

FutureCare Closedown Report

July 26

Contents

1. Executive Summary 3
   - What was delivered 3
   - Challenges remaining, and why 4
   - What happens next 4
2. Purpose of document 5
3. Programme summary 5
4. Background and strategic fit 5
5. Vision and objectives 6
6. Programme scope 7
7. Delivery review 9
   - Overview 9
   - Alternatives to Admission 10
   - Transfer of Care 10
   - Bed-based Intermediate Care 12
   - Home-based Intermediate Care 13
   - System Visibility and Active System Leadership 14
   - Change Capability 14
8. Key challenges faced 15
9. Provider performance wider performance context 19
10. Assessment against benefits plan 20
    - Run-rate 21
    - Performance against key performance indicators 22
    - Benefits delivered by organisation 23
11. Agreed priorities for the future 24
12. Conclusion 27
13. Appendices 28

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

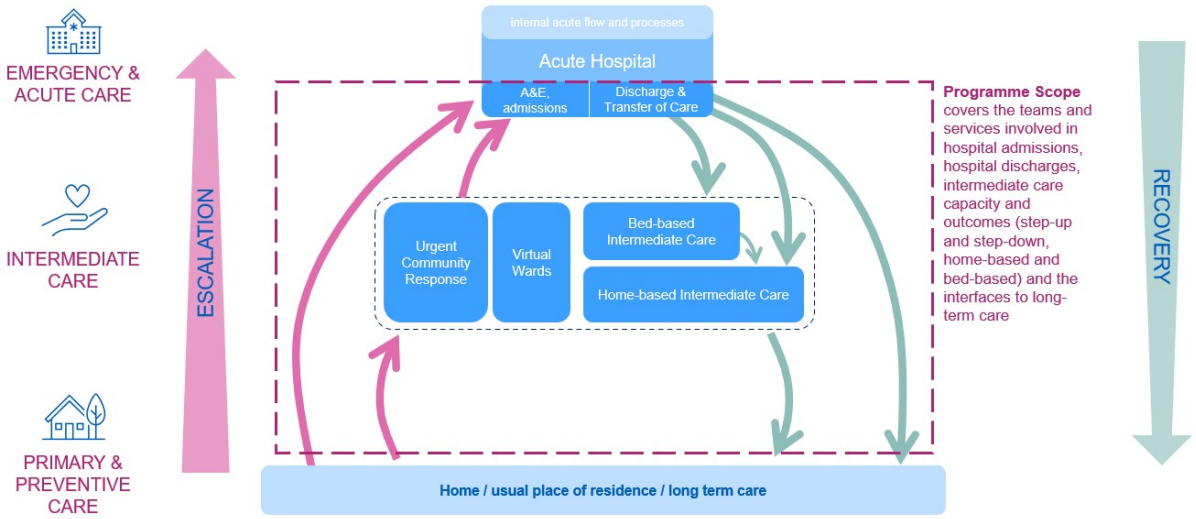
The vision set for the FutureCare programme was to achieve the best possible improvements in people's health and wellbeing; and to create strong partnerships, integration and shared goals across our health and social care organisations, voluntary organisations as well as with education, local businesses 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.



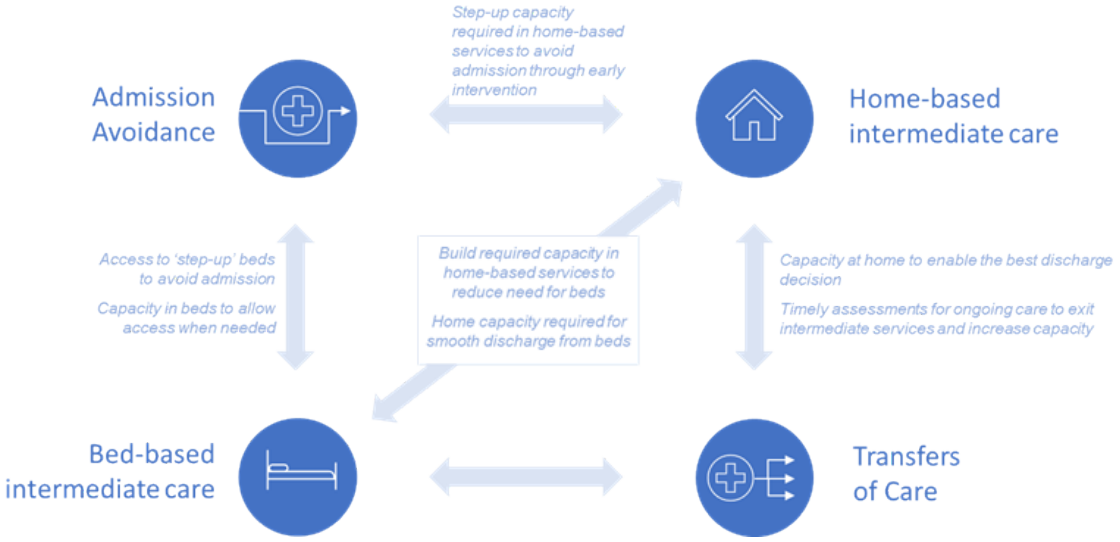
It was a time limited programme where a large amount of transformation support was provided over an eighteen-month period to deliver an agreed amount of operational benefit. From the outset it was recognised that the planned improvements would represent the first step in a longer journey and to achieve 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.

