Dorset HealthCare
University NHS Foundation Trust

Operational Plan Document for 2014-16

Dorset HealthCare University NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute the operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

Name	Ron Shields
Job Title	Chief Executive
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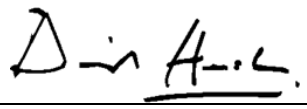
Tel. no. for contact	01202 277 004
Date	04 April 2014

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

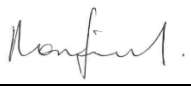
- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *Sir David Henshaw*	

Signature

Approved on behalf of the Board of Directors by:

Name *Ron Shields*	

Signature

Approved on behalf of the Board of Directors by:

Name *Jackie Chai*	

Signature

1.2 Executive Summary

Explanation

Dorset HealthCare is presently in subject to enforcement action. As part of dealing with its recognised shortcomings, the Trust is producing a formal Blueprint. This full 5-year financial projection and narrative will be presented to Monitor on Monday 28 April 2014.

The Trust has always recognised that this is a large piece of work that directly coincided with the first part of the 2014/2015 Annual Planning round. To deal with this, the Trust decided to produce a single 5-year financial number set and use it, once it was completed on 24 March 2014, without change, to feed all requirements of both the Annual Plan and the Blueprint.

While this has worked for the financial data, the narrative timings have provided a greater challenge, as the Annual Plan 2-year filing is just too early for the Trust's Blueprint process.

Accordingly, this narrative tries to meet Monitor's Annual Plan needs. However, we ask that it is recognised that it is, in practice, extracts of an early draft of what will be more fully developed for the Blueprint.

Executive Summary

Dorset HealthCare is responsible for all community and mental health services across Dorset, and today serves a population of almost 700,000 people, employs 5,000 staff and has an income of £240 million.

The Trust has recently been through a challenging period and is currently subject to enforcement action.

Care Quality Commission (CQC) inspections between June 2011 and December 2013 highlighted a number of service shortcomings in the Trust's mental health services. Some of these concerns were then either not addressed, not addressed with sufficient urgency or findings were not accepted. At the same time, the then senior leadership team displayed a number of other concerning characteristics, including an inability to work together.

Monitor issued enforcement undertakings on 23 April 2013. A review by Deloitte LLP, including the CQC outcome review, followed. The previous senior leadership team responded with a 'Trust Recovery Plan' which sought to address all findings, and to ensure the service areas were fully compliant to the CQC essential standards. Monitor imposed an additional licence condition on 4 September 2013 relating to governance requirements.

On 30 September 2013, under section 111 (5) of the Health and Social Care Act 2012, Monitor required the appointment of Sir David Henshaw as Interim Chair and additionally the deployment of suitable turnaround expertise. This was to ensure that the Trust Recovery Plan was fit for purpose and that all the underlying issues in the CQC inspections and the Deloitte independent review of governance arrangements were satisfactorily addressed.

Sir David Henshaw has led a radical shake-up of the Trust Board, its systems and process of governance. This has included 4 new NEDs, Ann Abraham as Chair, with effect from 7 April 2014, Ron Shields as interim CEO with effect from 30 October 2013 and on a permanent basis since 13 March 2014. The executive Directors of Finance, Nursing / Quality and Mental Health have all been replaced.

The Trust Recovery Plan had 331 actions of which 316 have been completed. Substantial progress has been made on the remaining 15 actions and these have now been incorporated into the Trust's 5-year Blueprint. This Blueprint will be formally presented to Monitor on Monday 28 April 2014 and will set out what the Trust has done, and will do, to restore confidence, rebuild relationships with commissioners, rebuild credibility, explain how it will deal with any outstanding points from the CQC Inspections / Deloitte Review / Trust Recovery Plan and justify a release from enforcement action.

The heart of the approach the Trust now intends to adopt is to implement a locality management structure and transform the Trust's service delivery model. This ability to deliver new models of service delivery reflects the commissioning priorities at both a national and local level. Underlying this is a need to deal with a number of historical issues and 'clear the decks' before the locality model can safely be provided.

This in turn requires key elements of what might be called a 'plan for a plan' to be developed, including the locality model itself, or models, since each will be determined locally. Service user and operational requirements need to be determined so that the enabling back office support can be planned, shaped, costed, benefits determined and commissioned. One example of this is how to ensure staff are supported by appropriate IT and data systems, to provide a service determined by the needs of patients.

The post-merger integration was not addressed fully at the time of the merger. The Trust is still effectively three organisations in many areas, as there was no integration strategy or plan. A major focus for the Trust will therefore be to seek to create a cohesive organisation, with a strong Organisational Development Plan and staff engagement. The Trust now also needs to be fully integrated so that a proper back office platform for the future locality operations it wishes to sustain can be put in place. Part of this work will include a major effort to transform what is a large estate with the Trust operating from over 220 properties, many of which were inherited from the PCT. The potential of the estate needs to be understood, utilisation maximised, surplus property disposed of, and a detailed maintenance programme for all properties drawn up. A redevelopment plan based on the needs of operational services must be developed, as must an effective internal system for the allocation of space. The Trust's IT infrastructure requires updating with data centres needing to be relocated to compliant locations. A number of issues in the HR and Finance functions also need to be addressed and these services restructured to support the new operating divisions.

A further plan is required as to how specific operational challenges will be resolved, such as the aspiration to move to two Mental Health inpatient hubs, one in the east and one in the west. Given the number of empty small local Mental Health units and the three current larger Mental Health hubs, all of which have varying degrees of unsatisfactory facilities, the need for decant space, continuity of service and major capital expenditure make this a complex programme.

It should be noted that none of the costs or benefits of the locality model and operational challenges are included within the Annual Plan or Blueprint numbers. The level of understanding as to what will actually be needed is just currently insufficient to include robust numbers. The numbers do, however, include dealing with known issues, so for example, the consequences of the end of NHS Rio licencing for the Mental Health service are included, but not the costs of how this Mental Health service will then be migrated into the locality model.

While some significant transformational change will take place during the first year of the Annual Plan, FY15, the majority of initiatives will be operational improvements as detailed planning is undertaken for the implementation of the locality model. The second year of the Annual Plan, FY16, will see a shift in focus towards major transformational change as locality working is implemented in earnest.

It is recognised that the financial environment is more challenging than that previously experienced by the Trust. The Dorset Health and Social Care economy will be in deficit in FY15. Nonetheless the Trust aspires to manage within these constraints, and after a small deficit in FY15, in part necessitated by the need to invest in clearing the decks, as referred to above, will return to a small surplus for subsequent years.

Dorset HealthCare is expecting to deliver an unaudited surplus of £0.4m (target: £1m) in the year just ended and had a cash balance of £29m at 31 March 2014. Furthermore, the Trust has reached agreement with its main commissioners and has agreed a broadly consistent income position for the current year of FY15.

The FY15 CIP programme is largely focussed on traditional CIPs as the Trust seeks to address its legacy issues ahead of transformational change in subsequent years. The Trust plans to deliver an £8m CIP in year, alongside the increased investment referred to above, which will result in a planned deficit of £4m before a return to a surplus of £1m in FY16 and subsequently.

1.3 Operational Plan

1. Operational Plan

1.1.An overview of recent history of the Trust

In July 2011 the Trust acquired all community services across Poole, Bournemouth and community and mental health services for western Dorset, leading it to become the provider of all community and mental health services in the county. As a result of this acquisition, the size of the organisation has almost trebled. The Trust serves a population of almost 700,000 people, employs around 5,000 staff and has an income of approximately £240 million.

Recent financial performance

The financial performance of the Trust has been healthy with reported surpluses in each year as set out below:

	Income	Surplus	
	£m	£m	%
2013/14*	242	0.4	0.2%
2012/13	227	11.8	5.2%
2011/12	214	10.4	4.9%
2010/11	88	4.4	5.0%

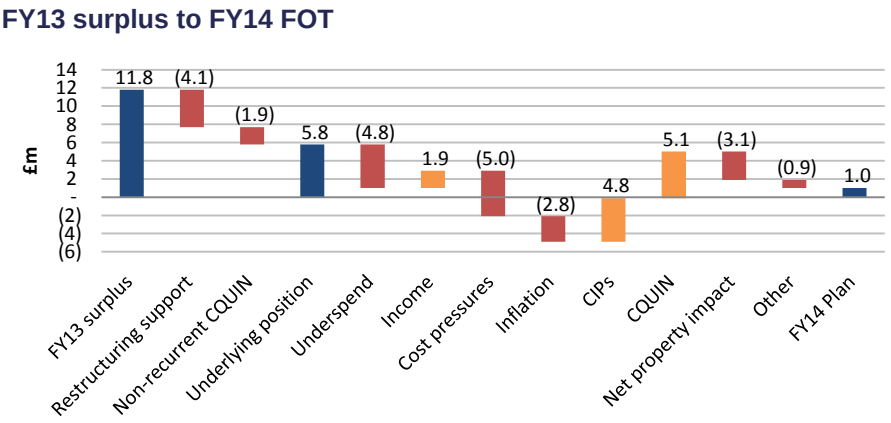
***Forecast at Month 11**

During FY14, the Trust was subject to enforcement undertakings by the regulator, Monitor on 23 April 2013. Monitor imposed an additional licence condition relating to governance requirements on 4 September 2013.

