Dorset HealthCare NHS
University NHS Foundation Trust

Summary of the Strategic Plan Document for 2014-19

Dorset HealthCare University NHS Foundation Trust

Introduction

Relative to other Trusts, Dorset HealthCare is well placed to continue to be a sustainable and successful Foundation Trust. With strong leadership it will capitalise on the advantages is has in its workforce, its estate and its considerable experience in areas of national priority.

The submission of the Operational Plan in April demonstrates sustainability in 2014/15 and 2015/16 and the Trust has strong liquidity during this period.

Whilst there are significant challenges and a great deal of work to do, the Trust is confidently sustainable in years 1-3 of the five year strategy. We are confident that the Trust Board will take all necessary steps to ensure clinical, operational and financial sustainably in years 4 and 5.

Dorset HealthCare University NHS Foundation Trust provides a comprehensive range of community and mental health services through 5,000 staff and a budget of £240 million to a population of almost 700,000 people.

We deliver these services across 13 GP localities in Dorset and the unitary authorities of the Borough of Poole and Bournemouth Borough Council. We also deliver the Steps to Wellbeing service in Hampshire and prison health services in Devon.

Context

In April 2013 Dorset HealthCare was found by the regulator Monitor to be in breach of its licence conditions and subject to Enforcement Undertakings to address a number of failings identified by the Care Quality Commission. A number of service locations were not compliant with essential quality standards and the Board did not have sufficient governance or quality assurance processes.

On the 17 June 2014 Monitor issued the Trust a certificate of compliance confirming the Trust is no longer in breach of its licence condition and is content with the leadership of the organisation and that the leadership will do the right things but, recognises also, how much work needs to be done, which is reflected in the strategic document, The Blueprint (May 2014).

The Trust is continuing to strengthen its systems and processes so that it may become exemplary. The Blueprint document sets out a total of 31 deliverable actions for improvement, as well as detailing Dorset HealthCare's interactions with Monitor and the CQC. The Blueprint carries forward the small number of outstanding actions from the 'turnaround' period, combined with newly identified priorities, to set out a clear direction of travel for organisational excellence, grouped under six key themes:

- Board and leadership development
- Organisational development and our people
- Governance, quality and risk management
- Staffing
- Performance and information reporting
- Partnership working and participation

The Blueprint actions include timescales and plans for completion that would in other circumstances have been completed and available to inform this document. The summary of deliverables is included at appendix A of this document and The Blueprint is available online at www.dorsethealthcare.nhs.uk.

This document builds on the commitments made in The Blueprint and identifies our key strategies to constantly improve our services for the people we serve.

An overview of our strategy

The essential elements of our strategy are to:

Secure and extend existing business in Dorset through a radical integration of all physical and mental health services, for all ages in the population, by wrapping services around GP practices and integrating with social care in each GP locality.

Capitalise on the advantage the Trust has in the diversity and skills of its workforce and strong track record of multi-disciplinary and multi-agency working.

Use the advantage of our estate, which provides operational platforms throughout the county. The community hospitals should be a real asset to the Trust ambition of being the system leader for integrated care in localities and the Trust strategy is to maximise utilisation of these assets.

Build on our key strengths that are aligned to national and local priorities and that offer the potential for growth: frail and elderly, long term condition management, end of life care, out of hospital care, closer to home services.

Build on and strengthen our position to be the system leader for integrated provision for the frail elderly, making personalised, integrated care a reality in Dorset.

Deliver a demanding but realistic QIPP programme based on service redesign and realising the potential of a currently poorly utilised estate and benchmarked staffing productivity.

Deliver an ambitious Organisational Development programme to fully engage and realise the potential of our staff.

Our population

We serve a county population of 412,900 people (2011 census) and it is a population that is among the oldest in England. 22.5% of our population is over 65 years of age, compared to an English average of 16.4% and increasing number of these people are living alone and becoming more vulnerable. This and predicted further population growth among the 65+ age group (1.7% per year) will place greater pressure on our funding and resources, particularly those concentrated on dementia, mental health and long-term conditions.

Whilst our large, elderly population is forecast to increase, the 20-39 age group is significantly underrepresented across the county (36.8% of the population vs. a national average of 41.6%), explained by 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.

Inequality and wellbeing in Dorset

Although Dorset is on average more prosperous than the rest of England, there is large variation between regions, with some areas of high deprivation, most notably in Weymouth & Portland and areas of Bournemouth.

