

Report subject	FutureCare Programme – Mid-Programme Review
Meeting date	1 st December 2025
Status	Public
Executive summary	At the midpoint of the FutureCare Programme, substantial operational benefits have been delivered. These include reducing the number of people moving directly into a residential and nursing home following a stay in a community hospital bed by 30%, increasing the number of people being referred to same day emergency care as an alternative to a hospital stay from a baseline position of 594 people per week to 649 per week and reducing the average length of time people stay in a community hospital or in a short stay care home bed from a baseline position of 38.2 days to a current position of 33.3 days. However, so far, the programme has only had a limited impact on reducing the length of time people spend in hospital waiting for a care package once they become medically fit. On 6 October, the average length of time a person was waiting to be discharged from hospital with a care package, was 9.64 days, against a target of 8.07 days. At the beginning of the programme, the average length of stay was 9.7 days. Overall, at the beginning of October the programme was on track against its operational benefits trajectory, delivering a projected £12.87m of annual operational benefits, against a target of £12.54m.
Recommendations	It is RECOMMENDED that: the Committee recognises the progress that the programme continues to make in respect of improved outcomes for people and the delivery of financial benefits to the Dorset Integrated Care System but that more

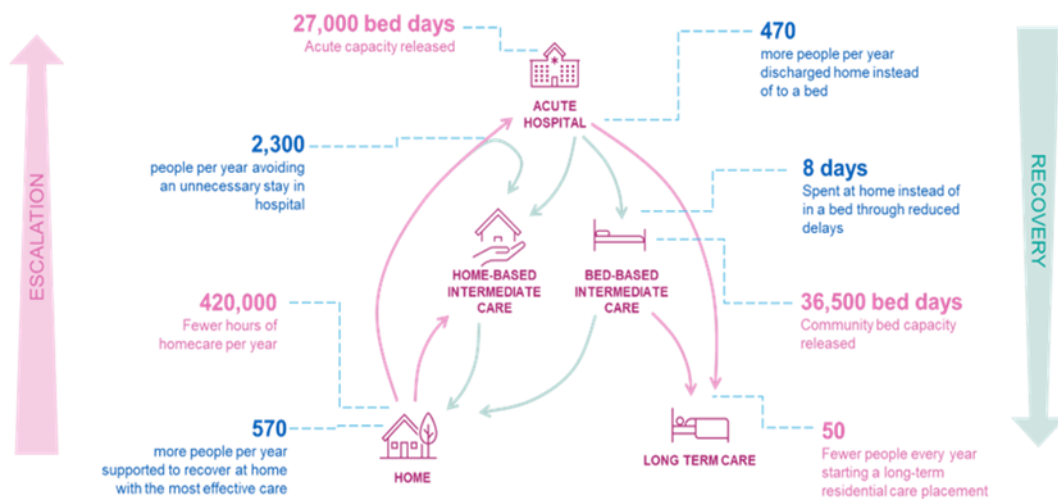
	work is required to reduce the average length of time people spend in hospital waiting for a care package.
Reason for recommendations	To provide assurance to BCP Council that the Scrutiny Committee is undertaking its role in monitoring the delivery of the FutureCare Programme and to confirm that the Programme is on track.
Portfolio Holder(s):	Councillor David Brown
Corporate Director	Betty Butlin, Director of Adult Social Care
Report Authors	Dylan Champion, Programme Director - FutureCare Programme
Wards	All Wards
Classification	Recommendation

1.0 Background

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

1. Reduce the length of time people spend in hospital by speeding up joint working and decision-making across organisations and starting discharge planning earlier
2. Support more people to recover better at home following a hospital stay, reducing the requirement for long term care packages at home and the need to move from home into long term residential or nursing care.

