Musgrove Park Hospital

Operational Plan 2014-16

Taunton and Somerset NHS Foundation Trust

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	**3 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)*	**Rosalinde Wyke**

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Jo Cubbon**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**David Hobdey**

Signature

Contents

Executive Summary

Taunton and Somerset NHS Foundation Trust faces significant challenges in the next two years. The population served by the Trust is getting larger and proportionately older. As a result, demand for services is increasing, particularly for emergency care, theatres and critical care. Patients, commissioners and government rightly expect these services to be delivered to the highest quality, and mandatory service standards have increased over recent years.

These pressures are challenging across the whole NHS, but are particularly difficult for acute Trusts like this one, serving a relatively small and geographically disparate population. The present NHS financial environment further exacerbates the challenge. For the year 2013/14 the Trust expects to post a deficit of £1.9m, excluding impairments, due to an under-achievement of its cost improvement plan. This reflects the growing challenge in finding genuine new cost improvements within the organisation which do not impact on clinical staffing levels or the quality of hospital care. It is also a consequence of the Trust receiving more complex emergency patient activity for which the national tariff rule of paying at 30% for activity above the 2008/09 baseline leaves the Trust with a loss, equivalent to £4m.

At the time of writing, the Trust is still in negotiations with its main commissioner, Somerset Clinical Commissioning Group (CCG) and with its main Specialist Clinical Commissioner over the contract for 2014/15. Based on the CCG's current proposal for 2014/15, the Trust's savings plan will need to be £13.0m to achieve a Continuity of Service (CoS) rating of 3. The Trust has developed an ambitious savings programme in response to this challenge. Whilst a significant proportion of this can be delivered independently of other organisations, approximately £3m of the savings programme is predicated on reducing the number of beds in the hospital. This will only be achieved by reducing lengths of stay and avoiding unnecessary acute admissions. This in turn will require a wider system response to ensure that alternatives to acute admission are maintained and developed along with continued access to a wide range of community services to ensure timely discharge of patients to community facilities and home.

The scale of savings required again in 2015/16 will be similar at £12.3m. The Trust does not believe savings at this level will be deliverable in 2015/16 without more radical options which can be implemented across the wider health system to target cost improvements. The Trust is therefore progressing more detailed discussions with other acute providers to test opportunities for major savings from greater integration, potentially leading to new forms of organisation. These opportunities will need to reflect the rural and geographically dispersed nature of the population served by the Trust to ensure that access to high quality services is not compromised. The work started in 2013 with the Royal Devon and Exeter NHS Foundation Trust provides a platform on which to develop new solutions to deliver clinically and financially sustainable services.

The Trust also believes that the cost base of the Trust and the underlying pressures faced by it are a symptom of wider health system configuration, which has led to the Trust having a disproportionately large share of the emergency market in comparison to elective activity. The Trust will continue to work with the CCG in developing new ideas for significant cost reductions which will be considered within a system wide acute services review in 2014.

During the next two years there are also other pressures which are more specific to the Trust. The first is the need to replace the hospital's Electronic Patient Record (EPR) system installed in 2007 as part of the national IT programme and funded centrally. The Trust has agreed an investment in a new EPR system with IMS. During 2014/15 the priority for the Trust will be to replicate the functionality of the current system to allow a trouble free transition to IMS by October 2015, when the BT Cerner contract ends. Investment has been agreed by the Trust to develop the system's functionality in subsequent phases to include a new clinical portal, e-prescribing and clinical notation. Whilst this presents a short term pressure on finances, it will have the potential to significantly improve patient safety and efficiency in the medium term.

Similar issues affect the Trust's estate. Many of the Trust's buildings are old and require costly ongoing maintenance. In 2014 the Trust opened a new 112 bed Jubilee Building to replace parts of the old hospital. Major challenges remain however, including the need to find a long term solution for the replacement of critical care and theatres which are based in 70 year old 'temporary' WWII accommodation. These challenges and opportunities are considered in more detail in the rest of this plan.

The Trust has opportunities for attracting new income for elective services currently being commissioned from neighbouring hospitals. It is actively bidding for new orthopaedic contract work in the Bridgwater area. Increasing the share of elective work is crucial to ensure an appropriate balance between elective and emergency work, effectively allowing elective income to subsidise important urgent and emergency services.

Overall the Trust continues to demonstrate high levels of patient safety and clinical quality, as recently evidenced by a Care Quality Commission (CQC) inspection in 2013. The Plan sets out how the Trust intends to maintain this focus over the next 2 years whilst addressing the growing financial challenge. One of the Trust's actions in this regard is its participation in the government's "Sign Up To Safety" initiative. The Trust has been invited to spearhead the initiative as one of 12 Trust's nationwide playing this leading role. "Sign Up To Safety" will involve five important elements in continuing to improve patient safety – putting safety first, continually learning, involving people in improving safety, working with partner organisations and supporting staff. Being at the forefront of this initiative will mean benefits for patients, and will also give the Trust the chance to work closely with others in sharing good practice.

These and other plans are set out in this document, and include a set of objectives to achieve the Trust's identified strategic aims and vision. The Trust's clinical strategy is outlined in this document, showing what initiatives are to be put in place across elective, acute, cancer, paediatric, maternity and frail elderly services to meet the challenges ahead. These include the enacting of a frail elderly strategy to align pathways to specific patient group need, the opening of new high quality surgical ward facilities to increase attractiveness compared to competitors, and working closer with partner organisations to streamline patient pathways The overall aim of this document is to set out the Trust's response to short-term pressures, in the context of ensuring the long-term sustainability of the organisation.

There is still a great deal of uncertainty over how national policy changes will impact on the Trust in the coming years. The NHS England publication, Everyone Counts (2013) sets out a vision for concentrating specialist services into 15 to 30 centres. As the Trust receives over £42m income for specialised services, with most being provided as an integral part of the secondary care service, how this policy is implemented will be critical to the Trust's future configuration. The Trust is now awaiting the release of a consultation document from NHS England in May 2014 which sets out proposals for the south west. The Trust will then initiate more detailed discussions with the Area Team to ensure any proposed commissioning changes are evidence based and protect future access to specialised services for the population served by the Trust. Similarly the same document refers to 'between 40 and 70 major emergency centres' and the policy aim of delivering 24/7 standards. Each policy will have a significant cost, with a disproportional impact on smaller rural acute providers, such as Taunton and Somerset. Greater clarity is urgently required on these policy changes so that their respective impacts can be assessed on the Trust's longer term financial and clinical sustainability. The assessments currently undertaken by the Trust suggest that without more radical reconfiguration of acute services across the population, the ambitions contained within Everyone Counts will not be affordable to the local health economy.

1. Short term challenge

Taunton and Somerset NHS Foundation Trust provides district general hospital services to a population of 350,000, with a wider catchment of 500,000 for a range of more specialist services. Like most acute providers, it now faces the most significant challenge in working within the local health system to design a model of acute care that is both clinically and financially viable in the longer term. This Plan looks at the planning environment for the Trust and describes the challenges arising from demographic trends, financial constraints, the need for changes in clinical services to meet new standards and the need to change the way staff will need to work in future to meet patient expectations and quality standards.

With the publication of recent national planning documents, summarised in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', a number of assumptions over the future model of acute care have been challenged. Everyone Counts indicates the future designation of 40 to 70 hospitals as major emergency centres, and by definition others as having a more supporting role in urgent care. It also indicates the concentration of specialist services in 15 to 30 centres. The outcome of these two policy initiatives will have a major impact on the shape of acute hospital services within Somerset and could directly affect the Trust's own vision as a provider of emergency care. Until there is greater clarity over how these issues will be interpreted and implemented in rural communities like Somerset, the Trust will by necessity be planning in an uncertain environment.

This Plan covering the two years 2014/15 to 2015/16 will describe the Trust's current thinking of the environment and how this may change in response to the issues described above. It will also refer to the potential strategic responses the Trust is considering over its future organisational form to respond to the challenges ahead.

Whilst this section refers to the short term challenge, this cannot be articulated without reference to the longer term planning environment. The scale of transformational change that will be required and the potential implications of this will require a period of detailed planning to be undertaken in partnership with the Trust's commissioners and other local providers. The greatest challenge in the short term therefore will be to ensure that the Trust can progress the essential changes required to meet commissioner activity and quality requirements whilst meeting its financial duties.

Each of the environmental challenges is described in this section. The Trust's operational response to them is described in subsequent sections of this Plan.

1.1. Demographic challenges

The demographic pressures affecting the local health economy (LHE) present challenges that are anticipated to grow in the medium to long term as the population grows and ages. These pressures inform strategic planning assumptions for both service transformation and capital investment. (A detailed Trust compendium of demographic and epidemiological and market analysis data has been developed to inform and support the Trust's longer term service ambitions).

Somerset has an older population, and a higher life expectancy, than the England average. An ageing population will present health challenges to the Trust and the LHE as it will to the country, but they will perhaps be more keenly felt in this LHE than elsewhere in England.

The population is growing overall, with increasing net migration, particularly of older people. The proportion of people aged 75 and over is expected to increase by 28% (to 73,000) between 2013 and 2021, representing 13% of Somerset's population. This will be accompanied by a slight decline in the working age population.

Such an increase in older people will have an impact on many health services, and poses particular challenges for services disproportionately used by older people, such as theatres, critical care, and pathways around long-term conditions, dementia and complex co-morbidities. Survey evidence suggests that the majority of people aged over 65 have two or more long term conditions, and the majority of over 75 year olds report having three or more. Trust figures indicate a rise of 40% in patients admitted with dementia between the period 2009/10 to 2011/12 and a 35% increase in admissions from nursing homes. The King's Fund reports that in the last 20 years there has been a 300% increase in elective surgical admissions in the 85+ population. As living into old age becomes more common, the trend in older people requiring hospital services will continue to increase.

Demographic pressures are creating year on year increases in emergency care demand, particularly patients with higher levels of acuity. The Trust has also seen an increase in emergency activity, proportionately higher than other hospitals in the LHE. Although this may be partially explained by the expanded cardiology service, the Trust's trauma status and helipad, opened in 2010, it also indicates a strategic shift in emergency volumes within the catchment, equivalent to 850 additional spells (identified within 'Analysis of contributing factors behind observed increases in [unscheduled] emergency admissions', NHS Somerset 2012).

The tariff regime restricting payment on additional ED presentations above 2008/09 levels to 30% of full tariff is being felt particularly keenly as a result of such activity, especially given that alternative treatment routes have not been developed within the LHE to an extent which fully offsets the increased demand. Such developments are outside of the direct control of the Trust, but it is the Trust which is financially disadvantaged by the tariff reduction.

Current growth rates in acute medical and elderly care patients indicate a shortfall in acute beds, rising to around 70 by 2018. Current funding and wider financial arrangements do not provide the Trust with sufficient income to generate surpluses to use for capital investment in additional facilities. Thus it will be a challenge to accommodate increased volumes of patients using hospital services. The solution clearly rests in developing capacity outside the hospital, which is central to the Trust's plans for avoiding admissions and speeding up discharges by adopting new clinical pathways of care, particularly for the frail elderly.

1.2 Clinical quality challenges

The Trust recognises the increased emphasis on meeting and monitoring clinical quality, in the wake of the Francis, Keogh and Berwick reports and as part of its responsibilities as a Foundation Trust. As well as the Trust's own relentless drive to improve the quality of care patients receive, there have been several externally mandated quality standard increases which represent new challenges.

There has been an increase in the development of minimum clinical standards for services. These are important to maintain consistent standards of care across the country, and the Trust supports their development. They often specify the provision of certain types of care, or the presence of consultants around the clock. Meeting such high standards in a small hospital means managing higher unit costs, and given that

standards are required to be the same in the biggest teaching hospital as in the smallest District General Hospital, those delivering services from smaller hospitals face larger challenges in delivering care to high national standards.

