Agenda Item:

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	10 September 2014
Officer	Director for Adult and Community Services
Subject of Report	**Dorset HealthCare University NHS Foundation Trust: Update report regarding Recovery Plan, Blueprint and response from Monitor**
Executive Summary	Dorset Health Scrutiny Committee has considered a number of reports from Dorset HealthCare University NHS Foundation Trust over previous meetings following concerns raised by the Care Quality Commission (CQC) and Monitor (the NHS regulatory body). At their last meeting (23 May 2014) the Committee requested an update regarding the Trust's Recovery Plan, further details regarding the Blueprint being drawn up to take the Trust forward and an update regarding Monitor investigations. This report contains: • The Trust's Recovery Plan as at 22 April 2014. • The Trust's Blueprint, which summarises the key areas of work that the Trust will be undertaking over the next two years, including longer term issues that arose from a review carried out by Deloitte in 2013 – such as the development of excellent governance, communications and organisational culture. • The letters from Monitor, the regulator of Foundation Trusts, confirming that Dorset HealthCare is no longer in breach of its Terms of Authorisation. The Chief Executive of Dorset HealthCare University NHS Foundation Trust, Ron Shields, will be attending the Committee on 10 September in order to respond to questions from members regarding the content of these documents.

Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset HealthCare University NHS Foundation Trust
	Budget: None.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
	Other Implications: None.
Recommendation	That Dorset Health Scrutiny Committee members consider the attached appendices with a view to having the opportunity to question the Chief Executive of the Trust regarding the matters contained therein.
Reason for Recommendation	Dorset HealthCare University NHS Foundation Trust is keen to build its relationship and communication with the Committee. The work of the Committee contributes to the County Council's aim to protect and enrich the health and wellbeing of Dorset's most vulnerable adults and children.
Appendices	1 Dorset HealthCare University NHS Foundation Trust Recovery Plan V23, 22 April 2014 2 Dorset HealthCare University NHS Foundation Trust: The Blueprint – Our journey to becoming an exemplary organisation, May 2014 3 Letters from Monitor to Dorset HealthCare University NHS Foundation Trust dated 17 June 2014 and 26 June 2014

Background Papers	Report to Dorset Health Scrutiny Committee, 23 May 2014: http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/A43CB74AF8F785C980257CD900522FC3?OpenDocument
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Combined Trust Recovery - Last updated 22 April 2014
Version 23

Dorset HealthCare NHS
University NHS Foundation Trust

Deadline Missed	R	A/R
On trajectory but not yet completed	A	
Completed and verified	G	

Risk of potentially being off Trajectory

Internal Trust Reference	New	Recommendation	Action	Who	When	Progress	Closed	Rag Rating	Evidence	Blueprint section	Blueprint page number	G3 workbook name	G3 milestones	Milestone name
DH 200		Consider how the Board can proactively bring the cultures together as part of organisational development.	Clear and unified message articulating the Trust culture to be developed with PR advice and approved by the Board	CEO	06/11/2013	A facilitated Director Development event took place on 3 September 2013 examining culture and clear messages for staff and patients. At the Board Workshop on 18 September 2013 the framework detailing the organisational development plan's milestones were considered and then agreed at the HR and Workforce Committee and subsequently at the Board The plan was developed with input from professional groups and the NEDs. The Board and CE have been explicit in their communications with staff about the culture, values and behaviours through a range of mechanisms (walkabouts, engagement events etc). The CE and interim Chair assessed that the organisation was lacking in capacity for Organisational Development. A new Director of Organisational Development, Participation and Corporate Affairs joined the Trust on the 22 April 2014. As a result of this new appointment the existing organisational development plan will be revised and re-presented to the Board in July 2014. In the short term there have been seven engagement events (Dec and Jan) held with staff that pulled together their views and ideas. The 'one Trust one culture' and engagement of staff was extremely positive and key messages were reinforced by the CE to over 470 staff that attended. The feedback has been pulled together and translated into the basis of a programme of engagement around specific areas, which includes focus groups of staff who volunteered to get involved. A staff 'temperature gauge' based on the NHS Employers tool, incorporating key questions from previous surveys, has been added to the quarterly vision test. The new tool went live in November and results were available from December 2013. In March 2014 we reported that 86% of staff strongly agreed or agreed that if a friend of relative needed treatment, they would be happy with the standards of care/service provided by my team. This tool is being developed nationally and will be updated to ensure benchmarking and compliance can take place with the NHS England requirements. This will be named the staff friends and family test. It is accepted that staff engagement and communication is an ongoing issue at Dorset HealthCare. These strands of work focus heavily in the Blueprint 5 year plan; ensuring work is continued and developed. Staff's ideas and feedback collated at the engagement events and through the outcomes of the staff survey 2013 results are being used to develop and inform the Blueprint. **This action has been moved onto the Blueprint.**	Open	R	OD and workforce culture report to HR and workforce committee and at Board workshop on culture. Report detailing the engagement events. Organisational Development Plan	Organisational Development	TBC when Blueprint finished	Organisational Development	TBC when Blueprint finished	We will develop the organisational development framework, which will include a clear message on unified culture and communication channels across the Trust by the end of July 2014. *NOTE: merged with DH201 to form one overall action in the Blueprint.*
DH 201		Consider how the Board can proactively bring the cultures together as part of organisational development.	To set out and implement with PR support a clear communication plan which will include CEO briefings, Directorate briefings, all staff communications	CEO	31/12/2013	At the Directors Development (21.11.13/22.11.13) communication was discussed and clear action points identified. The production of a clear communication plan was delayed by the change in Trust leadership, however the Interim Chair and Chief Executive looked at how communication could be best managed across the whole organisation and what expertise/capacity were required. There will be a new communications plan developed by the Director of Organisational Development, Participation and Corporate Affairs. There are clear examples that communication is still taking place across the Trust including CE letters to staff, Directorate briefings, Weekly Briefings and the engagement events with staff. **This action has been moved onto the Blueprint.**	Open	R	Communication and branding plan CEO briefings/letters <u>Directorate briefings</u> Nursing & Quality CAMHS MH CHS Corporate Weekly round up	Organisational Development	TBC when Blueprint finished	Organisational Development	TBC when Blueprint finished	We will develop the organisational development framework, which will include a clear message on unified culture and communication channels across the Trust by the end of July 2014. *NOTE: merged with DH200 to form one overall action in the Blueprint.*
DH 221		Develop a formal Board development programme to support cohesion of Board and to foster Board engagement across a range of areas	Annual skills, capacity, competency review and succession planning of Board	Chair	30/06/2014	There have been regular Board development events since the Interim Chair arrived in October 2013. In December there were four new NED appointments further strengthening the Board. There are clear roles assigned to the NEDs and their areas of expertise and interest are communicated. A Board Development Plan was considered and developed in 2013 which related to the previous Board. Although providers were selected for interview, it was felt important to revisit the original specification by the new NEDs in light of their appointments. At the December 2013 Board meeting a new proposal was signed off and sent to potential Board Development Providers Frontline was appointed in April 2014 to support the Board. The specification includes an annual skills audit, competency review and succession planning for the two NEDs whos terms are due to expire in 2014/15. The specification is also based on the new NEDs requirements and capacity. **This action has been moved onto the Blueprint and is also on the Board forward plan for June 2014.**	Open	A	Annual review and succession plans. See DH 11	Board and Leadership Development	TBC when Blueprint finished	Board and Leadership Development	TBC when Blueprint finished	In partnership with the chosen provider we will deliver a Board Development Programme which includes an annual skills audit, capacity building, competency review and succession planning through 2014/15. *NOTE: This action has been merged with DH 225 and DH 227 within the Blueprint.*
DH 223		Develop a formal Board development programme to support cohesion of Board and to foster Board engagement across a range of areas	To appoint provider to support Board Development.	Chair/DHR	31/10/2013	There have been regular Board development events since the Interim Chair arrived in October 2013. In December there were four new NED appointments further strengthening the Board. There are clear roles assigned to the NEDs and their areas of expertise and interest are communicated. A Board Development Plan was considered and developed in 2013 which related to the previous Board. Although providers were selected for interview, it was felt important to revisit the original specification by the new NEDs in light of their appointments. At the December 2013 Board meeting a new proposal was signed off and sent to potential Board Development Providers Frontline was appointed in April 2014 (04.04.2013) to support the Board. The specification includes an annual skills audit, competency review and succession planning for the two NEDs whos terms are due to expire in 2014/15. The specification is also based on the new NEDs requirements and capacity. **This action has been moved onto the Blueprint and is expected to close by the end of April.**	Open-04/04/2014	R	Appointment letter/ contract. See DH 11	Board and Leadership Development	TBC when Blueprint finished	Board and Leadership Development	TBC when Blueprint finished	We will appoint a provider to support the delivery of a Board Development Programme through 2014/15.
DH 225		Develop a formal Board development programme to support cohesion of Board and to foster Board engagement across a range of areas	Board profiling to be undertaken to inform future development plan for 2014/15 and address team dynamics	DHR	31/01/2014	There have been regular Board development events since the Interim Chair arrived in October 2013. In December there were four new NED appointments further strengthening the Board. There are clear roles assigned to the NEDs and their areas of expertise and interest are communicated. A Board Development Plan was considered and developed in 2013 which related to the previous Board. Although providers were selected for interview, it was felt important to revisit the original specification by the new NEDs in light of their appointments. At the December 2013 Board meeting a new proposal was signed off and sent to potential Board Development Providers Frontline was appointed in April 2014 to support the Board. The specification includes an annual skills audit, competency review and succession planning for the two NEDs whos terms are due to expire in 2014/15. The specification is also based on the new NEDs requirements and capacity. **This action has been moved onto the Blueprint and will be carried out by the new provider.**	Open	R	Board profiles. Development plan 14/15	Board and Leadership Development	TBC when Blueprint finished	Board and Leadership Development	TBC when Blueprint finished	In partnership with the chosen provider we will deliver a Board Development Programme which includes an annual skills audit, capacity building, competency review and succession planning through 2014/15. *NOTE: This action has been merged with DH 221 and DH 227 within the Blueprint.*
DH 227		Develop a formal Board development programme to support cohesion of Board and to foster Board engagement across a range of areas	Develop 2014/15 Board Development Plan	Chair	31/03/2014	There have been regular Board development events since the Interim Chair arrived in October 2013. In December there were four new NED appointments further strengthening the Board. There are clear roles assigned to the NEDs and their areas of expertise and interest are communicated. A Board Development Plan was considered and developed in 2013 which related to the previous Board. Although providers were selected for interview, it was felt important to revisit the original specification by the new NEDs in light of their appointments. At the December 2013 Board meeting a new proposal was signed off and sent to potential Board Development Providers Frontline was appointed in April 2014 to support the Board. The specification includes an annual skills audit, competency review and succession planning for the two NEDs whos terms are due to expire in 2014/15. The specification is also based on the new NEDs requirements and capacity. **This action has been moved onto the Blueprint and will be carried out by the new provider.**	Open	R	Development plan 14/15	Board and Leadership Development	TBC when Blueprint finished	Board and Leadership Development	TBC when Blueprint finished	In partnership with the chosen provider we will deliver a Board Development Programme which includes an annual skills audit, capacity building, competency review and succession planning through 2014/15. *NOTE: This action has been merged with DH 221 and DH 225 within the Blueprint.*
DH 235		Enhance the quality of the narrative within the Integrated Corporate Report to interpret the performance data, provide greater insight over performance at the directorate level, supported by contextual information such as trend analysis and benchmarking.	To further develop integrated dashboard and report informed by the granular level of reports available	DFPM	30/03/2014	The revised integrated corporate dashboard report commenced at the 26 September 2013 Board meeting. The quality of the narrative within the report has improved and there is a stronger focus on exception reporting and breakdown of operational directorate's performance. Further work is being undertaken through the information and performance work group, who met fortnightly initially to implement the major changes and now meet monthly. This group is made up of key staff from across the organisation involved in performance collation and reporting. The group is looking at how to continually improve the reports and enhance the performance culture. Areas of focus include forecasting, trends, benchmarking and action tracking. The report has increased visibility of service level performance, includes a changes tracker to ensure understanding of metrics being added or removed, includes data quality metrics to allow sight and assurance on the quality of data supporting the dashboards, has a clear source for all reported data, particularly whether the source is from a manual or electronic system, adequate explanations and clear action plans for all amber and red rated indicators, includes some areas of forecasting and trajectories and a rolling 13 month information and direction of movement. A new format of the report was introduced at the March 2014 Board and this was well received with some further suggested refinements. The report is a dynamic document, it evolves in response to suggestions and continues to improve to meet users' needs. A delay to the team level reporting development is now experienced due to the delay on the System One deployment. The System One implementation is currently awaiting a new deployment plan and the project is being extended into the next financial year. We will review the detailed team mapping spreadsheet in line with the deployment plan (when received) to assess the impact of this on further developments in the information and performance reporting. **This action has been moved onto the Blueprint.**	Open	R	Implementation report. Granular reports. Meeting minutes from sub group.	Information and Performance Reporting	TBC when Blueprint finished	Information and Performance Reporting	TBC when Blueprint finished	We will further develop the integrated corporate dashboard and report, informed by the granular level of reports available. This will include enhancing the quality of the narrative regarding interdependencies across metrics, providing greater insight and context, and identify deteriorating performance by the end of October 2014.