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



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

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

2.0 Workstream Updates

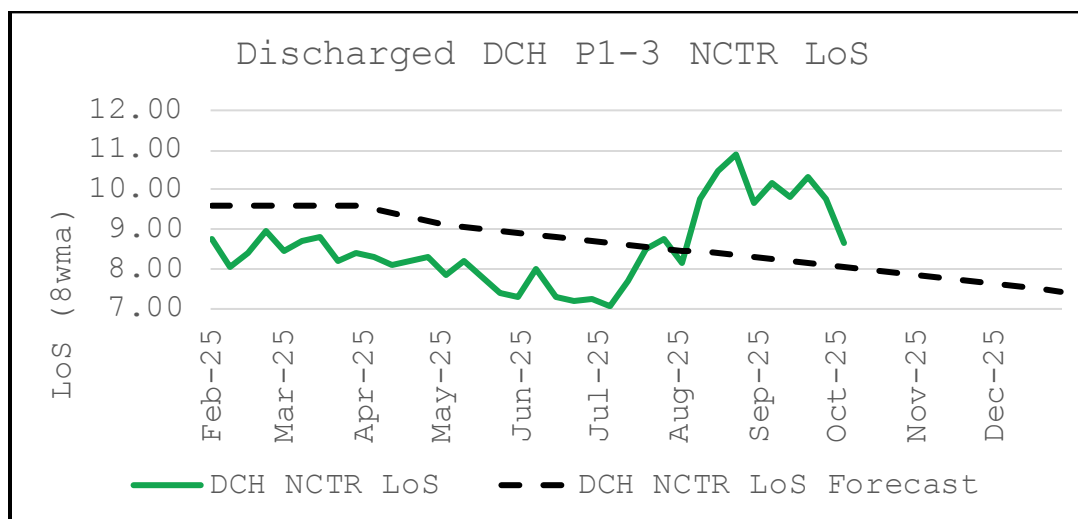
2.0.1 The Programme is structured around four key workstreams. Presented below is a brief update against each workstream.

2.1 Transfers of Care workstream

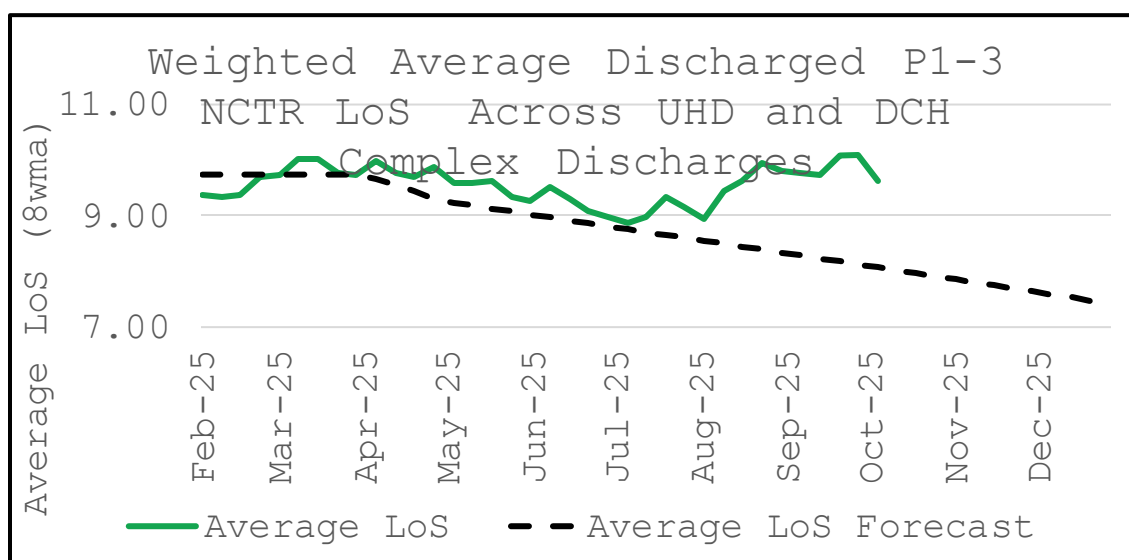
2.1.1 The transfer of care workstream aims to improve outcomes for people by increasing the number of people enabled to return home with an intermediate care package, once they are medically fit. This will be achieved by establishing two new Transfer of Care (TOC) Hubs, one at Dorset County Hospital and one at the University Hospitals Dorset, to provide a system-wide focus for managing the hospital discharge process and then, working with hospital wards, community and VCSE partners to support and deliver earlier discharge planning.

