Yeovil District Hospital NHS
NHS Foundation Trust

NHS
Somerset
NHS Foundation Trust

Full Business Case for merger of Yeovil District Hospital NHS Foundation Trust and Somerset NHS Foundation Trust

October 2022

Contents

Table of acronyms

Acronym	Meaning
A&E	Accident and Emergency
AHP	Allied Health Professional
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CYP	Children and young people
DCH	Dorset County Hospital
DHSC	Department of Health and Social Care
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EPMA	Electronic Prescribing and Medicines Administration
FFMF	Fit for My Future
FT	Foundation Trust
GDE	Global Digital Exemplar
GIRFT	Getting It Right First Time
GP	General Practitioner
HR	Human Resources
ICB	Integrated Care Board
ICP	Integrated Care Provider
ICS	Integrated Care System
ICU	Intensive Care Unit
IPC	Infection Prevention & Control
IQAB	Integrated Quality Assurance Board
IT	Information Technology
LD	Learning Disabilities
LMC	Local Medical Committee
LTFM	Long term financial model
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
MOU	Memorandum of Understanding
MPB	Merger Programme Board
MPH	Musgrove Park Hospital
MSK	Musculo-skeletal
NED	Non-Executive director
NHSE	NHS England
OD	Organisational Development
ONS	Office for National Statistics
PALS	Patient Advice and Liaison Service
PCN	Primary Care Network
PDC	Public Dividend Capital
PenARC	Applied Research Collaboration South West Peninsula
PFI	Private Finance Initiative
PIFU	Patient Initiated Follow-Up
PLICS	Patient Level Information Costing System
PLT	Psychiatric Liaison Team
PMO	Programme Management Office
PSF	Provider Sustainability Funding
PSIRF	Patient Safety Incident Response Framework

PTIP	Post Transaction Integration Plan
QAC	Quality Assurance Committee
QAG	Quality Assurance Group
QGAC	Quality and Governance Assurance Committee
QI	Quality Improvement
QIA	Quality Impact Assessment
RTT	Referral to Treatment
SDEC	Same Day Emergency Care
SEAG	Somerset Engagement Advisory Group
SEND	Special Educational Needs & Disability
SFT	Somerset NHS Foundation Trust
SIDER	Somerset Integrated Digital Electronic Record
SLR	Service Line Reporting
SPFT	Somerset Partnership NHS Foundation Trust
SPS	South West Pathology Services
SSL	Simply Serve Limited
STTS	Somerset Talking Therapies Service
STP	Sustainability and Transformation Partnership
SWAST	South West Ambulance Service NHS Foundation Trust
TSFT	Taunton and Somerset NHS Foundation Trust
ULP	Underlying position
VCSE	Voluntary, community and social enterprise sector
WTE	Whole Time Equivalent
YDH	Yeovil District Hospital
YDHFT	Yeovil District Hospital NHS Foundation Trust

Chairmen's introduction

We are delighted to present the Full Business Case for the merger of Yeovil District Hospital NHS Foundation Trust (YDHFT) and Somerset NHS Foundation Trust (SFT). This is the culmination of a six-year journey which has parallels with recent developments in the NHS – moving away from separate competing organisations towards genuine system working, focused on the needs of patients.

In 2016, the Chairs of the then three separate Foundation Trusts in Somerset (Taunton and Somerset and YDH, the acute trusts, and Somerset Partnership, the mental health and community trust) were considering ways to improve collaboration and, in 2017, they signed a statement committing to explore merger into a single Trust.

The aim of forming a single NHS Foundation Trust was driven by the needs of our patients - the same patient might need community, mental health and acute treatment, but handovers between separate legal entities get in the way of delivering excellent healthcare. As a single Trust we would have a unique opportunity to provide truly integrated mental and physical health care, spanning whole patient pathways from primary care through to community, mental health, learning disabilities and acute services. All three Trusts were small to medium-sized and would be more sustainable if combined. Finally, a single Foundation Trust in Somerset would have a coterminous boundary with the unitary authority of the county enabling us to work ever closer with colleagues in social care and public health, primary care and the voluntary sector to improve the lives of the people of Somerset.

Somerset Partnership and Taunton and Somerset FTs merged to create SFT on 1 April 2020, at the very beginning of the Covid pandemic. The merger proved its worth from the start: for example, mental health colleagues benefitted from the deep knowledge of infection control which is core to acute medicine, whilst acute patients and colleagues benefitted from seamless access to mental health support. Joining SFT and YDHFT enables us to extend across the whole of the county the benefits we have already delivered by bringing together acute, mental health, learning disabilities and community services through the creation of SFT.

YDHFT is a pioneer in the transformation of primary care through its Symphony programme. Symphony, an NHS Vanguard programme, helps patients live healthier lives at home and stay out of hospital through tailored care in the community. YDHFT's ownership of a quarter of the county's GP practices means the merged Trust will be able to test and implement new ways to join up services with primary care, and do so at pace.

Merging SFT and YDHFT will make our services more resilient and provide a unique platform for testing innovative models of care. It will strengthen our contribution to Somerset's developing neighbourhoods and help meet our shared system aim of providing more care closer to people's homes. It also helps us address inequities of care within the county so that everyone in Somerset has access to the same high quality care wherever they live.

Our Trusts have a history of strong collaboration. We have had a single executive team operating across both Trusts since January 2022, and our two Trust boards now meet jointly. We believe our merger, which will remove the remaining barriers between the two Trusts, will enable us to fully realise the opportunities to improve the health and wellbeing of the people we serve in Somerset and neighbouring areas.

Martyn Scrivens, Chairman YDHFT, Colin Drummond OBE, DL, Chairman SFT

1. Executive summary

Background

1.1 This Business Case presents the case for the merger of Yeovil District Hospital NHS Foundation Trust (YDHFT) and Somerset NHS Foundation Trust (SFT). YDHFT provides acute services across south Somerset and north and west Dorset, and runs 16 GP practices.[1] SFT provides community, mental health and learning disabilities services for the whole of Somerset, and acute services for the north, west and centre of the county and parts of Devon and North Somerset.

1.2 The proposed merger will bring together all of Somerset's acute, community, mental health and learning disability services, and around a fifth of primary care into a single NHS Foundation Trust.[2] The merged Trust will be in a unique position to provide truly integrated mental and physical health care, spanning whole patient pathways and will be the only NHS trust in the Somerset Integrated Care System (ICS).

1.3 Health and care services in Somerset are struggling to meet the increasing demands of the ageing population and a rising number of people with complex or long-term health conditions. In addition, a historical reliance on bed-based care, high demand for acute care and the high cost base of acute services have led to a structural financial deficit in the Somerset system.

1.4 The geography of Somerset and the surrounding areas, and local population demographics present challenges for the provision of health services. Somerset is a relatively small ICS with a population of c.572,000, but the population we serve is dispersed over more than 1,300 square miles. There is also now an increasing body of evidence around the challenges of providing health services to people living in rural areas and coastal communities.

1.5 We are struggling, like the rest of the NHS, with the impact of chronic nationwide workforce shortages, and this situation is exacerbated by local demographics as Somerset has proportionately fewer people of working age than other parts of the country. Many of our staff go above and beyond on a daily basis to do the best for patients, but the current position in some services is unsustainable, both for individual colleagues and our organisations.

1.6 Merger will enable us to build a stronger, more resilient organisation that will provide an environment where colleagues can thrive, develop their careers and are enabled to do the best job they can. Our People strategy sets out how we

[1] YDHFT group runs the GP practices via a wholly owned subsidiary, Symphony Healthcare Services Ltd. It currently has 16 GP contracts covering 20 sites, with a combined list size of 118,000.

[2] Proportion of primary care based on list size: 118,000 out of a total list size for the whole of Somerset c.584,000.

will do this in a way that enables us to retain the talent we have, and recruit the best people to come and work in Somerset.

1.7 Bringing together our acute services into a single provider will enable us to maximise the use of our combined capacity and streamline pathways to improve quality, performance and equity of access. It will facilitate our work to modernise the model of care in Somerset, and help us rebalance our resources away from bed-based care and into neighbourhood-based services that support people to remain healthy for as long as possible.

1.8 Merger will strengthen our contribution to Somerset's developing neighbourhoods by enabling us to offer support which spans patient pathways from community through to acute services. Bringing our acute care teams together will remove duplication and free up colleagues to give greater support to neighbourhood teams. In addition, YDHFT's ownership of 16 GP practices enables us to test new ways to integrate community, acute, mental health and learning disabilities services with primary care, and implement change at a faster pace.

1.9 This Business Case has been prepared following the approval by both Trust Boards of the Strategic Case, which set out the high-level case for merger. NHS England (NHSE) reviewed the Strategic Case and confirmed in July 2021 its support for the Trusts to proceed to Full Business Case stage. The purpose of this Full Business Case is to set out our vision for the merged organisation and how it will operate, the expected benefits, and our plans for integrating the Trusts.

1.10 We have worked closely with our system partners as we have developed our merger plans, and they support our proposed merger.

Strategic rationale

1.11 The scale of the challenge to improve health and wellbeing and reduce health inequalities in Somerset is immense and Covid showed that no individual organisation in Somerset has what it takes to respond to these challenges alone. We need to bring our skills, knowledge and resources in health together with those of our colleagues in social care, education, housing and the voluntary sector if we are to improve health, tackle health inequalities and enable our communities to thrive.

1.12 Furthermore, we face very significant workforce challenges, with the result that some of our clinical services are now extremely fragile. We urgently need to implement new and more efficient ways to deliver high quality care and improve the resilience of our services.

1.13 Isolated improvement projects will not be enough to drive the scale of change required. Instead we need to transform the way we deliver services to meet the challenges we face. By creating a single legal entity, merger will be the engine for this transformational change by removing institutional barriers and making it easier to implement widespread change across all our services, at pace.

1.14 In May 2020, YDHFT and SFT signed a Memorandum of Understanding (MOU) in which the Trusts committed to work together for the benefit of the Somerset population by aligning the Trusts' strategic goals and operational activities. We have achieved much under the MOU to improve services for patients, but it was not intended to be a permanent position. Moving towards acting as one Trust, while continuing to be two legally separate organisations carries cost and time inefficiencies which are hard to justify in the long-term. There is also a risk of lack of clarity around accountabilities as we continue to integrate and blur organisational boundaries.

1.15 Our ICS vision is to work together to support the people of Somerset to live healthy and independent lives through a high quality and efficient system of health and social care. The proposed merger is a key step in helping us realise this vision, and follows the creation of SFT in 2020 through the merger of Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust. The merger is aligned with the national strategy set out in the NHS Long Term Plan, and the national drive to integrate care.

1.16 The merged Trust and the local authority, Somerset County Council, will serve the same population of 572,000 people living in the county of Somerset. This will put us in a powerful position to implement a population health approach, building on the strong existing relationships with the Council, the local voluntary sector, and non-integrated primary care. The proposed merger would simplify local system architecture and facilitate the implementation of new models of care which support better health and wellbeing for the people of Somerset.

1.17 The removal of organisational barriers will make it easier to join up care between mental health and physical health clinicians in the south and east of the county, replicating the benefits we have already delivered in the north and west of the county following the creation of SFT.

1.18 The merged Trust will be one of the largest 'at scale' primary care providers in the country and this will create further opportunities to support primary care and integrate patient pathways. It will help us strengthen links between primary and secondary care, drawing on the learning from YDHFT's Symphony vanguard programme, and enabling us to improve our contribution to preventing the onset of avoidable illness.

1.19 The merger gives us the opportunity to capitalise on the innovations made during the pandemic and embed them across the county. Reducing the elective backlog that built up during the pandemic is a significant task, and the proposed merger will put Somerset in a better position to assemble and manage the

dedicated and flexible workforce necessary to achieve elective recovery, alongside business as usual.

1.20 Merger will mean we are more resilient to future periods of pressure and will give us greater capacity to flex and redirect our resources to areas of greatest need. It will also enable us to improve our offer to existing and potential colleagues to address our chronic workforce gaps.

1.21 The two Trusts have a good history of collaborative working which has yielded benefits for patients and the Somerset system. However, there are limits in how far we can go in integrating services while we remain separate legal entities. Separate line management structures, budgets and policies create barriers and, even when these have been overcome at individual service level, they generate delay and unnecessary cost in realising the benefits of collaboration. Merger will remove barriers such as separate budgets, policies and processes, and remove duplication. It will also enable us to increase the pace and scale at which we can integrate our services, and transform the way we provide care.

Vision for the merged Trust

1.22 Our vision for the merged Trust is: Thriving Colleagues, Integrated Care, Healthier People. This vision builds on the existing organisations' visions and reflects the integrated services which the merged Trust will provide and our commitment to focus on the health of the population we serve. Our vision is supported by shared values that we have developed following a widespread consultation exercise with colleagues from both Trusts.

Clinical strategy

1.23 The primary driver for our merger is to improve the health of the local population, and our clinical strategy puts the people we serve at the heart of our services. The strategy supports Somerset's population health approach and gives prominence to what matters to patients and carers. We have chosen to value patient and colleague time and to focus on making time in healthcare count and maximise years of healthy life.

1.24 Together with our partners in the Somerset system, we have agreed five health and care aims. These are:

- **Aim 1: Improve the health and wellbeing of the population**. Enable people to live socially connected, healthy, independent lives, promote early intervention and prevent avoidable illness.
- **Aim 2: Provide the best care and support to children and adults**. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.

- **Aim 3: Strengthen care and support in local communities.** Develop and enhance support in local neighbourhood areas and bring care and support closer to home.
- **Aim 4: Reduce inequalities.** Value all people alike, target our resources and attention to where it is most needed, giving equal priority to physical and mental health.
- **Aim 5: Respond well to complex needs.** Improve outcomes for children and adults with complex needs through personalised, co-ordinated support.

1.25 Our clinical strategy, which was developed in consultation with colleagues, patients and system partners, sets out how as a merged Trust we will play our part in delivering these five aims.

1.26 As part of our merger, we will maintain two fully functioning acute hospitals in Yeovil and Taunton, and bring together YDHFT and SFT's hospital-based care into single county-wide services, building on the best from both Trusts as we do so.

1.27 We will also integrate YDHFT's acute services with SFT's county-wide mental health, learning disabilities and community services, so that the benefits already delivered following the creation of SFT are felt in the south and east of the county too.

1.28 We will realise efficiencies by streamlining and standardising patient pathways, implementing shared IT systems, reducing patient transfers between the Trusts and stripping out duplicate tasks. Each clinical service in the merged Trust will operate according to consistent standards across the county and work to a single waiting list.

1.29 We will increase our work with partners to support prevention, self-management and early intervention to prevent avoidable illness and escalation of health need. Population health management will help us as a system to identify those groups most at risk of deteriorating health, and inform our work to tackle health inequalities. We will ensure people only receive bed-based care when it is right for them, to avoid harms such as deconditioning.

1.30 We will work closely with Somerset's 12 neighbourhoods and 13 Primary Care Networks and provide more coordinated care in people's homes and in the community. Our Hospital@home programme is an excellent example of care provided closer to home which is facilitated by merger. We will also increase our support and advice to primary care and ensure healthcare colleagues are able to direct people to neighbourhood resources to improve their health and wellbeing.

1.31 We will provide personalised, coordinated care to people living with long-term conditions and with complex care needs, and pursue parity of esteem for mental

health and physical health conditions regardless of the setting in which a patient first presents.

1.32 We will strengthen our relationships with other care and support providers in the county and beyond, and work with them to understand where there are gaps in the provision of health and other services. We will support other agencies to do the right thing for the people of Somerset, to improve population health and benefit all involved. This may involve sharing resources with our local partners if that is the most effective way to improve the health and wellbeing of the people of Somerset.

1.33 Our resources are limited and we are funding the merger ourselves. To make our planned changes requires us to free up some of our existing resource. We will do this through streamlining pathways, removing duplication, and realising efficiencies deriving from planned digital improvements and consolidating corporate overheads.

Enabling services

1.34 Significant transformation will be required to realise our vision for the merged organisation. We have developed a joint People strategy which will drive our work to support colleagues to deliver the best care and help create a compassionate, inclusive and learning culture where people feel they belong.

1.35 We recognise the need for a comprehensive approach to cultural harmonisation and change management and, following widespread colleague engagement, have developed a set of values and behaviours for the new Trust to help create our desired culture.

1.36 Digital and Estates are key enablers to our clinical strategy. We have developed a joint Digital strategy which sets out how we will integrate our systems in a way that allows our ICS partners to link into our systems. We are also developing a joint Estates strategy for the merged Trust which sets out how we will modernise our estates through delivery of our capital programmes and improve the safety and therapeutic value of our hospitals. Our Estates strategy will be aligned with plans for the primary care estate in Somerset.

1.37 We have also developed a single governance framework to support clear accountabilities for the provision of safe, effective care in the merged Trust.

Expected benefits

1.38 The key expected benefits of merger are summarised in **Figure 1**. In line with our clinical strategy we have considered patient benefits in terms of time – both maximising years of healthy life, and making time in healthcare count.

1.39 Merger offers us significant scope to deliver benefits for patients and this is the primary driver for merger. Merger also helps us tackle our workforce issues, which in turn helps to drive high quality patient care.

Figure 1: summary of expected merger benefits

<table>
<tr><th colspan="2">Benefits</th></tr>
<tr><td colspan="2">PATIENTS</td></tr>
<tr><td>More time in good health (from better health outcomes)
Earlier intervention meaning illness is less likely to escalate to crisis or emergency
Quicker access to diagnosis and treatment, including specialist care
Improved access to holistic care which meets both physical and mental health needs
Improved patient safety from simpler, quicker pathways and shared patient record systems
Better health outcomes as colleagues see wider range of clinical cases, share knowledge & best practice
Unwarranted variation reduced through consistent county-wide pathways
Ready access to patients' full clinical history via shared IT systems which increases patient safety and good clinical outcomes
Equity of care across the county from consistent approach
Improved patient experience from streamlined pathways, and in some cases less travel for care.</td><td>Making every minute count (by eliminating wasted time in healthcare)
Effective use of spare diagnostic and treatment capacity wherever it exists in the county
Eliminating wasteful steps in pathways, including duplicate investigations or steps without clinical value
Smoother transfer between acute, community and mental health settings when all are run by the same Trust
More care closer to home (in community settings) which increases patient choice and reduces patient travel time & inconvenience</td></tr>
<tr><td colspan="2">COLLEAGUES</td></tr>
<tr><td colspan="2">Improved wellbeing and motivation from more resilient services
Increased job satisfaction from broader career opportunities
Colleagues freed up for front line care by efficiencies deriving from streamlined pathways, shared IT systems, and removal of duplicate tasks
Greater colleague capacity to implement transformational changes which benefit patients</td></tr>
<tr><td colspan="2">TRUST & SYSTEM</td></tr>
<tr><td colspan="2">Improved recruitment & retention from improved staff offer
Fragile services placed on a more sustainable footing
Better able to respond to rising demand
Easier to redirect resources to services or parts of a pathway where most needed
Better placed to work with partners to implement new care models which are more responsive, and less bureaucratic & costly
Easier to integrate with the work of partners when we are one organisation
Better able to implement population health management and tackle health inequalities
Creates further opportunities to align functions and services in Somerset</td></tr>
</table>

1.40 We have already started to realise some of these benefits under the MOU, for example in services where staffing is very fragile, or where individual clinicians can see the benefits and want to get on with delivering them. However, the MOU alone cannot drive systemic change, and we now need to put our joint working on a permanent footing to drive integration consistently, across every service and pathway.

1.41 The **Patient Benefits Case** which accompanies this Business Case sets out the expected benefits for patients, their families and carers in more detail. The **Post Transaction Integration Plan** (PTIP) sets out how we will monitor the delivery of and evaluate merger benefits.

Financial case

1.42 Merger of the two organisations enables us to streamline patient pathways so they are more efficient, and creates capacity to absorb some future growth within existing resources. Combined teams will be more flexible and resilient enabling us to reduce our spend on temporary staff. The consolidation of support services also offers savings.

1.43 We have taken a conservative approach to estimating the financial benefits of merger, and estimate that merging the Trusts will enable us to make cumulative savings of £89.5 million over the 5 years to 2027/28. We have funded the costs of the transaction up to the point of merger (£3.1 million) from existing resources. Costs from 2023/24 (total £4.1 million) are included in the merger case. This means the net financial benefit of merger is £85.4 million cumulatively over the 5 years to 2027/28 compared to the position without merger.

1.44 The planned merger will also put the Somerset system in a better position to reduce the system deficit by making it easier to: implement more efficient models of care; consolidate functions and services; and make improved use of our combined resources in pursuit of ICS aims.

Transaction execution

Legal route to merger

1.45 This is a merger of equals with the two Trusts coming together for the benefit of the people we serve. The Boards considered the options for effecting the merger (and took legal advice), and for time and cost reasons decided the preferred legal route is merger by acquisition, where SFT acquires YDHFT.

Board composition

1.46 Following wide engagement with colleagues and stakeholders we have agreed the merged Trust will be called Somerset NHS Foundation Trust. We have developed a revised constitution which will come into effect at the point of transaction. The merged Trust's reconstituted Board will have Non-Executive Directors drawn from both YDHFT and SFT's legacy Boards. We have carried

out a Board skills analysis to confirm we have the necessary skills to oversee the enlarged range of services provided by the merged Trust. The Trusts' existing joint executive team will transfer to the merged entity. We intend to hold elections to the Council of Governors of the merged Trust shortly after transaction date to ensure representation from the constituencies set out in the revised constitution.

Plan to deliver transaction and integration

1.47 We have developed a detailed plan to deliver the transaction, which is owned by a named Executive Director and managed by a Programme Management Office. We have identified a wide range of projects focused on integrating individual clinical and support services across the two Trusts. The Trusts have well-developed internal expertise in project management and benefits realisation which supports the identification and quantification of tangible and intangible benefits and ensures projects deliver the expected benefits. We are using this expertise to support individual integration projects as well as to prepare for merger itself. Details of our plans to manage the integration programme are set out in the Post Transaction Integration Plan (PTIP) which accompanies this Business Case.

1.48 The joint executive team is overseeing the progress of the proposed transaction via a Merger Programme Board. Key decisions relating to the proposed merger are made by the two Trust Boards. The two Councils of Governors are kept sighted on progress via regular meetings. ICS partners are kept informed through monthly Provider Development Committee meetings, as well as other ICS meetings. We have developed an integration risk register to identify and manage risks associated with the integration of the Trusts.

1.49 Subject to receiving the necessary approvals and support from our Boards, governors, regulators and local stakeholders, we plan to merge our Trusts on 1 April 2023. Our timetable for merger aims to balance the need to move at pace for the benefit of local people, while also managing the risk of distraction from business as usual and potential deterioration in patient care.

1.50 As a result of the MOU between the Trusts and the creation of the joint executive team, the two Trust Boards already have a good understanding of each other's work. At Executive level, this knowledge is detailed since every member of the joint executive team has full access to the systems and records of both Trusts within their functional purview. For this reason, the Trusts undertook due diligence using internal resources, with the exception of Legal due diligence which was completed by our legal advisers.

Conclusion

1.51 We are ambitious on behalf of the population we serve and want to transform the way we deliver services to improve the health of the population of Somerset. Together with our ICS partners we want to better meet our patients' mental and physical health needs now and in the future. We will do this by providing integrated, holistic care, closer to patients' homes, with a focus on prevention and early intervention.

1.52 Although we have seen benefits from joint working under our MOU, merger enables us to take forward integration at a much greater scale and pace than is possible while we are two separate legal entities. The two Boards strongly believe that a merger of the two Trusts is an essential enabler to making these planned changes a reality within the timescale required.

1.53 The proposed merger of YDHFT and SFT will deliver substantial and lasting improvements to the health outcomes and experiences of the people we serve. It will also expand the professional opportunities available to colleagues, to help address staffing gaps and put our services on a more sustainable footing. The merger will create a more resilient and efficient organisation, and it will achieve these benefits while also putting the merged Trust in a stronger financial position than if we remained as we are.

1.54 This Business Case and its supporting documents are the result of significant effort by a large number of colleagues and system partners. The Boards of both Trusts would like to thank everyone who has contributed to the development of our merger plans.

Guide to reading this document

1.55 The content of the Business Case is set out as below, see **Figure 2**. Further detail on the expected patient benefits is contained in the **Patient Benefits Case**, and further detail on our implementation plans is contained in the **Post Transaction Integration Plan.** Both documents should be read in conjunction with this Business Case. A list of supporting submissions to this Case is at **Annex 10**.

Figure 2: Chapter contents

Area	Chapter	Description
Strategic Context	2. Background	• Sets out background to the Trusts and the challenges facing the Somerset health and care system.
	3. Strategic Context	• Summarises the national and local strategic context, including Somerset ICS's vision for health and care. Sets out how merger supports delivery of local and national strategy and why we need to merge to deliver the change Somerset needs.
How the merged Trust will operate	4. Vision for the merged Trust	• Sets out the vision and strategy for the enlarged organisation.
	5. Clinical strategy	• Describes the clinical strategy for the merged organisation. This chapter should be read in conjunction with our **Patient Benefits Case**.
	6. People, Governance & Operating Model	• Describes how we will develop a harmonised organisational culture, and our workforce approach for the integrated organisation. Also sets out the organisational structure and governance for the integrated organisation.
	7. Support Functions	• Sets out how key support services including Digital, Estates, Finance, Governance Support, Improvement and Communication will integrate and support the clinical strategy.
	8. Benefits	• Describes the expected benefits of the merger. This chapter should be read in conjunction with our **Patient Benefits Case**.
	9. Finance	• Sets out the incremental costs and financial benefits of the transaction, and how the transaction fits within the broader Somerset ICS financial strategy. Also sets out the merger-related financial risks and mitigations, and transaction and transformation costs.
Delivering integration	10. Transaction Execution	• Summarises our integration programme governance, transaction legal form and timeline and gives an overview of our approach to due diligence. (For further detail see **PTIP**).
	11. Communications and Stakeholder Engagement	• Sets out the merger communications and stakeholder engagement strategy, and describes our merger-related engagement activity.

2. Introduction

2.1 This chapter provides background on the two Trusts and the challenges faced in the Somerset system.

Somerset background

2.2 YDHFT and SFT are members of the Somerset Integrated Care System (ICS) alongside Somerset Integrated Care Board (ICB), Somerset County Council, and local primary care and voluntary sector partners.

2.3 The boundaries of the ICS and the County Council are coterminous which, given it has relatively few partners, makes the Somerset health and care system one of the simplest in England. The proposed merger will bring together all of Somerset's acute, community, mental health and learning disability services, and around a fifth of primary care[3] into a single NHS Foundation Trust, making our system even simpler still.

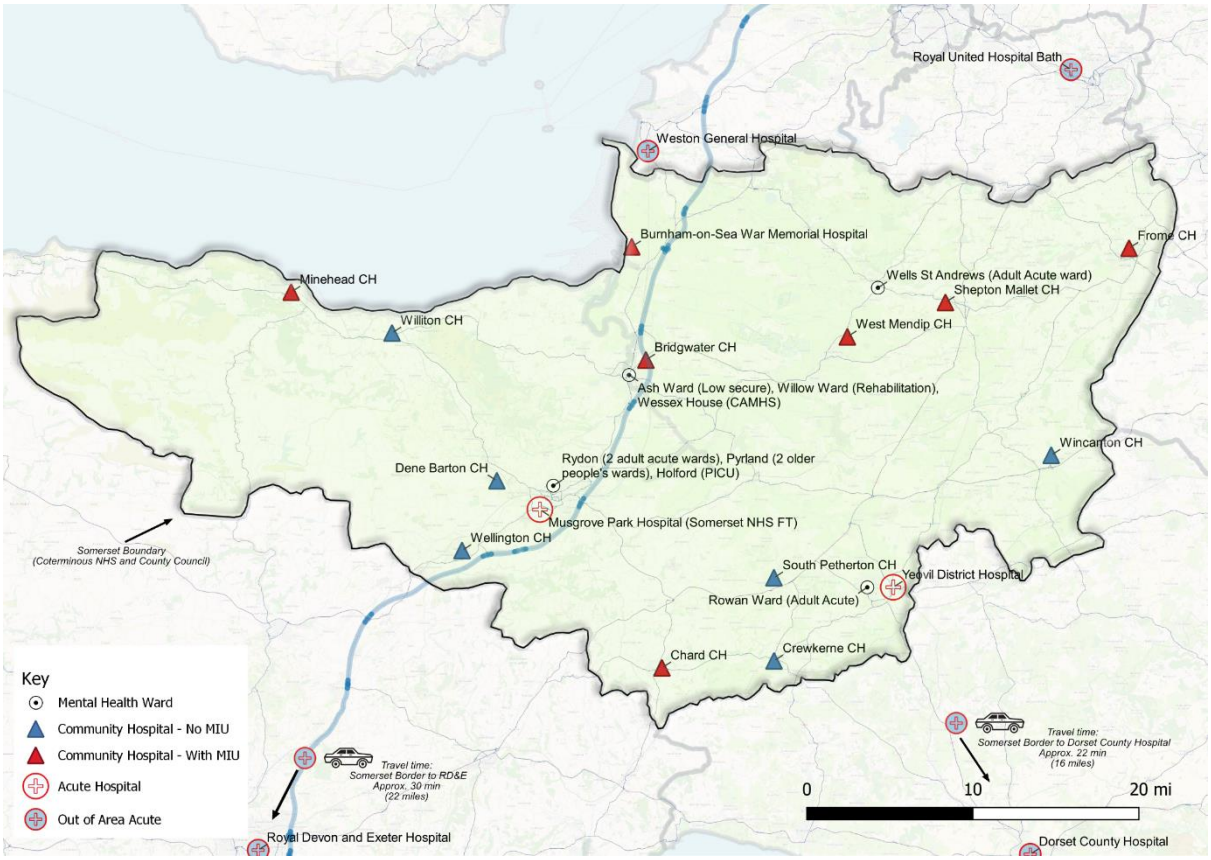
2.4 Somerset is one of the largest counties in England, extending to 1,300 square miles, with relatively low population density and significant distances between population centres. Travel times across the county are two hours East to West, and one hour North to South. The largest towns, Yeovil and Taunton, each have a District General Hospital: Yeovil District Hospital (YDH) is run by YDHFT and Musgrove Park Hospital (MPH) in Taunton is run by SFT. SFT also runs 13 community hospitals in other localities providing community services including mental health care and 7 minor injuries units.

2.5 The present configuration of services and the largely rural road network means many residents have long travel times between home and hospital. **Figure 3** below shows the distance between health facilities in Somerset. The travel time between YDH and MPH is c.45 minutes in light traffic, but this is via the A303 which is subject to congestion in the summer months; the blue light transfer time is c.30 minutes, door to door.[4] There is no direct public transport link between the acute hospitals.

[3] By list size.

[4] This blue light time does not include ambulance call up time or handover time.

Figure 3: distances between Somerset health facilities



2.6 At 572,000, the population of Somerset means patient numbers are high enough to support the maintenance of most specialist clinical skills in an economically efficient way, although it is harder to sustain smaller services across the county's two relatively small acute hospitals.

Overview of the Trusts

YDHFT

2.7 YDHFT provides inpatient and outpatient services to c.210,000 people in south Somerset, north and west Dorset and parts of Mendip. The Trust's main site at Yeovil District Hospital has around 350 inpatient beds. It operates a 24-hour Emergency Department and maternity unit, and provides a wide range of acute and general medical services, including emergency and general surgery. The Trust is part of the Severn Trauma Network.

