FutureCare

Care that works for everyone, wherever they are - home, community or hospital.

Transformation Programme Update

Our Dorset

Transforming urgent and emergency care together

Executive summary

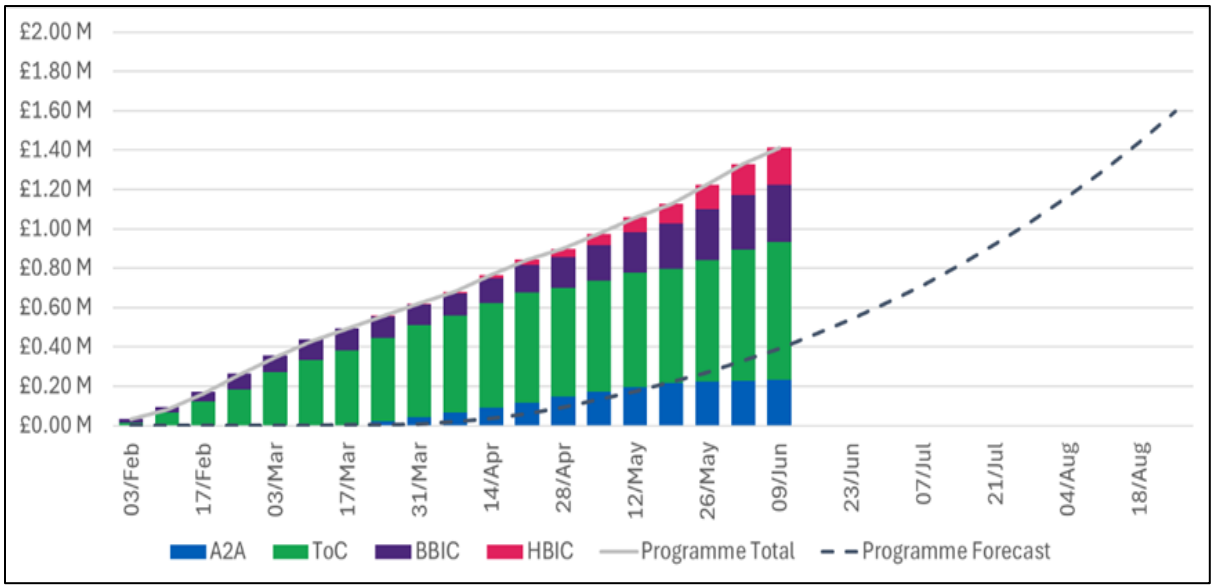
There has been good progress with the delivery of the FutureCare Programme in June:

- At Wimborne Community Hospital the average open length of stay for patients reduced by 12 days to less than 20 within 3 weeks of the pilot starting in May.
- At Dorset County Hospital, across the hospital the average length of stay for people with no criteria to reside reduced from a 4-week average of 10.1 days on 1 April 25 to 6.8 days on 6 June 25.
- The new Transfer of Care Hub has opened at UHD, and work is well underway to roll out early discharge planning across Older People's Services at UHD, and by the end of July across all adult wards.
- Several new digital and insight tools have gone live – the Home-Based Intermediate Care Capacity Tracker, the UHD TOC Dashboard and the Beta version of the System Visibility Dashboard. Greater use is also being made of the data and insight now available to track weekly performance through the weekly East and West UEC WIG Groups

Programme updates have been provided to:

