Dorset Council

HEALTH AND WELLBEING BOARD

MINUTES OF MEETING HELD ON WEDNESDAY 19 MARCH 2025

Present: Cllr Steve Robinson (Chair), Cllr Clare Sutton, Cllr Gill Taylor, Paula Bennetts, Margaret Guy, Rachel Partridge, Julia Ingram and Brad Stevens

Apologies: Patricia Miller, Jan Britton, Paul Dempsey, Stewart Dipple and Jonathan Price

Also present: Cllr Sally Holland and Cllr Chris Kippax

Also present remotely: Cllr Alex Brenton, Cllr Carole Jones and Cllr Jane Somper

Officers present (for all or part of the meeting):
Andrew Billany (Corporate Director for Housing), George Dare (Senior Democratic Services Officer), Alice Deacon (Corporate Director for Commissioning and Partnerships), Mark Tyson (Corporate Director for Adult Commissioning & Improvement) and Natasha Morris (Team Leader Intelligence)

Officers present remotely (for all or part of the meeting):
Laura Cornette (Business Partner - Communities and Partnerships), Louise Ford (Strategic Health and Adult Social Care Integration Lead), Sarah Howard (Deputy Director of Modernisation and Place), Sarah Sewell (Head of Service - Commissioning for Older People and Home First) and Judith Dean (Director of Transformation)

40. Apologies

Apologies for absence were received from Jonathan Price, Paul Dempsey, Jan Britton, Patricia Miller, and Chief Supt. Stewart Dipple.

41. Minutes

The minutes of the meeting held on 24 November 2024 were confirmed and signed.

42. Declarations of Interest

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

43. Public Participation

There was no public participation.

44. **Councillor Questions**

There were no questions from councillors.

45. **Urgent items**

There were no urgent items.

46. **Integrated Care System - Future Care Programme**

The Strategic Health and Adult Social Care Integration Lead introduced the item and gave a presentation to the Board, outlining the progress of the Future Care transformation programme. The presentation is attached as an appendix to these minutes.

The Vice-Chair of Healthwatch Dorset informed the Board that Healthwatch was asked to find out the experiences of patients who are discharged from an acute into a community setting.

Clarification was given about the role of Integrated Neighbourhood Teams, which was to support care in the community. Whereas the FutureCare programme was about which setting was the best place for someone to receive care.

The Board noted the progress with the Future Care Transformation Programme.

47. **Place-Based Partnership Update**

The Acting Director of Public Health updated the Board on developing the Place-Based Partnership. The Place-Based Partnership would be an opportunity to help deliver the strategic priorities on the Integrated Care Partnership and Health and Wellbeing Strategies. The next Health & Wellbeing Board meeting would have a report with a draft prospectus for the Place Based Partnership, setting out how it would operate in the Dorset Council area.

The Corporate Director for Adult Commissioning and Improvement said that the Communities for All council priority and a refresh of the adult social care strategy would be developed at a similar time to the Place Based Partnership, so it was important in ensuring coherence between them.

A representative of NHS Dorset gave endorsement for developing the Place Based Partnership.

The Board noted the update.

48. **Better Care Fund 2023-25: Quarter 3 2024-25 Reporting Template**

The Head of Service for Commissioning for Older People and Home First introduced the item and gave a presentation outlining the key points from the report. Three of the four performance metrics were on target, apart from the target for 'Falls'. The Better Care Fund plan for 2025-26 was being developed, and it included new objectives.

A member asked why there had been less community demand for rehabilitation and support at home. Officers advised that more people had been admitted to hospital in this period, and it was expected to go back to the normal levels.

Proposed by Cllr S Robinson, seconded by Cllr C Sutton.

Decision

That:

1. The Better Care Fund (BCF) Reporting Template be endorsed for:
   - Quarter 3 2024/25 approved under delegated authority.
2. The 2025/26 Better Care Fund policy guidance and work underway to develop new plans, be noted.

49. **Integrated Neighbourhood Teams**

The Director of Transformation, Dorset Healthcare, and Deputy Director of Modernisation and Place, NHS Dorset, introduced the item and gave a presentation outlining the development of Integrated Neighbourhood Teams. The presentation is attached as an appendix to these minutes.

Integrated Neighbourhood Teams had statutory services, however there was also a role for voluntary and community sector organisations. The pilot model in Weymouth and Portland had good links with the voluntary sector, however the Integrated Neighbourhood Teams followed a logic model which motivated and empowered staff to connect with individuals and communities which improved health outcomes.

Each Integrated Neighbourhood Team would have a leadership team made up of representatives for primary care, Dorset HealthCare, mental health, physical health, and links to the local authority.

The Corporate Director for Commissioning and Partnerships considered how the Health & Wellbeing Board helps to bring workstreams together which then identifies opportunities for linking work.

The Vice-Chair of Healthwatch Dorset updated the Board on how Integrated Neighbourhood Teams were developing in the Swanage and Purbeck area. There would be opportunities to create strong links between the local family hubs and Local Alliance Group.

A member raised the importance of engaging communities early in the development of Integrated Neighbourhood Teams, to ensure they are aware of the benefits of the teams, rather than parts of it. There were good opportunities for community activation and developing an activation tool.

The Board endorsed the approach to implementing Integrated Neighbourhood Teams.

50. **Joint Strategic Needs Assessment Update**

The Team Leader for Intelligence introduced the Joint Strategic Needs Assessment (JSNA) Update. The update had been scoped and developed over the past year, using data from a range of sources.

A member asked how the JSNA would be used with other programmes of work, such as Integrated Neighbourhood Teams and the Future Care Programme. In response, the Board was advised that the JSNA could be used as an evidence base for programmes of work. The JSNA is also a statutory duty of the Board which then contributes to the Board's strategies.

The Board noted the progress on the Children and Young People's Joint Strategic Needs Assessment.

51. **Right Care Right Person**

The Corporate Director for Adult Care introduced the report, which provided reassurance for the Board on the implementation of Right Care Right Person. The model was operationally live from April 2024. The model did not change police intervention when there was a risk of harm, however there were changes around welfare concerns, walking out of hospital, and transportation for mental health act assessments. The Safeguarding Adults Board and Safeguarding Children Partnership, as well as the Strategic Alliance for Children and Young People, ICB, and Police and Crime Panel have oversight over aspects of the work.

There were no questions or comments from members.

52. **Work Programme**

The Board noted the work programme.

53. **Exempt Business**

There was no exempt business.