2.8 Symphony Healthcare Services Limited (Symphony) is a wholly owned subsidiary of YDHFT which operates 16 GP practice contracts across 20 sites.[5] Symphony is an 'at scale' primary care operating company that uses an

[5] All practices are in Somerset, with the exception of Lynton in Devon, which has 2,463 patients.

innovative model to combine the benefits of scale while preserving the best of the independent nature of primary care. The establishment of Symphony Healthcare Services was part of the south Somerset Vanguard Project, alongside the Symphony Programme which established new models of care across south Somerset. The Symphony Programme introduced Health Coaches and Complex Care Teams to support people to live independently. It has enabled more personalised care for patients, freed up GP time, and reduced ED attendances and overnight hospital stays.

2.9 YDHFT has a second wholly owned subsidiary, Simply Serve Limited (SSL), which has provided estates and facilities management services to the Trust and other clients in the UK since February 2018. A third subsidiary, Yeovil Property Operating Company Limited, is now dormant and we expect to wind up this subsidiary in advance of merger.[6]

2.10 YDHFT employs around 2,400 colleagues.[7] In addition, SSL employs c.370 people and Symphony employs c.500. The Trust scored above benchmark group average across all 9 themes of the 2021 NHS staff survey, and achieved scores equal to those of the best organisation in England for its approach to colleague recognition and reward, teamwork, and flexible working offer.

2.11 In 2021/22, YDHFT delivered a surplus of £0.3 million, on group turnover of £239 million. YDHFT is forecasting a breakeven position in 2022/23, however, the Trust has an underlying deficit which is estimated to be £9.6 million. [8] Factors contributing to the Trust's underlying deficit position include diseconomies of scale due to size and rurality, the deficit position of Symphony, and an element of excess operational costs. Financial performance in 2020/21 and 2021/22 was affected by the interim financial framework put in place to ensure trusts were fully funded for the impact of the pandemic.

2.12 YDH is located near the border with Dorset, and is closer to Dorset County Hospital[9] (DCH) than to Musgrove Park Hospital.[10] The acute care services that YDHFT provides to a section of north and west Dorset patients (c.35,000 people) represents around 20% of the Trust's income. These cross-county patient inflows are most significant in the Emergency Department and services such as ophthalmology, dermatology and maternity. The Trust rents clinical space in The Yeatman hospital in Sherborne, Dorset for outpatient clinics and a theatre for ophthalmology procedures.

2.13 In recent years the Trust has taken on elective work in general surgery, orthopaedics and ophthalmology from SFT and DCH to help ease the waiting list for those specialties.

[6] Yeovil Property Operating Company was created to facilitate integration of primary care practices relating to Symphony Healthcare Services.

[7] Headcount figure excluding bank staff.

[8] Estimate as at time of 2022/23 planning

[9] DCH is run by Dorset County Hospital NHS Foundation Trust.

[10] Yeovil District Hospital is 21 miles from Dorset County hospital and 28 miles from Musgrove Park Hospital.

SFT

2.14 SFT provides a wide range of integrated community health, mental health and learning disability services for the whole of Somerset, as well as acute services for people in the north, west and centre of the county (population c.350,000) and parts of Devon and North Somerset. The Trust is also the regional centre for services such as bariatric surgery.

2.15 SFT was formed on 1 April 2020 when Somerset Partnership NHS Foundation Trust (SPFT) and Taunton and Somerset NHS Foundation Trust (TSFT) merged. The transaction was ground-breaking as it created the first Trust in mainland England to provide integrated community, mental health, learning disabilities and acute hospital services. The Trust was named Mental Health Trust of the year at the 2021 Health Service Journal awards.

2.16 SFT operates a 24-hour Emergency Department and maternity unit, and provides a wide range of acute and general medical services, including emergency and general surgery from its main site, Musgrove Park Hospital (MPH) in Taunton, which has 700 inpatient beds. The Trust also operates 13 community hospitals (with 218 beds currently open), providing inpatient, outpatient and diagnostic services, and seven Minor Injuries Units. The Trust runs five dental access centres in Somerset (which served 8,976 patients in 2021/22) and provides primary care dental services at three sites in Dorset (which served 1,507 patients in 2021/22).

2.17 SFT's community services are wide-ranging and include district nursing, stroke services, podiatry and diabetic eye screening. These services are provided in a range of settings including community team facilities, GP surgeries, local clinics, and patients' homes.

2.18 SFT provides mental health inpatient services and specialist healthcare for adults with learning disabilities from ten mental health wards across four sites.[11] Its community mental health services include Talking Therapies, Early Intervention in Psychosis, a community eating disorders service, and services for patients with autism and personality disorder. SFT is part of the south west Mental Health provider collaborative.

2.19 SFT is an early implementer of a new model of community mental health services called Open Mental Health, (see paragraph 3.13). In May 2022, the Open Mental Health alliance in Somerset won a national award from NHS Improvement in recognition of the alliance's work to find innovative ways to improve mental health.

2.20 SFT cares for people from neighbouring counties who live close to the county border. In 2021/22, the Trust treated around 20,300 people in total from across north Somerset, Devon, Dorset, Wiltshire and BANES.[12]

[11] SFT provides low secure and CAMHS inpatient care for the region.

[12] In 2021/22, SFT treated 7,782 Devon residents, 2,753 Dorset residents, 6,742 residents of Bath, North East Somerset, Swindon & Wiltshire, and 3,014 residents of Bristol, north Somerset & south Gloucestershire.

2.21 The Trust employs around 10,000 colleagues.[13] It scored at or above average in all 9 themes of the 2021 NHS staff survey, and particularly well on colleague engagement and teamwork.

2.22 In 2021/22, SFT reported a surplus of £1.9 million, on turnover of £667 million. SFT is forecasting a breakeven position in 2022/23, however the Trust has an underlying deficit which is estimated to be £29.2 million[14] which is caused by factors including diseconomies of scale due to size and rurality, PFI financing costs[15] and older estate which is more costly to run and maintain. Financial performance in 2020/21 and 2021/22 was affected by the interim financial framework put in place to ensure trusts were fully funded for the impact of the pandemic.

2.23 Key facts about the two Trusts are set out in **Figures 4** and **5**.

[13] Headcount figure, excluding bank staff.

[14] Estimate as at 2022/23 planning.

[15] The Private Finance Initiative (PFI) financing costs relate The Beacon Centre, SFT's specialist cancer centre in Taunton.

Figure 4: Key facts – Yeovil District Hospital NHS FT[16]

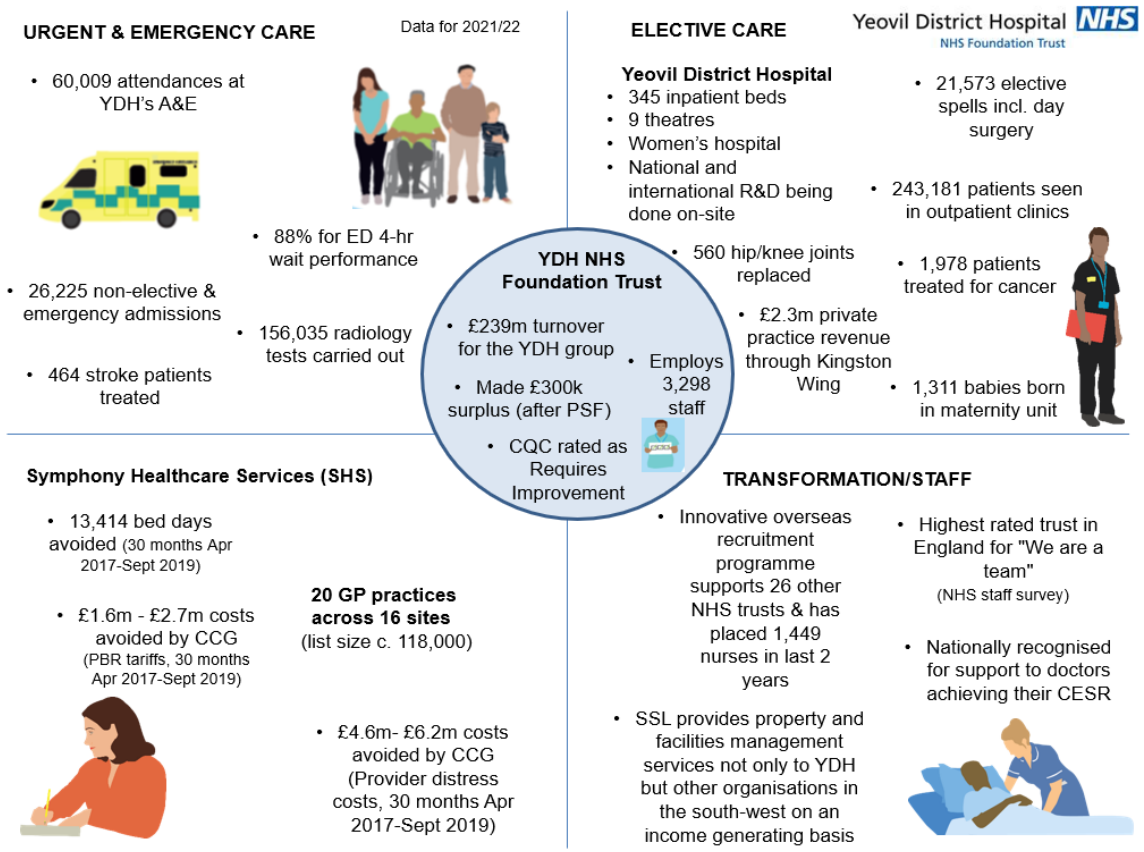
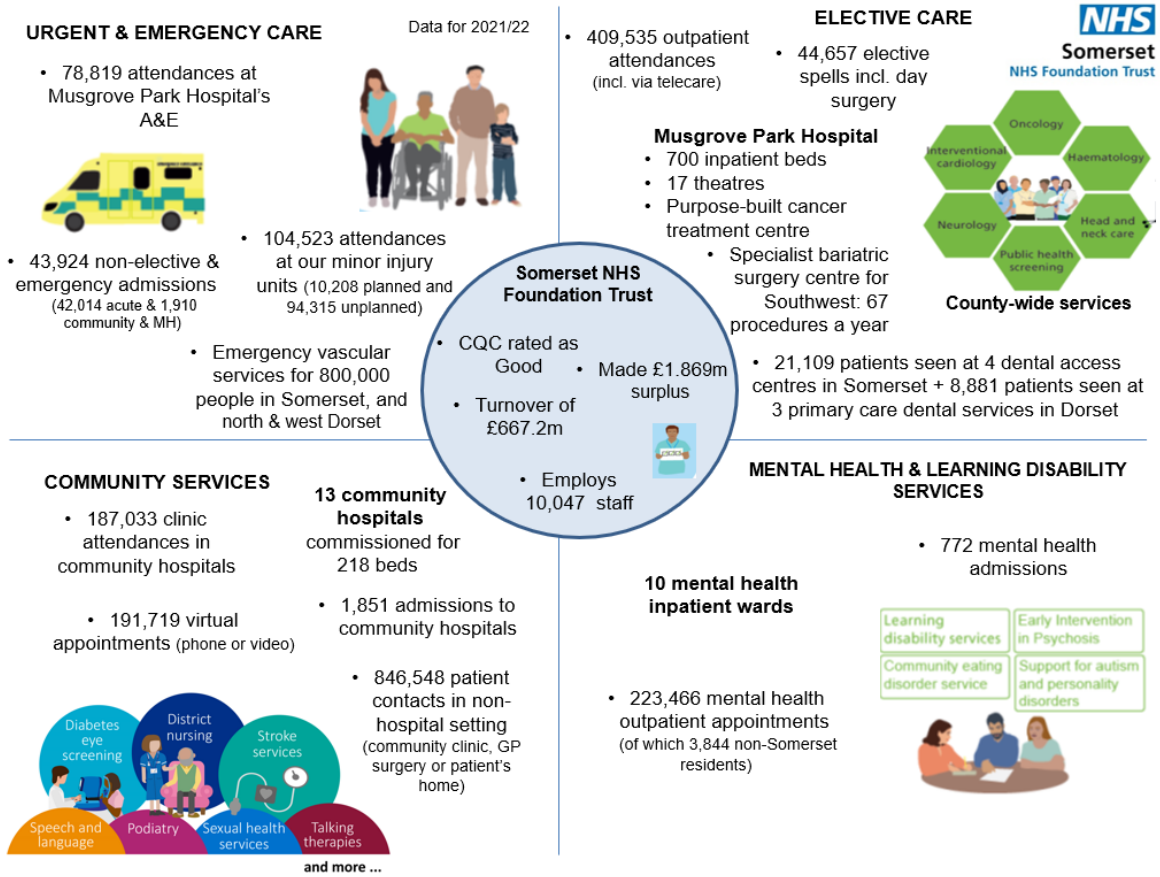


Figure 5: Key facts - Somerset NHS FT[16]



[16] Staff numbers are headcount figures excluding bank, but including YDHFT subsidiaries.

CQC ratings

2.23 The Care Quality Commission's (CQC) ratings of both Trusts are set out in **Figure 6**. The CQC has not completed an inspection of SFT since its creation due to Covid, so SFT's published ratings are the ratings given to its legal predecessor SPFT. However, in September 2022 the CQC carried out a Well-Led review and a limited core services inspection. The report of the inspection is expected to be published prior to merger.

2.24 SFT is rated 'Good' overall by the CQC. Yeovil District Hospital is rated 'Good', but YDHFT's overall rating is 'Requires Improvement' because of its use of resources assessment. Musgrove Park Hospital is rated Good.

Figure 6: CQC ratings

CQC domain	SFT's predecessor Trusts		Somerset FT	Yeovil District Hospital FT
	Taunton & Somerset FT	Somerset Partnership FT		
Safe	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Effective	Good	Good	Good	Good
Caring	Outstanding	Good	Good	Good
Responsive	Good	Good	Good	Good
Well-led	Good	Good	Good	Requires improvement
Use of resources	Good	n/a	n/a	Inadequate
Overall Trust rating	**Good**	**Good**	**Good**	**Requires improvement**
Acute hospital overall rating	**Good (Musgrove Park Hospital)**	**n/a**	**n/a**	**Good (Yeovil District Hospital)**

SFT CQC inspection

2.25 At SFT, the most recent published CQC inspection[17] found leaders had the capacity, capability and commitment to deliver high quality, sustainable care. There was a clear vision and credible strategy for the future, a strong culture, good engagement with patients, staff, and stakeholders and significant strength in innovation and quality improvement.

2.26 At the time of the most recent published inspection reports, areas of challenge at SFT related, in acute services, to management of waiting times; the safety of the anaesthetic cover out of hours (specifically in maternity and critical care services); and checking of emergency equipment. Areas of concern in community and mental health services related to nurse staffing levels; and risk assessments and crisis plans in Child and Adolescent Mental Health services (CAMHS).

[17] Findings are from CQC's inspection of Musgrove Park Hospital published March 2020 when Musgrove was run by SFT's legacy organisation, TSFT.

YDHFT CQC inspection

2.27 At YDHFT, the CQC inspection[18] found leaders were highly visible, approachable and supportive to staff. The culture was strong and centred on people who use services, and there was a strong culture of reporting incidents to learn and improve. There was an emphasis in the Trust on the safety and wellbeing of staff, and staff felt positive and proud to work for the organisation.

2.28 At the time of the inspection, areas of challenge at YDHFT related to the completion of patient records, including risk assessments, and mental capacity assessments in both medical care and end of life care; and pressures on children's services from patients with mental health problems which led, at times, to risks to the safety of the ward and the wellbeing of other children.

2.29 The Trusts' latest CQC reports, and the Trusts' action plans to address the concerns identified are provided as supporting submissions to this Business Case.

Primary care

2.29 There are 63 general practices in Somerset[19] within the 13 Primary Care Networks (PCNs). YDHFT currently runs 16 practice contracts through its wholly owned subsidiary, Symphony Healthcare Services. Four of these GP practices used to be managed by SFT, but SFT transferred them to Symphony in 2021/22 in anticipation of the merger. With a combined list size of 118,000 across the 16 practices the merged Trust would be one of the largest 'at scale' primary care providers in the country.

2.30 There is evidence that YDHFT's support to primary care practices (and SFT's historical support) has reduced overall costs (e.g. through reduced bed days), and enabled some GP practices in Somerset to continue to operate when they would otherwise have been unable to do so. The Symphony data set, developed through the South Somerset Vanguard programme, enabled the impact on hospital emergency bed days to be tracked, and showed a 14% reduction in non-elective bed days after 18 months of the new care models operating. Symphony has also helped practices raise their standards to Outstanding (CQC rating) by helping practices identify the particular services the local population needs, aiding the development of quality improvement action plans, and conducting mock CQC inspections. It also enables efficiencies to be made via shared corporate services (HR, Finance, Quality Improvement etc).

[18] YDHFT CQC report published May 2019.

[19] This is expected to reduce to 62 when the Essex/Tawstock practices merge.

Joint ventures

2.31 For several years, YDHFT and SFT have been participants in three related joint ventures: Southwest Pathology Services LLP, SPS Facilities LLP, and SW Path Services LLP which together provide laboratory services for the NHS and other organisations across the south west of England.

2.32 In addition, SFT has a joint venture with Practice Plus called the Shepton Mallet Health Partnership, to run a treatment centre, community hospital and minor injuries unit at Shepton Mallet. YDHFT has a joint venture with Prime plc called Yeovil Estates Partnership LLP to provide estates, infrastructure and service transformation. This joint venture has built a multi-storey car park on the YDH site and new staff residences in Yeovil.

Current capital programmes

2.33 YDHFT and SFT each has a capital programme underway. Alongside our existing capital plans these programmes are intended to ensure our estates meet modern standards for clinical safety and quality, and enable us to meet environmental targets. The programmes are known as YDH2030 and Musgrove2030 respectively and both are currently at Strategic Outline Case stage. These programmes, are based on a single, shared vision and will help provide the physical infrastructure to realise our clinical strategy.

2.34 YDH2030 (value c.£380 million) includes a new surgical centre which will help us implement our model for managing elective capacity in Somerset, expand YDH's emergency department to meet future demand, and upgrade YDH's wards. YDH2030 also include some short to medium term plans for the YDH site, which include for example the creation of the east Somerset community diagnostic centre.[20] Musgrove2030 (value c.£450 million, funded by the New Hospital Programme) will replace some of the oldest healthcare buildings in operation in England with modern facilities at the Musgrove Park site particularly the maternity, neonatal and children's facilities.

2.35 SFT's existing capital plans include the provision of an additional inpatient Mental Health Ward in Yeovil (c.£8.5 million) the re-provision of Theatre, Critical Care and endoscopy facilities (£87 million) and the development of an Acute Assessment Unit (£11.4 million), in addition to the ongoing maintenance and delivery of digital capability.

Performance against national standards

2.36 Like many other trusts across the country, neither SFT nor YDFT (as at April 2022) is meeting any of the four key national standards (4-hour A&E, Referral to Treatment, Cancer 62-day or 6-week diagnostics). Prior to the pandemic, YDHFT performed particularly well against national standards. Further detail on

[20] The £380 million value does not include the cost of the short to medium term plans.

the Trusts' current performance against key national standards is set out at **Annex 1**.

Covid context

2.37 The Covid pandemic placed unprecedented pressure right across the NHS, and our services are no different. At the start of the pandemic the south west had the fewest critical care beds per 100,000 in the country.[21] The two Trusts' ICUs provided mutual support as part of the regional network and helped each other at individual service level (e.g. Stroke care).

2.38 The creation of SFT in April 2020 made it easier to redeploy colleagues in community hospitals and community teams to support the provision of acute and intermediate care and introduce new care pathways. It also meant the role and perspective of mental health services has remained visible throughout the pandemic. Also, as a integrated Trust, SFT was able to rapidly spread its best practice in infection prevention and control from acute to community and mental health inpatient settings.

2.39 The Trusts actively supported system partners during the pandemic. For example, SFT gave local care homes access to its bank staff and helped them improve their bank staff processes to improve the resilience of their staffing situation.

2.40 Merger showed us that when we are able to put aside organisational interests and do what is best for the patient we can improve the provision of health and care. This model of system working is one we are continuing to follow as our ICS matures. The proposed merger facilitates this style of working by removing a key set of institutional barriers. It also gives us the opportunity to capitalise on the innovations made during the pandemic, especially in the digital sphere, and embed them across the county.

Benefits of SPFT/TSFT merger

2.41 SPFT and TSFT merged on 1 April 2020, at the start of the Covid pandemic. This meant some of our integration plans for that merger had to be paused while we responded to the unprecedented demands and constraints of Covid. However, merger did mean that SFT was a stronger and more resilient Trust than it would have been had it remained as two separate organisations.

2.42 The benefits realised from the merger of TSFT and SPFT are set out in the two-year review of the merger, which is provided as a supporting submission to this business case. We have classified the benefits into 8 categories:

- A culture which supports integrated care

[21] https://www.hsj.co.uk/quality-and-performance/revealed-huge-regional-variation-in-nhs-ability-to-meet-coronavirus-demand/7027153.article

- Improved organisational resilience and performance
- Increased system responsiveness and flexibility
- Greater equity between physical and mental health care
- Improved and integrated patient pathways
- Strengthened neighbourhood care
- Skills and knowledge sharing
- Efficiencies and financial savings

2.43 The two-year review contains a section on lessons learned from the merger. Key lessons include:

- Close working prior to merger
- Joint executive leadership
- Strong clinical engagement
- Dedicated merger programme management office.

2.44 We have taken this learning into account as we have planned this current merger.

Current challenges in Somerset system

2.45 Like many local health economies in England, Somerset is grappling with a combination of rising demand, workforce pressures and structural financial challenges.

2.46 The key challenges facing health care services in Somerset are summarised below, see **Figure 7**. Further detail is provided in **Annex 2**.

Figure 7: Key challenges in Somerset

Population factors	
An ageing population, and proportionately fewer people of working age	• The proportion of Somerset residents aged 65 and over is 25% (c.142,000 people) which is significantly higher than the average for England of 19%. • By 2043, the percentage of over 65s in Somerset is predicted to have increased to 33% of the total population, against a national average of 24%. • In parts of West Somerset and Burnham-on-Sea, more than half the population is expected to be aged 65 or over by 2033. • Somerset has proportionately fewer people aged 20-44 compared to the average for England. This means there are fewer adults able to provide unpaid care for a close friend or relative. • Older people make greater use of health care services than people of working age, which means the demands on the Somerset health and care system are proportionately greater than in a comparable area with the same total population but a more balanced demography.
More time spent in ill health	• People are spending larger proportions of their lives in poorer health which drives demand for healthcare - the gap between life expectancy and healthy life expectancy at birth in Somerset is 16 years for males and 18 years for females. • Life expectancy has fallen slightly in Somerset in recent years.

Inequalities due to mental ill health	• The average life expectancies of men and women with a mental health disorder are 19.7 and 17.5 years lower respectively than the rest of the Somerset population. • Somerset is in the worst quartile nationally for rate of suicide. • Somerset's hospital admission rates for people who have self-harmed or have misused alcohol are higher than benchmark, which either indicates greater rates of mental distress in the county or that we are missing opportunities to intervene sooner with these groups.
Inequalities due to social deprivation	• The gap in life expectancy at birth between the most and least deprived areas of the county is getting bigger, and now stands at 6.5 years for males and 5.1 years for females. • Social deprivation creates and exacerbates ill health. The number of Somerset neighbourhoods classed as 'highly deprived' rose from 25 to 29 between 2015-2019, and around 47,000 people now live in such neighbourhoods. • Around 1 in 10 households in Somerset is in fuel poverty, and 13% of children in Somerset are growing up in a low-income household. • Food bank use in the South West rose 74% between 2014/15 and 2021/22 and has increased significantly further still as a result of Covid and the cost of living crisis.
Rurality	• 48% of people in Somerset live in a rural area. Public transport links are poor, and one in five Somerset residents aged 65 or over has no access to a car; the proportion is even higher amongst women. Rurality contributes to social isolation and is linked to digital poverty.
Rising demand	• Independent forecasting by consultants Factor 50 suggests aggregate projected growth in elective demand through to 2024 will be 1.6% per year across Somerset. • Mental health: we are projecting a 7.5% increase in demand for community mental health services in 2022/23 from the 2021/22 level, in part due to the cost of living crisis. This represents a 48% increase on pre-Covid demand, although the pandemic makes accurate forecasting of demand very challenging. • Community physical health: While total referrals for community physical health services in 2020-21 fell as a result of the pandemic, demand rose back to pre-Covid levels in 2021-22 and we expect demand will rise again in 2022-23 by around 2%, based on projected demographic growth. • Alongside this rising demand, as a system we do not yet focus enough resource and attention on prevention and early intervention which would help to manage demand.
State of services	
Historical underinvestment in mental health services	• 2019 benchmarking data, (which pre-dates allocation of funding linked to the Long Term Plan for Mental Health), shows that funding levels for our adult community mental health services were in the lowest quartile nationally. This historical lack of investment in mental health creates pressure on other parts of the system. For example, the number of admissions to our adult mental health inpatient beds per weighted head of population is amongst the highest in the country (sixth highest of 56 mental health trusts benchmarked).
Resources focused on bed-based care	• Although work to modernise the model of care in Somerset is moving forward (through the development of neighbourhoods, the intermediate care service, Open Mental Health, and work with primary care), too much of our resource is still focused on bed-based care, rather than community-based services that support early intervention. • Somerset currently has 218 community beds open. Benchmarking data suggests the number of community beds in Somerset per head of population is at best around the benchmark and more likely above benchmark. • YDH and MPH routinely have 150-200 patients who do not meet the criteria to reside in an acute hospital.
Workforce gaps	• As at July 2022, SFT had 40.87 whole time equivalent (WTE) consultant vacancies, representing an 11.3% consultant vacancy rate. YDHFT had

	14.95 WTE consultant vacancies as at June 2022, representing 14.3% of the consultant establishment. Consultant gaps are particularly serious in Stroke and Cardiology. • As at July 2022, SFT had 191.4 WTE unfilled registered nurse posts which represents a vacancy rate of 7.7%. As at June 2022, YDHFT had 19.6 WTE unfilled registered nursing posts (2.1% vacancy rate). At the time of writing, nursing staff shortages mean community beds at four of SFT's community hospitals remain temporarily closed on patient safety grounds.[22] • SFT spent £19.904 million[23] in 2021/22 on temporary staff. YDHFT spent £19.495 million in 2021/22.[24] The high spend was driven in part by the need to cover high Covid-related sickness absence.
Financial pressures	• Both SFT and YDHFT are forecasting breakeven positions for 2022/23. However, these positions include exceptional Covid funding, so do not reflect the Trusts' true underlying financial positions. Both Trusts' underlying financial deficits are driven in part by diseconomies of scale due to size and rurality. • In 2021/22 the combined Somerset system financial outturn was £2.2 million surplus, and the Somerset system is forecasting a breakeven position in 2022/23. It is clear that to become a financially sustainable system we must transform the way services are delivered in the county (see chapter 9).

[22] Shepton Mallet, Wellington, Chard and Dene Barton.

[23] SFT spend in 2021/22 was split £8.624 million on medical temporary staff, £8.167 million on nursing temporary staff, and £3.113 million on other temporary staff

[24] YDHFT spend in 2021/22 was split £7.949 million on medical temporary staff, £8.492 million on nursing temporary staff, and £3.054 million on other temporary staff.

3. Strategic Context

3.1 This chapter sets out how our proposed merger aligns with local and national strategies for health and care, and summarises the rationale for merger.

Somerset health and care strategy

3.2 No individual organisation in Somerset can, on its own, address the health and wellbeing challenges that our population faces. We need to bring our skills, expertise and resources in health together with those of our colleagues in social care, education, housing and the voluntary sector if we are to tackle health inequalities and enable our communities to thrive. As an ICS, we will do this by working together to deliver our agreed Somerset system strategic aims, which are presented below.

Improving Lives in Somerset

3.3 In 2019, the *Improving Lives in Somerset* strategy set out the county's vision for supporting the people of Somerset in the coming decade. Working in partnership across the county the shared vision of public sector bodies and our partners is to create:

- A thriving and productive Somerset that is ambitious, confident and focused on improving people's lives
- A county of resilient, well-connected and safe and strong communities working to reduce inequalities
- A county infrastructure that supports affordable housing, economic prosperity and sustainable public services
- A county and environment where all partners, private and voluntary sector, focus on improving the health and wellbeing of all our communities.

3.4 The fourth bullet above is the element most relevant to health and care providers in Somerset. As an ICS, we have developed a strategy for health and care: *Fit for my Future: a Healthier Somerset,* which is the means by which we will deliver this fourth objective for public services in Somerset.

Fit for my Future: a Healthier Somerset

3.5 *Fit for my Future: a Healthier Somerset*[25] is Somerset's strategy for health and care. It sets out how local health and care providers will contribute to the overall *Improving Lives* vision.

[25] *Fit for My Future: a Healthier Somerset – Case for Change*; Somerset CCG and Somerset County Council; 12 September 2018.

3.6 The Fit for my Future (FFMF) vision is:

> "to support the people of Somerset to live healthy and independent lives, within thriving communities, and with timely and easy access to high quality and efficient public services when they need them."

3.7 As a system, we have identified 5 obstacles to achieving this vision, which are set out below:

- **There is a lack of focus on population health and prevention**. Healthy life expectancy is decreasing for some groups and we do not focus enough resource and attention on prevention and wellbeing.
- **There are fractured, clunky pathways and processes**. Our pathways are disjointed and frequently too long, wasting time and resources for people, carers and colleagues, and negatively impacting the environment
- **Too much resource is spent on hospital care**. We are overspent, with too much attention and resource spent on hospital care, and not enough on children's services, mental health and community based services.
- **Inequalities are worsening**. We have worsening health inequalities, impacted by Covid, with some groups having life expectancies 10-20 years shorter than others.
- **There is poor coordination of care for people with complex needs**. People with complex needs have poorly coordinated care wasting time, and leading to worse outcomes

Further information on these obstacles is given in chapter 5.

Five Somerset health and care aims

3.8 To guide our work, the Somerset system has agreed five health and care aims which will enable us, collectively, to deliver the FFMF health and care strategy. As a system, we developed these aims based on the challenges Somerset faces in delivering consistently high quality and efficient care (the obstacles set out above), as well as the current and future needs of the Somerset population.