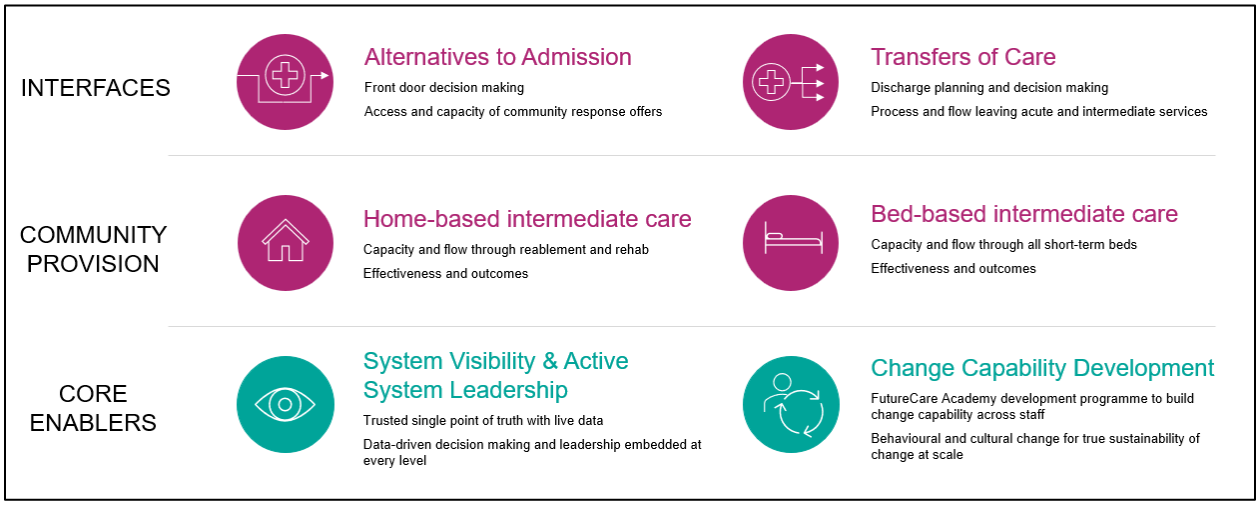
- BCP Health and Care O&S Committee and BCP Corporate Management Board
- Dorset Council Health and Wellbeing Board
- UHD Board
- Dorset GP Alliance Board

On Thursday 24 June, the FutureCare Steering Group received an update on the Benefits Delivery Plan. This confirmed that the programme remains on track to deliver anticipated benefits and that at the beginning of June, £1.4m of cumulative benefit had been delivered.



Programme overview

The FutureCare programme is made up of six workstreams, each led by a representative from organisations across Dorset's health and care system. More information about the four patient-facing workstreams is presented below.



Alternatives to Admission workstream

The Alternatives to Admissions (A2A) workstream primarily focuses on better utilising and referring more people to Same Day Emergency Care (SDEC) Services and other A2A services including Hospital at Home (H@H). This workstream is being led by UHD.

Our areas of focus

Supporting more patients to be discharged the same day through SDEC services

Increasing the number of patients who are able to benefit from SDEC services and who are subsequently able to return home through:

- Formalising the pull of patients from ED and having huddles throughout the day to review flow
- Regular improvement cycles to enable data-led action setting

Supporting more patients to be supported at home with H@H or community services

Increasing the number of patients accessing H@H, ASC, DHC virtual wards, ICRT, district nursing from an ED/SDEC attendance through:

- Improving knowledge and links with appropriate community services
- Identifying appropriate services that can support at the front door and clarifying referral routes

Trials started at Royal Bournemouth Hospital (RBH) on 19 May 2025, with FutureCare linking in and building on existing improvement initiatives. The changes rolled out include a morning and evening identification process, three times a day huddles, a new traffic light capacity system and additional data capture.

What have we been trialling in Med and OPS SDEC?

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To enable more patients to be supported in OPS and Med SDEC, a few changes, designed by the SDEC teams, have been trialled:

Morning Pull
ACPs and/or consultants head down to ED in the morning to review patients who could be pulled into SDEC. In Med SDEC this involves a clinician-to-clinician conversation, improving the links with ED.

Evening Pull
ACP and consultant head down to ED shortly before closing to review if there are any patients who can be sent home safely and brought back to SDEC the next day, preventing patients being admitted overnight unnecessarily.

Capacity Traffic Light System
A traffic light system is used to define how many patients SDEC is expecting to be able to see that day based on staffing, delays etc. and this is communicated with ED.

Three times a day huddles
The SDEC teams gets together to review patients who are currently in SDEC, if any are likely to be admitted, and if there are more waiting in ED who could be supported.

Improvement Cycles
All of these changes have been underpinned by improvement cycles – regular meetings to review data and performance of each SDEC to understand trends and agree actions and owners for future improvement actions.

