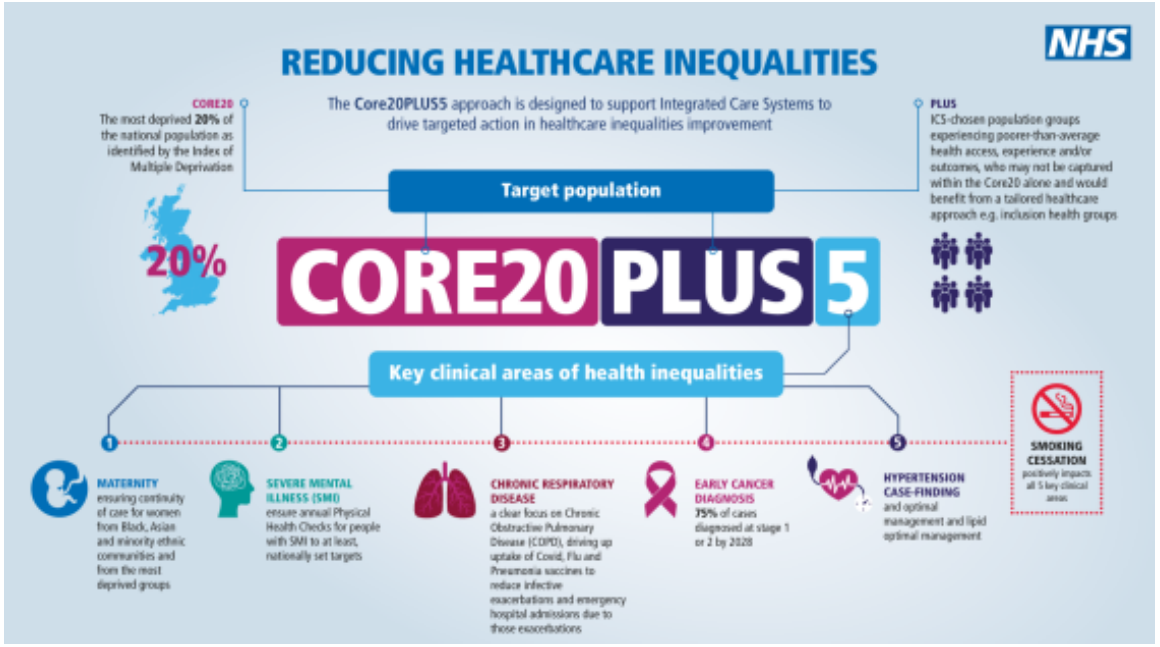
NHS plan on early diagnosis

The NHS 10 Year Health Plan seeks to improve healthy years by shifting diagnosis to an earlier stage, identifying disease before symptoms develop, and move from reactive diagnosis to predictive risk-based detection;

- earlier diagnosis of existing diseases i.e. early cancer diagnosis, expanding screening programmes, improve access to diagnostics and faster referral pathways
- earlier identification of high-risk individuals using population risk stratification, hypertension case finding, diabetes and CVD prevention and community and neighbourhood-based prevention
- and diagnosis before symptoms emerge i.e. AI and predictive analytics, genomics, polygenic risk scoring and continuous monitoring through wearables. [13]

The NHS Core20PLUS5 seeks to inform action to reduce healthcare inequalities through a targeted approach; one of which is a target of 75% of cancers diagnosed at Stage 1 or Stage 2 by 2028.[21]

These plans strongly support early detection and prevention of HLE related conditions, and DiiS is currently developing an Age at diagnosis of LTE condition tool to support early detection.



NHS Core20PLUS5 [20]

What can be done

Early Screening and Detection

Dorset already has a strong foundation of prevention programmes across the council, NHS and community sectors. There are opportunities to connect existing activity more effectively around residents, identify risk earlier and ensure that identification leads to appropriate follow-up, treatment and support. Early prevention is particularly relevant to HLE because avoidable deterioration can often be delayed when risks are identified and managed before they result in serious illness, disability or loss of independence.

Cancer remains an important cause of premature mortality in Dorset. Screening and earlier diagnosis can improve treatment options and outcomes for many cancers. Existing bowel, breast and cervical screening programmes, alongside targeted lung health checks where eligible and established cancer pathways, provide a strong foundation. The opportunity is to use local intelligence to identify communities with lower uptake and understand barriers to participation, targeted invitations, accessible information, community outreach and trusted local

Hypertension is common, often has no symptoms and is an important modifiable risk factor for cardiovascular disease and stroke. Existing primary care, community-pharmacy case-finding, NHS Health Checks and cardiovascular prevention programmes provide several opportunities to identify residents with previously undetected or poorly controlled blood pressure. The opportunity is to strengthen the pathway from Case-finding to confirmation, treatment, blood-pressure control and ongoing management. Also utilising existing health intelligence capabilities to help identify communities where detection or control may be poorer and support more targeted prevention through primary care, pharmacies and community settings.

NHS Health Checks offer eligible adults aged 40–74 a route to identify cardiovascular risks before they lead to serious illness. LiveWell Dorset's published offer includes targeted checks in community venues and workplaces. [15] The national programme review found better recording of risk and disease detection, but also variation in attendance and follow-up. The practical question is not simply how many checks take place, but whether people identified at risk receive and benefit from the next step. [16] Local monitoring should follow people from invitation through attendance to support or treatment. It should distinguish a high-risk result from a confirmed diagnosis, and a referral from support received.

Dorset Council, primary care, community pharmacies, NHS partners and LiveWell Dorset carries out this function. In Q1 2026/27, Dorset recorded 5,219 invitations and 1,140 checks, with an uptake of 21%. Dorset council should retain a universal offer while intensifying invitations, convenient community delivery and completed follow-up for deprived neighbourhoods, smokers, people with obesity and other higher-risk groups. It should continue to monitor invitations, completions, abnormal findings, referrals and referral completion.

Data Sources

Note: Fingertips data were downloaded in September 2026. This is a publicly available data which can be revised;.

[1] Office for National Statistics (2026). Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024. 19 February. Official statistics in development because of declining Annual Population Survey sample sizes. Source

[2] Office for National Statistics (2025). Life expectancy for local areas of the UK: between 2001 to 2003 and 2022 to 2024. 10 December. Source

[3] Department of Health and Social Care (2025). Health trends and variation in England 2025: a Chief Medical Officer report. 25 September. Source

[4] OHID. Fingertips indicators 90362 (HLE at birth) and 90366 (LE at birth), 2022–2024; HLE trend comparison 2019–2021. Dorset E06000059, South West E12000009, England E92000001; male and female, all ages, no category breakdown. Figure 1 and calculated gaps use one-decimal published values. Source

[5] Office for National Statistics (2026). Healthy life expectancy by national area deprivation, England and Wales: between 2013 to 2015 and 2022 to 2024. 15 April. England comparisons use national IMD 2025 deciles. Source

[6] Dorset Council. Deprivation Topic Data. Figures attributed on the page to the English Indices of Deprivation 2025. Counts refer to lower layer super output areas; the health deprivation and overall deprivation domains should not be conflated. Source

[7] OHID. Fingertips Local Health indicator 94359, Healthy life expectancy at birth 2021 Census based, 2019–2023. MSOAs E02004284, E02007006, E02004250 and E02004278. Figure 2 uses the published estimates and 95% confidence intervals. Source

[8] Office for National Statistics (2026). Health state life expectancy estimates for Middle layer Super Output Areas, England and Wales: 2019 to 2023. 30 July. Methods and interpretation of Census-based estimates. Source

[9] OHID (2025). Segment tool: November 2025 update. 12 November. Downloaded data tables: Life_expectancy-within_areas, Broad_causes and Detailed_causes; Dorset E06000059, Within area, 2022 to 2023. Deprivation quintiles use IMD 2019 under the tool methodology. Figure 3 is a replot, not a screenshot of the live tool. Source

[10] OHID (2023). Understanding the drivers of healthy life expectancy: report. 1 June. National associations and analysis; not a Dorset-specific attribution model. Source

[11] Dorset Council. Dorset Joint Strategic Needs Assessment. Sections Prevention – major health conditions and Prevention – healthy lives; Figure 9. Diagnosis-age estimates are not supplied by these passages. The smoking figure is reproduced from the published chart image. Source

[12] Department of Health and Social Care (2023). Chief Medical Officer's annual report 2023: health in an ageing society. Executive summary and recommendations. 10 November; updated 16 November. Source

[13] Department of Health and Social Care (2025). Fit for the future: 10 Year Health Plan for England. 3 July. Source

[14] Dorset Council. Heating and insulation grants. Healthy Homes Dorset service description. Source

[15] LiveWell Dorset. NHS Health Checks. Published community and workplace offer; this establishes the service, not its Dorset Council-only outcomes. Source