Dorset

The population of Dorset is generally healthy, with average life expectancy at birth for both men and women ranked inside the top ten in the country, at 85 years for women and 81 years for men in 2008-10. There are however, inequalities in health outcomes seen between districts across the county. Average life expectancy is 4 years lower for men living in Weymouth and Portland compared to East Dorset, with a gap of 3 years for women.

Bournemouth and Poole

Average life expectancy at birth in Bournemouth during 2008-2010 was similar to England as a whole for females, at 82.6 years, but was significantly lower than England for males (78 years compared with 78.6 for England). There are also inequalities in health outcome seen at a small area level within the borough. Average life expectancy is nearly ten years lower for men living in the tenth of areas most deprived, and 6 years lower for women, compared with least deprived areas.

The Public Health Dorset Joint Health and Wellbeing Strategy (2013) identifies key trends in local health and wellbeing, all of which affect or determine much of what we do and how we do it:

- Heart disease and cancer remain the biggest causes of death in Dorset (63% of all deaths), but rates are low compared to England and are falling, partly attributable to reductions in smoking prevalence (16%)

- Although mortality rates are generally lower than England, we have a greater burden of disease with prevalence rates for heart disease, stroke, respiratory disease, cancer higher than those in England and predicted increases in prevalence by 2020 estimated to result in potentially 9,278 additional patients with these long-term conditions

- Between 2002/3 and 2008/9 there was a 60% increase in hospital admissions for alcohol-related harm; this was not spread evenly, the highest rate being in Weymouth and Portland, where under-18s have significantly more admissions than the England average

- Drug misuse is generally low in Dorset, at 6 per 1,000 adults (that is 16 – 65 year olds), however, in Weymouth & Portland rates are significantly higher (11.2 per 1,000 adults) than the England average of 9.4 per 1,000 adults

- The prevalence of people with complex mental health problems (not including more common mental health problems such as depression) in the Dorset population is 0.67%, is similar to the England average, 0.77% (SWPHO 2011) but varies across Dorset

- Dorset has low rates of sexually transmitted infections. Teenage conception rates are also below the national average; however, there are six wards with a teenage conception rate that is either in the highest 20% in England or higher than 60 per 1,000 females. Five of these wards are amongst the most deprived wards in Dorset.

Children and young people

Many children and families living in Dorset are thriving and enjoy similar health to children and families elsewhere in England. Infant mortality rates are lower (although not significantly) than those of England. Measures of child obesity and physical activity are significantly better than their England averages, whilst child tooth decay is similar to the England average.

However, this generally healthy picture is not true in all areas, with small pockets of deprivation, particularly in Weymouth and Portland and areas of Bournemouth and Poole Poverty and inequalities in housing and education needs can all contribute to poorer outcomes for some children and families.

The population of 0-19 year olds is expected to increase by 1.1% per annum, between 2013 and 2019. However, a recent Children's Society report estimated that the number of vulnerable children is likely to grow more rapidly due to increasing deprivation.

This will increase demand for many of our Children's and Young People's services, potentially creating a need for changes to our models of care, or significant efficiencies if funding is not increased.

Capacity analysis: sufficiency of estates, beds, IT and staff to meet healthcare needs

Post-merger integration has not been adequately addressed since Dorset HealthCare acquired the county's community services from Dorset and Bournemouth and Poole Primary Care Trusts in 2011. The Trust remains three distinct organisations in some areas because there was no comprehensive integration strategy or plan, which means there is significant work required to better understand capacity and drive productivity and efficiency.

Estates

The Trust operates from more than 220 properties, many of which were inherited from the Primary Care Trusts. The potential of the estate needs to be understood, utilisation maximised, surplus property disposed of, and a detailed maintenance programme drawn up.

The 2014/15 – 2018/19 estates backlog maintenance plan is for a capital spend of £18 million. Our buildings are, in most cases, adequate for their purpose with some significant exceptions to be addressed. The Trust estate is too large and offers significant potential for economy. We are in the process of commissioning a 6-Facet survey that will review all our properties under the following headings: Physical Condition, Functional Suitability, Space Utilisation, A Quality Audit, Statutory Compliance and Environmental Management. This will provide the baseline for the Estates Strategy to go to the Trust Board in November 2014.

Beds

The Trust has sufficient beds to meet future needs and is in fact forecasting a reduction in total Community and Mental Health beds, reflecting the current utilisation rates and the planned increase in community services to support more people in their own home.

Bed capacity in mental health is forecast to reduce due to anticipated changes in commissioning, the need to improve our mental health provision and due to improvements made to the conditions of mental health sites in our estates.

The nature of the community beds offers great potential for future service growth. The strategy to maximise the utilisation of the community hospitals (295) will include greater use for end of life care and rehabilitation/elderly care.