Duration of meeting: 2.00 - 3.31 pm

Chairman

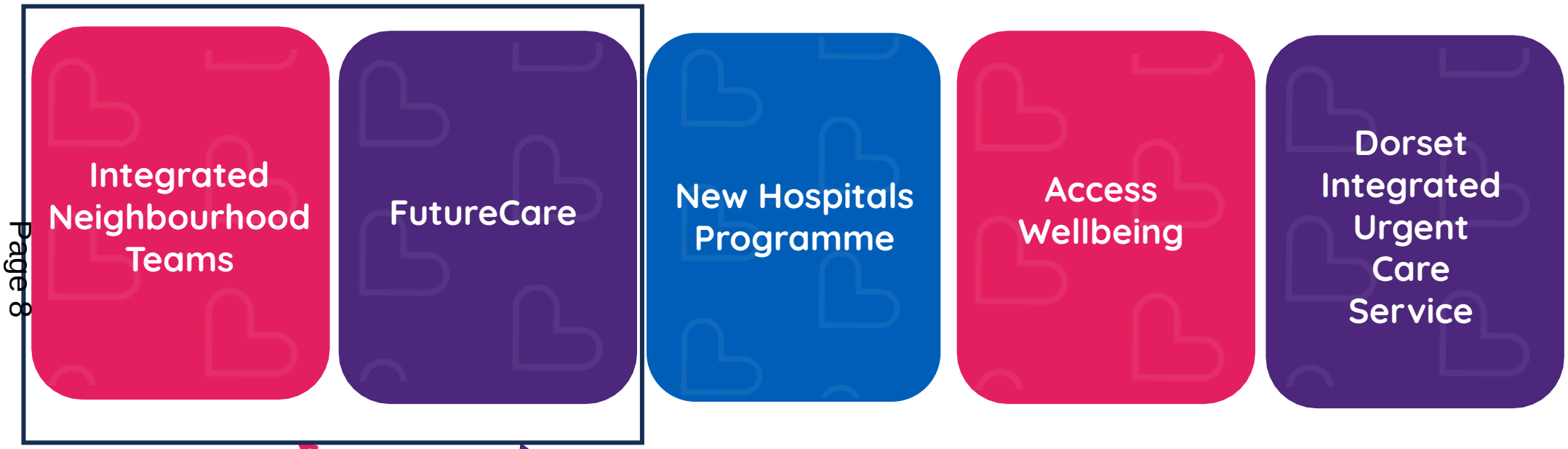
.....

This page is intentionally left blank

Our Dorset

Transforming health and care together

Transforming health and care together



Integrated Neighbourhood Teams and FutureCare are two of the priority transformation programmes across the Dorset system

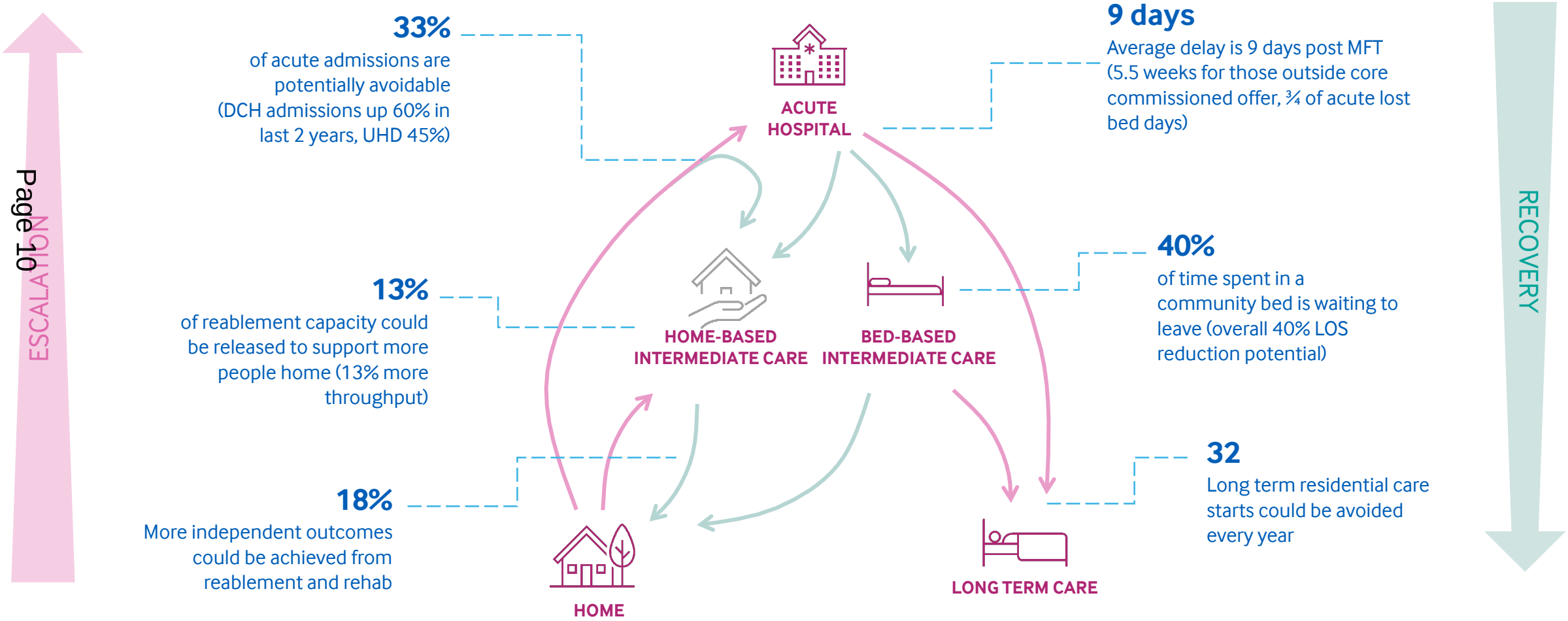
FutureCare

Our Dorset

Why FutureCare?

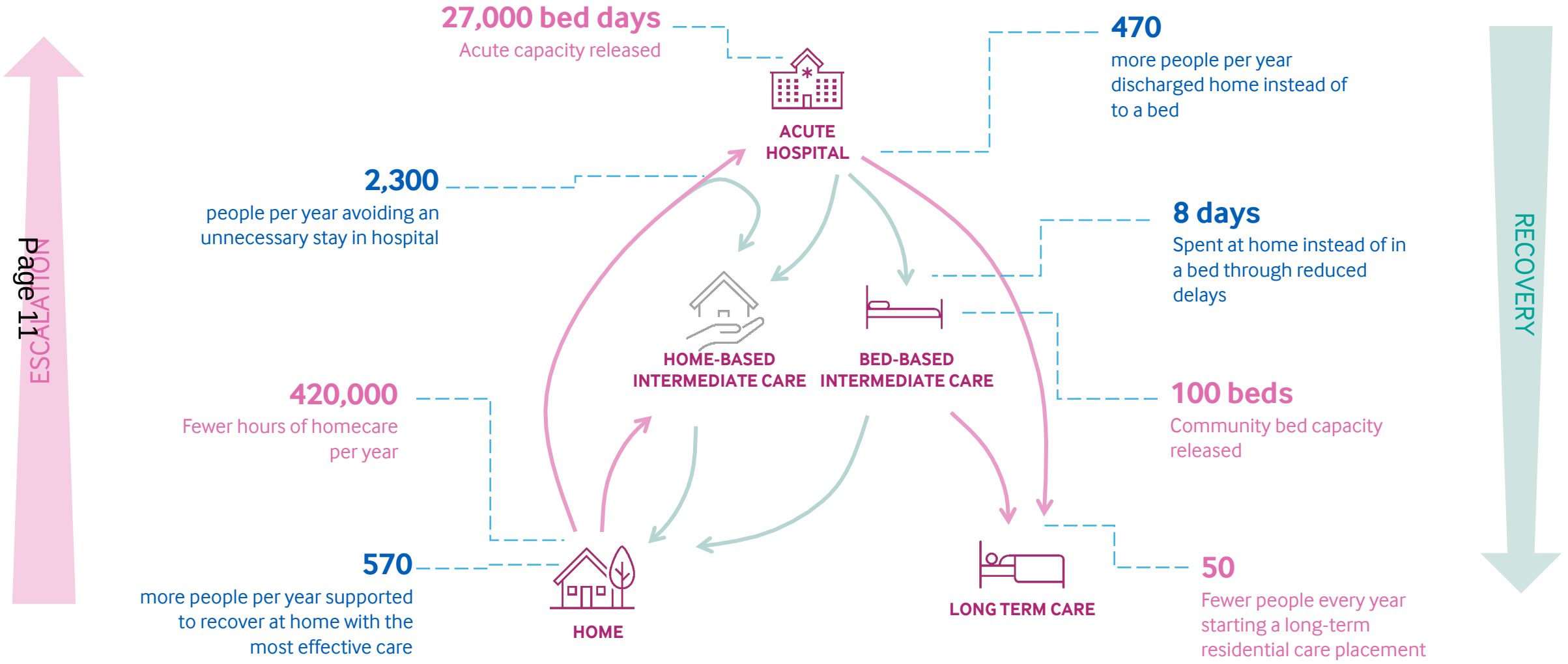
We have identified huge opportunity to improve outcomes for the people of Dorset

