Dorset County Hospital NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Dorset County Hospitals NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

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

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

Annual plan review 2014/15 guidance is available here.

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

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

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

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

The expected delivery timetable is as follows:

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

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

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

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Date	**3rd April 2014**

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Dr Jeffrey Ellwood

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Jean O'Callaghan

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Libby Walters

Signature

1.2 Executive Summary

Dorset County Hospital NHS Foundation Trust (the Trust) has had a successful year in progressing against its vision to provide high quality services; improve the patient experience; learn from experiences; value its workforce; whilst working within a constrained financial environment.

Continued progress has been made in improving the quality of services, and the Trust has implemented, and is preparing to implement, many recommendations from the recent national reviews into NHS service quality and patient safety.

Two main short term operational challenges face the Trust in 2014/15 and 2015/16. These include its ability to provide capacity at peak admission times, and to plan the delivery of key services when the impact of external requirements is not yet fully understood; such as outcomes from Dorset Clinical Commissioning Group's (CCG) review of clinical services across the county, and the implementation of the Better Care Fund.

Financially, the Trust is forecasting a surplus of £1.5million in 2013/14 which is greater than the planned surplus of £700,000. The Trust was on track to deliver the planned surplus of £700,000, which was achieved through the delivery of a £6 million Cost Improvement Programme (CIP). Additional non-recurring income totalling £850,000 has been received from Commissioners to support future cost improvement plans. The Trust is anticipating an income and expenditure position of a £900,000 deficit in 2014/15 and a £3 million deficit in 2015/16. These deficits reflect the Trust's inability to deliver the required level of CIP through Trust-wide schemes alone. However, it anticipates that this position will be recovered in future years through the implementation of the Trust's Clinical Services Strategy and Community Strategy; and the CCG's Pan Dorset Review.

The Trust is planning to invest £7.3 million in 2014/15 and a further £5.0 million in 2015/16 in its capital programme. In order to manage the cash position through a period of two years in deficit the current loan will be extended, the capital programme has been reduced and cash balances will be utilised. The Trust is planning to deliver a continuity of service risk rating of 4 in 2014/15 and 3 in 2015/16.

The highlighted quality risks for 2014/15 are the ability to deliver the performance targets for Clostridium Difficile and Emergency Department waiting times.

The Governors' views have been taken into account when preparing the Trust's Operational Plan. The Governors are supportive of the contents of the Operating Plan.

1.3 Operational Plan

Section 1 Short Term Challenges

The Trust has joined other providers within the local health economy (LHE) to identify the main challenges around providing high quality health services; both for the immediate years and as a platform for longer term change. Participation in both formal and informal LHE meetings and project boards has shown that many of these challenges can only be solved by a whole LHE approach; and the Trust is developing its response as part of the Trust's Strategic Plan, to be submitted in June 2014.

Three main points have influenced the Trust's prioritisation of its key short term operational challenges: challenges faced across the LHE, national recommendations on service improvement and internal operational abilities. The Trust has identified the main challenges over the next two years as:

- Ensuring sufficient capacity to meet peaks in demand for admission;
- Appointing to key consultant and middle grade positions;
- CCG's pan Dorset review of clinical services, especially its timely conclusion to make sustainable change.
- Being an early adopter of 7 day working practices;
- Better Care Fund, understanding the implications of the agreed targets and funding changes; and
- Delivery of the Cost Improvement Programme (CIP).

Ensuring Sufficient Capacity to Meet Peaks in Demand for Admission

The Trust continues to see significant peaks in patient admissions. Aside from the expected winter peaks, the Trust also experiences increases in the summer months due to its coastal location.

Previous attention to managing this has largely focused on maintaining patient flow by reducing length of stay (LOS), and therefore increasing the Trust's ability to provide sufficient bed days to absorb the increase in admissions. However, the achievement in reducing elective LOS has now flattened off, and the LOS for urgent and emergency admissions has actually increased over the past year from 6 – 7 days. This is due to the increasing complexity of the needs of many elderly and frail patients. To help alleviate this the Trust is working with the local health community Integrated Discharge Team, which is based in the hospital. This whole system planning has enabled delayed discharges to be kept at minimum levels for the last two years.

The Trust has experienced challenges during 2013-14 in meeting the emergency four hour access target. Although emergency attendances have not increased, the average length of stay for emergency patients has increased by one day. This is due to two reasons, namely acuity and capacity constraints in the external community for community hospital beds, rehabilitation services and residential and nursing home placements. In order to ensure the hospital is able to manage flow more efficiently, a number of work streams have been put in place. These include the introduction of a seven day Consultant delivered model to ensure senior assessment, a hospital at home service (virtual ward) to support admission prevention where possible, and the planned entry of the Trust into the domiciliary care market to ensure the availability of appropriate packages of care on discharge.

In response to these capacity pressures the Trust has carried out capacity planning across all clinical areas, and established a Patient Flow Working Group.

1) Capacity Planning

Capacity planning has been carried out in all clinical areas for both outpatients and admissions. The model for this is to ensure that the contracted activity baselines can be provided for, with a 5% contingency to allow for peaks in demand. This has highlighted the need for additional medical staff in Dermatology, Radiology and for more critical care beds.

To support capacity planning, the Trust uses Caplan software to predict emergency and elective activity based on previous activity trends and current elective bookings. It updates its predictions throughout the day; reflecting changes if actual admissions follow a different pattern from expected trends. This information is highly visible to clinical and service managers, and can be seen in real time on the Trust's intranet and accessed remotely. It is also used as the basis for the Trust's winter plan, helping to inform the number of beds and staff required.

Contract monitoring meetings are held monthly with the commissioners, and variances in activity levels - actual and anticipated through the referral tracker – are managed and planned for.

2) Patient Flow Working Group

The aim of this recently established group is to identify what causes blocks to excellent patient flow throughout the Trust, and to recommend how these are overcome. Its membership comprises representatives from all key clinical and non-clinical teams that have an impact on the timely implementation of all aspects of patient flow through the hospital. Currently the group is focusing on the pathways within the Trust, but this will be extended to include integration with community teams.

Early initiatives that are having a positive impact include focusing staff and patient expectations on the expected date of discharge and improved use of the discharge lounge. This is supported by the position of the Supervisory Sister who will take the role as Flow Coordinator for each clinical area.

Appointing to Key Consultant and Middle Grade Positions

The Trust has identified key consultant and middle grade positions required to ensure service capacity and continuity. Recruitment from within the UK has been augmented with an overseas search and selection programme. A number of applicants are progressing from an initial Skype interview to a formal UK selection process. It is expected that the key roles in Dermatology and Radiology will be successfully appointed to, but this remains a concern for service capacity until finalised.

Pan Dorset Review

The Trust will face significant financial challenges in 2014/15 and 2015/16, and being able to respond to these requires clarity on the services and volumes that the CCG will commission. Dorset CCG is preparing to carry out a review into clinical services offered across Dorset, which will be clinically led. The Trust has contributed to the aims of the review, and Trust clinicians have been involved in its scope. It is expected that they will also be actively involved in its investigations and recommendations. The CCG are currently sourcing an independent partner to carry out the review with them, and they expect to appoint by September 2014. The Trust understands that the partner will then have to March 2015 to make its recommendations, and that implementation should proceed in September 2015. Therefore, the Trust is currently developing operational and strategic goals without the knowledge of the CCG's commissioning

plans for 2015/16 and immediately beyond. To mitigate this, the Trust is planning its operational priorities for the next two years in light of its understanding of what the CCG may require, and to fit with its own ambition for service development and possible disinvestment.