[16] OHID (2021). Annex B: a summary of analyses and evidence on the current NHS Health Check programme. Updated 9 December. National programme review evidence; not an estimate of local impact. Source

[17] Department of Health and Social Care (2019, updated 2026). UK Chief Medical Officers' physical activity guidelines. Updated 10 July 2026. Adults and older adults sections. Source

[18] Active Dorset. Our Dorset – A Movement for Movement. Physical activity strategy covering Dorset and BCP; local reporting in this paper should use Dorset Council residents only. Source

[19] LiveWell Dorset. Health and wellbeing service: movement, weight, smoking and alcohol support. Source

[20] Dorset Intelligence and Insight Service (DIIS). Accessed: 12/10/2026 Source

[21] NHS England. Core20PLUS5 (adults): an approach to reducing healthcare inequalities. Source

[22] WHO Aging and Health Source

[23] UK Parliament Healthy Aging: physical activity in an aging society Source

[24] Department of Health and Social Care / NHS England. Neighbourhood health framework. Source

[25] Dorset Council; Age Friendly Dorset Source

[26] Volunteer Centre Dorset; Thriving Communities Source

Health and Wellbeing Board

18 November 2026

Pharmaceutical Needs Assessment Supplementary Statement

For Decision

Cabinet Member:
Cllr M Bell, Public Health, Prevention & Communities

Local Councillor(s):

Senior Leadership Team:
S Crowe - Executive Director, Housing, Prevention and Communities

Report author and job title: Eleanor Jeram, Public Health Intelligence Team Lead
Email: Eleanor.Jeram@dorsetcouncil.gov.uk

Statutory Authority: The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

Report status: Public (the exemption paragraph is N/A)

1. **Executive summary (maximum of 500 words)**

1.1 The Dorset Health and Wellbeing Board has a statutory responsibility to publish and maintain a Pharmaceutical Needs Assessment (PNA). The PNA informs commissioning decisions and pharmacy market entry applications by assessing whether local pharmaceutical services meet the needs of the population.

1.2 Since publication of the current PNA, several changes to local pharmaceutical service provision have occurred. These changes have been reviewed in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and national guidance.

1.3 The changes affect the availability of pharmaceutical services and should be formally recorded through a supplementary statement. Publication of a supplementary statement is considered a proportionate response and ensures that the PNA remains up to date for commissioners and decision-makers. The changes do not alter the findings or conclusions of the current PNA and do not require a full review of pharmaceutical need.

1.4 The Board is therefore asked to approve publication of the attached PNA Supplementary Statement.

2. Recommendation(s)

2.1 The Health and Wellbeing Board is asked to:

- Note the changes to pharmaceutical service provision that have occurred since publication of the current Pharmaceutical Needs Assessment.
- Note that these changes do not alter the findings or conclusions of the current PNA regarding pharmaceutical need.
- Approve publication of the Pharmaceutical Needs Assessment Supplementary Statement attached at Appendix 1.

3. Reason for the recommendation(s)

3.1 Publication of a supplementary statement ensures that the Pharmaceutical Needs Assessment remains current, and that NHS Dorset and other decision-makers have access to up-to-date information when considering pharmaceutical service applications and commissioning decisions.

4. The report

4.1 A Pharmaceutical Needs Assessment (PNA) is a statutory assessment of the pharmaceutical services required to meet the needs of the population within a Health and Wellbeing Board area. It informs NHS commissioning decisions and supports the consideration of applications to join or amend the pharmaceutical list. The PNA considers current provision, accessibility, future population needs and any identified gaps in service provision.

4.2 The current Dorset and Bournemouth, Christchurch and Poole PNA was published in October 2025 following statutory consultation and assessment. The PNA concluded that there was appropriate pharmaceutical service provision across the Dorset Integrated Care System area and identified no current or future gaps requiring additional pharmacy provision during the life of the document.

4.3 Following publication, the Health and Wellbeing Board has an ongoing responsibility to monitor changes to pharmaceutical service provision. The

Regulations recognise that changes can occur during the lifetime of the PNA and provide two potential responses:

- Publication of a revised PNA where significant changes in need are identified.
- Publication of a supplementary statement where changes relate to the availability of pharmaceutical services and a full revision would be disproportionate.

4.4 A supplementary statement is a factual update to a published PNA. It records changes to the availability of pharmaceutical services and becomes part of the PNA once published. The purpose is to ensure that commissioners and decision makers have access to current information when determining pharmacy applications and commissioning decisions. It does not revise the finding of the PNA, and does not identify new gaps in provision.

4.5 Since publication of the current PNA, several changes to pharmaceutical service provision have been formally notified to the Health and Wellbeing Board through NHS Dorset and Primary Care Support England.

4.6 These changes are summarised in Appendix 1 and for Dorset include:

- The opening of a new pharmacy in the Fortuneswell/High Street area of Portland.
- The relocation of 1 pharmacy, with no significant change to provision.
- Change of ownership for 15 pharmacies across Dorset, including those resulting from the closing of JHoots Pharmacies.
- Corrections and updates to opening hours for 6 pharmacies in the Dorset area.

4.7 The potential impact of each change has been assessed against the requirements set out within the Regulations and national guidance.

4.8 The review concluded that the identified changes represent changes to the availability of pharmaceutical services that should be formally recorded through a supplementary statement. However, the changes do not alter the conclusions of the current PNA and do not indicate a need for a full refresh of the assessment. Publication of a supplementary statement is therefore considered the appropriate and proportionate response.

5. Alternative options considered

5.1 No action – This option was discounted as the changes would not be formally reflected within the published PNA, resulting in decision-makers having access to out-of-date information.

5.2 Undertake a full revision of the PNA – This option was considered disproportionate as the identified changes do not amount to a significant change in pharmaceutical need and do not warrant full reassessment and consultation.

6. Legal considerations

6.1 The Pharmaceutical Needs Assessment and the proposed supplementary statement are governed by the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

6.2 Regulation 6 allows a Health and Wellbeing Board to publish a supplementary statement where changes to the availability of pharmaceutical services are relevant to the granting of pharmacy applications and where publication of a revised PNA would be a disproportionate response. The supplementary statement becomes part of the PNA once published.

7. Financial implications

7.1 There are no direct financial implications arising from publication of the supplementary statement.

7.2 The supplementary statement may assist NHS Dorset in future pharmaceutical commissioning and market entry decisions.

8. Natural environment, climate & ecology implications

8.1 The are no direct natural environments, climate or ecological implications arising from publication of the supplementary statement

9. Well-being and health implications

9.1 Maintaining an accurate PNA supports effective planning and commissioning of pharmaceutical services and helps ensure continued access to medicines and pharmacy services for Dorset residents.

9.2 Publication of the supplementary statement promotes transparency and ensures that changes to local pharmacy provision are formally recognised within the statutory assessment framework.

10. Other implications

10.1 None Identified

11. Risk Implications

11.1 Having considered the risks associated with this decision, the level of risk has been identified as:
Current Risk: Low
Residual Risk: Low

12. **Equalities**

12.1 The supplementary statement records factual changes to service availability and does not alter the conclusions of the existing PNA.

12.2 An Equality Impact Statement is not required.

13. **Appendices**

13.1 Appendix 1 – Pharmaceutical Needs Assessment Supplementary Statement.

14. **Background papers**

14.1 Pharmaceutical Needs Assessment 2025-2028

15. **Report sign-off**

15.1 This report has been through the internal report clearance process and has been signed off by the Director for Assurance & Governance (Monitoring Officer), the Director for Resources (Section 151 Officer) and the appropriate Cabinet Member(s)

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Supplementary statement to the Public Health Dorset Pharmaceutical Needs Assessment 2025 - 2028

The BCP Public Health and Communities team and Dorset Public Health and Prevention team produced the 2025 PNA for Bournemouth, Christchurch and Poole (BCP) Health and Wellbeing Board and Dorset Health and Wellbeing Board. This was published in October 2025.

This supplementary statement updates the PNA document that was published.

Date supplementary statement issued: 28th September 2026

1. Closing of a pharmacy

In the BCP Health and Wellbeing Board area;

- Canford Heath Pharmacy at 9 Mitchell Road, Canford Heath was closed on 28th March 2025. The pharmacy at 3 Adastral Square, Canford Heath moved to this location on 31st March 2025.

2. Consolidation of two pharmacies

In the Dorset Health and Wellbeing Board area;

- consolidation of two Avicenna pharmacies was granted on 18th August 2025. The locations at Barn Surgery, Gillingham and High Street, Gillingham will be consolidated onto the High Street, Gillingham site.

3. No significant change relocation

In the BCP Health and Wellbeing Board area;

- The pharmacy located at 3 Adastral Square moved to 9 Mitchell Road, starting pharmaceutical services on the 31st March 2025.
- The pharmacy previously located at 1215 Christchurch Road, Boscombe East has moved to 1227 Christchurch Road, Boscombe East, starting pharmaceutical services from the 29th September 2025.