The Trust was also criticised by Monitor for poor financial forecasting as reflected in the unplanned year end surplus of £11.8m, £10.8m above plan. These were largely the result of non-recurrent income received from the outgoing PCTs and operational under spend. The surplus for FY13 was £11.8m, £10.8m above the Trust's target plan level of £1m. This excess was generated primarily on a non-recurrent basis, and some of the driving factors were:

- Unutilised contingencies;
- Unutilised non-recurrent funds identified for QIPP planning and estate strategy planning; and
- In year pay underspends in respect of vacancies;

Set out below is a bridge between the FY13 surplus and the planned FY14 surplus of £1m.



The Trust is forecasting to deliver a surplus of £0.4m in FY14, £0.6m less than planned. This is the result of poorer performance within Dorset HealthCare's mental health services on out of area placements and reliance on temporary staffing. This trend has now been reversed. The Trust has also invested in safe staffing levels.

The Trust's cash position remains strong, with cash at 31 March 2014 of £29m. This will provide sufficient capital for investment in improved quality of care for patients and underpinning the Trust's liquidity element of the COSR rating of 4.

Trust quality challenges

The Trust's vision is to "provide care all of us would recommend to our family and friends". It will be the primary objective of the Trust Board to ensure the Trust consistently delivers safe, effective and efficient patient services. During FY14, shortcomings in care delivery by the Trust were exposed in visits by the CQC. Following initial issues identified, the CQC instigated a short notice announced inspection (19-29 April 2013) to review the Essential Standard 16. The outcome identified significant concerns.

As a result of this, Monitor intervened and through the Trust, commissioned Deloitte to undertake an independent review of governance arrangements which concluded with a report in July 2013. The Trust Recovery Plan (TRP) containing 331 actions, incorporates 61 recommendations and combines the Trust Development Plan and actions in response to the CQC Outcome 16 review. Monitor has since imposed a new condition on the Trust's licence which required it to ensure its Board and committees function effectively and are able to tackle the issues causing the Trust to be in breach of its licence.

The learning from the Francis, Keogh and Berwick reports are informing the Trust Board. The new Trust Board team have also identified other quality concerns which are being addressed.

The Trust identified that it was non-compliant with the provision of appropriate gender separation in eight of the Trust wards. Six of these have now been addressed through changes in operational arrangements whilst the remaining two, Flaghead Unit and Stanley Purser Ward, are projected to be compliant through small building schemes by 30 April 2014.

Recent quality concerns raised internally relate to safety and suitability of the St Ann's premises. In response the Trust has identified funding and developed a priority list to carry out refurbishments to acute mental health wards at the St Ann's site. Mental Health Delayed Transfers of Care are currently in excess of the 7.5% target. Having reviewed the implementation of delayed transfers, other monitoring indicators have also been reviewed to ensure accurate reporting. Further investigation of the crisis indicator is being taken forward. An action plan has been developed and the Trust expects to be compliant again by the end of April 2014.

The Trust has made substantial progress in resolving the governance issues identified by Monitor's review. This has been managed through setting up a Programme Management Office (PMO) and has held regular taskforce meetings. The Trust's Recovery Plan was formally closed on 1 April 2014, with fifteen outstanding actions captured in six future key areas:

- Organisational Development (including communication and staff engagement);
- Stakeholder Management and Patient Participation;
- Board (NEDs, Executives and Non-voting Directors) and Leadership Development;
- Risk Management (including escalation and Board Assurance Framework);
- Staffing; and
- Performance and Information Reporting.

The remaining issues will be addressed as part of the five year Blueprint due to be submitted to Monitor on 28 April 2014.

Work has been undertaken by the Director of Nursing and Quality and the Medical Director to review the Trust's in patient unit staffing levels. This work is subject to ongoing review as national staff benchmarks and more definitive guidance on what 'safe' staffing looks like, become available.

The Trust is working on the implementation of safe staffing levels on the inpatient units and intends to publicly display staffing levels in line with national recommendations.

The quality challenges for the Trust in FY14-16 can be summarised as:

- Providing ongoing systematic evidence of quality improvement in regard to the Essential Standards of Quality and Safety alongside the challenge to deliver CIP savings and financial constraints within the health and social care economy;
- Improving and embedding quality assurance processes and systems throughout the Trust ensuring the Board has a clear line of sight from Board to Ward;
- Improving and embedding information systems and quality metrics to demonstrate that all targets and indicators are

being reported accurately;
- Improving the quality of the patient experience through improving the environment, particularly the mental health units;
- Further developing the Board and risk management processes that support the effective operations of the Trust; and
- Developing a culture in the organisation that has a clear focus on quality improvement with a well-supported satisfied workforce who would recommend our services to family and friends.

Over the past six months, emerging issues with a negative impact on quality are being identified more quickly, reported on and actioned. This demonstrates a Board and organisation that is becoming more self-aware, open and transparent which is a significant shift in the competence and capability of the Board to deliver effective governance. Francis, Keogh and Berwick have brought a renewed focus on ensuring that patients are at the heart of all that the Trust does and ensuring Dorset HealthCare develops the strong quality governance and assurance systems needed. These will give assurance and feedback to the Trust's patients, governors, staff, commissioners and other stakeholders who take an active interest in the work of Dorset HealthCare.

How the Board derives assurance on the quality of its services

The Trust is clear that effective governance and leadership must be underpinned by strong assurance systems. The previous approach inappropriately relied too heavily on 'reassurance'. The new approach will deliver greater 'assurance' to the Board through the development of NED chaired Board Assurance Committees.

Sir David Henshaw has led a radical shake-up of the Trust Board, its systems and process of governance. This has included 4 new NEDs, Ann Abraham as Chair, with effect from 7 April 2014, Ron Shields as interim CEO with effect from 30 October 2013 and on a permanent basis since 13 March 2014. The executive Directors of Finance, Nursing / Quality and Mental Health have all been replaced. The Trust is confident that the new Board has the appropriate capability and determination to drive the required change in Board assurance through the organisation. The new Board has undertaken a critical self-review and has made significant changes to the Board assurance structure, but recognises this is still a work in progress. Key activities include:

- The Board approved the formation of a Finance, Investment and Performance Committee, chaired by a NED. The first meeting of the Committee was in January 2014;
- The Quality Assurance Committee was reviewed with the new Chair and as part of the governance structure review.
- From November 2013, three groups (Patient Experience, Patient Effectiveness and Patient Safety) were established and report to the Quality Assurance Committee (QAC);
- An integrated dashboard report continues to be developed and enhanced.
- An internal and external review of the Trust risk management processes, aligned to Monitors Quality Governance Framework (2013) including the risk register and Board Assurance Framework (BAF) recommendations, has been completed. This represents a solid platform for the Trust to further develop its approach to risk and the BAF.

1.2. What the Trust is doing to engage with commissioners, local authorities and other local partners and stakeholders to work together to understand the challenges, joint initiatives and collaborative working.

Engagement with Commissioners and the local health economy

The new Trust Board is focused on rebuilding its relationship with Commissioners through a variety of engagement methods. The Trust has just concluded the FY15 commissioning round where the CCG agreed to invest in additional district nursing staff; and to funding out of area placements for Mental Health. The Commissioners have also agreed to fund the 1.8% tariff reduction in FY15.

The Trust recognises that it still needs to gain the confidence of the locality GPs to enable the Trust to continue to be the prime provider of Community and Mental Health services in Dorset.

Dorset HealthCare is actively engaged in representation in each of the CCG clinical programme groups and the overall Pan Dorset Clinical Commissioning Group.

Links with GPs have been developed and in all localities the Trust has met lead GPs and gained support for the Trust's core strategy to deliver personalised locally integrated care.
The Trust intends to put all commissioners – GPs, local authorities, and specialist commissioning - at the heart of decision making.

The Trust is actively working with Commissioners in Purbeck and Poole to help develop integrated care. While the work continues within Purbeck, Dorset HealthCare have been identified as the provider of choice. The Trust's collaboration with Commissioners in Poole is at an earlier stage but is focused on integrating district nurses with GPs.