3.9 Our five clinical health and care aims are:

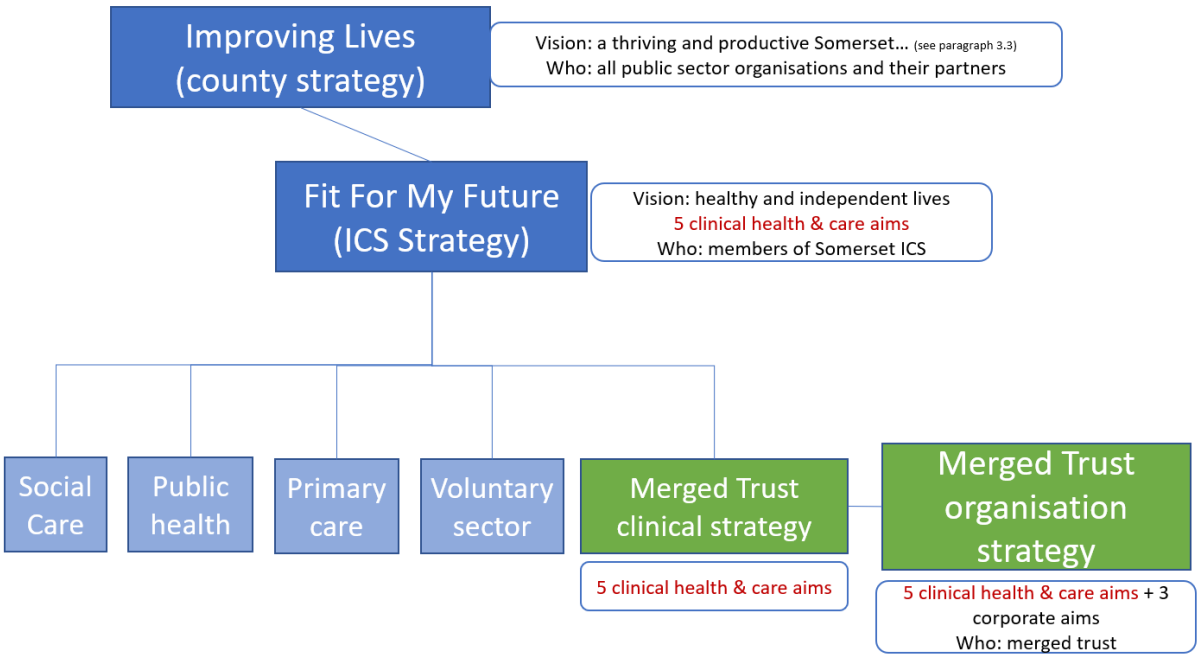
- **Aim 1: Improve the health and wellbeing of the population**. Enable people to live socially connected, healthy, independent lives, promote early intervention and prevent avoidable illness.
- **Aim 2: Provide the best care and support to children and adults**. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.
- **Aim 3: Strengthen care and support in local communities**. Develop and enhance support in local neighbourhood areas and bring care and support closer to home.
- **Aim 4: Reduce inequalities**. Value all people alike, target our resources and attention to where it is most needed, giving equal priority to physical and mental health.

- **Aim 5: Respond well to complex needs.** Improve outcomes for children and adults with complex needs through personalised, co-ordinated support.

3.10 The clinical care and support strategy for the merged Trust, which is described in detail in chapter 5 sets out how the merged Trust will contribute to the delivery of these five health and care objectives.

3.11 **Figure 8** below shows the relationships between the strategies described above.

Figure 8: Relationships between strategies



ICS development

3.12 Somerset ICS was created in July 2022 and is still maturing. Under our initial priorities for the ICS we will:

- put the health and wellbeing of the people of Somerset at the heart of our approach, and work together to address inequality by targeting our focus and resources towards prevention and early intervention, while ensuring the sustainability of our statutory services. We will underpin this with an ICS-wide approach to population health improvement.
- work as anchor institutions within our local economy and commit to 'buy local, employ local and invest local' wherever possible, playing our part in workforce development and economic regeneration.

- ensure that the views of the people of Somerset are central within our decision-making.
- develop an ICS collaborative working approach, underpinned by a systems mindset.
- establish the ICP and its ownership of the integrated care strategy for Somerset, in the context of the Health and Wellbeing Board's Improving Lives Strategy and the needs of the population.
- develop and implement a system-wide strategy to sustain and develop primary care.
- develop and begin to implement our 5-year joint forward plan and 2-year operational plan.

System progress in delivering ICS vision

3.13 Although there is much still to do to deliver FFMF, as a system we are already implementing programmes which are delivering our agreed priorities. Examples of our work as a system include:

- **Urgent care**: under the leadership of the Somerset A&E Delivery Board for System Wide Urgent and Emergency Care, and with support of the local Academic Health Sciences Network, we are using data about demand and capacity to inform our system-wide actions to manage urgent care demand. Changes made include the provision of Same Day Emergency Care to relieve pressure in our EDs, and mental health support in ambulance clinical hubs which has significantly reduced the number of patients with mental illness conveyed to ED. Somerset is now the second best performing system in the south west for urgent care (as at July 2022).

- **Elective care**: under the leadership of the Somerset Elective Care Delivery Board, we are planning interventions aimed at all aspects of elective care including: managing demand, increasing diagnostic capacity, optimising people for surgery, theatre capacity and productivity, improving access to cancer care, and reducing health inequalities amongst deprived groups. Somerset is currently the second highest performing system in the South West in terms of the scale of recovery of elective activity (as at July 2022).

- **Open Mental Health**: this pioneering and award-winning programme, run by a county-wide alliance of organisations, works to ensure people with mental health problems get the right support at the right time. It takes an 'open to everyone' approach to mental health and wellbeing support within neighbourhoods, with a focus on preventative engagement. Everyone who wants help is given support tailored to their needs by a range of voluntary sector and health professionals including specialists in mental healthcare, housing support, debt and employment advice, peer support etc.

- **Intermediate care**: In March 2020, Somerset brought its existing county-wide Rapid Response[26] and Discharge to Assess[27] teams together with third sector discharge support services under the umbrella term of 'Intermediate Care'. The service is led by a manager jointly appointed by SFT and Somerset County Council's adult social care team. The multi-agency service supports people to remain and recover at home wherever possible. It diverts up to 20 people a day away from hospital. A further 400-500 people a month are supported to leave hospital and return home sooner. Where it is not possible to support people at home immediately after leaving hospital, intermediate care supports c.300 people a month to complete their recovery in a bedded, community reablement facility. Operation of this service improved following the TSFT/SPFT merger as we no longer had to transfer patients across an organisation boundary, and discharges from MPH to community care was done under the same provider. The current proposed merger offers us the chance to extend this benefit across the whole county; merger will also enable us to consolidate our workforce to support a single rota, improve workforce planning and enable rotational posts across different settings. John Bolton, a national social care expert, described the service as "probably the best developed set of arrangements for health and care in the UK".

3.14 These examples show we are already working well as a health and care system. However merger will enable us to go further in joining up services to deliver our shared vision.

How merger supports the ICS vision

3.15 As a system, we are excited by the unique opportunity that bringing our two Trusts together offers to improve the health of the people of Somerset. Nowhere else in England has brought together the breadth of NHS services we plan to (mental health and learning disabilities, community, acute and primary care), and no other health and care system has just one NHS trust provider. The proposed merger is a key priority for Somerset ICS, and it lays the groundwork for truly integrated health and care in a way that does not currently exist elsewhere in England.

3.16 To achieve our shared FFMF vision, we need to join up our primary care, community, hospital, and ambulance services and adapt our models of care to focus on population health. YDHFT's Symphony programme introduced new models of integrated care to benefit people with complex needs, and SFT was

[26] Established in December 2018 the Rapid Response team supports people at home when they have a short illness that reduces their ability to look after themselves. Working closely with local voluntary organisations, such as the Red Cross, the service supports up to 20 new patients a day to remain at home.

[27] Established in 2017 the Discharge to Assess service (formerly Home First) aims to reduce length of stay and delayed discharges of care. A dedicated team of nurses and allied health professionals assess a patient's needs in their own home, community hospital or care home, and provide support until an ongoing out-of-hospital care package is in place.

created to realise the patient benefits of integrating acute, community, mental health and learning disabilities services. As pioneers of integration we are well placed to work with our partners to deliver the ICS vision of joining up care across the county in order to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money, and
- help the NHS support broader social and economic development with a particular focus on coastal and rural communities

3.17 Further information on how our proposed merger will help deliver further system improvement and the ICS vision are set out in chapter 8.

How merger supports national strategy

3.18 As well as supporting delivery of our local strategic vision, our merger also aligns with national NHS strategy, specifically the NHS Long Term Plan, and the national drive to integrate care.

3.19 The NHS Long Term Plan published by NHS England in January 2019 set out an ambitious vision for the NHS. The Plan was clear that the NHS needs to deliver transformative change to meet the increasing demands of a growing and ageing population, while at the same time maintaining and improving standards within available resources. **Annex 3** provides more detail on how the merger will enable us to deliver the national ambitions set out in the Long Term Plan.

3.20 In November 2020, NHS England published *Integrating care: next steps to building strong and effective integrated care systems across England* which builds on the Long Term Plan and signals a renewed ambition to support collaboration between partners in health and care. **Annex 3** provides more detail on how our merger meets the objectives set out in the Integrating Care report.

Case for merger

3.21 The final section of this chapter provides examples of collaboration between the two Trusts, and sets out the limitations of the current position. It concludes by summarising why we need to merge.

The two Trusts' collaborative achievements to date

3.22 YDHFT and SFT have worked closely for many years to support high quality care for local people. In May 2020, the two Trusts signed an MOU in which they

committed to work together for the benefit of the Somerset population by aligning strategic goals and operational activities.

3.23 The MOU formalised collaborative working which was already taking place between the two Trusts. Examples of collaborative work already underway between YDHFT and SFT (and our system partners) include the following:

- **Ophthalmology**: In February 2021, the Trusts introduced a single point of access across key ophthalmology referral pathways. Following assessment of referrals, the single point of access refers patients to the Somerset provider with the shortest waits for treatment: YDHFT, SFT or Shepton Mallet Hospital (run by Practice Plus Group). The aim is to reduce waiting times across the county and better serve patients' needs.

- **Urology**: YDHFT and SFT's urology teams came together in 2019 to address three key issues. Firstly, YDHFT's urology service had a long-term vacancy for a consultant which it had been unable to fill on a substantive basis. Secondly, vacancies at YDHFT and retirements at Taunton meant it was difficult to sustainably provide 24/7 emergency urology cover across the two sites. And thirdly, at the time, YDHFT had spare capacity to help reduce the growing waiting list at Taunton. The two teams agreed the key principles under which the combined service would run, which included recruitment to joint posts covering both the Yeovil and Taunton sites. This change facilitated the recruitment of a consultant to fill the gap that YDHFT had been covering with a high cost locum. The combined team was also able to establish an out-of-hours county-wide consultant on-call rota, which has helped improve patient care.

- **Pathology**: Somerset was one of the first areas in the England to implement a local pathology network and shared service. YDHFT, SFT[28] and Synlab set up Southwest Pathology Services (SPS) in 2012 as a joint venture to improve the delivery of pathology services. It now provides pathology services to over 500,000 people and more than 100 GP practices. The network facilitated the centralisation of services and upgrades to equipment and processes which released ongoing efficiency savings. Since 2012, SPS has made further developments including the use of digital scanning of histopathology samples which allows remote reporting. The Trusts were one of the first users of this service in the NHS.

Further examples of collaborative working between clinical services are set out in the **Patient Benefits case**, which should be read in conjunction with this business case.

3.24 Under the MOU, YDHFT and SFT have also taken the following steps to integrate support services:

[28] TSFT, a predecessor to SFT, entered into the joint venture.

- **People services**: our two HR teams are already working as a single team with many areas of working taking place just once across the two Trusts. These include: health and wellbeing initiatives, payroll, line manager training, sharing of investigating officers and panel members for disciplinary procedures, and shared events hosted by our staff networks. Plans are underway to implement a single colleague support line and single exit interview portal across both Trusts. We plan to bring together our medical rostering system in 2023.

- **Capital team**: the prospect of merger prompted our Capital teams to come together and pool their skills and capacity. This enabled a Strategic Outline Case for capital developments at the YDH site be developed and a bid made to the New Hospital Programme. The teams are now working together to deliver the strategic outline case and wider estates planning.

- **Joint ventures**: the Trusts have worked in partnership on joint ventures for many years (see paragraphs 2.31-2.32), and YDHFT's Simply Serve subsidiary currently provides facilities management services to a number of SFT sites in south Somerset.

Limitations of current position

3.25 Collaborative working between YDHFT and SFT has yielded many benefits for patients and the Somerset system. However, despite good progress to date, there are limits in how far the two Trusts can go in integrating services while the organisations remain separate legal entities.

3.26 Collaboration under the MOU was never intended to be a permanent position. It would not be appropriate to continue with a single executive team reporting to two separate Boards and Councils of Governors for the long term. It would risk a lack of clarity over accountabilities – especially clinical – as we move towards ever increasing integration of services and blurring of organisational boundaries. It would also place an unnecessary and inappropriate burden on the executive team.

3.27 The challenges of different line management structures, policies, procedures, IT systems and cultures present barriers to implementing change. These barriers generate delay and unnecessary cost in realising benefits. Furthermore, acting as one Trust but legally being two separate organisations carries cost and time inefficiencies which we cannot justify over the long term (e.g. paying for two Boards, producing two sets of accounts, and formally reporting twice on behalf of each Trust etc.).

3.28 Separate budgets make our desired reallocation of resources within patient pathways (i.e. away from acute services towards non-bed based community

services) more challenging, and fully flexible use of the combined estate is hampered while we are separate organisations.

3.29 The MOU and clear messaging from the two Trust boards have 'given permission' to colleagues to put patients before organisational interest; this has allowed us to build colleague buy-in to our shared vision. At an individual service level, colleagues have taken up the challenge and found ways around organisational barriers in order to integrate, and this has yielded patient, colleague and financial benefits. In this sense, merger is not essential for integration of any individual service. However, we now need to quicken the pace and drive integration systematically across all our services, under the framework set by our clinical strategy. It is this integration at scale and pace that we will struggle to deliver in the absence of merger.

Why we need to merge

3.30 There is an urgent need to drive transformational change in the Somerset health system, to improve care for the local population and address issues of financial sustainability. The two Trust Boards and our system partners are clear that closer system working is necessary to provide the best care we can for the people of Somerset.

3.31 SFT's experience of merging SPFT and TSFT showed the value of bringing colleagues together into a single team, where 'your success is my success'. When we are all on the same team, colleague relationships improve and we are able to take a shared view of how best to structure services to meet patient need. Furthermore, when services span more of the patient pathway, executives and senior managers adopt a wider lens in line with their new accountabilities, which also benefits patients.

3.32 Merger will allow us to establish fully integrated patient pathways across the county spanning primary, community and acute care and which respond to both mental and physical health needs. This will help improve patient outcomes and experience and ensure equity of care across the county.

3.33 Merger will remove the organisational barriers which currently exist and allow us to increase the pace and scale at which we integrate care. Moving to a single Board, governance and budget will enable us to maintain transformation at the pace required. If we do not merge, the colleague commitment we have built to date is likely to unwind, and momentum for further integration will be lost.

3.34 The two Boards believe that becoming one organisation will enable us to fully realise the potential benefits of integration. Merger will:

- Underpin our shared corporate vision, values and behaviours and drive a harmonised culture.
- Strengthen our actions to promote equality, diversity and inclusion.

- Signal to colleagues and other stakeholders the permanence of the change and underscore our commitment to maximise the benefits.
- Enable aligned staff terms and conditions, and avoid the potential for a two-tier workforce.
- Enable a single governance framework to be established with clear accountabilities.
- Support agile decision-making and the fluid movement of resources to better meet clinical need.
- Facilitate full integration of support services.
- Boost our resilience and create additional capacity to respond to operational pressures, staff shortages or other challenges
- Improve our links with neighbouring trusts (Dorset County Hospital, Weston General Hospital, Royal United Hospitals Bath, and the Royal Devon & Exeter) by providing a stronger, single voice for the county with consistent approaches and patient pathways.
- Create a provider in Somerset of sufficient scale to ensure its long-term sustainability.

3.35 **Figure 9** provides a personal reflection on the benefits of merger.

Figure 9: personal reflection Dr Meridith Kane

Personal reflection Dr Meridith Kane, Medical Director for acute hospitals

"I have worked in Somerset for almost 20 years, firstly as a paediatrician at MPH and then at YDH, latterly as the Chief Medical Officer there until the formation of the single Executive team for the merged organisation. I have seen first-hand what the two organisations have to offer; both centres of excellence with so much expertise to share and from which each can learn, both with a dedicated and compassionate workforce who want to do the absolute best for their patients. I have loved working in both organisations and feel nothing but pride and respect for them and what they do.

I have also seen, however, how 'history' between the two organisations has so often been a barrier to achieving true collaboration, sharing and learning, and has, at times, widened health inequalities across the county and stood in the way of the very progress that each clinician, regardless of organisation, has sought to achieve. Memories are long, change is difficult and organisational allegiances are strong, but there is no doubting the ability, commitment and aspiration of our Somerset healthcare workforce to deliver the highest quality services to our population.

I am now in a role that spans both the acute hospitals in Somerset, and after many years of faltering steps to work more closely together, already it is evident that, in a relatively short time, the impending merger between YDHFT and SFT is spurring on a pace of clinical integration and collaboration previously unseen. Rivalries are being put aside, misconceptions busted and prejudices laid to rest, as teams come together, soon to be one, with a common goal.

It's a marathon, not a sprint, and every individual is adapting at their own pace. It is a process, harder for some than others, but already I can see that even the most fearful and sceptical are acknowledging the new opportunities that are opening up to them as a result of the planned merger, and are starting to 'think big'.

Yeovil District Hospital will always have a unique and special identity, and a place in the hearts of the local population and those that work there. So too will Musgrove Park Hospital and all the sites that comprise SFT. Merging the two organisations doesn't take that away and I have seen a renewed energy to preserve all that is good

about each organisation and to shout about successes and achievements of which teams are rightfully proud, so that the learning and best practice can be shared. There will be bumps in the road for sure, but I truly believe we can already see that together we are so much more than the sum of our parts, and the future is bright."

Support from system partners

3.36 We have developed our merger plans in close consultation with ICS partners to ensure they serve the wider health and care system including primary and social care and the voluntary sector. This engagement has been at both strategic level e.g. around our clinical strategy, as well as at detailed project level including co-design (see chapter 5). This ensures we avoid duplication and that our plans support the achievement of our shared county-wide objectives. More detail about our stakeholder engagement is provided in chapters 5 and 11.

3.37 Our local partners - Somerset ICB, Somerset County Council, Somerset LMC and GP board and the local voluntary sector support our planned merger.

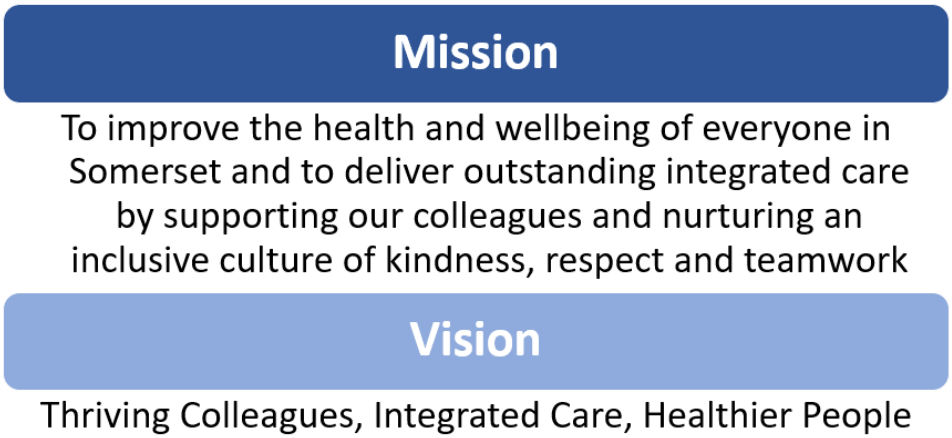
4. Vision for the merged Trust

4.1 This chapter sets out the vision and strategy for the merged Trust and explains how we will deliver them through our clinical strategy and other core strategies.

Mission and vision

4.2 We have developed a mission and vision for the merged Trust which focus on supporting our colleagues to deliver outstanding and integrated patient care, see **Figure 10**.

Figure 10: Vision and mission of merged Trust



Organisation strategy

4.3 We will deliver this mission and vision via our single organisation strategy which has the following 8 objectives:

1. Improve the health and wellbeing of the population
2. Provide the best care and support to people
3. Strengthen care and support in local communities
4. Reduce inequalities
5. Respond well to complex needs
6. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
7. Live within our means and use our resources wisely
8. Develop a high-performing organisation delivering the vision of the Trust

4.4 Our clinical strategy is core to the delivery of our vision for the merged Trust, and the first five objectives of the organisation strategy (above) replicate the five health and care aims which have been agreed at system level. These clinical aims sit alongside our strategic financial and people objectives as our core

three strategies. The final objective describes the type of organisation we want to be, linked to the delivery of our vision and values.

4.5 To ensure the new Board owns the delivery of our corporate strategy, these eight objectives form the basis of and will be monitored through the merged Trust's Board Assurance Framework.

Enablers

4.6 Alongside our three core strategies (clinical, people and finance), there are a number of key enablers which need to be in place if we are to bring our vision to life and deliver the expected benefits of merger. These are set out in **Figure 11**.

Figure 11: key enablers for Trust vision

4.7 We know that we cannot deliver the five system clinical health and care aims on our own, so effective working with our partners in Somerset and beyond will be key to our success. The remaining enablers, which are all internal, will be supported by the following strategies:

- **Green Plan**: our actions to deliver our target of being a net zero carbon Trust by 2040
- **Digital strategy**: how we will provide digital services that drive excellent support and care, communication, information, and improved efficiency
- **Estates strategy**: how we will make best use of our combined estate to support the delivery of safe, effective, high quality care
- **Quality strategy**: how we will ensure patient safety, learning and good clinical governance in the merged Trust[29]
- **Communications and engagement strategy**: how we will engage, inform and involve our stakeholders in our work.

4.8 Further detail on enablers to the clinical strategy are set out in the chapter 5.

Values and behaviours

4.9 With the support of a specialist independent consultant, A Kind Life, we have developed a joint set of values and behaviours for the merged Trust which help us deliver our vision. These values provide a common set of expectations for how we deliver care and work together in pursuit of our vision. They will guide colleagues and help inform the developing culture of the merged Trust.

4.10 To help develop our values, A Kind Life did the following:

- carried out initial engagement with executives, a sample of senior managers, and our engagement champions
- facilitated 8 'values workshops' in June 2022. In total, these were attended by c.500 colleagues
- considered the results of a cultural survey which a further c.500 colleagues completed in July 2022, and
- synthesised the data gathered and drafted proposed values and behaviours for the merged Trust.

4.11 **Figure 12** shows the agreed values for the merged Trust: Respect, Kindness and Teamwork. Each value is supported by a group of associated behaviours that have relevance for all colleagues, regardless of what we do or where we work.

[29] A draft of the Quality strategy will be available in December 2022.

Figure 12: Shared values and behaviours

	I will ...	I won't...
Respect		
Honesty	make it safe and easy for people to speak up about issues, give kind and fair feedback, and be open to receiving it too	criticise people for mistakes, stay silent when needing to speak up, be closed to feedback about myself
Integrity	set and deliver high standards, adhere to follow agreed, evidence-based practice, professional, ambitious, try to do the right thing, put patients first	accept low standards, 'walk past' issues when I see them, come across as 'too busy' or often be late, unprofessional, fail to adhere to agreed, evidence-based practice
Equity	embrace others' strengths, value different backgrounds, cultures and stories, include others, advocate for equity and diversity in the organisation	dismiss others' views, experiences or backgrounds, ignore if you see someone being treated differently because of their background
Civility	be polite approachable and welcoming to everyone, challenge each other respectfully, be considerate of others	belittle or dismiss others, be rude, uncivil, or use an abrupt tone of voice, undermine or bully others, be reactive to others or ignore others
Kindness		
Compassion	treat people as valued individuals, protect their dignity and privacy with compassion, be patient, understanding, self aware, patient	be indifferent to others struggles, or dismissive of their feelings, stories or journeys, make mean comments or be unkind
Positivity	be optimistic, bring a positive, 'can-do' attitude, bring a smile, welcome change, be hopeful about what is possible, act with courage	focus on problems rather than solutions, moan, be negative or complain without acting to solve or improve the situation, avoid challenges and growth opportunities
Understanding	put myself in other people's shoes, act with empathy; take the time to understand others' concerns, be self aware; be authentic, calm	refuse to see things from other people's perspectives, or consider what might be going on for other people
Appreciation	notice the little things other people do to make a difference and give ABC appreciation so that they feel valued, celebrate success	ignore it when people do great things or 'take the credit' for others' achievements, only give negative feedback without appreciating what is going well
Teamwork		
Support	be attentive to other people's needs and feelings, reliable, offer help, do what I say I will, encourage others and help them take responsibility	avoid helping when I see someone in need, make people feel 'a burden', have a 'not my patient / job' attitude
Collaboration	work together, seek opportunities to share, ask for ideas and input, seek cross team and service input, involve and encourage others, communicate clearly	work in 'silos', not seek out opportunities to work with or share learning with other teams, services or divisions, isolate or exclude others
Listening	listen with curiosity and empathy, giving people time to speak, welcome different views, seek out information	dismiss others' views or ideas without giving them a chance to explain, talk over people as if they aren't there, ignore concerns, dictate, interrupt, lecture or argue
Trust	be open and transparent when communicating, building trusting relationships with colleagues, reassuring	be 'economical with the truth', make no effort to share information, withhold information others need, or leave them 'in the dark'

4.12 We will start to roll out our new values and behaviours in autumn 2022 via colleague workshops, forums and other routes so that colleagues understand them. We will incorporate the new values right across the employee life cycle from attraction through to recruitment, reward and recognition and exit interviews. Regular feedback and coaching will focus on the values and behavioural framework. People policies and processes will also reflect the values to ensure a shared language and approach.

4.13 We will work with our Engagement Champions to help roll out and embed our new values; the values will also be integral to our leadership and OD programmes. The engagement work we will do around our new People Strategy (see chapter 6) will also support the cultural programme and our work to embed our new values and expectations throughout the organisation.

4.14 Further information about our work to socialise and embed our new values is at chapters 6 and 11.

5. Clinical strategy

5.1 Our clinical strategy is patient-centred and puts the people we serve at the heart of our services. The strategy supports our population health approach and gives prominence to what matters to patients, carers, colleagues and communities. It also values patient and colleague time, by making time in healthcare count and maximising years of healthy life.

5.2 Together with our ICS partners, we have assessed the current and expected future health needs of the people of Somerset, and the challenges the county faces in delivering consistently high quality, equitable and efficient care. Drawing on this analysis, and following widespread engagement across the county, the Somerset system agreed five clinical health and care aims. Our clinical strategy sets out how the merged Trust will play its part in delivering these five clinical health and care aims, alongside our partners in primary care, social care and the local voluntary sector.

5.3 Our clinical strategy is aligned with the objectives of the NHS Long Term Plan, and supports the national drive for integrated care[30] (see Annex 3). It builds on the strong foundations of the clinical strategy produced for the creation of SFT in 2020. However, we are now taking a wider lens than we did previously, because the strategy laid out here includes our vision for care across all hospital settings and our deepening partnership with primary care.

5.4 This chapter sets out the following:

- Our ICS vision and model of care in Somerset
- Obstacles to achieving our vision
- The merged Trust's contribution to the five clinical health and care aims
- Clinical support services
- Measuring our clinical strategy by valuing time
- Enablers to our clinical strategy
- How we developed the clinical strategy
- Next steps in implementing the clinical strategy

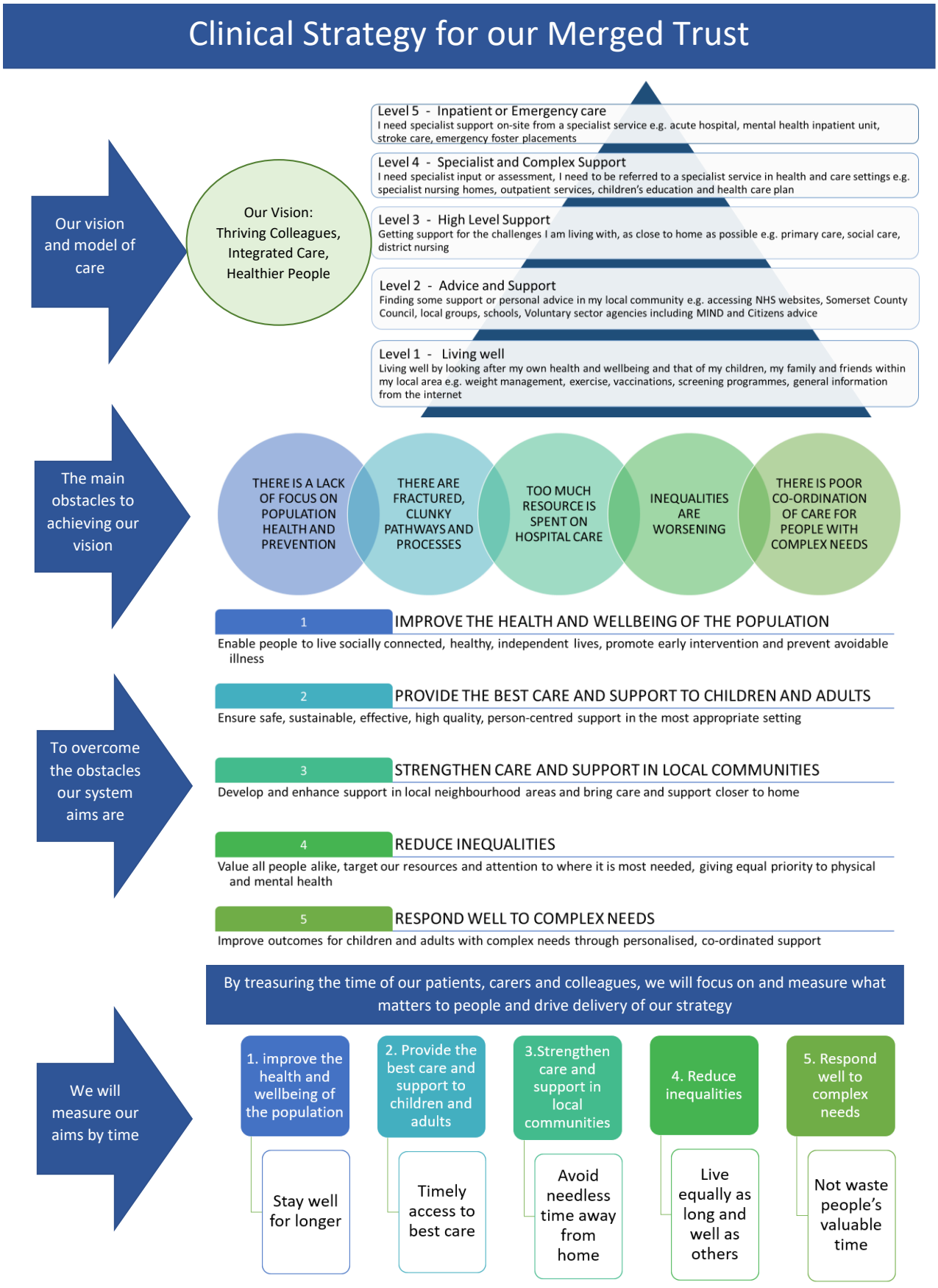
5.5 The **Patient Benefits Case,** which should be read in conjunction with this chapter, uses six service level case studies to set out the benefits to patients, their families and carers of our merger.

Plan on a page

5.6 A summary of the clinical strategy for the merged Trust is shown in our 'plan on a page', see **Figure 13**. This brings together our Trust vision, model of care, the obstacles to achieving our shared vision, the five clinical health and care aims, and how they link to valuing time.

[30] See *Integrating care: next steps to building strong and effective integrated care systems across England*, NHSE, November 2020.