IT

The Trust IT infrastructure needs updating and it is clear that improvements to the Information Management and Technology (IM&T) infrastructure will help the Trust to merge and integrate ways of working and systems and processes that have been inherited from the previous organisations. The Trust has made significant improvements in the past few years including introduction of a pan-Dorset mental health IT system, implementation of a community services IT system and the unification of inherited IT domains.

But the Trust still has disparate IM&T infrastructure platforms, systems and processes that require swift integration and upgrading to modern standards. A number of opportunities for consolidation have been identified and will be carried forward in to an IM&T strategy to be completed by the end of October 2014, which will also reflect the move to locality hubs.

Staffing

The acquisition of community health services in July 2011 saw our workforce grow significantly, from approximately 1,540 headcount to just over 5,000. The workforce comprises a wide variety of professionally qualified, support and administration staff.

The Trust is committed to improving recruitment to vacancies in all clinical and business areas and this is reflected in a planned increase in WTE from 2013/14 to 2014/15 that will reduce locum, agency and contract staff costs.

Funding analysis: historic trends and likely commissioning intentions

In real terms, NHS funding continues to be extremely constrained. Monitor and NHS England's 2014/15 National Tariff Payment System has stated cuts to national prices of 1.6% for 2014/15, with a 4.0% efficiency expectation of providers. In the short term, Monitor has estimated that the 'affordability challenge' for providers will be 3-7% p.a. over the next five years.

Dorset CCG will be receiving funding increases of 2.1% in 2014/15 and 1.7% in 2015/16, which equates to broadly flat funding in real terms, despite rising demand.

Since 2010, Local Authorities have faced a significant reduction in their spending power. Some of our community care services are commissioned by Local Authorities in Dorset, Bournemouth and Poole.

The National Audit Office's Adult Social Care in England overview found that "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".

Dorset, Bournemouth and Poole Local Authorities will experience slightly lesser funding pressures than the national average, but will still have to deliver significant reductions.

All of our commissioners will be forced to consider which services they purchase in meeting their statutory responsibilities to care for vulnerable individuals and will demand greater value and efficiency from our services.

Funding in the Local Health Economy

The Trust is funded by four main commissioners: NHS Dorset Clinical Commissioning Group (Dorset CCG), Wiltshire Clinical Commissioning Group (Wiltshire CCG), NHS England and Dorset County Council (Public Health).

The contract with Dorset CCG represents c. 78% of income in FY15 with a further 11% coming from NHS England. Financial planning assumes that tariff deflation with regard to our main commissioner contracts for FY17 and beyond will reflect 'Everyone Counts Planning for Patients 14/15-18/19' Guidance.

Total income for prior and future years is summarised below:

FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19
£214m	£227m	£243m	£237m	£234m	£232m	£231m	£230m

Taking activity, funding and inflation projections in account, Dorset CCG have forecast a do nothing funding gap for the local health economy over the coming years as follows:

FY15	FY16	FY17	FY18	FY19
£10m	£30m	£57m	£83m	£109m

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 to develop integrated care that is personal and closer to the patient's home.

Intelligence from the Local Health Economy

Local NHS commissioning priorities

Dorset Clinical Commissioning Group has identified three priority work streams:

- Better Together – the CCG is working with the three Local Authorities, Dorset HealthCare and the other three Dorset based provider Trusts to deliver integration, with new models of delivery and commissioning
- Clinical Services Review – to determine the service model that will best meet the future needs of our people in the context of projected demographic and economic change;
- Urgent Care Review – to redesign pathways of care for frail elderly and people with complex needs to deliver a better experience for individuals and to ensure optimum use of acute and community services.

The Dorset HealthCare Chief Executive sits on the overarching Sponsor Board that ensures the three priority workstreams are aligned. Being a partner in these initiatives enables us to not only gather intelligence to feed our business strategy but, to influence decision-making at the most strategic levels.

Better Together is a county-wide partnership that is committed to transforming health and social care services across Dorset for frail elderly, to enable and deliver a sustainable improvement in health and care outcomes. The partnership includes the Dorset CCG, the three Local Authorities and the four major local NHS providers to deliver integration, with

new models of delivery and commissioning, with the potential to realise more than £60 million in savings

Within the next eighteen months a Clinical Services Review is being undertaken by our main commissioner, Dorset CCG. This is looking in detail at how healthcare is delivered across Dorset and will almost certainly have a significant impact on the business of the Trust. The objective of the review is to determine the service models that will best meet future needs of local people in the context of projected demographic and economic change.