DH 237		Enhance the quality of the narrative within the Integrated Corporate Report to interpret the performance data, provide greater insight over performance at the directorate level, supported by contextual information such as trend analysis and benchmarking.	Develop plan for a comprehensive electronic management information system to provide access to the key metrics at team level across all domains of Quality, HR, Performance & Finance	DFPM	30/06/2014	Work is ongoing through the work stream and on track. This is an agenda item on the work stream meetings. The initial ideas for an electronic system were shared with the Directors at the away day on 21.11.13. The plan will work on delivery over two years, spend has not been quantified but is being linked with the QIPP and capital plans for 14/15 and beyond. **This action has been moved onto the Blueprint.**	Open	A	Plan for electronic system.	Information and Performance Reporting	TBC when Blueprint finished	Information and Performance Reporting	TBC when Blueprint finished	We will develop an information and performance plan for the Trust, which will include a comprehensive electronic management information system to provide the Trust with access to the key metrics at team level across all domains of quality, HR, performance & finance by the end of June 2014.
DH 242		To provide safe and therapeutic staffing levels.	Implement agreed recommendations following Board approval	DNQ	01/12/2013	A review of in-patient staffing levels was undertaken by the Director of Nursing and Quality and the Medical Director and the findings presented to the Board in February 2014. The review involved Directors and senior clinical staff contributing to the discussion and in mental health in-patient wards the use of: • Clinical judgment, • NHS Benchmarking Network (October 2013) Draft Report and • Benchmarking with 7 other mental health inpatient wards. In physical health in-patient wards this involved the use of: • Clinical judgment, • the Safer Nursing Care Tool and • Benchmarking with 4 other community hospitals in the South West. In adolescent in patient ward the review used data and information including: • Clinical judgment • Royal College of Psychiatrists • Quality Network for In-patient CAMHS (QNIC) As a result the Board of directors approved additional funding of £577,000 in mental health and £400,000 in community services (as cost pressures) to deliver appropriate safe staffing levels. The Medical Director and Director of Nursing and Quality assured the Board that staffing levels are appropriate with the information available but recognised that further work would be required going forward to validate these findings and to continually review staffing levels. A plan is being developed to implement the appropriate safe staffing levels. In February there were changes in the Director structure with a new interim Director of Nursing and Quality appointed. In The Trust also commissioned a review of the mental health in patient wards that took place in March 2014 and asked for a view on the staffing levels within the units as part of the review. This report has been received in draft and reports that the staff on shift appears appropriate and recommends further review on qualified to unqualified nurse ratio in some of the acute areas, which is under way. The Trust is using ward based data and metrics to further consider the appropriateness of staffing levels. The Trust is also working with the mental health in-patient wards with a view to undertaking an acuity-dependency rating tool to further triangulate the staffing information. **This action has been moved onto the Blueprint.**	Open	R	Recommendation evidence	Staffing	TBC when Blueprint finished	Staffing	TBC when Blueprint finished	We will implement the staffing plan agreed by the Board in February 2014 by the end of June 2014.
DH 244		To provide safe and therapeutic staffing levels.	To ensure systems are in place to monitor key metrics agreed by the Board including safe staffing levels agreed and consistently met, reduction in the use of agency vacancies within agreed tolerance limits	DNQ	01/12/2013	To mitigate any potential risk to patient safety there is an escalation tool in place to assist with monitoring staffing levels and the use of agency staff along with the use of Quest and an EWT tool. The staff ward RAG tool went live in February and is being developed in response to feedback. The Medical Director is conducting a review of the quality metrics and these were presented to the QAC in March. This included metrics on safe staffing which will then be reported to the Board. The QAC requested further consultation and to go back to the QAC in April and then on to Board in May 2014. **This action has been moved onto the Blueprint.**	Open	R	System documents. List of metrics reported to Board.	Staffing	TBC when Blueprint finished	Staffing	TBC when Blueprint finished	We will ensure systems are in place to monitor key metrics agreed by the Board including safe staffing levels agreed and consistently met, reduction in the use of agency vacancies within agreed tolerance limits by the end of May 2014.
DH 285		More formal monitoring and audit of rotas and unfilled shifts (all causes) is required, with feedback to staff on any actions taken. The Trust also needs to have in place a reliable system to monitor adequate staffing levels prospectively and retrospectively	Replace manual data by e-rostering as phases roll out	DMH	30/04/2014	A clear Project Plan is in place for this to happen and is being managed through the Mental Health Directorate. Providers were assessed in December and one selected. The contract with the selected provider was signed on the 29.01.14. The e-rostering project is progressing in line with the project plan and is moving forward to commence the pilot implementation phase. The Project Implementation Team commenced their training with Allocate on Monday 3rd March 2014 and the first pilot ward commenced on the 10th March 2014. It is anticipated the roll out will be completed by Mental Health – last unit implemented by 18th August, Children & Young Peoples Services – last unit implemented by 21st July, Community Health Services – last unit implemented by 15th September. **This action has been moved onto the Blueprint.**	Open	A	Project Plan is held locally Screen shots of e-rostering Post implementation review	Staffing	TBC when Blueprint finished	Staffing	TBC when Blueprint finished	We will roll out the e-rostering system for inpatient services in children's and young persons services (by end of July 2014), mental health (end of August 2014) and community health services (by the end of September 2014) to improve the production of off duties, and give this facility increased senior oversight.
DH 301		Recognising that the Trust engages with patients and service users through a variety of platforms, the Board should seek to consult with this group to more fully explore views on the variability of care standards.	Develop engagement plan with key milestones to increase patient and service user involvement in physical health service and ensure uniformity across the Trust	DNQ	01/01/2014	There is a Trust Patient and Public Engagement Strategy in place and this is being refreshed by the PPEE group with involvement from the Associate Director. A task and finish group is being established to refresh the plan with involvement from Healthwatch and other service user groups. An engagement plan is in place and four 'listening' events took place in April and March 2014. The proposed engagement plan for other areas was discussed at the Directors away day and was subject to a locality deep dive. **This action has been moved onto the Blueprint.**	Open	R	Engagement plan DH 62	Stakeholder Management and patient Participation	TBC when Blueprint finished	Stakeholder Management and patient Participation	TBC when Blueprint finished	We will build a programme of work to support the delivery of patient participation activity 2014/15 by the end of July 2014.
DH 321	New	Managers in all areas of the organisation need to ensure that staff are released for mandatory and other training, with appropriate supervision, appraisals and reviews.	Implementation of the National e-Learning Management System	DHR	31/03/2014	L & D are adopting the National Learning Management System which will enable the capture of e-learning data. Support from Health Education Wessex- funding to provide an external consultant. National e-Learning Management System (NLMS) will be launched end April 2014. Unfortunately the project plan slipped as there have been a few technical issues and this delayed the implementation of the NLMS. The IT upgrade to Windows 7 has meant that a few of the technical specifications required to play the eLearning content are no longer available on all systems. This includes the Flash and Java software. The project lead for this is working with IT to take this forward and resolve the issues. Also, there have been issues in allocating ESR positions to staff to enable them to access NLMS through Smartcards, the process has been found to be a lot more complicated for some positions than anticipated. Work is ongoing to progress this and additional support for this area has been provided, however, it is impacting on the implementation of the NLMS effectively prior to end March. We do not want to launch NLMS with only a proportion of Smartcard users being able to effectively access the system. Finally, the Trust are launching 2 eLearning platforms, and the Project Leads for both systems are working collaboratively together. In light of there being a slight delay with the NLMS launch into April, it makes sense to launch the 2 eLearning platforms (NLMS and Learning4Health) together so staff understand the eLearning strategy and the similarities and differences between the 2 systems. Communications advising of the launch of the eLearning platforms will commence in March to start awareness raising. Training sessions on both systems are also being organised across Trust sites from end April to show staff how to use both systems and support a joined up approach to eLearning. This project slippage does not pose a risk to staff being able to access core mandatory subjects online as we still have access to the core subjects through the Core Learning Unit online platform. **This action has been moved onto the Blueprint.**	Open- closed 06/05/2014	R	National e-Learning Management System	Organisational Development	TBC when Blueprint finished	Organisational Development	TBC when Blueprint finished	We will implement the National e-Learning Management System for mandatory training by the end of May 2014.
DH332	New	To promote shared learning and understanding of CQC standards. The Trust systems to monitor compliance with CQC essential standards of quality were neither systematic or effective	To instigate peer reviews around compliance with CQC standards and address actions as they are identified.	DNQ	31/01/2014	Provider Compliance Assessment (PCA) reports are currently reported on a monthly basis to the Clinical Effectiveness and Regulatory Group and onto the Quality Assurance Committee who in turn provide assurance to the Board on the % compliance for each operational Directorate against the 16 essential standards. The Trust is developing Peer Review of Essential Standard (PRES) to support the self-assessment process and provide further assurance of compliance. To support this process the Trust has commissioned NICHE Patient Safety (NPS) to deliver a training package to support compliance with the essential standards and to support staff to understand what robust evidence is, and how such evidence can be used to demonstrate compliance with the Essential Standards. Initial training was delivered on 20/11/13, 17/12/13 and 29/01/14. In February 2014 , two workshops were held; 24th February 2014 revisited Regulation 20; Outcome 21 Records and 25th February 2014 focussed on Regulation 11; outcome 7 Safeguarding people who use services and Regulation 9; outcome 2 Consent to care and treatment. Further training on assessment will be conducted in July. A review of the use of peer reviews and other methods will form part of the wider risk management strategy in 14/15. This will be pulled into the Blueprint as a key area and monitored by the PMO to ensure pace and focus remains on this area. This action has been moved onto the Blueprint. **This action has been moved onto the Blueprint.**	Open	R	PCAs. PCA overall report.	Governance, Quality and Risk Management	TBC when Blueprint finished	Governance, Quality and Risk Management	TBC when Blueprint finished	We will review the training and proposed roll out of the peer reviews process, to assess compliance with CQC essential standards and consider alternative methods to ensure that timely actions are taken to address any areas of non-compliance by the end of June 2014. NOTE: merged with DH333 to form one overall action in the Blueprint.
DH333	New	To promote shared learning and understanding of CQC standards. The Trust systems to monitor compliance with CQC essential standards of quality were neither systematic or effective	To complete peer reviews of compliance with CQC essential standards and ensure that timely actions are taken to address any areas of non compliance	DNQ	31/07/2014	See DH 332. **This action has been moved onto the Blueprint.**	Open	A	PCAs. PCA overall report.	Governance, Quality and Risk Management	TBC when Blueprint finished	Governance, Quality and Risk Management	TBC when Blueprint finished	We will review the training and proposed roll out of the peer reviews process, to assess compliance with CQC essential standards and consider alternative methods to ensure that timely actions are taken to address any areas of non-compliance by the end of June 2014. NOTE: merged with DH332 to form one overall action in the Blueprint.