Figure 13: Clinical strategy plan on a page



Our vision and model of care

5.7 As set out in chapter 4, our vision for the merged Trust is: Thriving Colleagues, Integrated Care, Healthier People.

5.8 Our primary driver for merger is to improve the health of our population by improving the care we provide inside and outside of hospital. We believe that doing the right thing for patients will drive efficiency more effectively than cost saving schemes which bring the risk of poorer patient care and/or experience. The experience of other healthcare systems, e.g. Jönköping in Sweden, Canterbury in New Zealand and the Montefiore model in New York, has shown that an intense focus on the person and what matters to them, and making sure all elements of the system deliver the right care for people, drives down the cost of acute health services[31] and improves health outcomes.[32]

5.9 Once merged, we will fully integrate YDHFT's acute services with SFT's county-wide mental health, learning disabilities and community services (vertical integration). For some services, such as Stroke, there are already strong links between YDHFT's acute services and SFT's community service; in other services there is further work to do to link up acute and community services which merger will accelerate. Similarly, while links between SFT's psychiatric liaison team and YDH's ED is well advanced, there is more to do in other areas to link YDHFT acute services with SFT's mental health services, e.g. linking paediatrics and CAMHS (see paragraph 5.185), perinatal mental health with maternity, and dementia services with geriatrics. There is also important work, that merger will aid, around improving the physical health of patients cared for by mental health services (see paragraphs 5.43 and 5.150).

5.10 Alongside vertical integration, we will also bring together YDHFT and SFT's hospital-based care into single county-wide services, building on the best from both Trusts as we do so (horizontal integration). Merger will help us create more resilient clinical teams, with improved clinical decision-making derived from larger MDTs and integrated digital systems (see Patient Benefits Case).

5.11 Our experience of merging SPFT and TSFT in 2020 showed that bringing colleagues together from community, mental health, learning disability and acute services into one organisation creates an environment that enables trusted relationships to develop across service boundaries. Colleagues are now more likely to seek each other's advice and exchange ideas than when TSFT and SPFT were separate Trusts. We are now receiving business cases developed jointly by physical and mental care services which capitalise on the opportunities that being an integrated trust offers, and which demonstrate this broadening of perspective.

[31] Specifically, reduced admissions and readmissions to ED.

[32] The Montefiore Health System in New York, Ben Collins, The King's Fund, July 2018; The quest for integrated health and social care A case study in Canterbury, New Zealand, Nicholas Timmins and Chris Ham, The Kings Fund 2013; Population health systems: going beyond integrated care. Hugh Alderwick, Professor Sir Chris Ham, David Buck. The Kings fund 2015.

5.12 As a merged Trust we will strengthen our relationships with other care and support providers in the county and beyond,[33] and work with them to deepen our understanding of where gaps in provision exist, both in health and other services. We will support other agencies to do the right thing for the population of Somerset, to improve population health and benefit all involved. This may involve sharing resources with our local partners if that is the most effective way to serve the health and wellbeing of the people of Somerset.[34]

5.13 We will co-produce changes to our services with the people who use them. There will be close collaboration between system partners and a focus on learning and continuous improvement to get care right for everyone.

5.14 To achieve our vision we will provide care at the lowest level appropriate for the person's needs, starting with self-management and only escalating through increasing levels of care if the person's health needs require it. This 5-level model of care is set out at the top of the Plan on a Page (Figure 13). Further detail on the model of care is provided in **Annex 5**.

Obstacles to planned care

5.15 Colleagues at both Trusts are rightly proud of their efforts to provide high quality services for the people they serve, especially in the very challenging circumstances created by the pandemic. However, there are systemic features in the way we provide care in Somerset which act as obstacles to the provision of optimal care. These obstacles, which we have identified as a system, are explained below.

Lack of focus on population health and prevention

5.16 The healthy life expectancy of some population groups in Somerset is now decreasing.[35] Our healthcare services have an important role to play in reversing this trend by supporting the prevention of ill health, and acting to prevent avoidable illness and disability at every stage of our care pathways. This includes devoting a greater share of our resources to prevention and wellbeing. As we move towards ever closer working in aid of our population health approach, there is also scope for us to do more to share resources and expertise with system partners.

[33] E.g. providers and commissioners in Dorset, Devon, BANES, Wiltshire and North Somerset.

[34] The Montefiore health system in New York has led the way on this with support for housing and community initiatives, recognising that these benefit both the patients who receive the support as well as the health services which those people would otherwise access.

[35] http://www.somersetintelligence.org.uk/life-expectancy.html

Patient pathways are fractured and clunky

5.17 The current provision of care has developed organically over time and is not integrated between services or across the county in a way that reliably meets people's needs. Many of our patient pathways are disjointed and too long. Some involve lengthy referral processes (e.g. to access a health coach for a patient seen in secondary care), have high thresholds for access to care (e.g. intensive dementia support), require duplicate assessments (e.g. therapies), or use a care approach that focuses on discrete diseases when many people have co-morbidities.

5.18 These complex and disjointed pathways waste time and resources for people, carers and colleagues, and can be confusing for colleagues and patients alike. They introduce delay in patients getting the care they need, and also impact negatively on the environment when more appointments than necessary are created.

5.19 Patient waiting times and access to specialist care differ significantly for some services between YDH and MPH, largely due to staffing gaps in certain acute specialties. There are also geographical inequities, for example in terms of waiting times or access to specialist care for people with acute needs (see **Patient Benefits Case**).

Too much resource spent on hospital care

5.20 The Somerset health and care system is in financial deficit, with too much attention and resource spent on hospital care, and not enough on children's services, mental health and community-based services.

5.21 The Somerset system is in deficit due in part to high or ineffective spend on acute services. Furthermore, 2019 benchmarking data (the latest available) shows that funding for adult community mental health services in Somerset is in the lowest quartile nationally.

5.22 Care in Somerset is weighted towards admission to inpatient beds (both acute and community). This means some people are in a hospital bed when more accessible local care and support would have been more appropriate had it been available. Inappropriate bed-based care exposes patients, in particular older people, to the risk of hospital-acquired harm. Given our largely rural setting, a bed-based model also means some patients spend a significant amount of time travelling to and from hospital which can cause anxiety and inconvenience.

5.23 The high cost of the current bed-based model makes it harder to invest in other important areas, such as mental health services and more local, flexible services based in communities.

5.24 The 12 neighbourhoods in Somerset continue to develop and have an increasing range of resources and community solutions to draw on to help improve the health and wellbeing of their local population. However, we have more to do to publicise the existence of neighbourhoods and improve access to neighbourhood care. Furthermore, there are no direct referral routes from secondary healthcare into neighbourhood health resources, meaning it is currently hard for healthcare professionals to help patients access this type of support.

Worsening health inequalities

5.25 The life expectancy of women in Somerset with a mental health disorder is 17.5 years lower than for women without serious mental illness; for men in Somerset the difference is 19.7 years. This discrepancy is replicated around the country and is attributed mainly to cardiovascular disease and cancer, rather than the underlying mental health condition.

5.26 People in marginalised groups also experience health inequalities. Across England, people affected by homelessness die on average around 30 years younger than the general population.[36]

5.27 Somerset is pioneering work to tackle health inequalities for people with mental health problems through Open Mental Health (see paragraph 3.13). However, addressing the deep health inequalities linked to poor mental health is a major programme of work that will take many years to fully implement. Our work on socio-economic health inequalities is at an early stage and has begun with work to analyse why in some communities there are higher rates of not attending appointments and what can be done to improve access to healthcare.

Poor coordination of care for people with complex needs

5.28 Our care of the increasing number of people with complex needs is often poorly coordinated. This wastes time and leads to poorer health outcomes. It is important that care for people with complex needs is personalised and well-coordinated so it focuses on what matters most to them and reduces their treatment burden. However, coordinating care remains a challenge, and the personalised care approach has not yet been implemented in many of our healthcare settings.

Care in different settings

[36] Thomas B. *Homelessness kills: an analysis of the mortality of homeless people in early twenty-first century England.* Crisis, 2012. https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf [Accessed 29 July 2022]

5.29 The next section sets out our approach to care in the wide range of settings that the merged Trust will operate.

Optimising bed-based care

5.30 The merged Trust will provide bed-based care from two acute hospitals, 13 community hospitals, 10 mental health inpatient wards, and in people's own homes via hospital@home.

5.31 Bed-based care in hospital exposes patients to the risk of harms such as infection, delirium and deconditioning. Some healthcare interventions can only be delivered in hospital settings, and it is our intention that people come to our hospitals only for those interventions which cannot be provided in another setting.

5.32 In the first instance we will aim to deliver care during the day and support people to return home at night, to recover in familiar surroundings. Where care requires an inpatient stay we will ask ourselves 'Where best next?' for everyone in a hospital bed, to keep hospital stays to a safe minimum.

5.33 Hospital attendances create cost and inconvenience for patients and carers who sometimes have to travel a long way to get there. Where a patient can be cared for in a community hospital closer to home, or in their own home via services such as hospital@home, rather than in an acute hospital we will aim to do that.

5.34 Our estates development programmes (see paragraphs 2.33-2.35) will focus on providing safe, therapeutic hospital environments which promote recovery and are accessible and easy to navigate for all.

Use of acute hospitals

5.35 Yeovil District Hospital and Musgrove Park Hospital will continue to provide emergency care 24 hours a day, 7 days a week. Both Emergency Departments will have access to all the services necessary to support their work.

5.36 The patient discharge pathways from the two acute hospitals into the community hospitals are currently different. Once merged we will align the discharge pathways from both acute sites to speed up handovers and improve patient experience. Further information on our strategic aims for the use of acute hospitals is at **Annex 7**.

Use of community hospitals

5.37 Our community hospitals will operate as thriving community hubs offering a range of healthcare services in neighbourhood settings. They will play their part in preventing the onset of avoidable disease, supporting people to access personalised care and to remain at home when that is best.

5.38 We will bring the discharge pathways from the two acute hospitals in Yeovil and Taunton into line to make the handover easier. Community hospital services will be delivered by an appropriate blend of health care professionals such as Open Mental Health workers, rapid response team members, district nurses, and primary care staff, working alongside voluntary sector colleagues.

5.39 As part of the creation of SFT in 2020, we made changes aimed at using community hospitals to provide care closer to people's homes and relieve pressure on acute services. This included for example conducting ophthalmology investigations at community hospitals and increasing community diagnostic capacity. We are now looking at ways to extend this approach by making use of SFT's community estate in south Somerset to support YDHFT and relieve pressure on its acute services.

5.40 In future some community hospitals may not have inpatient capacity, but this will be determined by the needs of the local community. For any significant proposed changes that meet the statutory requirement we will work closely with Somerset ICB to carry out appropriate public consultation.

5.41 Further information on our strategic aims for the use of community hospitals is at **Annex 8**.

Mental health and learning disabilities provision

5.42 The merger in 2020 of TSFT and SPFT to create SFT enabled a range of improvements to be made for patients with mental health needs in the north and west of the county. Mental health care has a healthy position and profile within SFT as evidenced by the Trust's success in being named Health Service Journal's Mental Health Trust of the year in 2021.

5.43 Stronger relationships between services at SFT have enabled patient and carer needs to remain at the heart of decision-making, rather than being displaced by service interests. For example, as an integrated Trust, SFT has been able to improve adult ED pathways for people with mental health problems, and implement improved pathways for children and young people with mental health needs who have been admitted as a paediatric inpatient. We have also been able to share staff knowledge, experience and skills between mental and physical health services to benefit patients. The proposed merger of SFT and YDHFT will enable these benefits to be extended to patients in the south and east of the county.

5.44 Merger offers us the opportunity to strengthen our care and support to people with Learning Disabilities (LD). For example, there are existing LD liaison services at MPH and YDH, but both are small and they differ in terms of workforce and delivery. The MPH service (2 registered nurses, 1.4 WTE) focuses on reasonable adjustments made during episodes of planned and unplanned care, the use of health passports and support around discharge. The YDH service (1 full time LD practitioner) offers advice on reasonable adjustments, provides training for departments as needed, and contributes to LeDeR[37] reviews. Both teams also liaise with family members and carers. Merger offers us the chance to implement a single leadership model for LD liaison, with consistent standards and function so there is equity across the county for people with learning disabilities.

5.45 The prospect of merger has promoted the development of new relationships with the Dorset system, specifically around mental health care. SFT's Medical Director for Mental Health, Learning Disabilities and Community Services has started to meet with the medical directors of University Hospitals Dorset NHS Foundation Trust and build relationships between YDHFT colleagues and mental health services in Dorset. She would not be doing this were it not for the proposed merger. These meetings bring mental health leadership into YDHFT and also support pathways into Dorset for mental health patients.

Care in our neighbourhoods (out-of-hospital care)

5.46 The focus of our community services is prevention and early intervention with the aim of preserving health, avoiding escalation of need, and diverting people away from hospital who don't need to be there.

5.47 Merger will bring together all the county's community teams and District Nursing teams into the same employer. Our intention is for ward-based teams to link closely with neighbourhood teams (consisting of our community colleagues, as well as primary and social care colleagues and voluntary sector organisations), to help people get back home as soon as possible, with the necessary support in place. This community support may include ongoing treatment, e.g. setting patients up to take intravenous antibiotics at home instead of remaining in hospital.

5.48 To make this model a reality, the way our acute services colleagues apply their expertise will change. Acute services colleagues will continue to care for the patients they currently see in the acute but, where appropriate, they will in future more frequently provide care to these patients virtually, in community settings or in patients' homes. Alongside this, acute colleagues will increase their provision of expert advice to clinical colleagues e.g. District Nurses or GPs who are caring for people in the community, aided in some cases by remote monitoring and/or virtual consultation.

[37] Learning from Life and Death reviews.

5.49 To implement this change we will need to modify how we model our workforce needs and, over time, job plans will change (subject to appropriate consultation) to support this shift to a new model of care. The new model will also see us using our estates differently, for example by using a community hospital or other community setting to run a condition-specific hub e.g. a weekly Diabetes clinic in the community staffed by primary and secondary care clinicians.

5.50 Our out-of-hospital care is a blend of national and local initiatives:

- Anticipatory care (see paragraph 5.181-5.184)
- Intermediate care (see paragraph 3.13)
- Hospital@home, our local version of virtual wards, (see paragraphs 5.124-5.219)
- Contributing to the development of neighbourhoods, (see paragraphs 5.130-5.141)

5.51 Effective community services relieve pressure on acute services and primary care and facilitate the post-pandemic recovery of elective care services. Merger will also put our community teams in a stronger position to work with GPs to develop community care pathways in individual localities.

5.52 The merger of SPFT and TSFT in 2020 demonstrated the benefit of bringing acute and community services under single leadership, and how partnerships with social care and primary care benefit when we are one organisation. The current planned merger of YDHFT and SFT gives us the opportunity to spread those benefits across the whole county.

5.53 The lessons we have learned so far from the early implementation of neighbourhoods, and which we are bearing in mind as neighbourhoods mature are:

- Ensure all system partners are involved in the collaborative effort, and use a multi-disciplinary 'team of teams' approach where we all act as if organisational barriers do not exist and instead keep a steadfast focus on what patients need.
- Recognise the value of support worker roles – colleagues who take a holistic view of people's needs, signpost people to relevant support and influence/advocate on their behalf.
- Identify the issues particular to each neighbourhood and shape services to respond to them
- Identify the local community assets that can be used in the provision of neighbourhood care. This includes estates, as well as the local offer from community and voluntary sector organisations.

Primary care

5.54 With Symphony as the single at-scale primary care provider in the county, the merged Trust will be well-placed to test and accelerate ways to integrate community, acute, mental health and learning disabilities services with primary care.

5.55 SFT and YDHFT are already supporting primary care in three areas. Relevant staff are employed by one of the Trusts, but work full- or part-time in a GP practice and receive training and supervision from the Trust. These areas are:

- **First contact practitioners**: these are physiotherapists who assess and treat musculoskeletal patients presenting in primary care. This model speeds up access to care, reduces the burden on GPs, and cuts down requests for unnecessary diagnostics or medication, and inappropriate referrals to secondary care.
- **Mental health nurses**: these nurses, embedded in general practice, provide low level mental health support to patients who are unlikely to require onward referral to community mental health services. This frees up GP time to see other patients, and can speed up access to care.
- **Peri-operative care**: we are running a pilot with 4 GP practices owned by Symphony to test the benefits of helping patients referred for surgery to optimise their health prior to their operation. These projects are part of our programme to develop a county-wide peri-operative service. (see **Patients Benefits Case** for further details).

5.56 The existence of Symphony and the trusted relationships it has created, enables us to test and implement change at a faster pace than if we had to engage with each GP practice individually. For example, the existence of Symphony and the signal of merger means as a Somerset system we have been able to make good progress in setting up community investigation hubs (see paragraphs 5.137-5.139).

Merged Trust's role in delivering the five health and care aims

5.57 In this section, we set out the contribution the merged Trust will make to the delivery of each of the five system health and care aims.

5.58 All five aims are part of the Board Assurance Framework for the merged Trust, and each aim has an executive sponsor responsible for oversight of its delivery.[38]

[38] Executive sponsors are as follows, Aim 1: David Shannon, Aim 2: Hayley Peters, Aim 3: Andy Heron, Aim 4: Matthew Bryant, Aim 5: Dan Meron.

Aim 1: Improve the health and wellbeing of the population

Enable people to live socially connected, healthy, independent lives, promote early intervention and prevent avoidable illness

5.59 This aim is about improving the health and wellbeing of the population. We will deliver this aim by working with our partners to:

- implement population health management
- support people to live independently
- promote early intervention, and
- prevent avoidable disease and deconditioning.

This aim is largely driven by the Somerset Public Health team, but with our input as system partners.

Population health management

5.60 Population health management[39] is key to our ICS approach to health and care in the county, and to implement it we need robust data and population analytics. There is much we have to do in Somerset to build our population health and intelligence capabilities, improve our data, and support the provision of shared information which drives decision-making. However, the simplicity of the Somerset system means that, as a system, we are in a strong position to implement population health management.

5.61 By April 2023, subject to the necessary approvals, there will be a single NHS Foundation Trust and a single unitary council with a strong, shared strategic vision for Somerset and a single, shared geographical boundary. Somerset ICS is participating in wave 3 of the Population Health Management programme run by NHSE, which will help us embed population health management across our health and care system.

5.62 Together with Somerset County Council we have set up a Collaboration Hub to provide data and improvement expertise for the whole ICS. Analysis of population health data will give us insight into the needs of the Somerset population and help us identify cohorts of people who are at risk of deteriorating health. It will also help us as a system identify local trends in disease, tailor care to local needs, and set investment priorities. Population health analytics will inform our plans to tackle health inequalities and help us drive out unwarranted variation.

[39] The King's Fund defines population health management as: "an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies." A vision for population health: towards a healthier future, The King's Fund, November 2018.

5.63 We will work with our partners in Housing, Environmental Health and the police etc. to get people the support they need to tackle the wider determinants of health (such as education, living conditions and housing). We will also work with the local Health and Wellbeing Board to identify areas where our financial resources and extensive specialist expertise can add value.

Support people to live healthy independent lives

5.64 Social isolation and loneliness[40] are increasing in society and have been exacerbated by the pandemic. Research conducted before the pandemic predicted that, without action, loneliness will reach epidemic proportions by 2030.[41] A meta-review of the impact of social isolation on mortality found that social isolation is comparable in its impact on mortality to other well-established risk factors for mortality.[42]

5.65 There are many parts of Somerset where social isolation is a significant driver of poor physical and mental health, and we have more work to do to connect the many creative and effective local initiatives going on in different neighbourhoods to address loneliness (see also Aim 3).

5.66 A Somerset GP project used targeted support and the creation of mutual support groups in the town of Frome to tackle social isolation and it reduced emergency admissions to hospital by 14% between 2013-2017.[43] This work gained national recognition, and there is now similar work going on in other areas of the county. For example, in south Somerset SPARK Somerset coordinates an online directory of local, low-cost activities and services giving local people access to a wealth of different groups and support services. They also coordinate village agents (paid, part-time local residents) who support vulnerable people in their communities. We want to work with partners to help extend these models to other parts of the county.

5.67 The two Trusts are also working together with an alliance of voluntary sector organisations to develop a dementia wellbeing model which will provide support and activities for people with dementia. Our work within the Open Mental Health alliance also helps people live healthy, independent lives.

Early intervention

5.68 We have been working hard as a county to shift our focus to preventing ill health and to undertake more activity early on in our pathways. There is a lot

[40] Social isolation is objectively measurable – the indicators are living alone, having few social network ties, and infrequent social contact. Loneliness is the perception of social isolation and is a subjective emotional state.

[41] Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review, Holt-Lunstad et al

[42] Ibid.

[43] See British Journal of General Practice, https://bjgp.org/content/68/676/e803/tab-article-info

of good health promotion activity going on in neighbourhoods, but it is currently hard for the clinicians in our Trusts to know what relevant support is available and how to refer patients into that support, and currently they sometimes have to refer people back to primary care for an onward referral which creates unnecessary delay.

5.69 The role of our hospital-based clinicians needs to evolve from focusing on hospital-based work, to helping patients earlier in the pathway. We will do this by improving our provision of specialist advice to partners in primary care and the voluntary sector to help them help people earlier on and prevent escalation of health need.

5.70 We have a number of projects and programmes where acute clinicians will play their part in supporting primary care and the voluntary sector to prevent ill health and support wellbeing, rather than just treating people once they have become ill. These include:

- **Peri-operative care**: this programme aims to optimise patients both physically and mentally prior to surgery so they recover quicker, have fewer complications and an improved experience. This programme is a partnership between our Trusts, primary care and the voluntary sector, and involves support for a range of modifiable risk factors for surgery including anaemia, diabetes, and substance misuse. See Patient Benefits Case for further detail.

- **Tobacco reduction**: SFT has recently created a tobacco dependency service and recruited a tobacco dependency programme manager to work across both Trusts. More than 700 people die in Somerset every year as a direct consequence of smoking, and more than 5,700 admissions to hospital were attributable to smoking in 2016/17.[44] From autumn 2022, this service will offer support to all smokers when they are admitted to our hospitals, see **Figure 14**.

- **Paediatric obesity**: this is a pilot programme providing tailored support to families with a child under 4 who is obese. Evidence suggest that long term outcomes are much better if interventions are made early in life (see **Figure 15**, Colleague story).

Figure 14: Patient story - Harold

Harold
Harold is a 56-year-old highly dependent smoker with Chronic Obstructive Pulmonary Disease (COPD). Harold experiences recurrent COPD exacerbations and regular hospital admissions. His breathlessness, tiredness and discomfort are becoming more acute which negatively impacts his

[44] Data from Public health Somerset.

quality of life and causes him considerable anxiety. Harold is unable to walk far and negotiating the stairs at home is proving difficult.

Currently there is no specialist smoking cessation support at either Trust. Harold struggles with tobacco withdrawal symptoms and can be disruptive when he can't smoke on hospital grounds. Some staff offer Harold a patch to lessen his tobacco withdrawal symptoms but there is no consistent approach. As a result, when Harold is offered nicotine replacement therapy during hospital stays the dosage and type of product may not be what he wants, and at other times he is offered nothing at all and he endures withdrawal symptoms. Harold has not been offered support to quit and continues to smoke.

Our vision for the future

We are looking to integrate tobacco treatment into routine care across both Trusts. All patients who smoke will be assessed on admission and will receive an intervention from a Specialist Tobacco Reduction Practitioner who will use their advanced motivational interviewing skills to offer behavioural support and appropriate medication. In addition, training for clinical staff about tobacco treatment will ensure Harold is more comfortable when he is in one of our hospitals. He will also receive up to 12 weeks of support post-discharge to increase his chances of quitting for good.

Figure 15: Colleague story - Paediatric obesity

Colleague story: Isobel Feakins, weight management paediatric dietician

"In Somerset, 22.3% of children aged 4-5 are overweight, obese or severely obese which is comparable with the national picture.[45] However, until recently SFT's dietetics team has been unable to accept referrals for obese children due to a lack of capacity. YDHFT were in a better position as they could offer a general dietetics appointment but it was still not a multi-disciplinary response.

Following submission of a joint business case by YDHFT and SFT's Paediatric and Dietetics teams, Somerset CCG (as it then was) agreed to fund a 1-year pilot to trial a weight management service for children, expected to take c.50 referrals a year. Work began in April 2022 and the team, which serves the whole county, now consists of me (a weight management paediatric dietician), a clinical psychologist, an assistant psychologist, two paediatricians (one from MPH and one from YDH) and some administrative support; all posts are part-time. Somerset Activity and Sports Partnership also provide input on physical activity.

We focus on the under 4 age group because parents are in control of their child's eating, so we know we can have more influence over what is happening, and intervening early to change behaviours has been show to have better outcomes.

Referrals mainly come from health visitors, GPs and paediatricians. I have an initial meeting with families via a home visit or virtual meeting to get to know the family and introduce our service. They then have an appointment with one of the paediatricians to make sure there are no underlying medical reasons for the child to be the weight they are. We deliberately keep the appointments away from the acute setting so appointments take place in the Families hub in Taunton (East Reach), the Robert Blake Child Health centre in Bridgwater, or South Petherton community hospital.

Our model is an evidence-based family lifestyle intervention using a psycho-social approach. We offer a series of six virtual group education sessions held monthly, but if families don't want to join a group session we see them separately at home or at one of our three sites. At the end of the six months, we offer them a further clinic appointment to discuss what's working and what further input they need.

[45] Data from the National Child Measurement Programme, 2018/2019

Early experience indicates that some families don't see their child's weight as an issue, and my challenge is to work with them to get them to the first clinic appointment.

Our next steps are to set up a focus group to get feedback from families who have been through the programme. We also want to look at how we can support self-referral into the service and how we can expand the age range.

I find it exciting to be developing a brand-new service and knowing it's an area where there hasn't been any support for these families before."

Preventing the onset of avoidable disease and deconditioning

5.71 Just 10 days of bed rest in older adults can lead them to lose 1kg of muscle mass and 16% of their strength.[46] It is therefore essential that we prevent deconditioning while people, especially older people, are in hospital.

5.72 Our hospital estates are currently configured around bed-based care and have limited access to outside spaces which enhance patient recovery. Very few wards have adequate day areas – most day areas are awkward spaces, away from nursing stations. The set-up of our wards makes spending time in bed the easy thing to do, rather than encouraging people to get up and move about if they are well enough, which would promote independence and prevent deconditioning.

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5.73 We will ensure people only receive bed-based care when it is right for them, to avoid harms such as deconditioning. When people do come to our hospitals as inpatients we want them to stay as active as possible to promote their independence and avoid deconditioning. All our wards will continue to encourage people to get up and get dressed to promote their healthiness and recovery.

5.74 Our estates redevelopment programmes will support this work by reconfiguring our estates and ward spaces to enhance independence and mobility. We will also develop our outside spaces, using plants and micro forests[47] to create welcoming places where patients and their carers can benefit from the proven therapeutic effects of being in nature, such as reduced blood pressure.[48] Both Trusts' art coordinators will work with the Estates Design Vision groups to ensure principles of therapeutic design and arts are incorporated into our planned capital works.

[46] Crabtree, A, Lane, TJ, Mahon, L, Petch, T and Ekegren, CL. The impact of an End-PJ-paralysis quality improvement intervention in post-acute care: an interrupted time series analysis. AIMS Medical Science. 2021;8(1):23-35.

[47] Developed by Japanese botanist Dr Akira Miyawaki in the 1970s, micro forests are small, fast-growing dense forests created using native species. They can be created on a tennis court-sized plot, and help people reconnect with nature, store carbon, attract wildlife, improve air quality and cut noise pollution.

[48] https://pubmed.ncbi.nlm.nih.gov/28814305/

Aim 1: Benefits

5.75 When we work with partners to intervene early, we help people stay well for longer. This is because:

- healthcare conditions are less likely to escalate to crisis or emergency
- periods of illness are less acute and recovery is quicker
- support for lifestyle changes can lead to an improved health trajectory.

5.76 This aim values time by:

- in some cases shortening the length of stay as illness is less acute when treatment starts, and
- reducing delays to surgery caused by modifiable risk factors (through effective peri-operative care).

5.77 The benefits for the system are:

- an improved ability to meet rising demand within our existing resources because fewer people's care needs become acute
- reduced pressure on our and our partners' services: primary and social care, and the voluntary sector because we intervene early to prevent ill health rather than dealing with acute illness and increased care needs which are usually more costly.

Aim 1: measurements

5.78 Our key measurements for this aim are:

- Pre-operative diabetes rates
- Smoking rates
- Cancer diagnosis times
- Suicide prevention training numbers

Aim 2: Provide the best care and support to children and adults

Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting

5.79 This aim is about providing timely access to high quality, person-centred care in the most appropriate setting.

5.80 Like other Trusts around the country, the pandemic had a profound effect on our ability to provide timely care. As a result, significant backlogs have built up for diagnostics and treatment, and our work to deliver elective recovery also sits under this aim.

5.81 We will deliver this aim by:

- Integrating our acute services to create county-wide services, including pathway redesign
- Driving elective recovery
- Delivering additional specific projects aimed at improving the quality of care and health outcomes.

Integrating acute clinical services

5.82 There is currently a lack of standardisation across Somerset, with different patient pathways operating in different areas of the county, and different offers from the two acute hospitals in terms of diagnostics and treatments. For example, although the community element of the leg ulcer service is delivered by a single county-wide team, the acute elements of the pathway are different at YDH and MPH. This means people in different parts of the county receive different care and because the Trusts work to their own waiting lists, waiting times differ too. There are also inconsistencies in referral criteria, onward referrals for the same medical problem, and different approaches to patient correspondence.

5.83 Many clinical pathways have developed organically and contain duplication and inefficiencies. We also know that some patients do not experience joined-up care, and find some pathways confusing and hard to navigate.

5.84 As part of the creation of SFT, a programme of work was established to improve patient pathways, and although some improvements have been made, progress was hampered by the pandemic. The prospect of merger with YDHFT has necessitated the re-shaping of plans to take account of the needs of patients in the south and east of the county and make sure they are fit for use county-wide.

5.85 As part of merger, all acute services in our two Trusts will come together with their sibling service to create a single county-wide service. Once integrated, these services will operate under a single management structure, with a single set of pathways and a single waiting list. Each service will operate to consistent standards and protocols right across the county, have a single budget and report as a single service.

5.86 This will reduce overall waiting times, improve care quality and consistency and reduce inequity of access. Combining teams will improve care quality by:

- giving colleagues exposure to a wider range of clinical cases
- increasing knowledge sharing and best practice across the enlarged team
- creating stronger MDTs due to a wider pool of expertise (and in some cases enabling MDTs for rarer conditions to be established where they do not already exist)
- driving standardisation of approach and removing unwarranted variation.

5.87 Combining teams will also boost the resilience of services, by removing duplicate tasks and individual single points of failure, see **Figure 16**.

Figure 16: Colleague story - Orthotics

Colleague story: Juliet Sturgess, Orthotics service lead, YDHFT
"The YDHFT Orthotics service is small but perfectly formed, and we have an equivalent service at SFT. When our teams met to talk about integrating we found that we work quite differently. However, both teams see the merger as an opportunity to take the best from both worlds for the benefit of patients. One thing we're united on is the struggle to recruit orthotists, as there's a massive national shortage. When you're a small team, it's quite difficult to grow your own workforce particularly when all the relevant university courses take place in the north of the country. So together our teams have developed apprenticeships and are supporting three new prosthetics and orthotics apprentices which will mean we have a larger pool of talent that we can deploy across Somerset and which will give us greater team resilience. When you start to see the benefits of working together on one project, you realise what we could do if we work together on all aspects of our service delivery. We're now exploring how we procure products because by joining YDHFT's and SFT's Orthotic services we will have more buying power and can provide a better range of products while also making savings. We're now mapping our services and I think there are opportunities not only to improve services but also to provide some additional services locally for patients who currently have to travel out of county due to our limited resources."