There remains a risk that the CCG's partner may not have the capability to implement the review's recommendations, and therefore limit the Trust's ability to put in place the changes it requires to achieve financial sustainability in 2016/2017 and beyond.

Being an Early Adopter of 7 Day Working

Being selected as an early adopter for 7 day working is an exciting opportunity for the Trust. It will involve transforming models of service delivery to achieve a seven day consultant delivered service. It is envisaged this will not only improve clinical outcomes, but also reduce length of stay through improved care and discharge planning. The challenges will be in ensuring that the benefits follow the investment, and make this financially sustainable, and that 7 day working can be achieved across all the required clinical services to give a whole systems approach. Some of this initial work has already been completed as the Trust was a member of the HFMA Finance Group working with the Seven Day Working Forum. But further detailed analysis will be required.

Preparation for the Better Care Fund

The Better Care Fund (BCF) provides a single pooled budget for health and social care services to work more closely together in local areas, to meet the needs of patients with long term conditions and complex needs. Understanding the risks, responsibilities and how this will be implemented is a significant challenge for the Trust. One of the key aims outlined in the BCF's business plan is the reduction of emergency admissions by 10%. This is likely to signal a reduction in income for the Trust. As previous research by the King's Fund has shown, the Trust has one of the lowest rates of avoidable admissions in England with less than 10% of inappropriate admissions. Therefore, a risk to the Trust is the inability to take costs out that match the reduced level of income, as minimum staffing levels will still be required to support 24/7 emergency services. Added to this is the risk of acute admissions not decreasing, and the Trust having to make a stepped increase in capacity at full cost.

Achieving the CIP

The Trust is required to deliver significant financial savings in both 2014/15 and 2015/16. Plans are in place to do this through improving efficiencies, service improvement and service transformation. The appointment of a dedicated project manager to lead the implementation of major change will enable the increased delivery of transformational change. The Trust is commitment to delivering savings without a detrimental impact on the quality and safety of services and this is requiring a renewed focus on the delivery of financial savings.

Section 2 Quality Plans

The quality strategy underpins the Trust's operational and strategic objectives. The quality priorities pull together the needs required to improve services as identified from within the Trust, as well as reflecting the national priorities and those from the LHE. They are founded on keeping patients safe, delivering high quality healthcare and ensuring that patients receive a positive experience at the Trust.

This section explains how the Trust's quality strategy is developed, what its quality priorities are and how they are governed. Into this the following areas are explained:

- Quality Assurance;
- The Trust's response to recommendations from the Francis, Berwick, Keogh and Cavendish reports and the National Quality Board (NQB) Human Factors Concordat;
- The national and local commissioning priorities;
- The Trust's quality priorities;
- Workforce Plans for delivering quality priorities;
- Quality priorities from regulators; and
- Quality risks and mitigations.

Quality Assurance

The Board of Directors is focused on the quality of services and is assured that quality governance is subject to rigorous challenge. This is achieved through Non-Executive Director engagement and chairmanship of the key Board-level committees. The Director of Nursing and Quality is supported by the Medical Director as executive lead for quality governance. The Board receives a Patient Safety and Quality Report monthly, in which areas of good practice, issues of concern, and performance against quality metrics are reported.

The Board also reviews specific examples of patient feedback, both positive and negative, at each meeting, with a view to learning from this and ensuring that appropriate action is taken to safeguard quality and improve the patient experience. A detailed Patient Safety, Effectiveness and Experience report is presented to the Board each quarter. The Board has revised its Quality Committee to scrutinise clinical and quality governance across the organisation, and to provide assurance to the Board on specifically designated areas of concern. In addition the Audit Committee will provide assurance on both clinical and non-clinical processes.

The Quality Committee meets every six weeks and receives reports on compliance against the Care Quality Commission's (CQC) Essential Standards, including details of the evidence supporting the stated level of compliance. The Committee is able to assure itself by scrutiny of the evidence in place that compliance is being maintained and, where gaps have been identified, that remedial action is being taken to attain or resume full compliance. The Committee also receives regular updates on the Trusts' CQC Intelligent Monitoring Report, so any movement in indicators can be tracked and assurance provided that deteriorations in performance are being managed appropriately. The Trust's Clinical Governance Committee, which is chaired by the Medical Director, reports to the Quality Committee by exception. The

Clinical Governance Committee has a robust reporting mechanism from the key clinical committees, while maintaining a strong focus on improving clinical based services and ensuring evidence based practice is the bedrock of clinical decision making.

The Finance and Performance Committee meets monthly and includes the detailed monitoring of all national and local performance targets within its remit. Many of these indicators contain quality components, for example CQUINs, infection control targets, the Cancer National Standards, Emergency Department Indicators, the National Stroke Strategy indicators, and levels of cancelled operations. In addition, the quality aspects of each CIP savings scheme identified are assessed by the Service Improvement Board, chaired by the Director of Operations to ensure patient safety and service quality are not compromised by the savings proposed.

The Board are continuously reviewing this process and identifying ways in which to strengthen it further.

The Trust's Response to National Reports

The Francis Report

The February 2013 Francis Report called for a "fundamental culture change" across the health and social care system to put patients first at all times. The Trust Board agreed to establish a Non-Executive Director led staff group to discuss the Francis Report and look at how it could ensure that its patient's best interests were always at the centre of its services. Twenty five members of staff met regularly during 2013 and made recommendations around the following sub-groups:

- putting patients first;
- a common culture;
- performance management and oversight;
- openness, transparency and candour;
- nursing;
- caring for the elderly; and
- leadership.

The Francis Report Review Group, reported back to the Trust Board on 12 March 2014. The Board accepted the report, with implementation of the recommendations to be overseen by the Quality Committee.

Many recommendations were made and the key ones are included in *Appendix 1: Key Sub-Group Recommendations.* Some are already in train, others are system wide proposals that cannot be implemented solely by the Trust. There were consistent themes from staff about what needs to be improved and what areas should be prioritised by the Trust. Simplifying the risk reporting system was identified by several groups as was the need for staff to receive timely feedback on the risks they report. A survey, carried out by the Group, identified that most staff would report a risk but there are some staff who would not feel comfortable doing so. There are recommendations around strengthening the NHS Constitution in all Trust documentation and taking a values-based approach to recruitment. There was strong support for the Trust's leadership development programme and other available leadership development resources and calls for more regular assessment of the cultural health of the organisation. Attention to clinical governance training and processes was recommended and there was a strong focus on improving aspects of care for older people; many detailed suggestions were made as to how this might be achieved.

In forming their views, the group took into account the Keogh Report, the Berwick Report and the

Government's response to the Francis Report.

The Berwick Report

The Berwick report made recommendations to make the NHS a safer place for patients, developing a culture that is dedicated to learning and improving, and that continually strives to reduce avoidable harm.