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

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

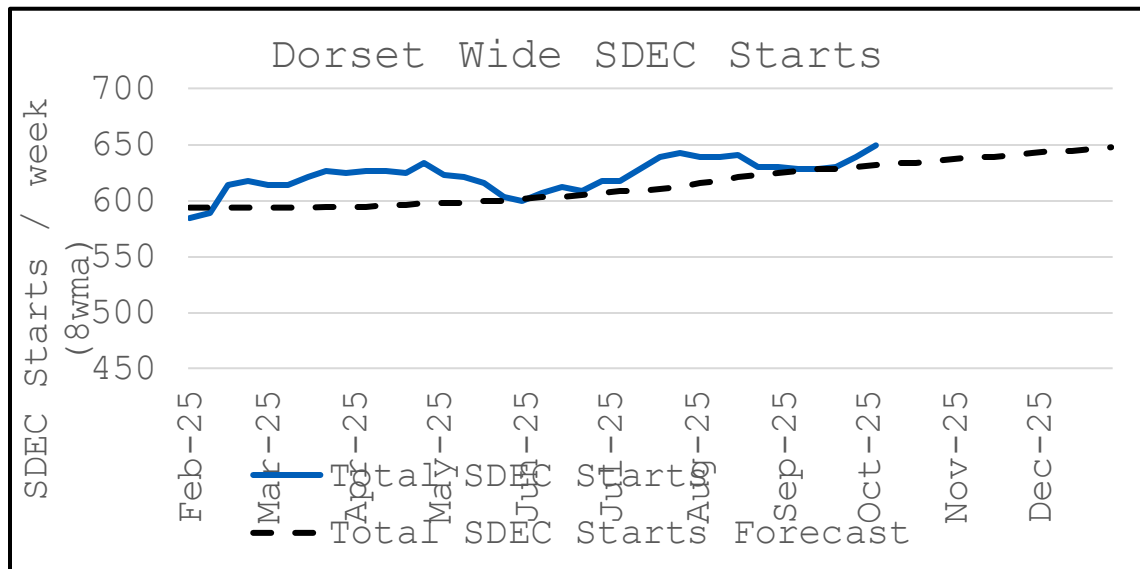


2.1.2 At UHD hospitals, it took longer to fully establish the East TOC hub but now this is complete and work has shifted to improving multi-agency working, overall system performance is also improving. The graph below sets out the combined performance across both hospital trusts.



2.2 Alternatives to Admission workstream

- 2.2.1 The Alternatives to Admissions (A2A) workstream primarily focuses on better utilising and referring more people to same day emergency care (SDEC) services as an alternative to admission into an acute hospital ward. Good progress has been made with this workstream at UHD hospitals and at DCH and so across Dorset this improvement trajectory is ahead of expectation.