Better Together

Dorset Better Together Partnership is 'committed to transforming health and social care services across the Dorset area, to enable and deliver a sustainable improvement in health and care outcomes through: person centred, outcome focussed, preventative, co-ordinated care'. This is a pan-Dorset approach including all commissioners. Dorset HealthCare is at the centre of this initiative as it is consistent with the Trust's approach to long term conditions and a locality focus. The first priority is to transform the services for the frail and elderly across Dorset.

Health and wellbeing boards and health scrutiny committees

The Trust's senior management team links in with the Bournemouth & Poole, and the Dorset Health and Wellbeing Boards, to ensure the Trust is represented and working collaboratively to meet the strategic direction of the health and social care agendas in Dorset.

The Trust regularly presents to and works with the different Health Scrutiny Committees across Dorset, Bournemouth and Poole. Dorset HealthCare looks to respond proactively to their concerns and ensure the local councillors are well informed. For example, the CEO presented to the Dorset Health Scrutiny Committee in March 2014 about the Trust's progress with Monitor and the emerging strategic direction in order to gain their support and confidence in the organisation.

Safeguarding Boards

The Trust is a key and active member of the Adult Safeguarding Boards and Children's Safeguarding Boards (Dorset and Bournemouth and Poole). The Trust is also engaged and involved in the sub groups of the four Boards, actively contributing to the scrutiny and development of safeguarding practice and being held to account for the quality of services delivered to safeguard children, young people and vulnerable adults.

Providers

The Trust is making efforts to work closely with the three acute hospitals in Dorset, and neighbouring trusts outside the county, to develop clearer clinical pathways. This has focused on prevention of acute admissions and supporting early discharges from the acute sector as part of the whole health and social care economy approach to winter FY14. Along with the acute providers in the health economy and social care partners, the Trust is a key member of the Urgent Care Board. This group commissioned a Kings Fund Report which identified key areas where the organisations could better work together. From this work the Urgent Care Board is developing a Frail Elders pathway for the whole of Dorset.

Third sector

The Trust is committed to working with third sector organisations across a range of areas. Some recent examples include the following:

- The Trust has recently submitted a joint bid with Help and Care to provide memory services across Dorset;
- A successful partnership arrangement with EDP (Exeter Drugs Project) in the delivery of Prison Services in Devon; and
- The Trust works in partnership with Rethink Mental Health to deliver a holistic Early Intervention in Psychosis Service in West Dorset.

The short term challenge

Dorset health economy

Dorset currently has a high proportion of older people compared to the rest of England, and this is projected to increase, resulting in a greater need for both formal and informal care. However, the 20-39 age group is significantly underrepresented across the county due to a period of low birth rates and the outward migration of this group. Dorset is therefore gaining an ageing population but losing its workforce and those with the ability to deliver care for family, friends and neighbours. The county is split into two broad categories – the Bournemouth and Poole conurbation and the more

rural and less densely populated north and west of the county.

The changing nature of demographics in Dorset will adversely impact on the health economy in the medium term. The Trust has identified six major trends which are expected to affect the Trust over the short to medium term:

Immediate

1. Funding constraints;
2. Sustaining the confidence of the GP commissioners;
3. Competitive environment;

Short to medium term

4. Pressure to deliver care closer to home;
5. Pressure to deliver integrated personal locality based care; and
6. Pressure to address other specific policy priorities.

National financial context

The financial constraints on the NHS of £20bn - £30bn by 2020, make the position in Dorset even more challenging.

Monitor, in partnership with the NHS Trust Development Authority and NHS England, has estimated the scale of the financial challenge facing providers in the next five years in *'Guidance for the APR 2014/15'*. By looking at the overall NHS budget settlement against likely procurement and pay inflation, activity growth and known policy commitments, it estimated that in the next two years the 'affordability challenge' for the NHS as a whole will be 3.1% for FY15 and 6.6% for FY16. This efficiency requirement will have to be met by the local health economy through internal efficiencies by providers and through more efficient partnership working.

Funding constraints

Dorset's financial position is increasingly challenging. Dorset CCG's funding will increase by 2.1% in FY15 and 1.7% in FY16, which in real terms means its budget will either be flat or slightly declining. NHS England define Dorset CCG's "*financial risk rating for FY15 and beyond as high risk*" due to increasing demand and worries regarding acute providers' sustainability.

Financial pressure on neighbouring acute Trusts is likely to have an additional adverse financial impact on Dorset HealthCare. Poole Hospital NHS Foundation Trust is being investigated by Monitor following concerns over its financial sustainability.

A recent survey showed that mental health Trust budgets had declined by c.2.4% in real terms between FY12 and FY14. This decrease is greater than that experienced by other types of Trusts. Consequently, despite the national 'parity of esteem' policy and Dorset CCG highlighting certain mental health issues (e.g. dementia) as key priorities, Dorset HealthCare are unlikely to see its funding increase, even in line with CCG budgets in the next two years.

The local health economy is also funded, although to a much smaller degree, by local authorities acting as public health and social care commissioners. The cuts in local authority spending on social care have been much more significant than similar NHS spending cuts, with the NAO estimating that at a national level *"local authorities' total spending on adult social care fell by 8% in real terms between 2010-11 and 2012-13 and is projected to continue falling".* This situation is mirrored in Dorset's local authority, with Dorset County Council cutting adult social care, and children and young people's funding by 7% and 4% respectively in FY14. Bournemouth and Poole Unitary Authorities are also being forced to make cuts.

Over the next two years the Trust will have to cope with funding constraints set against increasing demand, and pay and procurement inflation. As a result, the local health economy will be forced to redesign the models of care and deliver care more efficiently to drive quality without additional funding. To meet this challenge the Trust will need to redesign its delivery models. This will enable internal savings in delivering its existing services more efficiently, and health economy-wide efficiencies through more innovative partnership working by developing integrated care that is personal and closer to the patient's home.

Sustaining the confidence of the Trust's local GP commissioners

At a local level, Commissioners are currently carrying out a market testing exercise on the Trust's services. Dorset CCG have issued a market research exercise for the majority of mental health and community services on offer in the county, in order to "*gain an understanding of the providers in the market to enable future shaping of the services to ensure resilience of service delivery".* The exercise will allow them to ascertain which providers might be interested in offering services either as a prime or sub-contractor, and if interested, how quickly they could respond if they were to win a competitive tender.

This review closes on 4 April 2014. If there is greater tendering activity as a result, this will significantly impact the local health economy through increased competition from a variety of provider types offering services, in new and innovative ways. The Trust aims to be proactive in adapting to this challenge by working to improve the quality of its services and relationships with Commissioners.

Local authorities

Local authorities currently commission a number of services we provide such as school nurses, sexual health and stop smoking services. Local authorities will also take on commissioning responsibilities for Health Visitors from NHS England in April 2015. Local authorities are therefore an increasingly important stakeholder for the Trust and while we already have strong relationships with them through forums such Children Trust Boards Dorset HealthCare is focused on building relationships during FY15.

Competitive market

The recent increase in competitive pressure, in a historically non-competitive area, is an area of a key challenge over the next two years. The Commissioners are likely to test whether there are alternative providers who could offer the services that Dorset HealthCare currently provides.

This competition is likely to come from:

- GPs;
- Providers; and
- Private Providers**.**

GPs

Local GPs are increasingly interested in offering services Dorset HealthCare currently provide. A recent report by the King's Fund, 'Commissioning and Funding General Practice: Making the case for family care networks' has suggested that GPs should potentially control community services. GPs offering care tailored to patient and service user needs and offering community services (e.g. District Nurses) is an area of potential competition. Similarly, low acuity mental health services (e.g. IAPT) could be targeted by GPs as they work to tailor services to patients and service users.

Providers

The local acute providers have already expressed a desire for community services to be tendered, allowing them to vertically integrate and increase control over acute admissions. The acute providers are financially challenged and may see providing the Trust's services as a possible solution to make them sustainable in the medium term. New solutions maybe required for the local acutes following the rejection of the proposed merger between Poole Hospital NHS Foundation Trust and Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust.

Some clusters of services (e.g. services for children and the elderly) are being grouped together into care pathways, and the identification of a non-Dorset HealthCare lead provider for that pathway could erode the Trust's position.

The Trust will also face competition from NHS providers outside of the county. For example, Southern Health NHS Foundation Trust has also expressed an interest in taking integrated services outside of Basingstoke.

Private providers

The Trust has seen increasing competition from private providers. Nuffield Health recently won a tender to provide physiotherapy services for Devon and Cornwall, Dorset, Gloucestershire & Wiltshire Police while Agincare has seen significant growth in the region and has moved into providing Children and Young Person services. However, two of the leading private sector organisations are Serco and Virgin Health.