The main actions that the Trust has taken in response are as follows:

- **Named nurse and consultant above each patient's bed** – The Trust does do this, but not currently for every patient. This is being changed, with display boards to be added above every bed to be in place by July 2014.

- **The Trust carries out its own inspection regime** - this is carried out against the same criteria as the CQC's monitoring reports, focusing on: patient safety, experience, and whether services are effective, responsive and well-led.

- **NHS Safety Thermometer** – this is a point of care survey instrument that is used to provide a 'temperature check' on harm to patients. The Trust fully participates in the data collection for the safety thermometer for all inpatient ward areas. The information is reported at Trust Board and is also available to the public.

- **Never Events and Patient Safety Alerts** – NHS England sends out alerts on incidents that it identifies from its reporting system used to spot emerging patterns at a national level, and sends out appropriate guidance that can be developed locally to protect patients from harm. DCHFT takes these reports to the Trust Risk Committee for wider dissemination and for shared learning to take place.

- **Participation in Regional Patient Safety Events** – for example the Wessex Pressure Damage summit and patient safety events on falls prevention.

The Keogh Report

Following the Francis report, the Government asked Prof Sir Bruce Keogh, NHS Medical Director for England, to review services provided in 14 Hospital Trusts. The Trusts were chosen using national mortality figures, and the reviews focused on:

- mortality;
- patient experience;
- safety;
- workforce;
- clinical and operational effectiveness; and
- leadership and governance.

From these reviews, A Key Lines of Enquiry (KLOE) document was developed, which established the metrics to underpin the evaluation of services, in line with the areas identified above. It also reflects the new CQC inspection regime, which evaluates services for their effectiveness, safety, caring and responsiveness to patient's needs, and assesses whether services are well led.

The Trust uses the KLOE template to evaluate its own services and to identify areas in need of development. It is arranging with two other hospitals to provide inspections on each other's sites; in effect a tripartite mock inspection.

In addition the Trust has developed an inspection framework for Divisional Managers, which is based on the CQC framework to provide a real-time check of patient environments. The framework asks staff to evaluate the governance and leadership, clinical and operational effectiveness and explores the workforce

experience, patient experience and overall safety of services.

Triangulation of all quality, safety and experience metrics informs the Trust of any areas of exemplary service delivery, or areas in need of focused attention.

The Cavendish Review

As a result of the findings at Mid-Staffordshire NHS Trust, Camilla Cavendish was asked to perform a review of Health Care Assistants and support workers in both the NHS and social care. The review took place over 14 weeks and looked at recruitment, training, supervision, support and public confidence. It supported 18 recommendations, categorised into 4 key themes.

1. **Recruitment, training and education** - much of this supported the notion that Health Education England (HEE) should look at a 'certificate of fundamental care', although suggested that employers could look at the systems in place to support recruitment.

2. **Making caring a career** - a suggestion that the Nursing and Midwifery Council should make experience of caring a pre-requisite to nurse training, and employers should look at developmental pathways for people in caring professions.

3. **Getting the best out of people, leadership, supervision and support** - development of a 'certificate of fundamental care', and employers should also provide access to supervision.

4. **Time to care** - Employers should look to develop initiatives that provide staff with time to care, and review the pattern of 12 hour shifts.

The Trust's response to the recommendations is as follows:

- The Trust has worked in consultation with Health Education England 'Talent for Care' which specifically looks at the roles of staff at band 1-4, the skills essentially required for the roles and a career pathway structure.

- It is exploring alternative roles and functions that can be performed by other bands.

- It has implemented values based recruitment and incorporated the values of the Chief Nursing Officers 6C's into the interview process.

- Ward managers have identified health care assistants (HCAs) with exceptional qualities to become HCA supervisors. Interest was extremely high, and the group continues to develop the role further.

- The Trust is working with the HCA supervisors to develop a 'Code of Conduct' for all HCAs within DCH.

- The Trust is working with the Universities to explore the recruitment process into nurse training, to ensure that selection process reflects the values that the Trust requires.

National Quality Board (NQB) - Human Factors Concordat

The Trust has implemented Human Factors training into the organisation, following the guidance issued by the Institute for Innovation & Improvement, and investigations into never events and serious incidents. This has been supported locally by a Non Executive Director who is nationally recognised in the field of

Human Factors and is coordinated by the Education and Risk Management Departments.

Training has been delivered to newly qualified registered staff, through the Preceptorship Programme. It has also being rolled out to wider staff groups through dedicated training sessions, which incorporate the theory with practical scenarios. The Trust links with the Deanery, who deliver Human Factors education to trainee doctors, and the scenarios used with nurses and allied health professionals are reviewed during medical education sessions.

Investigations into Significant Risk Events, Serious Incidents and Never Events include a review of human factors, and this is commonly included in the investigation reports. The style of investigation report has recently been adopted by NHS England (South) as an exemplar for demonstrating investigative tools, including human factors, to other Trusts.

National and Local Commissioning Priorities

Dorset CCG Commissioning Priorities

The Trust's quality priorities, as explained in 3.4 are aligned to Dorset CCGs commissioning priorities for 2014/15, which are:

- Review and redesign urgent and emergency care services;
- Community services review; and
- Continued implementation of person centred and integrated care.

These commissioning priorities will lead to fundamental changes in how healthcare services are delivered in Dorset, and a large part of the Trust's strategic review and planning is based on them.

National Commissioning Priorities

The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to help the Trust to measure service performance, and to held account against them. Its focus is to look at how services perform across the healthcare system, and as such some of the indicators are shared with other providers in the LHE. The outcomes are split into five domains:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long term conditions;
- Helping people recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from harm.

Many of the quality indicators included within the domains form part of the Trust's quality priorities. They are also aligned with the Trust's Patient Safety and Quality scorecard, which is used to monitor the safety and effectiveness of patient care and the experience that they have in hospital.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of the income they give to providers to local quality improvements. CQUINS are issued by the local CCQ and specialised commissioners. From Dorset CCG, the CQUIN schemes for 2014/15 consist of three nationally mandated schemes and four locally agreed schemes as below:

National
- Friends and family test;
- Safety thermometer
- Dementia;

Local
- Admission (initial consultation within 14 hrs.);
- Admission avoidance (reducing admission for ambulatory conditions);
- Transfer discharge (reducing late transfers and discharges); and
- Delayed transfer of care (joint working between health care services).

The local schemes have been prioritised by the CCG to work towards reducing the emergency admissions into the acute sector, and further building on the ethos of providing care in the community through integrated care pathways. The CCG require all organisations to work in partnership to achieve the CQUINS with a strong focus on improving pathways of care for patients and breaking down institutional barriers. There is an inherent risk in this approach and, at the date of submission, the organisations within the LHE have not signed up to the proposed structure from the CCG.

There are a further four CQUINS from the Specialised Commissioners:

- Shared haemodialysis care;
- Breast milk in preterm infants;
- Retinopathy of prematurity screening; an
- IVIg panel referrals

The Trust is using the CQUIN frameworks to ensure its delivery against the targets. It has no current concerns about its ability to achieve them.