May 2014

Dorset HealthCare
University NHS Foundation Trust

The Blueprint

Our journey to becoming an exemplary organisation

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

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FOREWORD

The recent period for Dorset HealthCare has been one of significant challenge and change. The organisation was independently scrutinised and found to be failing in a number of areas critical to ensuring high quality care for our patients.

The Blueprint gives a clear, honest assessment of the Trust's shortcomings and governance failures, what has been done to recover to a level of good functioning and sets out the Trust's ambition to be exemplary. It is the document we will use to hold ourselves to account.

The environment in which we work is becoming increasing challenging. The growing and increasingly complex needs of the people we serve, changes in the way we are funded and changing commissioning intentions will all affect our plans for development of our services.

Alongside these challenging demands are the needs, expectations and aspirations of our patients and local people. We are absolutely committed to being open and transparent in all that we do and to listening and acting on what local people tell us they want from our services.

This document also recognises the importance of partnership working, of working across organisational and professional boundaries to develop services that revolve around patient need. We will work closely with all of our partners and especially GPs, local authorities, the Health and Wellbeing Boards and our commissioners.

We have ambitious and radical plans to ensure we deliver high quality, sustainable services. We will address some of the inflexible structures that block service development and provide arrangements that will empower our clinical staff and genuinely integrate care around the individual.

> "In publishing this document we are signalling our commitment and that of the Board, to ensuring we are a well led, well governed and successful Foundation Trust that gives every member of staff the opportunity and support to give their very best for our patients."

Ann Abraham, Chair

Ron Shields, Chief Executive

INTRODUCTION

Dorset HealthCare University NHS Foundation Trust has been through a challenging period and is presently subject to enforcement undertakings and additional licence conditions. As part of dealing with its recognised shortcomings, the Trust has produced this formal five-year Blueprint.

The purpose of the document is to record the organisation's recent journey - how it has responded to significant failings in both governance and in the quality of patient care - and its plans and ambition for the future, to become an exemplar in the delivery of personalised, integrated care in localities.

The Blueprint explains how during 2014/15 we will undertake a programme of governor, staff and wider stakeholder engagement to refresh our vision, articulate our organisation's purpose, reaffirm our values and renew our strategic objectives.