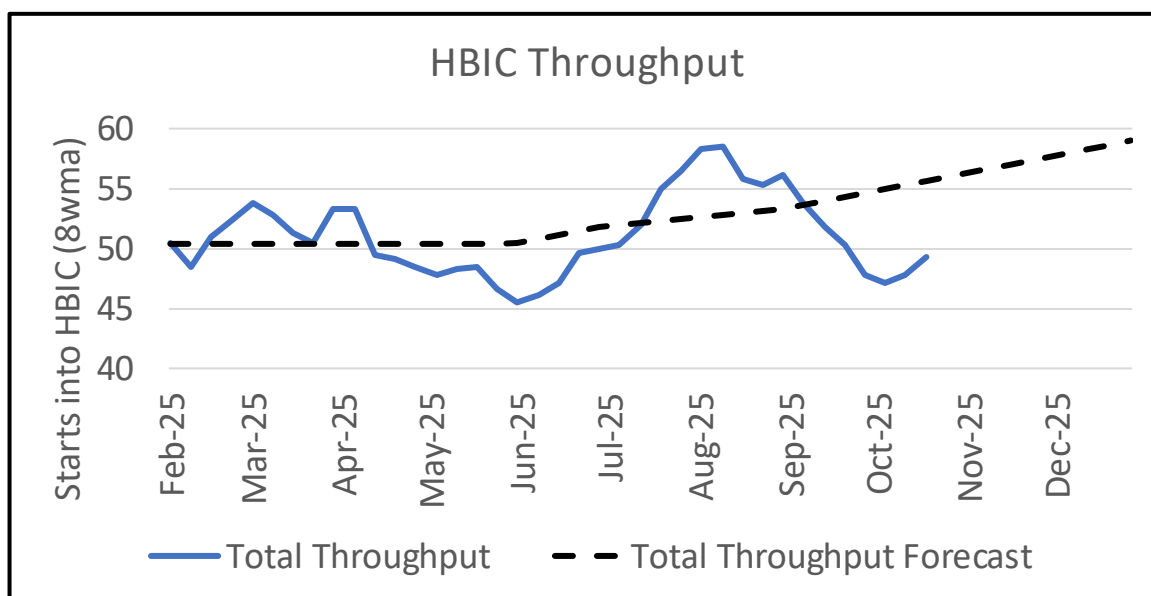


- 2.2.3 Focus is now shifting to working with community partners and in particular Dorset Healthcare to support more people to receive community support at home following a visit to an Emergency Department, rather than being referred to SDEC services or being admitted into hospital.

2.3 Home Based Intermediate Care (HBIC) workstream.

- 2.3.1 The HBIC workstream aims to increase the effectiveness of short-term care provided at home following a hospital stay, releasing more capacity to help more people and to improve the quality of the service.
- 2.3.2 Good progress was made with this workstream over the Summer period. During September there were challenges, across both council areas due to staffing shortages in reablement providers and amongst those teams responsible for sourcing packages, which limited the number of people who could be supported. As actions have taken place to address this and

capacity has increased, performance has begun to improve across both areas and this is anticipated to continue.



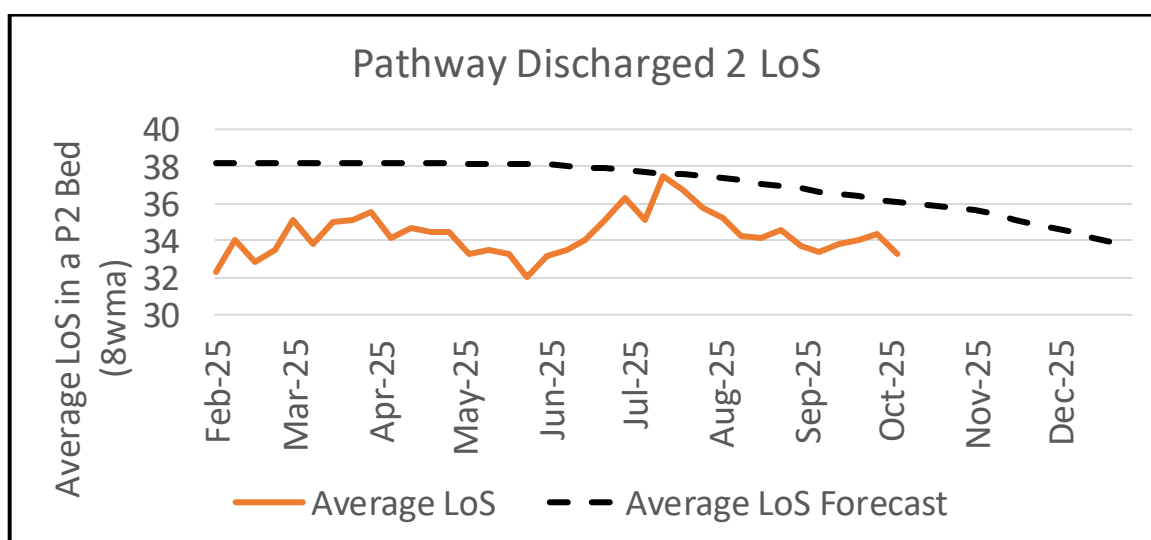
- 2.3.3 A key deliverable for the HBIC workstream is the launch of a new Reablement App. This allows residents to set personalised goals for their reablement programme and for reablement packages to be more tailored to individual needs. The App went live across Care Dorset and Tricuro reablement services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

