Taunton and Somerset NHS

NHS Foundation Trust

Operational Plan for 2019/20

1. TRANSFORMING AND IMPROVING SERVICES: ACTIVITY PLANNING

Our strategic objectives for transforming and improving services are to:

- promote a culture of learning, transformation and innovation, including through digital working, to improve safety, outcomes and efficiency
- deliver levels of performance that are in line with plans and national standards

The Trust has undertaken an assessment with its system partners, of the level of activity required in 2019/20 to meet elective and emergency demand. The assessment has used analysis of longer-term trends in demand (i.e. referrals / RTT clock starts, A&E attendances and emergency admissions) and changes in waiting list sizes across 2018/19 to estimate the following:

1) The level of elective activity required to re-base the Trust's activity to deliver un-met demand in 2018/19;
2) Forecast annual growth in demand for elective, A&E attendances and non-elective admissions in 2019/20.

Table 1 below shows the level of elective activity growth which is considered the minimum level to meet a 3.1% growth in demand forecast for 2019/20, and reduce the number of patients waiting over 52 weeks from Referral to Treatment (RTT) to zero by the end of March 2020.

	Activity growth over 18/19 Forecast Out-turn
First outpatients	3.6%
Follow-up outpatients	3.5%
Outpatient procedures	4.6%
Day-cases	5.1%
Inpatients	7.7%
Total	**3.9%**

Table 2 below shows the forecast level of unmitigated annual growth for A&E attendances and non-elective admission based upon long term trends. The activity growth figures include 0.3% growth due to the leap year.

	Activity growth over 18/19 Forecast Out-turn
A&E attendances	5.5%
0 day non-elective admissions	3.9%
1+ day non-elective admissions	3.8%
Total non-elective admissions	3.8%

Specialty-level figures which make-up the Trust level growth rates have been calculated to understand demand for individual services. The 2018/19 out-turn has now been used as the baseline activity assumption for 2019/20, before the agreed level of growth in commissioned activity has been applied. Activity delivered through transformational change will help to mitigate some of the growth in elective demand, as detailed in the RTT section. There are also schemes expected to mitigate non-elective growth, as detailed under the A&E section of this plan.

The following sections detail the activity planning which has been undertaken to support the delivery of the national access standards for Referral to Treatment Times (RTT), Cancer, Diagnostics and A&E.

RTT: Although contracted activity volumes were delivered in 2018/19, the Trust's RTT pathways have grown due to a growth in RTT clock starts (i.e. demand) of 2.7% above plan and 3.5% above the previous year. Taunton's & Somerset's RTT waiting list grew by 2,122 pathways over 2018/19 (inclusive of a service transfer from Yeovil District Hospital of 648 pathways). A significant driver is growth in demand for 2-week wait referrals, with referrals in 2018/19 as a whole being 20% higher than in 2017/18.

The level of growth in activity required to re-base elective activity to meet unmet demand in 2018/19, meet the underlying growth in referrals forecast for 2019/20 and undertake extra activity to get back

down to the level of the March 2018 waiting list size has been estimated at 11.1%, which is unaffordable to the system. The current level of investment only provides enough activity to meet the national target of having no patients waiting over 52 weeks RTT by March 2020. However, plans are in place to divert 1200 referrals from the boundary area between Yeovil and Taunton to Yeovil District Hospital. This will deliver a circa 1% improvement in the Trust's RTT performance and enable some progress to be made towards the March 2018 waiting list size.

As part of the delivery plan for 2019/20 the Trust will focus on the transformation of outpatient care, including increasing outpatient productivity. This area has the greatest potential to deliver gains in the shortest space of time, in terms of impact on numbers and length of RTT pathways, and benefits to patients. This work will include:

- changes to outpatient booking processes to reduce patient cancellations which currently extend pathways putting at risk the system aim of sustaining a zero 52-week wait position in 2019/20
- efficiency gains to be delivered to help meet recurrent levels of demand and reduce the need for incremental investment by commissioners in future years
- additional protected clinician capacity to extend Advice & Guidance, enhance gate-keeping and to test-out new models of care delivery
- more pro-active and responsive management of outpatient capacity in order to reduce eRS polling-out, which currently also generates long wait RTT pathways
- additional capacity to target the reduction of the backlog of longest waiting patients

The impact of the above programme of work is expected to enable circa 2200 more patients to be seen in outpatients within the funded baseline. In addition, improvements being made to theatre utilisation should enable 450 theatre procedures to be undertaken. At a specialty and service level the Trust has used the IMAS capacity & demand modelling developed by NHS Improvement to inform determine what capacity can be provided to meet the agreed level of demand. This informed the investment proposals the Trust submitted to commissioners which included providing additional capacity through locums, waiting list initiatives insourcing and outsourcing.

Plans to reduce the number of 52-week waiters to zero are dependent upon an increase in activity to reduce the numbers of patients expected to be waiting over 40 weeks. At a specialty level the shape of the RTT waiting list has been profiled, and plans developed to ensure capacity is sufficient to meet demand across the year. Capacity is sufficient to eliminate the remaining 52-weeks waiters by the end of September in all specialties, with the exception of the Maxillo Facial service, for which a small number of 52-week waiters remain during quarter 3. Clearance of the Maxillo Facial longer waiters is contingent on the successful appointment of an additional consultant in September, to increase the service capacity.

Cancer: The Trust's performance against the 62-day GP cancer standard improved across the last three quarters of the year. Performance has been heavily impacted by the exceptional levels of 2-week wait suspected cancer referral growth of 20% in 2018/19. Analysis of the long-term trends in Cancer demand carried-out in conjunction with commissioners suggests an underlying growth rate of 8% for 2019/20. This assumption has been used to derive the agreed levels of required elective activity and has been factored into specialty-level capacity plans. The system level aim is for the 62-day GP 85% standard to be achieved at a system level by March 2020.

Diagnostics: IMAS capacity and demand modelling has been undertaken for the key diagnostic modalities, to understand the level of service capacity required to meet recurrent demand. In addition, an assessment of the level of non-recurrent activity required for backlog clearance has been estimated. Annual growth rates inclusive of the 8% underlying growth rate for cancer and RTT backlog clearance have been applied to estimate total demand for relevant modalities. This has resulted in an estimate of a 12% required growth in MRI and CT scanning capacity to meet demand in 2019/20, relative to 2018/19. Investment proposals primarily related to capacity expansion and service resilience, have agreed with commissioners to enable the national diagnostic standard of at least 99% of patients waiting less than 6-weeks for a diagnostic test, to be achieved by March 2020. Achievement of the 99% standard is contingent upon the installation of a MRI and a CT scanner at

the end of quarter 2. For this reason improvements in performance towards the 99% standard will be slower in the first half of the year than the second.