The purpose of the Urgent Care Review is to redesign pathways of care for frail elderly and people with complex needs, to deliver a better care experience and to ensure optimum use of acute and community services.

Beneath these overarching workstreams, Dorset CCG has identified six clinical commissioning programmes currently working to establish a five year visions: maternity, reproductive and family health; general medical and surgical; cardiovascular disease, stroke and diabetes; musculoskeletal and trauma; mental health and learning disabilities; cancer and end of life.

Dorset CCG has published four strategic principles that underpin their work and that present an opportunity for Dorset HealthCare to strengthen its position in the health community:

- services designed around people
- preventing ill health and reducing inequalities
- sustainable health care services
- care closer to home

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. 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.

National commissioning environment and policy direction

Characteristics of high quality, sustainable services
NHS England publishes planning guidance for CCGs, setting out its priorities and principles for transformation of the NHS. *Everyone Counts*, the guidance for 2014/15 to 2018/19, outlines the six characteristics identified for high quality and sustainable services:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

We must expect to see local commissioners increasing commissioning for these outcomes, reflecting the national health and social care policy 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.

NHS England has also 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.

Improving care for those with long term conditions (LTC)

Sir John Oldham, Chair of the 'Whole Person Care Commission' (report of February 2014) 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 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.

In summary

A summary of our challenges and opportunities is presented in the diagram below. The combination of increased competition and changing commissioning priorities has the potential to significantly affect the way that Dorset HealthCare moves forward. Yet alongside that there are clear opportunities for the Trust to build on its competitive advantages of significant skills and experience in delivering community services and its estates, to become the clear system leader in Dorset for integrated, locality-based care.

Our vision, values and strategic objectives

Organisations are most effective when they have a clear vision and purpose, underpinned by a common set of values that have been translated with staff in to behaviours and actions for day to day business.

At Dorset HealthCare we have adopted the NHS Constitution values and added an additional value of our own:

- Working together for patients
- Respect and dignity
- Commitment to quality of Care
- Compassion
- Improving Lives
- Everyone Counts
- A learning organisation

Our current vision is *"to provide care all of us would recommend to our family and friends",* which is a statement of ambition, rather than an inspiring and compelling vision.

In The Blueprint we commit to renewing our vision and purpose statements and our strategic objectives by January 2015, which we will do via a thorough engagement programme with staff, governors and local people. This programme of activity will help to build collective ambition and to align all teams around a single-mindedness for our patients and quality improvement.

We anticipate that the strategic objectives will flow from the following overarching areas of vision and ambition, which are also reflected throughout this document:

We will:
Improve the quality of our services across the three domains of patient safety, patient experience and clinical effectiveness
Improve staff satisfaction and experience and become an employer of choice
Develop and deliver clinical service models that integrate physical and mental health services

Develop new relationships and improve our existing relationships
Manage our services in a financially sustainable way
Be a valued provider of choice, retaining existing and winning new contracts

The Blueprint sets the strategic direction for this document, with its six key themes and 31 deliverables, including our priorities of:

- Transforming our services: delivering personalised integrated care
- Transforming support services: the estate, information management and technology, administrative support functions

These are underpinned by:

- a robust financial strategy
- a workforce strategy

We set out further detail below in each of these priority business areas.

TRANSFORMING OUR SERVICES: delivering personalised integrated care

Our Locality Strategy will:

- Manage our services in the localities where they already operate.
- Extend the roles of interagency MDTs into larger locality based teams.
- Wrap the management of those teams and service delivery around GPs.
- Agree service models with GPs.

The Trust's ambition is to transform the current service delivery model to a locality-based structure wrapped around primary care and their patients:

- Integrating physical health and mental health
- Interagency and multidisciplinary
- Leadership not management
- Requires a major culture change empowering managers
- Devolved decision making and accountability SLH.

We aim to achieve the very best high quality outcomes with our patients. Within our current service delivery framework we have reached the limits of what can be achieved. The current existing structures impede the development of truly integrated community services.

The Trust intends to transform its services delivery model and leadership structure from a county-wide, service-led model, to a locality-based structure, in order to improve the quality of the services that we provide to local communities. In addition, the Trust has other specific areas which need to be addressed, which are broadly:

- Quality improvements;
- Service model developments (not directly linked to localities);
- Staff development, engagement and satisfaction;
- Financial and commercial performance improvements; and,

- Relationship development.

At present, the Trust is structured in to three operational Directorates (Mental Health, Community Health Services, Children and Young People's), with central oversight provided by the senior Executive team. Whilst this model has some operational advantages, it does not support our objective to develop and lead truly integrated, multidisciplinary and interagency, teams. Locality working will deliver localised personal care that will improve the service user and patient experience and meets the specific local needs of local communities in Dorset.