Trust Quality Priorities

The Trust has built up its quality priorities for 2014/15, based on the quality recommendations from national reports, commissioner and regulatory requirements and its own audit and assessment of the needs for service development. The Trust Board (March 2014), agreed to the following nine priorities. The plans to achieve them are currently being developed, and will be reported as part of the Trust's Quality Report, which is due to be presented to the Trust Board in May 2014. The priorities are:

- **Zero tolerance to Hospital Acquired Pressure Ulcers**

Pressure ulcers cause patients acute discomfort and can prolong their length of stay in hospital. There has been considerable work done in recent years to reduce the incidence of hospital acquired pressure ulcers. The rationale for keeping this priority into 2014/15, is that we believe further reduction is achievable by learning through the patient's experience.

- **Reducing harm to patients who fall in hospital**

Much work has been undertaken to prevent patients falling in hospital, and while this has led to improved awareness, the problem continues. The reasons for this are multifactorial and it is unlikely that falls can be totally prevented. However, reducing the levels of harm experienced by patients can be improved upon. For this reason we have included this critically important area in our priorities for 2014/15.

- **Improve access to clinics**

One of the areas that the Trust receives the most negative feedback on is access to clinics. There has been focused work to improve this in some specialties, which has led to greater satisfaction from

patients. Further improvements can be achieved by extending access and re-shaping clinic services across more specialties in 2014/15.

- **Management of diabetes as a co-morbidity to hospital admission**

The Trust has included care of patients with diabetes as a priority area for the last two years. Its inclusion for a third year is to improve the care of patients whose diabetes is a co-morbidity for their admission. Patients admitted with a primary diagnosis of unstable diabetes consistently receive the expert input required to support good diabetes management; those who present with diabetes as a co-morbidity factor are often not managed as effectively.

- **Improve the experience of carers of patients with Dementia**

The role carers play in supporting patients with dementia is critically important to both their loved one and to hospital staff. The Trust's rationale for including this priority is aligned to learning more about the strategies used by carers to support their loved ones, and thereby improve their experience while in hospital. The Trust also focuses on the needs of the carer while their relative is in hospital and through the discharge process.

- **All patients will be reviewed by a consultant within 14 hours of admission to hospital**

NHS Seven Day Working Forum has issued a set of clinical standards, one of which requires that all patients should receive senior clinical review within 14 hours of admission to hospital. Focusing on this priority will improve the safety of patients, improve patient flow and enhance the patient experience.

- **Zero tolerance to preventable cancelled operations due to equipment availability**

Cancellation of surgery is never undertaken lightly and much work has already been done to improve cancellation rates. Not all cancellations are preventable, but the Trust believes that no patient should be cancelled due to essential equipment being unavailable. The Trust has noted a growing trend of cancellations linked to lack of equipment and has developed a process map to prevent this.

- **Friends and Family test**

Patient feedback is vitally important to the Trust for gaining insights to improve services. The Trust has linked the Friends and Family test to the NICE standards for patient experience, and the national NHS WoW awards. Both have provided a platform to tell more people about patient's experiences. Focusing on this will further improve the engagement of patients in sharing their experiences, and extend the audience for the Trust to share this with.

- **Improve the effectiveness of discharge from hospital**

Effective discharge planning is vitally important to ensure the organisation uses its resources efficiently, and ensures patient safety continues when they leave the Trust's direct care. Timely discharge also helps to improve patient flow and satisfaction with their hospital experience. A particular focus in 2014/15 is on improving the timely availability of take home medications being available in a timely manner.

Workforce

The Trust has recently completed a workforce review in light of the national reports included in 3.2, its quality priorities and strategic options. The quality plans have specifically shape the following transformation recommendations, and will inform education and training programmes to result in a workforce that is flexible to support patients along extended care pathways.

Workforce developments need to address:

- the needs of an ageing population;
- provision of integrated services across a range of settings;
- sufficient staff with the right skills to continue to provide high quality services;
- culture of providing compassionate care is embedded across all services; and
- leadership capacity and capability is developed throughout the Trust.

- **Addressing the needs of an ageing population**

  The Trust is reviewing the skill mix of our clinical teams to enable it extend access to services across the length of the day and the week. The scope of Nurse Practitioners is being explored in some areas to improve the flow of patients and the continuity of care. The Trust's plans include developing the skills sets of front line staff to be able to support those patients with long term conditions and dementia.

- **Providing integrated services across a range of settings**

  More effectively managing the transition from hospital to community settings is providing The Trust's staff with opportunities to develop their skills across a range of settings. Rotational placements are being extended to nurses and doctors as part of the Trust's recruitment and career development strategy.

  The Trust is also contributing as an active partner in the Dorset 'Better Together' programme with its long term health and social care integration agenda focusing initially on rehabilitation and reablement services.

- **Ensuring sufficient staff with the right skills**

  The Trust has reduced vacancy levels to a minimum with a combination of effective local and overseas recruitment programmes, and efficient use of the internal nurse bank. This has allowed the Trust to take forward its plans to ensure that publicised staffing levels will give both the public and Trust staff a level of confidence in the quality of services. The recruitment strategy majors on the training and career development opportunities that The Trust can provide.

  Developing a reliable set of metrics to assure the Trust's commissioners that early warning indicators for staff shortages are in place will form part of our governance framework going forward.

- **Embedding a culture of compassionate care across all services**

  The most recent staff survey results showed an increase in the number of staff that would recommend the Trust as a place to work and for their family to be treated here. This is a positive endorsement of the work that has been undertaken to ensure the focus is on quality of care. The Trust has pioneered the use of the NICE patient feedback standards to categorise all patient feedback, and compassion is the category that consistently receives the highest feedback.

- **Developing leadership capacity and capability throughout the Trust**

  The Trust is committed to supporting leadership development which facilitates wider staff engagement. Plans include introducing a talent mapping framework for every individual occupying a band 7 or above, and every individual occupying a clinical leadership position. This will inform development plans at a Trust, service and individual level in the future.

  The Trust's leadership development programme focuses on service line management and staff are

also encouraged to participate in the range of programmes provided by the Leadership Academy.

Existing Quality Concerns

Care Quality Commission

The Trust's current CCQ status is registered in full without conditions. The CQC undertook an unannounced inspection over four days between 26th June and 2nd July 2013, reviewing eight essential standards, and covered a wide range of specialist areas over the four days.

The report contained many instances of excellent care witnessed by the inspectors and positive experiences by both staff and patients. However, the judgements reached by inspectors were that two standards met expectations, five identified moderate failings, and the Trust was served with enforcement action in relation to medicines management; specifically the safe storage of intravenous fluids and cold storage of medicines. A subsequent inspection against the Management of Medicines Standard was undertaken on 28th October 2013 by the CQC and the enforcement action lifted, detailing full compliance.