The Trust has identified the impact of meeting standards for its services in such areas as in emergency medicine, acute medicine, obstetrics and gynaecology, paediatrics, vascular surgery, interventional radiology and trauma. Meeting them at Musgrove Park Hospital will require at least another three consultant appointments in the ED (increasing the establishment from 7 to 10), and four consultant appointments in acute medicine (increasing from 6 to 10). In neonatal medicine, the Trust will need to increase middle grade cover by 3 whole time equivalents. In all cases, such increased staffing costs will not come with additional income gained through additional commissioned activity. These 'input' standards cannot be delivered by the Trust within current resources. The Trust is therefore looking at opportunities for how services could be better integrated across larger populations so that greater economies of scale can be generated to allow for these standards to be achieved.

There will also be challenges connected to increased 7 day working. The introduction of more 7 day services is another quality improvement which the Trust supports and which it will strive to deliver. The Trust has invested in consultant cover to boost 7 day services, but this has not yet extended to a whole range of diagnostic services, therapies, pharmacy, and theatre staff. If the Trust is expected to run a 7 day a week service across all these services, this will present significantly higher costs to cover similar patient demand levels as seen within 5 days. The Trust looks forward to working with fellow providers across the LHE to create a system which works for all services in Somerset throughout the week, recognising the financial burden that increased 7 day working will present. This issue is central to the Keogh review of Urgent and Emergency Care Centres. Services must be rationalised to allow designated centres to have the critical mass to meet 24/7 standards.

In certain specialties, the trend towards greater subspecialisation will create additional pressures on the Trust's ability to maintain and improve performance against operational and quality standards. This is due to the reduced level of flexibility within specialties, some of which may have a single or dual operator for a particular procedure/treatment or diagnostic test to respond to fluctuations in demand. Small variations in demand for such services can cause disproportionate impacts on access times. Creating larger critical mass would help to reduce such occurrences, and this presents opportunities for changes across the LHE. However, as with all such changes, patient choice and competition must be balanced with the need to maintain service quality and the financial viability of individual providers.

1.3 Financial sustainability challenges

i. Context

The NHS as a whole is facing unprecedented financial sustainability challenges. In July 2013 the Department of Health announced in 'A Call to Action' a potential funding gap in the NHS of £30 billion. This is translated for providers into an efficiency savings requirement of 4% per annum for the two years of this plan 2014/15 and 2015/16. Monitor indicates that there will be continuing deflations in tariff income for provider organisations in future years, at a time when demography is causing demand to increase, and when staffing costs are increasing in many areas due to increased quality standards.

Current tariffs do not meet the real costs of emergency care, which is effectively subsidised by income from elective activity. The risk of some or all of this elective income being lost to competition is significant. Removal of elective activity will mean that the Trust's financial viability is severely compromised.

Greater competition from the independent sector could reduce market share in elective care, outpatients, diagnostics and ambulatory care which would lead to a reduction in the contribution to overheads of providing 24/7 emergency cover in key specialties.

The challenge is exemplified by the Trust's orthopaedic services. Traditionally, the Trust has supplemented trauma services, also funded only at 30% above 2008/09 levels, by undertaking a full range of elective orthopaedic procedures. However, competition from providers new to the market has altered this model. New providers exclude complex elective or trauma patients, focusing on high volumes of low-cost simple procedures. Between 2011/12 and 2012/13, one local independent competitor increased the volume of its simple orthopaedic surgical procedures from 183 to 773. Almost all of those patients would previously have had their treatment at Musgrove Park Hospital, providing the hospital with income to subsidise more complex work which the competitor has no obligation (or wish) to provide. This income stream has now been removed, leaving the Trust with the high cost cases and the hospital infrastructure's overheads to maintain in order to serve the community as a trauma unit. In March 2014 the Trust opened its new 112 single room ward building (Jubilee) which will offer facilities as good, if not better, than any private provider and with the back-up of 24/7 critical care back up services. Together with low waiting times and excellent patient quality, this will help attract patients back.

These and other challenges are impacting the Trust's underlying financial position, which has deteriorated during 2013/14, as summarised below:

	2011/12 Audited Accounts £'m	**2012/13 Audited Accounts £'m**	**2013/14 Forecast Outturn £'m**	**2014/15 Plan £'m**	**2015/16 Plan £'m**
Income	244.6	256.3	250.1	252.4	248.5
Net surplus/(deficit)*	2.2	3.4	(1.9)	0.6	0.6

**stated before accounting for property impairment.*

A shortfall in achieving planned savings is the principal cause of weaker financial performance in the current year, with non-recurrent solutions largely masking a shortfall in recurrent savings of around £6.2m. This, in combination with above inflationary cost pressures in a number of areas and a base efficiency requirement of 4.0%, will lead to the requirement for a recurrent savings programme of £13.0m in 2014/15 and £12.3m for 2015/16. These plans remain subject to finalisation of agreements with the Trust's principal commissioner (Somerset CCG) and with the Specialist Commissioning Group.

Prior to 2013/14 the Trust reported satisfactory performance in the achievement of challenging Cost Improvement Programme (CIP) targets. Substantially weaker performance in the current year reflects the significant challenge of continuing to squeeze further efficiency gains in the absence of major change to care pathways across the wider LHE. The Trust's reference cost index is 98, which confirms a better than average overall efficiency and highlights the challenge of driving efficiency

substantially higher. Key factors that will continue to drive an above average CIP requirement for the Trust are:

- the disproportionate impact on the Trust of the continuing 30% tariff for emergency care volumes above historic levels, which is estimated to represent approximately £4m per annum in lost income to the Trust (the Trust has an above average skew of activity in favour of emergency activity relative to elective work);

- higher than inflationary cost pressures in major areas of expenditure, including a higher insurance premium (Clinical Negligence Scheme for Trusts). In 2014/15 the CNST premium will increase by 16% over the previous year – an increase of almost £1m. Increasing CQC fees and the impact of the Better Care Fund may also be significant. The Government has announced the transfer of funding from the NHS to Social Care with the equivalent value of £3.8bn by 2015/16. This is equivalent to a figure of £38m for Somerset CCG, of which a proportion is anticipated to come from a reduction in expenditure on acute care. The Trust is playing an active part in shaping plans for the Better Care Fund in Somerset and looks forward to continuing discussions about how this fund will be managed and how the impact on existing services will be mitigated across the LHE.

At the date of writing, the Trust has assembled an ambitious cost improvement plan for 2014/15, amounting to £12.3m. At the core of this are plans to reduce the hospital's bed capacity and improve theatre efficiency, although there are risks attached to these plans given the Trust's existing strong theatre productivity and length of stay performance, (with plans generally aimed at moving the Trust from upper quartile to upper decile performance, as referred to in further detail below). To preserve financial sustainability and operation at a Continuity of Service (CoS) rating of at least 3, the balance of the savings requirement for 2014/15 is likely to be met through a combination of:

- the identification of further CIP schemes (during the early part of 2014/15), which will build upon existing plans;
- non-recurrent means (e.g. one-off actions aimed at improving the Trust's liquidity position);
- finalisation of contract terms with Somerset CCG, which will be aimed at avoiding activity levels currently budgeted in excess of 2013/14 levels, for which additional funding cannot be identified. This may include the re-basing of A&E activity levels.

Although the Trust's financial plans provide for the preservation of a CoS rating of at least 3, projections show the Trust's cash balances falling from £19.2m at the end of 2013/14 to £10.8m at the end of 2014/15 and to £9.8m at the end of 2015/16. This position will impact the ability of the Trust to undertake any significant capital replacement and investment. The Trust's existing capital expenditure plans are relatively modest (£14.99m in 2014/15, which includes the cost of the final stages of completing the Trust's new Jubilee Building, falling to £9.6m in 2015/16) and heavily reliant on the Trust's existing cash reserves; the Long Term Financial Model currently excludes funding for any major capital schemes, including Theatres, HDU/ITU, Maternity and Paediatrics (all of which occupy ageing and deteriorating parts of the Trust's estate, with high maintenance needs). (See section 10).

The Trust's financial plans include contingency reserves of £2m and there is headroom in the plans equivalent to a deterioration in the net income and expenditure account

position of £2.1m for the year ending 31 March 2015 and £2.4m across the two years ending 31 March 2016 before the Trust's projected CoS rating declines from 3 to 2.

ii. Productivity

Recent analysis of relative productivity shows that the Trust has relatively high levels of operational efficiency. For length of stay, it has the 3rd lowest for elective spells out of 17 hospitals in the south west and 4th lowest for emergency spells.

There are however opportunities for further reductions in length of stay in areas such as general medical specialties. By reaching upper decile performance for acute medicine and care of the elderly, the Trust would be able to identify a reduction of 27 acute medical beds. This is in comparison to South Devon which benefits from an integrated model of acute and community care, demonstrating the need for whole systems thinking to achieve greater levels of efficiency.

The Trust has identified other areas for improvement such as in reducing avoidable readmissions. This has been prioritised in 2013/14 and is already seeing a tangible improvement in the Trust's position relative to other Trusts nationally (currently 42nd out of 161) (Source: Albatross system)

Reducing length of stay and avoiding admissions will be the Trust's priority toward reducing the hospital's bed base over the next year. This will require actions to improve operational efficiency within the hospital as well as integrated actions to ensure faster discharge into community hospitals by aligning incentives across the health economy. Community hospitals have the potential to help deliver more efficient pathways by reducing lengths of stay in acute hospitals. It is important that community hospitals and the Trust look to improve the potential for pathway optimisation wherever possible.

Beyond this saving the opportunity for more significant bed reductions will depend on the health system's ability to transform patient pathways to create alternatives to acute admission through improved primary care out of hours and weekend cover, improved domiciliary and social care and more flexible use of community care, including redesigning the contribution of the 13 community hospitals in Somerset to patient flow improvements.

iii. Partnerships

The policy drivers outlined in NHS England's Everyone Counts regarding emergency care and specialist services will require a larger population solution to provide improved economies of scale. Only through increased scale will further investments to meet higher standards be affordable. During 2013/14 the Trust has been working with the Royal Devon and Exeter NHS Foundation Trust (RD&E) to explore ways of improving the financial and clinical sustainability of a range of clinical services through closer integrated models. New ways of working across a range of service opportunities are being tested to reduce costs across the two catchments or provide critical mass to sustain services against higher commissioner standards. Opportunities for shared services for supporting functions, e.g. IM&T, finance, HR and procurement are also being explored.

At this stage many of the clinical changes have been small scale to resolve specific sub speciality issues such as the spinal service on call rota across the two counties. There is a growing acceptance that, in light of the challenges facing both organisations in the future, the scale and pace of these changes will need to increase. The Trust has

agreed to explore further with RD&E the potential for more substantial changes which may only be facilitated though a different organisational form. The potential options for reconfiguring services will be tested as part of the Acute Services Review being commissioned by Somerset CCG jointly with provider Trusts in Somerset. A similar exercise is to be undertaken in Devon to look at how organisations may look at achieving sustainability through new integrated models.

The Trust has also expressed an interest in exploring an opportunity to provide a more sustainable solution for acute care to the population of North Somerset, currently provided by Weston Area Healthcare Trust. It is not known at this stage whether this will be through a competitive market testing process or another form of support. Any decision to proceed with a transaction of this scale will be subject to the appropriate legal, financial and competition requirements and would need to demonstrate benefit not only for the services provided to patients in North Somerset, but to the patients already served by the Trust.

iv. IT

The Trust's patient administration system is currently funded through the national programme for IT. This contract ends in October 2015 when the Trust will be required to purchase an Electronic Patient Record from its own funds.

Extensive work has been undertaken to identify a preferred supplier of a new Electronic Patient Record (EPR) system. The Trust has confirmed IMS as its preferred supplier and approved a Full Business Case for investment in March 2014. The first phase of investment will replace Cerner functionality. This will require implementation of a new Patient Administration System (PAS), theatres, A&E and reporting modules with the aim of transition in May 2015. Subsequent phases will then be managed on an individual case by case basis to ensure the cost benefits are realised at each stage. This reflects the learning undertaken through the procurement period where there was insufficient evidence that new whole system EPR systems had delivered the level of clinical and financial benefits that had been predicted in their investment cases.