The benefits to service users and patients of integrating mental health and physical health services are well documented. Delivering integration at this level would have very positive impact on the outcome of our care if we are focusing on the 'whole patient' rather than just one aspect of their illness. In order to lead locally based, patient centred care the locality has to have primacy in the way we deliver our clinical services.

We plan to transform our business model from one that is service-led to one that is locality led. We will develop and implement a locality-based service delivery model and locality management structure that will enable clinical teams to operate at a local level, in conjunction with key GP and local authority partners. This will be supported by access to trust specialist services in line with patients' needs.

This model will encompass all of the services currently offered by our three Directorates and will ensure that we are able to deliver and lead innovative, integrated services.

In future, all of our services will be delivered by teams focussing on the three super localities based on existing GP collaboratives: Poole & East Dorset, Bournemouth & Christchurch and Dorset. Within each of these super localities, there are a number of GP localities, in which services and care will be delivered

via local multidisciplinary/interagency teams . The locality will become the main unit of delivery and operation management for the Trust. This will help to ensure that services meet the specific needs of local areas, and that decisions are made as close to the patient as possible.

We plan for a leadership structure that empowers the local leadership team and promotes relationships between GPs, clinicians, service users and other partners particularly social care. It is designed to ensure that services are delivered locally, improving the patient's experience and the quality of the care we offer.
The Trust executive team will be responsible for the delivery of the locality structure, and for ensuring that the model meets our objectives. For the locality model to develop and deliver it requires the corporate services (e.g. HR, finance, estates etc…) to radically change the way they deliver services and align to the new model.

Each super locality will have a Board Director who will be accountable for the provision and performance of all the services in their locality. Locality Managers will have delegated responsibility for all the resources (people, estates and money) in their locality .This will enable decisions to be made as close to the patient as possible. There will be fifteen locality managers two of the localities require additional support based on their population, staff numbers and the needs of the local population.

Some services because they are very small county-wide services, or because they need to be managed as a county-wide service, will not be divided into localities.

These will be managed by five additional Specialist Services posts. In addition to each of these five posts we will also have a range of smaller specialist services in their portfolio.

The portfolios for these posts will include:

- Acute Mental Health Services
- Offender and Addiction Services
- Adult and Children's Learning Disabilities Services
- AQP and Specialist Community Services
- Steps to Well Being – moving these services to Locality model.

In addition each of these five posts will also have a range of smaller specialist services in their portfolio.

The core staff are the main point of contact with our patient and service users. This daily interaction will allow staff to develop a deep understanding of locality-specific needs and, therefore, be able to provide highly tailored care. In addition to increasing the overall quality of care delivered, teams can advise locality managers on the necessary types and levels of service provision that are required in their locality.

The trust is forecasting a number of benefits from adopting a locality-based model. The implementation of interagency team working on a locality basis supports:

- our efforts to offer care closer to home;
- the delivery of a more truly 'whole person' care for those with both physical and mental health issues;
- A patient experience that is free of discontinuities or unnecessary handovers.

In addition to the closer integration of our services with primary care providers and other locality-specific service providers, we expect the developments to support improvement of the quality of our services for patients. In particular, we will deliver improvements in patient and service user access, in the patient experience, and in our clinical outcomes.

At present, access and proximity to our services varies significantly across different localities within Dorset. The adoption of a locality-based model will enable us to address these variations, by identifying a 'core offer' of services that we will deliver in a similar form, and to a similar standard in each locality.

As highlighted by our market research, our localities vary significantly in their composition and needs profile (e.g. demographics, deprivation, incidence and prevalence of particular physical and mental health conditions). Adopting a locality-based model of services will enable us to tailor specific services – over and above our 'core offer' – that meet the particular needs of the patient and service user groups in each locality.

Empowering managers in each locality to engage with commissioners, patients and service users to scope local needs and develop tailored service provisions is a key element of our proposed locality-based management model. This will build on work that we have already undertaken in some localities, where commissioners have already requested the development of tailored local services.

We will improve the quality of our relationships both with GPs as primary care providers and with GPs as commissioners. Feedback from GPs suggests that we are not currently doing enough to engage with them as they fulfil either capacity, and that some wish to have more detailed conversations with dedicated Trust staff about local needs.

The adoption of a locality-based model of service delivery will see our services truly operating in conjunction with key GP and Local Authority partners, with dedicated operational and clinical staff aligning with GP services. This model of working will strengthen our relationships, and enable us to be more responsive in discussions with GPs.