Serco announced in December 2013 that it is reshaping its UK healthcare business, in response to recent contract performance issues and commercial challenges. It will no longer offer acute and primary care services, as signalled by its intent to exit early from contracts to run Braintree Hospital and to offer GP out-of-hours services in Cornwall.

Serco is a potential competitor to Dorset HealthCare in relation to its provision of community healthcare services. Serco currently provides a broad range of community health services in Suffolk, many of which are analogous to services currently provided by Dorset HealthCare.

Since it entered the healthcare market by purchasing Assura Medical in 2010, Virgin Care has built up a broad portfolio of patient-facing care delivery services. It focusses predominantly on the primary and community care sectors, and its key services include outpatient services, community hospitals and out of hours services. Virgin have recently won a contract for the provision of community services in Lyme Regis. In addition, they have also recently won large contracts to take control of community services in Surrey and integrated children's services in Devon, and are one of the final four bidders for the £800m older people's services contract in Cambridgeshire and Peterborough. The scope and scale of these services demonstrates Virgin's commitment to controlling care pathways. Virgin Care has also stated that it will consider contract opportunities in any region of the country, subject to contract terms.

Virgin Care is a potentially significant private sector competitor to Dorset HealthCare. If Commissioners in Dorset and surrounding areas carry through with their stated intention of exploring opportunities to tender care pathways or sets of services, Virgin Care has the experience and expertise to bid competitively (e.g. in elderly care, district nursing, and broader community services).

However, the Trust continues to be successful, for example, Dorset HealthCare have been awarded the tender for the Dorset Community Persistent Pain Management Service for the next three years. The Trust has expanded the services it provides to Devon Prisons. Devon services include: primary care; substance misuse; mental health; pharmacy; dental; learning disabilities; and health and wellbeing. Other recent success includes delivering the Steps to Wellbeing service in Southampton for the next five years. In addition, there are potential opportunities to take on Social Care services to address issues such as Delayed Transfers of Care. The Trust does not underestimate the threat of competition.

Impact of national and local commissioning policies

Delivering care closer to home

Care closer to home continues to be a central principle of commissioning across the NHS, referring both to:

(i) the repatriation of services to within a patient or service user's region; and
(ii) the delivery of appropriate care as close to a patient or service user's home as possible.

The second point is the most important to the Trust's services, since it requires the development of care models to provide flexible, accessible and timely care close to people's homes to facilitate independent living and reduce NHS costs. The principle fits with the concept of patient choice and with the aim of delivering patient-centric care, which are central features of the Health and Social Care Act 2012.

Dorset CCG, the Trust's primary Commissioner, has four core principles, one of which is to deliver care closer to home. This principle informs a number of commissioning priorities that seek to shift activity into community settings. As a result, the CCG has a stated ambition to re-profile its spend within sectors to better reflect the need to provide care closer to home.

The Trust's major public health commissioners, Dorset and Bournemouth Local Authorities, are also seeking to focus on care in the community to avoid emergency and acute admissions wherever possible.

Demand for the Trust's services is likely to increase as commissioners seek to shift demand out of acute settings and into community settings. Models of care will have to be adapted to ensure that certain lower acuity services can be delivered effectively, close to patient or service user's homes. The impact is likely to be felt across all of the Trust's localities and service areas.

Delivering integrated, personal locally based care

National health and social care policy remains focussed on delivering integrated physical and mental care across seamless pathways with fewer patient and service user 'handovers' or service breaks.

In 'No Health Without Mental Health' (2011), the Government outlined its commitment to integrated, care acknowledging that "*services can achieve more through integrated, pathway working than they can from working in isolation from one another*". This is central to the Trust's strategic direction.

Long term conditions (LTC)

Sir John Oldham, Chair of the 'Whole Person Care Commission' has highlighted that the NHS, as currently configured for long term condition care, is not sustainable in the face of the projected future level of need. Sir John Oldham recommends the creation of functionally integrated holistic teams at a locality level. These teams should include community services, allied health professionals, social services, and specialist nurses and should be linked to GP practices.

Continuing to align with national policy and addressing local commissioning priorities presents a significant challenge for the Trust. It necessitates the redesign and improvement of services internally to promote integration between mental and physical care, and between services within these categories. Further to this, it requires the Trust to build upon its current strong relationships with other care providers to create condition-wide pathways, to provide service users and patients with a seamless experience of care. The impact of integrated, personal, locally based care will influence all of Dorset HealthCare's services and localities. This presents significant opportunities for the Trust.

Other specific priorities

NHS England has highlighted a number of priority areas in mental health on which it is seeking to focus attention and improve standards:

- Improving Access to Psychological Therapies, which Dorset HealthCare delivers as the 'Steps to Wellbeing' programme, has been given more ambitious targets. The target are that 15% of all anxiety cases are addressed, and that 50% of the cases addressed achieve positive outcomes; and
- Improving dementia diagnosis, so that by March 2015 diagnosis rates have been improved to 66%, from the current national average of c.50%. This is supported by the Early Diagnosis of Dementia framework.

Dorset CCG has highlighted six priority areas in its five year strategy as well as Pan Dorset priorities (see appendix 2). The Pan Dorset priority list includes a review of Community services which would be a direct threat to 60% of the Trust's services.

Local commissioners also have a number of specific target areas aside from the national priorities, including:

a. Developing joint commissioning of autism services to create an expanded and extended diagnostic and assessment service;
b. Improving mental health in primary care beyond just IAPT; and
c. Mobilising a Pan-Dorset Memory Advisory and Support Service.

Forecast financial performance

The Trust needs to carefully strike the balance between managing the quality issues identified by the CQC and the delivery of cost improvement plans if it is to report a financial surplus. The Trust is forecasting a deficit position of £4.0m in FY15.

Dorset HealthCare income is from block contracts, the largest being with NHS Dorset CCG. In a major step towards the integration of Mental Health Services into PbR, the use of care clusters was mandated from April 2012. Despite the dedicated Mental Health PbR guidance advising that it is not yet possible to introduce a national tariff in FY14, the Trust remains committed to its 16 joint deliverables with commissioners and expects to see local shadow tariffs in place for the financial year FY16.

The contract with Dorset CCG represents c. 75% of income in FY14 with a further 11% coming from the National Commissioning Board. The Trust is forecasting income to remain broadly constant in the short term with a slight downward trend.

Identified cost pressures and IT enablers totalling c. £12m have resulted in a FY15 CIP challenge of c. £12m. Currently £8m of CIPs have been identified resulting in a £4m deficit. The Trust's forecast cash position is expected to remain healthy at

£27.9m at 31 March 2015.

The Trust is forecasting a £1m surplus in FY16. This is predicated on the delivery of c. £9m of CIPs as the Trust addresses legacy operational issues from its formation and focuses on a move to transformational CIPs to deliver the Trust's vision of locality services.

The forecast financial position is set out below:

£m		
Income & Expenditure	**FY15**	**FY16**
Income	236.9	234.4
Pay	(173.7)	(170.5)
Non Pay	(67.2)	(63.0)
Surplus /(Deficit)	**(4.0)**	**1.0**
CIP Target (incl values identified)	8.1	9.1
Closing Cash Position at 31 March	27.9	28.4

2. Quality Plan

2.1.National and local commissioning priorities;

Commissioning for Quality and Innovation (CQUIN)

The key aim of the Commissioning for Quality and Innovation (CQUIN) framework for FY15 is to support improvements in the quality of services and the creation of new, improved patterns of care. The National Tariff Payment System document, published by Monitor and NHS England, sets out the key challenges for FY15, in improving quality and outcomes for patients whilst keeping within a fixed NHS budget by improving productivity.

There are four national CQUIN goals for FY15:

- Friends and Family Test - where commissioners will be empowered to incentivise high performing providers;
- Improvement against the NHS Safety Thermometer, particularly pressure ulcers - reduction in the prevalence of pressure ulcers for inpatients of community services and older people's mental health services;
- Improving dementia and delirium care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR) - this does not apply to community or mental health Trusts; and
- Improving diagnosis in mental health - where providers will be rewarded for better assessing and treating the mental and physical needs of their service users.

In agreement with the Commissioners, local partners and stakeholders the Trust has agreed CQUIN targets for FY15 that address all of the points above.

2.2.The foundation trust's quality goals, as defined by its quality strategy and quality account;

Quality

The Trust's top priority will be the quality of care. It will be at the forefront of all that the Trust does, and firmly embodied in the Trust's vision is to provide the care all of us would recommend to our family and friends. High quality care and compassion will sit at the heart of the organisation. Every member of staff has a responsibility to provide compassionate and high quality care, and Dorset HealthCare will drive this through strong leadership at every level.

In line with national policy, the Trust defines quality as care that is safe, effective and experienced by each individual patient in a positive way. Quality care is not achieved by focusing on one or two aspects of this definition; rather, high

quality care encompasses all three aspects with equal importance.