A&E: Trust performance against the target of treating all patients within four hours of their arrival at A&E has been below the national target for most of the year, although performance has been strong relative to the national picture and in most months has been above trajectory. During 2018/19 the Trust has seen 2769 more patients in under four hours than the same period last year. The Somerset A&E Delivery Board maintains oversight of a work programme aimed at reducing un-necessary emergency demand. This includes the following schemes:

- 7 day working
- Rapid response hubs
- Single point of access arrangements
- Continued work with care homes
- Reduction in patients with a long length of stay
- Full implementation of Home First (discharge to assess)

The above schemes commenced in 2018/19 and the full effect is anticipated from the start of 2019/20. However, this assumption will need to be further tested given the observed high growth rates in quarter 4. The forecast reduction in numbers of ED attendances, non-elective admissions and bed-day savings has been assessed to inform the level to which demand will be mitigated in 2019/20. Overall, the impact of these schemes at a Somerset system level fully mitigates emergency growth. At a Trust level the level of mitigation results in agreed growth rates of 0.8% for non-elective admissions and 1.9% for ED attendances. There is no additional investment in the current plan for winter, so further mitigations will need to be identified.

2. SAFE AND HIGH QUALITY CARE: QUALITY PLANNING

Approach to quality improvement

Our Chief Nurse, Hayley Peters, is our executive lead for quality improvement. Our organisation-wide approach to quality improvement (QI) is focused on achieving ongoing and sustainable improvements to the quality of care that we provide and underpins our aim to improve our Care Quality Commission rating from ‘Good’ to ‘Outstanding’ in all domains, including ‘Well Led’. Our established structure for QI, which runs throughout the organisation from our front-line services to our Board, consists of five main elements:

1. A blended methodology combining proven Institute for Healthcare Improvement (IHI) methodology with project management and benefits realisation, designed to ensure effective governance and monitoring of projects, and drive out and capture benefits. Central to our methodology is delivering the IHI ‘quadruple aim’ benefits of Improved Health Outcomes, Better Care, Lower Costs and Improved Colleague Satisfaction.
2. An improvement team with the skills and experience to partner with and coach clinical and operational teams to deliver their improvement projects. We have invested in sophisticated project management and are bringing together the tracking and reporting of all of our change projects (including QI, Digital, Merger, GIRFT, and STP projects) onto a single system, enabling us to track the progress, dependencies and interrelations of all such projects.
3. A governance structure of clinician-led ‘Improvement Boards’, bringing together clinical and operational leaders. Each board has a nominated Executive or dedicated representative with overall responsibility. The boards ensure that front-line teams can directly access senior clinical, operational or Executive level support for their QI projects. The improvement programme reports to our alliance-wide Executive Committee (which includes senior clinical and non-clinical leaders) and to our Trust board.
4. The team aims to deliver a comprehensive training plan to equip individuals and teams with the skills they need to improve their own part of the organisation. Our tiered approach means that we offer focused and experiential training, which links learning to live projects, with the aim of embedding QI capacity and capability throughout the organisation, to enable us to implement and sustain change.

5. An evidence based approach to improvement, ensuring that we use the experience and best practice of others and proactively share our own learning. Data is captured and used at all levels of the QI programme from manual collection of data on the front line to the production of Statistical Process Control charts to monitor for significant changes to major indicators.

We employ a range of key performance indicators, assigned to each of the IHI quadruple aims, to monitor progress and demonstrate the impact of QI, including but not limited to:

Better Patient Experience	**Improved Health Outcomes**
• patients having access to both physical and mental health care as appropriate • patient experience survey • numbers of complaints	• performance against national standards • average length of stay • numbers of serious untoward incidents
Increased Colleague Satisfaction • sickness absence rates • 'Pulse check' results – leadership capability and wellbeing • % of colleagues leaving for another job in another organisation	**Lower Costs** • delivery of financial plan against target • % of spend on frontline clinical care • % of spend on mental health and community services

Working as an alliance with Somerset Partnership NHS Foundation Trust, we are implementing these arrangements across local community and mental health services, to ensure that we have sustainable QI capacity and capability embedded across both Trusts. As part of the further development of alliance working, the existing acute Trust Boards will be reconfigured to incorporate community services and link to neighbourhoods.

Summary of the quality improvement plan (inc. compliance with national quality priorities)
Quality concerns and key risks are monitored at Board level via the corporate risk register. Our quality concerns focus on other areas covered in this plan, such as our ability to maintain safe and effective services when activity is increasing and whilst our financial position remains challenging. There are also quality concerns around temporary staffing which are covered in the Workforce section of this plan. Other major quality concerns include the condition of our estate and the likely impact on services such as critical care, theatres, maternity, breast care, haematology and paediatrics which are still housed in 1940s temporary war accommodation. Whilst we have maintained the accommodation to provide as high quality a patient environment as possible, the buildings are poorly designed for modern healthcare, and have poor infrastructure support. A bid for capital funding to replace theatres and critical care has been approved, with an expected completion date of 2024.

Intelligence regarding risks to quality is gathered via an extensive annual assurance programme, overseen by our Governance Support Unit, with direct input into the risk register and escalation to our Governance & Quality Committee of any risks or areas of inadequate assurance. This assurance process includes a specific focus on external sources (e.g. GIRFT, regulator reports, best practice guidance and national investigations), ensuring appropriate action is taken to address any areas of concern. For example, a joint review has been undertaken across both Trusts, of high-risk medicines practices and governance, in the light of the significant failings made evident via the June 2018 report of the Gosport Independent Panel. Our joint review provided significant assurance regarding the arrangements in place in both Trusts, as well as identifying areas where further assurance was required, leading to the development of an action plan that includes a detailed clinical audit of the use of syringe drivers.