What this is meaning for patients: Lewis

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

2.4 Bed-based intermediate care workstream.

- 2.4.1 The aim of the Bed-Based Intermediate Care (BBIC) workstream is to deliver better patient outcomes for people receiving care in community hospital and local authority-provided intermediate care beds. In particular, the aim is to reduce the average length of stay from more than 39 days at the time of the diagnostic to 31 days or less.
- 2.4.2 Wave 1 improvement cycles focussing on community hospitals began in the middle of July and significant reductions in the length of stay have been achieved across these sites. The average length of stay in a community hospital had reduced from 36.7 days at the beginning of the programme to 31.9 days in the period up to 6 October.
- 2.4.3 In September and October, improvement cycles also began at Tricuro sites within BCP and at the Care Dorset Castleman site and significant progress is now also being made. At the beginning of October the average length of stay at Coastal Lodge was 28 days, a significant reduction from the 39.9 days in the 8 weeks to 29 September.



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

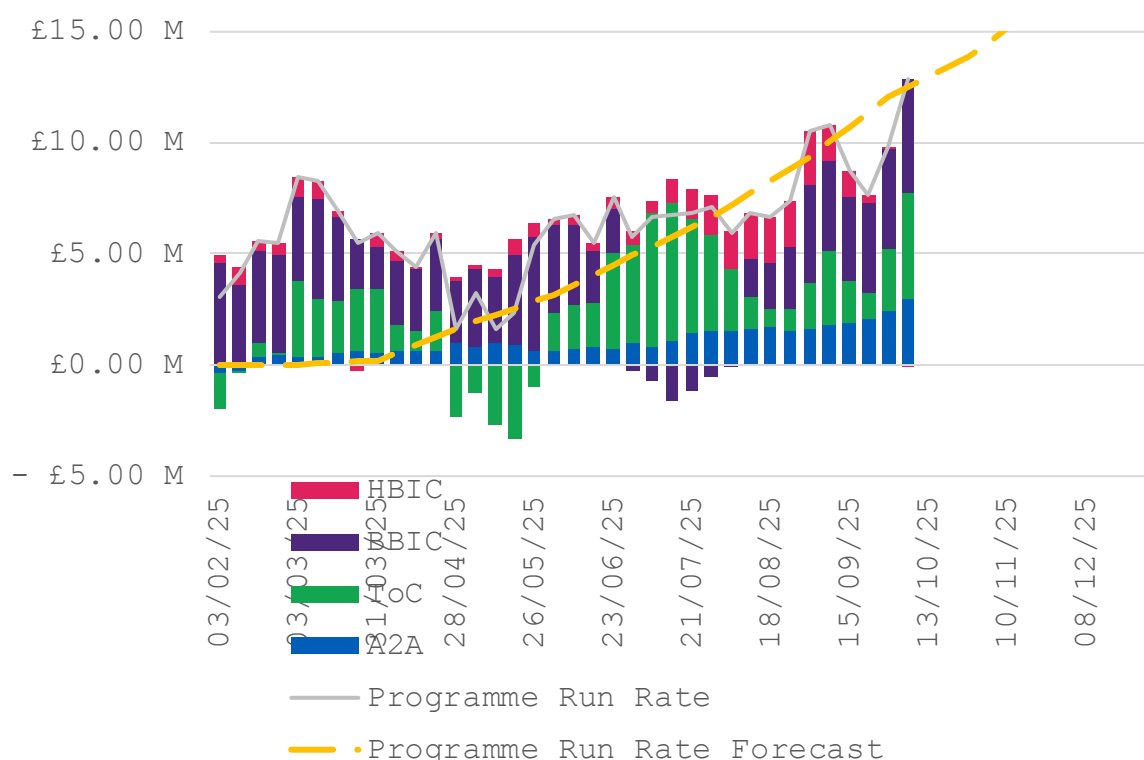
2.5 Mid Programme Review and Transacting Benefits