As outlined in the Trust's Quality Strategy, Dorset HealthCare measures and judges its quality performance using four key measures:

- Patient and carer experience;
- Outcome measures - both patient and clinician reported measures;
- Patient Safety - harm free care; and
- Staff recommending services to family and friends.

In addition to focusing on these priorities, the Trust will continue to strive to meet and exceed its legislative and regulatory requirements in the form of the CQC Essential Standards, Monitor's Quality Governance and Risk Assessment Frameworks and NHSLA compliance. In so doing, Dorset HealthCare will discharge its commitment to provide patient centred, safe, effective, and compassionate care.

Quality Account Priorities

The Trust has been through an extensive process of staff, public, partner and patient engagement and involvement, to consider the key quality priorities in relation to clinical effectiveness, patient safety and patient experience for FY15. These quality priorities reflect both national and local priorities for improvement and have been developed to have relevance and impact across the Trust taking into account progress made in FY14.

The quality account priorities and indicators were discussed at the February 2014 Quality Assurance Committee and agreed at the Trust Board on 12 March 2014. The priorities are set out below:

1. All Trust inpatient units to have safe and therapeutic staffing levels (Patient Safety Domain);
2. The Trust demonstrates integrated personal care for patients (Clinical Effectiveness Domain);
3. The Trust improves responsiveness to patient and carer feedback (Patient Experience Domain); and
4. The Trust improves the management of and learning from complaints (Patient Experience Domain).

More detail on the quality indicators for each priority is included in appendix 3. The quality priorities are specific and measurable; quality improvement needs to be driven by an effective performance monitoring process that can ensure awareness and accountability from Board to Ward. This should include a robust programme of monitoring to assess performance; reporting of performance indicators within the corporate dashboard reviewed at the Board and disseminated monthly to the Directorate Management Groups.

Quality Strategy

The Trust's Quality Strategy will be refreshed in 2014 in line with the Annual Plan, Blueprint and Quality Account priorities for FY15, and will include SMART objectives. In the light of the new CQC Inspection Framework the quality strategy will consider service delivery and organisational quality governance in relation to the following five domains:

- Are we safe?
- Are we effective?
- Are we caring?
- Are we responsive to people's needs?
- Are we well led?

The strategy will be developed in line with a framework, approved by the Trust Board, with the aim of ensuring a high level of engagement and involvement from across the Trust, patients and service users and partners.

2.3.The key quality risks inherent in the plan and how these will be managed

Since the merger in 2011, CQC inspections have identified that the Trust needs a robust process to assure the Trust Board that it is meeting the required standards and that in situations where it is not meeting requirements, these are identified and sustained improvements are made.

Key areas of risk to the plan:
• Maintaining our focus on continual quality improvement and meeting the standards to achieve and evidence ongoing compliance with CQC and Monitor standards and registration requirements.
• Improving the information systems to demonstrate that all quality targets and indicators are being reported accurately with clear line of sight from Board to ward.
• Embedding improved quality assurance processes and systems that support the effective operations of the Trust
• Managing our finances effectively to deliver the cost improvement programme and failure to achieve the CQUIN targets and loss of potential income as a result.
• Ineffective working in partnership with commissioners and social care partners resulting in loss of business and the threat of ability to effectively deliver the integrated locality model of working.
• Failing to engage and managing our workforce during a period of significant change and challenges in efficiency and productivity resulting in demotivated staff.
• Improving our relationship and reputation with GPs, commissioners and partners in building confidence in the Trust's ability to provide responsive, high quality and safe services.

Key quality risks inherent in the plan as identified in this report will be monitored through monthly reporting of the quality indicators, and progress against plans reported to the Trust Board and designated quality sub-groups.

The Trust recognises that the successful delivery of the Service Transformation / CIP plans for FY15 requires effective leadership and engagement from all the clinical teams and directorates. In order to deliver this requirement there is a clearly identified process for the development and risk management of Trust-wide projects and service specific projects. As part of the ongoing PMO process, all project leads identify and complete a risk register specific for each project. The named clinical lead for the project also completes a Quality Impact Assessment (QIA). The QIA and associated risks are split into 4 categories:

- Impact on Clinical Effectiveness
- Impact on Patient Safety
- Impact on Patient Experience
- Impact on Equality and Diversity

Risks are all categorised by their impact and likelihood to the stated project then rated in accordance with the Trustwide Ulysses software and system.

Between the PMO and Project Lead, risks are discussed as an inherent part of the process and escalated as appropriate.

The Board Assurance Framework is set by the Audit Committee and approved by the Trust Board annually. The assurance framework sets out:

- the principal objectives to attain the Trust's overall goals;
- the principal risks to achieving those objectives;
- the key controls to mitigate against those risks;
- the assurances on those controls, and
- any gaps in assurance.

The Trust is committed to the effective management and monitoring of performance across the organisation. Directorate Management Groups meet on a monthly basis with a monthly Performance Challenge meeting that highlights delivery against the key performance indicators and follows an approach where any targets that are at risk of not being met will be proactively reviewed. Actions to rectify potential areas of concern are agreed and risk implications discussed and managed.

2.4.An overview of how the board derives assurance on the quality of its services and safeguards patient safety

The Trust has regularly reported to Monitor on its progress against the delivery of the Trust Recovery Plan. This plan was closed on 1 April 2014. However, the Trust felt it was important to maintain a strong focus on key areas within the TRP to provide assurance that governance changes were embedded throughout FY15 and beyond. It was agreed therefore there would be six key areas that should be continued to be monitored:

- Organisational Development (including communication and staff engagement);

- Stakeholder Management and Patient Participation;
- Board (NEDs, Executives and Non-voting Directors) and Leadership Development;
- Risk Management (including escalation and Board Assurance Framework);
- Staffing; and
- Performance and Information Reporting.

A detailed action plan is being developed for each of these areas (or aligned to existing action plans), be monitored by the PMO and reported to the Programme Board, providing assurance to the Trust Board.

One of the primary concerns following the CQC findings in 2013, was that the Council of Governors (COG) were not able to adequately fulfil their role due to a lack of role clarity but also visibility and access to the NEDs. Training was provided to clarify the role of the Council of Governors and information channels were reviewed. It was also agreed to reduce the size of the COG and from the beginning of April 2014 the number of Governors was reduced to 26.

The Trust is clear that effective governance and leadership must be underpinned by strong assurance systems. The previous approach inappropriately relied too heavily on 'reassurance'. The new approach aims to deliver a greater 'assurance' to the Board through the development of Board Assurance Committees, chaired by a non-executive director. At each board meeting the Assurance Committee Chairs provide a briefing statement on the actions undertaken by the Committees including any issues that require escalation to the Board.

Performance

The Trust's Integrated performance report and dashboard provides board level insight into performance and incorporates:

- Indicators on the five domains of quality including Trust priorities;
- Workforce metrics;
- Performance;
- Finance;
- Governance and Financial ratings; and
- Compliance with essential standards.

The Board also receives exception reports highlighting areas and / or teams below their performance level target and actions to address these as well as an ongoing review of the Risk Register.

Patient and Public Experience and Engagement

The Trust needs patient / service user and carer participation to enable it to drive and deliver services which are truly patient-centred and meet the needs of the local population, delivering high quality services at every point of contact.

The Patient and Public Experience and Engagement (PPEE) group receive reports and updates on the activities being undertaken which inform the patient experience strand. This is passed to the Quality Assurance Committee.

Below is a brief overview of the mechanisms in place to enable people to get their views heard and how this feedback is then used to develop services and improve patient experience:

- Carried out over 7,500 surveys since January 2013 (incorporating patient experience surveys in 35 service areas and the Friends and Family test);
- Throughout 2013 the Trust held meetings and focus groups with patients covering a range of topics including Wheelchairs; end of life; and mental health;
- The Trust introduced patient and carers' stories as a permanent feature on the Board of Director monthly agenda from May 2013 and other senior management meetings including the Quality Assurance Committee and the patient and carer experience group. This helps to provide a focus on patient and carer experience prior to decision making and gain assurance that the Trust is learning from patient stories in order to benefit the wider patient audience;
- From November 2013 the introduction of the patient and carer experience group has assisted the Quality Assurance Committee in obtaining assurance that standards of care and patient experience are monitored and reported, identifying developments, improvements and risks to patient experience;
- In March 2014 the Trust held a listening event where patients and carers shared their thoughts on what good quality health care looks like. Following the success of this event another is schedule during April; and

- The Trust works in partnership with Dorset Mental Health Forum who are regularly involved in Forums and WaRP (Wellness and Recovery partnership) activities.