1.4. Workforce challenges

The Trust is subject to nationally determined contracts and Terms & Conditions for staff which leave little flexibility for local determination of pay, new ways of reward and recognition or developing a more flexible workforce.

There has however been significant effort made in 2013/14 to develop new ways of rewarding and recognising staff achievement within the framework of existing terms and conditions. These will be rolled out over the coming year, in parallel with changes to be made at a national level on matters such as automatic incremental pay progression, wider changes to the Agenda for Change contract and changes to the consultant contract. Local changes have included the development of a new system of appraisal which has made incremental progression dependent on the achievement of values-based performance targets. This will be rolled-out from October 2014.

Consultant and other doctor pay represents £47m of the Trust's total budget of around £260m. Pay levels and excellence awards are defined nationally and not directly linked to the Trust's own delivery of priorities. National renegotiation of medical contracts may help, but until those negotiations are finalised there is little that can be done locally within the LHE to address this issue.

The financial challenges faced by the Trust will have a significant workforce impact. Meeting the efficiency targets required of the Trust means a reduction of 200 whole time equivalent posts every year. Directorates have been charged with identifying savings schemes and to specifically note the impact of these schemes on staff numbers. All of the Trust's wider efforts to reconfigure front-line and back-office services look to promote efficiency in staffing, but it remains a significant challenge to meet required standards and targets in a period of reducing posts.

The Trust and LHE partners face further pressures in the recruitment of staff required to keep services running in the event of vacancies.

There is a shortage of newly qualified staff nurses due to the loss of a Somerset-based training provider. The Trust is attempting to boost nurse recruitment by pro-active measures such as holding open days, and working closely with training universities at Plymouth and Bristol, but recruitment remains a concern. Scientific and technical staff recruitment is difficult due to external competition from organisations offering more flexible (and sometimes preferable) terms and conditions. Key consultant appointments are difficult in some specialties due to a national shortage in areas such as histopathology, stroke and emergency medicine.

For future sustainability, Trusts will need to look at more flexible HR models which optimise scarce resources, potentially over a wider population. The Trust looks forward to engaging with the CCG and LHE partners in this regard.

1.5. Estate challenges

The urgent short term challenges described above sit alongside estates challenges which, whilst manageable into the short term, nonetheless have an impact on service quality today which will become more pressing into the future.

A third of hospital buildings on the Musgrove Park Hospital site need replacement. Currently these have high backlog maintenance and energy costs whilst offering poor and inflexible clinical space. The Trust's current priorities include replacement of the Old Building theatres and ITU / HDU, all of which have serious issues relating to the age and construction of flat roofed buildings, including water damage, air handling and electricity supply. The anticipated cost of replacement is £25m. In addition, the maternity and paediatric units are also based in 70 year old 'temporary' accommodation.

Developing new facilities for these services would represent a very large cumulative deficit against the Trust's available cash over the next 5 years. There are currently no alternative financial options available to the Trust, e.g. lease, PF2, as these will require long term financing on a static income base, due to the nature of the schemes i.e. predominantly replacing existing facilities. The Trust is therefore looking to mitigate as many of the risks associated with poor and aged accommodation through a 'make do and mend' strategy.

Many capital schemes are also facing planning difficulties due to uncertainties related to the future shape of the LHE. For instance, modelling critical care bed demand is difficult whilst it is unclear how large the Trust's future catchment population will be following potential future reconfigurations. The Keogh Review and NHS England guidance indicates future reductions in centres for specialist and emergency care. The Trust currently provides both such types of service, and has been modelling future capital requirements on assumptions which will now change. Until further detail is provided, it is challenging to make certain predictions and plan accordingly.

More detailed information on the risks associated with the Trust's estate and the shortage of funding required to undertake the required level of investment is included in section 10.

1.6 Commissioner strategy and plans

The Trust's main commissioner is Somerset CCG who commission over 90% of non-specialist care from the Trust. This represents around 70% of all clinical income received by the Trust. The Trust also provides services to Devon, Dorset and North Somerset CCGs. Approximately 18%, or £40m of the Trust's income comes from a contract with NHS England for specialist services.

Somerset CCG has made clear its outline priorities for the coming year in the document entitled "Commissioning Intentions for Foundation Trusts 2014/15" and in its emerging 5 year commissioning strategy. The emerging commissioning strategy was presented to other stakeholders at the end of January 2014 and sets out priorities for the coming years.

The CCG has identified four emerging strategic themes – Health and Wellbeing, Person Centred Care, Urgent and Acute Care, and Sustainable and High Quality Services. It has set out a strategic statement and a series of aspirations underneath each theme. The theme of most relevance to the Trust is Urgent and Acute Care, where the CCG has made specific mention of the following important next steps:

- A review of the benefits of 7 day working, with implementation of revised working arrangements where improvements are necessary.
- Better support for people with complex care needs, particularly the frail elderly, through the reconfiguration of the urgent care system.
- The development of major emergency centres for those with the most serious or life threatening conditions, following a review of need.
- A programme to review acute services based on a strategic overview of the opportunities and risks inherent in services.

The Trust has developed its own future strategy with reference to these commissioner priorities. As demonstrated below, the key strands of Trust development in future years will include 7 day working enhancements, development of services for frail elderly and patients with complex needs, and a focus on better emergency care. Like the CCG, the Trust has identified opportunities and risks across many of its service lines and is taking them forward as appropriate.

The Trust will look to play a significant role in the review of acute services, particularly in regards to the establishment of a Major Emergency Centre for Somerset. Major Emergency Centres are a key proposal from the Keogh Review, and the Trust is well placed to assume this important role in the future. The Trust has invested in the hospital's emergency department (ED) in 2013 to provide new capacity for resuscitation and major cases. At this stage it is not clear as to how the policy initiative will be interpreted in Somerset to reflect local circumstances, in particular travel distances and times. A recent study showed that patients in West Somerset had the second average longest journey distance to an ED in England. This will be considered as part of the Somerset Acute Review, commissioned by the CCG and provider organisations. The Trust is also exploring alternative approaches to deliver the required standards over a

larger population as part of the project commenced with Royal Devon and Exeter NHS Foundation Trust.

In addition to the above, the CCG identifies many QIPP (Quality, Innovation, Productivity and Prevention) schemes which it is progressing, many of which are similar to the Trust's own areas of improvement work. For instance, there are identified QIPP schemes for dementia, falls prevention, end of life care and stroke, all of which are services which the hospital has also been working to improve.

The CCG is considering the future shape of the hyper-acute stroke service for Somerset. The Trust has submitted a proposal to provide a county wide service to ensure sufficient critical mass to allow the level of investment to meet the highest standards of care. A decision is expected from the CCG by October 2014.

A key commissioner-led development is the opening of the new Bridgwater Community Hospital on 1 April 2014. The Trust will continue to provide a range of outpatient services to the population out of the new hospital, however, the costs of the facility will increase significantly with the opening of the new building, adding to cost pressures faced by the Trust in maintaining the same levels of activity. The new Bridgwater Community Hospital will also include a new endoscopy unit. This will be rented by the Trust to provide the flexible sigmoidoscopy screening service, to be funded as part of the national programme.

The CCG has also led on two competitive tender exercises for services delivered from the new Bridgwater Community Hospital – ambulatory care and orthopaedics services. The Trust decided not to bid to provide ambulatory care services due to uncertainty surrounding the scope of the work. However, a bid to provide orthopaedic services was completed and the tender process is ongoing. If successful, the Trust anticipates a small net increase in referrals from this population. The facilities now available in the Jubilee Building mean that Musgrove Park Hospital offers the best environment for patients in the region. In addition, maintaining and increasing elective income means that more subsidy can be provided to the loss-making emergency services that are vital to the community and provided by no other local provider. As the market for elective procedures grows, the risk of a growing imbalance between elective and emergency procedures is not just a risk for the Trust, but for the sustainability of services across the LHE. In order to preserve a functioning emergency service under current commissioning and financial arrangements, there must be an appropriate level of elective activity undertaken by the Trust.

2. Responding to challenges over the next two years

Having identified the key challenges, articulated in the previous section, the Trust's operational plans look to manage them over the next two years. Some operational plans are the beginnings of transformational change which will serve the Trust's resident population into the future. Others manage resources to keep services running now whilst alternative pathways are developed for the longer term.

2.1. Trust response to challenges

The Trust is clear in its vision and goals. A series of core objectives sit beneath them, feeding plans for improvement within individual directorates and services. The work of the Trust will support the stated aims of commissioners, sustaining and developing quality services for the local people.

i. Vision, strategic goals and short term objectives

The Trust's vision is:

"To be an exemplary provider of healthcare, supporting patients in and out of hospital"

There are four strategic goals to help achieve this vision. They are:

1) Musgrove Park Hospital (MPH) will provide the highest quality, safe and consistent clinical services 24/7.

2) MPH will become the lead provider of emergency and urgent care services, coordinating the best care for patients throughout their care in and out of hospital

3) MPH will seek to develop a clinically and financially sustainable model of acute hospital services across Somerset and neighbouring counties in partnership with health and social care organisations

4) MPH will achieve excellent performance through an engaged and inspired workforce

The Trust also has outlined its objectives over the next 2 years which look to provide a framework to achieve not only the strategic goals but also the relevant stated objectives of the CCG and NHS England. They are:

1) To ensure that the Trust at all times puts patients first, complies with all fundamental standards and fosters an open and transparent culture from clinical areas to the Board.

2) To make the most effective use of the experience, skills and talent in the workforce to meet the demands of the changing NHS environment, including working flexibly across seven days.

3) To enhance the Trust's operational and financial capability to drive improvement.

4) To develop robust capital plans in partnership with commissioners for replacing and enhancing key clinical services.

5) To progress the development of the Electronic Patient Record (EPR) as an enabler of transformational change and managing patient information and supporting patient pathways.

6) To develop the Trust's strategic response to Weston, in light of plans by the Trust Development Authority (TDA) to examine alternative provider models.

7) To co-lead a programme of transformational change with all health and social care partners to create a sustainable financial and clinical model of services across Somerset.

8) To increase capacity and scope in core services to meet new commissioner requirements and deliver sustainable services.

There is a Board-level action plan which describes the actions required to deliver each of the above goals, together with risks, key performance indicators and how each links to Trust's four strategic aims. Those key actions are summarised in the table below in terms of broad areas of focus. There is also an explanation of the reason why each core objective has been identified and how achieving it will take the Trust closer to achieving its strategic goals:

Core Objective	**How will achieving the Objective help the Trust achieve its strategic goal?**	**Areas of focus in 2014/15 and 15/16**
1. To ensure that the Trust at all times puts patients first, complies with all fundamental standards and fosters an open and transparent culture from clinical areas to the Board.	In order to be a lead provider of care, patients must want to choose the Trust and be confident in MPH's ability to provide safe and effective care. This is especially true for patient groups traditionally under-served and/or with growing needs. At the same time, staff must be confident that there is a supportive culture where safety and respect are paramount.	Delivery of all actions arising from CQC visit in late 2013 (set out in Appendix 1). Review of compliance against new 24/7 standards as proposed in NHS England review 2013 and consideration of the impact of these standards on the acute model of care across Somerset as part of the Acute Service Review. Development of clear clinical metrics and robust delivery and monitoring process. Management of high consequence falls and pressure ulcers. Improvements for patients with dementia. Active improvements to culture of openness.
2. To make the most effective use of the experience, skills and talent in the workforce to meet the demands of the changing NHS environment, including working flexibly across seven days.	The NHS is facing major challenges which will require radical changes in the way services are delivered. Engaged and empowered staff are essential in making these changes at pace. An explicit goal of the Trust is to ensure that the highest quality is maintained throughout the day and night and throughout the week. Ensuring flexibility amongst the workforce will help to achieve this. In turn, a more flexible workforce will be more efficient and allow for improved financial sustainability which	Enhancements to Trust Organisational Development activity. New values-based recruitment / performance review. Revision to pay and reward (including clinical excellence). Review of job plans and reduction in SPA time. Changes required to facilitate 7 day working. Standard operating procedures to encourage flexibility across clinical areas. Roll-out of real-time pulse checks.