- 2.5.1 A mid programme review report has recently been considered by the FutureCare Steering Group and will be presented to partner boards and the Council Health and Wellbeing Committee. As well as looking at the value of

operational benefits delivered by the programme, it also considers the impact that the programme has had on reducing the number of people waiting to be discharged from hospital while an intermediate care package is sourced

Operational benefits

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



2.5.3 While the programme is on track, week on week, performance is variable and subject to significant variation. During August, significant benefit was being delivered via the home-based intermediate care workstream, due to capacity challenges in reablement providers and west flow teams in September, this benefit has diminished but now these have been addressed will increase. Similarly, there is still significant variation, month on month with the amount of benefit delivered via the TOC workstream and significant under-performance against the anticipated trajectory.

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

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

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

2.6 Reducing the number of people waiting to be discharged from hospital

2.6.1 A second key measure for the mid programme review is success in releasing system pressures, and in particular, reducing the number of people waiting in hospital to be discharged with a care package. As indicated above, though reductions in the key NCTR ALOS indicator are now being achieved, particularly at Dorset County Hospital, the programme is currently behind trajectory against this key indicator, with an average length of stay of 9.64 days being achieved on 6 October 2025.

2.7 Programme reset

2.7.1 To address this challenge a programme reset has been undertaken. Moving forward, the focus of the programme will increasingly be focussed on bringing together workstreams to collectively improve system flow and to speed up decision-making across organisations. More Newton resources will also be invested in to the programme at no extra cost to system partners.

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

2.7.3 In combination, it is anticipated that these changes will ensure that system pressures will reduce in coming weeks and performance against the key NCTR ALOS indicator will improve and return to trajectory by December 2025.