It identifies the six key themes where we must continue to develop for organisational excellence and signposts the more detailed strategies and plans that will follow:

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

In addition, the Blueprint sets out the immediate and medium-term financial plan for the organisation, aligned to our annual Operational Plan and five-year Strategic Plan.

Crucially, the Blueprint shares the Board's vision for the transformation of our community and mental health services into fully integrated teams, built around GP localities and solely focused on responding to individual patient need.

We will use this document to monitor and report on progress internally and externally against all the deliverables in this Blueprint, which are summarised in Appendix 1. A summary of risks to those deliverables is in Appendix 2.

OUR VISION, VALUES AND STRATEGIC OBJECTIVES

We know that 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 into behaviours and actions.

Our current vision is to "provide care all of us would recommend to family and friends". This is definitely a clear statement of ambition for our staff, but does not set out our vision for the future of our services.

In our current statement of values we embrace the NHS Constitution values:

- Working together for patients
- Compassion
- Respect and dignity
- Improving lives
- Commitment to quality of care
- Everyone counts

To these we have added the value of being a learning organisation, which is open to challenge and where skills and competence are valued.

During 2014/15 we will undertake a programme of governor, staff and wider stakeholder engagement to refresh our vision and articulate our organisation's purpose, reaffirm our values and renew our strategic objectives, ensuring they are aligned with the needs of the local population and the ambition of our staff.

The previous Board of the organisation signed off a Trust strategy for 2013-16. The new Board will revisit that strategy and develop with staff and partners a renewed set of strategic objectives that will have the full commitment of the Council of Governors, the new leadership team and local people. We will do this by January 2015. We will develop key performance indicators to enable us to monitor and report progress against our strategic objectives.

We anticipate that our strategic objectives will stem from the following overarching areas of our vision and ambition:

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, retaining existing and winning new contracts.

GOVERNANCE AND QUALITY ASSURANCE AT DORSET HEALTHCARE

An overview of problems at the Trust: an organisation in breach of its terms of authorisation

The Care Quality Commission (CQC) inspected 14 sites between June 2011 and April 2013. Four locations were assessed fully compliant and 10 sites were found non-compliant with a number of the essential standards assessed. Several locations were found to be non-compliant on successive visits, with significant failings in some areas (notably Waterston Ward, Forston Clinic and Blandford Hospital).

A review of 'Outcome 16: Assessing and monitoring the quality of service provision' in April 2013 and visits to eight locations confirmed that:

- The organisation did not have consistent pace, control and grip across all of its services or of how decisions were being implemented
- The Board did not have a clear line of sight of what was happening in its services
- The Board was reliant on reassurance and lacked real assurance

There was a lack of fundamental response from the then leadership in responding to CQC concerns regarding significant gaps in governance and assurance. This resulted in Monitor taking enforcement action in April 2013 that required the Trust to:

- Ensure compliance with all remaining CQC recommendations;
- Commission an independent review of governance arrangements; and
- Provide Monitor with external assurance the Trust had addressed underlying issues.

A review by Deloitte LLP during May and June 2013 found that the Board needed to address the significant challenge of bridging the cultural gap between legacy organisations.

The report also highlighted that there was a lack of medical leadership for physical health services and recommended the Board undertake a skills audit to ensure members had the right skills to operate effectively as one unit. It further advised that systems for escalation and management of risks and learning from adverse incidents needed to be improved.

How the Trust responded

The previous senior leadership team was slow to take action. Some of the concerns were either not addressed, not addressed with sufficient urgency or findings were not accepted by the then Trust leadership. This raised significant questions about the adequacy of the Trust's leadership, quality assurance and governance processes.

The Trust responded with an Action Plan in August 2013, which, in conjunction with the outcome of the Deloitte Governance Review, led Monitor to conclude that the Trust board was failing to take sufficient action to secure a return to compliance with its licence conditions. As a result, Monitor imposed an additional licence condition on 4 September 2013 relating to governance requirements.

A more substantial Trust Recovery Plan was established in September 2013. The plan comprised a total of 331 actions, which included tasks and actions from the Deloitte review (253 actions), further actions identified internally by the Trust, plus actions in response to the CQC Outcome 16 review (April 2013).

A Programme Management Office (PMO) was also established to track the progress of the Trust Recovery Plan and provide regular updates to the Trust Board via the Trust Recovery Plan Programme Board. This PMO has subsequently been strengthened through support from PwC since January 2014.

Moving from dysfunctional to functional: changes in senior leadership

The appointment of Sir David Henshaw to the role of interim Chair in October 2013 marked the beginning of significant improvements, particularly in strengthening board capability and capacity through new appointments and the creation of new posts.

The additional deployment of turnaround expertise in the appointment of Iain Lynam as Turnaround Director supported Sir David in ensuring the Trust Recovery Plan was fit for purpose and that all underlying issues identified in the CQC inspections and Deloitte independent review of governance were addressed at pace.

Sir David led a radical shake-up of the Trust board, its systems and processes of governance. New appointments to the board were:

- Permanent Chair, Ann Abraham (with effect 7 April 2014; previously newly-appointed non-Executive Director)
- Permanent Chief Executive, Ron Shields (as interim CEO with effect from 30 October 2013 and substantively with effect from 13 March 2014)
- Non-executive Director, Lynne Hunt
- Non-executive Director, Ian Cordwell
- Non-executive Director, David Brook OBE

The Executive Director posts of Nursing and Quality and Director of Finance were both replaced with very experienced interims and the Director of Mental Health has also been replaced. Two new board roles have been created to strengthen the capacity and capability of the board: Director for Organisational Development, Participation and Corporate Affairs; and Director of Strategy and Business Development. A skills audit of the Board was undertaken in September 2013 and refreshed in April 2014, to take account of the appointment of new Board members.

The **Council of Governors** has been substantially restructured and the Trust is working to improve the quality and flow of information, to nurture genuine openness and transparency. The number of members has been reduced to 26 following the recent election, allowing the Council to work more effectively and efficiently. Roles have been re-defined and we will work with governors on development and training opportunities so that the Trust may benefit from their insights and be held to account by the people it serves. The Council of Governors has already acknowledged the improvements in culture and openness.

Further, a **Trust Executive** was established in October 2013, to meet on a monthly basis. This group brings together senior and key clinicians and Directors in a unique forum that focuses on the strategic direction of the Trust, looking across physical and mental wellbeing and across all ages.

Selected quotes from the PM Governance Ltd review:

"In the last 12 months the Trust can demonstrate it has developed its risk management and quality governance capability following a review by Deloitte and intervention by Monitor."

"...at the time of Monitor's intervention, as evidenced in Deloitte's report, the Trust was seriously dysfunctional. It is clear that the Trust has responded robustly to the issues identified by Deloitte and Monitor, and has made progress in a relatively short period of time to develop and improve governance arrangements."

Becoming functional: establishing robust governance and assurance

At the time of Monitor's intervention, as evidenced in the Deloitte report, the Trust's governance was such that the Board was unable to demonstrate compliance with CQC essential standards. Today, the organisation has come a long way from that position and has taken a number of steps internally to move from a place of reassurance to one of assurance. It now has the evidence to demonstrate compliance and has the ambition to constantly improve and move beyond minimal compliance.

A review of quality governance structures led to the strengthening of the **Quality Assurance Committee**, a sub-committee of the Board, through: defined terms of reference and responsibility; increased frequency of meetings; improved flow of information; and introduction of a new non-Executive Director Chair to provide robust challenge. We also established a Board sub-committee for **Finance, Investment and Performance** to ensure finance and performance issues are subject to the appropriate level of Board scrutiny in a dedicated and focused environment.

The previous Board approved a new **Board Assurance Framework** in November 2013, but the current leadership team identified the need for further improvement, along with other improvements in risk management.

Those other improvements in risk management have included:

- a review of the risk management strategy;
- implementation of a new risk management IT system (Ulysses); and
- the introduction of rolling risk register audits

The process of continuous improvement identified further issues along the way and led in part to the Trust commissioning a further independent review of the Trust's Risk Management and Quality Governance Arrangements, from PM Governance, to support the development of our ambition to demonstrate exemplary governance.

The PM Governance review assessed and assured the impact of the Trust's mitigating and recovery actions, focusing on the strengthened risk management and quality governance processes. We have now commissioned PM Governance to provide further support, starting with a Board Workshop on 14 May 2014 and support around development and implementation of risk management procedures, a risk register, an escalation framework, a corporate risk register and the Board Assurance Framework.

"…the culture is changing towards a more open and inquisitive working environment where constructive challenge is actively encouraged and handled in a positive way."

"We are confident the Trust has improved on its position compared to July 2013; the Board's focus on promoting a quality-focused culture, and engagement with patients, staff and stakeholders on quality, improving the most."