5.88 The work to combine services has already begun in some areas including palliative care, oncology and urology (see **Figure 17**) with benefits for patients see **Figure 18**. Further detail about our work to integrate our oncology, maternity, stroke and cardiology services is included in the **Patient Benefits Case**.

Figure 17: Integration of urology service

YDHFT and SFT each provide urology care from their acute hospital site (YDH and MPH respectively). In addition, SFT provides a countywide community continence service.

The two services came together in October 2019 to consider how urology services should be provided in Somerset in the face of two major workforce challenges: the lack of urology consultants, and how to staff parallel on-call rotas at each acute site.

> The teams agreed to move to one Somerset Urology Service with joint consultant appointments, and in September 2020 they moved to a shared 7-day out-of-hours on-call consultant rota.

Work to review clinical pathways has begun, and this will address the current inequities of service provision and ensure prompt management of urological emergencies. As part of their review in 2018 the national GIRFT team recommended that 5-day elective care be provided at YDHFT, and that SFT provides a 24/7 acute service with acute urology admissions going direct to MPH. Implementation was paused due to Covid but the teams plan to resume this work post-winter 2022.

The two teams have adopted cross-county working through the use of honorary contracts, which enable colleagues to work across both acute sites. This creates a larger, more resilient combined

team with a broader range of skills. SFT colleagues are also using YDHFT theatres to operate on SFT patients to tackle the backlog of long waiters.

The teams have already introduced joint governance and audit meetings; one of their next steps is to jointly develop urology investigation units across the county.

Figure 18: Patient story - Sandra

Sandra
Sandra is a 60 and a retired teacher. She is under the care of the urology team at SFT and has waited two years for surgery to improve her stress incontinence. Her incontinence has caused Sandra to stop socialising which has had a big impact on her quality of life. In a bid to manage long waiters, YDHFT and SFT began sharing theatre capacity in autumn 2021. This led to Sandra being offered a date for surgery in November 2021 at YDH. However the surgical expertise needed for her procedure lay in the SFT team, and the SFT surgeon encountered a number of issues when he tried to operate at YDH. He was unable to access Sandra's scans, her patient record, or the operating theatre list because YDHFT and SFT use separate clinical IT systems. Furthermore, as Sandra's procedure is not normally done at YDH, a necessary item of surgical equipment had to be transported by car from SFT to YDH. Colleagues managed to overcome these issues and Sandra's procedure was not adversely impacted, however the process was very clunky for clinical colleagues involved. After surgery, Sandra recovered overnight at YDH. However, as her procedure was not routinely done at YDH, the nursing expertise was not available on site to supervise her post-operative care. It was therefore agreed Sandra would go home with the catheter and return to SFT one week later for supervised catheter removal. During this time Sandra was unsure who to contact for advice which left her feeling vulnerable and anxious. **Post-merger** Post-merger patients like Sandra will receive the care they need at the hospital site best able to meet their needs. Colleagues will be able to access clinical records, investigations and the necessary equipment, whichever site they are working at. And with shared expertise across both sites, clinical staff will have better knowledge, skills and experience to manage patients both pre and post-surgery leading to more efficient care and fewer hospital attendances (e.g. in Sandra's case returning to have her catheter removed).

5.89 As part of integrating services, we will review and redesign pathways from the patient perspective and ensure care is focused on what matters to them. We will work with partners in primary and social care and the voluntary sector to streamline and standardise care pathways to remove duplication and inefficiencies, and break down the barriers that exist between health and care services.

5.90 We know from work done on the leg ulcer pathway that there is scope to significantly reduce the number of steps that patients go through on some pathways, and thereby improve patient care and experience. We will also remove procedures which are of limited diagnostic value.

5.91 Bringing together the acute parts of pathways with community and mental health pathways also helps complex patients to be identified and treated at an

earlier stage, and for an integrated workforce to offer more targeted support to patients.

5.92 We want to make sure patients are seen by the right clinician and only have a face-to-face appointment when one is clinically required. We will deliver care in the least intensive, most appropriate setting (e.g. at home, or in a community setting).

5.93 We will take a 'digital first' approach to patient contacts, with care occurring virtually where possible - either via telephone or virtual consultation, and pathways will include patient activation mechanisms such as Patient Initiated Follow Up (PIFU) and advance booking. This will be more convenient for patients, reduce cost, and free up clinical time to help reduce waiting lists and manage rising demand.

5.94 Where we have capacity, there will be specialist review early in the pathway to aid early intervention and prevent escalation of need. Currently this occurs in the MSK pathway (see paragraph 5.55).

5.95 We want our new county-wide pathways to be easy for patients, carers and colleagues to understand and navigate. We will also streamline referrals between specialists to cut the incidence of complications and patient complaints that arise from delays in referrals between services.

5.96 We know that improved communication between clinicians within a pathway supports swifter and more effective patient care, and merger will facilitate communication between our colleagues and other clinicians and care professionals in Somerset.

5.97 Patients' core information will be shared between IT systems eliminating the need to re-state basic facts. We will put in place consistent administrative processes (including standardised patient communications which clearly explain what is happening) and which support good patient and carer experience.

Elective recovery

5.98 Activities under our elective recovery programme sit under this aim and they include:

- **managing demand**: includes demand & capacity modelling, roll out of self-help app, review of MSK pathway
- **increasing diagnostic capacity**: includes community diagnostic centres programme and increasing echocardiogram capacity
- **optimising people for surgery**: includes peri-operative care, roll out of My Planned Care app
- **outpatient transformation**: includes Advice First, 'front door' design

- **theatres**: includes increasing capacity, and theatre engagement project to improve productivity
- **improving access to cancer care**: includes earlier diagnosis, faster diagnosis, and personalised care.

Additional projects aimed at improving health outcomes

5.99 We have a range of further projects aimed at improving health outcomes in specific ways. These include:

- Medicines optimisation
- Same Day Emergency Care
- Last 1,000 days
- Support to carers

Medicines optimisation

5.100 Medicines optimisation is a person-centred approach which uses shared decision-making to ensure people get the best possible outcomes from safe and effective use of medicines. It aims to help patients take their medicines effectively, avoid the adverse effects of medicines, and avoid problematic polypharmacy – when the use of multiple medicines has negative outcomes, or poor treatment effectiveness.

5.101 SFT has already begun a de-prescribing project in mental health, and we plan to extend this to the community hospitals and both acutes. We want to support people to use medication effectively, and facilitate 'responsible prescribing' to address polypharmacy and overprescribing to minimise medicines-related harm. We will also embed self-management of medication (with clinical supervision where required) in acute, mental health and community health services.

5.102 Implementation of effective population-wide medicines optimisation requires effective working and communication across the healthcare system. Merger will remove many organisational boundaries and thus facilitate efficient medicines optimisation. For example, effective transfer of care including around medicines will be facilitated by the use of a unified electronic health record and single electronic prescribing and medicines administration (EPMA) system across the merged organisation.

Same Day Emergency Care

5.103 Our provision of same day emergency care (SDEC) has been increasing over time, but further development of this service at the two acute sites will support patient independence and reduce avoidable illness and harm from bed-based care. This will sit alongside day surgery and would mean that, where clinically appropriate, we will treat patients on the same day and support them to return home that day.

5.104 Intermediate care services are key to the effective provision of SDEC by getting people home at the end of the day with the necessary support in place to help them recover. We will put in place consistent SDEC pre-discharge pathways to help intermediate care do their job, and merger makes it easier to put these consistent pathways in place.

Last 1,000 days

5.105 Merging SFT and YDHFT will allow us to enhance the reach and ease of implementation of our *Last 1,000 days* flagship programme and give it single leadership. The aim of the programme is to maximise the time people have at the end of life to do what matters to them most. We will enhance our advanced care planning and treatment escalation documentation, and extend this approach to patients who are being considered for treatment in our intensive care units. Having the right conversations with patients and their families/carers will ensure they receive the treatment and care that is right for them.

Support to carers

5.106 Involving and supporting carers is an important part of getting care right. We want to listen to carers throughout the period of care their relative or friend receives, and involve carers when we develop services. Patients who are supported by someone familiar to them and who understands their needs can enhance treatment, hasten recovery and help people to stay at home. However, the strain of caring can have a negative impact on the mental and physical health of the carer.

5.107 The 2011 census found that 10% of adults have an unpaid caring role, and many of them are themselves older people living with multiple long term conditions.[49] Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, stress and social isolation.[50] Up to 40% of young carers report mental health problems arising from their experience of caring.[51] We want carers to feel supported and listened to right across the merged Trust as a vital part of the care team.

5.108 Our joint work to support carers is steadily progressing. YDHFT has a vibrant health and wellbeing hub which provides information to patients and carers and signposts them to other sources of support. At SFT, the Involvement Coordinator (Carers) is developing the offer for carers who care for people admitted to MPH. The Coordinator also ensures that carers contacting the patient experience team have someone to talk to who can offer support and guidance. In addition, SFT's carers assessment service specialises in

[49] NHS Long Term Plan, page 17
[50] NHS Long Term Plan, page 42
[51] NHS Long Term Plan, page 43.

supporting the carers of people with mental health conditions. Both Trusts already work closely with 'Somerset Carers' a VCSE-commissioned service providing free support and information for carers who care in an unpaid capacity.

5.109 As part of our plans for carers, we are refreshing our ambitions for the Triangle of Care initiative[52] which involves carers in the planning of care and treatment for individual patients. It is our intention to roll out what is working well at each Trust to the other e.g. the hub, and the coordinator role. We are also using the NHSE new statutory guidance 'Working in partnership with people and communities' to ensure we are listening to communities and co-producing changes to meet local need as best we can, and carers are essential voices in these developments.

Aim 2: Benefits

5.110 This aim focuses on timely access to the best care. The anticipated benefits from this aim include:

- improved health outcomes from quicker access to assessment, diagnosis and treatment, including specialist care
- improved patient, carer and colleague experience and increased patient safety from simpler, more efficient pathways that are easier to navigate and work within
- improved end of life care which supports individuals to make the most of their time
- better support for carers and their families to help them continue to play their critical role in promoting health and well-being
- better health outcomes as colleagues get exposure to a wider range of clinical cases, share knowledge and best practice across the enlarged team and unwarranted variation is reduced
- more effective use of our combined diagnostic and treatment capacity which reduces patient waits
- equity of care across the county from a consistent approach
- improved ability to meet rising demand within our existing resources
- easier partnership working when we have a single set of referral pathway and processes, rather than two.

Aim 2: measurements

5.111 Measurement of this aim is split into three elements. Our key measurements for this aim are:

<u>Receive timely treatment</u>

- Patient initiated follow-up rates

[52] The Triangle of Care is a collaboration, or 'therapeutic alliance' between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.

- Ambulance handover times

Care at the right time and place

- Elective operations cancellation rates
- Palliative care same day discharge development

Avoiding harm

- Inpatient infection rates
- Inpatient falls rate
- Inpatient skin pressure damage occurrence

Aim 3: Strengthen care and support in local communities

Develop and enhance support in local neighbourhood areas and bring care and support closer to home

5.112 Somerset has struggled in recent years with insufficient domiciliary care to support patients at home (and their families/carers) when they become ill or their needs increase. This means some people reside in hospital or a nursing home because they are unable to look after themselves in the normal way at home. They are admitted (or cannot be discharged) from hospital not because they require bed-based care but because there are no other options available locally to help them manage at home.

5.113 Unnecessary bed-based care exposes patients to the risk of hospital-related harm, is inconvenient for patients and carers who have to travel a long distance to hospital, and incurs cost for the system that could be spent elsewhere.

5.114 20% of pensioners who attend an NHS outpatient appointment say they feel worse afterwards because of the stress involved in the journey alone.[53] According to the Sustainable Development Unit,[54] NHS-related traffic accounts for 5% of all road traffic in England, and this traffic is responsible for 13% of the NHS's carbon footprint.[55] [56] Our care delivery needs to factor in the hidden costs of healthcare including environmental impact and patient anxiety, as well as the costs incurred by patients for missed work, additional childcare, travel costs etc.

[53] Outpatients: The Future, Adding value through sustainability, Royal College of Physicians, 2018

[54] The Sustainable Development Unit is funded by NHS England and Public Health England.

[55] www.sduhealth.org.uk/areas-of-focus/carbon-hotspots/travel.aspx

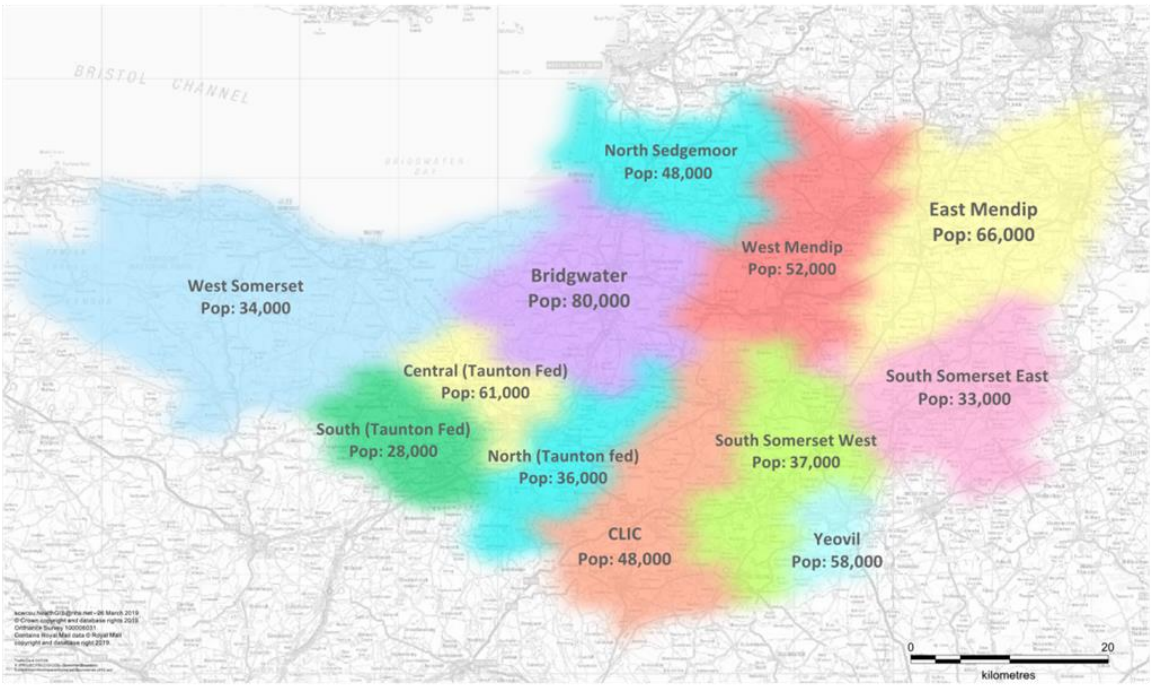
[56] NHS road traffic is associated with 85 deaths and 722 major injuries a year. Source: Outpatients: The Future, Adding value through sustainability, Royal College of Physicians, 2018.

5.115 The NHS in the south west is estimated to be short of around 2,500 beds. In the face of this lack of capacity, and without the space or capital to add beds, we need to find alternative ways to provide the care local people need.

5.116 Working in collaboration with our partners in primary and social care and the voluntary sector, the purpose of this aim is to provide more care in local communities, closer to people's homes, where it is clinically appropriate and cost effective to do so, and bearing in mind patient and environmental considerations. This will help avoid needless time spent away from home, and help preserve hospital care for patients who really need it.

5.117 As a rural county, Somerset has strong local identities, and together with our system partners we want to support the resilience and social cohesion of our local communities. The FFMF strategy included the creation of 12 neighbourhoods across Somerset, each consisting of around 30,000-50,000 people, see **Figure 19**.

Figure 19: Somerset's 12 neighbourhoods



5.118 Somerset's 12 neighbourhoods are coterminous with the 13 primary care networks (PCNs), with the exception of the East Mendip neighbourhood which covers two PCNs: East Mendip and Frome.

5.119 Within these neighbourhoods, the ICS is bringing partners together to provide care closer to patients' homes with the aim of maintaining wellness and intervening early and preventing escalation of mental and physical health need. As an ICS we believe that working through neighbourhoods will improve patient experience and support financial sustainability of public services.

5.120 Each neighbourhood brings together colleagues from across the county's health and social care partners: YDHFT, SFT, Somerset County Council, primary care and the voluntary sector. This includes District Nurses, Social Workers, Older People's Mental Health specialists, Occupational Therapists, Community Midwives, Community Paediatricians, Health Coaches, Health Visitors, Care Coordinators, MSK First Contact Practitioners and many more.

5.121 Our system intention is that neighbourhoods offer easy access to advice on staying well, a range of preventative services – including those that support social connectedness – and simple, joined-up care and treatment close to people's homes. Services will be tailored to the needs of the local community, and accessible through both digital and non-digital routes to prevent exclusion of people without online access. We intend to use a model of self-referral wherever possible.

5.122 As a system, we want to provide care at the lowest level appropriate, starting with self-management and only escalating through increasing levels of support if the person's health needs require it. The services offered at neighbourhood level focus mostly on levels 1 and 2 but will also play a role in care at levels 3 and 4 (see Figure 13).

5.123 The merged Trust's contribution to this aim includes:

- Hospital@home (virtual wards)
- Intermediate care (see paragraph 3.13), and
- supporting the development of individual PCN/neighbourhoods.

Hospital at home (virtual wards)

> "If there was ever a thing that merger was for, it's to enable Hospital@Home."
>
> Andy Heron, Chief Operating Officer (Mental Health and Community Services)

5.124 Hospital@home is our local name for virtual wards. The programme involves caring for people in their own homes who would otherwise be in hospital. This is done through remote digital monitoring and home treatment which is available 24/7 from district nurses and other community staff, including community geriatricians. Under the programme, some treatment which would have been given in hospital can now be given at home. For example, intravenous therapies initiated in the acute setting can be continued at home with appropriate clinical support.

5.125 Under Hospital@home, patients are under the care of a hospital consultant but may not set foot in a hospital. We are integrating this work with our successful Intermediate Care service (see paragraph 3.13) which has similar

aims of reducing admissions to and facilitating earlier discharge from acute hospitals.

5.126 We are initially taking forward Hospital@home as a test and learn project with 275 beds across Somerset in people's own homes, split as follows:

- 140 frailty beds
- 100 acute respiratory illness beds
- 30 peri-operative beds
- 5 heart failure beds

5.127 Merger makes an enormous difference to our ability to plan and implement Hospital@home because while the programme is run by community services, it cannot operate without the input of acute clinicians. We know that other community trusts have struggled to get sign up from acute colleagues in different trusts, and have had to navigate practical challenges around job plans, separate budgets and differing organisational priorities. By contrast, we have been able to get on with implementing the model because SFT is already an integrated acute, community and mental health Trust with services under single leadership. Furthermore, the signal of the planned merger has also enabled us to press ahead with implementing this model across the south and east of the county, served by YDHFT.

5.128 Merger facilitates the operation of hospital@home in the following ways:

- Patients are under a single care plan, delivered by community and acute clinicians working under the same single leadership; this also aids continuity of care as patients move between settings
- Single clinical governance arrangements help us manage risk at the interface between community and acute services and supports continuity of medical responsibility.
- We do not need to admit patients across an organisational boundary and incur the associated administrative burden
- It is easier to engage with partners in social care, primary care and the voluntary sector in the delivery of hospital@home when we are one Trust rather than two.

5.129 The benefits for patients of hospital@home are illustrated in **Figure 20**.

Figure 20: Patient story - Sam

Sam
Sam is 72 and lives with his wife in Burnham-on-Sea. He has heart failure which is worsening, and which causes him breathlessness, fatigue and swollen legs. Sam has been admitted to hospital several times in the last couple of years, for 3-4 weeks at a time, to receive intravenous diuretics. Sam's wife is unable to drive, so struggles to visit Sam while he's in hospital, and they miss each other a lot while he is in hospital. Sam's concerns for his wife make him keen to be discharged at the earliest opportunity. Following discharge, Sam remains under the care of the heart failure team

who oversee his treatment at home with oral diuretics, provide ongoing monitoring and advice and amend his medication as needed.

Future
With the creation of Hospital@Home, Sam can be discharged from hospital after 10 days, with a personalised management plan. An Advanced Clinical Practitioner or District Nurse will provide Sam with intravenous or sub-cutaneous diuretics safely in the comfort of his own home. Heart failure nurses will continue to carefully monitor Sam and give him advice and support which reduces the risk of him being re-admitted to hospital. They are also able to alter his medication as needed. Sam is pleased to be away from home for less time and receive care in familiar surroundings in the company of his wife.

Supporting PCN development

5.130 The development of neighbourhoods in Somerset is a shared endeavour alongside our partners in primary care, the county council, and the voluntary sector.

5.131 Our Trusts contribute to the development of neighbourhoods in two ways. Firstly we are working with partners to give strategic leadership via the Neighbourhood Board which is co-chaired by Somerset County Council's Director of Adult Social Care, and our Chief Operating Officer for Mental Health and Community Services.

5.132 The Neighbourhood Board is leading the development of a vision for neighbourhoods. Although the vision has not yet been finalised, our collective aim is to create integrated community teams (consisting of colleagues from primary care, social care, the third sector and the Trusts), which work across organisational boundaries. These teams will adopt a personalised approach to care for people at home or in their community, and make sure people know where to go when they need help. Different neighbourhoods face different challenges and the work of community teams will be informed by neighbourhood-level population health data so they can respond to local needs.

5.133 Secondly, we are playing our part in the development of individual neighbourhoods. Somerset's PCNs/neighbourhoods are at different stages of development, and as the largest single provider of health services in the county, we have a key role in supporting collaboration at a local level and contributing our expertise and resources to make neighbourhoods a success.

5.134 The existence of Symphony significantly helps in this regard (see paragraphs 5.54-5.56). We also have a role in bringing our acute clinical skills into neighbourhoods so that more patients can receive care in their community rather than having to travel to an acute hospital for care. For example, the Trusts' Diabetes consultants join virtual MDTs with GPs, practice nurses, health coaches and Diabetes specialist nurses to review complex patients. These MDTs reduce referrals to secondary care and, through peer education, increase colleagues' understanding of how to manage complex patients in the community.

5.135 Merger will strengthen our contribution to neighbourhoods by enabling us to offer support which spans patient pathways from community to acute services. Bringing our acute care teams together and pooling our resources removes duplication and frees colleagues up to give better support to neighbourhood teams. It also ensures the offer from secondary care is consistent across the county.

5.136 **Figure 21** describes our contribution to the development of three neighbourhoods. All three are areas of high deprivation.

Figure 21: Examples of the two Trusts' contribution to the development of neighbourhoods

North Sedgmoor
North Sedgmoor contains some of the areas of greatest deprivation in Somerset. The ICS is bringing together all health and care services including the Symphony-owned primary care to provide better community care, using a 'team of teams' approach where there are no organisational boundaries/barriers. Initial work includes:

- Anticipatory care: colleagues from the SFT neighbourhood team, PCN, hospice, etc. meet daily to discuss patients that require the input of the multi-disciplinary team to prevent a health crisis. The MDT uses intelligence from organisations across the ICS, and population health management data to anticipate people who are likely to deteriorate and helps them to maintain their independence and stay well in their own home or local community for as long as possible.
- SFT have established a dressings clinic to relieve pressure on local primary care and the Minor Injuries Unit for wound care. Our longer-term vision is to provide a dressings clinic and wound club (a group where people have their wounds dressed) to secure the benefits of peer support. SFT colleagues will work alongside PCN colleagues, Health Coaches and Village Agents from the wider neighbourhood team to ensure a personalised, enabling and holistic approach to wound care.
- A community investigation hub at Burnham-on-Sea community hospital (see paragraph 5.138 below).

This neighbourhood development work is being led by the clinical director of the PCN, with support from SFT, and is overseen by the Neighbourhood Board.

South Somerset West
In South Somerset West we are looking to integrate YDHFT's Same Day Care with the PCN. The GP practices in South Somerset West are all owned by Symphony, and as a merged Trust we want to use South Somerset West as a demonstration site where we push the boundaries of partnership working and demonstrate the merits of a model that could be applied to other PCNs in the county.

Bridgwater
In Bridgwater, the focus is on families and children's services. The ICS will shortly re-open the former Victoria Park Medical Centre as a hub from which services for young people, families and older people will be delivered.

Care coordinators will be the first point of contact for the public to understand individuals' needs and direct them accordingly to colleagues from primary or secondary care, public health and the voluntary sector. People can either receive care on site or be signposted to partners for support. There will be an emphasis on preventative care and self-management for long term conditions and we aim to create an environment in which individuals are empowered to seek support and take responsibility for their own wellbeing.

Community investigation hubs

5.137 We are also supporting the development of community investigation hubs in PCNs. Community investigation hubs provide investigative care closer to home and reduce footfall in acute hospitals and primary care. The hubs are run by primary care and carry out routine investigations (usually requested by secondary care) including phlebotomy, electrocardiograms and spirometry. They make better use of system resources, provide care closer to home, and offer more rapid results. The role of the two Trusts to date has been to support development of these hubs, including helping to recruit staff, providing estate and participating in future planning.

5.138 So far, 3 PCNs in Somerset have a Community Investigation Hub, with more planned. In North Sedgemoor for example, the Investigation hub operates alongside the outpatient services at SFT's community hospital in Burnham-on-Sea. SFT hosts the staff working in the hub and has also seconded a member of staff to the PCN to support the hub's operation.

5.139 Once merged, our combined capability in acute and community services across the whole county means we will be ideally placed to support the operation of the hubs. Merger also means our offer will be consistent across the county and streamlined because we will be one organisation rather than two.

Benefit of Symphony in neighbourhood development

5.140 Providing seamless integrated care, and thereby driving better patient care and experience is at the heart of our merger. Symphony's presence in the merged Trust enables us to support the delivery of 'place' level care by strengthening further the existing links between general practice and community, mental health and acute services. Merger will enable us to explore new ways to improve care by joining up pathways and working more closely with primary care.

5.141 The presence of Symphony also enables us to make a stronger contribution to the development of neighbourhoods, for example through the provision of staff such as First Contact Practitioners and Mental Health nurses to work in primary care settings. The prospect of merger also enables us to run tests of change with PCNs (e.g. Peri-operative care for people with Diabetes, see Patient Benefits Case).

Aim 3: Benefits

5.142 This aims focuses on avoiding needless time away from home. The anticipated benefits from this aim include:

- better patient health outcomes from earlier intervention

- patients are supported to stay well in their own home to preserve their independence
- improved patient and carer experience - lower anxiety and greater convenience from not having to travel so far to receive care and having their time valued
- improved Trust ability to meet rising demand within existing resources by curbing inappropriate admissions
- empowered and confident partners in primary care and voluntary sector, working with us to achieve our shared vision for the county

Aim 3: measurements

5.143 Measurement of this aim is split into two elements. Our key measurements for this aim are:

Stay at home if best – there's no ward like home

- Rapid response outcomes
- Hospital@home outcomes
- Urgent community response rates

Stay well at home

- Re-admission rates
- Family hub development
- Primary care networks with integrated partnerships models established

Aim 4: Reduce inequalities

Value all people alike, target our resources and attention to where it is most needed, giving equal priority to physical and mental health

5.144 This aim seeks to address health inequalities. We will initially focus on four forms of health inequality:

- Parity of esteem between physical health need and mental health
- Vulnerable groups, including homeless people and rough sleepers, Gypsies and travellers, and people with substance misuse problems
- Health inequalities deriving from social deprivation or rurality

5.145 Our initial focus is on addressing those health inequalities for which we already have data e.g. the shorter life expectancy for those with a mental health disorder. However, we recognise that significant data gaps exist, and we are committed to working with our partners in public health to better understand local health inequalities. Population health analytics has a

powerful role to play in helping us identify where and what health inequalities exist in Somerset. Our capacity to do this work will be improved by merger through the Collaboration hub (see paragraph 5.62) and because we will be able to implement solutions as one health provider rather than two. See **Figure 22**.

Figure 22: Children and Young People's Neurodiverse Pathway

Following a joint OFSTED/CQC review in March 2020, Somerset was identified as poorly performing in its provision for children with Special Educational Needs or Disabilities (SEND). The report highlighted the complexity of the assessment process, often resulting in children's needs not being accurately understood. Nine priorities were identified that required significant improvement. Priority 5 was to 'develop a more effective neurodevelopmental pathway' as the provision was inequitable, unclear and not fit for purpose.

In February 2021, the two Trusts co-funded work on a paediatric autism pathway. The objective was to design and implement a multi-agency single pathway for the referral, triage and assessment of children in Somerset with autism. The pathway will be based on strength-based assessment in line with current understanding of autism and the barriers the condition can present to individuals.

Following the successful pilot, a multi-agency team was established to ensure the receipt of referrals, triage of each case and ongoing assessment is equitable county-wide.

A merged organisation will make it easier to set the long-term vision and pathway for the neurodiverse patient cohort within Somerset. A single management team and single budget will remove the organisational and funding barriers that have previously existed, enabling a more effective use of the resources. Currently there are differences in the way data is collected and measured across YDHFT and SFT, which makes prioritising service improvement opportunities challenging; a merged organisation will allow this to be standardised for easier review. One waiting list and agreed acceptance criteria will ensure that all young people of Somerset have the same access to services, irrespective of their location and condition.

5.146 Co-production with the people that use our services is fundamental to tackling health inequalities; we will listen to the people who use our services and work with them to address the concerns they raise. We will also work closely with partner organisations, both statutory and voluntary, to design and deliver integrated services. We have demonstrated co-production in our approach to the design of services for people with mental health problems, see **Figure 23**.

Figure 23: Co-design with mental health service users

In Somerset, our Experts by Experience are known as Recovery Partners. Recovery Partners have helped co-design the following mental health services:

- The Stolen Years flagship programme, which was established as part of the SPFT/TSFT merger, aims to increase the life expectancy of people with mental health problems by improving their physical health. Through first-hand accounts we have learnt about times when there is a mismatch of expectations and barriers to effective consultations for patients presenting with both physical and mental health needs. Recovery Partners and clinicians identified five themes which have an impact on attendance and care delivery, and the group are now planning a workshop with physical health colleagues from both acute Trusts, primary and community care settings to discuss this learning. In this way the experience of mental health service users will be spread across the merged Trust and incorporated in the design and delivery of services.
- Co-production methodology is particularly well embedded in our Psychiatric Liaison Teams (PLT) where colleagues and Recovery Partners have completed Quality Improvement training together, and have taken forward a number of improvement projects. PLT have also recently recruited a Recovery volunteer to the team. The projects currently underway within PLT range from a large scale national self-harm project involving the development of a web page providing information, resources, and stories of hope, to smaller but powerful projects around how letters are written, and resource packs for people with mental health problems attending ED. In addition, PLT and Recovery Partners have a monthly forum where Improvement projects are monitored, and patient and carer feedback is reviewed so improvements can be made.
- Recovery Partner involvement in the development of the 'Open Mental Health' programme (see paragraph 3.13) led to the agreement of a standard operating procedure which combines 'traditional' pathways with innovative approaches. By being challenged on the language used and focusing on what people wanted rather than the conventional medical approach, we were able to create a new, award-winning service model which better meets service users needs.

5.147 Further data on health inequalities in Somerset is contained in **Annex 2**.

Parity of esteem

5.148 The life expectancy of women in Somerset with a mental health disorder is 17.5 years lower than for women without serious mental illness; for men in Somerset the difference is 19.7 years. This discrepancy is replicated around the country and is attributed mainly to cardiovascular disease and cancer, rather than the underlying mental health condition.