The Trust has consulted and engaged GPs who are enthusiastic about the plans for the Trust. The confidence of GPs in our provision of services to them, will strengthen their wish to commission those services, and others, from us.

Before deciding that we will implement a locality-based model, we completed two major streams of work:

- First, we assessed our local health economy to identify the key challenges and opportunities to which our strategic plan would have to respond.
- Secondly, we considered a range of potential strategic responses to these challenges, before choosing a transition to a locality-based model.

We rejected the option to do nothing as GPs would do more to position themselves, GPs as commissioners would tender individual services with which they are unhappy, Local Authority integration would be impacted and Trust services would not meet patient needs.

The current model for delivering community services is not sustainable. Incremental changes to services, on an ad hoc basis, will not meet the ambitions of GPs for their patients.

We also rejected the option to have the existing three Directorates, but in three localities. This would not drive integration, deliver personalised service delivery and/or deliver savings. The locality model will be built on the essential elements of integration:

- Key worker for patients with long term conditions
- Extended multi-disciplinary teams developing to full interagency teams in the locality.
- Triage and single access point for specialist services
- An aspiration for one shared assessment
- An aspiration of a shared patient record

Risk management

There are a number of key risks associated with transforming our services to deliver personalised integrated care. The Board have considered these risks and have ensured the appropriate controls and actions are in place. Below is a summary of the risks:

Service delivery

- Key clinical services and ownership of services 'get lost' in the transition to the Locality model, therefore not resulting in truly integrated personalised care delivery.
- The spread and difference (population, density, social deprivation scale, local investment from other stakeholders) of the localities makes them difficult to compare and set up similar operational structures.
- Changes in operational delivery of clinical services in the Locality model result in a negative impact on patient experience, patient safety and/or clinical effectiveness.
- Delivery of too many changes at the same time, results in success not being achieved in one or more areas.
- Existing IT systems cannot support the operational delivery of the Locality model.

Stakeholder/commissioners

- The Locality model (having multi-disciplinary teams) makes it easier for the commissioners to re-tender our core business.
- The outcome of the general election in May 2015 impacts on the way NHS services are commissioned and subsequently delivered.
- Lack of support from key stakeholders for the Locality model and/or change process being undertaken.
- The Locality model and project process does not link in with the Better Together county wide project.

Workforce

- Lack of staff support for and engagement with the Locality model and/or change process resulting in low morale, low motivation, increased sickness levels, loss of key people, tribunals.
- The Trust does not have staff with the capability or capacity to deliver the Locality model; Project Management.
- The Locality model project is not adequately resourced, managed, tracked and/or delivered within the agreed timescales.

TRANSFORMING SUPPORT SERVICES: the estate, information management and technology, administrative support functions

The estate

The Trust estates more than doubled following the property transfer from Primary Care Trusts on 1 April 2013. There is a need to rationalise and modernise the expanded estate portfolio in order to provide the right facilities in the right places and support our wider strategy of integrated locality services. This will be the focus of the Trust's estates strategy, which will be delivered the end of November 2014.

We will adopt a radical approach to managing our estates and reconfiguring our space to support locality teams and our patients in a timely and responsive way. Our community hospitals are our assets and these, along with other new hubs will be revitalised to provide the right environment in which to house our staff and deliver for patients, seeking to co-locate with our partners wherever possible.

Information management and technology

IT will act as an enabler through the five year trust strategy. It needs to be recognised that one single record for integrated services is an aspiration that needs to be aimed for in the long term. However some short to medium objectives will be required to support the locality model which includes:

- 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;
- To enable patient access to information.
- To maximise the use of RIO and System One to enable shared information wherever possible

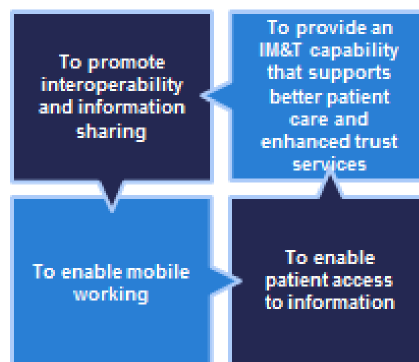
IM&T will provide us with the necessary capability to not only monitor our performance but use the information to drive service improvement across the Trust. The development of

these systems and processes will be a focus for our IM&T strategy and work alongside the specific projects we are working on.

The Trust currently has over 25 projects which are at varying stages of plan development. The methodology used to prioritise these projects needs to be guided by the Trust locality model (strategy) and business stakeholder input.