Core Objective	How will achieving the Objective help the Trust achieve its strategic goal?	Areas of focus in 2014/15 and 15/16
	will, in turn, strengthen the ability of the Trust to meet future challenges.	
3. To enhance the Trust's operational and financial capability to drive improvement.	There is growing difficulty in achieving Cost Improvement Plans year on year. As a result, the Trust's goal of ensuring financial sustainability is threatened. Better capability in these areas will equip the Trust to maintain its status and improve its services.	Robust monitoring of Trust's internal Performance Assurance Framework targets. Strengthened role of corporate services as business partners to operational management, facilitated by improved management accounting and extension of SLR at individual patient level and infrastructure improvements, including integration of payroll and ESR, inventory management and other increased automation of routine processes. Increased focus on good commercial practices.
4. To develop robust capital plans in partnership with commissioners for replacing and enhancing key clinical services.	Poor quality buildings, equipment and facilities threaten the achievement of all of the Trust's goals. Not only does the environment compromise excellent patient experience, but it also affects efficient and flexible use of staff. Old buildings are also inherently inefficient due to the age and condition of infrastructure and do not allow efficient adjacency of facilities for optimal patient care. The scale of the financial challenges ahead mean that the Trust will not have the necessary funds required to undertake important developments, unless they are part of a system wide solution with full commissioner support.	Development of business cases to replace WWII era buildings and seek wider system support for recognition of the need for investment and in turn changes to acute service configuration to make this financially viable. Undertake high risk backlog maintenance in Old Building. Explore opportunities for redesigning maternity services across Somerset to enable appropriate investment in improved facilities.
5. To progress the development of the Electronic Patient Record (EPR) as an enabler of transformational change and managing patient information and supporting patient pathways.	EPR is a safer, more efficient and better way of managing patient records. It is popular with patients and staff, allowing for quicker and easier information sharing and providing patients with better information should they require it. There is also significant partnership working and innovation potential, using IT	Introduction of new EPR system by October 2015. Work closer with RD&E regarding joint IT procurement of an EPR system, ideally to act as shared platform for subsequent change. Further use of EPRO software to provide digital solution for handovers and discharge summaries.

Core Objective	How will achieving the Objective help the Trust achieve its strategic goal?	Areas of focus in 2014/15 and 15/16
	to link primary and secondary care and act to support direct patient access to hospital systems such as bookings.	Nursing, midwifery and therapy staff to move to “paper-light” working.
6. To develop the Trust’s strategic response to Weston, in light of plans by the Trust Development Authority (TDA) to examine alternative provider models.	The Trust’s place in a re-designed LHE is crucial to its continuance as a lead provider. The changes in Weston may have a significant impact on clinical models, emergency care delivery and staff (particularly support staff where efficiencies are possible). Managing the strategic response to this opportunity will be very important to maximise potential benefits to improve critical mass across a larger population.	Develop high quality response to TDA’s market testing approach, and test against strategic ambitions of the Trust to ensure any extended role adds value to the population served.
7. To co-lead a programme of transformational change with all health and social care partners to create a sustainable financial and clinical model of services across Somerset.	The scale of the financial challenge is such that increasing operational efficiency will be insufficient to meet the challenge of financial sustainability over the long term. As well as this, changing demography, technology and expectations mean that traditional service delivery will require new models of working both at clinical service and organisational level.	Support the review and implementation of Somerset-wide transformation priorities including establishment of Better Care Fund. Progress reduction of bed base. Streamline elective care pathway (improvement project). Explore greater integration opportunities with other providers. Develop and implement frail elderly strategy. Develop plans to become a Major Emergency Centre for Somerset.
8. To increase capacity and scope in core services to meet new commissioner requirements and deliver sustainable services.	There are immediate concerns in a number of specialties due to higher demand forecasts or changes in commissioner requirements which the Trust must respond to in 2014/15. The costs of these have been included in the financial plans and income assumptions built into contracts with commissioners.	Develop hyper-acute stroke service subject to CCG business case decision. Develop pathways to support earlier discharge. Develop new elective orthopaedic pathways for Bridgwater (subject to award of contract). Manage transfer of services from old to new Bridgwater Community Hospital. Develop business case for increasing radiotherapy capacity.

Core Objective	How will achieving the Objective help the Trust achieve its strategic goal?	Areas of focus in 2014/15 and 15/16
		Manage transfer of arterial patients from North Devon to MPH as part of specialist commissioner plans to centralise services. Respond to opportunities for emergency care arising from the Keogh review.

ii. Clinical strategy

The first six objectives above are perhaps best described as enabling schemes, helping to provide support to Trust services to work better in the future. These enabling schemes, concerned with financial sustainability, supporting infrastructure and the shape of the LHE, are the framework on which service development rests.

The final two objectives are more service-based, ensuring that quality of patient provision develops even in challenging times.

They are concerned with transformational change, and in increasing the capacity and scope of services to deliver high quality in the future. It is these two objectives which have inspired the Trust's clinical strategy – MPH's clinical quality response to the challenges it faces.

The clinical strategy continues the clear thread running from commissioners to the Trust as an organisation, and down into individual service lines. The Trust's vision, goals and objectives stem from those set out by commissioners. The Trust's clinical strategy focuses on the Trust's final two objectives and sets out how individual service lines will work in the future.

The clinical strategy looks forward five years and more, because both the Trust and its commissioners have medium and long term ambitions as well as short term goals. This document is concerned only with the operational initiatives for 2014/15 and 2015/16, and they are outlined below. Longer term initiatives from the clinical strategy are set out in the Trust's Strategic Plan return, submitted to Monitor in June 2014.

Operationally over the next two years, the clinical strategy has been defined in relation to 6 key service lines:

- Frail Elderly
- Paediatrics
- Acute Care
- Elective Care
- Maternity
- Cancer

A series of goals have been set in relation to these service lines, which will help to meet the challenges faced by the Trust and the LHE, and which will improve the quality of services in a way which lays the foundations for more strategic developments into the future. Each goal has a series of initiatives associated with it which are being progressed. Taken together, these initiatives present a summary of the key operational responses that the Trust is making to its challenges in the next two years.

The goals and initiatives are as follows:

Service Line	Goal	Initiatives
Frail Elderly	To redesign frail elderly pathways in partnership with other providers and CCG, which meets aspirations of commissioners for reduced dependency on acute admissions and acute inpatient stays.	• To progress implementation of aspects of Frail Elderly Strategy (to be agreed early 2014). • To influence the acute service review to develop a sustainable model of services for frail elderly for Somerset making optimal use of non-hospital services where this can lead to a reduction in overall cost by removing higher costs associated with acute admission. • To close acute hospital beds through internal improvements in operating procedures, triage assessment, ongoing management of patients and discharge arrangements to meet contribution towards CIP requirements in 2014/15. • To become the lead provider for the total pathway based on the expertise developed in frail elderly and long term condition to support vertically integrated models of care. • To align the service models with the aspirations of the Better Care Fund supported by Somerset County Council and Somerset CCG to recognise the need for integrated health and social care models, which make net overall financial saving.
Paediatrics	To develop alternatives to hospital admission to enable a reduction in the number of beds required for the catchment population to provide flexible options for offering services to a wider catchment population, including North Somerset, or enable an overall downsizing in the facilities required reducing net cost of service to the two commissioners.	• To extend the pilot in the Paediatric department for admission avoidance schemes within Taunton Federation and consider potential expansion based on evidence. • To explore new models of greater integration with other providers including cross cover arrangements and out of hours cover to reduce overall cost in Somerset.
	To develop new models for supporting GPs to successfully manage paediatric care through the extension of advice and guidance to a wider catchment population and alternative models of provision in GP practices where these can be provided at sufficient scale and economy.	• Pilot schemes in one Federation and test for ability to scale up service

Service Line	Goal	Initiatives
Acute Care	To work with Somerset CCG and other providers in developing a model of sustainable acute care in line with the recommendations of the Urgent and Emergency Care Services Review 2013.	• To undertake a gap analysis of current services against new standards as defined for Major Emergency Centres. • To develop a transition plan to meet the standards, including improved consultant cover within a wider framework that recognises financial constraints on investment and takes into account the impact of standards on other local providers, including Yeovil District Hospital NHS Foundation Trust. • To develop an integrated plan to meet the Keogh recommendations which are owned by the wider health community. • To review the opportunity for ceasing to provide neuro-rehabilitation on the MPH site by working in collaboration with an alternative provider to provide enhanced care for the Somerset population, thereby releasing bed capacity for acute medicine • To explore the potential for creating a new MAU / SAU within MPH through the use of existing wards in Duchess building to provide an integrated unit that can optimise patient pathways and has the capacity required to meet anticipated growth in demand for acute admissions from the Somerset and potentially North Somerset population (linked to releasing other bed capacity as above). • To review all emergency acute services against the 7 day working week requirements and prioritise any additional investment to meet the essential standards of a Major Emergency Centre. • To seek an integration of out of hours services with the ED through partnership working with commissioners in the specification to create a combined 'Primary Care ED front door' allowing triage and appropriate streaming 24/7 and reducing the impact of non-appropriate patients on ED performance.
	To develop stroke service for Somerset with a hyper acute base at MPH and enhance services for early supported discharge in the community (dependent on Somerset CCG Business Case – October 2014).	• To maintain quality and access standards of existing services. Identify additional resources to deliver service to wider population to ensure rapid implementation of change once agreed by commissioners.

Service Line	Goal	Initiatives
	To explore opportunities arising from the potential acquisition of Weston Hospital to increase critical mass for a range of acute services e.g. cardiology, gastroenterology, to provide greater resilience and cost effectiveness providing services to a wider catchment with enhance local facilities to the population of North Somerset.	• To respond to the Trust Development Authority's (TDA) approach to seek alternative organisational options for Weston Area Health Trust, once known. To continue to provide support in specific service areas to Weston.
Elective Care	To drive productivity improvements in the existing theatre capacity on the MPH site, reducing costs whilst maintaining existing activity levels.	• To maximise the potential flexible use of operating facilities at weekends where this is safe and economic to do. To be progressed through the 7 day working action group to provide detailed analysis of cost benefit analysis for a range of emergency and elective service extensions to working week.
	To develop county-wide services for a range of smaller specialities where critical mass is imperative for future sustainability, including ophthalmology, ENT and dermatology.	• To influence commissioners through the input to the acute service review to describe the benefits of greater integration and network models of care across the county, both for clinical and financial impact.
	To extend the Trust's market share of orthopaedic services.	• To succeed in the bidding process for Bridgwater orthopaedic contract and establish capacity to meet higher activity levels from Bridgwater population and wider catchment. • To promote the new elective care facilities available at MPH, including the Jubilee build with 112 en-suite single rooms to attract patients away from using other AQP providers.
	To maintain a range of specialist services provided at MPH where the Trust can demonstrate the higher standards and where these services can be provided within tariff.	• To critically appraise the viability of specialist services within the new policy framework to be developed by specialist commissioners. • To extend joint programme with RD&E to develop integrated models of care serving both Devon and Somerset populations in areas such as head & neck, urology and gynae-oncology thereby maintaining local access to services for populations.
Maternity	To provide a balance of obstetric and midwife led services across the county that provides choice and local access where appropriate, whilst still maintaining critical mass within	• Transfer existing midwife-led unit into new Bridgwater Community Hospital and test longer-term clinical and financial sustainability in partnership with commissioners.