The Trust was rated as "Good" overall following its CQC inspection in August and September 2017, and was rated as "Outstanding" for caring. The report highlighted many areas of good practice, including a number of outstanding projects and innovations to develop technology to support patients, staff and other professionals in the wider health community. We were also rated as "Good" for the well-led domain and were found to have a "strong culture for delivering high quality care", a "strong focus on improvement". It was noted that "the trust was a learning organisation". The CQC identified some areas for improvement and detailed action plans were developed and implemented accordingly.

Our risk register identifies our top three risks as:

1) The Trust's financial performance and its ability to return to financial balance. Mitigation is detailed in the 'Financial Planning' section of this plan.
2) The quality of the Trust's estate and its ability to continue to provide quality services from outdated accommodation. Mitigation for this is detailed above.
3) Increasing levels of demand for services. Mitigation for this is detailed in the 'Activity Planning' section of this plan.

Our strategic objectives for the delivery of safe and high quality care are to:

- deliver person-centred care in the most appropriate setting, delivering improved outcomes and satisfaction for patients, as close as possible to patients' homes
- deliver and maintain the highest quality care standards

Our Quality Account priorities for 2019/20 are as follows:

- **Safer Care:** Improving the quality of discharge summaries
- **Safer Care:** Improving Sepsis recognition and treatment
- **Right care, right time, right place:** Expansion of the Rapid Response Service
- **Patient experience:** Co-design/user involvement in all project work to improve service quality
- **Mental health and holistic care:** Parity of Esteem – physical health in mental health settings, mental health in physical health settings. Looking after the patient 'as a whole person'
- **Learning from deaths:** Learning from incidents, complaints and mortality reviews

In agreeing further areas for quality improvement in 2019/20, we will also be developing plans to progress the national priority areas outlined in chapter 3 of The NHS Long Term Plan, 'Further Progress on Care Quality and Outcomes'.

We are compliant with standards 5, 6 and 8 in relation 7-day working (access to diagnostics, access to interventions and ongoing consultant review), but we are not compliant with standard 2 (time to first consultant review), for which we scored 74% in the last national audit, against a target of 90%. Significant work has been undertaken to identify and address areas of underperformance. The two main issues identified were incomplete record keeping in patient notes, and insufficient consultant resource in some areas of medicine. We are rolling out a real-time electronic record system, which will reduce the likelihood of incomplete note-taking, and have the facility to alert consultants immediately to patients in danger of breaching the target. A business case for investment in 7-day working has been presented to NHS Somerset for inclusion in the 2019/20 contract. Work continues on rota changes and recruitment efforts to boost staff numbers. Compliance will be measured in line with the new Board assurance processes set out by NHS Improvement. We aim to be compliant as soon as possible.

With regard to learning from deaths, we designed a mortality review tool to assess the quality of care provided. Reviewers record the key aspects of care for which concerns are judged to have occurred and rate the quality of care on a scale from 'A' (no significant care issues identified and care considered to be excellent despite the outcome) to 'E' (serious issues identified). Our mortality surveillance group has the remit continually to monitor policy implementation across the Trust, including ensuring adequate levels of case review, and to commission themed reviews where these are agreed to be warranted. As reflected in our policy, we actively promote the use of mortality and morbidity meetings to begin the learning process when discussing mortality review cases. We monitor the number of mortality case note reviews which have demonstrated significant care concerns that may have been related to death and these numbers have remained consistently low. The mortality surveillance group has oversight of significant changes within 'care concerns' throughout the Trust over time. This information is used to investigate further, any potential changes related to deterioration (or improvement) in care for mortality cases. We continue to refine our processes around learning from cases where there is thought to be a care concern contributing to death. Where a serious care issue is identified, the mortality review case is referred through to the serious incident

review group and, as appropriate, a serious incident investigation is undertaken. In cases where there are significant care concerns, but the impact on the outcome of death is not known, cases are referred back to the relevant directorate team for further review.

Somerset has plans in place to reduce Gram-negative bloodstream infections by 50% by 2021, aligned with wider health economy plans through a cross-county working group, chaired by Somerset Clinical Commissioning Group, and a shared cross-provider action plan. All Somerset NHS inpatient providers undertake post-infection reviews on all E Coli blood stream infections where the likely source is the urinary tract, to highlight lapses in care and identify any lessons learned. Developments have included:

- the formulation of a patient-held urinary catheter passport, initially a joint initiative between Somerset Partnership and Taunton and Somerset Infection Prevention and Control Teams, progressed countywide through the 100 days improvement strategy
- local initiatives to assess patients with indwelling urinary catheters and remove any devices not clinically indicated as there is a well-established link between indwelling devices and an increased risk of blood stream infection
- reducing unnecessary antimicrobial prescribing by decreasing reliance on urinalysis as a diagnostic tool, emphasising instead, clinical presentation and symptoms.

As a Trust, our ambition was to have no more than 32 trust apportioned cases during 2018/19. Unfortunately this has not been achieved and by 28 February 2019 there had been a total of 36 such cases. In response, from December 2018, we extended our post-infection reviews to include all trust apportioned cases (not just those with a likely source of urinary tract) and in addition, to include all community apportioned cases where the patient had an inpatient stay or a relevant invasive procedure undertaken in MPH in the previous seven days.

We implemented the national early warning score (NEWS2) in September 2018, to improve the identification of deteriorating patients and we are now developing an app-based tool for recording observations and escalating care concerns. This development will have dashboard access to enable teams throughout the Trust to have an overview of all patients' observations and the capability to review remotely for areas of concern.

Section 3: Summary of quality impact assessment process

Our quality impact assessment (QIA) process is structured according to a number of gateways for our Cost Improvement Plans (CIPs). These gateways are:

1. Proposed Project
2. Gateway 1
3. Gateway 2
4. QIA Approval
5. Project in process
6. Completed
7. Project no longer going ahead

In the initial 'Proposed Project' gateway the front-line service directorate makes the scheme known to our Programme Management Office, for inclusion in the overall CIP programme. The directorate team will then produce a summary of the project, its proposed benefits, stakeholders and interdependencies with other schemes. To move the scheme from 'Gateway 1' to 'Gateway 2', the additional detail required includes:

- a more comprehensive overview of the project, its benefits and interdependencies
- a Quality & Equality Impact Assessment, to identify any such impacts for a range of stakeholder groups, and specifying actions to mitigate any negative impacts identified
- an overview of the main risks of the project, scored against the CIP risk rating matrix, specifying the likelihood and impact of each risk, the risk owners and mitigations.