The assessment against the eight essential standards was as follows:

Essential Standard	Outcome	
Respecting and Involving people who use services	✓	Met this standard
Care and welfare of people who use services	x	Action needed
Meeting nutritional needs	✓	Met this standard
Management of medicines	x	Action needed
Staffing	x	Action needed
Supporting workers	x	Action needed
Assessing and monitoring quality of services	x	Action needed
Records	x	Action needed

An action plan was developed to capture and monitor the improvements required to ensure that the Trust is compliant with the CQC essential standards, and further improves the services it provides. This was approved by the November 2013 Trust Board. In the action plan, each standard has a nominated Executive Director with lead responsibility. Individual actions are owned by members of the Trust staff, who have specific responsibilities as part of their role or have been allocated responsibility for tasks aligned to their particular field of expertise. The leads are responsible for progressing and reporting against the required actions and for testing their compliance. Progress is monitored by the Senior Management Team on a monthly basis and on a bi monthly basis scrutinised by the Quality Committee. Progress towards compliance is reported to the Trust Board quarterly.The action plan is on target to resolve all the outstanding requirements by the end of June 2014.

The Medicines and Healthcare Products Regulatory Agency

The Medicines and Healthcare Products Regulatory Agency (MHRA) undertook a planned regulatory visit in February 2013. This review highlighted that a cease and desist notice could potentially be served, due to management failure to progress the actions previously identified as required to meet the MHRA standards. Throughout 2013/14, the MHRA have undertaken regular subsequent inspections and have reported on significant progress in meeting the required standards. The next inspection is anticipated in June 2014.

Quality Risks and Mitigations

The Trust's quality agenda is the basis for the development of many of its operational priorities and strategic principles. With quality plans forming such an important part of the Trust's Operational Plan it's essential to understanding the risks for achieving the main quality priorities.

The identified quality risks fall into three main categories:

- **Sustainability of services aligned to national standards** - The Trust is reviewing its clinical services to ensure that they are sustainable. A key area of concern continues to be the changes in junior doctor training, and the reduction in numbers coming to the Trust. The Trust is preparing for these changes by developing alternative roles, such as consultant midwives and surgical practitioners, and by working with Bournemouth University to develop the training that will be required to bridge this skills gap.

  Maintaining viable on-call rotas for some services is achieved through partnering with neighbouring acute providers, and the future of these arrangements is being considered as part of the Trust's Strategic Plan, as well as the need to achieve a critical mass of activity in certain specialisms.

- **Ability to recruit skilled staff -** Nationally there is difficulty in recruiting experienced nursing staff. The Trust has been successful with overseas recruitment, and is planning to do this again in the spring of 2014.The Trust has actively been working with Health Education England to explore how to increase commissions of nursing students in the area during the coming years, as well as exploring the reasons why people leave the nursing profession or do not complete their training programme. Rotational posts are being developed to provide recruits with an added incentive to apply at the Trust.

  The Trust is also developing a programme following the 'Talent for Care' initiative looking at the training and competence required for the bands 1-4 development. This recognises the need to explore new ways of working to mitigate the difficulties in recruiting experienced qualified nursing staff. The fundamental of this is that patients have access to the right person, with the right skills at the right time.

- **Increasing impact of the regulatory framework** – The challenge remains very real for a small DGH to continue to deliver all the required regulatory standards, and provide an internal assurance mechanism that ensures robust evidence of compliance. In addition, the increasing number of organisations that have enter and view rights, or the ability to undertake unannounced inspections, poses a logistical challenge for the Trust to manage both the inspections and the consequences of the action plans that may follow. Time spent on these areas is often time taken from patient care.

  The Trust is very focused on providing systems that allow for the collection of the information required by the regulators, and in response to national quality recommendations; ensuring that it can evidence its achievement of standards and quality priorities. The main difficulty is aligning paper and electronic records, to provide a single contemporaneous health record. The Trust is developing the use of its VitalPac clinical software system, and consolidating the paper records still required.

- **Clostridium Difficile target** – the target for 2014/15 is 22; the number for 2013/14 is anticipated to be 27. A robust framework is in place to undertake a root cause analysis for each case of Clostridium Difficile. This is then reviewed and signed off by the Infection Prevention Committee. The Risk Management Committee is responsible for ensuring that the learning from each incidence is embedded in the Trust.

Section 4 Operational Requirements and Capital

An assessment of expected activity levels

The Trust did not see significant movements in activity during 2013/14. In order to understand anticipated demand in 2014/15 an exercise has been undertaken using historic growth levels together with known future developments. This exercise has only highlighted growth in: ophthalmology; dermatology; critical care; and high dependency paediatrics. The table below highlights the key movements.

	2013/14 Growth (%)	2013/14 Activity	2014/15 Planned Growth (%)	2014/15 Planned Activity	2015/16 Planned Growth (%)	2015/16 Planned Activity
Elective	0.2%	84,242	(2.7%)	82,011	1.0%	82,831
Non Elective	(1.6%)	20,528	(0.3%)	20,461	-	20,461
Outpatients	(6.0%)	271,059	0.6%	272,679	0.9%	275,100
Emergency Department	(2.2%)	40,751	5.6%	43,046	-	43,046

Understanding expected activity levels, and being able to meet the peaks in demand, has been identified as one of the Trust's short term challenges. Planning to understand the expected volumes of activity over the next two years is explained in 2.1.1, which is based on referral trends and clinical knowledge of future service models.

Key risks to delivery and their mitigation:

- Not being able to recruit to Radiology and Dermatology, as explained in 2.2;
- Demand exceeding supply, the 5% contingency added to expected demand allows for some flexibility at marginal delivery costs. The monitoring of referral trends and the proactive approach taken in partnership with the CCG allows for early management when increases go beyond the agreed threshold;
- Expanding theatre capacity by the addition of an outpatient procedure suite; enabling groups of procedures currently undertaken in Day Surgery to be moved to an outpatient setting, expected to be in the region of 3,700 procedures pa; and
- Inability to reduce LOS for non-elective admissions, and to improve timely and effective discharge planning. Improving patient flow and working with the community discharge group will support this.

Section 5 Productivity, Efficiency and CIPs

Approach to Delivering Cost Improvement Plans

Historically the Trust has delivered its required level of Cost Improvement Plans (CIP) through a combination of cost cutting, improved productivity, efficiency gains and service improvement. The Trust will be required to deliver significant savings over the next two financial years. In order to do this, without a detrimental impact on the quality of services, the Trust is developing an increased focus on delivering savings through a service transformation approach. This will be achieved through both the delivery of the Trust's Clinical Services Strategy and the Pan Dorset Review currently being commissioned by Dorset CCG.

There is a significant risk to the Trust of Dorset CCG's Clinical Services Review not being implemented in time to make the savings required in 2014/15 and 2015/16, in order to achieve the Trust's original planned annual surplus of £700,000. The Trust has identified CIP plans for 2014/15 of £4.5 million and for 2015/16 of £4 million and as a result the Trust is planning a deficit position for both years.

Cost Improvement Plans have been identified through the business planning process and a scheme leader has been identified for each. The following table summarises the planned savings for 2014/15 and 2015/16.