In the Dorset Health and Wellbeing Board area;

- Permission is granted for the pharmacy at Shop 3, 42 Middlehill Road, Wimborne, BH21 2SE to relocate to 10 Weston Road, Dorset, BH21 2SF.

4. Opening of a pharmacy

In the BCP Health and Wellbeing Board area:

- An application to open a distance selling pharmacy at Unit 1, 470 Ringwood Road, Poole has been granted.

- An application to open a distance selling pharmacy at 48 The Grove, Christchurch has been granted.

In the Dorset Health and Wellbeing Board area;

- An application to open a new pharmacy in the Fortuneswell/High Street area, Portland, Dorset has been granted.

5. Change of ownership

In the BCP Health and Wellbeing Board area;

- From 1st January 2025, Lansdowne pharmacy at 5 Holdenhurst Road, Bournemouth will be operated by Holdenhurst Services Ltd
- From 3rd March 2025, the pharmacy at Talbot Medical Centre, Bournemouth will be operated by Jaspers Health Ltd
- From the 1st May 2025, Parkstone pharmacy at 10 Station Road, Poole, will be operated by Parkstone (2024) Ltd.
- From 31st October 2025, the pharmacy at 24-26 Cunningham Crescent, Bournemouth will be operated by Dragon Retail 807 Ltd.
- From 19th January 2026, the change of ownership was granted for the pharmacy at 446 Kinson Road, Bournemouth which will be operated by Medicine Clinic Ltd.
- In December 2025, the change of ownership was granted for the pharmacy at Rosemary Road, Parkstone which will be operated by Medicine Clinic Ltd.

In the Dorset Health and Wellbeing Board area;

- From 9th June 2025, the pharmacy at Middlefield House, Gillingham will be operated by Dragon Retail 533 Ltd.
- In October 2025, the change of ownership was granted for the pharmacy at 77 Cheap Street, Sherborne which will be operated by Wellbeing United Kingdom Limited.
- From 28th November 2025, the pharmacy at Middlefield House, Marlott Road, Gillingham will be operated by Dragon Retail 533 Ltd.
- In January 2026, the change of ownership was granted for the pharmacy at 22 Gloucester Street, Weymouth which will be operated by AP SD Two Limited.
- From 27th January 2026, the pharmacy at Bridport Medical Centre, West Allington, Bridport which will be operated by AP SD Two Limited.
- In February 2026, the change of ownership was granted for the pharmacy at 19 St. Helens Road, Wareham which will be operated by AMB Pharma LTD.

- In February 2026, the change of ownership was granted for the pharmacy Lyme Regis CCC, Uplyme Road which will be operated by AP SD Sixty Four Limited.
- From 28th February 2026, the pharmacy at High Street, Gillingham will be operated by Dragon Retail 533 Limited.
- From 10th March 2026, the pharmacy at 27 Buxton Road, Weymouth will be operated by Malhotra Pharma Ltd.
- From 20Th April 2026, the pharmacy at Abbey View Medical Centre, Shaftesbury will be operated by AP SD Thirty Two Limited.
- From April 24th 2026 the pharmacy at 19 St. Helens Road, Wareham will be operated by AMB Pharma Ltd.
- In May 2026, the change of ownership was granted for the pharmacy Touts Pharmacy Dorchester, which will be operated by Tout's Healthcare Limited.
- In May 2026, the change of ownership was granted for the pharmacy at Chiltern Drive, Verwood which will be operated by Pharmland Ltd.
- In July 2026, the change of ownership was granted for the pharmacy Allied Pharmacy, Bridport which will be operated by Medscheck Ltd.
- In August 2026, the change of ownership was granted for the pharmacy at 244 Dorchester Road, Weymouth which will be operated by Weymouth Pharma Ltd.

6. Reduction in core hours or significant changes to opening hours

In the BCP Health and Wellbeing Board area;

- The pharmacy at 12 Neighbourhood Centre, Culliford Crescent reduced its Saturday closing time from 13:00 to 11:30 starting 1st January 2025.
- The pharmacy located at Unit 4, The Commerce Centre, Poole extended it's weekday closing hours from 17:00 to 18:00 and Saturday closing hours from 14:00 to 18:00 from 6th January 2025.
- The pharmacy located at 95 Poole Road, Bournemouth reduced its Saturday closing time from 17:30 to 14:00 from the 1st August 2025.
- The pharmacy at 23 Saxon Square, Christchurch started opening on Sundays from 10:00 to 16:00 starting 7th September 2025.
- The pharmacy at 7 Poole Road, Westbourne started opening on Saturdays from 09:00 to 15:00 starting 10th January 2026.
- The pharmacy at 18-20 Commercial Road, Bournemouth extended its opening hours by adding an extra hour from 13:00 to 14:00 Monday to Saturday, starting 13th May 2026.
- The pharmacy at 6 Gillett Road, Poole, reduced its closing time on weekdays to 18:00 from 18:30 with immediate effect 19th August 2026
- The pharmacy at Lilliput Medical Centre updated its opening hours, opening later on weekdays, from 08:30 instead of 08:00, and will close for a lunch

break from 13:00 to 14:00 Monday to Friday. With immediate effect 9th August 2026

In the Dorset Health and Wellbeing Board area:

- The pharmacy at Ferndown Medical Centre, St Marys Road, Ferndown removed the midday break, remaining open continuously from 31st March 2025.
- The pharmacy at 4 North Street, Wareham extended its weekday opening hours from 09:00 to 08:30 starting 1st July 2025.
- The pharmacy at 4 North Street, Wareham reduced its Saturday closing time from 18:30 to 17:00 from the 31st July 2025.
- The pharmacy at 40 Station Road, Swanage ceased opening on Saturdays (ending a temporary Saturday hour increase) from 27th September 2025.
- The pharmacy at 22 Station Road, Swanage opens on Saturday from 09:00 to 13:00 from 4th October 2025.
- The pharmacy at 4 North Street, Wareham, Dorset will close earlier on Saturdays, from 17:00 to 15:00 starting 31st January 2026.
  The pharmacy at 11-13 South Street, Wareham updated its opening hours, opening earlier at 08:30 and closing later at 18:30 from Monday to Friday, and opening on Saturdays from 09:00 to 13:00. With immediate effect 19th August 2026

Supplementary statement issued by: Dorset Council on behalf of Dorset and BCP Councils.

Date: 28th September 2026

Health & Wellbeing Board

18 November 2026

Strategic Alliance for Children and Young People – Babies, Children, Young People and Families' Plan 2023-33 – Annual Report 2026

For Review and Consultation

Cabinet Member:
Cllr C Sutton, Children, Families & Education

Local Councillor(s): **All**

Senior Leadership Team:
P Dempsey - Executive Director, Children's Services

Report author and job title: Sunita Khattra-Hall, Corporate Director Quality Assurance and Safeguarding
Email: sunita.khattra-hall@dorsetcouncil.gov.uk

Statutory Authority: Health and Social Care Act 2012, Part 5, Chapter 2 (Health and Wellbeing Boards).

Report status: Public (the exemption paragraph is N/A)

1. Executive summary

1.1 The Strategic Alliance for Babies, Children and Young People is a multi-agency partnership bringing together organisations from across health, education, social care, policing, early years, the voluntary and community sector and wider public services to improve outcomes for children, young people and families across Dorset.

The Partnership's Babies, Children, Young People and Families' Plan 2023-33 sets out a shared vision:

"We want Dorset to be the best place to be a child, where communities thrive, and families are supported to be the best they can be."

This report presents the Strategic Alliance Annual Report 2026 and highlights progress delivered during 2025/26 across the Plan's seven strategic priorities:

- Best Start in Life

- Young and Thriving
- Good Care Provision
- Best Education for All
- Best Place to Live
- Local Family Help
- Safe at Home and in the Community.

The report demonstrates the impact of partnership working across Dorset, including achievement of an Outstanding Inspection of Local Authority Children's Services outcome, continued national leadership through the Families First Partnership Programme, expansion of Family Hubs, improved educational outcomes, increased support for care-experienced young people, strengthened safeguarding arrangements and greater participation of children and young people in decision making.

The report also identifies emerging priorities and next steps for delivery during 2026/27 as partners continue working together to improve outcomes for babies, children, young people and families.

2. Recommendation

2.1 To note the progress made in delivering the Babies, Children, Young People and Families' Plan 2023-33 (formerly the Children and Young People's Plan 2023-33) and the achievements highlighted within the Strategic Alliance for Babies, Children and Young People Annual Report 2026.

3. Reason for the recommendation

3.1 To provide oversight of the progress and impact of the Babies, Children, Young People and Families' Plan and demonstrate how collaborative partnership working contributes to delivery of Dorset Council priorities and improved outcomes for babies, children, young people and families.