OPS SDEC			Average weekly number of patients attending SDEC and discharged same day	Med SDEC		
22	→	27		57	→	61
Jul-Aug 24		Current		Jul-Aug 24		Current

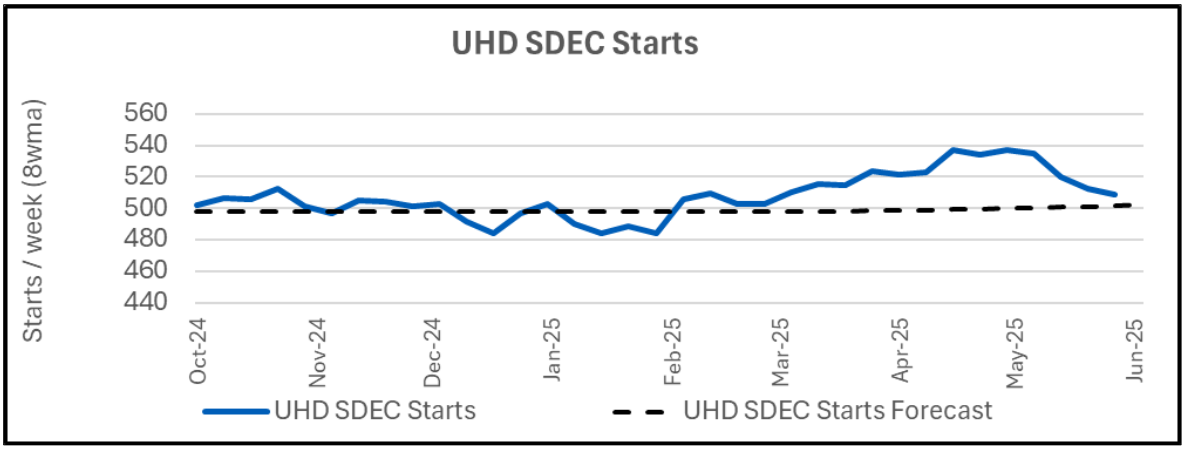
On the first morning three additional patients were identified to be supported by Medical SDEC, and this was despite it being a 'red' day for capacity.

Nurse Consultant ED

Transforming the way we manage urgent and emergency care starts with recognising that hospital admission isn't always the best or only option.

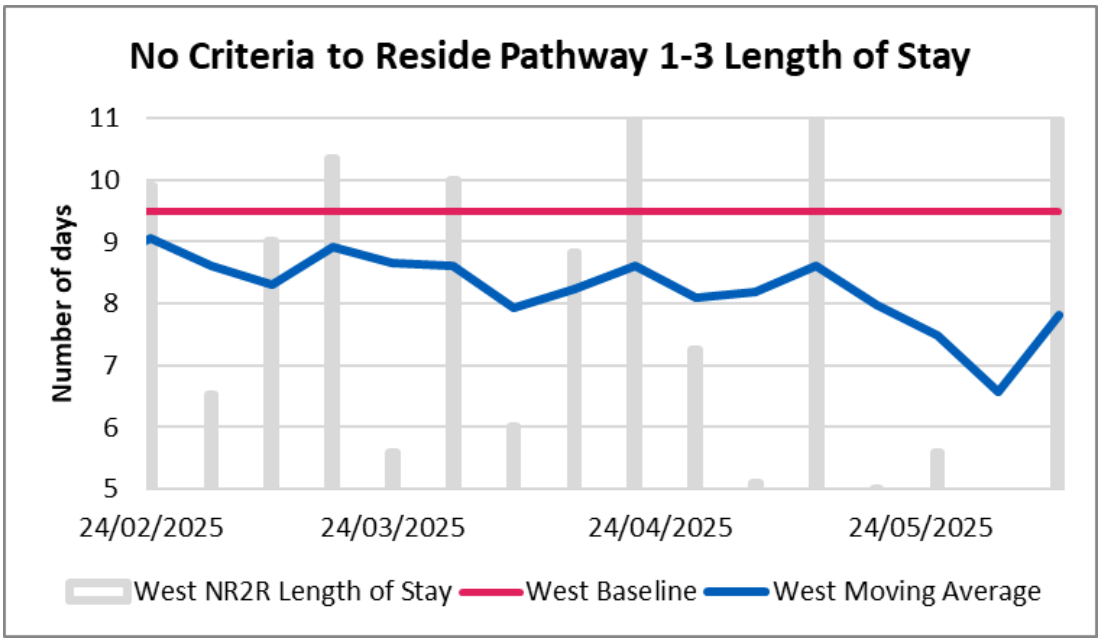
I see first-hand the impact that early identification and timely alternatives can have — not just on patient outcomes, but on flow, safety, and staff wellbeing.

Work is now underway to replicate the approach at Dorset County Hospital (DCH) and work will begin at Poole General Hospital (PGH) shortly. The graph below sets out UHD SDEC performance so far.