Once this information has been provided, the PMO team will assess if the scheme needs to be signed off by the Chief Nurse and Chief Medical Officer, and will pass to both post holders accordingly. If the scheme meets the agreed criteria it moves to the 'Project in Process' stage. If extra information is required, the PMO team will work with directorate teams accordingly. Once the savings from a project

have been realised and are reconciled to adjustments within the ledger, the project is moved to the 'Completed' gateway. If a project is unable to move forward and no savings can be realised it is marked as 'Project no longer going ahead'.

Projects are reviewed against the quadruple aim, which is the basis of our QI work: Better Patient Experience, Improved Health Outcomes, Increased colleague Satisfaction, Lower Costs. We also review the quality impact with regard to Patient Safety, Clinical outcomes, Patient Pathways, Patient Experience, Accessibility, Staff, and Equality.

Triangulation of intelligence regarding quality is predominantly via our Integrated Performance Report, which is considered at every meeting of the Trust Board, and monthly at Directorate level within Performance Assessment Framework (PAF) meetings. The reports consider an agreed set of key domains in operational delivery including activity, finance and value, and patients and people including workforce indicators, enabling effective triangulation. These are 'RAG' rated, with discussion of exceptional areas, to inform improvement planning. Measures include, but are not limited to:

Workforce	Finance	Activity
• sickness absence rates • 'Pulse check' results • vacancy rates	• delivery of financial plan against target • agency spend levels • cost improvement plans	• operations completed/ cancelled • elective and non elective activity levels • outpatient activity

Under each domain, a further set of performance indicators is managed at sub-Board level. The use of statistical process control charts in our reports to our Board enable us to identify any statistically significant changes which go beyond the levels of common cause variation, identify any potential deterioration in the quality of care, and develop actions as necessary to address those changes. Our Board also receives a quarterly report on progress against our key objectives for the year, based on the priorities which we set out in our operational plan, and other priorities identified through our strategic planning process, drawing upon the views of patients, carers, Governors and staff. These reports and our wider governance forums allow us to triangulate information across a range of indicators and help us to identify and address any issues arising.

3. COLLEAGUES AND CULTURE: WORKFORCE PLANNING

As an alliance, Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust have a single People strategy that supports, engages, and develops colleagues and underpins robust workforce planning across both organisations. Our People strategy sets out our plans to ensure that we have the right staff with the right skills, delivering safe, high quality care.

Our strategic objective in relation to colleagues and culture is to:

- Engage, Develop and Resource the workforce across the whole alliance whilst aligning and developing a positive and progressive culture to deliver high quality, cost effective care whilst ensuring the alliance is a great place to work

As part of our alliance-wide workforce planning and monitoring arrangements, we engage with front line clinical teams to assess current baselines and project forward our workforce requirements in order to understand future requirements and options to satisfy them. There are clear links, integral to our performance assessment processes, between the financial, workforce and operational performance of services, ensuring that finances and activity plans are aligned with workforce plans in order to ensure the delivery of safe care to patients. As at 28 February 2019, the latest data available, our rates in respect of key workforce measures were as follows:

- rolling 12-month sickness absence: 3.9%
- rolling 12-month turnover: 12.1%
- mandatory training compliance: 88.7%
- non-medical appraisal rate: 86.3%

- medical appraisal rate: 85.2% (this is set to rise to 91.8% by 31 March 2019, based on booked appraisals)

Table 3 below sets out some of the principal workforce challenges that we currently face, the impacts of those challenges, and the mitigations which we have put in place.

Workforce challenge	**Impact on workforce**	**Initiatives in place**
Supply: particularly a shortage of ward-based registered nursing roles, across acute, community, and mental health services	• difficulties in recruiting to establishment levels • high reliance on agency usage and impact on levels of expenditure	• bank premium enables colleagues to earn a premium if they have fulfilled their baseline hours. This has been commended by NHS Improvement (NHSI) as exemplar practice. • tiered agency expectations, where agency rates are compared on a weekly basis. • reduced use of the most costly tier 3 rate. • development of new roles and ways of working • overseas recruitment stepped up
Capacity and demand	Burnout, particularly within medical specialities	Our Health and Wellbeing Strategy sets out a range of actions across mental health and physical health to support colleagues
Retention, especially regarding registered nursing roles	Adverse impact on morale and high work levels for individuals	We are an active member of the NHSI retention programme, using QI methodology.
Supply: shortage of some medical roles	Increased burden on colleagues	We have a dedicated medical recruiter, who has been directly responsible for 15+ doctors recruited into mental health
Brexit	Uncertainty, particularly colleagues from overseas	We are providing support through our overseas nursing forum, as well as human resources support to colleagues, and regular communications, to ensure that colleagues know how highly they are valued
Long Term Plan	Need to develop the workforce to ensure the right capacity and skills to deliver new models of care	Participation in the NHSI retention programme and Colleague Health and Wellbeing programme. Career development and pathways. Focus on equality, diversity and inclusion. Leadership development.
Overseas recruitment	• recruiting to establishment levels • high reliance on agency	Recruitment activity is continuous, including programme of overseas recruitment. We have a revised RN recruitment trajectory that includes recruitment from within the UK, new graduates and overseas pipelines.
Changes to NHS nursing allied health professional bursaries	Fewer people entering training	Presents a further risk to supply of UK trained nurses.

Table 4 below provides an outline of our current workforce risks, issues and mitigations in place to address them.

Description of workforce risk	**Risk impact**	**Risk response strategy**	**Timescales, progress to date**
Supply into hard to fill roles including RN Ward based roles, Medical Consultant roles (various)	High	National and international recruitments plans in place. Dedicated recruiters working with hard to fill areas to develop local action plans.	Nursing: June 2019 Other areas: ongoing

Description of workforce risk	Risk impact	Risk response strategy	Timescales, progress to date
The supply of staff from Europe and beyond	Medium	We have recruitment plans in place and have developed a Brexit plan which spans the alliance	Ongoing
NHS nursing and allied health professional bursaries	Medium	We have recruitment plans in place and have developed a Brexit plan which spans the alliance	Ongoing

An outline of our long-term vacancies and how we are planning to fill those vacancies is outlined in Table 5 below.