4. The report

4.1 The Strategic Alliance for Babies, Children and Young People is Dorset's partnership for improving outcomes for babies, children, young people and families. It brings together senior leaders from Dorset Council, health partners, education providers, Dorset Police, Dorset & Wiltshire Fire and Rescue Service, the voluntary and community sector, Dorset Parent Carer Council and other key agencies.

The partnership works collectively to deliver the Babies, Children, Young People and Families' Plan 2023-33 through seven strategic priorities which focus on improving outcomes throughout childhood and into adulthood.

4.2 The 2026 Annual Report demonstrates significant progress across all priority areas during 2025/26, including:

- Dorset becoming a Children's Rights Respecting Authority and recognising care experience as a local protected characteristic.
- Achievement of an Outstanding Inspection of Local Authority Children's Services outcome.
- Continued development of Dorset's Families First Partnership Programme as one of the first national Pathfinder authorities.
- Publication of Dorset's Best Start Local Plan and expansion of Family Hub provision.
- Improved educational outcomes including progress in phonics, Key Stage 2 attainment and Good Level of Development.
- More than 17,000 hours of Short Breaks delivered for children and young people with SEND and disabilities.
- Increased support enabling children to remain safely within their family networks and communities.
- Strengthened multi-agency safeguarding arrangements and continued reductions in youth justice and knife crime indicators.

4.3 The report evidences the positive impact of partnership working across Dorset and demonstrates how agencies are working together to improve life chances, deliver earlier intervention and keep children safe. **The Strategic Alliance Annual Report 2026 is attached as Appendix 1.**

5. Alternative options considered

5.1 No alternative options have been considered. The Strategic Alliance Annual Report provides an opportunity for the Health and Wellbeing Board to maintain oversight of progress against the Babies, Children, Young People and Families' Plan 2023-33 and the collective impact of partnership working across Dorset**.**

6. Legal considerations

6.1 There are no direct legal implications arising from this report. The Strategic Alliance supports partners in fulfilling their respective statutory duties relating to children, young people and families, including safeguarding and promoting children's welfare.

7. Financial implications

7.1 Delivery of the Babies, Children, Young People and Families' Plan continues to be achieved through the collective commitment and resources of partner organisations.

7.2 The partnership is focused on delivering earlier intervention, prevention and integrated support through initiatives such as the Families First Partnership, Family Hubs and Local Alliance Groups. These approaches aim to improve outcomes for children and families while ensuring resources are used effectively across the wider system.

8. **Natural environment, climate & ecology implications**

8.1 There are no direct environmental implications arising from this report. The partnership continues to support Dorset Council's environmental ambitions through activity within the Best Place to Live priority, including increasing opportunities for young people to participate in climate and environmental action and supporting sustainable communities where children and young people can thrive.

9. **Well-being and health implications**

9.1 The Babies, Children, Young People and Families' Plan is designed to positively influence the health and wellbeing of babies, children, young people and families through collaborative working across health, education, social care, community safety and voluntary sector organisations.

9.2 Examples highlighted within the Annual Report include the Best Start Local Plan, Child and Adolescent Mental Health Services transformation, Family Hubs, emotional wellbeing support, healthy activities through the Holiday Activities and Food programme, and targeted support for vulnerable children and families.

10. **Other Implications**

10.1 None identified.

11. **Risk Implications**

11.1 HAVING CONSIDERED: the risks associated with this decision; the level of risk has been identified as:

Current Risk: Low
Residual Risk: Low

11.2 The Strategic Alliance governance arrangements support the identification, management and mitigation of risks affecting babies, children, young people and families through regular multi-agency oversight and performance monitoring.

12. **Equalities**

The Strategic Alliance is committed to improving outcomes for all babies, children, young people and families and reducing inequalities across Dorset.

12.1 The Babies, Children, Young People and Families' Plan promotes inclusion, participation and equitable access to services. During 2025/26 the partnership strengthened this commitment by becoming a Children's Rights Respecting Authority, supporting Rights Respecting Schools, increasing opportunities for young people's participation in decision making and recognising care experience as a local protected characteristic.

12.2 Equality Impact Assessments continue to be undertaken where appropriate by individual partner organisations when developing or changing services.

13. **Appendices**

13.1 Appendix 1: Strategic Alliance for Babies, Children and Young People Annual Report 2026.

14. **Background Papers**

14.1 Babies, Children, Young People and Families' Plan 2023-33.

14.2 Health and Wellbeing Board Report: Strategic Alliance for Children and Young People Annual Report 2025. **Item 12 pages 37-82.**

15. **Report sign-off**

15.1 This report has been through the internal report clearance process and has been signed off by the Director for Assurance & Governance (Monitoring Officer), the Director for Resources (Section 151 Officer) and the appropriate Cabinet Member(s)

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Dorset Strategic Alliance for Babies, Children and Young People Annual Report 2025/2026

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2. Chair's introduction

"I am delighted to present the Annual Report of the Strategic Alliance for Babies, Children and Young People, highlighting the progress we have made together during 2025/26 to improve outcomes for babies, children, young people and families across Dorset.

This year has seen significant achievements across our partnership, including outstanding inspection outcomes, continued innovation through the Families First Partnership Programme, and tangible improvements in the lives of children and families. These successes reflect the dedication of colleagues across health, education, social care, policing, early years and the voluntary sector, working together towards our shared vision of making Dorset the best place to be a child.

While there is still more to do, I am proud of what we have achieved collectively and grateful to the children, young people, families and partners whose voices, experiences and commitment continue to shape our work. I hope this report demonstrates the positive difference we are making together and our ambition for the future."



Councillor Clare Sutton, Lead Member for Dorset Children Services and Strategic Alliance Chair

3. Introduction



The Strategic Alliance for Babies, Children and Young People is a unique partnership of organisations across Dorset, united by a shared ambition: to make Dorset the best place to be a child. Working together across health, education, social care, policing, early years and the voluntary and community sector, we are committed to improving outcomes for babies, children, young people and families.

During 2025/26, our partnership continued to grow in strength, delivering significant achievements and driving innovation across the children's system. From securing outstanding inspection outcomes and strengthening safeguarding arrangements, to expanding family support and improving opportunities for care-experienced young people, partners have worked collectively to make a positive difference in the lives of children and families.

This report highlights the progress we have made against our seven strategic priorities and demonstrates how partnership working, shared leadership and the voices of children, young people and families are helping to create lasting change across Dorset.

4. Governance

How the Strategic Alliance for Babies, Children and Young People fits into our wider partnership delivery.



Our Children and Young People (CYP)

Dorset has almost 88,000 0–24-year-olds. This makes up just under a quarter of Dorset residents.

The population has decreased by about 6,600 since 2011, and estimate to predict this trend will continue.

The percentage of children eligible for free school meals has been increasing.

Some areas of Dorset have high deprivation, and overall, 11% of under 16's live in low-income families

Dorset has some unique environmental features which makes it a special place. However, greenspace access is not equitable.

About 6,500 0-15 year olds live in overcrowded households.

In Dorset, CYP generally achieve well. The percentage of young people not in education, employment or training continues to improve.

Pupil absence remains high post-pandemic.

Generally, the health behaviours of our CYP compare favourably to England.

We do see variation – activity levels are lowest for Years 3-4, and some areas see higher rates of obesity.

Nationally 1 in 6 children are estimated to have a mental health disorder.

We have seen an increase in SEN pupils with Social, Emotional and Mental Health as their primary need.

Hospital admission rates for CORE20Plus5 conditions have been improving, however some have increased in the last 2 years.

Children in care are identified as a priority group for oral health

Breastfeeding rates and mothers smoking at time of delivery have continued to improve.

There may be some needs around motor skills and fine personal-social skills in young children.

Some areas continue to see increasing demand for services including SEND and CAMHS.

Social Care referrals remain below the England average and children in need decreased in 2022/23.

Health needs for consideration in future planning include; smoking and vaping, digital wellbeing, growing mental health challenges, physical fitness and obesity prevention.

Variation in immunisation uptake rates.

6. Young People's Voice, Choice and Independence

What children and young people in care told us:

- 92% of children said they always feel safe where they live.
- 93% of children aged 4-7 reported feeling happy.
- 76% of young people regularly talk to trusted adults about things that matter to them.
- Every child aged 4-11 and all but one older child said they trust the adults they live with.



These are excellent indicators of belonging, relationships and wellbeing.

What families told us:

- 98% understand why children's services are involved
- 75% report life has improved for their child
- 80% are satisfied with the service they received

High levels of family understanding and satisfaction demonstrate effective communication and partnership working

Young People's Voice, Choice and Independence

What children and young people in care have told us:

"Since M has been supporting me, things are a lot better for me. M has helped me more than any social worker I have ever had."