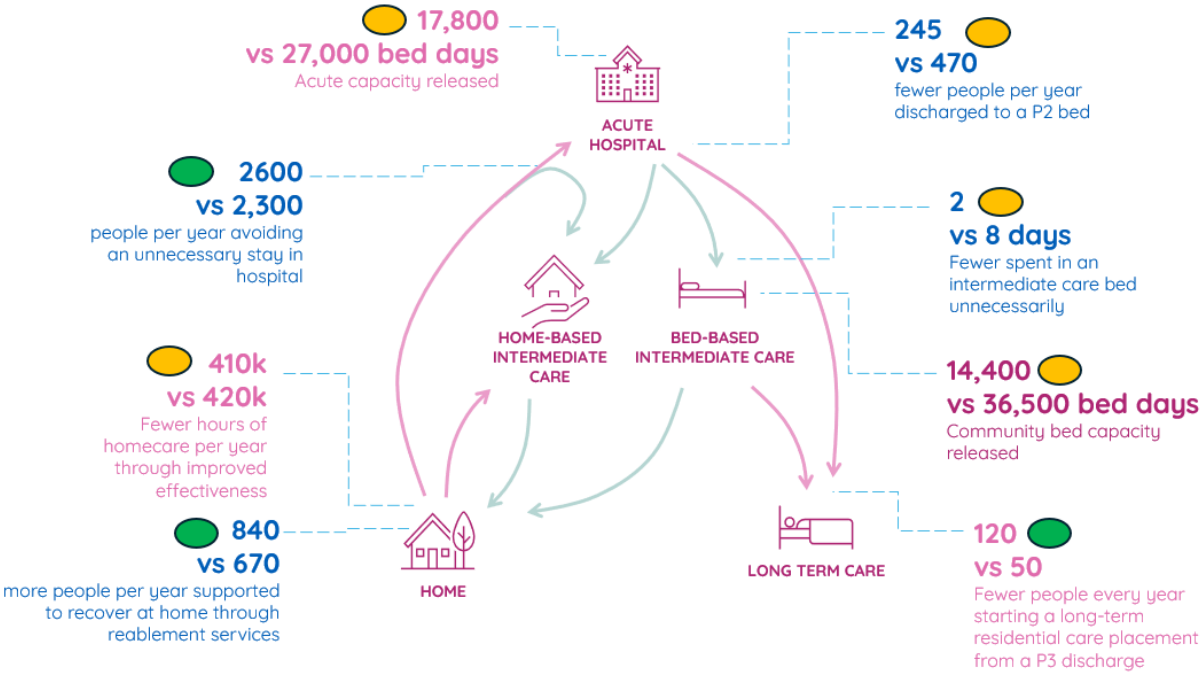
7. Delivery review

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.