Description of long term vacancy, including the time it has been a vacant post	WTE impact	Impact on service delivery	Initiatives in place along with timescales
General Ward based registered nurses	70	Significant agency spend, reduced continuity of care	Overseas registered nursing activity, with four pipelines including New Zealand and Canada.
Breast Care: consultant oncoplastic breast surgeon (10 PA) and Staff Grade breast surgeon	2	Not using bank or agency	Post Associate Specialist offered on 5 February 2019.
Care of the Elderly Consultant vacancy advertised on 24 April 2018, 5 June 2018, 14 Sept 2018: no applicants. Two Care of the Elderly roles have gone to advert in October and December 2018. No applicants.	2	Use of agency in recent months. There have been issues with getting an agency member in, due to accommodation shortage.	Being re-advertised in a few weeks' time.
Endocrinology: one colleague on maternity leave from 21 December 2018. No recruitment into her post. Ad placed for a substantive post in October 2018. No suitable applicants.	2	Currently being filled by agency staff.	Awaiting response from Endocrinology clinical service lead on advertising one post.
Rheumatology: post advertised on 24 August 2017, and subsequently on another six occasions up to 8 June 2018. Advertised again in Nov/Dec 18	2	Issues with securing agency cover. A locum is due to commence, start date not confirmed.	One whole time equivalent due to start on 20 March 2019 and out to advertisement for the other position.
Paediatrics combined community and safeguarding role. Advertised on 21 July and 15 November 2018: no applicants	1	Being covered in house	The job description is being revised. Post to be re-advertised.
Acute Medicine has not been out for advert	2	Winter pressure. Out with agency	Considering recruiting 5 WTE; currently 2 WTE vacancies
A Respiratory role went out to advertisement on 31 July 2018 but has not been out to advert since.	1	An agency locum started during the week commencing 4 February 2019, for six months	Awaiting on confirmation from Respiratory clinical service lead to go to advert.

Description of long term vacancy, including the time it has been a vacant post	WTE impact	Impact on service delivery	Initiatives in place along with timescales
Urology 2 x 10 PA advertised on 19 October 2017,27 March 2018: no applicants. Posts were re- advertised 9 October 2018	2	The vacancy is currently being covered within the team.	Two starters: 1 February and 1 April 2019. Post offered 9 October 2018.

Our People strategy makes clear the alignment of our priorities with those of the wider STP. Our recruitment initiatives have seen us recruit nurses from Europe and beyond, and we will continue to undertake recruitment initiatives collaboratively, as an STP footprint. The recruitment pipeline (including overseas recruitment, supported by Yeovil District Hospital) confirms registered nurse recruitment levels will be reduced significantly by June 2019. Trusts are part of the NHS Improvement retention programme with improvement work underway in this area. New roles which are in place or under development include Trainee Nurse Associates, Physician Assistants, and Apprenticeships across a range of disciplines. Staff shortages may mean that some services are not viable in the long term in their current format, and transformational change is required in order to meet future needs. To ensure a sustainable longer term solution for nursing workforce supply given the lack of a university within Somerset, an innovative partnership has been established between NHS providers, other health and care employers and Bridgwater & Taunton College to introduce a new local nursing degree programme (building on the success of the locally-delivered trainee Nursing Associate programme). System level collaboration to develop a strategic approach to apprenticeships has led to the development of initiatives to increase the breadth and number of apprenticeships offered within the county. This will provide valuable employment opportunities and new pipelines for developing skilled staff. In relation to new clinical role development, a system-wide Faculty of Advanced Practice has been established to harmonise and develop further advanced clinical practitioners as a key component of the future workforce.

We are developing new models of care and redesigning pathways to improve our offer to our workforce and deliver better quality care for patients, examples of which include the development of the Rapid Response service, Home First, and countywide Psychiatric Liaison, and new Nursing Associate roles. We are also in discussion with the University of the West of England to take Physician Associates for 2019/20, to support gaps for clinicians, and we will also continue to strengthen bank provision, minimise agency use, and further develop e-rostering.

As an alliance and as an STP, our workforce focus is on creating a balance in workforce supply and demand, with the right skill mix, maximising the potential of our current skills and providing the workforce with developmental opportunities. As an alliance, we are exploring developing specialist nursing roles in critical care and paediatrics, to provide enhanced care without the need for additional difficult-to-recruit consultant posts. We are also developing new technical roles in some medical specialties, as a result of innovative working with local education providers to train school and college leavers and help keep them in the area.

We are now considering the use of shared bank arrangements with other Somerset providers, and we are procuring e-rostering and job planning systems, to enable more effective rota management and staff utilisation, focused on flexibility around patient need. The STP provides opportunities for collaboration and improved workforce productivity, which has already begun with more closely linked back office services, and will be further developed in the coming year. As an alliance, we have undertaken work to consider the Carter review to benchmark our services for efficiency, including a workforce review to explore the scope for efficiencies within our establishment. As part of our current Cost Improvement programme we use a number of resources to prompt the review of workforce within each financial year. This includes information from Model Hospital, NHS Improvement Benchmarking data and findings from NHS Benchmarking Network projects.

The apprenticeship levy is fully established in supporting the recruitment of new apprentices as level two health care assistants and administrative support. The levy also supports workforce development and leadership development plans through colleagues utilising the levy to develop their careers. This

helps with retention and promotion from within the alliance, enabling new apprentices to join at the entry level, with clear options for progression. Our People strategy priorities for 2019/20 include:

Resourcing

1. Develop tools and resources to support decision making through workforce planning, to include the provision of a template workforce planning model
2. Develop and advertise a more sophisticated total reward package and incentive schemes to enhance and differentiate the alliance as a great place to work
3. Provide comprehensive reporting on all stages of the recruitment lifecycle
4. Create flexible approaches to work and retirement which support our people as they move through their working lives;
5. Design a people framework and employment models which support new ways of working across organisational boundaries
6. Design and development of more flexible roles, enabling colleagues to work with a core set of skills, whilst being flexible in their approach within their scope of practice.
7. Further explore more flexible terms and conditions such as part time options, job sharing, secondment opportunities and new, more flexible career paths;

Engagement

8. Develop and implement a communication and engagement plan for cascading values and behaviours across the alliance
9. Implement a "you said we did" approach to ensure where feedback is being received the actions are being communicated in a regular robust and consistent way
10. Ensure improvement methodology is embedded into everyday leadership;
11. Through a survey ask colleagues what they believe the recognition schemes currently are and what they would want;
12. Review the actions from the "Great Place to Work" and build on this along with results from the staff survey;
13. Develop a plan for reward and recognition that links to performance.
14. Provide an occupational health service focused on intervention and prevention;

Development

15. Implement a robust and effective performance review process;
16. Focus on the quality of reviews as well as the quantity;
17. Enable colleague feedback on the on-boarding experience and improve availability and choice of learning to support career development;
18. Identify skills required and carry out a skills analysis to identify gaps;
19. Review training to ensure it supports innovative and evidence based practice;
20. Create a learning environment where colleagues feel empowered to make a difference.
21. Prioritise the introduction of succession planning for all key leadership positions across the alliance

Further priorities will focus on Equality, Diversity and Inclusion, TUPE transfer to support the merger, harmonisation of policies and procedures.