FutureCare



FutureCare will realise the benefits identified

FutureCare



We also need to change for the people in our system

FutureCare

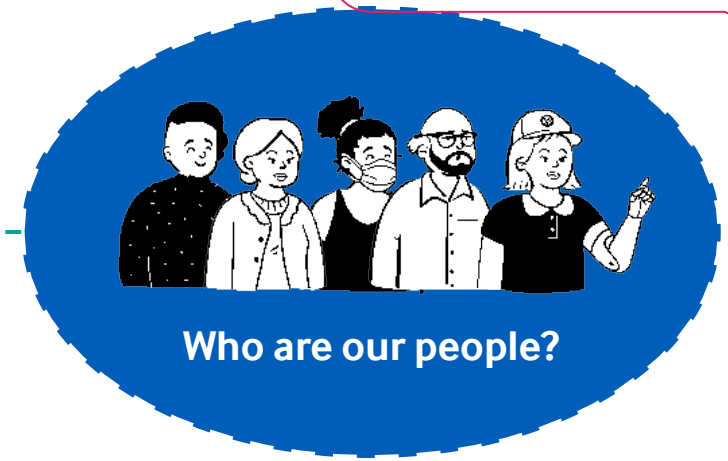
"We live and work here; we have our family and friends here; We care about the system and want it to thrive"

"We have tried to make changes multiple times and it does not stick"

Colleagues who ***live and work*** in Dorset, and experience firsthand the ***operational challenges*** in the system

"The vision for the system is clear, we just don't know how we get there"

"We are stretched across the system and have other ongoing change initiatives, how do they all link?"



"Whilst waiting [for a package of care], he deteriorated due to the long length of stay, suffering 18 falls in hospital. After an 89-day length of stay, he died from covid."

"I could have been told what care package was in place, for how long and at what cost. I knew nothing."

Residents and neighbouring residents using Dorset services

"I didn't know this service was visiting me, until they suddenly turned up at my door"

"I was told I'd six weeks [of care]. I got two."

FutureCare is an ambitious programme to transform UEC and intermediate care across Dorset by 2027

Working together to achieve;

- Seamless Care Pathways – Partners working together to provide the right care, first time.
- Faster, Safer Discharge – Reducing unnecessary hospital stays.
- People-centred Care – Empowering individuals in care decisions.
- **Data-Driven Improvement** – Investing in shared tools for better coordination.

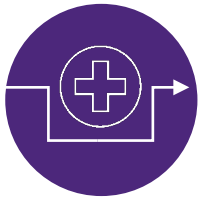
Why it Matters;

- Reduces system pressure & improves patient flow.
- Enhances patient experience & outcomes.
- Optimises resources & workforce capacity.

> **FutureCare is a huge opportunity for Dorset – delivering better services through collaboration, innovation, and digital transformation**
>
> Patricia Miller

FutureCare Workstreams

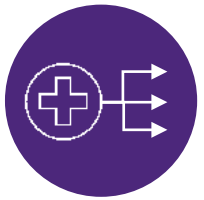
FutureCare



Alternatives to Admission

Front door decision making
Access and capacity of community response offers

SRO: Mark Mould, COO, UHD



Transfers of Care

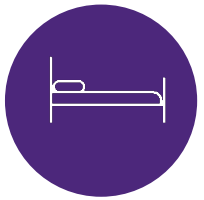
Discharge planning and decision making
Process and flow leaving acute and intermediate services

SRO: Becky Whale, Dep Dir UEC, NHSD

Home-based intermediate care

Capacity and flow through reablement and rehab
Effectiveness and outcomes

SRO: Betty Butlin, ED ASC, BCP Council



Bed-based intermediate care

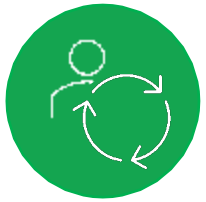
Capacity and flow through all short-term beds
Effectiveness and outcomes

SRO: Rachel Small, Interim COO, DHC

System Visibility & Active System Leadership

Trusted single point of truth with data-driven decision making and leadership embedded at every level

SRO: Louise Ford, Health & Adult Social Care Integration Lead, Dorset Council



Change Capability Development

FutureCare Academy development programme to build change capability across staff
Behavioural and cultural change for true sustainability of change at scale

SRO: Anita Thomas, Interim COO, DHC

Programme SRO: Patricia Miller, CE, NHS Dorset

Deputy Programme SRO: Dean Spencer, NHS Dorset

We have a structured approach to programme delivery

Mobilise

The ambition, structure and resources for the programme are established, communicated and well understood by stakeholder groups

Stakeholders have committed the time required and are excited and motivated to get started

Stakeholder groups have been onboarded and understand the ongoing support they will receive through things like The Academy

We have access to data to inform the programme

Inform

For each workstream we have agreed the **best known practice approach** we will take for improving the relevant services

All workstream stakeholders understand the intended direction for changes and show **visible commitment to collectively work together** to implement it

We have agreed the measures to track benefits and identified the digital solutions and dashboards that will enable adapting and trialling changes

Adapt

Through **co-production** we have refined the best practice approach and agreed the specific changes we will implement in Dorset

We have a solution design that we know will **deliver and sustain the benefits** and are confident to begin scaling

We have an agreed implementation plan covering **people, process, data and tools**

We have established **rapid data driven improvement cycles** and are measuring and refining the changes

Implement at Scale

We have rolled out changes in a structured way at an ambitious pace across the system and delivered all necessary training, documentation and tools using a rigorous change management methodology

KPIs used to track the benefits are consistently above our target and we are seeing positive outcomes for residents and staff

We have evidence of effective adoption and utilisation of the solution design and tools

Sustained Change

Teams have demonstrated their ability to maintain the changes without support

Ownership of sustaining benefits and delivering further opportunities sits with specifically identified substantive roles in the Dorset system

Programme leadership have agreed the impact of the programme and are confident in its sustainability

There is a clearly prioritised plan in place for ongoing transformation and improvement with the capability to deliver it

Key Highlights

- Below are some key highlight and achievements from the programme to date:

- Work on the first improvement cycle to establish a more effective **Transfer of Care Hub at Dorset County Hospital began on Wednesday 12 March**; the approach will be rolled out at UHD hospitals from May.
- **No Criteria to Reside** numbers have fallen slightly since the start of the programme.
- **Benefits tracking for the programme begins in April;** overall the programme remains on track to deliver overall target benefits
- The first iteration of the **System Visibility Dashboard** has been developed and shows performance across the UEC pathway.
- Inform phases complete or nearing completion.