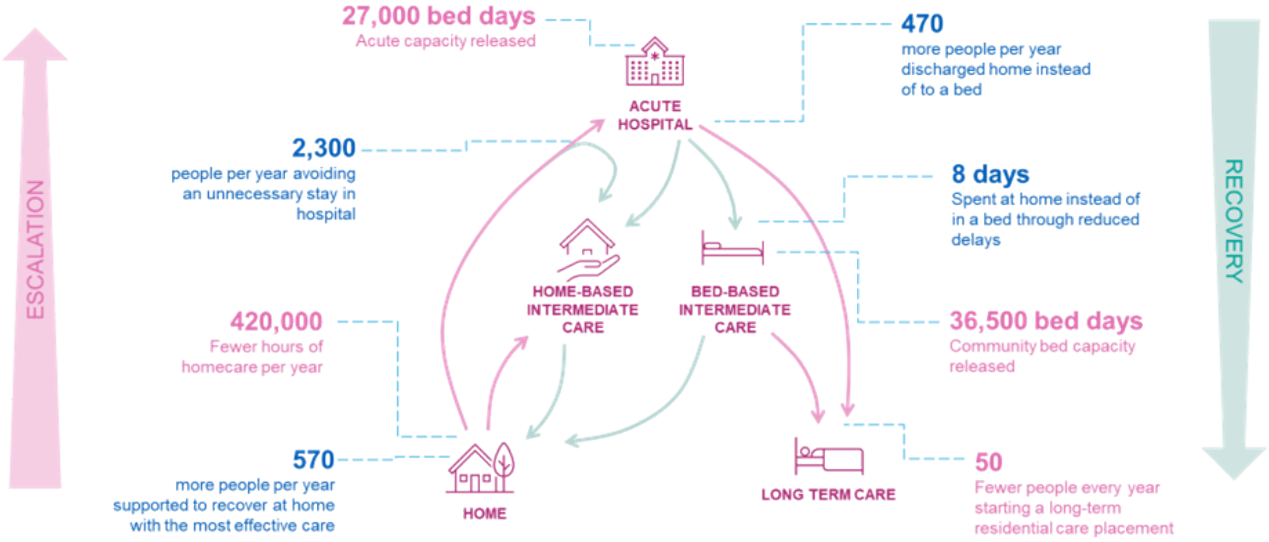
Variable	Current 8WMA 06/26	Same time period 2024 (8wma at w/c 06/24 2024)	Variance
# Beds	192	208	-8%
# Starts pw	37	35	6%
# Discharges pw	38	34	12%
Closed LoS (days)	31.0	37.7	-18%
Bed Occupancy %	93.2%	91.5%	2%
NCTR %	35.4%	25.8%	37%

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.