"…the Trust is more stable now and is beginning to function more effectively; they are also firmly committed and aspire to achieve, exemplary governance."

Becoming functional: assuring high quality services

In addition to strengthening the Quality Assurance Committee the Trust took further steps to respond to the CQC reports and continues to improve its approach to assuring quality.

Independent checks on the implementation of the CQC action plans are now being undertaken by the Head of Regulation and Compliance and the Trust's Assurance Facilitator, assisted by key member of each directorate's management team. The checks are focused on ensuring that evidence of the implementation of actions exists and is available, and that the actions are achieving the desired outcomes. Follow-up checks, audits and spot checks are also performed to further support those areas which are not fully compliant. The findings from the independent checks are reported to the Quality Assurance Committee on a monthly basis, whilst the status of live action plans is updated to the Board.

We have renewed our focus on Provider Compliance Assessments (PCAs) with direct lines of accountability to the Quality Assurance Committee and to Directorate Management teams. The Quality Assurance Committee receives a monthly report which details compliance rates for each of the 16 Essential Standards of Quality and Safety. This report is broken down by directorate and gives historical trends and changes to compliance rates that month. We are now reporting 97% compliance across the Trust. This is compared to evidence of only 68% PCA compliance in July 2013. There are action plans in place to address areas where full compliance is not currently being achieved.

In addition, we are now working hard to share the lessons and good practice actions from across the Trust. This has included producing a booklet entitled 'Care Quality Commission visits. Positive practice points and lessons learnt'. This document is available on the Trust's intranet page, and is updated as relevant new content becomes available as a result of CQC inspections, and findings from the independent checks.

The Trust is now in the position of being able to monitor against basic CQC standards, but it is absolutely critical to continue to improve and to not slip back. Our priority is to raise the bar for our patients and to constantly improve the standards of service delivery.

We are strengthening our quality strategy and planning, to ensure that we are improving across all three domains of quality, with a particular focus on the patient experience. Quality improvement must be the driving principle in all that we do and we will work to nurture ownership of quality in all parts and at all levels of the organisation.

Immediate ways we are moving forward include:

- The start of a peer review initiative with an external organisation, Berkshire Healthcare NHS Foundation Trust, who have been invited to peer review our community mental health teams, an area of our work where we know we will benefit from external insight and feedback;
- Supporting staff to be part of a CQC peer review team at St George's Healthcare NHS Trust in London; and,
- Attending learning and sharing events in areas where CQC inspections have taken place.

Moving from functional to exemplary: Deloitte Review and Trust Recovery Plan to this Blueprint

The Trust is confident now that it has the right people, doing the right things, in the right place.

The original independent review of governance arrangements performed by Deloitte resulted in a report with 61 recommendations. The actions arising from the recommendations were dovetailed in to an overall Trust Recovery Plan that addressed further organisational issues. Progress against the Trust Recovery Plan has been reported to Monitor via regular updates and review meetings.

The majority of Trust Recovery Plan actions have now been implemented. As of 1 April, there were 15 outstanding actions, which we have continued to progress and they are carried forward in this Blueprint and will continue to be tracked for delivery. The Trust Recovery Plan was closed down on 1 April 2014.

This Blueprint continues by providing detail of our ongoing actions, divided in to six key themes, building on the insight and learning of the CQC, Deloitte and PM Governance reports.

> "We are clear that we absolutely cannot lose the progress that has been made and that we must not go backwards."

OUR SIX KEY THEMES

In addition to regular progress review meetings, Monitor has met with the Project Management Office (PMO) (February 2014) and received regular updates from the Trust about the Trust Recovery Plan. The Trust has performed a self-assessment of its response to the Deloitte recommendations and has commissioned an independent review of this response to be undertaken in May 2014. This review will help to provide independent assurance to the Trust Board, to Monitor and to our members, on the progress we have made.

The PMO is working with teams to develop and track individual workbooks (project plans) for each of the six key themes below, to ensure the actions are progressed and monitored. This is the detailed project planning and performance measurement that will track the impact of the changes we make and provide visibility across the Trust and to the Board, on progress. Progress against six key themes workbooks will be reported via a dashboard to the Programme Board and on the Trust Board along with the Cost Improvement Programme and other change projects.

Board and leadership development

Significant progress was made in developing the Trust Board and leadership capacity from October 2013 and we will build on this as we move forward. We now have the right people, doing the right things, in the right way. The Board is providing appropriate challenge and setting ambition.

We have capability in the Board and we are building the capability throughout the organisation. The clinical leadership programme in the Trust will continue to develop and promote team development opportunities for all teams.

We have conducted a skills audit of Non-Executive Directors which is informing the recruitment to our two existing non-Executive Director vacancies.

In April 2014 the newly-created Director for Organisational Development, Participation and Corporate Affairs took up post.

Board development will have a particular focus on governance, risk management and assurance systems.

To continue our board development we have appointed Frontline to support delivery of a programme of work throughout 2014/15. This programme will include an annual skills audit, capacity building, competency review, succession planning, and developing to work as a unitary team.

In completing the locality restructure we will appoint to three locality director posts in September 2014. We have already appointed a Programme Director to lead the locality transformation work.

We will:	Deadline
Deliver a development programme for the Board	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	end June 2014

Organisational development and our people

We have been in a position where three legacy organisations did not merge or share a single common purpose, in which too many staff do not relate to Dorset HealthCare, feel undervalued and not listened to.

There have been incremental improvements, but there is much more to be done to break down functional silos, embrace matrix working and multi-disciplinary team working and ultimately unite the organisation in common purpose. In the short-term, organisation-wide engagement events have allowed staff to share views and ideas.

We have already: introduced Chief Executive and non-Executive services visits; increased direct communication between the Chief Executive and all staff; spent more time with staff representative organisations and improved engagement with our clinical staff. There has been a positive response from staff and a clear commitment to change, with a desire for one organisation with strong, visible leadership. We have implemented the national e-learning management system for mandatory training.

A broader organisational development strategy will nurture a strong, positive culture that supports and enables all staff to deliver consistently excellent standards of care. A focus on our cultural development is particularly important after a period of concentration on ensuring rigorous systems and processes are introduced and embedded across the organisation.

We will:	Deadline
Develop 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	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 trans-parent flow of information across and around the organisation	end July 2014
Review staff involvement in the development of QIPP and CIP projects across the Trust	end August 2014

Governance, quality and risk management

We have set out the early improvements that have been made to take the Trust from a position of being unable to assure itself of the quality of its services to one where it is much closer to functioning and monitoring its quality and performance.

We will continue to work with PM Governance to respond to the findings of their independent review of the Trust risk management and quality governance arrangements.

We will:	Deadline
Continue to work with PM Governance to further develop and enhance our risk management and quality governance arrangements.	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	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	end October 2014
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	end July 2014

Staffing

Staffing - having the right levels and mix of skills, experience and knowledge, in the right place - is fundamental to delivering consistently high quality care. We are committed to recruiting and retaining a workforce that can flex the skills and capacity to where they are needed.

A review of staffing levels was undertaken as part of Trust recovery and an escalation tool introduced to highlight areas where wards are not appropriately staffed. In response, further action and assurance came from the Director of Nursing and Quality and the Medical Director and additional funding was committed. We will review staffing levels on an ongoing basis and further refine the escalation tool to ensure it incorporates professional and clinical judgement alongside staffing levels.

We also commissioned a review of Crisis and Home Treatment services and in-patient mental health wards, which gave assurance that staffing levels were appropriate numbers, but that we must do more to ensure the appropriate skills mix.

A clear escalation process for in and out-of-hours has been introduced and Directors regularly review this information. A recruitment and retention group was established to improve the efficiency of recruitment processes and to reduce the vacancies within the Trust.

We will:	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	end June2014
Ensure an internal audit is undertaken on the appropriate staffing ward escalation tool, specifically examining the quality assurance of the tool and how regularly checks are undertaken	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	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	[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

Performance and information reporting

We have done much to improve the monitoring and reporting of performance at team, Directorate, Committee and Board level, taking best practice into consideration as highlighted in the Monitor Quality Governance guidance.

The integrated corporate dashboard has been significantly updated to include directorate performance set against updated quality metrics, as well as overall Trust performance that is now tracked with trend analysis over a 13 month period.

Further improvements to the way we track team and directorate performance have been introduced, with team outcome reports that drill down to ward level now available across a range of metrics and the introduction of directorate performance review meetings. These meetings review and challenge quality metrics with a focus on ensuring swift action is taken where changes in performance are identified.

We will:	Deadline
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	end July 2014
Implement changes from the review of quality metrics to improve Board to ward sight of performance	end October2014
Ensure internal audit is conducted on the reporting of quality metrics	end August 2014
Implement standardised team level reporting across all domains	end October 2014
Continue to improve the integrated corporate dashboard and report, including enhancing the quality of the narrative about interdependencies across metrics, providing greater insight and context and clearly identifying deteriorating performance	end October 2014

Partnership working and participation

Partnership working and building a local coalition for quality and service improvement are critical for us to successfully move to delivering patient-centred, integrated services. A summary of our partners and stakeholders can be found in Appendix 3.