5.149 The number of children in England with profound and multiple learning difficulties has increased by 40% since 2004.

5.150 As a combined acute, community, mental health and learning disabilities Trust, SFT has been able to improve the physical healthcare given to people with mental health problems, and also improve the mental health support given to people with physical illness by bringing together clinicians from physical and mental healthcare services**.** Further detail is also in available the

Two-year review of TSFT/SPFT merger which is provided as a supporting submission to this Case.

5.151 By merging YDHFT and SFT we will be able to extend this model right across the county and ensure it is reflected in all the care settings run by the merged Trust, thereby moving towards our aim of putting mental health on a par with physical health, see **Figure 24.**

Figure 24: Patient Story - Maurice

Maurice
Maurice is 61 and has heart problems. In 2022, he had a respiratory arrest which led to him being admitted to Yeovil's ICU. Maurice found the experience of the arrest and his time on ICU very difficult, and after discharge from hospital he found himself unable to move on from recollections of his illness and time on ICU. In addition, Maurice's cardiac issues was causing him to feel further generalised anxiety. As a result, Maurice became withdrawn and stopped walking his dog, or even meeting up with his family. The signal of merger has encouraged colleagues from mental health and physical health services to seek out and explore opportunities to work across departments. After being diagnosed with Post Traumatic Stress Disorder relating to his experiences, Maurice was referred to the Somerset Talking Therapies Service (STTS) run by SFT. After listening to Maurice's problems, the STTS practitioner made arrangements with Yeovil's ICU team to accompany Maurice on a visit to ICU. Once there, the ICU team explained to Maurice what had happened during this stay, allowed him time to go round the ward, and ask questions about equipment and his treatment. This helped Maurice update his memory of events with factual information and to overcome his previous negative thoughts about the experience. Maurice has since returned to walking his dog and seeing family again. Following merger, colleagues will be able to access patient clinical records and contact other teams more easily which will make it more straightforward to provide holistic care which serves patients' mental and physical health needs.

5.152 By merging YDHFT and SFT we will be able to extend this model right across the county and ensure it is reflected in all the care settings run by the merged Trust, thereby moving towards our aim of putting mental health on a par with physical health, see **Figure 25**.

5.153 Prior to the pandemic, we began implementing our county-wide 'Stolen Years' flagship programme which aims to increase the life expectancy of people with mental health problems by improving their physical health. This programme will span all the levels of care (see Figure 13), from mental health care in neighbourhoods, through to support for people with a mental disorder when they are in physical healthcare environments. The latter will include helping people cope with their inpatient stay and ensure they get care for their mental illness while they are in hospital.

Figure 25: Colleague story - Dr Katalin Fernando

Colleague story: Dr Katalin Fernando, Associate Medical Director for Unplanned care, YDHFT
"In September 2022, I took on an additional portfolio role looking at the interface between acute medical and mental health services to better address the unmet physical healthcare needs of patients with mental health problems. This role covers both YDHFT and SFT. Our vision is to fully integrate physical and mental health care. These two aspects of health are closely interdependent and there is clear evidence that neglecting one can damage the other. Our planned actions include: 1. Improving how each service can access the right mental and physical health management for their patients in a timely way. 2. Integrating mental health colleagues with the acute teams in both Trusts 3. Promoting physical health among people with mental illness, linking with community resources 4. Using education to promote integrated patient care (focusing on physical health related scenarios in mental health facilities) 5. Working with Dr Sathya Cherukuri, Consultant Psychiatric lead for 'Stolen Years Flagship' which focuses on improving the physical health of people with mental health problems 6. Linking with the test and learn project currently underway which aims to fully integrate SFT's acute paediatric team and child and adolescent mental health care team. I look forward to making a positive difference to the care for people in Somerset."

Vulnerable groups

5.154 In England, people affected by homelessness die on average around 30 years younger than the general population.[57] Patients in Somerset with chaotic lifestyles, those with dual diagnosis (mental health problems and substance misuse) or people who are homeless, currently have problems accessing good mental and physical health care.

5.155 The care in Somerset for these groups has historically been fragmented as a result of historical commissioning decisions. People have to navigate a variety of discrete services including addiction services, mental health, primary care and acute services, as well as voluntary sector support and other public sector provision such as housing. As a result, the care and support offered to people in these patient groups is often disconnected and can lead to poorer health outcomes.

5.156 In the Strategic Case for merger we described plans to develop an outreach service for homeless people providing targeted, accessible mental and physical healthcare services. This service has now been established and is developing consistent pathways into both acutes to provide proactive care for people experiencing homelessness. Further detail is provided in the **Patient**

[57] Thomas B. *Homelessness kills: an analysis of the mortality of homeless people in early twenty-first century England.* Crisis, 2012. https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf [Accessed 29 July 2022]

Benefits Case. A key next step for this programme is to work with partners to develop plans to support other vulnerable patient groups including prison leavers and travellers.

Social deprivation and rurality

5.157 Although Somerset has lower overall deprivation than the England average, pockets of deprivation exist which create and exacerbate ill health, and deprivation is worsening. The number of neighbourhoods classed as 'highly deprived' rose from 25 to 29 in the period 2015-19, and around 47,000 people now live in such neighbourhoods.[58] The pandemic and the current cost of living crisis are expected to exacerbate poverty and its associated impacts on health.

5.158 The male healthy life expectancy at birth for those living in the most deprived parts of Somerset is 8.9 years lower than for those living in the most affluent areas. The difference for females is 8.0 years.[59]

5.159 Many long-term conditions are more than twice as common in adults from lower socio-economic groups, and mental health problems are also more prevalent.[60] Around 1 in 10 households in Somerset is in fuel poverty, often living in damp, cold conditions which cause and exacerbate health problems.[61]

5.160 Somerset is geographically large and one of the most rural counties in England, with a population density of 1.5 people per hectare (compared to a national average of 4.1).[62] 48% of people in Somerset live in a rural area.[63]

5.161 People with the worst health and the lowest incomes struggle the most to travel to health services.[64] One in five Somerset residents aged 65 or over has no access to car or van; the proportion is higher amongst women,[65] and public transport links in the county are poor. This creates challenges for access to our services. Furthermore, rurality contributes to social isolation and is linked to digital poverty.

5.162 Somerset has coastal communities along c.40 miles of its north coast including at Minehead, Watchet and Burnham-on-sea. Coastal communities attract older, retired citizens who tend to have more health problems. In addition, attracting NHS and social care staff to peripheral areas is harder, and public transport is limited. In 2021, the Chief Medical Officer noted that

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58 http://www.somersetintelligence.org.uk/files/English%20Indices%20of%20Deprivation%202019%20-%20Somerset%20summary.pdf

59 https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000049/pat/6/par/E12000009/ati/102/are/E10000027/cid/4/tbm/1

60 https://www.bma.org.uk/media/2084/health-at-a-price-2017.pdf

61 https://www.gov.uk/government/statistics/sub-regional-fuel-poverty-data-2020

62 https://www.yumpu.com/en/document/read/63829671/hidden-somerset-rural-isolation

63 http://www.somersetintelligence.org.uk/profile-of-rural-somerset-from-the-2011-census.html

64 English Longitudinal Study of Ageing 2012/13

65 2011 Census

coastal communities have some of the worst health outcomes in England, with low life expectancy and high rates of major diseases, with deprivation and ill health at the coast hidden by relative affluence inland because geographic data is often insufficiently granular. [66]

5.163 As noted above (paragraph 5.132), the provision of care in neighbourhoods will be tailored to the needs of the local population, which will help tackle health inequalities. Development of our neighbourhood provision will also bring more care closer to where people live which will help address the access challenges presented by geography. The increased use of virtual consultations will also improve access by removing the need to travel for some elements of care.

5.164 We are also developing new ways of taking care into rural communities rather than expecting people to come to us, see **Figure 26**.

Figure 26: Farmers' markets health hubs

Farming is physically demanding and can be a stressful occupation. Farmers often live and work in isolated communities, and many often place the health and welfare of their livestock above their own wellbeing and put off seeking medical help.

We now have three rural health hubs operating in Somerset, offering physical and mental health checks to farmers, agricultural workers and their families at easy-to-access locations. The hubs take place twice a month at locations farmers visit in the course of their work: Sedgemoor Auction Centre in Bridgwater, Frome Livestock Market and Exmoor Farmers Livestock Auction.

The hubs are operated by a team of NHS nurses with support from farming and community-based charities and local businesses. Nursing staff for the hubs were recruited specifically for their farming backgrounds, and work alongside volunteers from the Farming Community Network and local Health Connectors who encourage farmers to visit the health clinics.

Attendees don't need an appointment, and nurses are on hand to carry out basic health checks, such as blood pressure monitoring and blood sugar testing; they also offer emotional wellbeing checks. The team can either offer advice on the spot, recommend a visit to the GP or signpost people to other sources of care such as Somerset Talking Therapies Service. By picking up health problems early and signposting to sources of early intervention they help reduce demand on secondary care at both acute sites.

Feedback from the first hub at Bridgwater shows that having nurses and volunteers who understand farming communities helps farmers connect and engage with health services where they may not otherwise have done so. The hubs also contribute to reducing the stigma around mental health in the farming community.

Aim 4: Benefits

5.165 The overarching benefit from this aim is improved life expectancy for those experiencing health inequalities - living equally as long as others. This will derive from:

- improved physical health outcomes and experience of care for people with mental health illness, learning disability and autism;

[66] *Chief Medical Officer's Annual Report 2021 - Health in Coastal Communities – Summary and recommendations (publishing.service.gov.uk)

- better care for vulnerable groups including people with dual diagnosis and people experiencing homelessness; and
- a reduction in health inequalities based on socio-economic status or rurality
- improved access to holistic care which meets both physical and mental health needs.

Aim 4: Measurements

5.166 Our key measurements for this aim are:

- Physical health checks undertaken within specialist mental health outpatient clinics
- Open Mental Health accessed
- Talking Therapies outcomes
- Maternity care for women from Black and minority ethnic communities
- Planned surgery wait times for people with learning disabilities

Aim 5: Respond well to complex needs

Improve outcomes for children and adults with complex needs through personalised, coordinated support

5.167 This aim seeks to improve the care of people with multiple health conditions or long term conditions, through improved coordination and personalised care. Although it covers the whole population, the focus of this aim is on those with complex needs, or people living with multiple long-term conditions who spend the most time in healthcare.

5.168 The needs of the people we care for are changing. People are living for longer with more complex health and care needs. By 2035, two-thirds of adults in England are expected to be living with multiple health conditions, and 17% will have four or more conditions.[67] In Somerset, 4% of patients account for 50% of all health expenditure.[68]

5.169 Patients with complex needs often require personalised, coordinated care. However, healthcare pathways tend to develop around one disorder, and many colleagues are trained in distinct specialties which focus on a particular discipline or organ system, for example endocrinology or vascular surgery. It is hard for patients to navigate different pathways and interact with different specialties at the same time. It is especially hard for people who have a

[67] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

[68] http://www.somersetintelligence.org.uk/files/JSNA%202017%20Ageing%20Well%20Summary.pdf

mental health condition such as dementia alongside a physical condition, because their mental health condition makes it harder to access care.

5.170 Siloed pathways means the care that people with multiple health problems receive can be fragmented, with each health problem being treated in isolation, and cumulative or overlapping issues not being addressed. There is sometimes limited specialist overview of the combined medication given to the patient (because clinicians do not always have access to the full patient record), and clinicians are at risk of making incorrect assumptions about what other specialties are doing for a person. At worst, a lack of coordination can lead to the treatment for one disorder exacerbating other disorders.

5.171 People with complex care needs suffer the greatest treatment burden and have a large amount of their time taken up in health and care-related activities. A 2018 study found that to comply with all disease-specific guidelines, patients with three chronic conditions[69] take between 6-13 different drugs a day, visit a health professional between c.2-6 times a month, and spend around 50-71 hours a month in health-related activities.[70]

5.172 To give better care to people with complex needs we need to improve the coordination of healthcare interventions and reduce the treatment burden as much as possible.

5.173 We will deliver this aim by working with our partners to implement two national programmes: personalised care, and anticipatory care. Alongside these programmes we will also deliver local programmes which contribute to improved care for people with complex needs (see paragraph 5.185).

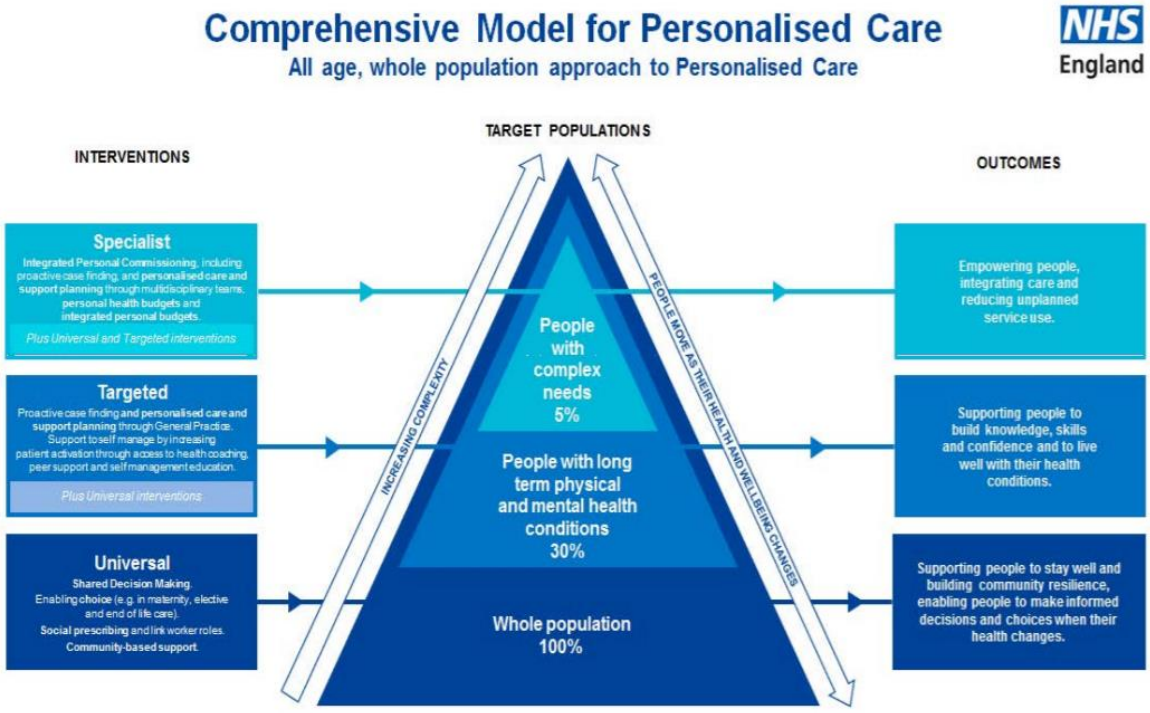
Personalised care

5.174 Personalised care is a requirement of the NHS Long Term Plan. It gives people more choice and control about how their health and care needs are met. They are more involved in decisions that affect them and supported to talk about the things or outcomes that matter most to them and the best course of action to achieve those outcomes. Evidence shows that people who are confident in their ability to manage their health conditions have fewer GP contacts and fewer emergency admissions. The NHSE comprehensive model for personalised care is set out at **Figure 27**.

[69] Any combination of chronic obstructive pulmonary disease, coronary heart disease, diabetes, osteoarthritis, hypertension, and depression.

[70] Claudia C Dobler, Nathan Harb, Catherine A Maguire, Carol L Armour, Courtney Coleman, M Hassan Murad, Treatment burden should be included in clinical practice guidelines BMJ 2018;363:k406

Figure 27: NHSE Comprehensive model for personalised care



5.175 There are six standard components to personalised care:

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets

5.176 The introduction of personalised care has been found to have a positive impact on health inequalities, and people from lower socioeconomic groups are able to benefit the most from personalised care,[71] so this work also supports Aim 4.

5.177 SFT is currently providing training on personalised care to health coaches in Somerset's PCNs. In the coming years we will implement personalised care in Somerset in line with the commitment set out in the NHS Long Term Plan,[72] although this work is currently at an early stage.

5.178 To implement personalised care in Somerset we need to work closely with our partners in primary and social care and the voluntary sector to bring together the multidisciplinary teams that are needed to care for people with complex needs. These patients sometime require intense focus from a wide range of specialists. It will be easier to implement personalised care across the county

[71] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

[72] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf page 25

when we are a single Trust because it will be easier to link up clinicians from different specialisms to support people with multiple needs.

5.179 An example of work to implement personalised care is the care of children and young people with Asthma. Asthma is the most common long-term condition affecting children and young people, and is the most frequent reason for child presentation at ED and admission to hospital. Personalised care with a focus on prevention rather than crisis response, can give children with asthma and their families a better quality of life, see **Figure 28**.

Figure 28: Patient story - Fleur

Fleur
Fleur is 12 and lives with her mum and three younger siblings. Since the age of 2, Fleur has had multiple admissions to hospital to receive emergency treatment for acute shortness of breath and wheeze. Her exacerbations come on suddenly with little warning. Approximately twice a year Fleur is admitted to HDU for intravenous therapy as she is so unwell, and despite being on maximum treatment, Fleur has repeated asthma attacks. When Fleur is acutely unwell she misses out on family time, education and time with friends. When she's in hospital her mum Claire struggles to juggle care of her younger children with visiting Fleur. She also feels guilty about whichever children she isn't with. Claire has become very reliant on grandparents and friends to help during these regular crises. Simple things which should be enjoyable, like going for a day out or a holiday, are stressful for Claire as she is worried that Fleur will suffer an asthma attack out of the blue. Fleur's asthma affects their entire family life. In 2018, SFT appointed a children and young people's specialist asthma nurse to provide individualised care packages for children and young people with problematic asthma. For Fleur, this meant she had assessments at home and school to examine the reasons for her frequent attacks, and identify any triggers and other modifiable factors. She was given intensive support through increased outpatient clinic reviews, and home and school visits to help her adhere to her asthma plan and ultimately get better control of her condition so it no longer has such an impact on her life. Once she reached the age where it was possible to use different medication it was possible to change her inhaler type and treatment regime to achieve even better control. This approach has been a completely success. Fleur is now able to go to school full time, her mood has improved, and she has a much better quality of life. She has gone from needing a clinic appointment every other month to having one every six months. Claire feels that a significant weight has been lifted from her and says the support they received has transformed their family life. With the signal of merger, SFT's specialist asthma nurse is aiming to offer this service county-wide, as there isn't currently an equivalent role in YDHFT. As one organisation post-merger it will be easier and quicker to develop services county-wide and establish a consistent agreed pathway. This will ensure the benefits of this care are offered for all young people like Fleur and their families.

Anticipatory care

5.180 Anticipatory care is the provision of proactive care for people at high risk of unwarranted health outcomes to help them live well and independently for longer. Typically, this involves structured care and support from a

multidisciplinary team focused on a group of patients with similar characteristics (e.g. frailty).

5.181 The provision of anticipatory care in Somerset is a joint endeavour by primary care, SFT's community services, social care and the voluntary sector. Together we use Artificial Intelligence to review GP lists and population data to identify individual patients within a PCN who are vulnerable to becoming unwell, or needing to go into hospital or a social care setting. We then develop a multi-agency care plan to respond to the needs identified.

5.182 The needs in our PCNs vary, e.g. South Somerset East might have more people needing support for frailty while obesity might be the challenge in Frome. Our anticipatory care offer is still developing and includes:

- A 2-hour urgent community response available between 8am-10pm
- a falls service that can respond urgently, as an alternative to ambulance conveyance.

5.183 Our planned merger facilitates the provision of anticipatory care because it enables specialist acute skills to be brought to bear on the early treatment of people in the community without the need for a hospital admission or specialist referral.

Local projects under Aim 5

5.184 Local projects we are taking forward to deliver Aim 5 are set out below:

- **Integrating paediatric care and CAMHS into a single county-wide service**: Bringing together of our paediatric and CAMHS services into county-wide services will improve the focus on children in Somerset, which has historically been a cause for concern, especially regarding children with mental health problems. Our intention is to fully integrate CAMHS and paediatrics on both sites to better cater to children with mental health problems. The bulk of this work will be around eating disorders and will aim to remove the need for tier 4 care (which is not available in Somerset) by acting early and treating people at home so they do not require the use of out-of-county care. This work will also aim to improve the knowledge of paediatric staff in dealing with challenging patient behaviour.

- **High intensity users**: with recently agreed ICS funding we will create a High Intensity Users service in Somerset to provide coordinated and personalised care for individuals identified by ED staff, SWAST or primary care as been intensive users of services.

- **Improved transition from paediatric to adult services for young people with eating disorders**: this projects aims to create a more

intensive community-based patient pathway for young adults with an eating disorder to avoid the 'cliff edge' they currently experience when they move from paediatric to adult care. The aim is to extend the advantages to young adults of the paediatric pathway in terms of the package of care. The approach will be less 'adult' for the first year of transition and will serve the whole county.

- **Functional neuro disorders**: this describes motor and sensory symptoms that are genuinely experienced but cannot be explained by a neurological disease or other medical condition. People presenting with this issue often have persistent physical symptoms and attend multiple hospital appointments seeking a diagnosis, but can have negative experiences of healthcare arising from poor knowledge on the part of healthcare professionals who may dismiss their symptoms. There is a high personal cost to the individual and a high financial cost to the system of not managing these conditions effectively. We have established a system-wide group to consider the ideal pathway which combines physical and mental health approaches and to make a service recommendation. We are also running two pilot studies looking at managing persistent physical symptoms for gynaecological pain and unexplained abdominal pain, through mental and physical health approaches. We hope this will inform our support for other persistent symptoms e.g. movement disorders.

Aim 5: Benefits

5.185 This aim focuses on not wasting patients' precious time. The anticipated benefits from this aim include:

- improved health outcomes and sense of wellbeing for patients and their families from personalised, targeted health interventions
- greater patient control and involvement in decisions about their care
- improved patient and carer experience from tailored care and greater knowledge, skills and confidence to self-manage
- less anxiety and lower treatment burden
- improved clinical decision-making in the care of complex patients from services that are more joined up
- reduced outpatient appointments, and fewer emergency attendances and admissions (and an associated reduction in costs) than would otherwise be the case.

Aim 5: measurements

5.186 Our key measurements for this aim are:

- Time in ED
- Time to assessment for children and young people with special educational needs and disabilities

- Time to assessment for children and young people with eating disorders
- Persistent physical symptoms outcomes
- Anticipatory care outcomes
- Dementia diagnosis rates.

Clinical support services

5.187 There are a range of clinical support services that will support the introduction of the clinical strategy, including Pharmacy, Clinical Research, Medical Education, Infection Control, Safeguarding, and PALS. Further detail on these is provided below.

Pharmacy

5.188 The Trusts' pharmacy teams have worked together for some years in the following ways:

- The YDHFT pharmacy department has provided a pharmacy supply service to SFT's community and mental health services through a commercial contract since 2012.
- The pharmacy teams have also supported each other during times of pressure including:
    - **Covid vaccine**: SFT is the lead provider for Covid vaccine in Somerset, and YDHFT pharmacists supported SFT when it was struggling to find sufficient pharmacists to staff the vaccine centre in the east of the county.
    - **HIV care**: SFT pays for a pharmacist employed by YDHFT who works with HIV patients across the county.

Merger opportunities – pharmacy

5.189 Like the rest of the country, Somerset faces a shortage of pharmacists and pharmacy technicians. At the same time there is an intention to increase the number of pharmacists and pharmacy technicians in PCNs across England, including in Somerset, which makes our workforce challenges even harder.

5.190 We have already appointed a single Chief Pharmacist across both Trusts and, together with our partners, we have established a system-wide pharmacy workforce group[73] to look at how to ensure a sustainable pharmacy workforce in Somerset.

5.191 As a single Trust, with just one senior decision-maker (the Chief Pharmacist), it will be easier to support and play our role in a system-wide approach to pharmacy workforce. For example, our merger plans have made it easier to

[73] The system pharmacy group has representatives from YDHFT, SFT, Heath Education England, community pharmacies and PCNs.

offer joint placements for foundation trainee pharmacists and pre-registration technicians to increase the local pipeline of pharmacy trainees.[74]

5.192 We aim to have an integrated clinical team for pharmacy in place by Day 1 . The team structure will be aligned to the merged Trust's service groups (see chapter 6), including a lead pharmacist for each service group, a single lead for aseptic pharmacy and a single lead for the interface with primary care.

5.193 As a single team we will be able to take advantage of economies of scale and remove duplication e.g. we will need just one lead for trainees rather than two. Where time is freed up this will be redirected to helping reduce pharmacy errors at discharge to improve patient safety.

5.194 By the end of 2023, we will have the same electronic prescribing and medicines administration system (EPMA) across all settings (acute, community and mental health). This will reduce the current patient safety risk that comes from not having full visibility of a patient's medicine record. A single EPMA also aids staff movement across settings (as the system will be familiar to all) and improves operational efficiency. We are looking in future to create an interface with primary care (via the SIDER programme) to pull in GP information when patients attend our sites, and push medication information to GPs at the point of discharge.

5.195 Merger also facilitates a planned move to a single pharmacy stock control system which will enable us to free up staff time, rationalise our stock holding, and reduce wastage. This proposed shift would not be possible without merger.

5.196 Additional merger benefits include exploring the option of using SSL to provide a cheaper alternative to the relatively expensive system of FP10 prescriptions currently in place at MPH, and ensuring continuity of operations during future planned works at both aseptic pharmacy sites.

Clinical research

5.197 Good clinical research goes hand in hand with high quality clinical care and there is good evidence that patient outcomes are better in organisations which are active in research.

5.198 SFT is a medium-sized player in the South West Peninsular Clinical Research Network but is one of the biggest recruiters into clinical studies in the region, relative to its size. CQC's last inspection of MPH noted the Trust's strong culture and ethos around research.

5.199 YDHFT is the smallest acute Trust in the regional clinical research network. The Trust has a good reputation in recruiting to research and consistently

[74] The plan is to get to 24 joint trainee placements per year by 2023.

appears in the National Institute for Health Research's league table of the top ten small acute trusts for recruitment and complexity of studies. In some services e.g. oncology, the lack of substantive consultants means the Trust has to turn down studies due to a lack of clinicians with the capacity to take on research. This has a knock-on effect on recruitment as research plays a big part in attracting high-calibre staff.

5.200 As a single organisation providing care to more than half a million patients across acute, community, mental health, learning disabilities and primary care services, the merged Trust would be a very attractive prospect for both formal research, and improvement and innovation projects. It is complex to run trials along clinical pathways which span multiple organisations and merger would remove these complexities. Based on latest performance, the merged Trust will be the second highest recruiting trust into portfolio research studies in the regional network.

5.201 Merger means we will be able to increase the patient cohort for studies whilst reducing administrative overheads; this will free up resources which we can redirect into research delivery. It will also give us increased influence in the clinical research network and enable us to attract more research funding into the area. A stronger body of research would help us go further in reducing differences in care, give patients access to novel treatments across all sites, and provide colleagues with training in up-to-date investigations and treatments. Additional business opportunities with commercial partners may also become possible with the larger volume of patients.

5.202 The two Trusts established the Somerset Research Collaborative some years ago and have run several clinical trials under it. However, staff need to have an honorary contract to enable them to access IT systems etc. at the different sites. In a merged Trust these barriers would be removed, making it easier to run research studies across all locations and reducing the associated administration for HR teams and managers.

5.203 Staff at both Trusts have good links with the universities in the region, the South West Academic Health Science Network, the National Institute for Health Research and the Peninsula Collaboration for leadership in applied health research and care (PenARC), and through these we can attract high-calibre staff seeking career progression. Merger will enable us to better leverage these links and make a more attractive offer to potential recruits by offering research time as part of medical job plans and nursing roles.

5.204 The Trusts have complementary strengths in their current research portfolio which will allow us to build capacity across a wider research base. Our research strategy for the merged Trust will have an increased focus on community and mental health services and primary care, and we will develop our research capability and capacity to support integrated care and population health programmes. These areas are an emerging priority for national and

regional research bodies, and the merged Trust will be uniquely placed to play a leading role in these developing areas.

Medical education

5.205 Both Trusts have existing strengths in medical education. YDHFT is nationally recognised for its support to doctors achieving their CESR[75], and SFT has achieved excellent educational ratings from Health Education England. Merger would enable us to combine our medical education teams and associated facilities and remove duplication. The two Trust teams have already started working together, specifically on a joint procurement exercise for medical workforce software. YDHFT and SFT now use the same software packages for job planning, appraisal and revalidation and other related functions.

5.206 Merger offers the opportunity to adopt a consistent approach to medical education across Somerset, and remove the doubling up of key medical education roles such as the Guardian of Safe Working and British Medical Association representatives etc. Merger will enable us to enhance our educational offer through greater breadth of rotation opportunities, and better use of our combined educational estate – the Academies at both the YDH and MPH sites. Combining our medical education forums and committees would make more efficient use of clinicians' time. We will also be able to offer more specialist support to trainees in difficulty and colleagues who are new to the NHS. This is turn should improve recruitment from our trainee pool into post-qualification roles.

Infection prevention and control

5.207 The Trusts appointed a single Director of Infection Prevention and Control in April 2022. All Infection Prevention and Control (IPC) guidance and advice is now developed by drawing on the best from each organisation, and is communicated in common across both organisations, resulting in standardised practice.

5.208 The combined IPC team will be better able to support clinical colleagues to deliver safe IPC practice. Merger will enable this by:

- improving communication of infection status between acute and community settings
- ensuring standardisation of IPC practice across acute and community settings
- facilitating single focus campaigns to improve practice across the system such as hand hygiene

[75] Certificate of Eligibility for Specialist Registration.

- strengthening microbiology support across the system achieving parity of service and more equitable access for clinicians, 7 days a week.
- enabling the existing IPC advice service for YDHFT to be extended to 7 days a week with minimal resource impact.

5.209 Further detail on IPC integration is contained in the PTIP.

Safeguarding services

5.210 The YDHFT and SFT Safeguarding teams cover the safeguarding of adults and children; midwifery; PREVENT; the Mental Capacity Act; Deprivation of Liberty Safeguards; and domestic abuse. Additionally, SFT provides safeguarding services to Public Health at Somerset County Council.

5.211 We appointed a joint Director of Safeguarding in April 2022 and have implemented a new combined team structure. Our training content is now uniform, and delivered across both Trusts to make better use of our resources. A single point of access will go live in November 2022.

5.212 Merger enables the combined Safeguarding team to better support colleagues to protect patients and their families in the following ways:

- the creation of a single pool of trainers creates more training capacity and enables a standardised training offer across the Trusts. This frees up time to support front line colleagues
- improved data sharing across the organisation to identify safeguarding issues
- increased peer support, guidance and sharing of experience amongst the team
- a more flexible and resilient service.

5.213 Further detail on Safeguarding integration is contained in the PTIP.

PALS/patient experience

5.214 Combining our Patient Advice & Liaison Service (PALS)/Complaints teams will enable us to take the best from each team's processes and share resources. This will enable us to provide a consistently high quality service, and resolve complaints more quickly. It will facilitate the provision of standardised patient information across all settings. Merging our teams will boost our resilience and ability to cover staff absences, and will free up capacity for continual quality improvement.

5.215 We have appointed a single interim Director of Patient Care (Experience, Quality and Safety) and an interim Head of Patient Experience and Engagement across both Trusts, and will have agreed a new structure by

December 2022. We are also aligning our processes such as PALS target response times to patients.