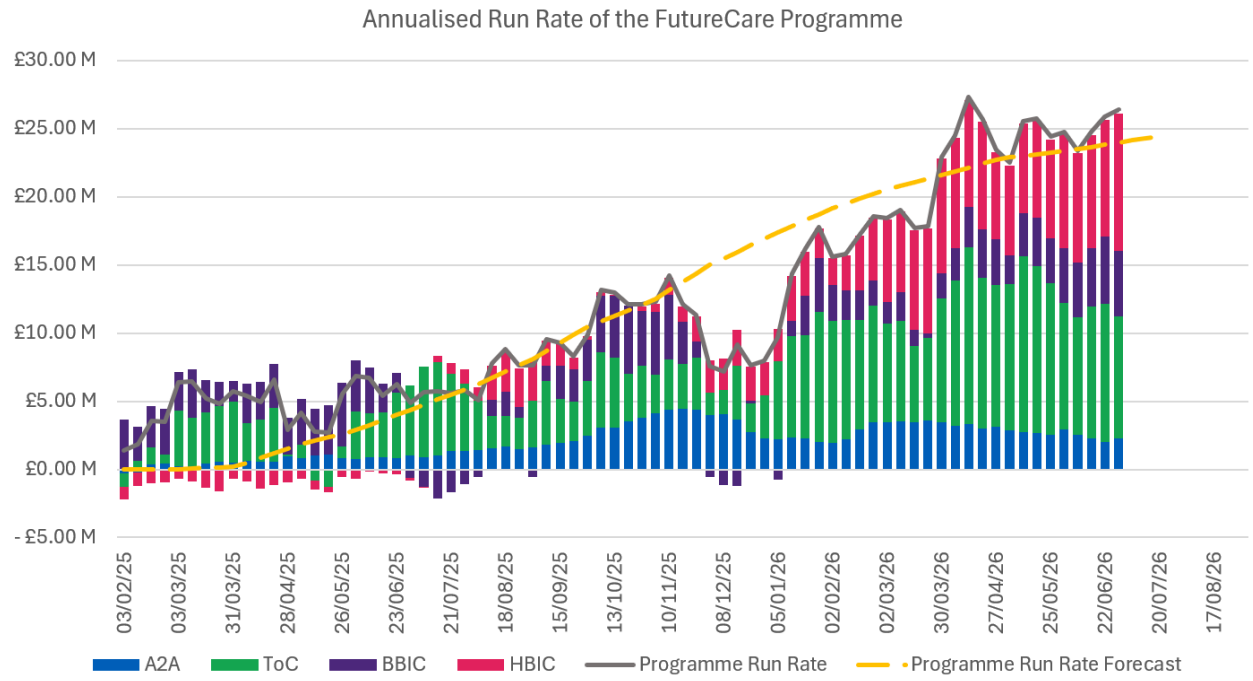


Project	Opportunity	UHD	DCH	DHC	BCP	DC	Total
Home-based Intermediate Care	Reablement Throughput				£ 2.03m	£ 0.78m	£ 2.81m
	Reablement Effectiveness				£ 0.37m	£ 3.30m	£ 3.67m
	Reablement Overlap				£ 0.06m	£ 0.33m	£ 0.39m
	Project Total:	-	-	-	£ 2.46m	£ 4.41m	£ 6.87m
Bed Based Intermediate Care	BBIC 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.

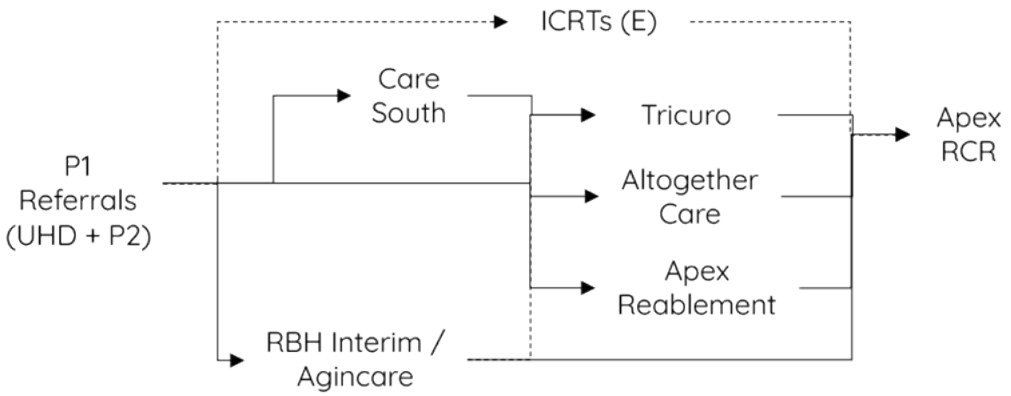
Action 4: Home Based Intermediate Care capacity

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

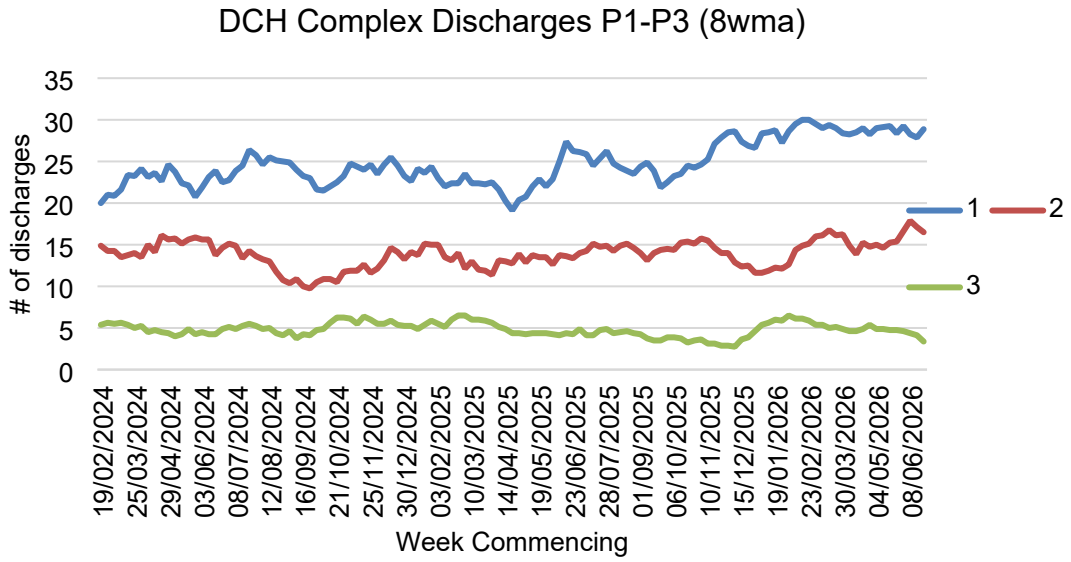
complexity at home. Initially this is a commissioning challenge and will require close working between both local authorities and Dorset Healthcare.