CIP	**2014/15 Planned Saving - £m**	**2015/16 Planned Saving - £m**
Workforce Efficiencies	1.753	2.500
Clinical Supplies	0.754	0.500
Drugs	0.346	0.250
Clinical Pathway Redesign	0.508	-
Energy Efficiencies	0.150	0.100
Non Clinical Supplies	0.520	0.400
Technology	0.100	-
Revenue Generation	0.369	0.250
Total	4.5	4.000

Efficiency CIPs

These schemes cover the following areas:

- **Workforce efficiencies -** further reductions to workforce costs are planned through a review of consultant job plans, junior doctor bandings and developing network arrangements for services. The Trust will also focus on reducing spend on agency and locums, as well as managing vacancies more effectively and consistently. A task and finish group comprising clinical, finance and HR colleagues has been established to maximise the safety and efficiency benefits from the integrated Rostering and Bank systems. The Trust will use the comprehensive workforce information to assess the drivers for Bank and Agency demand and take appropriate action to capitalise on the substantive workforce rostering. This will include a rolling recruitment programme to address the demands created by anticipated staff turnover, long term sickness absence and parental leave**.**

- **Clinical supplies** – procurement savings through involving clinical input to limit the range of products used, and driving savings through robust price negotiation and contract management.

- **Drugs** - savings are planned on drugs expenditure through both reviewing with clinicians the range of drugs prescribed, and the implementation of an e-prescribing system.

- **Energy efficiencies –** this will be achieved through a renewed focus on energy utilisation and the investment in a combined heat plant.

- **Non clinical supplies** – procurement savings will be achieved through review of contracts relating to maintenance together with a review of the use of non clinical products.

- **Technology** – releasing savings through increased use of technology and a review of contracts relating to IT systems.

- **Revenue generation** - additional income is expected to be generated through commercial schemes including optical services and an increased offering of private healthcare services.

Transformational CIPs

Opportunities for transformational change, which will enable the sustained delivery of high quality and affordable services, have been identified through the Clinical Services Strategy, the Community Strategy and the focus on entering new markets and commercial opportunities. The Trust has invested in a dedicated strategic planning role to ensure that opportunities for entering new markets and expanding current markets are maximised. The main points are as follows:

Clinical Services Strategy

This has been developed through a sustainability review of all clinical services, under the following criteria:

- is the service part of the Trust's core portfolio;
- is the service profitable;
- can the service demonstrate and sustain quality;
- is the service able to reach an acceptable level of efficiency;
- does the service have a sustainable workforce;
- is the service able to meets its regulatory and legal obligations within budget, together with delivering national and local quality standards;
- does the service present an opportunity to increase market share or enter new markets; and
- is the service able to deliver twenty four hour emergency services seven days a week?

The output of this work has identified services that could be provided through a significantly different clinical model. The models identified are as follows:

- **Service delivery led and managed solely through the Trust** - these services have been defined as not being appropriate to run as part of a network model. However, opportunities to run them more efficiently or increase our market share have been identified.

- **Networked model** - services have been identified that could be provided through a network model with other trusts. For some of these services the Trust could be the centre hub, responsible for the leadership and delivery of a high quality, safe services and it would sub contract work to other

organisations in Dorset as part of a spoke to the hub.

- **Disinvest** - these are services which don't fit the evaluation criteria and therefore the Trust should consider ceasing.

The Trust has identified each of its services into the above categories, and is now working with the Dorset CCG and the Specialist Commissioning Group to look at developing these models further. Future work will include full financial modelling to ensure changes to service delivery support the Trust's long term financial sustainability; increasing income and adding value to the patient pathway. More detail will be included in the Trust's Strategic Plan.

Progress has already been made on a number of transformational projects including:

Pathology provision – a project has commenced to review the provision of the Trust's pathology services. The service is currently out to tender and it is anticipated that the contract will be awarded to an outside provider in September 2014, with the majority of the financial benefit being realised in 2015/16.

Private patients – a concentrated look at how the Trust can develop the culture of providing private healthcare is underway. This project will commence with an incremental increase in private healthcare services in 2014/15, and with more significant increases planned for 2015/16.

Community Strategy

A community strategy has been developed, which clearly identifies the priority areas for the Trust to enter into new markets. The basis of this strategy is to develop services that offer the opportunity to integrate patient pathways from the community, through the acute period of care and back into the community. It is anticipated that each of these additional services will achieve a number of qualitative and quantitative benefits to the patient and the Trust; reducing admissions and length of stay, improving the patient experience, supporting independence and self-management, and offer increased value for money.

Resource has been put into such corporate projects to ensure that opportunities are maximised and that the Trust can respond effectively and competently when competing for such work.

Two models currently being developed are:

- **Integrated model for the frail elderly** - 25% of the population of W Dorset is of retirement age and this population accounts for a significant proportion of emergency admissions and readmissions. This revised model will offer an integrated service, focusing on admission prevention.

- **Hospital at home –** the current Acute Care at Home model being provided for COPD will be evaluated when the pilot phase ends in March 2014. The initiative has saved 6 acute beds in the Trust. The Trust is discussing running this model fulltime with the CCG, and to include a frail elderly model to save an expected further 10-15 beds in the Trust.

Section 6 Income and Expenditure Position 2013/14 to 2015/16

The Trust anticipates delivering a surplus of £1.5 million, compared to the planned surplus of £700,000, in 2013/14. This position was achieved through the delivery of a £6 million CIP together with £850,000 additional non-recurring funding from Commissioners. The Trust is anticipating an income and expenditure position of a £900,000 deficit in 2014/15 and a £3 million deficit in 2015/16. These deficits reflect the Trust's inability to deliver the required level of CIP through Trust-wide schemes alone. However it anticipates that this position will be recovered in future years through the implementation of the Clinical Services Strategy, Community Strategy and the Pan Dorset Review. The table below summarises these figures:

	2013/14 Forecast Outturn £m	**2014/15 Plan £m**	**2015/16 Plan £m**
Commissioning Income	140.0	139.7	138.4
Other Income	12.9	11.4	11.8
Total Income	**152.9**	**151.1**	**150.2**
Employee Benefits	96.1	99.9	100.6
Non Pay Expenses	47.3	47.3	46.9
CIP/Revenue Generation	-	(4.5)	(4.0)
Total Expenses	**143.4**	**142.7**	**143.5**
EBITDA £m EBITDA %	9.3 6.10%	8.0 5.27%	6.3 4.21%
Non Operating Expenses	8.0	9.3	9.7
Surplus/(Deficit)	**1.5**	**(0.9)**	**(3.0)**

Income

The activity forecast included in section 4.1 underlines the commissioning contracts for 2014/15 and the plan for 2015/16. The majority of commissioning income for 2014/15 is on a flat cash basis, but it is anticipated that this will reduce by 1.5% in 2015/16.

The Trust has a number of commissioning contracts in place as follows:

- **Dorset CCG** - commissioning on behalf of the Dorset population. The majority of the Trust's income is from Dorset CCG. The basis of the contract with Dorset CCG is projected demand in 2014/15, funded at the national tariff. The activity, finance and performance schedules have been agreed with them, and it is anticipated that the contract will be signed soon. The following assumptions have been agreed with the Commissioners as to how the national rules will apply to the Trust's contract:

    - In order to manage the risk of demand increasing above the contracted level a risk sharing agreement is in place, which includes a threshold of tolerance and the application of marginal rates.

    - The national rules state that any emergency activity above the 2008/09 outturn (financial value) will be paid at 30% of the tariff value. The forecast financial value for 2014/15 remains below

2008/09 levels, and therefore marginal rates are not expected to be incurred in 2014/15 or 2015/16.