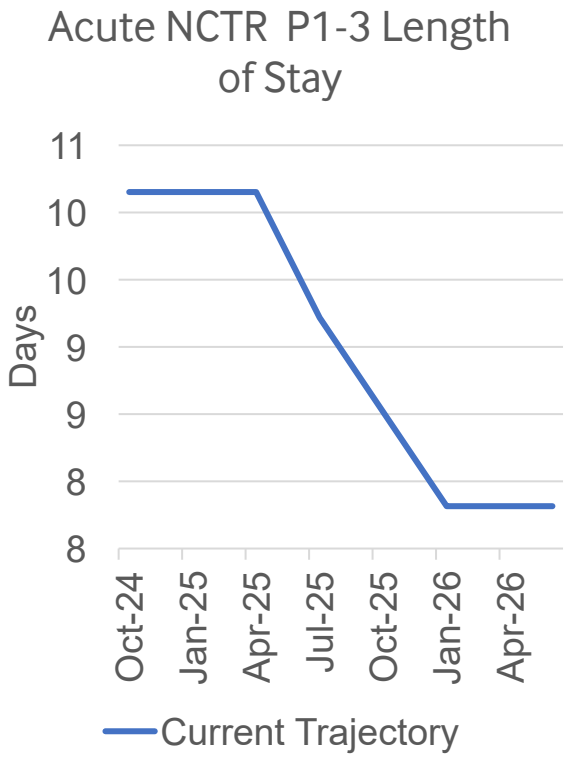
Transfers of Care

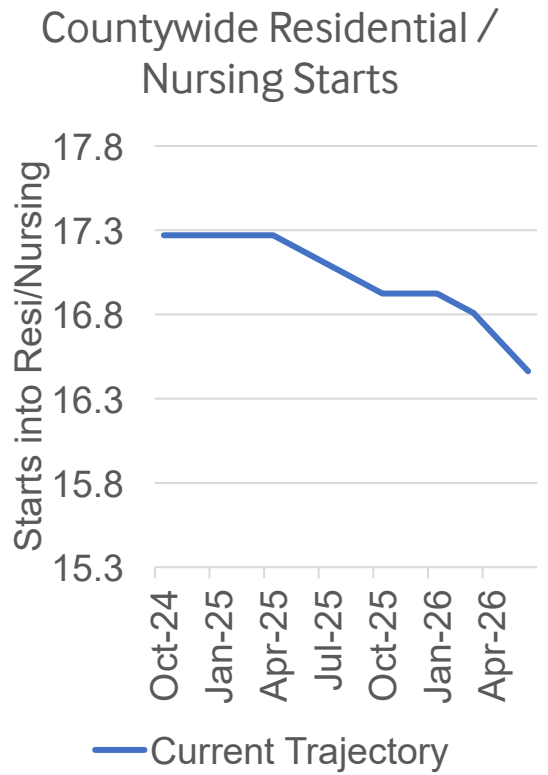
FutureCare

The Transfers of Care (TOC) workstream is primarily focused on reducing the length of time it takes for people to leave hospital once they are medically fit. Key to this is implementing at scale more effective and earlier discharge planning on hospital wards and implementing a consistent on-site multi-agency Transfer of Care team who can facilitate more effective and timely transfers from hospital and with a focus on discharging more people to home. The first improvement cycle aimed at transforming the TOC Hub at DCH will begin in early March and will centre on creating a dedicated physical space for collaboration and problem-solving between TOC partners and with ward teams. Work will commence with three wards initially focused on earlier and more effective discharge planning with a view that this will reduce both avoidable delays in discharge linked to our process; and create more opportunity to make better use of community offers by bringing TOC expertise closer to the patient. . This is expected to impact on both length of delay and numbers referred for bedded intermediate care.

Identified opportunities from completed inform phase

- A single decision point (3.2 days of decision making; 22% of Pathway 2 patients who could have been home)
- Systems and information (3.2 days of decision making)
- Assessments (~10.5 days per person)
- Early discharge planning (up to 5.1 days)
- Grip and patient communication (1.8 days from family disagreements; 18% non-ideal outcomes)
- Operational escalations, patient escalations and strategic priorities
- Ensure that our core offer is suitable for more patients' needs