Service Line	Goal	Initiatives
	the main obstetric unit.	• Explore opportunities arising from greater partnership / integration with Weston Hospital for maximising the use of the midwife-led unit at Weston. • Review continuation of neonatal service as part of specialist commissioner's strategic review and proposal for reduced number of providers. Trust to assess implications of policy directive once greater clarity is known and action accordingly as part of wider networked solution
	To enhance the existing facilities for maternity at MPH to provide a short to medium term solution with an enhanced environment for delivery and post-natal.	• Complete initial Phase 1 building works in delivery rooms and (dependent on Department of Health funding) progress to Phase 2 delivery rooms. • Develop case for extension of building works to post natal ward.
Cancer	Negotiate agreement for flexible use of Beacon Centre to reduce overall overhead costs and make most effective use of available capacity through flexible out of hours working.	• To agree and sign a contract variation with Taunton Linac Company for extending operating hours of linear accelerators. • To respond to wider 7/7 working arrangements across the Trust to offer weekend services when appropriate.
	Develop longer term plan for ensuring ability to meet Specialist Commissioner requirements for all cancer services, including cancer site surgery, working in partnership with RD&E to provide local flexible solutions.	• To develop options for additional capacity to enable refresh programme of LINACs in 2018/19, linked to potential hub and spoke models for cancer care. • To develop plans for ensuring sustainable specific cancer site surgery in partnership with RD&E.

iii. Quality goals (from the Trust's Quality Account)

As well as operational service goals which will increase quality in a changing environment for the LHE, there are also specific quality goals to which the Trust is working. The Trust's quality goals are outlined in its Quality Account for 2014/15. There are seven in total. The areas of patient care which they cover are as follows:

- **Patient flow, right place, right time, reducing internal transfers**
  Patients will receive more timely care and have a better experience if they are cared for on the most appropriate ward for their condition, and if they are treated in a timescale which meets Referral to Treatment (RTT) targets. It is also recognised that patients stay longer in hospital if they are transferred between wards for non-clinical reasons (i.e. to create additional bed space for new patients). The Trust wants to minimise the number of transfers for non-clinical reasons and the number of patients cared for on the 'wrong' ward (outliers).

- **Visibility of Ward Staffing**
  Strong links between patient acuity and dependency, workload, staffing and quality have been established in recent years. Evidence in the literature now links low staffing levels and skill mix ratios to poor patient outcomes. The Trust wants to ensure that it has the right staff, with the right skills and in the right place. This will involve the introduction of real-time, whole hospital visibility of actual staffing levels using the Safer Nursing Tool. This approach will enable the Trust to critique and evidence arrangements for nurse staffing and safe patient care. It also contributes in a dynamic way to the debate for new roles such as assistant practitioners, volunteers and apprentices.

- **Patient Safety (Infection Control)**
  The Trust wants to ensure a safe environment where patients feel assured regarding infection prevention and control practices whilst in hospital. The Trust's Board and Council of Governors' have asked for this to remain a priority and our commissioners have set some expectations – 0 cases of MRSA, and continuing to meet the national trajectory for C.difficile. Where cases do occur, there will be thorough investigation and appropriate action to ensure that they do not occur again.

- **Discharge**
  Although the principles of discharging patients from hospital have not changed over many years, the process and pace of discharge planning has changed beyond all recognition. NHS resources provide for an increasingly ageing population, the needs of which are sometimes complex. From a patient experience/safety perspective there is a reduced risk of complications if the patient can be discharged in a timely manner. There is also a recognised correlation between timely discharge planning, length of stay and bed occupancy. The Trust will make the most efficient use of bed stock, streamline patient pathways and by doing so make discharge pathways more efficient. There is work ongoing across the hospital to reduce lengths of stay which will further contribute to discharge improvements.

- **Patient Safety (Falls, Pressure Ulcers)**
  Musgrove Park Hospital is striving to provide 'harm free care'. Hospital acquired falls, pressure ulcers, infections and new thrombosis are all examples of sub-optimal care causing harm to patients. Over 200,000 patients every year experience one of these harms, leading to avoidable suffering and additional treatments for patients at a cost to the NHS of more than £400million. The goal in the Quality Account is to continue with targeted work to reduce harm to patients. Specifically, the Trust will aim to reduce falls by 10% this year on a journey to an eventual target of zero high consequence falls. In terms of pressure ulcers, there has been a reduction of 40% in hospital acquired pressure ulcers. Work will continue to sustain this progress through new ways of working, new equipment and intentional rounding. Specific targets will be set within specific services to recognise differences.

- **Caring for frail elderly (including dementia)**
  The dementia challenge was launched in March 2012 by the Prime Minister and MPH is committed to transforming to a 'dementia friendly' hospital to reflect Somerset's above average older population. In 2014/15, there are National Dementia CQUINs setting acute hospital trusts the target to screen for dementia and delirium in patients over 75 years; to gain carers' feedback, to deliver a training and education programme and provide clinical leadership. The CCG are

anticipating integrated working to address the frailty pathway and improve the outcomes for this patient group.

- **Communicating decisions about treatment to patients (TEP)**
  This priority focusses on difficulties associated with Do Not Attempt Resuscitation (DNAR) forms, introduced to allow identification of patients who would benefit from cardiopulmonary resuscitation. The Treatment Escalation Plan seeks to address these difficulties. It is a document which is designed to support communication between health care professionals and to support communication between healthcare professionals and patients and their families.

- **End of Life**
  End of Life Care is an integral part of the work of MPH. About 1,000 patients a year will die in the hospital. If patients who are recognised to be in their last year of life have had an opportunity to prepare an advance care plan before the final phase of their illness, the likelihood that they will die in hospital is reduced from 70% to 15%. The Trust will work to improve care for those nearing the end of their life, and communicate more effectively with patients, their families and the wider health community (GPs, district nurse, ambulance trust, Out of Hours) when it is recognised that someone has a life shortening illness to allow advance care planning. There will be an increase in the number of patients MPH entered on the Electronic Palliative Care Coordination register (EPaCC) when in their last year of life. The Trust plans to introduce an individualised End of Life Plan for those who are expected to die during an admission to Musgrove Park Hospital. This will replace the now obsolete Liverpool Care Pathway. The Trust will pilot the introduction of Musgrove Companions to support patients who are dying and their families.

3. Existing quality concerns and plans to address them

The Care Quality Commission (CQC) undertook a “new style” inspection of the Trust in October 2013. The Trust was one of a small number of Trusts selected for the first wave of new style inspections. The selection of first wave hospitals chose a mixture of those considered low, medium and high risk. This Trust was considered low risk.

The CQC reported that most patients received safe and effective care. Surgical procedures were safe and most patients were being treated according to best practice guidelines. Most staff had received the specialist training they needed, but improvements were required in some areas. The Trust was pleased that the CQC found that most areas of the hospital were clean and that infection rates were low compared to other hospitals.

The CQC reported that patients were treated with dignity and respect and were involved in their treatment and care. The patients that the CQC spoke to were very satisfied with the service they received and all patients praised the caring, helpful and compassionate attitude of staff.

The CQC reported that surgical procedures were safe and that the Critical Care service performed better than most other similar units across the country. Women reported good experiences of child birth to the CQC. Children’s care was found to be coordinated and services were being designed to make children comfortable in hospital. The CQC said that End of Life care was managed by a passionate and specialist team. Most outpatient clinics were described as being managed efficiently, and patients reported that they felt that communication was good. This reflected progress made against one of the Trust’s own quality improvement plans.

However, the inspection identified a number of areas for improvement which inform the Trust’s current quality initiatives. A summary of the CQC’s identified actions, and the Trust’s response, is included at Appendix 1.

The CQC improvement plan at Appendix 1 sits alongside operational and strategic quality improvement plans addressing a Trust-wide and a local level the concerns raised internally and externally. All plans report ultimately to the Board of Directors.

Performance against a range of key quality metrics, both internal and external, is reported to the public and the Council of Governors annually in the Trust’s Quality Account, which forms part of the Trust’s Annual Report. Trust performance in the last reporting year available (2012/13) against these measures is as follows:

- Summary Hospital Level Mortality Indicator (SHMI): Performance as expected, with mortality rates slightly lower than the England average in all reporting periods during the year.

- Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust: Trust scored amongst the lowest of all Trusts in the country.

- Patient Reported Outcome Measures (PROMs): PROMs measure a patient’s health status or health-related quality of life from the patient’s perspective, typically based on information gathered from a questionnaire that patients complete before and after surgery. Adjusted average health gain levels were recorded for groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery.

- Patients re-admitted to hospital within 28 days: Performance was broadly in line with the national average for children's services, and significantly better than average for adults.

- Responsiveness to the personal needs of patients: Composite results against five patient experience questions in the annual CQC patient survey showed an improved score for the Trust compared to the previous year, maintaining its position as scoring above the national average.

- Ensuring that people have a positive experience of care: The annual NHS staff survey includes a question asking whether, if a relative were ill, staff would be happy with the standard of care provided to them by the Trust. Results were broadly in line with the previous year, significantly higher than the national average.

- Patients admitted to hospital who were risk assessed for venous thromboembolism: The Trust performed above the 90% target throughout the year.

4. Risk analysis

The fundamental risks to the Trust are those for the LHE in general: how to maintain and develop a system of care which is clinically and financially sustainable both in the immediate and longer term.

This section considers the various categories of risk that the Trust faces – achieving its cost improvement programme and Continuity of Service measure, redesigning services to manage a 4% efficiency target, developing its estate, maintaining an efficient staffing model and ensuring that quality targets in the NHS Constitution are met.

The table below sets out the risks faced by the Trust, and the mitigating actions to be put in place.

Category of risk	Description of risk (including timing) and Potential Impact	Mitigating actions / contingency plans in place
Achievement of cost improvement programme	The Trust's savings target is challenging and ambitious. There is a risk that the savings programme may fall short of the target because of insufficient planning and/or execution.	There are a number of mitigation measures that have been put in place. For instance, a programme management structure is being implemented, with improved governance of savings plans that will highlight milestones, resource requirements and risks to delivery. This will allow a forward look to identify key risks to delivery and a clearer view of the actions that are required to facilitate or bring forward delivery and where additional schemes are required to cover the shortfall. The Trust's focus over the next two years will be to identify and execute a substantial programme of cost improvements, both in its capacity as an individual organisation and as a significant provider within the local health economy, recognising the need for transformative change. Directors will challenge Directorates to hold vacant posts where clinical risk is not affected in order to reduce expenditure and provide headroom for recurrent savings schemes to be developed. In addition, the Trust will work to speed up the realisation of potential new schemes including a systematic review of all consultant job plans to optimise efficiency and delivery of direct clinical care through review of all activity and time allocated to supporting professional activities (SPA time). Given the scale of the challenge, it cannot be said with certainty that this risk has been fully mitigated.
Achievement of the Continuity of Service (CoS) measure	The Trust's financial position means that there is an increased risk of failure to maintain an appropriate risk rating.	The Trust has a £2.0m revenue budget headroom before the CoS measure reduces from level 3 to 2. There is also further flexibility to sustain a CoS of 3 by increasing liquidity in the event that cash balances are reduced due to non-delivery of cash releasing savings (e.g. management of the capital programme to delay cash outflows, release of cash through lower stock levels following implementation of a new inventory management system or through the sale of non-essential property assets).