5.216 Further detail on Patient Experience integration is contained in the PTIP.

Maintaining patient safety

5.217 We are alert to the risk that patient safety could deteriorate during or after implementation of our planned changes and are addressing this in two ways:

- a robust approach to clinical governance in the merged Trust
- carefully planned, staged implementation of change in line with improvement methodology.

5.218 The merged Trust's clinical governance approach, including our approach to Quality Impact Assessments, monitoring of themes from Serious Incidents etc. is set out at **Annex 6**. To develop this approach we drew on the best from both Trusts and wider good practice sources. We use the Health Foundation's framework for monitoring safety as a guide to ensuring a holistic approach to safety.

5.219 We do not anticipate a drop in the quality of care as we integrate our services – in fact we expect care quality to improve as a result of our merger. Through carefully planned, staged implementation we will make changes gradually, in line with our agreed clinical governance approach to maintain patient safety. We have a well-established and robust improvement methodology that ensures project objectives are met and safety is maintained e.g. Plan, Do, Study, Act cycles.

5.220 Quality measurement will continue to be included as part of the overall performance reporting to the Board of the merged Trust, using a range of indicators, measured using Statistical Process Control (SPC) methodology to highlight variation. In addition, our patient safety data analysts will continue to monitor a wide range of quality indicators, both qualitative and quantitative, and highlight any concerns through the Patient Safety Board and Quality and Governance Assurance Committee

5.221 Alongside development of the clinical strategy for the merged Trust, we are reviewing all clinical policies, and harmonising them where appropriate, to ensure consistency of care across the merged Trust.

5.222 Our intention through the clinical strategy is not only to maintain but to improve patient safety standards. Safe care is a key feature of our new clinical strategy (see Aim 2). The move away from a bed-based model of care will also reduce the risk of hospital acquired harm – deconditioning and acquired infections.

5.223 As part of the integration plan for the governance team, a senior role has been created to lead the implementation of the Patient Safety Incident Response

Framework (PSIRF). This role will be supported by an implementation team involving members from the governance, patient safety, quality improvement, organisational developmental and patient experience teams, along with key operational staff.

5.224 Progress on implementation will be monitored by the Patient Safety Board (with changes to the membership and terms of reference to ensure PSIRF is central to all of the patient safety work in the integrated Trust), with regular reports to the Quality and Governance Assurance Committee.

5.225 At their last published inspections, CQC rated both Trusts 'Requires Improvement' for the Safe domain.[76] We have set a target to achieve a 'Good' rating for the Safe domain at our next CQC inspection (merged Trust), and 'Outstanding' at the subsequent inspection.

5.226 The continued integration of mental health services with acute services will support the areas requiring improvement at YDHFT identified by the CQC. Consistency in approach to record keeping – including the development of the digital agenda – will strengthen this area for the merged Trust. We are also taking action around areas for improvement at SFT identified by CQC, which included monitoring of systems to avoid patient harm, staff wellbeing and learning from deaths investigations.

5.227 As part of our progress towards a 'Good' rating for Safety, we will monitor safety indicators, including hospital acquired infection rates, serious incidents and adverse reactions to medication. We will also use the scores in the annual NHS staff survey and our local 'pulse' surveys to monitor progress in improving patient safety.

Measuring our clinical strategy by valuing time

5.228 Valuing time - both patient and colleague time - is a key part of our clinical strategy. For most people the outcome they want from health and care services is to be as well as possible to be able to do the things that matter to them. This means spending as little time as possible in healthcare, and avoiding long waits or interventions of little clinical value, We also want to give time to patients through interventions which increase their healthy life expectancy so they stay healthy for as long as possible. Finally, we want to explicitly value colleague time and make doing the right thing for patients, the easy thing to do.

5.229 Many of our patients are older people in their last 1,000 days, and we are particularly committed to maximising the amount of high-quality time they have

[76] YDHFT CQC report published May 2019; TSFT CQC report published March 2020 (TSFT was a legal predecessor to SFT and ran Musgrove Park Hospital.

with their loved ones during the precious days at the end of life, see **Figure 29**.

Figure 29: Professor Brian Dolan on valuing time

"For those with many more days behind them than ahead of them, it's a time that's not available to be wasted and while we may sometimes treat older people like they have all the time in the world, looked at differently, they are the ones in a hurry." Professor Brian Dolan

5.230 We intend to use 'time' as our primary measure to ensure people are spending the right amount of time in healthcare settings. This supports our focus on putting patients at the heart of our services and maximising the time they have to do what matters to them.

5.231 Using time as a measure allows us to focus on the dignity and autonomy of the people we serve, as well as demonstrate our humanity and compassion. Time is simple to understand and is engaging for patients and colleagues alike. It also supports our aim of making the right thing the easy thing. Some of the ways we will demonstrate our commitment to valuing patient and colleague time are set out in **Figure 30**.

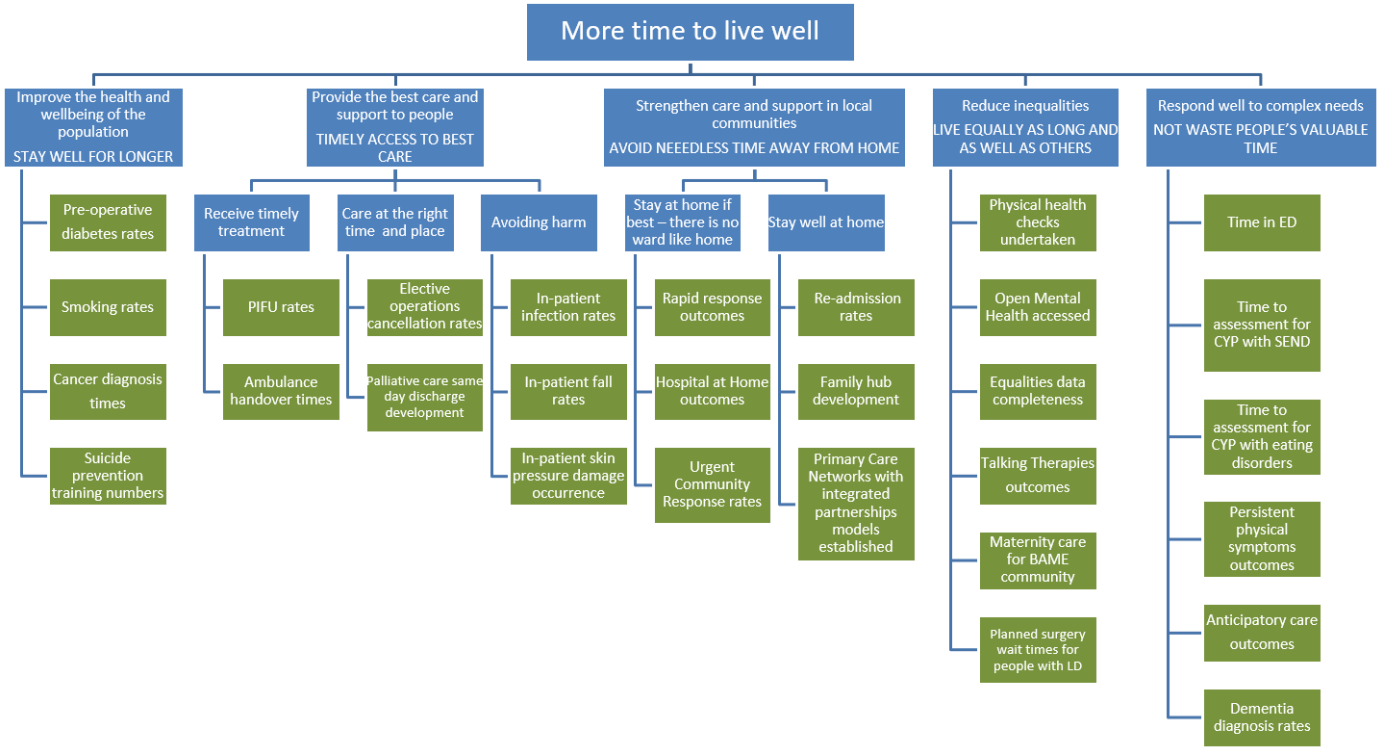
Figure 30: Valuing patient and colleague time

Valuing patient time means we will:	**Valuing colleagues' time means we will:**
• work to increase healthy life expectancy • act early to prevent avoidable illness • reduce the period between the time of need and the fulfilment of that need (i.e. reduce waiting times) • streamline pathways to reduce waits and time spent in healthcare • safely reduce the time spent in hospital having treatment • reduce the time spent waiting for diagnostic results • avoid non-value adding healthcare interventions, and unnecessary follow-up appointments • reduce the treatment burden e.g. arising from polypharmacy • reduce the time spent accessing and navigating healthcare • streamline administrative procedures and remove duplication so patients only have to share basic information once • reduce unnecessary travel to receive healthcare (through virtual consultations, or care closer to home).	• maximise the time colleagues spend on patient interventions and training • maximise time spent working at the top of their licence to make best use of colleague skills • support colleagues in determining how much time patients need to spend in health care and in taking calculated risks if that promotes self-management for patients • reduce bureaucracy to the minimum, and remove non-value adding tasks.

5.232 We already collect data about time spent in healthcare processes, e.g. length of stay in hospital, number of outpatient appointments, number of home visits for treatment etc. We will work with system colleagues to supplement these with indicators of increased healthy life expectancy, via measures such as pre-operative diabetes rates, smoking rates and physical health checks for people with mental health problems.

5.233 **Figure 31** below shows the measures we will use to measure the impact of implementation of our clinical strategy.

Figure 31: measures for valuing time



Enablers to the clinical strategy

5.234 Key enablers to our clinical strategy are set out in **Figure 32** below.

Figure 32: enablers to clinical strategy

Enabler	How it supports the clinical strategy
People • Motivated & engaged colleagues who feel they belong • Senior leaders who model our values and 'give permission'	• A centrally-led 'command and control' style model will not drive the level of change we want to see. We need engaged clinical teams to lead the service change. • To do this, our colleagues need to feel sufficiently motivated to shape the future of their service and deliver the desired change. • Leaders need to give colleagues autonomy and freedom to think creatively and innovatively as they plan the transformation of services
Operating model • Distributed leadership with localised senior decision-making	
Improvement & knowledge • Capability for transformational change • Understanding of the evidence base about what works	• Colleagues need the knowledge, training and support to be able to plan and implement changes in their service • Transformation plans need to be informed by an understanding of what has been shown to be effective elsewhere in the NHS and globally

Digital & Information • Integrated IT systems • Accurate data to inform decision-making	• A single set of IT systems across the merged Trust will improve patient safety and efficiency • Accurate data and corporate information ensures planned changes are evidence-based
Estates • Fit for purpose modern estates	• Modernised estates support the provision of great care and support patient recovery and well-being • Addresses inequalities by ensuring our estates are accessible and easy to navigate for all
Professional leadership & research • Learning culture & continuous improvement in clinical practice • Training & development	• To deliver our ambition of delivering the best care we need our clinical practice to stay up to date with emerging advancements and for all colleagues to nurture a learning mindset

5.235 Further information about our support services and how they support the clinical strategy is given in chapter 7.

Development of the clinical strategy

5.236 Development of our clinical strategy has been clinically led by our Clinical Integration Team. All clinical members of the Clinical Integration Team have continued their clinical practice while seconded to the team to maintain their skills and links with front line service. Collectively the team has expertise in: acute services, care of older people, community services, mental health, therapies, patient experience and clinical IT transformation. The team is also supported by colleagues from our Improvement team providing benefits realisation and project management expertise, and has had assistance from our Patient Partners.

5.237 We have drawn on national and international evidence and experience, including the Canterbury model from New Zealand, Nuka model from Alaska, the Montefiore model from New York and other examples. We have used international research findings to select and shape our clinical integration plans, and inform our understanding of their expected benefits. We have taken learning from other parts of the NHS e.g. Barts Health, and Torbay and South Devon.

5.238 The diagrams in **Annex 4** set out some of the key programmes by which the merged Trust will contribute to the delivery of the five clinical health and care aims. In the coming months and years we expect to identify further opportunities to deliver our aims.

5.239 Just as we expect to identify new clinical integration projects in the future, so too do we expect to continue iterating our clinical strategy together with colleagues, system partners and patients. Further detail on how we have

engaged to date with colleagues, ICS partners, patients and carers is set out below. This engagement will be ongoing as we take our integration forward.

Clinical and stakeholder engagement

5.240 We know from the previous merger of SPFT and TSFT that a positive inclusive approach, good relationships (both within the county and beyond), and ongoing communication are key to the development of a robust and embedded clinical strategy. We have invited colleagues from Dorset HealthCare and University Hospitals Dorset NHS Foundation Trust to attend our strategy groups and will continue to build links with neighbouring trusts.

5.241 The detail of our engagement work is set down in the engagement log which is provided as a supporting submission to this Case.

Development of the five system health and care aims

5.242 The Somerset system's five clinical health and care aims were developed at ICS level. The system took as its starting point, the four clinical aims formulated for the merger of SPFT and TSFT, and convened an 'engagement group' consisting of more than 120 colleagues from primary care, Somerset County Council, Somerset ICB and the local voluntary sector to further develop them.

5.243 Three significant changes were made to the aims during this process:

- the inclusion of a fifth aim about prevention (which became the first aim of the five). Given the importance of preventing illness and early intervention to the overall functioning of the Somerset health and care system we agreed this work should be highlighted in an aim of its own.
- Describing the aims as clinical health and care aims, to reflect the importance that social care has in delivering our ICS strategy.
- Refining the language of the aims to better reflect the challenges we face and our goals.

5.244 The five agreed clinical health and care aims are now reflected in the ICS health and care strategy as well as our Trust clinical strategy (with the latter setting out our role in delivering the ICS health and care strategy).

5.245 Clinical integration team members have attended a wide variety of system forums alongside our system partners to talk about the five clinical health and care aims.

5.246 We have also engaged with system partners about the detailed projects which sit within our Trust level clinical strategy. For example we have co-designed with system partners a wide variety of service changes ranging from Hospital@home to Diabetes care, see **Figure 33**.

Figure 33: Diabetes integration

The acute Diabetes services at YDHFT and SFT each have dedicated inpatient beds on a general medical ward at YDH and MPH respectively. They also run specialist outpatient clinics, and provide advice to GPs through the 'Consultant Connect' system. SFT also provides the community intermediate care service for the whole county.

The SFT and YDHFT Diabetes services have worked closely with each other and other system partners including GPs and voluntary services for a number of years. This has generated patient benefits including diabetes prevention and remission programmes, the use of the MyWay Diabetes online platform and the piloting of virtual MDTs in primary care (see paragraph 5.134).

The Trusts have also worked with system partners to develop a single county-wide, end-to-end Diabetes pathway. This work has continued regardless of organisational boundaries, particularly in relation to the interface between the intermediate care community team and the secondary care teams at both acutes. However, some organisational issues e.g. different digital systems have resulted in clunky pathways.

The merger of SPFT and TSFT in 2020 enabled the acute diabetes services in the west of the county and the community diabetes service to come together as one team. The benefits to date of that merger include weekly complex care meetings for acute and community diabetes teams, shared education programmes, rotational staff posts across community and acute settings, and aligned and streamlined diabetes processes and workforce.

A merged organisation will make it easier to deliver our vision of a county-wide approach to diabetes. We want all people to have the same access to services, irrespective of their location and condition through a single waiting list. As a single health care provider we will be able to collaborate more effectively with partners in primary care, social care, and the voluntary sector which is key to providing care in local communities with a focus on prevention and self-management. The signal of merger has prompted us to begin a workforce review looking at staff numbers, roles and the use of non-medical specialist posts. We have also started work on a workforce strategy, including a professional pathway for training, supervision and succession planning for diabetes specialists nurses as many are due to retire in the near future.

Working with colleagues to develop the clinical strategy

5.247 Senior clinicians from both Trusts have participated in the development of the clinical strategy for the merged Trust, including the five system aims and individual projects within the strategy.

5.248 Members of the clinical integration team have used a variety of forums to present the clinical strategy to Trust colleagues and show how colleague contributions informed it. These forums have included group engagement sessions, team meetings, one-to-one meetings, and working through the Engagement Champions to share information about our plans. We have shared written information with colleagues about the strategy and made a short video to tell the story of why we need to transform and how we intend to do so. Our engagement log shows more than 1,000 colleague contacts about the merger either face to face or virtually.

5.249 This engagement was aimed at all colleagues – not just clinical colleagues - as we need everyone to be motivated to drive transformation in the merged

Trust. We have also worked with People, Digital and Estates colleagues to ensure their developing strategies fully support the clinical strategy.

Working with patients and the public to develop the clinical strategy

5.250 We have discussed our clinical strategy with and sought feedback from various local patients' and public groups including:

- Governors – through regular presentations and briefings on all aspects of merger including the clinical strategy
- Patient Voice group – this includes people with personal, carer and volunteer experience of our acute, community and mental health services and children's and adult services. This group helped to shape our developing clinical strategy and inform our thinking around healthcare buildings and technology.
- Somerset Engagement Advisory Group[77] – through regular briefings on our merger plans. This group includes carers.
- MPs – through correspondence about our merger plans.
- Patient Participation Group Chairs' Network – attendance to discuss the development of our clinical strategy.

5.251 **Figure 34** describes the engagement we undertook for the development of our Somerset vision for community hospitals and shows how we altered that strategy in response to feedback.

Figure 34: Stakeholder engagement – community hospitals vision

Stakeholder engagement – community hospitals vision

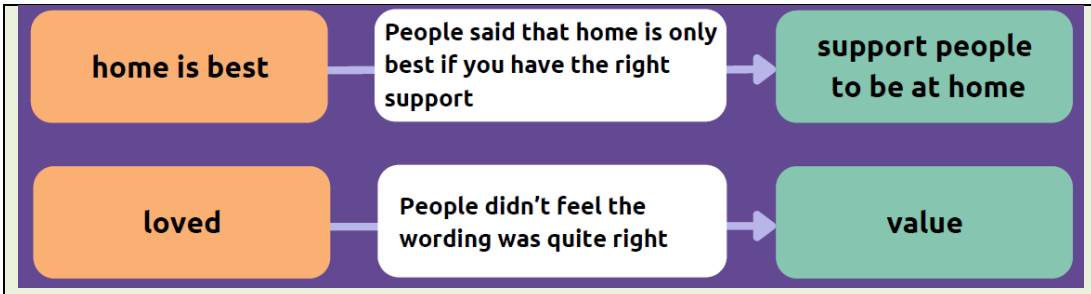
Between April-October 2021, SFT led an engagement exercise on our system-wide vision for the county's 13 community hospitals. This engagement involved staff from the two Trusts, Trust governors, Somerset CCG, Somerset county council, representatives from local VCSEs, primary care, the hospital Leagues of Friends and other interested parties.

The first stage of engagement was to understand what was important to people when they think about using community hospitals in future. From this we drafted a vision statement and aims. The second stage of engagement involved people commenting on the draft vision statement and aims.

Feedback was gathered via workshops, an online survey and other opportunities for individual and group feedback. Nearly 2,000 comments were received during this process.

Feedback led to changes in language to make sure it matched what people were thinking and was clear. For example we changed the text on the left (below) to the text on the right (below).

[77] Chaired by Healthwatch Somerset, the Somerset Engagement Advisory Group is a formal group established to ensure we continuously listen, feed back and are held accountable for our work that impacts on People and Communities. SEAG members include many different local community groups, voluntary organisations, charities, and others.



The resulting agreed vision and strategic aims for community hospitals are in **Annex 8**.

5.252 Patients have also been involved in co-designing some of our clinical projects, see Figure 23**).**

Next steps in implementing the clinical strategy

5.253 We will bring together all the services in the two Trusts into single county-wide services which will each have a single set of pathways and work to a single waiting list. We intend all services to be operating county-wide within three years of merger, with the majority having achieved this within two years.

5.254 Each clinical service will set its own priorities and timeline for integration based on what they believe is best for the people they serve, although we expect all teams to be working to a single team ethos from Day 1 of our merger.

5.255 We believe it is essential that clinicians own their clinical integration projects in order to fully drive out the potential benefits. The work of clinical integration will be driven by the services themselves and, as services integrate, we will support teams to consider how their service will focus on population health, tackle health inequalities, move more care into neighbourhoods, and adopt a personalised care approach. Services will be asked to focus on getting things right for the person who is receiving the healthcare and their carer(s) and ensure the time of all those who work in and receive our care is valued.

5.256 Our existing, well-established improvement teams and the clinical integration team will support clinical colleagues to plan, implement, monitor and report on the development and implementation of their integration plans. This work is already underway, and is most evident in the services described in the Patient Benefits Case.

5.257 Our support to integrating services includes a Clinical Integration Guide which amongst other things sets out the features of a single clinical services. These are:

- A single agreed vision for the combined service
- Single operational/ line management structure
- Single set of county-wide patient pathways

- Single waiting list
- Unified governance
- Single set of policies and protocols
- Single budget
- Reporting as one service, based on aligned information systems

5.258 All clinical services are preparing a charter which sets out the teams' unified vision, the benefits they envisage, and the indicators they will use to monitor the delivery of those benefits. All integrating services are also preparing a detailed transformation plan to support their integration.

5.259 Alongside the integration of our clinical services, we also have a range of programmes through which we will play our role in implementing the five health and care aims (see **Annex 4**).

5.260 Further detail on our approach to managing the overall integration, implementation of our detailed clinical projects (including implementation risks) and the benefits realisation plan is included in the PTIP.

Timeline for implementation of clinical strategy

5.261 Our proposed programme of work is significant, and experience from other healthcare systems around the world shows that transforming services is a long term project requiring 20 or more years to fully implement and embed. Nonetheless, we are moving at pace to integrate services and are determining the priority order in which clinical services will integrate according to a set of objective criteria. These criteria are set out in the PTIP. The PTIP also provides a schedule of the expected timing for the integration of individual clinical services, although this schedule is the first iteration and is expected to evolve.

Impact Assessments

5.262 We will undertake equality impact assessments as part of any planned service changes at the appropriate point. We will also consider the impact on equality during consultation on any changes to working practices.

6. People, governance and operating model

6.1 This chapter sets out our People and Organisational Development agenda, the governance arrangements for the merged Trust, and our new operating model. It also explains how these support our vision for the new Trust and the clinical strategy, as described in chapters 4 and 5 respectively.

People and Organisational Development agenda

6.2 This section covers culture, our people strategy, workforce planning, and support for change.

Culture

6.3 Both Trusts have positive cultures as demonstrated by the staff survey results and other engagement tools. As part of our merger preparations, each Trust commissioned a cultural maturity audit to help us understand the existing cultures, and identify matters to consider in our merger planning.

Cultural audits

6.4 The SFT cultural audit took place in June 2021, and the YDHFT cultural audit took place in January 2022. The audits were conducted by our independent internal auditors BDO, and involved interviews with board directors and senior managers, alongside review of relevant documentation such as staff survey results.

6.5 The audits assessed the Trusts in the following areas:

- tone from the top
- structure and governance
- policies, procedures and training
- branding and communication
- operations, and
- measurement, accountability, rewards & recognition.

Maturity was assessed according to five categories: immature, reactive, proactive, mature, and continuous improvement.[78]

6.6 The cultural maturity audit of SFT found the Trust has clearly defined its values and desired organisational culture, has clear governance structures, and a clear relationship between the desired culture and corporate objectives. The audit noted work still to be done following the merger which created SFT in 2020 – specifically it recommended further work to support the feeling of being 'one organisation' including work to complete the integration of policies and

[78] These categories are defined in the audit reports, which are provided as supporting submissions to this Case.

procedures. The audit also recommended the creation of a cultural assurance dashboard, and the further development of ways to communicate effectively with colleagues.

6.7 The cultural maturity audit of YDHFT found the Trust has a strong corporate identity through its stated vision and values, and that colleagues have a strong affinity with the Trust. The audit found clear links between the desired culture and corporate objectives. The audit noted the proposed merger had been challenging for some colleagues, with some feeling their ability to participate as equal partners in merger planning had been impacted by limitations on their capacity in the face of ongoing operational pressures. The audit recommended the development of a clear change management plan to support YDHFT colleagues through the merger process.

6.8 The results of the two cultural maturity audits are summarised in **Figures 35** and **36** below. The cultural maturity audit reports are provided as supporting submissions to this business case.

Figure 35: summary assessment of YDHFT cultural maturity audit

	Tone at the Top	Structure and Governance	Policies, Procedures &Training	Branding & Communications	Operations	Measurement Accountability Rewards & Recognition
Current	Continuous Improvement	Mature	Mature	Mature*	Mature	Continuous Improvement
Target	Continuous Improvement	Continuous Improvement	Continuous Improvement	Continuous Improvement	Continuous Improvement	Continuous Improvement

*: The auditors recognised that YDHFT does not have a formal brand strategy or KPIs in place, but rated Branding & Communications 'Mature' due to the Trust's distinct visual identity and strong Trust vision and values.

Figure 36: summary assessment of SFT cultural maturity audit

	Tone at the Top	Structure and Governance	Policies, Procedures &Training	Branding & Communications	Operations	Measurement Accountability Rewards & Recognition
Current	Mature	Mature	Proactive	Mature	Mature	Mature
Target	Continuous Improvement	Continuous Improvement	Mature	Continuous Improvement	Continuous Improvement	Continuous Improvement

6.9 We have developed action plans to implement the recommendations of these cultural maturity audits. These plans include the development of a cultural dashboard which contains metrics aimed at capturing how colleagues experience working at the merged Trust, and steps to improve the cascade of information.

6.10 We recognise there are strong existing identities at both Trusts, and our narrative will be that a strong identity within health settings will not be eroded or lost but enhanced under the umbrella of the new merged Trust.

6.11 We also responded to the concerns from YDHFT colleagues about their ability to participate as equal partners in merger planning by running face-to-face sessions for YDHFT colleagues to hear their concerns and work through solutions. We subsequently had good engagement from YDHFT colleagues for our values workshop and cultural survey.

6.12 Progress on the actions arising from the cultural maturity audits is overseen by the joint People committee.

Desired culture

6.13 We want to create a sense of belonging for all colleagues in our new Trust and have a culture that:

- is open, honest and supportive
- enables colleagues to speak up and feel safe
- enables everyone to be the best they can be and thrive, and
- empowers colleagues to make decisions in their own areas
- helps us work according to our shared values and behaviours.

6.14 We also want people to see us as a Trust that:

- delivers great care
- is innovative and ground breaking, and
- does the right things for the right reasons.

6.15 Our approach to developing the values for the merged organisation involved asking colleagues what they value most in their working day and what behaviours contribute to making their day at work good and bad. From this we are clear about what we want to keep, and take through into the culture of the merged organisation.

6.16 However, we also know that different departments, sites, specialities and locations have their own positive sub-cultures which, in their different ways, adhere to the values framework and we want these to continue to flourish. We want our values to be the common thread running throughout our new Trust, while also embracing the existence of positive local sub-cultures.

People strategy

6.17 The two Trusts, and the NHS in general, are facing chronic workforce shortages across many roles, and it is essential that we evolve how we attract, retain and support staff in order to maintain safe, sustainable services. At the same time our clinical strategy is ambitious, and we need the appropriate mix of motivated, skilled, diverse and compassionate colleagues to enable us to deliver it.

6.18 People services therefore has a key role to play in helping to deliver the merged Trust's vision through the recruitment and retention of skilled, motivated and appropriately trained colleagues, and helping to nurture our desired culture.

6.19 We have developed a joint 5-year People strategy (2023-2028) which sets out how we will attract, develop, retain, and inspire our people. Our People strategy is aligned with the NHS People Plan, the People Promise, the NHS Long Term Plan, and the South West regional People plan. The strategy's development has also been informed by corporate data and the results of our cultural audits.

6.20 The aim of our People strategy is to put People First, by living our values of Respect, Kindness and Teamwork. Our People strategy has five commitments:

- **Care for our people**: this includes prioritising the health and wellbeing of our colleagues, reducing violence and aggression, ensuring colleagues can speak up and share ideas, and creating a environment where people are celebrated, recognised, respected and rewarded.
- **Develop our people**: this includes providing the right training and development opportunities to enable colleagues to realise their full potential, helping them build their career, and using partnerships and digital solutions to enable colleagues to learn and grow.
- **Compassionate and inclusive leadership**: this includes encouraging leadership that overtly values equality, quality, diversity and inclusion, listening to and learning from colleagues, providing support for leaders at all levels, and ensuring senior leadership is visible.
- **Retain and attract talent**: this includes focusing on retention and leading the way in attracting and retaining a more diverse and representative workforce, embracing flexible working, and developing innovative roles and ways of working.
- **Learning and transforming**: this includes using technology to drive greater sustainability and team flexibility, developing pathway workforce planning, and ensuring our decision-making is evidence-based to improve our people practices.

6.21 These commitments are underpinned by measures which will be included in our reporting to the joint People Committee about delivery of our People strategy ambitions. The People strategy is provided as a supporting submission to this business case.

6.22 The People strategy will be accompanied by a detailed action plan setting out the steps we will take each year to achieve our ambitions. All actions within the plan will have our values weaved through to ensure we bring the values to life for colleagues and use them as the basis for how we do things.

Approach to equality, diversity and inclusion (EDI)

6.23 Inclusion is a key part of our People strategy and we have developed an inclusion roadmap which ensures we are clear on our focus and approach to inclusion as we take forward our People strategy actions.

6.24 We know that when our colleagues have a better experience, patient outcomes and satisfaction increase too. We want to be a Trust where everyone knows that their unique skills and abilities are valued, and where each member of our community feels they belong. We also want to create a truly inclusive culture, with policies and ways of working that are equitable.

6.25 Both Trusts have made progress towards equity and inclusion, and we are now investing in our capacity to embed a new approach which aims to 'fix the system' rather than 'fixing people' by addressing the cultures, behaviours, policies and processes which create or maintain inequality.

6.26 We will do this by using data and targeted consultation to identify where action is needed and to track our progress on EDI over time. We will embed inclusion into all our organisational policies, processes and ways of working and support colleagues to drive inclusion in their own teams and work.

How merger helps us deliver our People strategy

6.27 Merger helps us deliver our People strategy in the following ways:

- as a fully integrated NHS provider we will be able to offer a broader range of roles (including innovative roles) and more ways to develop professionally which helps us recruit and retain staff.
- removes duplication in attracting, training and developing colleagues which used to happen when colleagues moved between our Trusts in Somerset.
- increases our chances of filling hard-to-fill posts as potential recruits with families looking to relocate to the county will have more options about where they are based.
- boosts our colleague retention through greater opportunities for career development and promotion without staff having to change employer.
- strengthens our ability to respond to challenges as we will have greater flexibility in deploying skills where they are needed most. This helps sustain services for patients and increases colleague wellbeing by reducing the stress caused by long term vacancies.

Workforce planning

6.28 As part of our People strategy we intend to develop a strategic workforce planning framework which will help us better analyse the gap between our current and future workforce needs, and develop and implement strategies to address workforce gaps.

6.29 Steps we are taking to address workforce gaps include:

- Support to supply chains e.g. closer engagement with universities and colleges running healthcare courses, see **Figure 37**.
- New routes to registration, e.g. trainee nurse associates as a route to becoming a registered nurse
- New sources of candidates: new routes include Return to Practice, reservists, and the SWAPs programme[79] run by the Department for Work and Pensions which helps people into work.
- Use of innovative roles: for example consultant nurse specialists, and also ensuring our colleagues are working at the top of their licence.