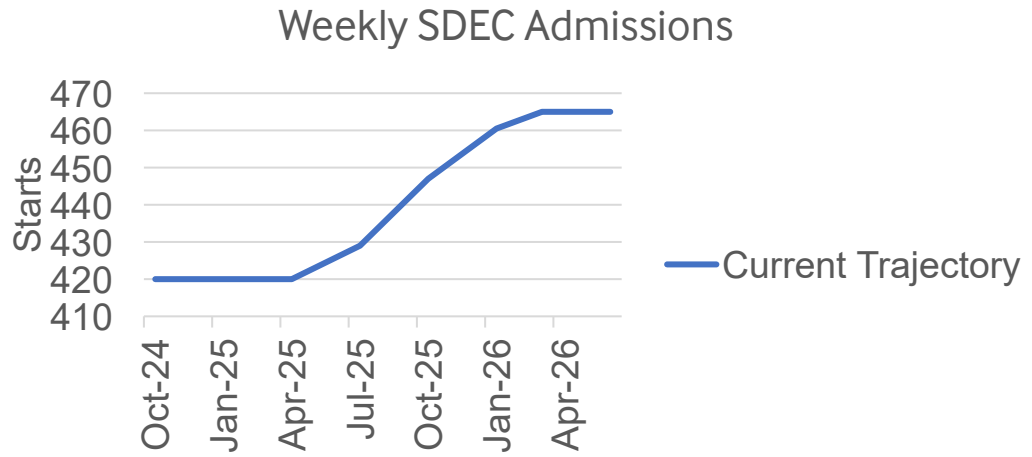
Alternatives to Admission

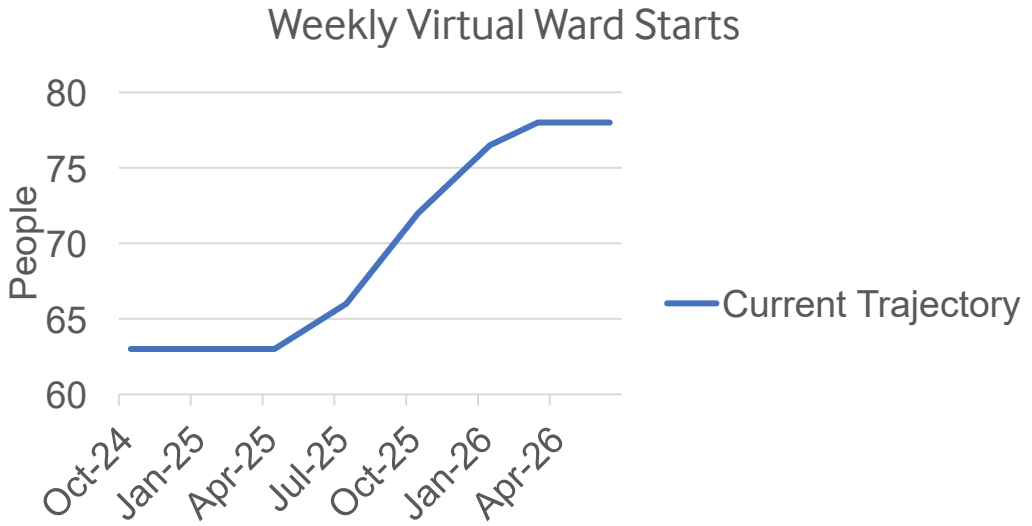
FutureCare

This workstream is currently in the ‘Inform’ phase of the programme which is due to be completed in mid-March and there have been high levels of clinical engagement. Following this, the adapt phase will see changes to identify and stream patients to alternative services starting to be trialed, with the first improvement cycle starting at the beginning of April. The rollout across Dorset County Hospital and UHD (Poole and Bournemouth sites) will be slightly staggered, with approximately 2 weeks between starts at each site. A decision on which site will start first will be made by the end of next week.

A second workstream, focusing on flow through SDECs and assessment units, is planned to start in May, dependent on the results and demand seen in the identification and streaming workstream.

The workstream is particularly focused on an aligned plan across the two acute trusts to develop a shared model that is fine tuned for each trust.





Home Based Intermediate Care

FutureCare

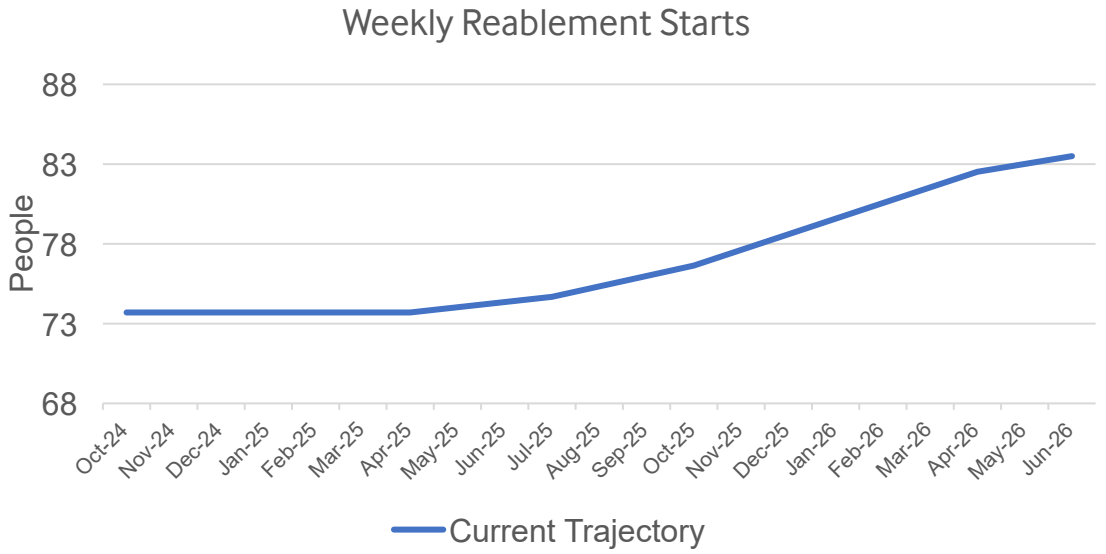
The final inform session for Home Based Intermediate Care takes place on the 13th March. In parallel FutureCare is working to determine an initial view of capacity demand for Pathway 1, to inform commissioning decisions and the extent of improvement required to deliver a sustainable and effective Pathway 1 model.

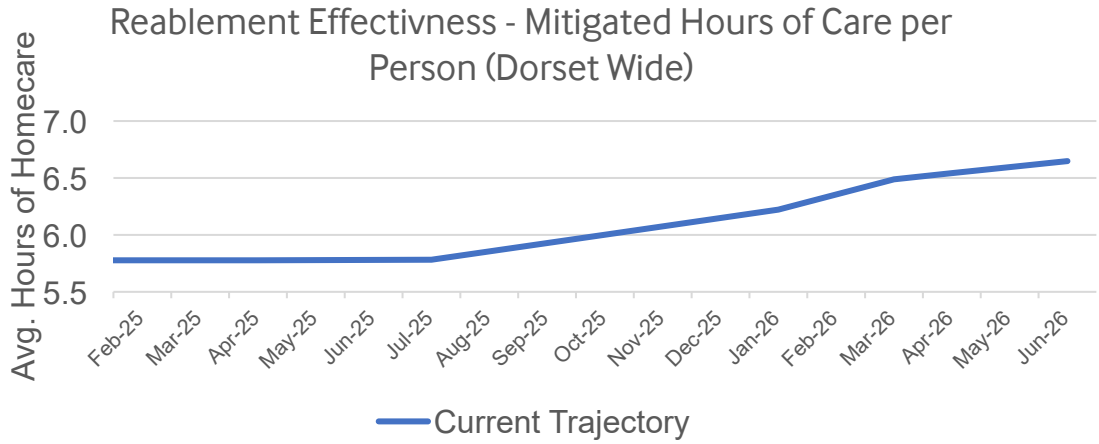
Initially CareDorset and Tricuro have been pulled into the inform sessions, along with commissioners of RCR and representatives from across the system, but by the end of inform the extent of providers required to be involved will be determined, and what the sequence of engagement across the providers will be.

The adapt phase will then be tailored to involve the relevant providers and attendees of the inform sessions in the specific changes that will be developed and rolled out across the system.

The identified problem statements that will be addressed through the workstream include:

1. Effective capacity and demand management and matching of P1 discharge services
2. Maximising the impact of our current reablement offer, through digital goal scoring tools and visibility for RCR, CareDorset, Tricuro
3. Consistency of the trusted assessor model to enable backdoor flow
4. Holding capacity within care providers such that restarts do not require brokerage of the full package.