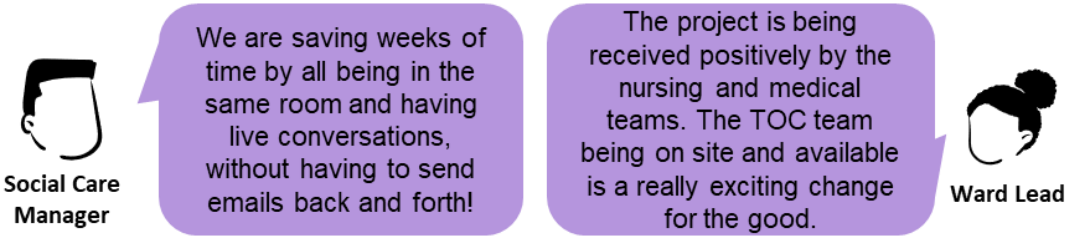
Transfers of Care workstream

The Transfers of Care (TOC) workstream aims to reduce the number of days that people are delayed in hospital, once they are medically fit, whilst they wait for ongoing support. This workstream mobilised first and work began at DCH at the beginning of March 2025. This involved establishing a dedicated physical space called a TOC Hub, where teams from different organisations (including VCSE, BCP Council, and Dorset Council) work together and problem-solve to help more people to get home sooner. Initially, the work focussed on supporting three hospital wards (which accounts for more than 50% of the complex demand in DCH) but from 12 May 2025 the scope has been expanded to include all DCH beds.



As can be seen from the chart above, the average length of stay for people waiting to be discharged in a hospital bed from DCH **has reduced from a 4-week average of 9.0 days on 24 February 2025 to a 4-week average of 7.8 days on 9 June 2025**. This reached as low as 6.6 days, but recently spiked as many of the longest stayers were discharged.

Valuable feedback has also been received from team members involved in the trial.



Transfer of Care Hub at UHD

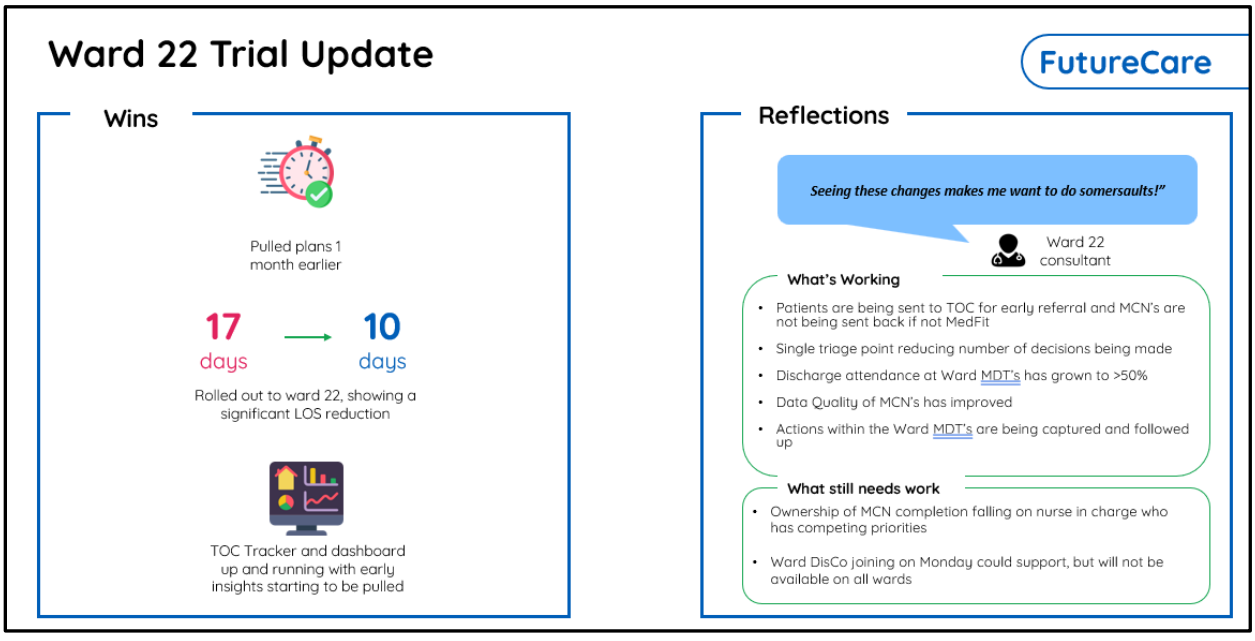
Following the success of the new approach at DCH, the **TOC Hub at UHD has now become operational**, a site has been identified, and teams have now been co-located from Monday 23rd June 2025. The team are also being supported by a **new TOC referral tracking tool**, which is helping teams to monitor referrals and make decisions