Category of risk	Description of risk (including timing) and Potential Impact	Mitigating actions / contingency plans in place
Ability to redesign acute services to meet financial efficiency improvement of greater than 4% per annum	These services comprise all specialties providing medical and surgical care, including ED, the Medical Assessment Unit (MAU) and the Surgical Assessment Unit (SAU). A number of risks to ED have already been mentioned, particularly the emerging agenda of Major Emergency Centres in the light of the Keogh review. More specifically, the Trust has no option in exiting from the provision of emergency services regardless of changes to tariff arrangements. This puts the Trust in a significantly worse position than local competitors in relation to delivery of elective work. Uncertainty over the future of neighbouring Trusts and of the LHE in general presents a risk. Were the Trust to assume responsibility for another hospital, this could have a major impact on bed configuration and service need. Uncertainty in this area makes strategic planning very difficult. When certainty is gained, this will also present significant challenges either in expanding provision or in managing the transfer of services elsewhere.	The Trust has successfully managed patient flow through the 2013/14 winter, with changes to bed management arrangements resulting in far fewer bed pressures. The opening of additional ED facilities in early 2014 enhance the Trust's status as an accident and emergency provider and place MPH in the best position it can in negotiations to become a Major Emergency Centre post-Keogh. There is a significant amount of work under way to rework pathways and manage the needs of certain patient groups better so as to reduce the burden on acute medical beds. Such work includes the adoption of a frail elderly strategy to provide more appropriate care for this particular group of patients. This work marks a departure from condition-specific service planning towards a more joined-up approach considering the needs of different patient groups. It is more in keeping with the desire for more joined-up care planning across the LHE, and will allow the Trust to take better advantage of national initiatives such as the Better Care Fund and its £3.8bn of joint NHS/Social Care money. The CCG has confirmed its expectation that a baseline assessment has identified a figure of £2.9m as the initial value for transfer from the CCG's contract for frail elderly to the Better Care Fund in 2015/16. As this will continue to be commissioned by the Local Authority (LA) via the CCG's contract, the Trust will aim to mitigate risk associated with any change in use of this funding by working jointly with the LA and CCG to ensure that any reduction in commissioned activity can be matched by a reduction in Trust costs, through reducing associated beds and staffing. The Trust's own strategy for frail elderly is consistent with the ambition to reduce reliance on acute hospital beds. Discussions continue with the CCG and partners over the future configuration of acute services, and the CCG's Acute Services Review (due to report later in 2014) will provide the clarity and direction for the Trust to follow in developing its services. MPH will play a part in shaping this agenda as well as in delivering it.

Category of risk	Description of risk (including timing) and Potential Impact	Mitigating actions / contingency plans in place
Ability to develop and improve estate and facilities to meet modern standards for clinical services	Much of the estate from which acute medical and surgical services are delivered is either poor quality or difficult to alter, presenting a risk to future expansion if such expansion is needed. HDU and ITU facilities are in a particularly poor state, with refurbishment costs in excess of £10m. General theatres are in a similar state, with costs for refurbishment at a level similar to HDU/ITU. The Trust does not have an Interventional Radiology theatre, and there is no investment potential currently. The MAU is compromised due to its size for the level of admissions, reducing flexibility in how it operates. It is also geographically distant from SAU and thus misses out on efficiencies that proximity would bring. This presents quality and financial risks as well as risks to patient experience. Maternity facilities are housed in WWII-era accommodation, with a lack of en-suite delivery rooms. Accommodation is of a very poor standard and markedly inferior to other facilities such as the midwifery unit in the new Bridgwater Community Hospital.	Facilities have improved, and continue to improve. An enlarged ED, capable of handling more major emergencies, opened in early 2014. Two thirds of the delivery rooms in Maternity are being refurbished in Spring 2014 to provide larger, en-suite accommodation. In addition, a number of Outline Business Cases have been developed including for general theatres, critical care and new non-PFI radiotherapy facilities, which present options and costs for refurbishment as well as clinically-approved designs. The Trust's financial position is such that the scope for capital service developments in the short to medium term is minimal. Unavoidable EPR costs, ongoing maintenance, and a future inability to generate surpluses, means that there is no money available for important capital schemes. Critical schemes such as replacing theatres and ITU/HDU have been removed from the programme on affordability grounds. Although the Trust is investigating lower cost solutions for these services, these can only provide a short term response, in view of the condition and design of the aged facilities.
Ability to meet increasing national standards of clinical care whilst maintaining an efficient	A large number of national guidance documents, produced by the Department of Health, Royal Colleges or as a result of national reviews, have recommended minimum service delivery requirements. These are difficult to achieve in areas with low population density like Somerset, because the volumes of activity do not easily allow for the sustainability of large numbers of consultants. In Paediatrics, for instance, the Royal	The Trust has provided increased medical staffing in many of its services to meet increased national guideline numbers. The commitment to providing safe services remains, even where the financial challenge to do so is greater. Beyond internal resources, the Trust has commenced a large piece of work with the Royal Devon and Exeter NHS Foundation Trust (RD&E) regarding the feasibility of delivering various smaller services jointly at scale, rather than maintaining separate units both struggling to serve small to medium population bases. As well as this work

Category of risk	Description of risk (including timing) and Potential Impact	Mitigating actions / contingency plans in place
staffing model	College of Paediatrics and Child Health report entitled "Facing the Future" would require the appointment of 3 to 4 more consultants. Without such appointments there is a quality risk, but proceeding with the appointments presents a financial challenge. There is a further risk around paediatric surgery. Staff retirements and the difficulty in recruiting a specialist for a hospital with a relatively small catchment population presents difficulties, especially given that there is resistance to cross-county service rationalisation. Similar concerns exist in various smaller specialties such as ENT, ophthalmology and maxillo-facial surgery.	with RD&E, more focused and service-specific work has been undertaken with other local providers with the same intention in mind, namely to ensure that all specialties can be delivered safely to the regional population at a level which is clinically and financially sustainable.
Ability to meet national performance standards and compliance with NHS Constitution: • **Referral To Treatment**	The NHS Constitution confers rights for every patient to be seen within 18 weeks from referral to treatment (RTT). A failure to comply with the constitution represents financial, reputational and quality risks. After difficulties in meeting this target in previous years (particularly in orthopaedics) significant efforts have been made to improve performance for the benefit of both patients and the organisation. This has included work to clear backlogs which, in the short term, have resulted in breaches of the target for the Trust as a whole. These breaches are the intentional result of work to remove RTT backlogs, undertaken so as to ensure that future patients receive their treatment quicker. The national contract includes provisions for commissioning organisations to include penalties against the non-delivery of key performance targets. The Trust has entered into its work on backlog clearance with this in mind, but will be able to provide a	RTT compliance is now managed through detailed capacity planning within each directorate which can highlight potential issues. The Trust has also used private facilities to deal with backlogs and reserves the option to use this solution again should it be required. Daily monitoring arrangements are in place to match capacity to demand across specialties and thus to appropriately target resources to deal with spikes in demand. In orthopaedic services, additional consultant capacity has been created alongside a review of consultant specialist capacity to reflect changes in case mix.

Category of risk	Description of risk (including timing) and Potential Impact	Mitigating actions / contingency plans in place
	better service for the rest of the year once this work has been completed. The Trust has developed good communications and relationships with commissioners to ensure that where problems are foreseen, they can be managed appropriately through the more effective targeting of resources.	
C. difficile	The national contract contains a clause allowing for contract penalties where cases of C.difficile exceed the baseline threshold. This reduction could be up to 2% of the total.	Infection control continues to be a top priority for the Trust. One of the 2013/14 Quality Account priorities was to ensure a further reduction in C. difficile infection rates to 15, a reduction of over 75% on levels seen three years ago. This work has included the implementation of the Trust's Control of Infection plan. The Trust's achievement of a target of 15 means that infection rates are now almost at the de minimis level (12) with our performance in the past 2 years continuing to be amongst the best in England (4th best for Trust apportioned C.diff cases per occupied bed days). Further reductions will understandably be very challenging. Whilst the Trust's target for 2014/15 has been set at 11, the Trust will be performance managed by its commissioners on avoidable cases of infection. The regulatory target for Monitor, however, does not distinguish cases in this way, leading to a higher regulatory risk of breach. Any changes in clinical practice, such as changes in antibiotic policy are agreed in consultation with commissioners with an assessment of the impact on reportable infections.

The above risks have informed the Trust's objectives and operational plans mentioned elsewhere in this document. There are plans in place for the longer term to manage or mitigate many of the risks outlined above. These mitigations will be explored in more detail in the Trust's Strategic Plan return to Monitor, completed in June 2014.

5. Response to Francis / Keogh / Berwick

The CCG has made clear its approach to responding to the Francis, Keogh and Berwick reports. The CCG has reiterated the need for providers to maintain a focus on improvements to safety and quality, with a rigorous adoption of the new Duty of Candour. To this end the Trust has already held information sessions with the senior team and departmental teams regarding the Duty and its impact. The CCG are monitoring untoward incident investigations, complaints and concerns, and the Trust supports them in their efforts.

The Trust has made efforts this year to re-state the importance of candour as an integral part of the Trust's values, not least in the recruitment of new staff which is now values-based as well as competency-based.

The Francis Report represented a challenge to all Trusts within the NHS. It re-iterated the importance of compassion in care, and re-emphasised the primacy of patients. The Trust adopted a pro-active approach to sharing the findings of the report and implementing Francis' recommendations where they were in its gift to do so and where they were not currently in place.

Following this, there were a range of events with senior clinical and non-clinical staff addressing some of the issues highlighted in the report to ensure that key messages were disseminated and to facilitate discussions at all levels about the challenges posed by Francis and the best way to respond.

Much of the focus of recent reports like Francis has been about organisational culture, and MPH has continually tried to foster a culture of openness. The Trust's approach to whistle-blowing, incident prevention and clinical audit attempts to be supportive yet challenging. The new Duty of Candour placed on Trusts and their staff formalises this approach, and amongst other things the Trust dedicated one of its monthly "Exec Exchange" sessions to a facilitated discussion about how best to maximise the positive impact of cultural change in the context of the new duty.

There is a dedicated Francis Steering Group, chaired at Board level and with an action plan broken down into separate action plans for different staff groups. The Nursing and Allied Health Professional action plan, for instance, is owned by the Executive Director of Nursing and Governance and contains a range of actions designed to ensure that the lessons outlined in Francis are put into practice in the hospital. It contained specific actions related to nurse leadership, culture and recruitment to ensure that quality and compassion were at the heart of the nursing workforce. This approach has been continued corporately through a number of initiatives including the introduction of values based recruitment and values-contingent pay progression. Now, for the first time, jobs and salaries are specifically linked to putting values into action, and these are inherent to realising the aims of compassion and care in Francis. The Trust was visited by a Department of Health team in early 2014, reviewing progress since the publication of the Francis Report. The Team commented very positively on work undertaken at the Trust.

The Trust's commitment to patient safety has also been enhanced by the recommendations in the Berwick report. Musgrove Park Hospital is committed to ensuring that patients are safe, and the organisation was gratified that many of the recommendations made in the report have already been actioned here. For instance, the Trust participates fully in a Safety Thermometer programme, analysing current practice and trends to make patient safety improvements. This process is led by the Director of Nursing and Governance and involves the full range of nursing staff.

As with Francis, the Board and senior staff took the lead on ensuring that recommendations fed action plans and were implemented where not already in place.

The Keogh Review into the provision of emergency care will potentially have a significant impact on the way that services are delivered across Somerset. As mentioned elsewhere in this document, it is likely that there will be only one Major Emergency Centre in the county. Given the Trust's location, size, status as a trauma unit, and the recent £2.9m investment in Accident and Emergency facilities, it is anticipated that MPH will be the Major Emergency Centre for Somerset. This will have an impact on the required levels of care and staffing available to local people, potentially increasing costs. However, the increases in activity generated by the enhanced local facilities will mean that MPH will be able to offer the best services in Somerset to a wider catchment population as part of a county-wide rationalisation. The Trust is also focussing efforts on admission avoidance in frail elderly and in paediatrics by providing senior medical assessment at the 'front door' and GP access to consultant opinion, which will reduce pressure on ED and on beds to enable the Trust dedicate capacity to those sicker patients who require urgent and emergency care and where no other alternative option is available.

6. Board assurance on quality

The Trust Board leads efforts to keep quality high, both in the direction of strategy and in providing the necessary support and input to front line service delivery. The Board has led the Trust's response to the national reports on quality, which have been produced recently, such as Francis, Keogh and Berwick. The Trust's actions as a result of the recommendations in these reports are allied to the action plan produced after the CQC visit in late 2013.