We know that in the past there were many fractured, dysfunctional relationships, both internally and externally and we have been working hard to repair and rebuild these. Confidence has been restored in some cases, but those relationships are still fragile and we recognise there is much more to be done.

We intend to develop formal and informal mechanisms to improve our partnership working and build strong working relationships, including seeking opportunities to work more closely with local partners such as the Health and Wellbeing Boards, and Healthwatch Dorset.

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.

Our ambition for participation is to empower individuals and their carers in their interactions with our services. We will work much more closely with our local population, to determine the future direction and design of our services. We will welcome 360 degree feedback and introduce rigorous mechanisms to understand local experiences of our services, local perceptions and people's ambitions for our services.

We will build on the work done to date to strengthen the Council of Governors and continue to develop and support them in their role in the organisation and seek to expand the membership of the Trust, so that we may genuinely hear from every part of our local population.

We will:	Deadline
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	end July 2014
Further develop and intensify 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

FINANCE, INFORMATION AND PERFORMANCE

The focus of our financial planning and management must be to invest our resources to get the best possible quality services for our patients. We must do this in a way that secures the best value for our investment and that allows us to plan for the future and ensure the sustainability of our actions.

The Trust was rightly criticised by Monitor for its poor financial planning and forecasting. Recent years saw year on year, large surpluses and at year end 2012/13 we had an unpredicted £11.8 million surplus against a plan of £1 million. For the year 2013/14 we have delivered a surplus of just over £0.4 million against a plan of £1 million.

We have significantly strengthened our financial reporting and planning oversight and assurance with the creation of the Finance, Information and Performance committee – this ensures the Board is alerted to and is able to monitor the risks and strengths of our financial planning and delivery.

We have also changed the financial leadership at board level; an interim Director of Finance and Performance is currently in post and a substantive appointment will be made by October 2014.

A sustainable financial plan

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 2014/15 we plan to achieve a £8m Cost Improvement Programme (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 2013/14, 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 the financial years 2015/16 and 2016/17 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.

The Continuity of Services Risk Rating (CoSRR) for the Trust is presently 4. With the planned deficit in 2014/15, it is forecast to fall to 3 before rising back to 4 in 2015/16.

A detailed summary of our financial performance and forecasts is given in Appendix 4.

TRANSFORMING OUR SERVICES: DELIVERING PERSONALISED, INTEGRATED CARE

Our ambition is to get the very best, high quality outcomes for our patients and local people. We feel we have reached the limits of what we can achieve within our existing service delivery framework and the development of truly integrated community services is impeded by many of our existing structures.

Like most community and mental health trusts, the organisation of services reflects history, not the needs of patients. Services are professionally determined and based on the assumption that the needs of a patient can be made to fit into quite separate physical and mental health services, divided by age. A patient is expected to fit in with multiple services because that is how health services have been historically and professionally organised.

We plan to transform our services so that we offer integrated care designed and delivered around individual need. We believe this is right for local people and our communities and that it will enable us to work hand in hand with primary care professionals to co-develop services that are effective and sustainable.

The transformation to multi-disciplinary teams that interface directly with primary care services takes us far beyond simply aligning services around smaller geographies. Moving to locality teams will strengthen clinical leadership, remove some of the management structures that we know are inflexible and give our frontline staff far more freedom to take action and make decisions with their patients.

Our proposed model of care will give ownership of quality to those delivering services and we are confidence that our governance structures will keep a clear line of sight to the Board.

The design principles

The organising principle for our locality model is **people**. We start with the whole person, their family and their multiple needs and design our teams to offer specific support that can be accessed where, when and how people need it.

The centrality of primary care

Our GP locality-based, integrated teams will end the disconnect between our existing community services and primary care. Locality will have primacy over existing functional groupings of services. We will work with GPs and Local Authority colleagues to stratify locality populations and design service delivery models specific to need.

The maximisation of value

Our strategy is to achieve maximum value from all of our community-based resources, with a particular focus on our 12 community hospitals.

Progress to date

The Board has made a commitment to taking forward this change and a May 2014 Board paper sets out greater detail against the model itself, risks and mitigating actions, key milestones and project support. A Programme Director has been appointed to lead this priority work.

We have already begun discussions internally and with some of our partners, to share our vision. We have already secured commitment from many GPs, from the CCG, our Local Authority partners and from our Council of Governors.

Crucially, we are not starting this work from a blank canvas and can point to a number of teams that are already working in locality pilots, which means we have examples of best practice and lessons learned that will help us take this transformation forward.

Purbeck Community Services

The Community Services in Purbeck deliver planned care to patients in their own homes and in residential care and aim to provide high quality and proactive case management, community nursing and community therapies in an integrated and coordinated manner, promoting independence, self-management and wellbeing.

A recent innovation has been the introduction of a locality Complex Case Forum. These forums utilise the Dorset Interagency Risk Management Protocol. This Protocol arose from a recent Serious Case Review and details multi-agency partnership working in situations where an adult who appears to be in need of community care services, and may be unable to take care of his/her self, and is causing concern within their community. This applies particularly to those who have mental capacity but are vulnerable due to self-neglect.

The team leaders for the Locality meet on a monthly basis. Part of this meeting involves discussion of every adverse incident within the locality, to ensure that any required actions have been undertaken, and to share learning. Root Cause Analysis both from the locality and from elsewhere in the Trust are also discussed to ensure sharing of lessons learnt. Any actions as a result of these discussions are then taken forward by every team in a consistent way.

A gentleman treated last year at The Browning Centre

N lives at home. He has been a patient of the Community Dental Service since 1986.
N has Downs syndrome and a severe learning disability. He has historically been treated with General Anaesthesia up until 1995, since then he has all his treatment by sedation (oral and intravenous). N does not like being touched therefore we also use safe holding for him.

For his last appointment the Intensive Support team assisted N to attend The Browning Centre, he had safe holding and sedation for a full dental examination and treatment. While sedated he had bloods taken to check his medication levels, the podiatrist treated his feet and the audiologist came in and syringed his ears. Intensive Support then assisted him on his journey home.

TRANSFORMING SUPPORT SERVICES

The estate

We know that our estate has been poorly managed in the past. We know that, with 220 locations delivering care, our estate is too big, too expensive, in places underused and in some cases – unacceptably – not fit for purpose.

We have already combined the legacy estate teams in to a single estates team, headed up by a newly-appointed Associate Director for Estates, with responsibility for the whole of the organisation's estate. We will look to recruit additional estates expertise in the appointment of one of two new non-Executive Directors. An audit is underway to stocktake, properly map and understand our estate and its responsibilities and we will develop a much better system for determining operational locality needs in conjunction with staff and partners. An Estates Strategy will go to the Board for approval in November 2014.

We have already prioritised:

- Investing £1m in to St Ann's hospital to bring three wards up to standards we expect whilst planning for the long-term use of the site
- Essential resilience and disaster recovery
- A £12m capital programme, including building maintenance, newbuild activity and equipment

Information management and technology

Our IT capability needs significant enhancement and investment; a reliable and accessible IT infrastructure is critical to delivering high-quality care.

We know that we have many unhappy IT users, that there are still considerable legacy software issues and that there are difficulties sharing information with partner organisations or even across our own services. Our server and network infrastructure has shortcomings and basic resilience is inadequate.

We will significantly increase the number of users and internal 'experts' on the IM&T steering group and work with the existing systems to improve the user experience, operational support and available tools.

Achieving a better interface between all of our clinical systems, across primary care and with local authorities will dramatically improve patient care, as well as updating our data sharing protocols and mobile working guidance so that staff have the information they need, when they need it, to get the best outcomes.

An immediate IM&T strategy went to the Board in January 2014 and a further paper will be presented to the Board in October 2014 as part of activity to support the transition to locality working.

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.