"She's the best." (when asked whether their practitioner listened to and acted on their wishes and feelings)

"I don't drink, I am accepting support, I get along really well… I trust she will be doing the right thing for me."

"Support for me has been really good." (Young person rating support 10/10)

Listening to children and young people remains central to improving services. Through quality assurance audits, feedback was gathered from young people during 2026, with 89-90% reporting a positive experience of support from Children's Services. Young people described trusted relationships with practitioners, feeling listened to and supported through challenges in their lives. Their feedback has also highlighted areas for improvement, including communication, keeping promises and ensuring their views directly influence planning and decision-making.

Audit findings continue to drive service improvements, reinforcing our commitment to making children's voices visible, influential and at the heart of practice.

Children & Young People's Voice continued

The following are case studies of young people involved with **The Harbour,** which is an integrated service for children and young people which brings together a range of accommodation options, services and outreach support centred around a residential hub in Weymouth.

Case Study 1 - A young person experiencing multiple placement moves and complex challenges was supported by The Harbour through a trauma-informed, relationship-based approach.

- Improved engagement with trusted adults and support services.
- Greater awareness of risk, exploitation and personal safety.
- Increased emotional insight, resilience and self-awareness.
- Improved understanding of healthy relationships.
- Demonstrated accountability and empathy through restorative work.
- Continued engagement with professionals despite experiencing 13 placement moves.
- One-Sentence Impact Statement

This story demonstrates how consistent, trauma-informed relationships can help vulnerable young people build resilience, strengthen protective factors and maintain hope and engagement through periods of significant instability.

"Having trusted adults who don't give up on you can make all the difference."

Children & Young People's Voice continued

Case Study 2 – A young person with ASD/PDA experienced significant instability, including family breakdown, educational disruption, exploitation concerns and 13 care placement moves. Repeated changes in living arrangements made it difficult to build trusting relationships with professionals and increased their vulnerability to risk.

The Harbour provided consistent support throughout this instability, using a trauma-informed, relationship-based approach to build trust, increase emotional awareness, address risks around exploitation, and strengthen understanding of healthy relationships. Through practical support and restorative work, the young person was supported to reflect on their experiences, take responsibility for their actions and develop positive coping strategies.

As a result, they remained engaged with support despite multiple placement moves, developed stronger relationships with trusted adults, improved their awareness of risk and personal safety, increased emotional resilience, and built protective factors that will support them into adulthood.

"Before Harbour, I would have just got angry and walked away. Now I think more about what's going on for me and how my actions affect other people. It's helped me understand myself better.“ - *Young person supported by Harbour*

Children & Young People's Voice continued

Case Study 3 - A young person facing family breakdown and emotional wellbeing challenges was supported by The Harbour to rebuild family relationships, improve stability and prepare for adulthood.

- Family relationships successfully rebuilt through reunification work.
- Self-harming behaviours significantly reduced through trusted relationships and emotional wellbeing support.
- Missing episodes and exploitation concerns ceased.
- Progression to Weymouth College and positive plans for adulthood.
- Young person's voice, wishes and aspirations remained central to planning and support.

"Having someone who listened, understood and stayed alongside me made a difference."

Young people supported through the **Outreach Service** continue to shape their own futures and make progress towards goals that matter to them.

Examples include young people securing employment, accessing education and training opportunities, developing greater independence, improving wellbeing, and articulating their aspirations for the future. Staff report that young people are increasingly exercising choice, building confidence and taking active steps towards adulthood.

7. Strong Partnerships, Real Impact

The Strategic Alliance for Children and Young People brings together partners from across health, education, social care, policing and the voluntary and community sector with a shared ambition: to help every child and young person in Dorset thrive. By working collaboratively, sharing responsibility and listening closely to children, young people and families, we are creating a more connected system of support that delivers better outcomes for our communities.

This commitment to partnership and co-production is making a tangible difference across Dorset. During 2025/26 we celebrated several significant achievements, including:

- Dorset Council established a Children's Rights Committee, to embed the principles of the UN Convention on the Rights of the Child
- 94% of young people supported by Harbour Outreach remaining safely with their families
- Outstanding Inspection of Local Authority Childrens Services (ILACS) outcome
- Pupil attendance rates remaining above national comparators at 88%
- 71% of children in care living in foster homes
- 99% of care leavers reporting it is easy to contact their worker
- More than 98% of care leavers living in suitable accommodation
- Over 17,000 hours of Short Breaks delivered for children with SEND and disabilities
- The number of first-time entrants to the youth justice system remained at historically low levels in 2025/26, continuing the downward trend from 106 in 2018/19 to 48 in 2025/26.



These outcomes reflect the collective impact of organisations working together through a shared vision and a whole-system approach.

8. Putting Partnership into Practice

One of the strongest examples of this approach is the Families First Partnership Programme. As one of only three original Pathfinder local authorities, Dorset helped test and shape children's social care reforms that are now being rolled out nationally across England.

Through collaboration across early help, family help, health, education, policing and community services, partners are strengthening support for families earlier, reducing duplication and ensuring children receive the right help at the right time. This work directly supports the Alliance priorities of Best Start in Life, Young and Thriving, Local Family Help, and Safe at Home and in the Community.

Local Alliance Groups also play a vital role in turning strategic priorities into local action. Through place-based partnership working, funding has been directed towards community-led projects, local family support initiatives and Dorset Parent-Infant Psychotherapy (DorPIP) programmes, enabling solutions to be designed and delivered by the communities they serve.

The Families First Partnership (FFP) Programme Guide

Delivery expectations for statutory safeguarding partners in England: Year 2 (2026 to 2027)

March 2026



9. Keeping Children Safe Together

Strong partnerships are particularly evident in safeguarding. Across Dorset, agencies continue to work together through integrated safeguarding arrangements, sharing information, coordinating responses and improving outcomes for vulnerable children and young people.



Dorset Police have achieved notable successes, with Dorset ranking first nationally for knife crime rate performance and second nationally for knife crime positive outcomes. The proportion of knife crime offences resulting in a positive outcome increased from 23.2% in 2024/25 to 29.5% in 2025/26, with arrest rates remaining stable at around 40%. Effective multi-agency safeguarding arrangements contributed to arrests linked to child abuse investigations more than doubling during the year, while specialist police teams delivered almost one-third of all positive outcomes for rape and serious sexual offences across Dorset.

The Dorset Safeguarding Children Partnership continues to strengthen the workforce through high-quality multi-agency learning. Between 2023 and 2026, more than 410 training courses have been delivered to over 5,100 practitioners, with satisfaction rates consistently between 98% and 99%. The impact is clear: over half of participants reported changes to their professional practice, while three-quarters identified a positive impact for children, young people and families.

10. Delivering Better Outcomes Through Collaboration

The Dorset Combined Youth Justice Service demonstrates the benefits of effective partnership working. National inspection activity highlighted the service as an example of good practice, recognising strengths in joint working with Dorset Police, restorative justice approaches and speech and language support. Collaborative initiatives such as the Re-Engage Project, cross-sector training and integrated health support help children access services earlier, remain engaged in education and avoid escalation into the youth justice system.

These partnerships have contributed to stronger victim-focused outcomes, improved access to support and more positive long-term outcomes for children, young people and families across Dorset.

As a national Families First Pathfinder, Dorset is contributing to sector-wide improvement by sharing learning, evidence and practical experience with other local authorities, helping to shape future approaches to family help, safeguarding and integrated service delivery.

11. Leading Innovation and Transformation

Dorset continues to demonstrate sector leadership through a range of innovative programmes and nationally significant developments. Alongside the Families First Pathfinder, partners are driving transformation through initiatives including the Best Start Local Plan, Children and Young People's Mental Health Transformation and THRIVE implementation, Valuing Care, Valuing SEND, the Birth to Settled Adulthood model and the Private Law Pathfinder.



Through models such as Multi-Agency Safeguarding Hub (MASH), Operation Encompass and Families First Partnership, partners have strengthened information sharing, reduced duplication and improved early intervention across the system.

Together, these developments reflect a partnership that is not only working well today but is also shaping a stronger, more joined-up children's system for the future. Most importantly, they demonstrate how collective leadership, shared accountability and the voices of children and families are driving real and lasting impact across Dorset.

12. What external inspections said about Dorset

- Outstanding ILACS inspection (March 2025).
- Ofsted recognition of effective multi-agency decision-making.
- Positive Public Digital review of the Front Door (January 2025).
- All Childrens Homes rated Good or Outstanding.

"Strong collaborative working is evident from operational delivery through to strategic decision-making."

"Children continue to be placed at the heart of Dorset."



"Children and families receive the help they need at the earliest point."

"Children at risk of exploitation receive a well-coordinated multi-agency response."

13. Our strategic priorities

The next section will look at a summary of progress and impact over the last 12-months, and next steps for the 7 Priorities in our Babies, Children, Young People and Families' Plan 2023-33.