2.5.What the quality plans mean for the foundation trust's workforce

The Trust recognises that its aspiration to provide care of the highest quality is reliant upon its workforce being fully engaged with Trust aims and values, fully trained and equipped, highly motivated, and well led and supported. The risks of failing to engage with staff are recognised, as is the impact of change, and failing to recognise and manage work-related stress. Further work is required to develop greater authenticity in communications and responsiveness to employees' legitimate concerns raised through the staff survey. The Board of Directors have sought to address this through the appointed a Director of Organisational Development, Participation and Corporate Affairs. Significant investment in leadership across the organisation has sought to support an improvement in the staff survey results, and the delivery of appraisal and Personal Development Review (PDR) arrangements. Recognition of the risks of failing to ensure the suitability of staffing has seen an on-going focus on recruiting up to establishment, reducing reliance on temporary staff, and ensuring that pay and terms and conditions support cost-effective service delivery.

2.6.The foundation trust's response to Francis, Berwick and Keogh;

On 25 March 2013, a presentation and discussion took place with Nursing Advisory Committee and the Health professional Advisory Committee with the objective of producing a prioritised response to the recommendations in the Francis Report. On 27 March 2013, a joint Trust Board of Directors and Governors Workshop was also held.

At the Directors Meeting on 25 June 2013, the Chief Executive reported that, in response to the recommendations in the report, broad themes from across the Trust had been identified and were presented as series of pledges to the July 2013 meeting of the Trust Board. These are detailed below:

- Patients, service users, carers and their facilities;
- Frontline staff;
- Clinical and managerial leadership teams; and
- External governance structures.

These pledges were subsequently included in the 'Trust Quality Strategy - 2013/2016' which was presented to, and approved by the Trust Board on 31 July 2013. The Board Executive Summary stated that the strategy had been prepared in line with Monitor's quality governance framework, relevant Deloitte governance recommendations, and incorporated the Trust response to the Francis Report. The strategy also stated that the ambitions set out in the Keogh Report had been reflected in the strategy and strategic implementation plan.

An external audit on the Francis Report Outcomes (11 November 2013), identified that there was limited assurance within the Trust that the 290 recommendations had been sufficiently reviewed due to the absence of a detailed action plan. To address this deficit the Trust convened a Francis Task and Finish Group, chaired by the Director of Nursing and Quality, and developed an action plan to progress the initial work of the Trust and ensure all accepted recommendations that are relevant to the Trust are implemented with ongoing monitoring and evaluation. The Group has since:

- Reviewed the 290 recommendations and refreshed the areas applicable to the Trust;
- Reviewed progress against the four priority strands the organisation identified directly from the Francis;
- Recommendations and pledges/actions made that informed the 'Quality Strategy 2013/16';
- Identified areas where the Trust had no assurance against relevant recommendations and developed plans to rectify this position, and
- Actively engaged with the public through listening events co-produced with Dorset Mental Health Forum.

A review of progress was undertaken by internal audit in March 2014 which indicated significant assurance in the Trust to monitor and implement the Francis recommendations.

The Francis, Keogh and Berwick reports collectively highlight five golden threads that are woven within the Trust's plans going forward:

- Putting patients first, listening to and involving them;

- Listening to staff, nurturing and supporting them;
- Quantitative data has strengths but is limited. Collect stories from patients and staff, use and value qualitative data and include it in meetings and informing decisions;
- Where quality of care and patient safety are concerned, it is the culture of teams and organisations that count; and
- Healthcare leadership.

The Trust is actively responding to the three reports in development of all its plans.

3. Operational requirements and capacity

3.1.Physical capacity

The Trust has a large estates footprint, currently operating out of over of 220 locations. Of this, 45 are freehold properties with title deeds, 26 are leaseholds with formal leases, 4 are held under license and 1 under user rights. The balance of 144 has no appropriate documentation that has been identified by the Trust. While the Trust experiences occasional pinch points on available capacity throughout the year as a result of changes in patient flow, there is consistently excess capacity within the overall footprint. The Trust currently has nine empty wards as well as an empty day hospital and therefore has capacity to flex its provision to meet forecast changes in demand.

The current portfolio extends to c.100,000sqm, of which c.41% of the total portfolio is not used for patient related activities, which is similar across the mental health sector. The estimated annual property spend is in the region of £18.5m (£185/sqm). Current data indicates that there is c. £12m of investment required to bring the estate up to acceptable standards of repair (Backlog Maintenance).

The Trust's move to a locality based model. This will result in a more focused physical capacity with mixed use sites centred around the 13 GP localities in the county. These 'hubs' will look to be supported by strategically located 'spokes'. Detailed planning is required to develop this model and the estates strategy will act to facilitate this move. This will move services away from the current disparate range of locations to fewer, more appropriate locations.

The Trust has a range of mental health beds across Dorset, it is currently evaluating its inpatient mental health stock to determine where the two hubs (east and west) will be sited for mental health services.

In the meantime the Trust has identified productivity gains through the rationalisation of unwanted and poorly utilised properties. To date, six non-core properties have been identified which are no longer fit for clinical use and are not required under any scenario. The Trust will look to exit these over the next two years with the reduction in operating costs reflected in the financial forecast for the next two years. Going forward, the Trust envisages that a 'leaner' estate with a higher quality and value for money building stock can be achieved.

3.2.Technology and IT infrastructure

The Trust has recognised that it needs to improve and overhaul its IT infrastructure to become more efficient and responsive to future patient needs. In the future the Trust expects technology will be a transformational tool to enable personal care. In the meantime, a number of opportunities for consolidation have been identified, however, these will need to be aligned with the Trust's future IM&T strategy. In addition, the IM&T strategy will need to align to the requirements of a locality model (e.g. locality information).

The Trust has set out four strategic themes to act as both catalysts and instruments of change which will be integral to the locality model. These themes are grouped below:

- To promote interoperability and information sharing;
- To enable mobile working;
- To provide an IM&T capability that supports better patient care and enhanced trust services; and
- To enable patient access to information.

To achieve these objectives investment in a number of technologies will be undertaken. These include:

- Mobile technology across Community and Mental Health services;
- Community Health Services patient administration system;
- Mental Health patient administration system upgrade;

- Electronic document management system; and
- Digital dictation

3.3.Workforce

The acquisition of community health services in July 2011 saw the Trust's staff number grow significantly from approximately 1,500 to just over 5,000. The workforce includes a wide variety of professionally qualified, support and administration staff.

One of the Trust's long term targets is to reduce the overall workforce by 10% over the next five years and refocus the workforce with a higher proportion of patient facing time. The Trust believes this will not only benefit patients but also the experience of the Trust's employees. This aim is supported by external benchmarking analysis that indicated £6m-£12m of potential workforce cost efficiencies within the Trust. The Trust could potentially realise this level of pay savings through reducing its total workforce operating costs, in line with the peer upper quartile or 'best in class' Trust. This potential efficiency opportunity reflects a range of specific workforce saving and improvement areas, including: size and shape (skill-mix) efficiencies, senior staff and management cost saving opportunities, corporate function efficiencies and potential improvements in temporary staffing usage/controls. The Trust will, in conjunction with adapting the workforce with the locality model, continue to progress these cost efficiency opportunities identified across all service areas.

To make this possible the Trust's support services and administration back room staff will represent the majority of the workforce reduction. In addition, the Administration and Clerical staff will need to align to these localities to support the focus on patient care. This will require a radical approach to stream line business processes to allow the locality managers and clinical teams to focus on the delivery of patient care.

Additional savings are anticipated in Year 2 and beyond through remodelling support service functions to align to the locality delivery model as well as further efficiency savings. Once the Trust has developed sufficient certainty in respect of the scale of the workforce changes, a formal consultation period shall commence.

Model employer

The Trust is committed to becoming a model employer. The Trust's staff satisfaction results indicate that action is required to achieve this. Dorset HealthCare recognises the Trust needs to improve Dorset HealthCare employees experience of working for an integrated organisation and that this will require a cultural change.
Dorset HealthCare has three areas of priority:

- Improving recruitment;
- Improving our people experience; and
- Changing roles and culture.

Over the course of the last year, the Trust has taken positive steps to reduce the vacancy rate with the appointment of a dedicated recruitment and retention officer and dedicated recruitment programmes. This has had a positive impact on vacancy levels which have reduced from a peak of 13% to c. 8%. However, despite this there are clear areas where improvement is required to help reduce the staff absence rate and improve the level of staff satisfaction.

The key areas highlighted by the Trust's recent Staff Survey are as follows:

- Improving percentage of staff having well-structured appraisals;
- Increasing the level of support staff feel they are receiving from their immediate managers;
- Improvement in the percentage of staff reporting good communication between senior management and staff;
- Improving staff satisfaction; and
- The level of staff receiving equality and diversity training.