  - Readmission penalties of £1.5 million have been included within the contract value.

  - Contractual penalties will be applied if the Trust fails to deliver the targets for C Diff, cancer breaches, referral to treatment time delivery at specialty level and ambulance handover times in line with national guidance.

  - Additional funding of 2.5% can be earned under the Commissioning for Quality and Innovation scheme (CQUINs). National and local CQUINs have been agreed.

- **The Specialist Commissioning Group (SCG)** - for services that are commissioned on behalf of the National Commissioning Board (NCB). Contracts are held with the NCB which include specialist services, military work, prisons and dental. Outline financial agreements and performance schedules are agreed for 2014/15. However, there remains a risk as the SCG in Wessex are currently unable to sign final contracts due to their financial position. They are awaiting a regional and national review to resolve this.

- **Somerset CCG** - commissioning on behalf of the Somerset population. A contract has been agreed with Somerset CCG for 2014/15 based on the anticipated demand, which will be signed by mid April.

- **Local Authorities** - commissioning Public Health Services. Outline financial agreements and performance schedules are agreed for 2014/15 and it is anticipated that contracts will be signed by mid April.

The Trust is not anticipating significant movements in other income, with the exception of specific project funding received in 2014/15 on a non-recurring basis, where the corresponding costs will cease.

Costs

The process for identifying future year costs has been through the Trust's annual business planning framework which is predominantly activity and risk driven. It is anticipated that costs will increase by £5.2 million in 2014/15 and a further £5.2 million in 2015/16 as shown in the table below:

	2014/15 **Cost Increase - £m**	**2015/16** **Cost Increase - £m**
Inflation	4.0	5.2
Developments	0.6	-
Risks	0.6	-
Total	5.2	5.2

Assumptions made in the above cost increases are as follows:

- **Inflation** – pay inflation includes pay awards, incremental drift, clinical excellence awards and pensions. Non pay inflation includes the anticipated price increases on supplies, services and Clinical Negligence Scheme for Trusts (CNST), together with the increased cost of capital. The following inflation assumptions have been made in line with national guidance:

	2014/15 Cost Increase %	2015/16 Cost Increase %
Pay - Inflation	1.0%	1.0%
Pay – Incremental Drift	1.28%	1.28%
Pay - Pensions	-	0.7%
Non Pay	2.5%	2.9%
CNST	4.2%	-
Cost of Capital	12.2%	4.3%

- **Developments –** a number of developments have been included to enable the delivery of the planned activity in 2014/15. These include staffing for dermatology, cancer services and the implementation of seven day services.

- **Risks –** a number of new risks have been identified through the business planning cycle, including the management of safe staffing for high dependent patients and the risk of demand increasing beyond planned levels.

Information Management and Technology

The Trust has developed an outline IM&T Strategy to identify the priorities of moving towards an increased digital environment. Progress has been made against this including the appointment of a Chief Information Officer, the amalgamation of services to create a Health Informatics Function and the strengthening of governance arrangements. The Trust is in the process of developing a full IM&T Strategy to continue with this work. In 2013/14 the Trust was successful in securing funding through the NHS Technical Fund which will enable the following projects to be implemented in 2014/15: electronic prescribing and single clinical sign-on. The majority of costs for implementing the IM&T Strategy are included in the capital programme and there is a minimal impact on revenue.

Capital Plans

A capital programme has been set for the next two years to ensure there is a managed programme of capital investment based on a risk based approach which ensures the safety of the Trust's services. A detailed plan has been identified for the next three years which is line with the longer term five year plan previously highlighted.

The following table sets out the summary capital expenditure requirements along with the resources available in each year.

	2014/15 £000's	2015/16 £000's
Capital expenditure requirements	**7,265**	**5,000**
Internally generated funding		
- Funds from previous year	1,000	1,000

- Depreciation	6,400	6,832
- Surplus/(Deficit)	(900)	(3,000)
- **Less depreciation on donated assets**	(360)	(360)
Total Internally Generated Funds	**6,140**	**4,472**
Externally generated funding		
- Technical Fund	695	0
Total Externally Generated Funds	**695**	**0**
Total Funding	**6,835**	**4,472**
Excess/(Shortfall) in Funding **Funded from cash reserves**	**(430)**	**(528)**

The requirements for capital investment have been identified through the annual business planning process. The majority of funding is to be generated internally with external sources expected to be from:

- **The NHS Technology Fund** - £695,000 has been confirmed to be received in 2014/15. Should opportunities for further funding arise these will be pursued.

- **Energy Loans** - the Trust is working on a Combined Heat Plant(CHP) solution and external funding may be sought for this. No external funding sources for CHP have been included within the plans.

Capital investment is planned in each of the following areas:

- **Medical Equipment Replacement_**- in order to identify the required level of investment for replacing medical equipment a risk assessment has taken place on current medical equipment which assesses clinical priority and likelihood and consequence of failure. A total of £3.465 million of expenditure is planned on medical equipment replace in 2014/15 and £2.970 million in 2015/16.The Trust is planning to replace the CT scanner in 2014/15, and charitable funding has been agreed for this.

- **Estates Schemes** - investment in the estate is being made in order to ensure there is a suitably safe and well maintained estate. A total of £2.348 million of expenditure is planned on the estate in 2014/15 and £1.140 million in 2015/16. The key areas of investment in 2014/15 include the expansion of the Emergency Department; refurbishment of day theatres; enablement work for a second CT scanner and general maintenance of the estate.

- **Information Technology - i**n line with the Trust's IM&T Strategy, investment is planned on IT that moves the Trust towards a digital environment. Funding of £695,000 received through the NHS Technical Fund has enabled a number of projects to commence in 2014/15, the most significant being the implementation of electronic prescribing. A total of £1.452 million is planned to be invested in ICT in 2014/15 and a further £890,000 in 2015/16.

Liquidity

The Trust has updated its liquidity strategy in 2013/14 to ensure the continuous improvement of the cash position, while supporting the capital investment programme. The Trust has a loan of £4.6 million from the Foundation Trust Finance Facility (FTFF), which is due to be repaid in March 2016. It is anticipated that the loan will be extended beyond this point and this is currently being negotiated with the FTFF.

The planned deficit position will be managed by delaying repayment of the loan, reducing capital expenditure in 2015/16 and utilising existing cash balances.

The table below highlights the opening and closing cash position.

	2013/14 £million	**2014/15 £million**	**2015/16 £million**
Opening Cash Balance	10.2	8.5	6.8
Closing Cash Balance	8.5	6.8	4.9
Liquidity Days	22	17	13

Risk and Mitigations

Continuity of Service Risk Rating

The Trust is planning to achieve a minimum Continuity of Service Risk Rating of 3 in each of the next two financial years. The table below highlights the key figures within the risk rating.

	2014/15	**2015/16**
Liquidity Ratio Value	2.1	(2.4)
Risk Rating	4	3
Capital Servicing Cover Value	2.55	1.99
Risk Rating	4	3
Overall continuity of service risk rating	4	3

Key Financial Risks

The key financial risks for 2014/15 and 2015/16 together with the associated mitigating actions have been evaluated and are highlighted in the table overleaf.