The Trust recognises that it needs to assess what IM&T capabilities will be required to:

- Facilitate the implementation of a locality based model. For example centralised contact centre and care planning and management may be required; and
- Effective IM&T enablement to release potential productivity gains through supporting cost effective, localised, personal care.



As part of the locality model development, the Trust will need to prioritise its IT project portfolio. The priority view shown here is illustrative. The Trust's Informatics working group plan to engage with IM&T end users (business and operational) to agree upon the priorities which best align to support the locality model.

Administrative support functions

Every part of the organisation will be considered for quality and efficiency improvements and our back office functions are included. Building on the move to a single corporate headquarters at Sentinel House, there is much more to be done to integrate the work of our administrative support teams, to work far more as 'one team' and achieve further cost savings.

Relationship with Bournemouth University

We will strengthen our partnership with Bournemouth University, which brings benefits including supporting innovation, attracting and retaining high quality staff, professional development and research opportunities. We will work with the university to ensure our new models of service delivery are based on best evidence, supported by training and robustly evaluated. We also recognise that our services will be most effective and of the highest quality where we have involved local people and patients in their design and delivery and have listened to and acted on what people tell us they want from our services.

PEOPLE AND WORKFORCE STRATEGY

Delivering the locality model we will require major organisational change in Dorset HealthCare culture. We will need to ensure that we are able to recruit the right clinical leadership in a very competitive and limited pool of staff.

Increases in 2014/15 nursing numbers reflect the outcome of an initial review of appropriate staffing levels in light of the Keogh and Francis reports. This resulted in an additional £1.5m being invested in the nursing establishment. Future nursing and front line care establishment levels will be kept under review to ensure safe staffing. The Trust is progressing with the national programme to increase Health Visitors.

The Trust recognises that its aspiration to provide care of the highest quality and which we would all recommend to family and friends 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.

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 arrangements.

The Trust's workforce will be one of the key enablers for driving and embedding sustainable change across the organisation in 14/15 and beyond. The Trust's workforce strategy identifies the need for innovative and transformational workforce solutions that align to the five year strategic plan as well as unlock areas of increased organisational efficiency. In brief this aligns to the following aims;

Aim 1: Invest in workforce planning and support leaders and managers, to deliver the Trust's strategic aims and objectives, delivered through investment in their skills, empowerment and confidence involving;

- Delivery of Management and Leadership programmes, events and networks to support learning and development;
- Workforce Planning embedded into our services which include attraction strategies, reconfiguration of job roles and responsibilities, retention and succession planning.

Aim 2: Enable organisational change through changed structures and practices to support Trust wide Integration, Directorate and Team level changes by;

- Supporting the implementation of changed organisation structures;
- Developing specific strategies to support Trust leaders in effectively managing large scale change programmes.

Aim 3: Review, analyse, develop and implement processes and procedures that maximise Support Services effectiveness and efficiency through;

- Reviewing the end to end processes, developing and implementing new ways of working that utilise technology ensuring efficiency, robustness and legal compliance;
- Reviewing Support Service structures to support integrated locality working and efficiency.

Aim 4: Become a local healthcare Employer of Choice through;

- Understanding our competitors and our own unique selling points;
- Effective staff engagement and partnership working with our recognised Trade Unions;
- Effective management of Health and Safety, Occupational Health and Violence and Aggression.

FINANCIAL STRATEGY

At the core of our financial planning is a commitment to investing in those things that are critical for our future: staffing, information management and technology, board and team development, locality transformation, and our estate. We recognise the need to deploy our cash balances to significantly reshape and renew our estate in particular and the overall cost of this will need to be supported through additional asset sales.

The Trust has a strong balance sheet and forecast cash position. For the financial year FY15 we plan to achieve a £8m CIP and we are forecasting a £4m deficit, for one year only. This is a positive, deliberate and managed position to enable us to significantly invest and still deliver a realistic CIP figure when faced with a £12m cost pressure.

The £8m CIP is a doubling of the CIP saving of FY14, which we believe is stretching, but achievable. The risks to delivery have been identified and will be robustly managed via the PMO and the Finance, Information and Performance Committee.

In FY16 and beyond we plan to return to a surplus of £1m through transformational CIP improvements and actively managing our strong balance sheet and cash balances. We are introducing a new approach to CIP planning by involving our staff and governors in the decisions about where we believe we can make real quality improvements that will also reduce our costs. We expect to see further cost savings from rationalisation of estates and back office and, through the transformation to locality working.