Trials of new ways of working together at ward level started in Ward 22 at RBH. From Monday 23 June 2025 these changes have also begun to be rolled out across the RBH Older People's Services (OPS) wards and from Monday 30 June 2025, PGH OPS Wards.

By 21 July 2025 the new ways of working will be rolled out across **all UHD adult wards**.

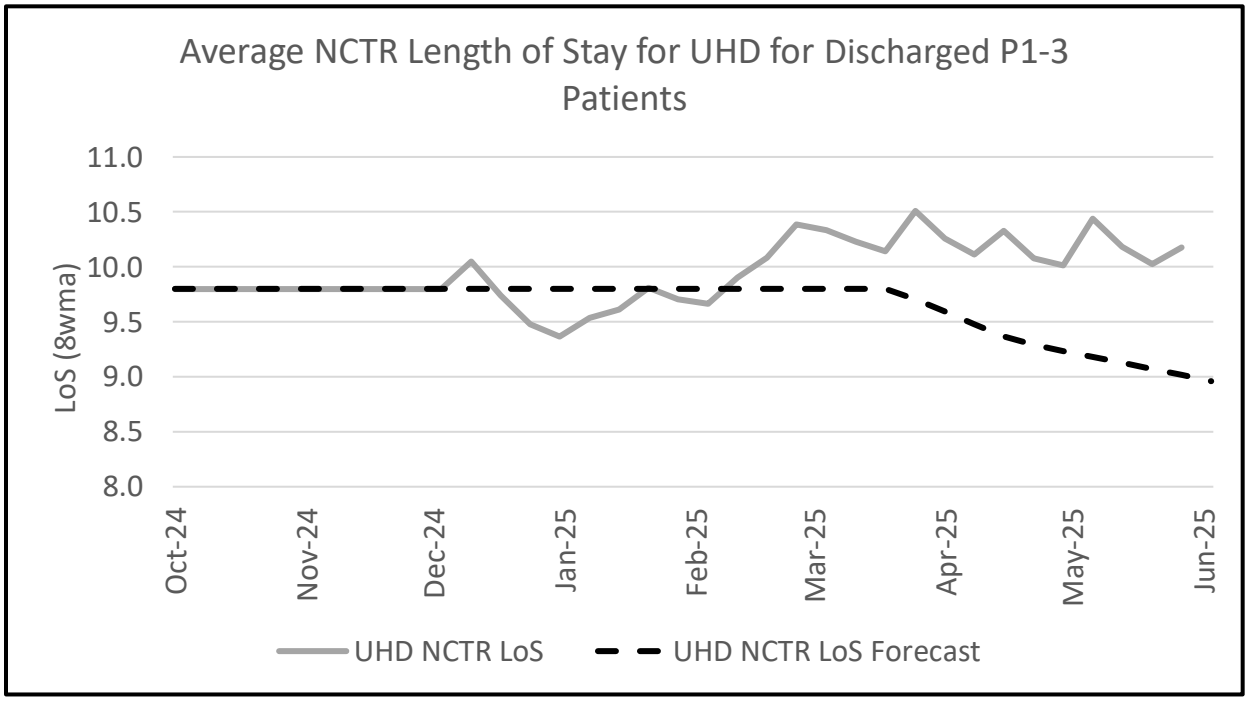
Senior Matron on Ward 22

Ward 22 has made such improvement to length of stay in such a short period of time, the ward is running more efficiently, and staff wellbeing has improved and teamwork has become even stronger.



Despite positive initial results on Ward 22 and the UHD team rapidly scaling the new Transfer of Care processes across the rest of the organisation, it should be noted that the overall Length of Stay position for NCTR for P1-3 patients remains at the baseline level and hence is behind where the programme trajectory had been forecast to be at this time.

This has been noted by the workstream, the programme Steering Group, and UHD Exec teams, and work is underway to accelerate and increase the impact to get back on trajectory.