Triangulation of performance in respect of workforce, quality and finance is undertaken via our Integrated Performance Report, which is considered at every meeting of the Trust Board, and monthly at Directorate level within Performance Assessment Framework (PAF) meetings. Further details are included in the 'Quality Planning' section of this plan.

4. VIABILITY AND GROWTH: FINANCIAL PLANNING

Approach and Oversight

The Trust's approach to financial planning is grounded on an understanding of the underlying financial performance of the Trust and key performance drivers. The Trust has a fully integrated business planning process whereby the financial plans are built up from and aligned with workforce and activity and capacity plans.

The internal business planning process is overseen by the Business Planning Management Group (BPMG), chaired by the Director of Finance with key members drawn from the clinical directorates and corporate areas, including performance, quality, nursing and workforce. The Trust is also an active partner in the STP, ensuring that the Trust planning approach is aligned with and visible to STP partners.

Internal work with budget holders using forecast outturn data is used to derive the underlying position and horizon scan the impact of other known changes and developments including the identification of unavoidable cost pressures.

Directorates use the IMAS model to determine their capacity requirements and assess the gap to the system agreed demand assumptions. Directorates develop business cases to address their capacity issues and any other investment required to maintain safety and quality (e.g. safer staffing). These are reviewed internally by BPMG and if supported then submitted for STP review. Senior leaders from the constituent STP partners peer review all business cases to ensure there is a robust level of challenge and consistent approach. CIP planning starts with indicative targets set for all clinical and corporate areas of the Trust. Progress is reviewed by the CIP Review Group and CIP Board. The PMO and Improvement Team are an internal resource who support directorates in the identification and delivery of their efficiency plans. Regular updates are provided to the Finance Committee and Trust Board.

Underlying Position

The Trust undertakes a detailed review process to ensure it fully understands its underlying financial position and uses this as the basis to build up its financial plans.

The underlying position uses the forecast outturn as the starting point then adjusts for the impact of factors including non-recurrent costs and income, the full year impact of in-year developments, CIP, and the 2018/19 pay award. Staff costs are fully rebased on an individual basis and reconcile to agreed establishment levels and ward rotas.

The underlying position as at 31 March 2019 is a deficit of £20.7 million (2018/19: £17.1million) and is shown in Table 6 below:

Underlying Position	£m
18/19 Outturn	**(10.8)**
Adjustments:	
PSF (achievement Q1-3)	(6.2)
18/19 achieved NR vacancy factor added back	(3.4)
Vacancy factor & FYE of CIP	4.5
NR CIP	(3.6)
NR Benefits/costs	(3.5)
Pay Award FYE (Increments)	(1.0)
Pay Award 18/19	(2.8)
National Pay Award Funding 18/19	3.8
FYE Developments	(3.9)
Income uplift	2.5
Removal of Agency	12.0
Rebasing Agency	(1.4)
Rebase Establishment	(6.9)
Underlying position as at 31 March 2019	**(20.7)**

2019/20 Plan

The Trust has identified a number of unavoidable cost pressures in addition to the routine inflationary uplifts through the business planning process and in response to operational and clinical pressures across the hospital. These in the main are:

- the need to avoid significant investment in agency nursing in 2019/20 by continuing the work on recruiting additional overseas nurses. There is recognition that there will be a non-recurrent cost pressure into Q2 until recruitment is at a level which is sufficient to offset the number of vacancies and predicted normal turnover;
- the revenue impact of the capital programme and in particular the impact of the investment the Trust has made in digital technology resulting from the Global Digital Exemplar Programme;
- the impact of the change in the Royal Institution of Chartered Surveyors (RICS) guidance in relation to asset lives;
- investment to support the merger business case,
- increased staffing in the neo-natal unit to provide a safe level of staffing
- other unavoidable cost pressures such as the impact of the new procurement top-slice.

Investment in capacity and safety of £4.8 million has been reviewed by STP partners and supported. This will enable the Trust to respond to demand growth and improve RTT, diagnostic, cancer and 52 week wait performance across the Trust.

Inflationary uplifts (net of tariff deflator), PSF transferred into tariff for urgent and emergency care and MFF uplifts are also agreed. The contract with the main commissioner (Somerset CCG) has been agreed on a fixed block basis with the exception of GP direct access activity which will continue on a pass-through basis. Contracts with all other commissioners will continue to be on a fully variable PbR basis. The bridge from underlying to the final plan is shown in Table 7 below:

2019/20 Plan	£m
Underlying position as at 31 March 2019	**(20.7)**
Pay and prices	
2019/20 Pay award	(4.1)
Drug/Non pay/capital inflation	(1.9)
	(6.0)
Cost pressures and developments	
Overseas recruitment & Agency costs	(4.8)
Revenue impact of GDE/capital programme	(1.8)
Neonatal Staffing Increase	(0.2)
Depreciation – asset lives adjustment	(1.5)
Procurement top-slice	(0.3)
Other cost pressures	(0.5)
Sub total	**(9.1)**
Capacity & Safety investment	**(4.8)**
Tariff uplift	3.4
PSF Transferred to tariff	5.4
CIP (3.7%)	13.3
MFF Increase	0.6
Plan before non-recurring income items	**(17.9)**
MRET	5.0
PSF	5.3
Financial Recovery Fund	1.6
Total non-recurring income items	**11.9**
Final 2019/20 Plan	**(6.0)**

Control Total	(6.0)

The plan is compliant with the deficit control total of £6m

The statement of comprehensive income is shown in Table 8 below:

Statement of Comprehensive Income	Plan 2019/20 £m
Operating income from patient care activities	297.3
Other operating income	45.0
Employee expenses	(209.7)
Operating expenses excluding employee expenses	(132.6)
Operating Surplus/(Deficit)	**0.0**
FINANCE COSTS	
Finance income	0.1
Finance expense	(2.0)
PDC dividends payable/refundable	(4.0)
NET FINANCE COSTS	**(5.9)**
Share of profit/ (loss) of associates/ joint ventures	0.2
SURPLUS/(DEFICIT) FOR THE YEAR	**(5.7)**

Adjusted financial performance	Plan 2019/20 £m
Surplus/(deficit) for the period/year including PSF, FRF and MRET funding	**(5.7)**
Add back all I&E impairments/(reversals)	0
Adjust (gains)/losses on transfers by absorption	0
Surplus/(deficit) before impairments and transfers	**(5.7)**
Remove capital donations/grants I&E impact	(0.3)
Adjusted financial performance incl PSF, FRF & MRET funding	**(6.0)**
Control total incl PSF, FRF & MRET funding	**(6.0)**
Performance against control total incl PSF, FRF & MRET funding	**0.0**
Performance against control total excl PSF, FRF & MRET funding	**(11.9)**

Liquidity

The Trust will continue to manage working capital to preserve cash but is anticipating the need for interim revenue support of £6m to support operational delivery. We have assumed the working capital loan of £4.4m due for repayment in January 2020 will either be extended or a further interim loan will be required to enable the existing loan to be repaid.

Agency

The Trust faced unprecedented nursing agency pressures in 2018/19. This was the result of much higher than planned vacancies, increases in patient acuity and the need to special a number of highly complex patients. To some extent, these costs have been mitigated slightly through the leveraging down on premiums by reduced usage of tier 3 nurses. Despite this, the Trust has made progress in reducing the reliance on medical and nursing agency. The Trust has an overseas recruitment strategy which aims to reduce expenditure on nursing agency in 2019/20. Further detail is included within the workforce section of the operational plan narrative.

Efficiency Plans

CIP has been set at 3.7% or £13.3 million, with the expectation this will be delivered through recurrent schemes. This is considered a stretching but realistic assumption.
The current rag rating of schemes is shown in Table 9 below:

Risk rating	£000
Low	3,633
Medium	4,626
High	5,032
Total	**13,291**

48% of schemes are low/medium risk. The high risk schemes represent schemes where work is underway to scope the opportunity but where clear plans are currently in development. The breakdown by efficiency type is shown in Table 10 below:

CIP scheme type	£000
Pay (Skill Mix)	4,921
Pay (WTE reductions)	3,340
Non pay	4,381
Income (Patient Care Activities)	492
Income (Other operating income)	157
Total	**13,291**

Capital

Digital Exemplar funding and expenditure has been re-phased, moving some expenditure into 2019/20 from 2018/19 with an element then moved into 2020/21. Completion will now be in 2020/21 rather than the previous plan of the programme finishing in 2019/20. The new programme phasing has been agreed with NHS Digital.

The phasing of costs for the Phase 2 Surgical Centre FBC is still being developed with the recently appointed P22 partners Kier. The full loan drawdown is expected to take place during the 19/20 financial year with final drawdown in quarter 4. Funding will be drawn down from the Department of Health and Social Care in line with expenditure. The extended loan drawdown profile has been agreed with the Department of Health and Social Care.

The proposed programme is over-committed by £500,000. The programme has been significantly reduced from an initial over commitment in excess of £3.0 million. In an effort to balance the programme there have been a number of important investment requirements excluded from the proposed programme. These include:

- approximately £1 million of medical equipment investment related to service development business cases that have been approved subject to available capital, but have been excluded from the capital programme
- a significantly reduced medical equipment replacement programme. The consequence will be £1.0m of unfunded equipment, with a risk score of 12
- a significantly reduced backlog maintenance programme
- reduced Trust funding of the GDE programme
- no allowance for creating additional winter pressures physical capacity.

5. SUSTAINING A HEALTHY COMMUNITY: LINKS TO THE LOCAL SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

The Somerset STP sets out the following key priorities:

- Developing an Integrated Care System
- Development of Local Services
- Strengthening more specialist and Acute Services
- Prevention
- Improving our Financial Position

In 2019/20 the Somerset system will collectively deliver transformation in line with the system vision agreed in late 2018, and the single system and programme approach to strategy, transformation and collective system management.

The key deliverables will be the improvement of access and reduce waiting time for elective care in the west of the county and move towards more equitable access across the county, with short-term actions in place to reduce the size and length of the waiting list, and transformational projects focussing on outpatients and diagnostic delivery. The system will invest in core mental health services, recognising the current level of investment and service gaps, and implement universal support services for children and adults aimed at mitigating specialist demand, and has commenced delivery of the key schemes agreed across the system. We will implement neighbourhoods across the system to work to support the longer-term mitigation of demand growth and these will be inclusive of the setup of primary care networks and will review the scope and range of community services (across health and care). Through the neighbourhoods and local services we will have a centred, prevention focussed approach to stop or reduce escalation, with specific clinical pathways to be focussed on. These will, as a result, ensure that we are prepared to support the move away from an (excess) reliance on bed-based care. Within our acute services, we will be implementing the quick wins from the external review of paediatrics, finalising the future of acute stroke services and commence implementation and developing proposals for longer-term changes to elective referral patterns on the back of in-year work aimed at improving waiting times.

The STP acknowledges that the county's health and care services are not keeping pace with the changing needs of local people and that the Somerset system requires radical transformation to ensure its financial and clinical sustainability. Much of our work in the last year has been focused on developing ways of achieving this, and our preparations for merger over the coming year will ensure that we maintain that focus.

Our strategic objectives in relation to sustaining a healthy community are to:

- deliver the benefits of integrated care within a merged organisation, and work with primary care, social care, public health and voluntary sector partners to deliver integrated, high quality services.
- work with STP partners to deliver the Fit for My Future strategy, prioritising prevention and neighbourhood working, to maintain a sustainable county health economy.