A summary of our financial forecast is given below:

£m Income & Expenditure	FY15	FY16	FY17	FY18	FY19
Income	236.9	234.4	232.3	231.0	229.7
Pay	(173.7)	(170.5)	(169.6)	(168.3)	(167.2)
Non Pay	(67.2)	(63.0)	(61.7)	(61.7)	(61.5)
Surplus / (Deficit)	(4.0)	1.0	1.0	1.0	1,0
CIP Target (£)	8.1	9.1	7.6	4.5	3.7
Closing Cash Position at 31 March	27.9	28.4	31.1	35.6	39.3

Appendix 1 Blueprint deliverable:

General	Deadline
• New strategic plan and objectives, outcomes and performance measures	end Jan 2015
• Estates strategy to the Board	end November 2014
• IM&T paper to the Board	end October 2014
Board and leadership development	**Deadline**
• Deliver a development programme for the Board [A B]	commences end July 2014
• Strengthen the board by appointing a Director of Strategy and Business Development, having been unsuccessful in efforts to date to recruit to this new post	end July 2014
• Make permanent appointments to the posts of Director of Nursing and Quality, and the Director of Finance and Performance	end October 2014
• Appoint a further two non-Executive directors	end July 2014
• Agree a programme for ward and team visits, to include the purpose, frequency and content of the visits. [B]	end June 2014
Organisational development and our people	**Deadline**
• Develop and deliver an organisational development framework that will enable us to: develop and articulate our vision and purpose; drive cultural improvement; build trust; support a single patient focus and empower all of our staff to deliver the very best for our patients [A, B]	end July 2014
• Develop a communications and content strategy to ensure we have the appropriate formal and informal channels and feedback mechanisms in place to enable the timely and transparent flow of information across and around the organisation [B]	end July 2014
• Review staff involvement in the development of QIPP and CIP projects across the Trust [B]	end August 2014
Governance, quality and risk management	**Deadline**
• Work with PM Governance to develop our risk management and to support the implementation of systems and processes to embed a culture of risk management [B]	end December 2014
• Review the training and proposed rollout of peer review processes to assess compliance with CQC standards and consider further, alternative ways to ensure that timely actions are taken to address any areas of non-compliance [A]	end June 2014
• Refresh the Trust Quality Strategy to ensure its objectives are SMART and that quality goals are aligned to business objectives. We will involve staff and stakeholders in the refresh [B]	end October 2014
• We will clearly communicate our quality priorities through a range of channels, including information displays in clinical and non-clinical areas, so that we may be held to account [B]	end July 2014
Staffing	**Deadline**
• Carry out a root and branch analysis of recruitment and retention issues	end August 2014

• Continue Implementation of the staffing plan agreed by the Board in February 2014	end June 2014
• Ensure systems are in place to monitor the key metrics agreed by the Board including staffing levels and a reduction in the use of agency staff to within agreed tolerance limits [A]	end June 2014
• Ensure an internal audit is undertaken on the appropriate staffing ward RAG tool, specifically examining the quality assurance of the tool and how regular checks are undertaken [B]	end June 2014
• Be open and transparent about staffing levels on a daily basis through displays on notice boards on wards and by publishing information on our website for all inpatient wards [B]	end June 2014
• Review mandatory training compliance and develop an action plan to address non-compliance by directorate	end June 2014
• Roll out e-rostering for inpatient services in Children and Young People's services[1], Mental Health[2] and Community Health Services[3] to improve production of off-duties and give this facility increased senior oversight [A]	[1] end July 2014 [2] end Aug 2014 [3] end Sept 2014
• Review the community hospitals' staffing levels using the safer nursing care tool as part of ongoing monitoring	end July 2014
• Develop an information and performance plan for the Trust, which will include a comprehensive electronic management information system that will give access to key metrics at team level across all domains of quality, workforce, performance and finance [A]	end July 2014
• Implement changes from the review of quality metrics to improve Board to ward sight of performance [B]	end October 2014
• Ensure internal audit is conducted on the reporting of quality metrics [B]	end August 2014
• Implement standardised team level reporting across all domains [B]	end October 2014
• Continue to improve the integrated corporate dashboard and report, including enhancing the quality of the narrative about interdependences across metrics, providing further insight and context and clearly identifying deteriorating performance [A, B]	end October 2014
• Develop a strategy and work programme to maximise individual and collective participation at Dorset HealthCare, recognising patients and local people as equal partners and valuable assets in all of our work. Elements will include an insight dashboard and the introduction of 360 degree feedback [A B]	end July 2014
• Introduce training and development opportunities for the newly-formed Council of Governors, to focus on their role, the role of the Lead Governor, the effectiveness of the Council overall and the way that information flows between the Council and the Trust	end September 2014
• Agree a new Memorandum of Understanding with Bournemouth University	End November 2014