Our strategic priorities as set out in our 10-year plan

- **Best Start in Life**
- **Young and Thriving**
- **Best Education for All**
- **Best Place to Live**
- **Local Family Help**
- **Good Care Provision**
- **Safe at Home and in the Community**

Our Babies, Children, Young People and Families Plan can be accessed here:
Children, Young People and Families' Plan 2023 to 2033 - Dorset Council

13.1 Best Start In Life - Progress

Best Start in Life – Ensuring babies, young children and their families receive the early support, care and opportunities they need to have the healthiest possible start in life. Our Best Start in Life priority has been refreshed through Dorset's new Best Start Local Plan, creating a more integrated approach to supporting babies, young children and families.

- Co-produced and published Dorset's Best Start Local Plan, creating a single countywide framework across health, education, family hubs, early years settings and the voluntary and community sector.
- Successfully secured and mobilised government funding to expand the Best Start Family Hub Network, increasing access to integrated support for families.
- Established the subgroup for the School Readiness Partnership and Action Plan, aligning multi-agency activity towards improving children's readiness for school and achievement of the Good Level of Development target.



- Expanded evidence-based parenting and early intervention programmes across Dorset, increasing opportunities for families to access support locally.
- Initiated development of the multi-agency workforce development plan review through delivery of training and practice improvement programmes across Family Hubs, health services, early years settings and community partners.
- Continued implementation of targeted health improvement initiatives, including Healthy Movers, supporting families to develop healthy lifestyles and improve outcomes for young children.
- Maintained strong partnership governance for Best Start in Life through the new 0-25 Early Help Partnership Group, enabling coordinated action to reduce inequalities and improve outcomes from pregnancy to age five

Best Start In Life - Impact



- Enhanced support for care-experienced parents includes:
  - Family Hub support
  - Enhanced health support
  - Peer mentoring
  - Family Network Meetings
- 71% of parents participating in parental conflict programmes reported reduced conflict at home, helping create calmer and more stable environments for children.
- 35 care-experienced young people who were pregnant or parenting received targeted support during the year.
- Family Hubs are expanding from existing provision towards a network of 11 Family Hubs across Dorset, increasing access to integrated support.
- Improved partnership working between health, education, Family Hubs and community services is strengthening earlier identification of need and intervention.
- Good Level of Development (GLD): 74.9%, up 5.2 percentage points from last year and above the national average of 72.3%.
- 55% of children are meeting the activity recommendations, an improvement on pre-pandemic levels.
- An average of 60.9% of infants were breastfeeding at 6-8 weeks during 2025/26 higher than the England average.

Best Start In Life - Impact



The difference being made for children and families:

- More joined-up support: Families can access support more easily through better coordination between health, education, Family Hubs and community services.
- Earlier help: Children are more likely to receive support sooner, preventing needs from escalating and improving outcomes.
- Improved school readiness: A stronger focus on communication, language and early learning is helping children arrive at school ready to learn.
- Reducing inequalities: Targeted support is helping disadvantaged children and families access the services and opportunities they need to thrive.
- Stronger support for care-experienced families: Care-experienced parents and young people are receiving tailored support, while the partnership's developing Corporate Grandparent approach is improving support around babies and infants.

Partners are increasingly working as one system to provide earlier, more accessible and targeted support, helping children get the best start in life and reducing the likelihood of needs escalating.

Best Start In Life – Next Steps

Strategic Priorities

Keeping babies safe

- Earlier identification of concerns.
- Strengthen support for parents and carers.

Healthy growth and development

- Promote infant feeding, healthy lifestyles and vaccinations.

School readiness

- Strengthen language, communication and social development.

Supporting families

- Expand Family Hubs and local support networks.

Key Aim

Increase the percentage of children achieving a Good Level of Development by 2028, particularly for disadvantaged children.



13.2 Young And Thriving - Progress

Young and Thriving – Supporting children and young people to be healthy, resilient, engaged and prepared for adulthood, employment and independent living. Here is a high-level summary of the progress and impact we've made over the last year. We have also identified our next steps over the next year.



Progress

- Continued development of the Birth to Settled Adulthood Service.
- Expanded support for young people with SEND preparing for adulthood.
- Strengthened employment and training opportunities and support for successful transitions post 16
- Increased focus on young carers and vulnerable young people.
- Continued investment in youth work, participation and youth voice.
- Developing a youth sufficiency needs assessment which will inform a Dorset wide youth strategy
- Improved partnership focus on emotional wellbeing and mental health.

Young And Thriving - Impact



- Expansion of Birth to Settled Adulthood services.
- 17,000+ hours of Short Breaks delivered.
- 150 young people and their families attended Coffee and Careers events facilitated by Dorset Careers Hub, offering advice and guidance around next steps to employment and training
- 103 young carers supported.
- 71% of care leavers aged 18-25 are in education, employment or training, exceeding council targets and outperforming many comparators.
- 24 care leavers are attending university, including one doctoral student and two postgraduates.
- 15 care-experienced young people are employed through Dorset Council apprenticeships, with a further 10 opportunities secured.
- 68 young people engaged with Dorset's Pathway to Employment programme.
- 99% of care leavers say it is easy to contact their Personal Adviser.
- 97% of young people were involved in creating their pathway plan.
- 98.4% of care leavers are living in suitable accommodation.
- 36 young people remain in Staying Put arrangements, enabling gradual transition into adulthood.
- Dorset has expanded accommodation provision and now provides housing for up to 24 care leavers across council-owned properties.
- Partnerships with landlords have secured accommodation for 15 care leavers.

These show genuine progress towards adulthood and independence.

Young And Thriving - Impact

The difference being made for young people:

- **Preparation for adulthood -** More young people are gaining skills for independence and employment.
- **Improved support for SEND -** Better pathways into adulthood and employment.
- **Improved wellbeing -** More coordinated and earlier emotional wellbeing support
- **Greater participation -** Young people increasingly influence services and decision-making.



Young And Thriving – Next Steps



Strategic Priorities

- Strengthen services that enable young people to achieve their aspirations and realise their potential as they prepare for adulthood, supporting increased participation in education, employment and training opportunities
- Focus on how we can better support young people with their emotional wellbeing and access to early intervention
- Continue to promote meaningful youth voice and participation ensuring children and young people with SEND experience positive transitions and preparation for adulthood.
- Continue to develop the youth work offer in Dorset, ensuring all young people can access safe places, someone safe to talk to who cares, and something to do

Key Aim

Ensure every young person has access to opportunities, support and relationships that help them thrive into adulthood.

13.3 Good Care Provision - Progress

Good Care Provision – Making sure children who need care or protection receive the right support, in the right place, at the right time, as close to home as possible. Here is a high-level summary of the progress and impact we've made over the last year. We have also identified our next steps over the next year.



Progress

•Expanded Dorset's focus on keeping children close to home.

•Increased support for kinship care arrangements.

•Continued development of local fostering capacity.

•Improved support for care leavers.

•Increased emphasis on stable, loving relationships.

•Enhanced support to prevent children entering care where safe to do so.