The alliance between Somerset Partnership and Taunton and Somerset NHS Foundation Trusts has worked actively as a partnership to drive forward the vision of the local STP through improved ways of working, and transformational programmes involving the development of new models for the delivery of better quality care for patients, including:

- **Rapid Response**: this team provides GPs and the South West Ambulance Service NHS Foundation Trust with a credible alternative to Accident and Emergency for frail older people, helping to reduce bed occupancy by the equivalent of 20 beds across the STP by reducing preventable admissions and caring for people in their own homes.
- **Home First**: this Discharge to Assess service **reduces** length of stay in hospital and also the number of delayed transfers of care. A team of nurses and allied health professionals assesses the needs of patients their own homes, community hospitals or care homes, and provides support until an established out of hospital care package is in place.
- **Psychiatric Liaison Team**: this enhanced, nationally-compliant service means more liaison psychiatrists and psychiatric liaison nurses are available to assess, treat and signpost mentally unwell patients presenting at both TSFT and Yeovil District Hospital to alternative locations for

care, such as Crisis Intervention and Home Treatment. Its aim is to reduce by 20% the admissions and length of stay for mentally unwell patients presenting at the acute hospitals.
- **Complex Care Hubs**: These hubs treat the increasing number of patients with multiple long-term conditions and enable patients' whole care needs to be assessed and managed in one place. The hubs bring together existing community services with primary care and are located across the county in existing community services localities, with plans to create additional hubs in advance of winter.
- **Better Births:** this £1 million project is one of seven nationwide pilots aimed at digitally-enhancing maternity services, in line with the recommendations of the Better Births review. The project involves data collection, access to information and records for families and staff, and linking data systems across hospitals and primary care. A new post-natal nurse associate post is supporting this work, providing continuity of care for vulnerable families, as well as offering a new career opportunity for support workers.
- **Nursing Associates:** Nursing Associates provide care and support to patients, addressing a gap in care skills between healthcare assistants and registered nurses. The roles represent a further option for career development and can be used as a stepping stone to graduate-level nursing qualifications. The third cohort of Nursing Associates is in place, and the initiative is another example of how we are 'growing our own' workforce to address skills shortages.

How our 2019/20 Priorities will link to the STP

The themes of the integration programme between Taunton and Somerset NHS Foundation Trust and Somerset Partnership are consistent with the STP's key priorities and wider aims. The proposed merger between the two trusts strongly supports the STP's strategic objectives of integrated care and strengthened community services for the people of Somerset. It will create a financially sustainable organisation that will help address the Somerset STP's financial challenges and support the development of an integrated care system for the county.

The following summary shows how our plans for merger serve the key priorities of the STP:

- **Prevention**: we will work with partners to improve our focus on and investment in preventative care to help reduce demand particularly for mental health, cardio-vascular services, cancer, respiratory disease and musculoskeletal services
- **Development of Local Services**: we will work with our commissioner and primary care partners to focus our resources away from acute services and into mental health and community services so we can provide care for patients in their own homes, or as close to home as possible, and developing the neighbourhood model of care delivery
- **Strengthening more specialist and Acute Services**: we continue to work with neighbouring acute Trusts to identify solutions to unsustainable acute services, either by consolidating acute services or by developing out of hospital models of care
- **Creating an Integrated Care System**: the development of the merged trust's clinical model is a first step on the road to creating an integrated provider organisation in Somerset, and subsequently an Integrated Care System
- **Improving our Financial Position**: our financial plan will support the improvement in the system position by delivering our own financial aims, and will deliver additional system benefits including improved early intervention to reduce escalation of need / demand for emergency care and reduce reliance on bed-based care. Savings will also be secured through combining support services and some clinical teams

Links to other STP areas

We will continue to play a key role alongside STP partners in developing the planned Somerset neighbourhoods and align our community-based work and inpatient care with them. We will provide increased support and advice to primary care, improved community-based diagnostics, and work with partners to support early intervention to prevent escalation of health need. We will also continue to work in partnership with and support local voluntary sector organisations. We recognise the

importance of IT as an enabler to the delivery of integrated care and we are developing a programme of work to take forward integration of our IT systems in a way that allows interoperability with our STP partners. We also continue to work with local partners on the development of the Somerset Integrated Digital Electronic Record.

6. MEMBERSHIP AND ELECTIONS

The Council of Governors of Taunton and Somerset NHS Foundation Trust is made up of 29 elected and appointed governors who provide an important link between the Trust, local people and key organisations, sharing information and views that can be used to develop and improve services. It is chaired by the Trust Chairman and comprises the following:

- 15 public governors from four constituencies (Taunton, West Somerset, East Somerset and Rest of England). There is one vacant seat (Rest of England).
- five staff governors elected by self-nomination and constituency voting, representing a minimum of three out of the following five staff groups:
  - medical and dental
  - nursing and midwifery
  - hotel and estates services
  - clerical, administrative and managerial
  - allied professionals, scientific and technical

  There are no vacant seats in the staff constituency.
- nine appointed governors, including:
  - four local authority governors
  - one youth governor (vacant)
  - four partnership organisation governors (two vacant seats).

Governor elections in previous years and plans for the coming 12 months
In 2018 elections were held successfully in three public constituencies, Taunton Deane (two seats), East Somerset (two seats) and West Somerset (one seat) and the staff constituency (one seat). There was also a vacancy in the Rest of England constituency, but no nominations were received and so this seat remains vacant. A new candidate was appointed to represent the Mendip and South Somerset District Councils.

As part of the proposed merger between Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in 2019 we have established a joint Constitution Review Group to consider the composition of the membership constituencies and the Council of Governors for the merged organisation. The recommendations from this Group will inform the development of a new Constitution, which will form the basis of any elections in 2019.

Governor recruitment, training and development and membership engagement
Training and development are essential for governors to perform their duties. Some examples of the ways in which they are supported with this include attending Trust induction, undertaking hospital tours and ward visits, being invited to the South West Governor Exchange Network (which includes regular discussion about the roles and responsibilities of governors, as well as strategic updates), annual training on the role, provided by the Trust's external auditors, weekly briefings sent electronically to governors and attendance at key governors' meetings and the Board.

The focus of our membership strategy is on improving meaningful engagement with our members. In support of this aim, we engage with our members via email, through the publication of a regular members' briefing and through events and meetings such as the annual members' meeting held in September each year. Our membership (which is reviewed by the Communication and Engagement Working Group on behalf of the Council of Governors and the Board), is broadly representative of the population it serves. According to 2011 census data, the majority of Somerset residents are 'white British'. Somerset also has an increasingly older population, and our membership reflects this trend.