Appendix 1: Summary of Deliverables

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

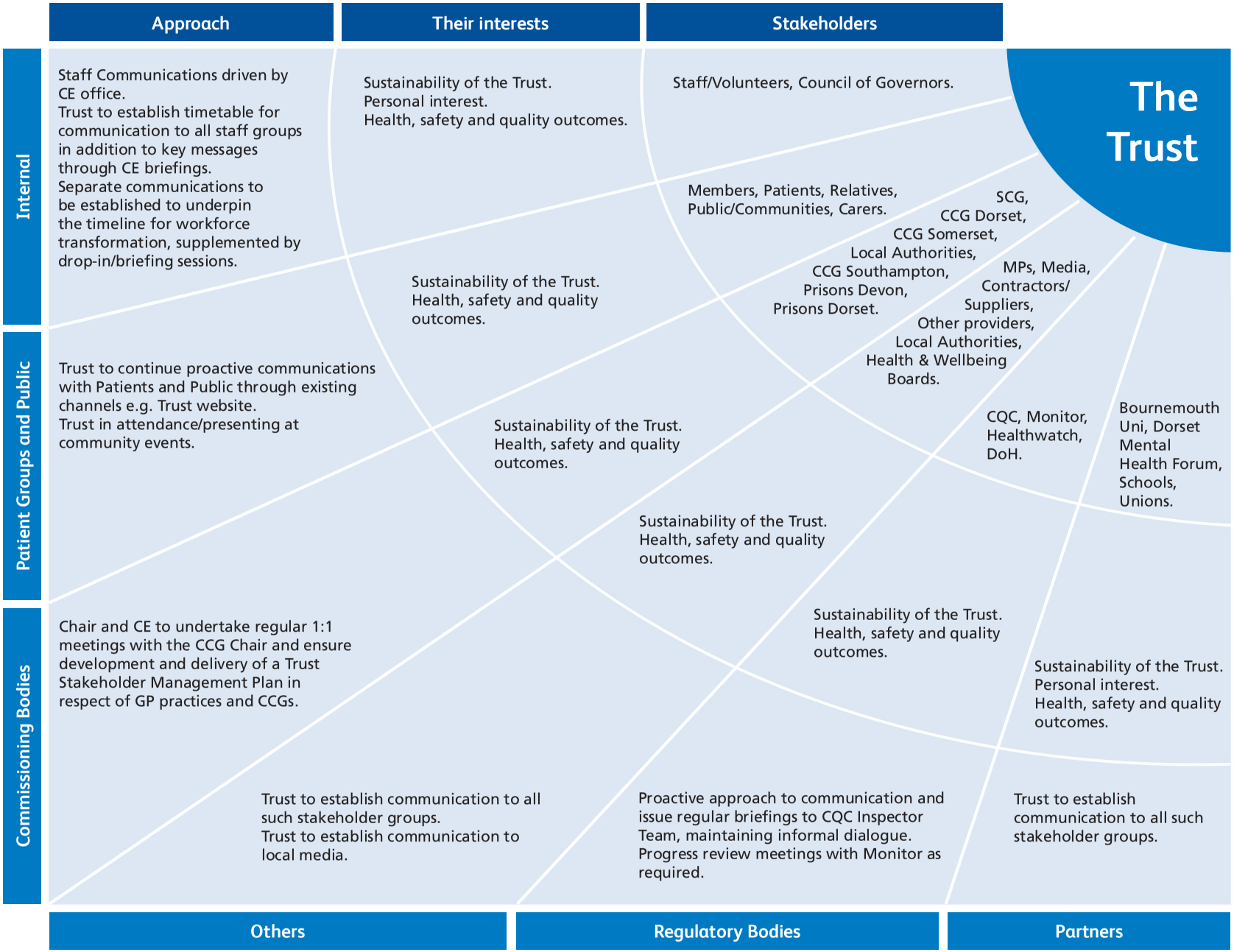
Staffing	Deadline
Carry out a root and branch analysis of recruitment and retention issues	end August 2014
Continue Implementation of the staffing plan agreed by the Board in February 2014	end June 2014
Ensure systems are in place to monitor the key metrics agreed by the Board including staffing levels 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
Performance and information reporting	**Deadline**
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
Partnership working and participation	**Deadline**
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

Key:
[A] denotes an action carried from the Trust Recovery Plan
[B] denotes an action to meet an outstanding Deloitte recommendation

Appendix 2: Summary of Top Ten Risks for Delivery of the Blueprint

Risk	Date applies	Likelihood (1-5)	Impact (1-5)	Overall Rating (likelihood * impact)	High level mitigating activity
Board does not progress at sufficient pace, the necessary changes to culture, to systems and to processes	Ongoing	3	4	12 (high)	New governance structure and PMO in place to escalate performance issues
Further failures in quality of care such that services do not meet CQC essential standards	Ongoing	2	4	8 (high)	New governance structure, further work with PM governance to improve line of sight, increased focus on reporting and peer review
Sustaining appropriate and safe staffing levels	Ongoing	3	4	12 (high)	Ongoing monitoring of staffing via assessment tool, ongoing recruitment activity, seeking external learning and best practice
Locality model transformation cannot be delivered	Ongoing	2	3	6 (moderate)	New governance structure and PMO in place to escalate performance issues, specific capacity increased to project management team
Non-delivery of CIP and non-delivery of a sustainable financial platform for 15/16	Ongoing	3	3	9 (high)	PMO and finance department tracking financial performance and escalating concerns regarding under-delivery to the Finance, Information and Performance committee
Our staff do not engage or support service transformation	Ongoing	2	4	8 (high)	Engagement and communications strategy will be developed and delivered including face to face briefings and significant improvements to digital channels
Negative impact of management restructure on service delivery	Ongoing	2	4	8 (high)	Strong staff engagement and support in place, rigorous quality metrics and reporting
Insufficient capacity and capability to progress the actions required (either through lack of experience or conflicting priorities)	from September 2014	4	4	16 (extreme)	Additional capacity in the plans to transform to the locality model, additional external support may be called upon
Lack of staff capability to fill new locality management posts	Ongoing	3	4	12 (high)	Proactive skills review and recruitment and retention strategy as part of locality model programme management
Unable to respond to external reviews and changing commissioning intentions, such as the outcome of the CCG-led Clinical Services Review	Ongoing	2	4	8 (high)	Work with external partners and CCG to anticipate and influence commissioning intentions, deliver flexible locality model

Appendix 3: Our Stakeholders and Partners



Appendix 4: Detailed Financial Planning

Financial performance

(a) Historical

Since the acquisition of Community Services, the financial performance of the Trust has been healthy with reported surpluses in each year as set out below:

	Income (£m)	Surplus (£m)	%
2013/14*	242	0.4	0.2
2012/13	227	11.8	5.2
2011/12	214	4.4	4.9
2010/11	88	10.4	5

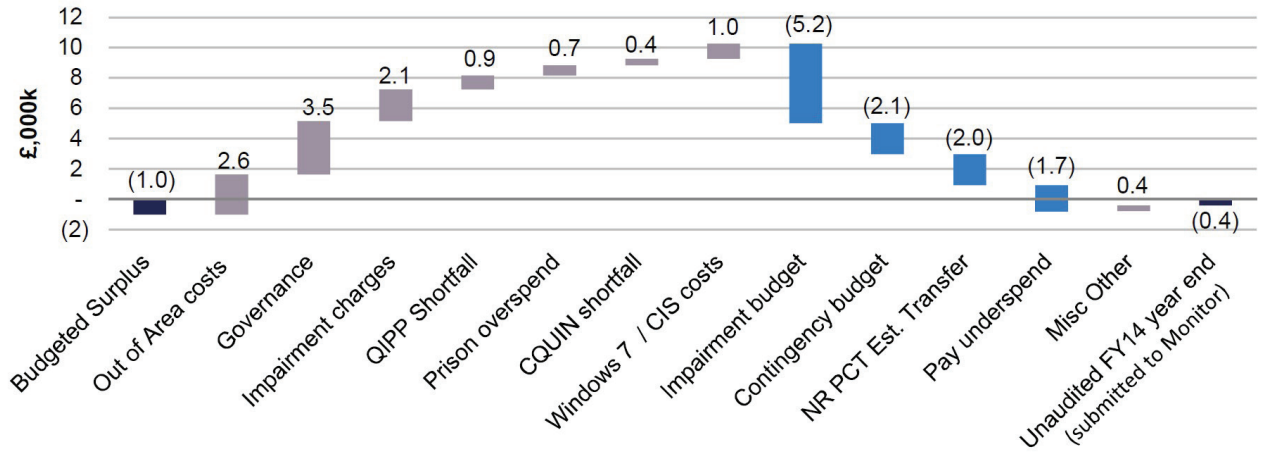
*unaudited year end submitted to Monitor