Bed Based Intermediate Care

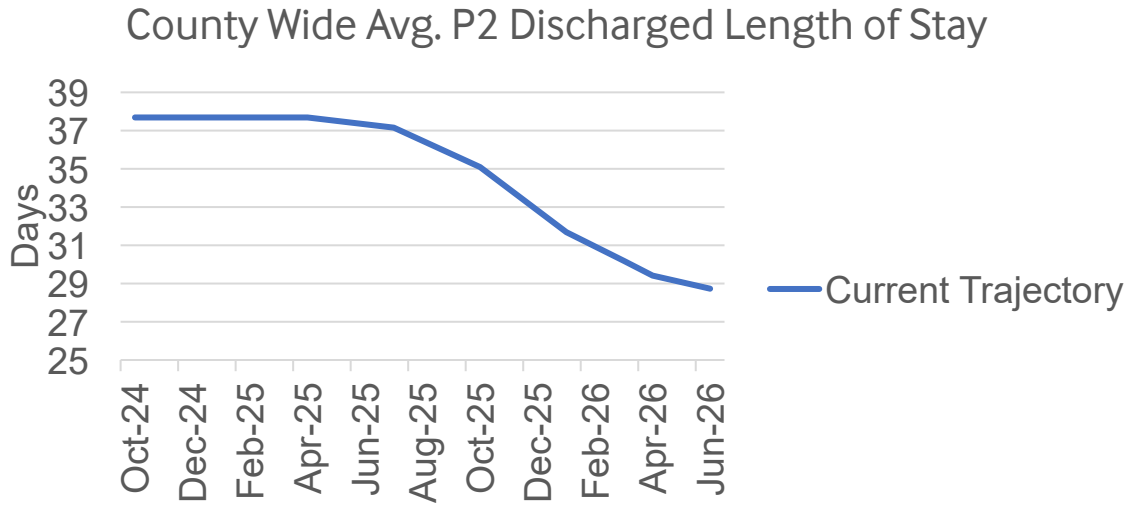
FutureCare

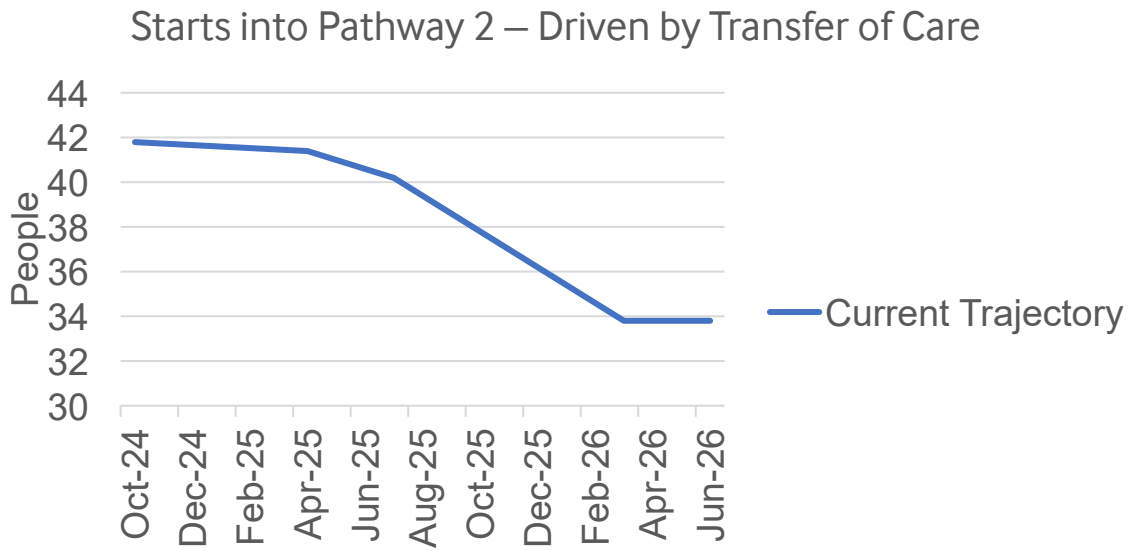
The vision for the Bed Based Intermediate Care workstream is that people be admitted to beds for the right reason, stay for the right length of time and get back home faster when that's the best option for them. In accordance with the original programme plan, this workstream is has been mobilized slightly later to offset resource requirements but the Inform phase will be completed by Easter

The workstream will take a sequenced approach to rolling out across the Pathway 2 bed base, 2-3 sites at a time, starting with Blandford, Wimborne and Coastal Lodge. These inform sessions will focus on the operational and clinical processes that impact length of stay and outcomes within a P2 bed, and have appropriate colleagues from DHC, BCP, DC, DCH and UHD to inform this discussion. This work, and data collection through Transfers of Care, will inform the capacity demand modelling for a system wide P2 strategy and provision, which will be led by the workstream outside of the operational focus of Inform.

The first set of changes will be rolled out by end of June. Throughout the inform and initial adapt, colleagues from other sites will be kept up to date on progress, and feed in any concerns. Towards the end of the rollout, the next wave of sites will be engaged through an adapt phase, to understand how to tailor the process improvements to their site and specific issues. Thereafter it will be a rolling 3 monthly cycle working with each site to rapidly rollout improvements and monitor the impact.

By July, there will be sufficient evidence to more accurately determine the long term provision of P2 required, and inform a commissioning strategy across all of the P2 sites.

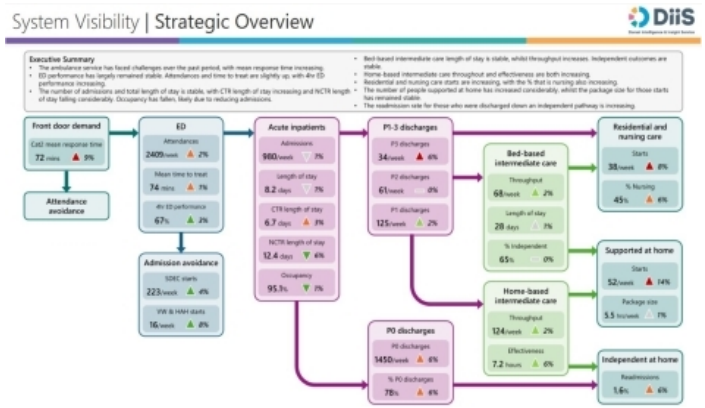




System Visibility and Active System Leadership

Mission: Enabling access to the **digital capability and trusted data** we all need to co-design process and **cultural change**, make our people's jobs easier and ultimately support everyone across Dorset with the right care.

System Visibility Dashboard (Capability)



Surfacing data from source systems

Sustainable data architecture & flows

System wide data visibility & access

Active System Leadership (Culture)

Decision-making

The right people at each level to make data-driven decisions.
Shared accountability and consistent data visibility

Culture

Establishing the shared working principles for effective across organisation decision-making

Data-driven decision-making

Root causing problems before acting

Shared accountability

Cross-service and organisation support

FutureCare

Our Dorset

Change Capability

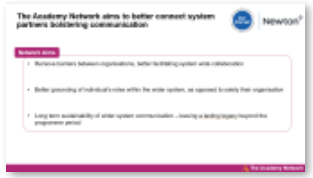
FutureCare

Leaders across Dorset NHS and Local Authorities are united behind an exciting and ambitious improvement of the care system by 2027. This builds on our collective work to date and enhances our current change methodologies, taking a system-wide view and holistic approach. The Change Capability workstream puts behavioural and cultural change at the heart of our success. A new Academy training and development initiative will give our people the additional capabilities and confidence they need to design, implement and sustain long-term, transformational change at scale.