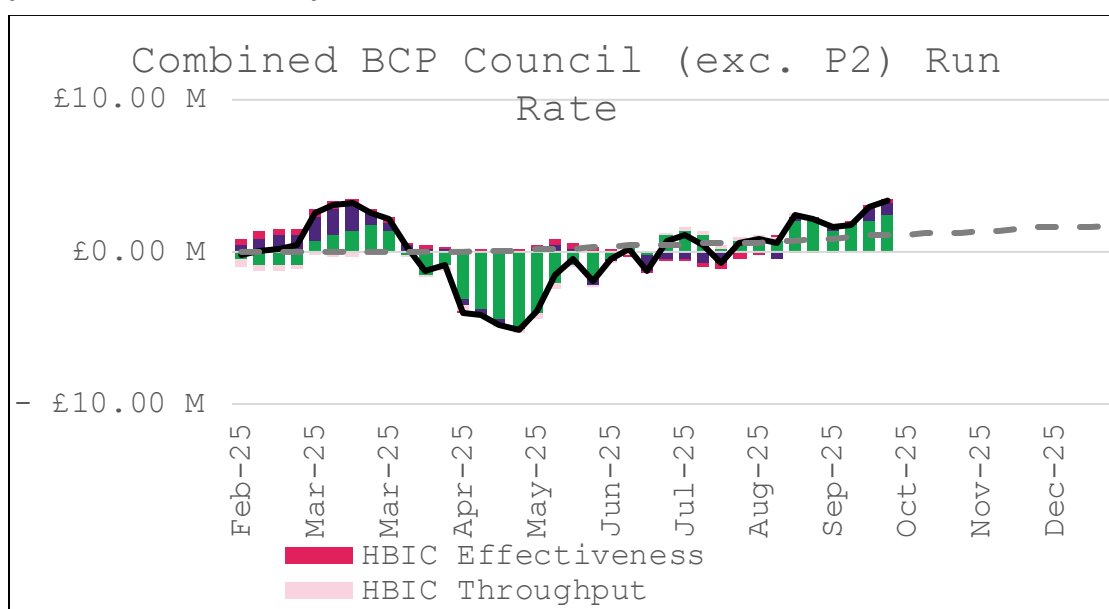
3. Options Appraisal

3.1 Not applicable.

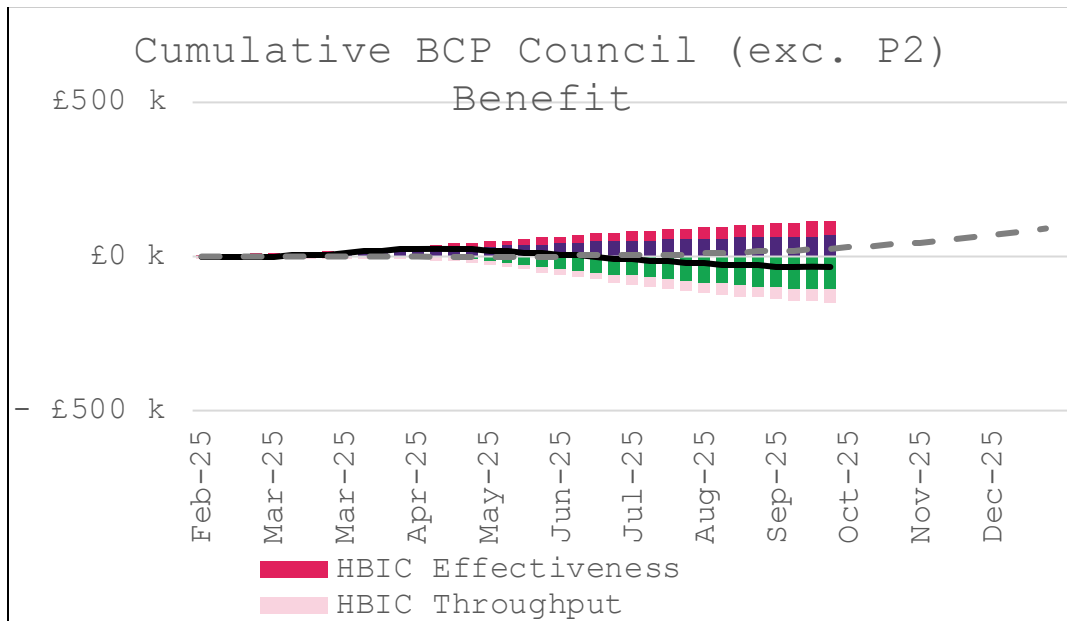
4. Summary of financial implications

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

4.2 The graph below presents the benefits delivery trajectory for BCP Council. Run rate measures the annual value of a benefit when it is released. While the impact on a person is often immediate (they go home early, or are not referred into a long term nursing or residential care bed), there is often a gap in the time it takes to release the financial value of the benefit because this is the total cost of the care that would have been provided in the period following the hospital discharge. This means that Run Rate rate is a better indicator of the impact that the FutureCare Programme will have on ASC budgets next year, rather than this year.



4.3 Savings delivered in-year are tracked as a cumulative benefit (below) – savings that have actually been delivered. At the beginning of October, the programme had delivered a net cumulative benefit of -£32,000 for BCP. This is because there was a temporary increase in the number of placements into long term care from hospitals around Easter (April and May). Since then, there has been a reduction in the number of placements from hospital and it is anticipated that this will result in the cumulative benefits delivered moving back to a positive trajectory in January or February.



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

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

5. Summary of legal implications

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

6. Summary of human resources implications

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

6.2 Some changes in the delivery of home based reablement care services and intermediate bedded care services provided in care homes is envisaged but

these will follow a co-design process and a subsequent re-commissioning of services if required. Where this is the case then an appropriate consultation and change process will be undertaken.

7. Summary of sustainability impact

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

8. Summary of public health implications

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

9. Summary of equality implications

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

10. Summary of risk assessment

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

11. Background papers

11.1 FutureCare Mid Programme Review.

12. Appendices

12.1 There are no appendices to this report.