In recent months the Trust has had a concerted focus on organisational development to address these and other issues. This will continue into FY15 and beyond. Recent activities have included:

- Development of an Organisational Development Framework and Action Plan input from professional groups and the Non-Executive Directors (NEDs). The Board of Directors and Chief Executive (CE) have been explicit in their communications with staff about the culture, values and behaviours through a range of mechanisms (e.g.

walkabouts, engagement events);

- Seven staff engagement events were held during December 2013 and January 2014 capturing views and ideas from staff, Governors and NEDs. Attended by over 470 individuals, feedback on the key themes was provided and staff are engaged in the delivery of key outcomes and change;
- The Trust carried out its second Vision Test in December 2013 with a total of 1,601 responses (equating to a response rate of 28%). Of the respondents, 82% said they would recommend the Trust's services to a friend or family member. The vision test has also been adapted to track culture measures related to staff engagement;
- The Trust have continued to evaluate performance using feedback from the Staff Survey 2013 to gauge staff perspective and where appropriate to implement key actions and recommendations to increase staff empowerment and engagement; and
- The Trust has invested in the leadership development strategy which focusses on Team Leaders and Consultants to ensure that they understand their role.

3.4.Beds

The Trust is focussing on improving the efficiency of its services provision across both Community and Mental Health services. The Trust has reviewed current bed utilisation, length of stay, and suitability of the site across each of its 11 Community Hospitals and 9 Mental Health sites to identify the potential for efficiency savings. This has been done in conjunction with the Trust's understanding of the focus of local Commissioners and with engagement of senior clinicians, and fits with the strategy of providing care closer to home. For example, Substance Misuse inpatient beds are expected to reduce as commissioner intentions move towards community based detox placements.

The Trust is forecasting an 11% reduction in total Community and Mental Health beds over the next two years to reflect the underutilisation of the current bed capacity the Trust holds. Community Health has predicted a 6% reduction in both Year 1 and 2. Mental Health estimate a 12% reduction in the Year 1, followed by a 2% decrease in Year 2. These changes are prior to the implementation of the Locality model. Is it important to recognise that within the reduction in mental health beds there is an increase in PICU beds which will improve the position on out of Area placements and that the major bed reductions reflect formal closure of beds in OPMH services currently not being used as a result of a more community focussed approach.

The bed capacity within Mental Health is forecast to reduce due to anticipated changes in commissioning, the requirement to improve the Trust's Mental Health provision and improvements to the conditions of Mental Health sites in the Trust's estates. The Trust's forecast change in bed capacity will evolve as detailed planning for the Trust's transformation programme begins in earnest.

Activity

The Trust, looking forward into FY15 and FY16 has no major change to commissioned services that will present a significant shift to the activity figures reported for FY14.

There are however, some planned changes to commission services which the Trust is sighted on in FY15 and FY16. For example, the Dorset Prison Service is being tendered with the new contract starting in the autumn of FY15 for which the Trust is participating. For planning the Trust has assumed continuity of service due to the lack of information at the time of writing.

3.5. Key risks

1. Negative impact on care – The Trust is currently addressing a broad range of service turnaround and improvement objectives. Dorset HealthCare must ensure that this work proceeds alongside the Trust delivering high quality care to its current users.

2. Loss of commissioner support – the Trust's main commissioners have made it clear their intention to review existing commissioning arrangements. The Trust needs to ensure it rebuilds relationships.

3. Lack of staff capability and capacity – the Trust's current staff may not have the full range of capabilities needed to deliver the required service delivery and the Trust may struggle to adequately recruit appropriate staff. Dorset HealthCare must both develop and recruit to address this risk.
4. Lack of staff / union support for engagement – the Trust must engage with staff to ensure that they understand the

rationale for the Trust's future transformation and efficiency focus, and that the workforce transition required is managed sensitively and in line with the Trust's behavioural hallmarks.

4. Productivity, efficiency and CIPs

4.1.CIP governance

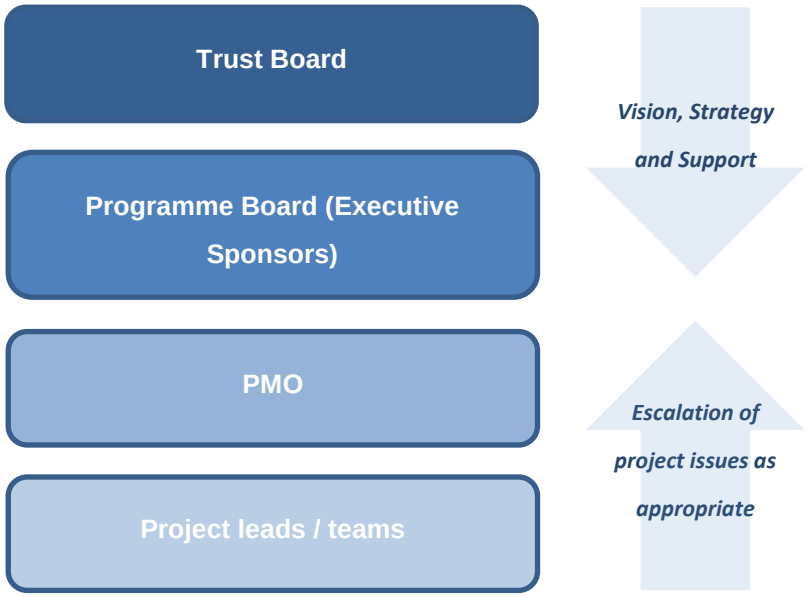
The Trust has taken significant steps to improve its approach to the development and delivery of operational efficiency and cost improvement plans.

The process of plan development is led by the new PMO. A clear and robust structure has been established and is currently being embedded within the Trust.

The PMO reports to the Programme Board, which is chaired by the CEO and comprises the executive sponsors of the projects. The Programme Board's aim is to provide strategic leadership for the development and implementation of the Programme. The Board will monitor the delivery of the Programme objectives and provide leadership and guidance in respect of operational issues and risks where these are escalated to it by the PMO who RAG assess each of the work streams.

The reporting structures and programme board meetings allow any problems, delays or blockages to be quickly identified and escalated in order to achieve resolution. The PMO aims to ensure that projects are aligned, that inter-dependencies are managed and that opportunities to develop improved and more efficient models of care and cost savings are realised. In addition the PMO helps hold the work streams to account, manages information flows between stakeholders, and objectively assesses progress.

The Project leads / teams develop detailed and robust plans for their areas and report progress against agreed milestones to the PMO through regular meetings.



4.2.CIP challenge

Responding to identified cost pressures of £12m including IT enablers of £562k in FY15, the Trust set a CIP challenge of £12m (5%). Historically the Trust has not been required to deliver large scale cost reduction to meet its target financial position and therefore does not have a track record of such significant CIP delivery. As a result, the Trust has identified a more realistic (3.4%) CIPs target of £8.1m. The Trust is forecasting a deficit of £4m in FY15 before a return to a £1m surplus in FY16.

The PMO has assessed the CIP schemes using a proven methodology that assesses the deliverability of the schemes against

a range of criteria including the quality of the milestones, Quality Impact Assessment (QIA) and the financial analysis included. There is a clear methodology for how plans for each scheme are to be developed and approved.

To provide rigour and challenge, initial plans are passed through a gateway process of being reviewed by three members of the programme board, who sense check the project for realistic savings, timeframes, resource requirements and potential impacts on quality.

Plans that are passed through this gateway are worked up into project workbooks. This provides a consistent template approach that can be monitored by the PMO throughout project delivery. The workbooks include the following:

- Project overview;
- Milestone Plan;
- Financial Benefits and phased savings;
- KPIs;
- Risks and mitigating actions; and
- Quality impact assessment.

4.3.CIP scheme themes.

The schemes identified in the current year are consistent with the Trust's longer term strategy of resolving underlying legacy issues from the Trust's merger while planning for the adoption of the locality model.

At the time of submission, the Trust is embarking on the development of its long term vision of moving to a locality model. As a result the CIP schemes for FY16 and beyond will transition to a locality model.

This will lead to a more streamlined, efficient footprint of the estate with a provisional target of an overall reduction in workforce of 10% over the next five years. At present FY16 CIP plans include a full year effect of £0.9m and work is underway in assessing the potential to make the non-clinical A&C more effective.
As a result the Trust's FY15 saving schemes are largely focussed on improving operational and back office efficiency. However, included in the themes identified below is c. £0.5m locality CIP which is part of the transformation towards a locality model. The FY15 CIP programme is split across the following themes:

- Locality;
- Operational productivity;
- Divisional / Directorate efficiency;
- Estates;
- Non pay; and
- Other.