Key Risk	Mitigation and Management
Maintaining safe services whilst delivering significant savings	Governance arrangements for CIP to be reviewed
Delivering sufficient CIP to meet the financial challenges	Review CIP approach
Dorset wide sustainability solution not being implemented quick enough	Continue to work with Dorset CCG
Admissions not reducing in line with the assumptions made in the Integrated Care project resulting in demand exceeding capacity	Participation in the project
Managing demands on our services	Work with Commissioners
Contractual penalties	Contract monitoring arrangements in place
High usage of temporary locum and agency staff due to recruitment difficulties	Controls and governance
Achievement of RTT targets at specialty level	Contract monitoring arrangements in place
Ability of commissioners to pay for activity levels	Risk sharing arrangements in place
Achievement of CQUIN delivery targets	Contract monitoring arrangements in place

Downside Modelling

The Trust has undertaken financial modelling of the downside risks inherent within its plan for 2014/15 and 2015/16.

For 2014/15 the Trust believes its income levels are secure and has therefore focussed on expenditure risks, especially the delivery of CIP savings targets and control of agency/locum staffing expenditure. The downside scenario in the plan assumes the Trust underperforms against its CIP target for 2014/15 by £1 million and incurs an additional £0.5 million of agency staffing costs in excess of the plan for the year. The Trust is reviewing the governance of its CIP and the management of agency staffing to ensure these risks are minimised as far as possible. However, there is limited mitigation that the Trust can implement in the short term should these downside risks occur.

The impact of these risks is that they would reduce the income available for capital investment and the cash available for liquidity. Therefore the Trust's Continuity of Service Risk Rating would reduce for 2014/15 to 3 (from the plan rating of 4).

For 2015/16 the implementation of the Better Care Fund could significantly reduce the Trust's income from emergency admissions, whilst having only a limited impact on operating costs. Therefore the downside

scenario in the plan assumes the Trust loses 10% of its income for emergency admissions (amounting to approximately £3.3 million). In addition, a £1 million shortfall in CIP savings and £0.5 million of additional agency costs are included (as for 2014/15). In mitigation, the Trust has assumed that it would be able to reduce staffing and non-pay costs by £2.4 million as a result of the reduced level of emergency admissions. In order to reduce the impact on the Trust's cash position a reduction of £1.5 million in capital expenditure for 2015/16 has also been included. The Trust is actively involved in the Integrated Care Fund project to ensure this risk does not materialise.

As for 2014/15, the impact of these risks would reduce the income available for capital investment and the cash available for liquidity in 2015/16. Therefore the Trust's Continuity of Service Risk Rating would reduce for 2015/16 to 2 (from the plan rating of 3).

Appendix 1: Francis Report - Key Sub-Group Recommendations.

Below is a list of all key sub-group recommendations, compiled in December 2013

- the ethos of putting the patient first is explicit and prominent in all key documentation;
- the expectations of staff, as detailed in the NHS Constitution, are explicit in the Trust's staff charter and job descriptions;
- a values-based recruitment framework is developed and implemented;
- strengthen core element of the leadership development programme to include NHS Constitution and values and their application in practice;
- include reference to the requirement to abide by professional and management codes of conduct within job descriptions and contracts of employment;
- develop a simplified risk event reporting form and ensure feedback to reporter on the outcome of the risk event;
- quarterly Board oversight of safe staffing levels;
- clearer name badges or lanyards and identification of named consultant and nurse responsible for each patient;
- regular assessment using cultural barometers to assess the cultural health of the organisation and individual teams;
- divisional governance meetings to be multidisciplinary;
- better quality appraisal informed by peer review;
- review of Health Care Support Worker role particularly in regards to recording observations;
- review the "Being Open" policy to ensure it is accessible, up to date and unambiguous and that staff are trained in using it;
- publish Board statement regarding standards of care expected within the Trust (use Trust Vision or a new statement from the Board). Include reminder guidance on what to do if standards are not being met;
- promote and embed understanding of CQC standards and Provider Compliance Assessments (PCAs) through the Trust, measuring compliance and being open about gaps/risks and actions;
- explore the value of 360^{o} Personal Development Reviews (PDRs) for all staff groups;
- improve the nutritional care and fluid balance of elderly people by implementing a protocol/care bundle for delivering and monitoring of beverages, meals and supplementary nutrition and hydration;

- introduce weekly, multi-disciplinary case conferences in all wards with elderly patients. Case conferences should be actively supported by consultants with proven knowledge and skills in multi-disciplinary case conferencing to enhance patient care.

  The multi-disciplinary case conference should also actively include contribution from Health Care Assistants and Domestics who are core members of the ward team;

- all staff should actively seek out relatives when they are visiting (or helping with care) to update them with accurate information about their relative. To aid this, multi-disciplinary notes should be adopted by all wards;

- all medical staff, particularly junior medical staff and elderly care nurses, should have training in recognition and management of delirium;

- specialist care/advice for patients with dementing illnesses and their relatives should be available 24/7 from the Care of the Elderly/Elderly Psychiatry Services;

- ensure drugs rounds are protected to ensure that drugs are physically ingested and given at correct times;

- all staff should feel able and be encouraged to identify with ward mangers occasions when poor care of elderly patients is observed;

- ensure all staff are aware of and trained in their responsibilities for clinical governance;

- all divisions must be able to demonstrate robust clinical governance processes; this should be subject to peer review and audit for assurance;

- ensure all senior managers have a personal development plan that includes leadership training;

- invite mock CQC/peer review internal visits from neighbouring Trusts as a commitment to continuous quality improvement;

- continue the service improvement/leadership training delivered in the Trust. Promote and create opportunities for staff to access programmes and establish a network to support staff engaged in leadership development. Identify the minimum leadership requirements of posts/roles and ensure that post holders have access to and take up training and that their leadership competence is assessed and maintained;

- the Board adopts a common code of ethics, standards and conduct;

- the Risk Management Committee asked to consider the need for a systemic review of current clinical governance structures throughout the Trust and make a recommendation to the Clinical Governance Committee;

- ensure a highly visible senior nursing team so that patients and their relatives are able to identify who to escalate concerns to;

- targeted staff surveys to understand morale (barometer survey);

- ensure job descriptions incorporate the values of the Chief Nursing Officer's six Cs (care, compassion, courage, communication, competence, commitment) and that values-based recruitment supports the process;

- reintroduce ward teaching sessions between morning and afternoon shifts (share between area by utilising a link nurse and involve F1s to promote team working);

- make customer care training mandatory;

- support, promote and maintain the role of supervisory sister with key objectives of monitoring and improving patient's quality and safety;

- ensure appropriate and safe staffing levels by:

  - continued daily reviewing of staff levels underpinned by two yearly dependency audits;

  - visible and transparent reporting of each ward/department quality indicators;

- education must be invested in e.g. McKinsey projects; utilising link nurses on the ward and involving F1s in teaching. Supported development of support staff (bands 1-4), which includes basic nursing care;

- improved ward teaching sessions e.g. Pharmacy;

- promote the duty of candour within the nursing profession;

- a clear performance framework aligned to national, contractual and local performance metrics; and

- dissemination of performance metrics through divisional structures.