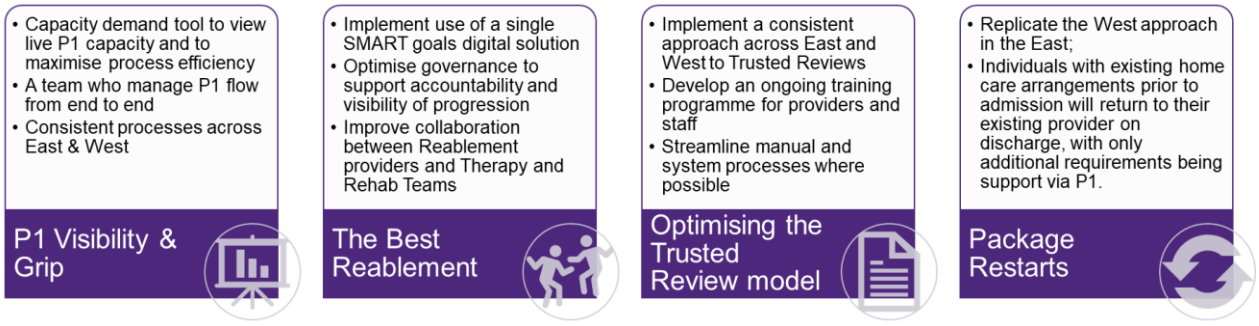


Home-Based Intermediate Care workstream

The Home-Based Intermediate Care (HBIC) workstream aims to increase the effectiveness of short-term care provided at home following a hospital stay, releasing more capacity to help more people and to improve the quality of the service. The initial focus of activity is working with the two local authority care companies – Tricuro and Care Dorset – to improve the effectiveness of existing reablement services. New technology is planned to increase flow and effectiveness and to reduce delays in the handover of support from reablement providers to long term care packages when required.

Having achieved this, the second part of the delivery plan will focus on simplifying the reablement pathway, reducing the number of providers and hand-offs and embedding a more therapy-based approach to reablement and a genuine discharge to assess model.

The diagram below sets out in more details plans for the first four improvement cycles.



A key deliverable for the workstream will be a **SMART Goals App** which will be used to help people and their reablement workers to set personal goals that matter to them, and which helps in their journey towards independence. The App, which will initially be utilised until June 2027 should be operational by Autumn 2025.

Improving Home Based Intermediate Care in Bournemouth, Christchurch and Poole

A significant change that has been agreed by UHD, BCP Council and NHS Dorset is to **trial a new approach to home-based support** for residents when they leave hospital.

Rather than 59% of capacity being used to provide interim support, once a person has left hospital, whilst they wait for reablement capacity to become available, it has been agreed that the interim support will be refocussed to a **proactive, recovery led approach**, more aligned to a reablement model. This will improve the effectiveness of the support, which will enable people to become more independent more quickly.

Specifically, it is **Care South and Apex services** that will be refocussed, with agreement to continue funding for the remainder of 2025/26 via current funding streams, but with a recovery/reablement focus. There will also be a particular focus with Apex to reduce the length of stay, which at present is well above 30 days. Both improvements should release enough capacity to support approximately 7+ additional people per week across the BCP footprint.

It is anticipated that following the agreement of funders and providers, these arrangements should be in place by the end of August 2025.