Operationally, the Trust's Executive Director of Nursing and Governance and the Trust's Medical Director share responsibility for the quality of services, defined within a Memorandum of Understanding to ensure there are no gaps in assurance. At each Board meeting, the Board receives a quality report which is produced by the Medical Director and the Director of Nursing and Governance. This is supplemented each quarter by a more detailed report covering a wider range of topics including patient complaints and concerns. These quality reports provide the Board with information on performance with respect to a variety of quality indicators and issues. A Governance Committee also exists to address relevant matters and ensure that the Board as a whole is informed and able to influence Governance issues.

In addition, executive and non-executive Board members frequently visit different areas of the hospital and spend time within services, speaking to staff to see the care given first hand and to learn about issues which require reporting and action. Patient stories are shared at the Board as part of the learning process.

Whilst Board level involvement in the management of quality provides assurance and direction, quality must be at the heart of every interaction between staff, patients and the public across the whole hospital. All of the Trust's services are set up, managed and audited with quality in mind. The Trust has established quality monitoring across the hospital, ensuring a clear flow of information and action from wards and services to Directorate management teams for information and action, and on to the Trust's Governance Committee, a sub group of the Board. This ensures the continual monitoring of the quality of care and of on-going assessment and review involving Directors, staff, patients, commissioners and Governors.

The Trust looks for emerging quality risks through regular audits, reporting and visits to clinical areas from the most senior medical and nursing staff (including members of the Board). There is also a significant complaints management and response function, closely aligned with the Patient Advice and Liaison Service (PALS). Governance processes include the identification of issues raised through complaints, Serious Untoward Incidents and claims and the implementation of actions arising from them. Through this mechanism the Governance Committee provides assurance to the Board on Governance arrangements. In addition, the Trust Board receives each month a dashboard, and exception report, which sets out KPIs against each of the Trust priorities, including those that are required for the Monitor Compliance Framework, national priorities, and the Quality Account as well as performance against contractual and Trust objectives. Quarterly Quality Monitoring meetings are held with the commissioners underpinned by monthly reporting. These will continue in the future as the Trust actively manages its arrangements for quality service provision.

The increased emphasis on specific quality initiatives which has come about after the Francis, Keogh and Berwick reports has meant a closer examination of all practices and processes. The Trust is firmly committed to maintaining a focus on quality even in financially challenging times. All cost improvement schemes are assessed for their impact on quality, and those above £100,000 in value require sign-off from the Executive Director

of Nursing and Governance and from the Medical Director (those under £100,000 require sign-off from the Directorate Clinical Director and Matron). In addition, there is a specific requirement for all Directorates to consider the quality impact of their operational and financial priorities for the year.

As part of the development of its Quality Account, the Trust has identified a number of key quality priorities, with key milestones and KPIs to ensure success can be identified. These are described in the 'Quality Goals' section of this plan above. The Trust has a robust and well-embedded governance process in place to ensure that these quality goals are met and that standards elsewhere are maintained and improved.

The Trust has also developed an annual programme of assurance reporting on a range of key topics linked to CQC requirements. This includes a review of arrangements in place for monitoring and improving quality. Compliance is assessed on a simple scale, with actions required to address any areas of concern identified. Results are triangulated to take into account findings from internal audits, policy monitoring, compliance audits, national surveys, detail of incidents, complaints and claims and measures included on the CQC's Quality and Risk Profile for the Trust. Following the recent CQC visit to the Trust, there is further information to inform this programme, which will continue to be enacted.

7. Workforce impact on quality

There are many workforce challenges which the organisation must overcome. Many of these have been previously described. In simple terms, it is difficult to make the Trust's required financial savings without reducing the number of staff, recognising that 60% of the Trust's expenditure is on staff. At the same time though, increasing expectations from patients and in national guidance means that staffing levels can often not fall.

There are opportunities which will come in the medium to long term as reconfigurations of services lead to inevitable efficiency opportunities. In the short term the Trust has recognised the need to reduce staff headcount to help contribute to its financial target. The Trust has initiated a MARS (Mutually Agreed Resignation Scheme) to identify potential posts which can be taken out which minimises the need for any compulsory redundancy.

Business planning and CIP planning processes specifically require Directorates to identify the staffing impact of change schemes, including reductions in posts. The Trust looks to encourage new ways of working to make services deliver better outcomes using the same or less staffing resource. There are regular workforce reports to the Board of Directors, and a new Executive Director of Change was appointed in late 2013 to lead organisational change and development.

The nursing workforce presents particular challenges, as patient numbers grow and patient acuity increases. The Trust plans to reduce bank and agency staff usage. Less than 5% of nursing staff are agency staff in a typical month. Substantive nursing posts have increased in recent months, reflecting both an increased focus on staffing levels for quality purposes and a shift of agency and bank nurse usage into permanent posts. However, recruitment difficulties persist, in part because of the relative geographical isolation of Taunton and also because of a lack of a local training provider.

There are also recruitment difficulties in some medical specialties, caused in part by the Trust's relatively small size.

The Trust works hard to ensure a satisfied workforce with the opportunity for staff to develop. One of the Trust's four strategic goals is to achieve excellent performance through an engaged and inspired workforce. In the 2013 NHS Staff Survey there were many results showing that work in this area was paying off. Overall, across the three measures of engagement measured in the survey, the Trust scored above the average for acute Trusts and obtained improved scores compared to 2012. Between 2012/13, there was a 12 point increase in the percentage of colleagues agreeing that care of patients is the organisation's top priority, with a score of 76%. There was an 11 point increase in the percentage of patients able to deliver the standard of care to which they aspire, with a score of 74%. And there was a 9 point increase in the percentage of staff who would recommend the Trust as a place to work, which put the Trust in the top 20%.

There was also an increase in the percentage of staff saying that the organisation acted on concerns. 88% of staff felt encouraged to report errors or incidents.

There were some areas of concern, including declines in the percentages of staff receiving feedback or being consulted prior to management taking decisions. The Trust scored lower than average in terms of the recognition of senior managers, and has seen a decline in the percentage of staff feeling able to make suggestions for improvement (from 78% to 73%).

These findings will inform organisational development and training activity in the coming months, but demonstrate that whilst there are many areas of success there remain some challenges.

2013/14 was the first year of the NHS Staff Friends and Family test, which asked staff whether they would recommend the Trust to a friend or relative as a place to receive treatment and as an employer. In both measures, the Trust scored above average, which is good news. However, with scores of 69% and 78% respectively, there is more work to do. As a result, a scorecard of further measures has been established which will be monitored and reported to ensure that improvements are sustained.

8. Operational requirements and capacity

The Trust has assessed future trends in demand based on clinical intelligence of activity movements, historical trends and known changes in commissioner requirements at speciality and sub specialty level. Detailed capacity plans are then developed in response which have been fed through into new year budgets to ensure all directorates are appropriately funded to deliver the anticipated activity movements.

The analysis shows the following changes in activity for 2014/15 against the expected outturn position for 2013/14.

	2013/14 FOT (M8)	2014/15 Plan	Activity	%
Elective Inpatients	8,192	8,607	415	5.1%
Elective Day Cases	35,129	37,204	2,075	5.9%
Non-Elective (exc. Ante/postnatal spells)	35,988	36,952	964	2.7%
OPD First	101,905	106,779	4,874	4.8%
OPD Follow Up	178,303	185,343	7,040	3.9%
OPD Procedures	37,487	38,277	790	2.1%
A&E	57,477	57,934	457	0.8%

The major changes in activity are associated with:

- higher referrals in 2013/14 for certain surgical specialties such as ENT and ophthalmology including increased demand for Lucentis treatments for wet Acute Macular Degeneration (AMD) and Diabetic Macular Oedema (DMO)
- an increase in day cases linked to a new termination of pregnancy service commissioned by the Trust from the BPAS (this reflects a transfer of work from another independent provider and other NHS Trusts during 2013)
- a transfer of surgical arterial work from North Devon hospital in 2014 to meet specialist commissioner standards for vascular surgery
- a small increase in orthopaedic cases based on the assumption that the new Jubilee service and low RTT waiting times for many orthopaedic conditions will begin to attract back work lost to other providers in 2013
- An overall growth of 2.7% for all emergency specialities, with 3% increase in medical specialties.
- A small increase in bariatric surgery, based on evidence that demand from outside Somerset is likely to increase in 2014/15
- An extension to the flexi-sigmoidoscopy screening service for bowel cancer for over 55 year olds, commencing in 2014

The Trust has put in place operational capacity to meet the elective areas of growth. The most significant change is in gynaecology where additional theatre capacity has been created by using Saturday lists. Ophthalmic capacity has also been increased by more flexible use of rooms for Lucentis treatment to reduce the need for theatre time, whilst new models of care delivery are developed.

For 2015/16 the Trust has assumed no further growth in activity. To achieve this will require a reversal of recent trends in emergency activity and greater controls on elective referrals. The Trust is working with the CCG to ensure all clinicians, GPs and consultants understand the pressures on commissioning budgets and the need to reduce patient activity wherever possible. Two examples previously described are in paediatrics to reduce inpatient admissions by providing consultant assessment at the 'front door' i.e. in ED and over the telephone to give GPs immediate access to advice and in services for frail older people where there is evidence that greater consultant input can reduce admissions.

The CCG has provided assumptions over activity trends over the next 5 years. These are shown below for information:

	Elective Admissions	Day Cases	Non-Elective Admissions	First Outpatient Attendances	Follow up Outpatient Attendances	A&E Attendances
2014/15	-106	-454	-670	-800	-1635	-958
2015/16	-366	-1524	-1341	-2144	-7885	-1910
2016/17	-733	-3047	-2234	-4289	-15769	-3184
2017/18	-847	-3533	-3575	-5157	-17636	-5054
2018/19	-960	-4001	-4469	-6016	-19492	-6313

Reduction Required	Elective Admissions	Day Cases	Non-Elective Admissions	First Outpatient Attendances	Follow up Outpatient Attendances	A&E Attendances
2014/15	-1.39%	-1.42%	-1.89%	-1.02%	-1.25%	-1.92%
2015/16	-4.73%	-4.71%	-3.73%	-2.71%	-5.93%	-3.77%
2016/17	-9.35%	-9.29%	-6.14%	-5.36%	-11.72%	-6.20%
2017/18	-10.65%	-10.61%	-9.69%	-6.38%	-12.93%	-9.71%
2018/19	-11.90%	-11.85%	-11.95%	-7.36%	-14.09%	-11.97%

As these tables indicate the CCG is assuming a reduction in activity across the board, in line with the NHS England's ambitions as set out in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' including a 15% reduction in emergency admissions (page 9, point 18) and a 20% productivity improvement (page 30, table item 9) delivering better outcomes with 20% less resource. The CCG model assumes that activity can be reduced at full cost. It also assumes that the reduction in inpatient elective work can be achieved in part (33%) by moving work to day cases and subsequently moving days cases to outpatient procedures to release cost. It notes that the 'remainder has been achieved by removing activity from the system'.

Whilst the Trust supports the general principles for reducing activity into the hospital and the need for year on year productivity gains it believes much further work is required in assessing each of the service proposals being developed within the health system to determine whether these high level theoretical assumptions are valid and indeed could lead to a direct reduction of cost at 100% as assumed in the model. This would also need to take into account the relative performance of each Trust in terms of the level of day surgery and outpatient procedures already achieved. Basing future planning assumptions on such high level models presents significant risks to the Trust and to the LHE.

In determining a more robust model of demand and capacity, the Trust supports the proposal for an acute service review to model activity change based on demographic data and to identify the factors which will influence demand in the future. This work will need to

reflect the potential movement of activity within the CCG area associated with service changes, such as the proposal to create one single hyper acute stroke unit for Somerset. The model would also need to adjust assumptions for the outcome of decisions regarding the development of a Major Emergency Centre as this could have far reaching implications for demand and capacity at each of the District General Hospitals in Somerset and on the periphery, for example Weston hospital.