Good Care Provision - Impact

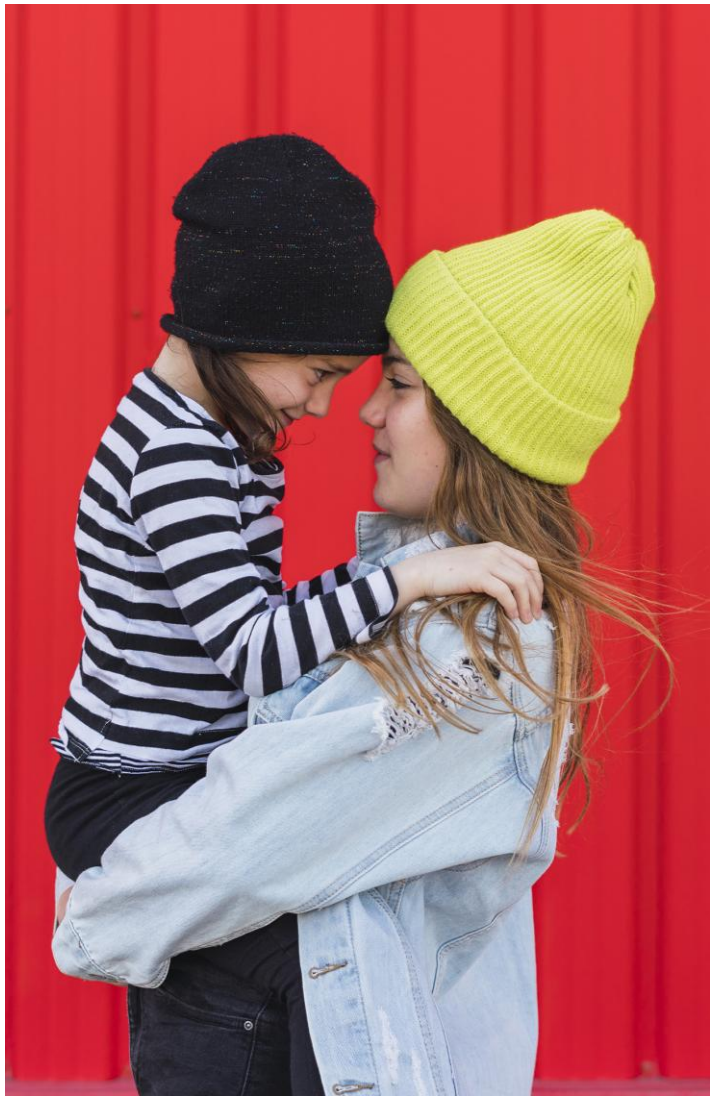
- 94% of Harbour-supported children remained safely with their families, helping prevent entry into care.
- All Dorset children's homes rated Good or Outstanding.
- Increased kinship care and Special Guardianship Orders.
- High placement stability compared with statistical neighbours.
- Valuing CARE delivering improved matching and greater placement stability for children.
- 98% of children in care are in suitable accommodation.
- 71% of children in care now live in foster care, exceeding both national and statistical neighbour averages.
- 71% are in education, employment or training.
- 88% attendance for children in care.
- 13% of children achieved permanence through adoption, an increase from 10% the previous year.
- 24% of children leaving care achieved permanence through reunification with parents or those with parental responsibility, up from 16% the previous year.
- 99% of care leavers in touch with services.
- 36 Staying Put arrangements in place.
- Special Guardianship Orders increased significantly, with 16% of children leaving care achieving permanence through an SGO compared with 5% the previous year.
- 92% of children reported they always feel safe where they live.
- 80% of children aged 11-17 said they always feel settled where they live, up from 71%.

These tell a compelling story about permanence, belonging and safety.

Good Care Provision – Impact

The difference being made for children and families:

- **More children remaining within family networks -** Greater use of kinship arrangements where appropriate.
- **Improved stability -** Children experience fewer disruptions and stronger relationships.
- **Better local provision -** More children remain connected to family, school and community.
- **Stronger preparation for adulthood -** Care experienced young people receive improved support as they transition to independence.



Good Care Provision – Next Steps



Strategic Focus:

- Keeping children close to home.
- Increasing fostering capacity.
- Growing kinship care support.
- Improving care sufficiency.
- Strengthening support for care leavers.

Key Aim

Provide every child with a stable, loving home and enduring relationships.

13.4 Best Education For All - Progress

Best Education for All – Enabling every child and young person to access high-quality education that helps them achieve their potential, regardless of their circumstances. Here is a high-level summary of the progress and impact we've made over the last year. We have also identified our next steps.



Progress

•Aligned local ambitions with the Government's education reforms.

•Continued focus on inclusion and belonging.

•Strengthened support for children with SEND.

•Expanded collaboration between schools and partners including the Department for Education, Multi-Academy Trust CEOs, Regional Improvement for Standards and Excellence (RISE), and Headteachers.

•Increased focus on narrowing attainment gaps

Best Education For All – Impact

As at Summer 2026

- Attendance at 88%, above national comparators.
- Virtual School conference attended by 120 professionals with 99% reporting positive impact.
- 9 education settings participating in Inclusion and Belonging action research.
- Suspensions for children in care reduced from 15% to 10% of the cohort.
- No children in care have been permanently excluded.
- 98% of Personal Education Plans were judged good or outstanding.
- 165 children and young people had educational achievements celebrated through the Virtual School.
- Since the introduction of the revised Ofsted inspection framework in Autumn 2025, every inspected school in Dorset (100%) has met Ofsted's safeguarding requirements.



This demonstrates that vulnerable children are not only attending school but achieving and participating.

Best Education for All – Impact



The difference being made for children and young people:

Educational outcomes improved across Dorset during 2025/26, reflecting the commitment of pupils, schools, settings and partner services. While work continues to reduce variation and further improve outcomes, provisional results show encouraging progress:

- **Phonics:** 84.2%, up 5 percentage points from last year and above the national average of 81.8%.
- **Key Stage 2:** Improvement across all measures, with Reading, Writing and Mathematics combined increasing by 3 percentage points to 60%. Although still below the national figure of 63%, Dorset improved at a faster rate than nationally, narrowing the gap. Individual improvements included Mathematics (+3%), Writing (+2%), Grammar, Punctuation and Spelling (+2%), and Reading (+1%).
- **Key Stage 4:** 73% achieved English Grade 4+, 70% achieved Maths Grade 4+, and the combined English and Maths measure increased by 2 percentage points to 63%. National figures are yet to be confirmed.

In June, more than **120 Headteachers and Senior Leaders** from over **70 Dorset settings** attended the Dorset Education Conference, with a strong focus on leading inclusive schools.

Best Education For All – Next Steps



Strategic Focus

- Further improve outcomes at Key Stage 2.
- Fulfil requirements of the SEND reform proposal in Dorset.
- Continue work to ensure the long-term sustainability of education settings across Dorset.

Key Goals

- Submit the School-Based Nursery (SBN3) multi-year proposal by 30 September 2026.
- Improve attainment so that Dorset outcomes are at least in line with national averages, with a particular focus on continued improvement at Key Stage 2 and Key Stage 4.
- Increase inclusion for children and young people with SEND across all settings as part of the wider SEND reform programme.
- Move into the Dorset Local SEND Transformation (formerly Reform) Plan – including the introduction of new frameworks to strengthen Dorset's Universal Offer and establish a Dorset Inclusion Charter.
- Implementation of the new RISE funding - this will be used to strengthen partnership working with schools, trusts and other stakeholders to secure improved educational outcomes for all children and young people.
- Monitor and evaluate progress through the use of performance data, school engagement and targeted support.

Best Education for All – Since March 2026

Dorset Local SEND Transformation Plan Developed to Implement National SEND Reform

During 2025/26, Dorset developed and secured approval from the Department for Education for its Local SEND Transformation Plan. Shaped through extensive engagement with children and young people, families, education settings, health partners and support services, the plan sets out a shared commitment to improving outcomes for children and young people with SEND through a more inclusive and responsive education system.

At the heart of the plan is Dorset's vision that children and young people are healthy, happy and safe, feel valued and understood, and achieve meaningful outcomes that enable them to lead fulfilling and independent lives. Through inclusive education, high-quality support and strong partnership working, we aim to ensure that all children and young people are empowered to reach their full potential.

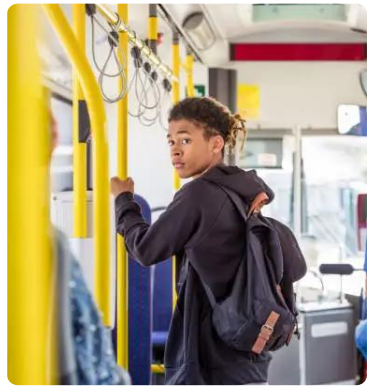
This vision will be delivered through a more inclusive, preventative and locally responsive system, underpinned by Dorset's Expertise Offer (our local Experts at Hand model), which will build confidence and capability across settings to identify and meet needs earlier.

Implementation is now underway, focused on delivering four key outcomes:

- Identify needs earlier and deliver timely support in the right setting
- Strengthen inclusive, local provision
- Improve outcomes and experiences for children, young people and families
- Ensure long-term sustainability and effective use of resources

13.5 Best Place To Live - Progress

Best Place to Live – Creating safe, inclusive and sustainable communities where children, young people and families can flourish and feel connected. Here is a high-level summary of the progress and impact we've made over the last year. We have also identified our next steps.



Progress

- Increased opportunities for youth participation.
- Expanded work with Youth Parliament and youth voice groups.
- Greater focus on inclusion and belonging.
- Increased involvement of young people in environmental priorities and climate action.
- Increased involvement of young people in SEND reform and service development.
- Became a Children's Rights Respecting Authority and recognised care experience as a local protected characteristic, strengthening support for care-experienced children and young people.
- Young people involved in reviewing education resources to ensure they remain relevant and accessible.
- Youth Parliament and Dorset Youth Council leading campaigns on wellbeing, education, transport and rurality.
- Young people helping to make funding decisions through the Youth Grant Fund.
- Expanded focus on the Safe & Settled and Identity priorities through Dorset Unstoppables Network.
- Delivered holiday activities, food and enrichment opportunities through 73 providers operating across 80 venues throughout Dorset, helping children and young people access positive experiences close to home.
- Expanded provision into 17 villages, improving access for children and families living in rural communities.
- Supported providers through SEND training and additional funding for 1:1 support, increasing opportunities for children with additional needs to participate.