5. Financial plan

Within its income projections, the Trust has assumed the following:

- FY15 - 0% reduction to its block contract income with Dorset CCG and 0% reduction to its block contract income with Dorset County Council (Public Health). 1.8% reduction to income from NHS England as per national expectations;
- 1.8% income deflator for all contacts in FY16 except for Dorset CCG where 0% has been agreed for planning assumptions. For FY17, FY18 and FY19 1%, 0.6% and 0.6% has been applied as a deflator to all income contracts as per Everyone Counts: Planning for Patients FY15 to FY19 NHS planning guidance.
- Full year effect of FY14 contract variations in FY15;
- Known agreed FY15 new investments and contract variations;
- CQUIN funding at 2.5% assumed to continue throughout the 5 years of the plan;
- Split of 'Community' Block income and 'Mental Health' Block income reflective of Directorate budgets;
- Income, being mainly Block in nature, is phased evenly across the year; and
- No CQUIN or contractual penalties are planned. Any actual reduction in income in this area could be mitigated via the Contingency.

The income values within the plan are consistent with agreements for FY15 with the Trust's main commissioners, where the

contract for Dorset CCG has been signed, along with the services provided to Dorset County Council and NHS Hampshire as Associates to that contract. The contract values for NHS England Prisons and NHS England Public Health are agreed but not yet signed. The contract values for NHS England Specialist Services and NHS Public Health remain outstanding, but are included in the plan at the value expected to be agreed.

The NHS England contract for Dorset Prison services is subject to re-tender during FY15 and the current contract expires on 30th September 2014. For planning purposes, the budget includes the full year effect of the existing contract value (£4,345k) and assumes that the Trust will secure the new contract and continue to provide these services.

5.1.Costs;

Within its pay expenditure projections, the Trust has assumed the following:

- 1% pay inflation for all staff groups for each of the 5 years of the plan;
- Inclusion of incremental drift costs for Medical staff in all years. Incremental drift costs for other staff groups are expected to be covered within existing budgets as pay budgets had up to FY12 been funded year on year for incremental drift since the introduction of Agenda for Change in 2004, with no attendant reduction following staff turnover;
- All posts to be covered by filling vacancies or by use of bank / agency (i.e. no reliance upon any planned pay underspend);
- Full year effect of FY14 contract variations in FY15;
- Known agreed FY15 new investments and contract variations;
- Funding of cost pressures (including the additional cost of reviewed safe staffing levels of £1.5m); and
- The Guidance for the Annual Planning Review FY15 advised Trusts that pension costs are likely to increase in future years. Consistent with the planning assumptions identified within the document, additional costs equivalent to 0.7% and 1.4% for FY16 and FY17 respectively have been included within the plan.

Within its non pay expenditure projections, the Trust has assumed the following:

- FY15 non-pay inflation at 5% for drugs, 2% for clinical supplies and non-clinical supplies and 2.3% for other non-pay expenditure. For future years non-pay inflation funded at 2% pa for drugs and clinical supplies and 2.3% pa for other non-pay expenditure, in line with annual Trust planning assumptions. The inflation rate set for non-pay takes account of historical experience that this level of funding is sufficient for the Trust's requirements;
- Full year effect of FY14 contract variations in FY15;
- Known agreed FY15 new investments and contract variations;
- Funding of cost pressures;
- No planned non-pay underspend; and
- Severance costs are included within FY15 at £2.35m. This most significantly relates to the cost expected to be associated with the Locality model QIPP scheme.

Expenditure phasing assumptions are as follows:

- All expenditure assumed to be evenly phased except-
  - QIPP (CIP) – phased as per plans; and
  - Cost pressures – phased as per expected timing of each item.

5.2.Capital Plans;

The PCT estate transferred to Dorset HealthCare on 1 April 2013. Expenditure on capital has significantly increased as a result.
Areas for potential capital expenditure have been identified throughout the Trust. A method of prioritisation has been applied to ensure that those areas that might impact on services are addressed first. This will assist the Trust in meeting its strategic plan and overall vision.

Planned maintenance expenditure in FY15 totals £11,967k including routine statutory compliance, routine service reconfiguration, backlog infrastructure, equipment and Information Technology schemes.

In addition to maintenance there are a small number of small value building projects being undertaken which total £365k in

FY15:

- Inpatient Mental Health Development initial planning;
- Alderney Hospital new car park and additions;
- Secure clinical waste holds; and
- Sentinel House Standby Generator Housing.

Future year capital expenditure plans total £7,697k, £5,522k, £3,946k and £4,547k respectively in FY16 to FY19.

Each scheme is being financed through the capital programme. The cash funding comes from a mixture of 'in-year' depreciation funding and cash reserves brought forward from earlier years. None is planned to be met from borrowing.

As per the Trust's letter to Monitor on 9 January 2014 regarding the 5 year capital plan submitted in January 2014, there has been a significant movement between the two sets of capital figures submitted. This arises because of all the work that still needed to be completed by PwC and the Trust at the time of the January submission, before completion of its new Blueprint for April 2014. The submission in January 2014 could only be the Trust's best estimate before that work was undertaken and completed. The Trust requires further time to work on its estates strategy for Mental Health and therefore the new build of £14m from Year 2 onwards originally submitted within the January 2014 plan has been subsequently removed.

The FY15 budget assumes that the following properties will be sold but, for planning purposes, no profit is assumed: St Leonard's, Foxbrake House, Sedman Unit at Shelly Road and Conifers.

5.3.Liquidity

The Trust's current planning does not significantly forward commit its very healthy level of historically banked cash resources. FY15 will be used to scope and prioritise its major capital investment planning, however, any significant projects are expected to be funded partly by potential disposal of existing estate rather than by committing currently held cash.

Risk Ratings

The Annual Plan submitted delivers a COSRR (Continuity of Services Risk Rating) of 3 in FY15, rising to a 4 in subsequent years. The FY15 COSRR 3 arises as a result of the planned deficit and the increase in Public Dividend Capital Dividend arising from the PCT estates transfer.

Key Assumptions Table and Commentary:

	FY15	FY16	FY17	FY18	FY19	Comment
Dorset CCG Tariff Deflator	0.0%	0.0%	-1.0%	-0.6%	-0.6%	FY15 and FY16 based on flat cash from Dorset CCG. Subsequent years based on *'Everyone Counts Planning for Patients 14/15-18/19'* Guidance.
Other Contracts Tariff Deflator	0.0% Dorset CC, -1.8% Other contracts	-1.8%	-1.0%	-0.6%	-0.6%	FY15 as per contract discussions. FY16 onwards based on *'Everyone Counts Planning for Patients 14/15-18/19'* Guidance.
Pay	1.0%	1.0%	1.0%	1.0%	1.0%	Based on 1.0% pay award.
Drugs	5.0%	2.0%	2.0%	2.0%	2.0%	5% FY15 due to supplier contract service charges being yet to be agreed. FY16 onwards returning to prior year historic experience.
Clinical Supplies	2.0%	2.0%	2.0%	2.0%	2.0%	Based on historical Dorset HealthCare experience.
Other Non Pay	2.3%	2.3%	2.3%	2.3%	2.3%	Based on historical Dorset HealthCare experience.
Additional Pension Cost (£'000)		1,604	3,208			Based on 0.7% and 1.4% for FY16 and FY17 respectively, advised in *'Guidance for Annual Planning Review FY15'.*
Cost pressures (£'000)	11,960					Includes safe staffing, governance changes, addressing legacy issues from PCT merger and IT enabler projects of £562k.
Severance Costs (£'000)	2,350					Provided in respect of locality model QIPP plan.

5.4.Downside and upside scenarios.

Current potential risks to the delivery of the financial plan in FY15 are:

- Achievement of CQUIN targets, where the plan assumes 100% funding;
- Achievement of QIPP schemes and their planned savings, where the plan assumes 100%; and
- Loss of the Dorset Prisons contract, which would see an attendant cost pressure as economies of scale across the Dorset and Devon prison services, are no longer present.

The financial template models downside scenarios associated with these risks. In respect of CQUIN, a downside risk of £1.4m has been modelled, reflective of the value of the CQUIN which at 1st April contains some uncertainty over delivery. QIPP downside risk has been modelled at £3.4m, based on those schemes currently assessed as having risks to delivery. The prison contract has been downside modelled at £0.2m based on the part year cost pressure that would remain in FY15 in advance of restructuring to mitigate the impact in the subsequent year.

Depending on the degree of downside risk, options available to the Trust for mitigation are:

- Use of the contingency funding (£1,300k);
- Defer expenditure on IT enabler projects over full five years (£924k);
- The Trust could elect not to proceed with pay spine increases (incremental drift) (c£1.1m);
- The Trust could elect to enact an up to 12 month 'vacancy freeze' which from past experience could provide circa £1m mitigation; and
- The Trust could elect not to initiate national pay awards in future years (c£1.6m).