Academy & Network

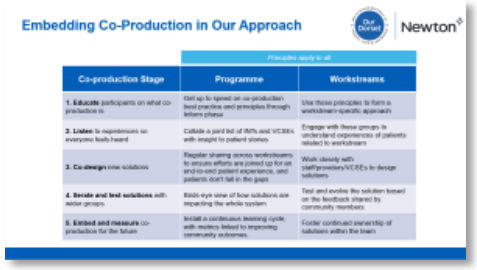
Driving change capability through embedding of Academy in workstreams

Promoting system connection through a networking initiative



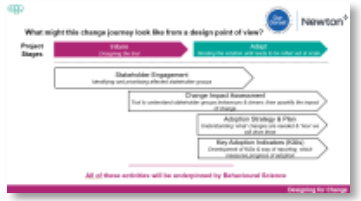
Co-Production

Ensuring people are central to change through co-design & co-production



Change Readiness

Supporting workstreams throughout change & adoption planning



Providing a Programme View of Change Readiness

Systems Thinking & Leadership coaching

Embed a systems thinking approach across the wider partnership

Integrated Neighbourhood Teams

March 2025

Our Dorset

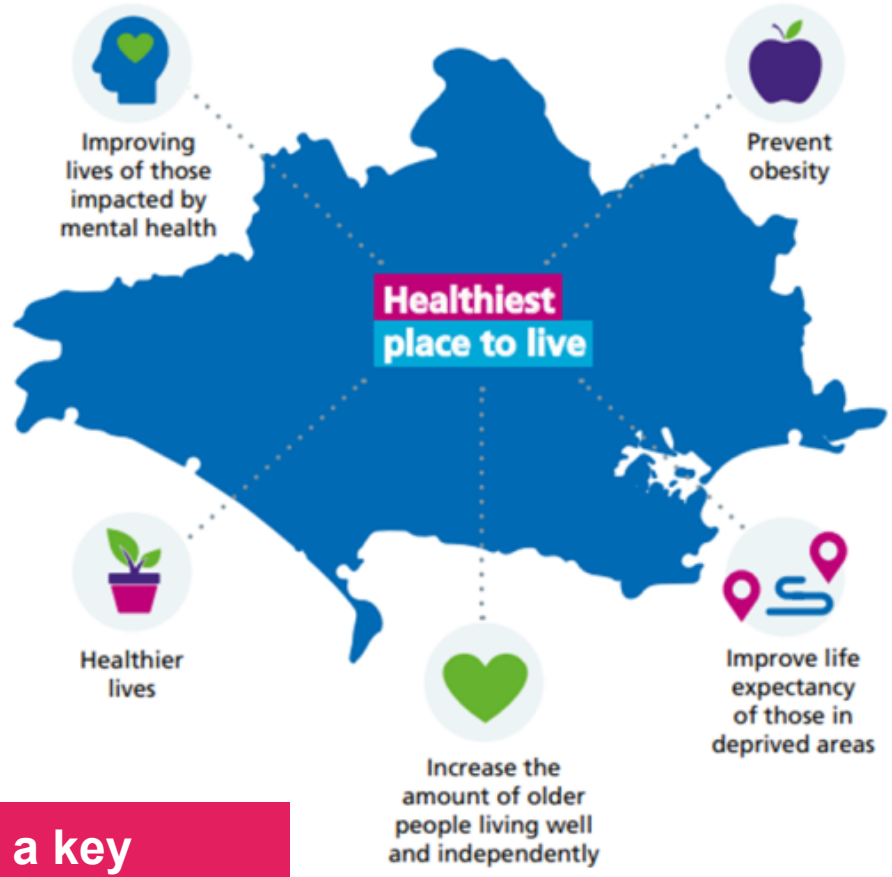
Improving health and wellbeing in Dorset

Our Dorset vision is to work together to deliver the best possible improvement in health and wellbeing.

Our priorities are:

- Prevention and early help
- Thriving communities
- Working better together

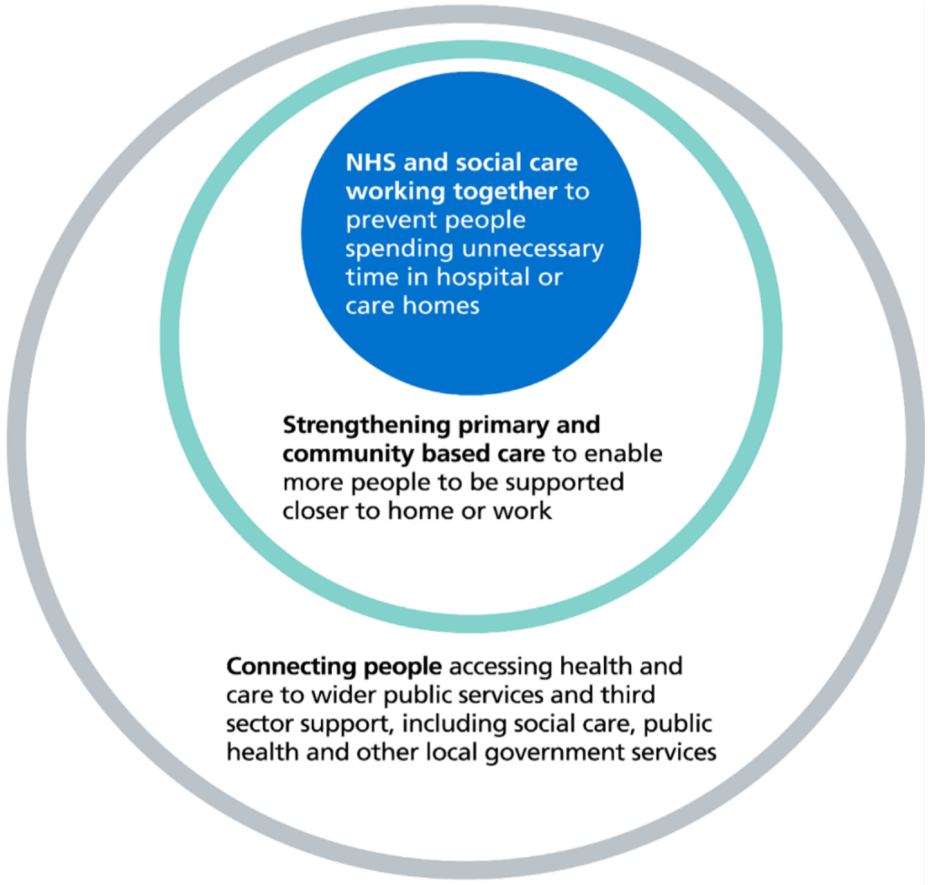
Our Joint Forward Plan sets out priority outcomes.



The development of Integrated Neighbourhood Teams is a key component, although not the entirety of the work to realise this ambition.

Our Dorset

Vision for all neighbourhoods (NHSE Neighbourhood Health Guideline 2025/26)

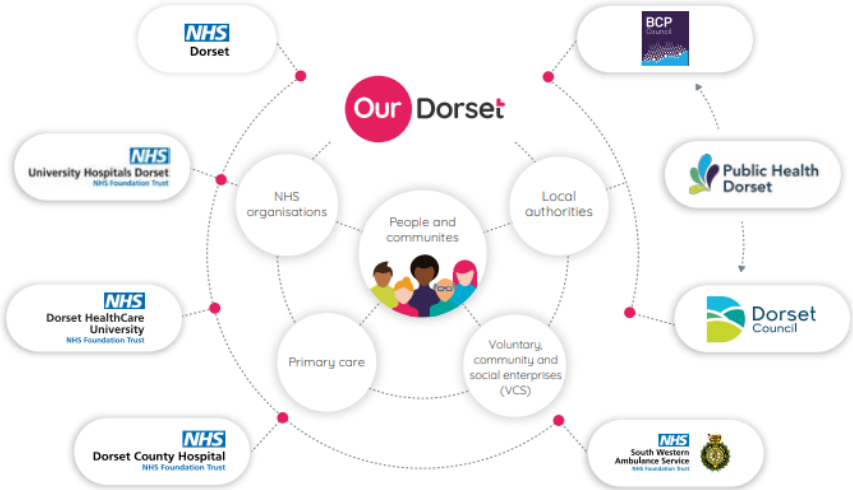


Our Dorset

How will Integrated Neighbourhood Teams (INTs) help?