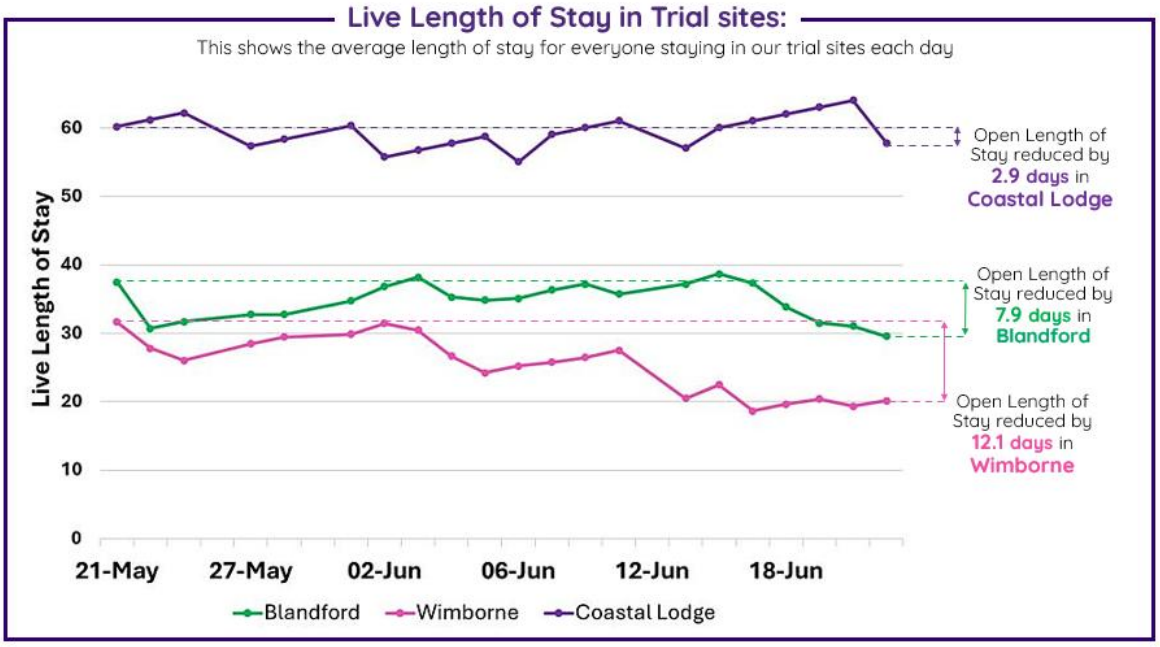
Bed-based intermediate care workstream

The aim of the Bed-based intermediate care (BBIC) workstream is to deliver better patient outcomes for people receiving care in community hospital and local authority-provided intermediate care beds. In particular, the aim is to reduce the average length of stay of a patient from 37 days to less than 30.

While this workstream began later, good progress has already been made. Initial trials began in Blandford and Wimborne Community Hospitals and at Coastal Lodge, which is operated by Tricuro.

Wave	1	2	3	4
P2 Beds	Wimborne Blandford Coastal Lodge	Bridport Westhaven	Alderney Swanage Westminster Yeatman	Castleman Castleman Plus Figbury
Kick-Off	July 2025	July 2025	August 2025	TBC
Sustain Starts	August 2025	September 2025	September 2025	TBC

Feedback from team members has been positive, and through improved collaboration across teams, some of the longest-staying patients in community hospitals and local authority beds have been supported to return home. The graph below indicates how performance has improved in each of the first trial sites over the four-week trial.



Whilst this work across sites looks to optimise the process, to minimise the length of stay within current constraints, it is well known that there are limitations to the current bed-based intermediate care offer, and this contributes to delays to discharge within the acute. As such, the workstream is also supporting with addressing the longer-term changes needed to meet this need in an appropriate setting.

There is work in progress to evaluate our provision and improve our bed-based intermediate care offering for patients. This will occur in phases; initial understanding of required capacity based on projected demand will enable us to decide what provision is needed. Once agreed, we will evaluate different options of how to offer this – specifically looking to address unwarranted variation between sites whilst also considering the option of tailored provision for particular cohorts of patients.

Following this, supporting work to optimise our estate and set-up will ensure that we can support as many patients as possible. This work is being completed as part of a comprehensive approach, to ensure that BBIC supports the wider system.

Working with VCSE and other partners

Work is already underway with Care Dorset, Tricuro and other partners to improve services at home and in care homes where short term support is provided.

A **'Transforming Health and Care' event** with VCSE partners was held in April 2025. With support from the Dorset Voluntary and Community Sector Assembly (VCSA), colleagues from across the FutureCare, Integrated Neighbourhood Teams, Data & Insight and partner organisations came together to introduce how we are collaborating as an integrated care system to improve health and social care outcomes for people.

On Tuesday 24 June 2025, the first meeting of the **FutureCare VCSE Reference Group** took place and an initial work programme for the group agreed. In July, the Group will focus on contributing to the FutureCare Intermediate Care Commissioning Plan, and in September the focus will be on access to services and a subsequent session will focus on support for carers.

Next steps

Delivery of the programme is still at an early stage and is currently scheduled to complete in June 2026. The **next 10 weeks of the programme will be critical** in accelerating the delivery of the programme and ensuring that in-year benefits targets can be achieved and to assist partners in preparing for seasonal pressures.