9. Productivity, efficiency and CIP

The Trust's financial performance deteriorated during 2013/14 as the challenge of finding further significant efficiency savings increases and the consequences for 2014/15 and the following year have become ever more acute, as a result. This is illustrated in the table below, which reflects a financial plan aimed at ensuring the Trust sustains a minimum Continuity of Service rating of 3:

	2011/12 Audited Accounts £'m	2012/13 Audited Accounts £'m	2013/14 Forecast Outturn £'m	2014/15 Plan £'m	2015/16 Plan £'m
Income	244.6	256.3	250.1	252.4	248.5
Net surplus/(deficit)*	2.2	3.4	(1.9)	0.6	0.6
CIP requirement				13.0 *5.1%*	12.3 *4.9%*

**stated before accounting for property impairment.*

A shortfall in achieving planned savings is the principal cause of weaker financial performance in 2013/14 as indicated above and this highlights, in particular, a challenge in containing pay costs, especially in relation to nursing and medical staffing as the Trust continues to sustain the highest quality of care and responds to a mix of activity which is becoming increasingly skewed to more complex cases and to an increasing proportion of emergency, relative to elective activity.

The Trust's business planning process during 2013/14 has therefore had an increased focus on revisiting basics and on gaining an increased understanding and control of expenditure more as a first step to increasing efficiency again. There has been a significant amount of work undertaken to determine underlying expenditure, so as to enable efficiency targets to be set against actual, rather than budgeted expenditure.

The Trust's Service Line Reporting and patient level costing processes have been strengthened during 2013/14 and enable productivity to be measured more accurately. This will be of increasing benefit in the refinement of cost improvement plans and managing financial performance generally, by allowing, for instance, bed day costs to be determined more accurately by ward including indirect costs such as radiology, pathology and medical staffing.

The Trust's CIP requirement is therefore determined by reference to income, underlying expenditure, service development costs and non-avoidable additional costs. Service development costs are potentially-avoidable costs such as additional staff ostensibly required to manage additional activity. Such service development costs are subject to challenge, with Directorates encouraged to think innovatively to transform pathways to make activity-based income go further, rather than simply increase costs in line with activity. Non-avoidable cost increases, such as rates, CNST and pay increments are absorbed into the underlying 2014/15 budget. Many of these costs have risen above the rate of inflation and contribute significantly to the CIP challenge exceeding the notional 4% efficiency requirement targeted by current NHS practice.

Based on the above methodology and on the current assumption that the Somerset CCG and Specialist Commissioners' contracts will together provide the Trust with income of approximately £209m in 2014/15 for activity projected to be at a similar level to 2013/14, the Trust's Cost Improvement Programme is determined as £13.0m for 2014/15 and

£12.3m for 2015/16, with further substantial savings (in excess of 4% of total income) required in subsequent years.

At c.5.1% of income, the size of the 2014/15 CIP reflects the requirement to achieve new 4% efficiency savings in the coming year, to cover above inflationary rises in key of unavoidable cost (as referred to above) and the need to compensate for recurrent savings not achieved during the current financial year.

There will be substantial continuing effort (including collaborative work with Somerset CCG) focused on the reduction of avoidable cost pressures and to change pathways within the hospital aimed in particular at avoiding the additional costs required for anticipated activity in excess of 2013/14 outturn (currently, the planning process has identified up to £4m additional expenditure that may be required to meet additional activity during 2014/15).

The 2014/15 CIP plan has been developed over a period of months, led by the Board and involving clinicians and managers from across the organisation. Plans (some of which remain under-development at the time of writing) focus on a number of major areas, including:

- Reductions in patient lengths of stay, aimed at moving the Trust's upper quartile performance into the top decile, which will reduce the need for beds and thus permit the closure of wards. Plans are centred on a new care of the frail elderly strategy, aimed at reducing the length of stay of patients who might typically stay for seven days or more, on improved management control of acute ward staffing and increased shift standardisation;

- Other patient flow improvements, including better discharge planning, to ensure that patients are treated in the correct location and for the appropriate amounts of time. This too will reduce unnecessary bed occupancy.

- Theatre efficiency improvements to ensure that some of the Trust's most capital intensive assets are used as cost-effectively as possible. Whilst the Trust's theatre utilisation rates are already high, the Trust aims to realise additional scope for improvement, by increasing the flexibility of consultant job plans, for example.

The plans in place are ambitious and, like the challenge itself, are probably unprecedented in size and scale. However, they build on significant good work already carried out and implemented within the hospital.

Planning to date has indicated CIP schemes aimed at delivering total savings of £12.3m during 2014/15, albeit that £7.1m of these plans remain at a relatively early stage in their development. The details of all schemes are included in the financial return accompanying this document. In headline terms the major schemes include the following transformational schemes:

- £2.8m savings from improved management control of acute ward staffing, avoidance of opening 8 additional beds during the winter period and from the closure of an acute ward from 1 August 2014 (underpinned by, among other plans, the frail elderly strategy, referred to above);

- £0.9m savings from improved theatre efficiency;

- £2.1m savings from improved procurement processes, more efficient purchasing and improved inventory management (including the automation of the latter during 2014/15)

- £2.3m savings (or the equivalent) from other workforce efficiencies (including a reduction in headcount) and new income generating schemes.

The operational Directorate Management teams have also so far identified savings of £4.4m to be delivered through "traditional" CIP schemes, typically aimed at delivering simpler efficiency gains from established processes. The Trust's nine Directorates have been challenged with identifying savings from within their services, and these have been presented for discussion and challenge at a range of business planning meetings facilitated by members of the Executive team throughout the year. Work will continue on a 'business as usual' basis to continue to identify further potential savings and new CIP schemes to deliver total savings in excess of the £2.1m schemes so far identified by the Directorates.

Despite these plans, there is a balance of £0.7m which must be met this year, for which specific plans have not yet been identified, and then further savings next year. It is also important to note that £7.1m of the plans so far identified for 2014/15 remain at a relatively early stage in their development, although are expected to be finalised early in 2014/15. Part of the additional savings required will come from the Trust playing its part in developing revised pathways as part of collaborative work with other providers and the primary care sector within its LHE. As new pathways develop, they will help to ensure that the inpatients using the Trust's services requiring longer term hospital care can be discharged at the earliest opportunity to an appropriate setting for their ongoing care. However, a large part will come from additional traditional CIP schemes identified internally by Directorates, and there is now a renewed focus within the Trust in ensuring that the right support for this purpose is in place. These additional savings plans will sit alongside the more transformational schemes described above (the impact of which is expected to reach into 2015/16 and beyond) and others, which will come from joint working and other sources.

A Senior CIP 'Oversight Group', chaired by the Director of Finance and involving amongst others the Associate Directors of Finance and Performance and Information and key members of the Operational Management team has been constituted to provide targeted support to Directorates in the identification of further CIP schemes. This group will use available data and benchmarking to identify areas where further cost improvement may be possible, and assist Directorate Managers in implementing such plans.

The size of the CIP challenge is daunting. Key schemes within the Trust's current plans cannot be achieved successfully by the Trust working in isolation, and the Trust will continue to work with partners across the LHE with a view to transforming pathways. For instance, were all patients in the hospital discharged when medically fit, this would free enough bed capacity to close wards immediately. However, challenges in identifying suitable onward care packages in the community mean that at any one time there are many patients in the hospital who no longer need acute hospital care. The same situation exists in emergency care, with significant activity presenting to the ED, which could be more appropriately managed elsewhere. Work is continuing in a variety of local and regional forums to try to address these issues. It remains to be seen how future reconfigurations of health services in the county, led by the CCG, will alter the demands for Trust services and/or the resources made available for MPH to deliver them. However, the Trust will continue to be pro-active in developing pathways across the county which deliver efficient and high quality services for patients.

10 Capital Programme

The table below shows the Trust's capital programme for the two year period of the Plan. During 2013/14 a number of capital schemes could not be completed to schedule. This has led to £4.3m of funding being moved into the 2014/15 financial year to cover these existing costs. The total value of the programme is therefore set at £15.04m with known commitments of £14.99m, leaving a very small uncommitted sum for contingencies of £50k.

Capital 2 Year Summary	2014/2015 Budget £000s	2015/2016 Proposed budget £000s
Notional Budget as per May 2012 LTFM	9,847	9,620
Additional external funding (Dementia)	150	
13/14 Underspend	700	
Slippage between years	4,343	
NOTIONAL BUDGET UPLIFTED (INC SLIPPAGE)	15,040	9,620
1.1 Site Risks / Plant & Equipment Replacement		
Miscellaneous site risks	913	670
Backlog Maintenance	1,141	2,124
Major Medical Equipment	2,303	2,998
Information Technology	1,545	865
Risk contingency	400	400
1.1 Total Site Risks / Plant & Equipment	6,302	7,057
Site and Service Development **Approved and being implemented**	**1,080**	**400**
Recently approved awaiting implementation		
Ward improvements for dementia patients	150	
Web site development	35	
Flexi Sig Screening service equipment	168	
EPR (IM&T programme) Phase 1	5,136	1500
Awaiting Approval		
Medical Electronics facility improvements		200
Departmental relocations	1,304	0
Strategic Development		
Jubilee Building completion	815	
1.2 Total Site and Service Development	8,688	2,100
Total Potential Capital Investment Required **Site Risks & Site Developments (sect 1.1 & 1.2)**	14,990	9,157
Balance/Shortfall for Site & Strategic Developments	50	463

***** Please note the financial plan includes £15.9m capital expenditure for 14/15 (including capital creditors), the difference is due to an updated slippage figure in the table above.

Other than capital required to maintain the site and replace existing medical equipment and IT infrastructure and hardware, the major scheme in 2014/15 is funding required to replace the Trust's main clinical IT system, or EPR. The scheme has been set out in a phased approach with phase 1 costing £5.1m. The programme currently excludes the costs of critically important schemes for the Trust, such as:

- Replacement of main theatres and critical care unit: The Trust has developed an initial case to the value of £25m for a new unit to co-locate these in a new build on site. Alternative options for their reprovision in existing ward areas in Duchess and Queen's buildings have been explored, however, in view of the specialised needs and volume of space there are no identified solutions. An alternative solution to refurbish the 70 year old building to bring the building up to condition B has been developed. This, however, has been costed at £10m but would not provide any greater critical care capacity and would still leave the units in the wrong location on site in buildings not designed for modern healthcare delivery. The Trust does not have the available capital to progress either solution at this stage, despite the CQC identifying the building as providing a poor clinical environment. This has been raised with the Somerset CCG as a system wide issue to resolve.

- Maternity: The Trust provides a full obstetric level service for its population along with SCBU and neonatal services to the whole county. These are provided out of WWII buildings. The Trust was successful in bidding for capital in 2014 and with Trust own capital invested in improving 6 delivery rooms in the building. The Trust has identified the need for further work, not funded from the national award to complete 3 more rooms and improvements to the bereavement room.

- Radiotherapy capacity: The Trust currently has 3 linear accelerators, 2 of which are provided within a PFI agreement. Whilst the Trust is currently negotiating extended hours for these PFI machines to provide greater capacity, it is faced with two major concerns for the future: the ability to refresh each of the 3 machines and manage the reduction in capacity which will be equivalent to the loss of 33% capacity for 12 months and secondly, the risk of growing demand and the Trust's inability to expand capacity to match this. A business case has been developed to consider the opportunity for a new 2 LINAC expansion from 2018/19. The cost of the new bunkers and machines would be c £10m. In light of the Trust's overall capital position and the inability to generate additional cash the Trust is unlikely to have any financial ability to increase physical capacity for radiotherapy patients. The Trust has raised this issue as a risk with specialist commissioners to explore alternative options to mitigate this risk.