Integrated multidisciplinary teams with a shared ambition to improve health and wellbeing for the population they serve, supporting:

- Better holistic care
- Improved outcomes
- Improved efficiency
- Enable better preventative and early intervention services
- Prevent hospital admissions
- Community engagement
- Reduce care costs



Why will INTs be better for local people?

MORE

- Joined-up focus on prevention to help you stay well for longer in your community.
- Information and support so that you can stay well, take better control of your own health to reduce the risk of developing ill health.
- Access to streamlined support so when you become ill or have an urgent need, you can see the right person the first-time round.
- Proactive, personalised support from a multidisciplinary team for your chronic or complex health and care needs.
- Services co-designed with local communities.

LESS

- Need to travel to a hospital for care, as more care and support will be provided in the community.
- Health complications and poor outcomes for adults and children with complex needs because of the support available locally from a mixed team of health and care professionals.
- Need for you to repeat your story to different staff because the team works closely together and have access to shared health and care information.

Our Dorset

Over the next 2 years we are asking INTs to focus on:

Build the teams

1. Bring teams together, so that teams know each other and what they do

2. Streamline systems and processes to release capacity to support increased proactive care

Integrate care

3. Integrate care around individuals with complex health and social needs (adults and children)

4. Work with partners to streamline care pathways and improved access to more specialist services

Targeted population cohorts

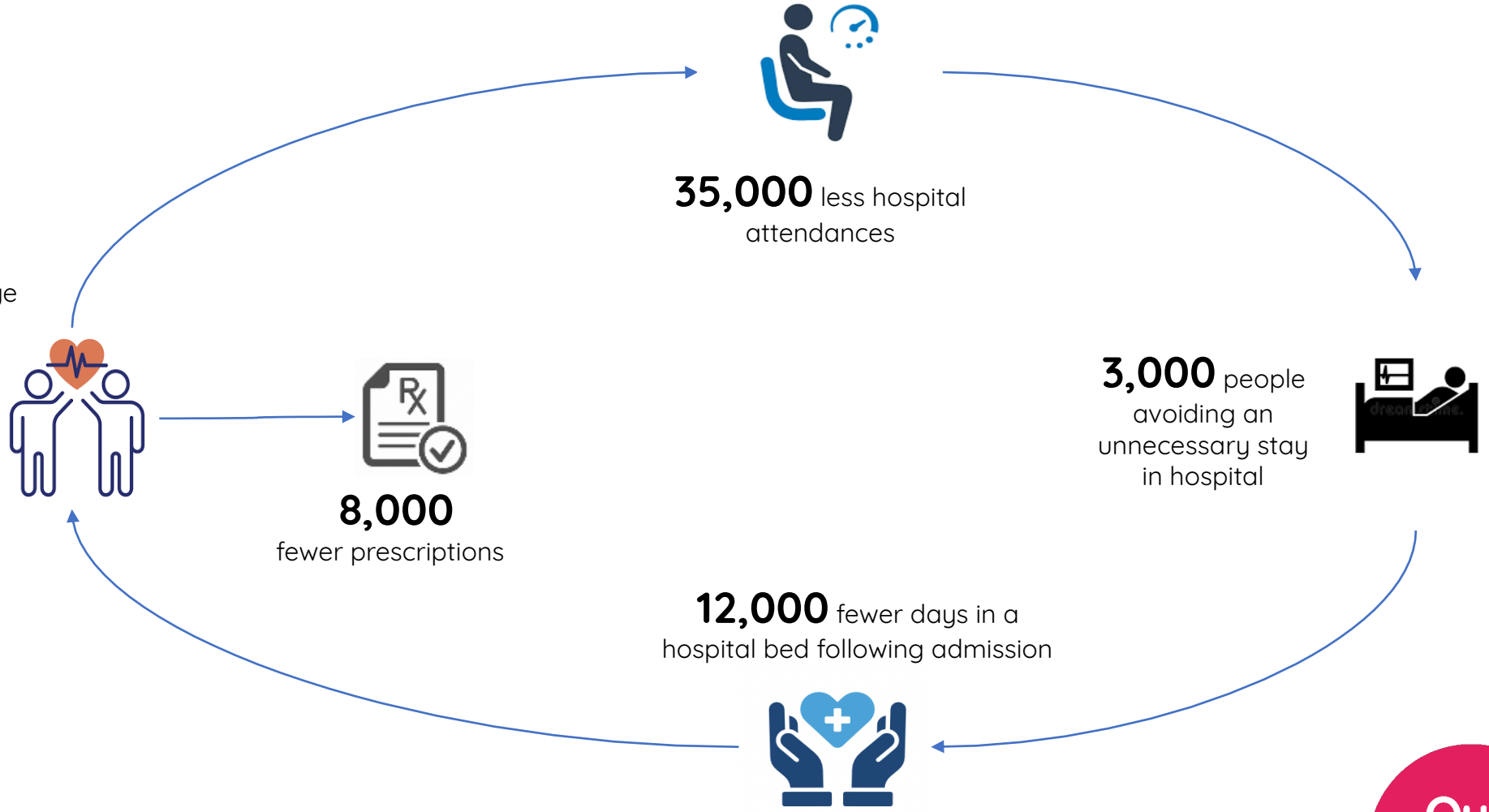
5. Use data to identify 'rising risk' population cohorts and engage with partners and communities to redesign the local care and support offer

6. Support the delivery of agreed system primary and secondary prevention priorities

Improve population health

Focus on the person → **Focus on the population**

Expected impact



Connecting Teams

Weymouth and Portland lunch and learn sessions

- 35 services/ organisations have already shared information, leading to significant increase in the before and after scores where teams were asked if they felt they understood other's services.
- Sessions also include talks on current good practice from senior subject matter experts in the system.

Purbeck

- Services within the INT have created posters to share with team members
- Planning is underway to produce a series of short video clips highlighting what services are available across the Purbeck INT footprint and how they can be accessed.

Our Dorset

Bringing teams together to make a difference to the local population

Weymouth and Portland

- Joint frailty triage meetings are now in place bringing together the Community Rehabilitation, PCN Frailty, Adult Social Care and Virtual Care teams.
- The new lower limb multidisciplinary team meeting has been established in Portland with Practice and District Nurses jointly reviewing the patients that each team sees.
- The INT are also establishing 'shadowing' between the teams to increase understanding of each other's roles and to identify further opportunities to strengthen integrated working.

Purbeck

- Using population health data for their communities to inform where they should start in terms of bringing teams together. Emerging opportunities include Frailty, Obesity and Mental Health so the teams supporting these areas are coming together to see how the current services can work more closely and remove barriers to them being able to provide integrated care.

Our Dorset

This page is intentionally left blank