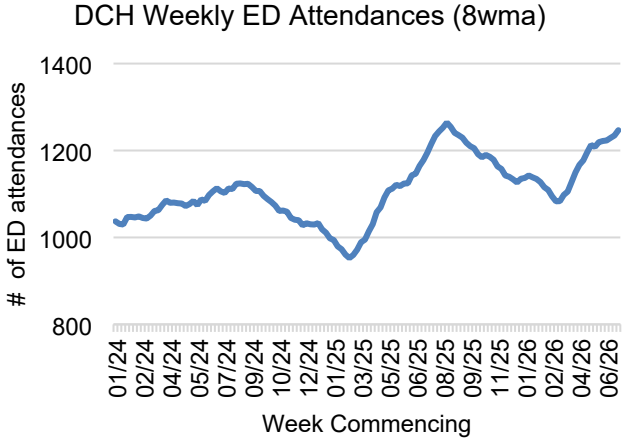
12. Conclusion

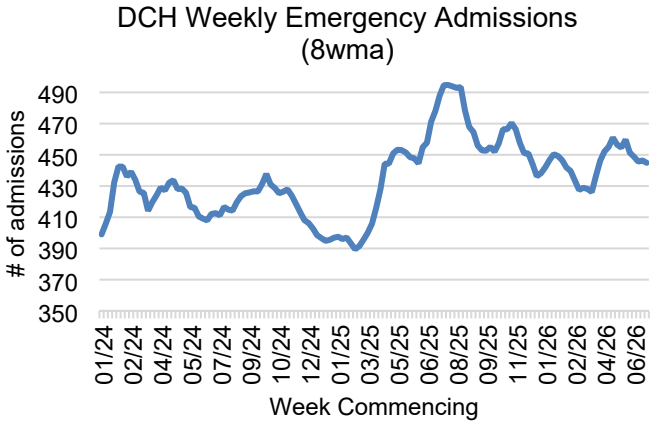
The FutureCare programme has delivered a meaningful and measurable improvement in the productivity of the Dorset urgent and emergency care system. But as described in this report, there is as much about what remains to be done as it is about what has been achieved. The diagnostic and work to date has 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.

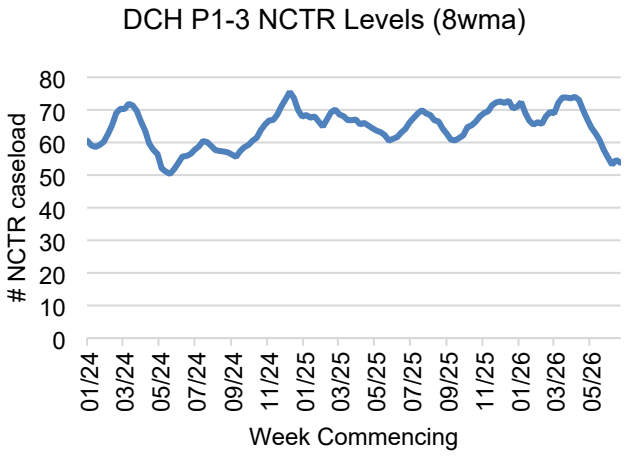
13. Appendices

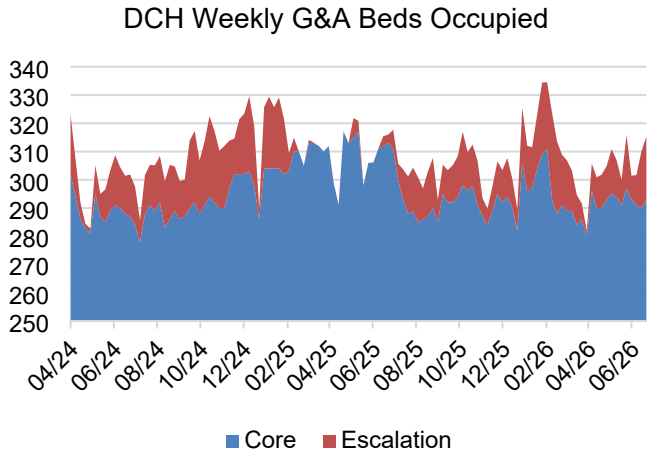
DCH performance time series from May 2024 to June 2026. All charts present a rolling 8 week moving average, for ease of observing trends in the volatile UEC environment.











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.