(b) Projected

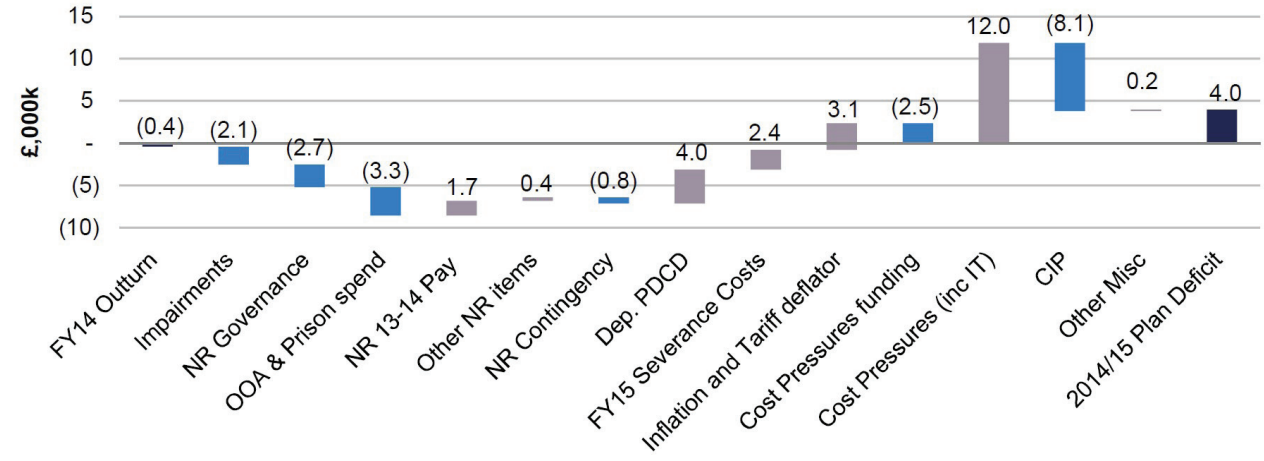
The forecast financial position is set out below:

£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**

FY14 budget to FY14 forecast



Bridge from FY14 to Plan for FY15



Cash position across the five years:

£'m	FY15	FY16	FY17	FY18	FY19
Surplus / (Deficit) from operations	6.3	12.7	13	13.1	12.8
Increase / (Decrease) in working capital	0.2	0.1	0	0.1	0.1
Net cash inflow / (outflow) from operating activities	**6.5**	**12.8**	**13**	**13.2**	**12.9**
Net cash inflow / (outflow) from investing activities	-2.8	-7.4	-5.5	-3.9	-4.5
Net cash inflow / (outflow) from financing	-5	-4.9	-4.8	-4.8	-4.6
Net cash inflow / (outflow)	**-1.3**	**0.5**	**2.7**	**4.5**	**3.8**
Closing Cash	**27.9**	**28.4**	**31.1**	**35.6**	**39.3**

Dorset HealthCare
University NHS Foundation Trust

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Monitor
Making the health sector work for patients

Mr Ron Shields
Chief Executive
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26 June 2014

Dear Ron

Dorset Healthcare University NHS Foundation Trust ('the Trust') – Application to Remove a Section 111 Additional Licence Condition

I write further to your application of 3 June 2014 for the removal of the additional licence condition imposed by Monitor on the Trust on 4 September 2013 in accordance with section 111 of the Health and Social Care Act 2012.

Decision
Monitor has considered the information outlined in the Trust's application to Monitor and other relevant evidence gathered and has decided it is appropriate for it to remove the Trust's additional licence condition.

The reasons for Monitor's decision are that Monitor is satisfied that:

- the Trust has complied with the additional licence condition imposed on 4 September 2013; and
- the governance of the Trust is such that the risk that it will fail to comply with its licence conditions has been satisfactorily reduced.

We have enclosed a Notice of Removal of Section 111.Additional Licence Condition as proof of Monitor's decision to remove the additional licence condition, which Monitor will publish on its website.

The Trust is no longer subject to enforcement action by Monitor as a result of:

- the issue of a Compliance Certificate dated 17 June 2014 relating to enforcement undertakings agreed on 23 April 2013; and
- Monitor's decision to remove the additional licence condition as above.

The Trust's governance risk rating will therefore be returned to Green.

The Trust will continue to be subject to Monitor's normal quarterly monitoring cycle and regulatory regime as outlined in the Risk Assessment Framework.

If you have any queries relating to the above, please contact Smitha Nathan, Senior Regional Manager, by telephone on 020 3747 0334 or by email: Smitha.nathan@monitor.gov.uk .

Yours sincerely

Paul Streat
Regional Director - South

cc: Ann Abraham, Chair

Enc: Notice of Removal of Section 111 Additional Licence Condition

Notice of Removal of Section 111 Additional Licence Condition

The following additional licence condition was imposed by Monitor on Dorset Healthcare University NHS Foundation Trust on 4 September 2013 in accordance with Monitor's power under section 111 of the Health and Social Care Act 2012:

SECTION 111 ADDITIONAL LICENCE CONDITION:

After Condition FT4, insert:

"Additional Licence Condition 1 – Additional governance requirements:

1. The Licensee must ensure that the Board and its committees-
a. are functioning effectively;
b. have sufficient capacity and capability to enable the Licensee to address the issues specified in paragraph 3 effectively;
c. carry out the strategic planning, and provide the leadership, necessary to address those issues effectively ; and
d. urgently take all reasonable steps to ensure those issues are addressed effectively.

2. The Licensee must ensure that its Council of Governors is operating effectively.

3. The issues referred to in paragraph 1 are the issues relating to the operation of the Licensee's board and its other governance arrangements, including those identified in any independent assessment of its governance arrangements, that have caused or contributed to, or are causing or contributing to, or will cause or contribute to, the breaches, or the risk of a breach, of the conditions of the Licensee's licence.

4. For the purposes of paragraph 1, an issue is addressed effectively only if it is addressed within a reasonable timescale, including any applicable timescale proposed in an independent assessment of its governance arrangements or agreed with Monitor."

Monitor has decided it is appropriate to remove this additional licence condition, as from the date of this notice, for the following reasons:

- Monitor is satisfied that the Trust has complied with the additional licence condition imposed on 4 September 2013; and
- Monitor is satisfied that the governance of the Trust is such that the risk that it will fail to comply with its licence conditions has been satisfactorily reduced.

Signed: 

David Bennett
Chief Executive

Date: 23 June 2014

Mr Ron Shields
Chief Executive
Dorset Healthcare University NHS Foundation Trust
Trust HQ
Sentinel House
4-6 Nuffield Road
Poole
BH17 0RB

17 June 2014

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Making the health sector work for patients

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Dear Ron

Dorset Healthcare University Foundation Trust ('the Trust') – Decision on Application for a Compliance Certificate

I write further to your application for a compliance certificate, received by Monitor on 3 June 2014, in respect of all of the Trust's Enforcement Undertakings accepted by Monitor on 23 April 2013.

Decision 1
Monitor has decided to issue a compliance certificate in respect of paragraph 1.1, 1.2, 1.3, 1.4, 1.5, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12 and 2.1 of the Trust's Enforcement Undertakings.

Monitor will publish this compliance certificate on its website.

Decision 2
Monitor has decided to refuse to issue a compliance certificate in respect of paragraph 1.6 of the Trust's Enforcement Undertakings.

Reason for Refusal
The reasons for the refusal decision are:

Undertaking 1.6

1) Paragraph 1.6 of the Undertakings required the Trust to submit its Governance Plan (defined in paragraph 1.5 of the Undertakings) to Monitor within two weeks of the final assessment report being issued. The final assessment report was issued on 24 July 2013. Although the Trust, under its former leadership team, submitted a plan to Monitor on 8 August 2013, the plan was of insufficient quality to constitute compliance with this Undertaking.
2) The Trust's failure to submit a satisfactory plan in accordance with this Undertaking was one of the factors contributing to Monitor's decision to impose an additional licence condition on the Trust on 4 September 2013.
3) Having missed the deadline for submission of the Governance Plan to Monitor, the Trust cannot now comply with this Undertaking. However, because further enforcement action was taken against the Trust, following which, the Trust submitted a satisfactory Governance plan, Monitor considers this Undertaking redundant.

Monitor will publish an explanatory note on its website alongside the Compliance Certificate to explain that, although this Undertaking has not been complied with, Monitor considers it to be redundant due to steps subsequently taken by the Trust.

Right of Appeal

In accordance with paragraph 13(1) of Schedule 11 to the Health and Social Care Act 2012, the Trust has a right of appeal to the First-tier Tribunal against Monitor's decision to refuse your application for a compliance certificate relating to Undertaking 1.6.

The grounds for such an appeal are that Monitor's decision is:

(i) Based on an error of fact;
(ii) Wrong in law; or
(iii) Unfair or unreasonable.

On appeal, the Tribunal may: (i) confirm Monitor's decision; or (ii) direct that it is not to have effect.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0334 or by email: Smitha.nathan@monitor.gov.uk .

Yours sincerely

Smitha Nathan
Senior Regional Manager

cc: Ann Abraham, Chair

Enc: Compliance Certificate

Monitor
Making the health sector work for patients

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CERTIFICATE OF COMPLIANCE

LICENSEE:

Dorset Healthcare University NHS Foundation Trust ('the Trust')
Sentinel House, 4-6 Nuffield Road, Poole, BH17 0RB

In accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012, Monitor hereby certifies that in respect of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12 and 2.1 of the Trust's Enforcement Undertakings accepted by Monitor on 23 April 2013, the Trust has been fully compliant.

Signed: Paul Streat

Position: Regional Director

Date: 17 June 2014