Best Place To Live - Impact

- Young people reviewed Virtual School education resources, ensuring support materials reflect their needs and lived experiences.
- Two Members of Youth Parliament (MYP) and two Deputy MYPs were appointed, championing young people's priorities around education, transport and rurality.
- Dorset Youth Council launched the "Wellbeing Matters Just as Much as Grades" campaign, promoting emotional wellbeing alongside academic achievement.
- Young people played a central role in allocating Youth Grant Fund funding, ensuring investment reflected the priorities of their peers and providing young people with somewhere to go, something to do and someone to talk to
- Following the Children's Rights Education Conference, 21 schools and education settings registered interest in becoming Rights Respecting Schools, supported through Dorset Council-funded accreditation.
- 86% of care leavers participated in the Bright Spots survey, up from 38% previously, giving more children influence over service design.
- More than 100 professionals attended "In My Shoes" training, helping services better understand care experience.
- Care experienced young people co-designed improvements through themed workshops covering identity, belonging, education, health and relationships.
- Children's feedback directly informs Corporate Parenting Partnership Delivery Group actions through a "You Said, We Did" approach.
- The Holiday Activity and Food programme delivered almost 6,000 places for children and young people with SEND during Summer 2025, helping ensure holiday activities are accessible and inclusive.

Best Place To Live - Impact



The difference being made for children and families:

Young people are increasingly influencing decisions that affect their lives, from shaping education resources and SEND reforms to leading campaigns, allocating funding and promoting children's rights across Dorset.

- **Children's voices shaping decisions -** Young people have influenced education resources, SEND reforms and service development.
  Greater sense of belonging - Work on identity and children's rights has helped young people feel heard, valued and represented.
  More inclusive communities - Increased awareness of emotional wellbeing, SEND needs and children's rights across schools and services.
- **Improved participation -** Young people are now helping to shape policy, allocate funding and lead campaigns on issues that matter to them.
- **Health** - Served more than 20,000 nutritious meals and worked with Friendly Food Club to provide cooking sessions for over 1,400 children, promoting healthy eating and food confidence.
- **Wellbeing** - Provided opportunities for children to be active, build confidence, develop new skills and create friendships through sports, outdoor learning, creative and cultural activities.

Best Place To Live - Next Steps



Strategic Focus

- Continuing to build safe and inclusive communities
- Strengthening youth participation
- Improving accessibility for children and young people
- Helping young people feel connected to their communities
- Supporting youth-led climate and environmental action
- Expanding inclusive holiday provision to reach more children and young people
- Increasing awareness and accessibility of the Holiday Activity and Food programme to ensure eligible families can benefit from available opportunities.

Key Aim

Ensure Dorset is a place where every child feels safe, welcome and able to participate.

13.6 Local Family Help - Progress

Transforming Family Support Across Dorset

During 2025/26 we continued to reshape support for children, young people and families through Dorset's Local Family Help approach, bringing partners together to provide earlier, more joined-up support.



Key achievements

- Published Dorset's Early Help Strategy 2026-2029
- Continued delivery of Families First reforms
- Established the 0-25 Early Help Partnership Group
- Expanded Family Hub and community-based support
- Strengthened Local Alliance Group partnerships
- Embedded the "tell your story once" approach

Local Family Help - Impact

Easier Access
Family Hubs and locality networks are making it easier for families to identify and access support earlier.

More Joined-Up Support
Children, young people and families experience better coordination between agencies, reducing duplication and improving family experience.

Earlier Intervention
Local Family Help partners are identifying needs sooner and providing support before issues escalate.

Stronger Communities
Investment through Family Hubs and Local Alliance Groups is increasing local capacity and community-led support.

Reduced Inequalities
The partnership continues to target support towards communities and families experiencing disadvantage.



Local Family Help - Impact

Evidence of Progress

- **8,869 contacts** received through Dorset's Front Door
- Referral and re-referral rates remain below statistical neighbour averages
- Children and families increasingly benefit from a Single Assessment process
- Consistency of worker relationships recognised through inspection activity
- Dorset continues to support national Families First implementation
- **£600k invested through Local Alliance Groups** to strengthen prevention and early intervention across Dorset localities
- Family Hubs continue to extend community access to support



Local Family Help - Next Steps



- **Embed Families First** - Continue implementation of Dorset's Local Family Help model
- **Strengthen Family Hubs and Early Support -** Expand access and improve pathways into support
- **Deliver a Stronger Best Start -** Improve school readiness and outcomes in the earliest years
- **Build a Connected 0-25 System -** Join up support from pregnancy through young adulthood
- **Strengthen Community Partnerships -** Grow the role of Local Alliance Groups and community organisations
- **Embed Family Voice -** Ensure children, young people and families shape services and decisions

13.7 Safe At Home And In The Community - Progress

Keeping Children Safe at Home and in the Community – Working together to prevent harm and ensure children and young people are protected, supported and safe wherever they live and spend their time. Here is a high-level summary of the progress and impact we've made over the last year. We have also identified our next steps.



Progress

- Adapted our Thrive model to comply with updated Families First Partnership guidance, with integrated family help and a multi-agency child protection team.
- Strengthened multi-agency safeguarding arrangements across Dorset.
- Expanded contextual safeguarding and Extra Familial Harm approaches with positive feedback from research led by the Global Centre for Contextual Safeguarding.
- Increased focus on domestic abuse, violence against women and girls, and child exploitation.
- Enhanced partnership work with Dorset Police and community safety partners to reduce violence and knife crime.
- Strengthened use of learning, audit and quality assurance to improve outcomes for vulnerable children.
- Whole family approach through Safeguarding Families Together, which now includes a new family court pathway for high-risk harm relating to parental substance use.

Safe At Home And In The Community - Impact

- Missing episodes continue to reduce.
- 113 young people supported through Extra Familial Harm arrangements.
- Increasing use of Family Networks and Family Group Conferences supporting more children to be supported safely within their family networks.
- Multi-agency audits identified strong partnership responses to children experiencing extra-familial harm, leading to better engagement, improved attendance and increased safety.
- Child abuse investigation arrests more than doubled, reflecting improved identification of vulnerability and earlier safeguarding intervention.
- Operation Encompass expanded into Early Years settings, enabling vulnerable children exposed to domestic abuse to receive support sooner.
- The Family Support and Advice Line provides an increasingly integrated approach to children, families and partners to access a range of signposting, support, assessment and intervention.
- Targeted interventions with young people identified as habitual knife carriers are contributing to low levels of reoffending.
- Dorset ranks 1st nationally for performance dealing with knife crime and 2nd nationally for positive outcomes.
- Multi-agency learning continues to strengthen practice, with over 5,100 practitioners participating in safeguarding training between 2023 and 2026.



Safe At Home And In The Community - Impact

The difference being made for children and families:

- **Safer at home** – Earlier identification of domestic abuse, neglect and safeguarding concerns enables families to receive support before risks escalate.

- **Safer in communities** – Children at risk of exploitation, violence and extra-familial harm benefit from coordinated multi-agency intervention.

- **Earlier help and prevention** – Families receive support sooner through improved information sharing and partnership working.

- **Confident safeguarding workforce** – Ongoing multi-agency learning helps practitioners identify risk early and respond effectively.

- **Stronger protective relationships** – Children are increasingly supported by trusted adults and family networks, helping them build resilience and reduce vulnerability.



Safe At Home And In The Community – Next Steps

Strategic Focus

- **Strengthening safeguarding practice -** Ensure children and families receive timely, coordinated support through effective multi-agency working and continuous learning.

- **Reducing exploitation and extra-familial harm -** Build on contextual safeguarding approaches to reduce risks associated with criminal exploitation, violence and missing episodes.

- **Improving online safety -** Work with children, families, schools and partners to increase awareness of online risks and promote safe digital environments.

- **Building safer communities -** Strengthen partnerships with police, community safety and voluntary sector organisations to prevent harm and support vulnerable children.

- **Delivering Families First reforms -** Continue embedding integrated family help and safeguarding arrangements that provide the right support at the right time.

Key Aim

Ensure every child in Dorset feels safe, protected and supported at home, online and within their community.

14. Epilogue: Together, Making Dorset the Best Place to Be a Child



This year has shown what we can achieve when we work together.

Across Dorset, partners, communities, children, young people and families have helped us make progress towards our shared vision: '**making Dorset the best place to be a child, where communities thrive and families are supported to be the best they can be.'**

Together, we have worked to give children the best start in life, help young people be healthy, happy and thriving, support families earlier through local family help, and ensure children are safe at home and in their communities.

We are proud of what we have achieved together, but we know there is more to do.
Over the coming year, we will continue to listen to children, young people and families, work together across organisations, and focus on improving outcomes for everyone.

Thank you to everyone who has contributed to this work. Together, we are building a brighter future for Dorset's babies, children, young people and families