Figure 37: working with local education providers

As a merged Trust we will be able to offer students a broader learning experience than we could as separate Trusts as a result of a greater breadth of services over a wide geography, as well as larger services caring for a higher number of patients.

Since 2021, University Centre Somerset (part of Bridgwater and Taunton Further Education college) has offered degree-level nursing programmes accredited by the University of the West of England (Bristol). In the first year, SFT and YDHFT supported around 47 Nursing Associate Apprentices and 7 Registered Nursing Degree Apprentices who studied at the Centre. Although both Trusts already invest in nursing apprenticeships, the sustainability of our investment will be more assured when we are an enlarged Trust. This in turn supports the sustainability of the University Centre programme, and helps provide a strong pipeline of nurse associates, registered nurses and registered mental health nurses to work in the merged Trust.

6.30 Merger provides us with a unique opportunity to create, develop and sustain a single clinical workforce across our services, and work across the Somerset system to integrate clinical care models. Merger puts us in a better position to fill workforce gaps by offering greater flexibility across service and geographical locations. It also allows us to create wider development and learning pathways for colleagues to develop, grow and progress within our Trust and across the system. As a larger entity we will benefit from greater leverage and economies of scale when working with external parties (learning providers/temporary staffing agencies etc) and we will be better able to influence 'working differently' in pursuit of our shared Somerset vision for health and care.

6.31 Together with our partners we are developing a shared vision for workforce across the ICP, and merger supports our work to address wider system-wide workforce issues. For example, we know as a system that if we focus on certain key areas of workforce shortage e.g. domiciliary care and discharges, we can help relieve operational pressures in healthcare.

6.32 Together with our partners in Somerset system we have agreed to support the 'passporting' of mandatory training[80] between NHS employers. Further discussions are underway to determine how this will be done and explore the possibility of having one learning management system across the system. This

[79] SWAPs: Sector-based work academy programmes.

[80] This applies to training which is aligned to the Skills for Care core skills framework.

will reduce the replicated training that occurs when staff move from one organisation to another. Work is also work underway to develop a single set of clinical skills and competencies.

Change management support

6.33 The merger will mean significant change for many colleagues. We are committed to following our agreed policies and processes for fully consulting colleagues about any potential changes to their working arrangements and role.

6.34 Where teams are being restructured prior to Day 1, our HR colleagues are supporting conversations about what the future looks like, new ways of working and potential challenges. HR advisers are providing technical support for consultation processes and ensuring compliance with the organisational change policies of both Trusts.

6.35 Our Leadership Programme, Rising Star Programme and Management Essentials Programme now run across both Trusts, and each focuses on leadership and the skills needed to be a strong and effective leader in all situations, including periods of change. Our planned quarterly leadership forums, which will start in October will equip senior leaders with knowledge and understanding of merger and provide tools and techniques to support open, honest and transparent conversations with colleagues, and help them through periods of change. We are also offering teams and individuals support to handle change tailored to their needs.

6.36 Many of our board members have experience of organisational change including the merger in 2020 which created SFT. We also have significant improvement expertise across the two Trusts in how to plan and manage change, which we are applying to work of integrating our services. Further details are provided in the PTIP.

Corporate governance

6.37 The following section sets out the current and proposed governance arrangements.

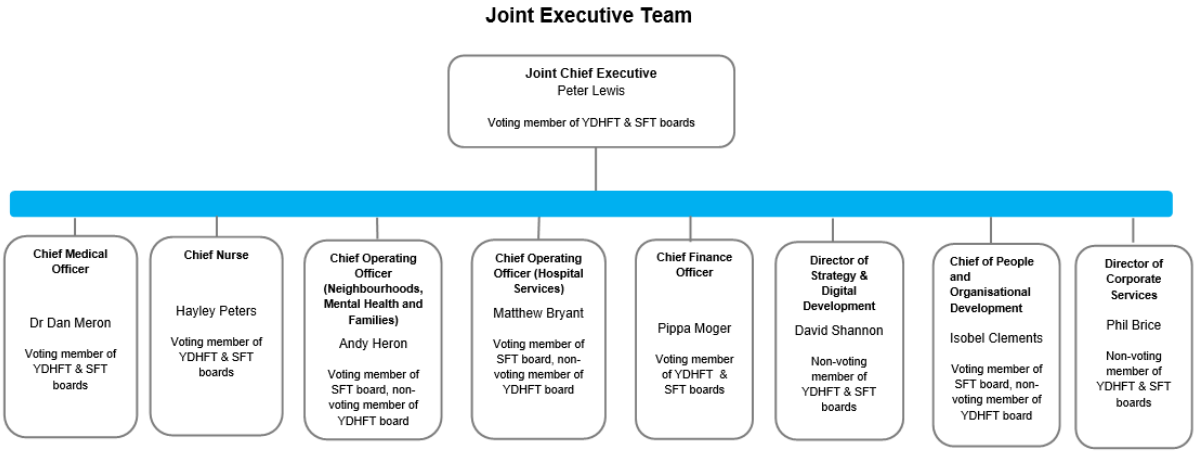
Current Boards of Directors

6.38 In the MOU signed in May 2020, the two Trusts committed to work together for the benefit of the Somerset population by aligning the Trusts' strategic goals and operational activities.

6.39 In January 2022, the Trusts established a joint executive team to oversee all aspects of the two Trusts' operations. The joint executive team consists of eight Executive Directors plus the joint Chief Executive Peter Lewis (see **Figure 38**). Appointments to the joint executive team were made through competitive

processes, and the appointments were approved by both Trusts' Nomination and Remuneration Committees.

Figure 38: Composition of joint executive team



6.40 Although there is a single joint executive team, the Trusts retain their own Boards. YDHFT currently has 4 Non-Executive Directors including the Chair, and SFT has 7 Non-Executive Directors including the Chair. Since April 2022 the Boards have met at the same time, although formally the Boards remain separate.

Board of merged Trust

6.41 At the point of transaction the merged Trust will have a reconstituted Board with Non-Executive Directors drawn from both legacy Trusts. The role of the enlarged organisation's Board of Directors will be to:

- provide effective and active leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed;
- ensure compliance with the Foundation Trust Terms of Authorisation, the Constitution, mandatory guidance issued by NHSE, and relevant statutory requirements and contractual obligations;
- set the strategic framework taking into account the views of the Council of Governors, review progress and manage performance;
- assure the quality and safety of care, education, training and research;
- ensure that functions are exercised effectively, efficiently and economically; and
- help set the vision, values and standards of conduct and ensure obligations to members, service users and other stakeholders are understood, clearly communicated and met.

6.42 The board of the merged Trust will have nine Non-Executives, including the Chairman, at the date of merger. Six of the non-executives will come from the SFT board and three will come from the YDHFT board. In September 2021 the SFT Council of Governors approved the appointment of Martyn Scrivens (Chair of the YDHFT Board) to the SFT Board, and then in June 2022 the SFT Council of Governors approved Graham Hughes and Paul Mapson (both YDHFT non-executives) as members of the SFT board with effect from 1 April 2023. The Chairman of the merged Trust will be Colin Drummond (currently Chairman of SFT).

6.43 The existence of the MOU and the fact that Board meetings are now held as meetings in common has given Board members the chance to learn about each other's organisation and the key risks. In addition, joint meetings of Board sub-committees have provided further opportunity for Non-Executives to gain insight to both organisations (see paragraph 6.47).

6.44 The existing members of the joint executive team will transfer to the executive posts in the merged Trust. The Executive team structure was reviewed in 2021 as part of the creation of the joint executive team, and it will be further reviewed following the merger. This is to ensure the structure continues to serve the needs of the merged Trust, and that it is providing the capacity and capability to drive ongoing transformation and capital programmes alongside business as usual.

6.45 The merged Trust will span a wide geography and provide a very broad range of mental health, learning disabilities, community, primary care and acute services. In developing the Board structure we have been mindful that the Board of the new organisation will need a broad range of skills and experience to provide effective leadership and oversight of the enlarged Trust. The proposed Board has significant merger, integration and service redesign experience across both Executives and Non-Executives. Short biographies of the proposed Board members of the merged Trust are at **Annex 9**.

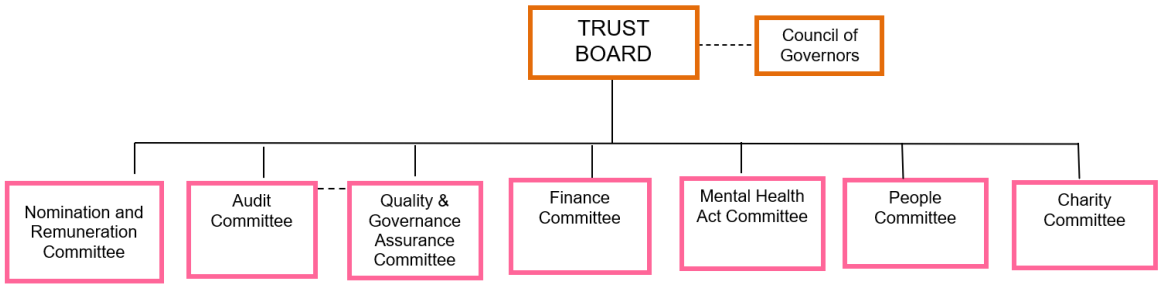
6.46 We have carried out a skills analysis of the proposed board of the merged Trust. This analysis concluded that, from 2024, the areas of lowest expertise will be primary care; mental health and social care due to the end of tenure of a number of the SFT Non-Executives. These areas will be a focus for recruitment when filling future board positions. The skills gap analysis is provided as a supporting submission to this Business Case.

Board Committee structure and Governance Framework for merged Trust

6.47 The Trusts currently have the following joint Board sub-committees: Finance (joint from February 2022), Workforce (joint from March 2022), and Quality and Governance Assurance (joint from May 2022). In line with legal advice the Trusts have maintained separate Audit Committees although these have met in common from July 2022.

6.48 The committee structure for the Board of the merged Trust will be as shown in **Figure 39**.

Figure 39: Board committee structure for merged Trust



6.49 The Board committee structure was reviewed as part of the review of the Constitution and was further reviewed by the committees in both Trusts. The review concluded that the committee structure for the merged Trust is consistent with the existing committees at YDHFT and SFT which have been found to be effective and meet the needs of the current Boards.

6.50 The Terms of Reference for the committees were approved by the SFT Board in October 2022. The Boards have agreed a process to finalise committee Chairs and membership in the next few months.

6.51 Quality and Performance reports to the Trust Board and executive committees will enable clear visibility of operational performance at lower levels of the organisation and will be presented in a format that supports identification of trends and highlights areas for improvement. Trust level reporting will encompass operational performance across all sites and cover all statutory national performance standards, alongside other indicators of patient quality, safety and patient experience. The proposed format of the combined Performance Reporting Pack is provided as a supporting submission to this Business Case.

6.52 The regular meetings between executives and senior clinicians and managers (Senior Operational Management Team at SFT and Hospital Leadership Group at YDHFT) will be brought together in autumn 2022, as we start to move to shadow-running of the new organisational structure.

Constitution

6.53 In June 2021, the Trusts established a Constitution Review Group, to develop proposals to support the move to a single Constitution and Council of Governors from the date of merger. The group was led by Ria Zandvliet, SFT

Trust Secretary and consisted of three governors from each Trust, three Executive Directors and the Associate Director of Integration (who was formerly Trust Secretary at YDHFT).

6.54 The Group used the model constitution and the existing two Trusts' constitutions as the basis for its work. The Group identified differences in the way the Constitution and Standing Orders for both Trusts were structured. The Constitution for the merged Trust follows the structure of YDHFT's Constitution as the Group felt that structure provided a better grouping of the relevant sections.

6.55 The key changes to the SFT Constitution which will be the Constitution of the merged Trust relate to the following:

- ordering of content in line with the YDHFT Constitution;
- reflecting the new name of NHS Improvement (Monitor);
- changes to references to the NHS Foundation Trust Network;
- a change in the maximum number of Non-Executive Directors from eight to nine to reflect the increase in the number of post-merger Non-Executive Directors;
- wording to reflect the agreed process in relation to the Staff Governor elections from the date of merger;
- the inclusion of a reference to wholly and partially owned corporate entities (subsidiaries); and
- clarification or simplifying processes or wording.

6.56 The composition of the Council of Governors was reviewed as part of the review of the Constitution, and changes to the composition of the Council of Governors were approved at the September 2021 SFT Council of Governors meeting. These changes related to:

- an increase in the number of South Somerset seats from 4 to 8 (2 additional seats to ensure equal representation and 2 temporary seats)
- a new Dorset Public governor seat
- a reduction in the number of West Somerset and Taunton seats from 10 to 7 (to ensure equal representation).

These changes were implemented from 1 May 2022 to enable existing YDHFT members and Governors to stand as Governors on the SFT Council of Governors in advance of merger.

6.57 The revised SFT Constitution was approved by SFT's Council of Governors in December 2021 and SFT's Board in May 2022. The Constitution also went to YDHFT's Council of Governors in December 2021 and YDHFT's Board in May 2022 for information. The revised Constitution is provided as a supporting submission to this Case.

6.58 The Standing Financial Instructions and Scheme of Delegation for the merged Trust were approved by the two Boards in October 2022.

Governors

6.59 Currently SFT has 43 Governors, and YDHFT has 24 Governor posts. A YDHFT staff member and a YDHFT Public Governor have been elected to the SFT Council of Governors with effect from 1 May 2022. One SFT Public Governor has been elected as a YDHFT Public Governor from June 2022.

6.60 From Day 1 of the merged Trust, the YDHFT Council of Governors will cease to exist and in recognition of the increased number of people served by the merged Trust and its enlarged staff base, the number of Public Governors on the SFT Council of Governors has already been increased to 25 with effect from 1 May 2022. The number of staff Governors will increase from the date of the merger from 10 to 12. The two new staff governor seats plus the two existing staff Governor vacancies will be held for current YDHFT staff. A further six Staff Governor vacancies will become vacant from either 1 April or 1 May 2023 and these seats will be open to both SFT and YDHFT staff. The elections for these seats will take place after the merger. We will keep the size of the Council under review on an ongoing basis.

6.61 The statutory role of the Council of Governors is set out in the Constitution. Governors fulfil their role through close working with the Boards, for example, through joint meetings of the Board and Governors to agree Trust strategic objectives, an open invitation to attend Board Committee meetings, and Board member attendance at the Council of Governors' meetings and Development Days.

6.62 Both Trusts currently have Governor working groups and the aim will be to move to joint meetings from October 2022. At the Joint Governor Development Day in July 2022, governors from both Trusts agreed that the merged Trust will have four governor working groups: Quality and Patient Experience; Strategy and Planning; People; and Membership Engagement and Involvement.

Membership

6.63 As at August 2022 SFT had over 20,500 members across two constituencies (Public and Staff) and YDHFT had over 9,000 members across two constituencies (Public and Staff).[81] Members have the opportunity to contribute to the strategic direction of the Trust, stand as a Governor or elect Governors, and join focus groups as required. We have begun developing a membership strategy for the merged Trust.

6.64 The General Data Protection Regulation means it is not possible to transfer the YDHFT membership to the merged organisation on an opt-out basis. Instead, all YDHFT members have been sent a communication with follow up reminders about the need to sign up to the SFT membership database.

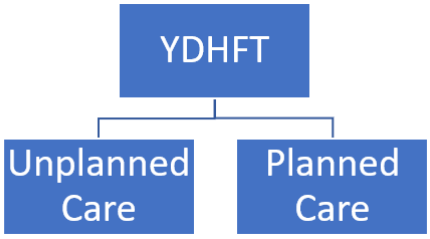
[81] SFT has 8,247 public members and 12,268 staff members, a total of 20,515.. YDHFT has 7,014 public members and 2,431 staff members, a total of 9,445.

Operating model

Current organisational structure

6.65 The current organisational structures at YDHFT and SFT are shown in **Figure 40** and **Figure 41** below.

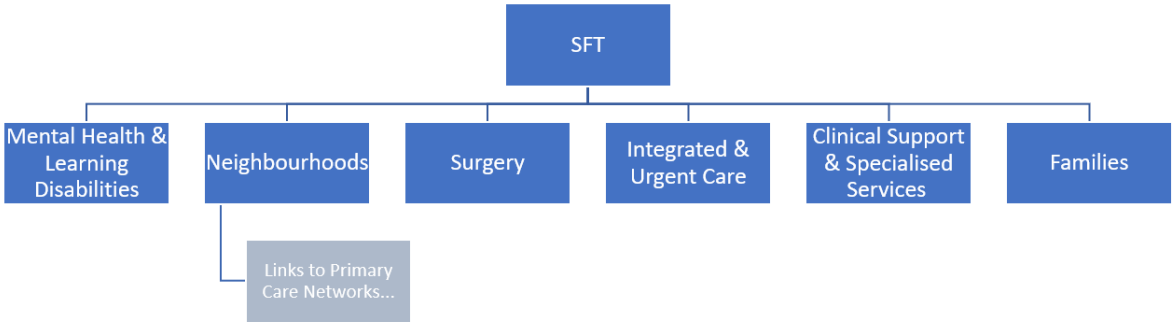
Figure 40: YDHFT current organisational structure



6.66 YDHFT's divisions are each led by a Deputy Director who reports to the Director of Operations. The Deputy Directors also liaise closely with the YDH Site Medical Director.

6.67 The YDH site is led by a triumvirate consisting of the Director of Operations, Site Medical Director and Deputy Chief Nurse.

Figure 41: SFT current organisational structure



6.68 SFT's current six directorates are led by a triumvirate team comprising the directorate Director (a manager or clinician), the Associate Medical/Clinical Director and the Associate Director of Patient Care (nurse or AHP). The triumvirate is responsible for patient safety and experience, people, operational performance, and budget management in their directorate. Each directorate has a single accountable officer but the triumvirate is expected to work as a senior team. Professional roles have a dotted line of accountability to their professional leads outside the directorate.

6.69 The MPH site is also led by a triumvirate consisting of a site director, site Medical Director and Deputy Chief Nurse.

Operating model for merged Trust

6.70 We have formulated a set of design principles to guide the development of our operating model, see **Figure 42**. These principles are aligned with the vision for the merged organisation, our clinical strategy and our desired culture.

Figure 42: Design principles for operating model

Our new clinical operating model must enable us to:

- Ensure patient care is at the heart of all we do
- Enable front line clinical leadership so that decision making is as close as possible to the point of care
- Support delivery of a culture of empowerment, in line with our organisational values and our desire to enable colleagues to be the best they can be in delivering care
- Enable digital transformation
- Minimise hierarchy
- Provide an environment for natural communities of healthcare professionals to come together to deliver services that meet patient needs
- Allow working across intra and inter organisational boundaries
- Deliver our clinical strategy – which is focused both on acute-to-acute integration and integration between community and mental health services, as well as reshaping our relationship with primary care
- Ensure clear arrangements for acute hospital site leadership

6.71 We have reviewed existing arrangements at the two Trusts with the aim of building on the best of both organisations. We have also looked at best practice from similar organisations and discussed operating models with other trusts including Barts Health, and Torbay and South Devon.

6.72 We have engaged with senior teams in both Trusts to gather colleague feedback, and this feedback emphasised the need for the model to:

- help us deliver our clinical strategy
- support vertical integration across pathways, and facilitate cross-boundary working, and
- create semi-autonomous business units with strong clinical leadership.

Requirements of the new operating model

6.73 The operating model of the merged Trust needs to support the provision of safe care, in line with our clinical strategy, and support cross-boundary working both between colleagues in different service groups,[82] and externally with PCNs and other system partners. It also needs to enable clear accountabilities, and support a distributed model of leadership across the large number of sites and wide geography that the Trust will cover.

[82] 'Service group' is our agreed new term for divisions or directorates.

Organisational structure

6.74 We want our service groups to operate as semi-autonomous business units, with clear accountability for delivery from ward to board, across a balanced score card of patient safety and experience, people, performance and finances. Service groups need to support a multi-professional approach to care delivery, and be 'right-sized' in terms of having sufficient critical mass but not being too large to manage effectively.

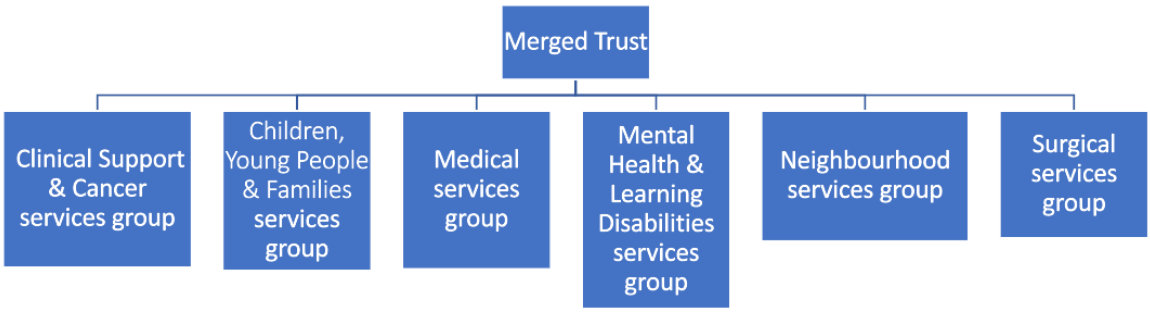
6.75 We considered three options for our organisational structure:

a) Retain separate site-based groupings (i.e. maintain the existing two divisions at YDHFT and six directorates at SFT, see Figures 40 and 41)
b) Organise ourselves around patient groups or geographies, for example grouping all services in South Somerset together, or around patient groups e.g. cancer care
c) Create an integrated model across the merged Trust (4-7 groups).

6.76 Feedback from discussions with senior teams at both Trusts indicated a strong preference for option c) as it will support delivery of our clinical strategy and facilitate integration between the acute sites, as well as between acute, community and mental health services. Option a) would miss many of the opportunities offered by our merger, e.g. to reduce silo working and duplication and take advantage of economies of scale. It was felt that option b) risked entrenching silo working and duplication. It was also felt to be the most complex option to implement.

6.77 We have agreed that the organisational structure for the merged Trust will consist of six Service Groups, as shown in **Figure 43**. The number of service groups and how services are clustered within a group was decided based on natural linkages or thematic cohesion (e.g. grouping ED and medical specialties together) and also consideration of the relative size of each potential group – seeking to ensure the groups are broadly consistent in size. We believe our proposed structure is the best way to arrange our services into groups of manageable size, while maintaining clear accountability.

Figure 43 Organisational structure for merged Trust



6.78 All service groups include a community element to promote vertical integration and ensure focus on the broadest span of patient pathways under our control.

6.79 Each service group will be supported by input from corporate services: finance, people, governance, estates, digital etc. using a combination of central support and business partner support embedded within each service group.

6.80 We will continue to use a triumvirate approach to the leadership of the service groups. Leadership will comprise a service group Director, Associate Medical Director and lead nurse/allied health professional. The triumvirate will be responsible for leadership of the service group and ensuring visibility and site presence, but ultimate accountability will sit with the service group Director. We will support service group triumvirates to define the sub-structures within their service groups.

6.81 The service group Director will line manage the Associate Medical Director and lead nurse/allied health professional of their service group, although professional lines of accountability will sit outside the service group. Each service group Director will be line managed by the relevant Chief Operating Officer.

6.82 Currently there are inconsistencies in the approach to senior clinical structures for nursing leadership between SFT and YDHFT. We will use the creation of service groups as an opportunity to strengthen clinical leadership at service group level and create more opportunities for nursing/AHP career progression.

Site management

6.83 Site management at the two acute sites (YDH & MPH) will be performed by a triumvirate consisting of a Site Director, Site Medical Director, and Site Nursing Director. The triumvirate team will oversee the safety and smooth running of each site day to day, and will be responsible for ensuring adequate flow and visible senior leadership at all times.

6.84 The two site directors will assume day to day leadership on behalf of the site triumvirate team and will be line manged by the Chief Operating Officer (Hospital services). Site Directors will work closely with service group Directors and other senior leaders across the service group structure.

6.85 The Site Medical Directors and Site Nursing Directors will be line managed within their own professional structures but will have a dotted line of responsibility to their Site Director.

Transition to new operating model

6.86 We plan to implement our new operating model from day 1 of the new organisation (1 April 2023). To prepare for the transition the Directors of the

new service groups took up designate posts as of 1 September 2022, to give them time to familiarise themselves with their new portfolio of services.

6.87 We are currently going through the process of mapping all of our existing services to one of these service groups. We expect to complete this work by the end of October 2022.

6.88 From 1 November 2022 the Directors of the Surgical and Medical services groups will manage key personnel across both acute sites which will bring surgery and medicine respectively under single operational leadership.

6.89 We are currently finalising the plan for full implementation of our service group structure. This plan is being developed in coordination with our new medical and nursing/AHP leadership arrangements to ensure triumvirates are in place in each service group.

6.90 Between now and Day 1, we will continue to communicate and engage with other stakeholders about the transition to the new organisational structure.

6.91 We have taken steps to ensure we have the capacity to manage integration alongside business as usual. These include:

- For a transitional two-year period the two largest hospital-facing service groups (Medical and Surgical service groups) will each have two Associate Medical Director posts to maintain stability of medical leadership and free up senior time to support integration alongside business as usual.
- We have strengthened some of our senior resource in advance of merger, for example in elective care and recovery to recognise the importance of this work. This capacity will be maintained post-merger.
- We have also strengthened capacity in senior medical and nursing leadership roles.
- We are maintaining two Chief Operating Officer roles, one focused on Acute services, the other focused on Mental Health, Community and Family services to drive both horizontal and vertical integration of services alongside business as usual.
- We will maintain our Clinical Integration Team to support ongoing clinical integration work across the new Trust.

Enabling the clinical strategy

6.92 Our service group structure enables the clinical strategy by supporting the integration of acute services (e.g. through the creation of medical and surgical service groups which bring the acute services on both sites together into a single service group). Our service group structure also supports the integration of community and acute services, since each service group contains a community element.

Registered Office

6.93 The merged Trust's registered office will be Yeovil District Hospital.

6.94 The merged Trust will provide care from more than 70 locations, as well as patients' homes. In addition, many colleagues now spend at least some of the week working from home. Although the merged Trust is required to have a registered office, there will be no single site where the Trust is headquartered.

6.95 The factors taken into account when selecting the location of the registered office were:

- continuous operated location
- symbolic perception for colleagues
- adjacency to a clinical site and proximity to colleagues
- ease of access
- practicalities and facilities (meeting space etc.)

6.96 Two potential registered office locations were considered: Yeovil District Hospital and Musgrove Park Hospital. Both these locations met the selection criteria, but bearing in mind the importance of symbolism for colleagues, the Boards concluded that Yeovil District Hospital was their preferred location.

6.97 Although YDH will be the registered office, Board and executive meetings will rotate around a range of locations operated by the merged Trust to ensure continued leadership visibility.

7. Enabling strategies and support functions

7.1 Effective, efficient support functions which enable the implementation of our clinical strategy are key to the success of our integration. This section summarises the integration of key enabling functions: Digital, Estates, Finance, Governance support etc.

7.2 Each support function workstream has developed its integration approach, identified integration projects and populated an integration plan. Details of these projects and the benefits expected to be realised are contained in the PTIP. The PTIP also describes key risks and interdependencies for each workstream.

7.3 Alongside the integration of support functions described below, we are continuing to explore with ICS partners options for system-wide integration of payroll, some estates functions and an integrated business intelligence function.

7.4 This chapter describes our current support services, their plans for integrating, and how they will support delivery of the clinical strategy.

Note on SSL

7.5 Simply Serve Limited (SSL) is a wholly owned subsidiary of YDHFT which provides estates, facilities management and other services to the YDHFT Group and other clients in the UK. Taking into consideration the overall balance of benefits, risks and costs, we have decided that SSL will continue to provide these services to YDHFT, and subsequently the merged Trust, for the foreseeable future. The estates and facilities management teams and the procurement teams of the two Trusts are already partnering closely with each other and, rather than fully integrating at this stage, they will continue to work closely together post-merger, reflecting the continuance of SSL.

People

Summary of current services

7.6 The two Trusts' People teams, comprising c.240 WTE colleagues, began formally coming together in May 2022 and are now fully integrated. The teams operate as a single integrated team across the two organisations and apply the same processes wherever possible. However, many of the systems they use are different. Once we are merged, and single systems and streamlined processes are in place, the People function will be better placed to support the needs of the merged organisation.

7.7 Our joint Cultural Board began meeting across the two Trusts in autumn 2022. Our staff side representatives, local negotiating committees and wellbeing steering group also started meeting jointly in autumn 2022.

7.8 SFT was selected as one of NHSE's pilot sites for the People Promise Exemplar Programme, and we agreed with NHSE to run the Programme across both Trusts to make consistent progress pre-merger. The programme's aim is to test the assumption that by providing a consistent focus on key areas of the NHS People Promise, there will be improved outcomes and overall experience for colleagues, which in turn improves retention rates. Participation in the programme offer benefits e.g. in terms of benchmarking our performance and access to support packages.

7.9 The four portfolios in our new HR structure have been designed with the likely future needs of the Somerset system in mind. The proposed portfolios are as follows:

- Transformation & Strategy: this incorporates People plans, the People Promise and the NHS 10-year strategy for HR & OD.[83]
- Workforce Planning & Supply: this covers local and international recruitment pipelines, temporary staffing, apprenticeships and workforce planning (including the impact of changing skill mix and new care models)
- Colleague experience: this includes wellbeing, retention, resilience, flexible working, as well as HR advisory support in the development of a 'just & learning' culture.
- Learning & career development: how we support colleagues to develop professionally so they want to stay and can see their career develop.

7.10 Prior to integration, YDHFT's HR team was relatively small and this limited its capacity to run wellbeing, leadership and organisational development programmes. Although the SFT People team was larger, it had insufficient capacity to meet the demands of multiple change programmes within the Trust and across the wider Somerset system. Integrating the two teams has created additional capacity and expertise without the need to recruit new staff.

7.11 Being one of the first teams to integrate has put the People team in a better position to support integration across the rest of the organisation, both in terms of team restructuring as well as supporting cultural change.

Due diligence

7.12 The People and organisational development due diligence exercise (reported to the boards in September 2022, following earlier reports in February and May 2022) identified the following Red risks:[84]

[83] NHS England » The future of NHS human resources and organisational development report

[84] We rated issues 'Red' if they were major and either need to be addressed pre-merger to ensure we deliver benefits as planned, and/or are an ongoing issue in the organisation/system which is being managed but unlikely to be fully addressed pre-merger.

- Vacancies and potential vacancies: Both Trusts have areas of high vacancies, particularly in medical, AHP and specialist nursing roles. There are national shortages for these roles making recruitment especially hard.
- Staff absence and turnover: Absence is higher than average at both Trusts, and in particular at SFT. The impact of Covid and operational pressures have impacted staff resilience.
- HR capacity: capacity within the team is limited due to vacancies and the additional workload associated with merger, especially around organisational change.

7.13 The mitigations for these risks are set out in the due diligence board updates which are provided as supporting submissions to this Case.

Vision for a single People service

7.14 Our vision for the integrated People team is to:

- create an environment where our people feel valued, engaged and have a sense of belonging within the new organisation.
- ensure the new Trust is the best place to work, where colleagues thrive, are truly empowered and can make decisions locally in a safe, open, honest and inclusive environment.
- deliver our People strategy, which exceeds the national and regional priorities of the NHS People Plan, People promise and the NHS HR and OD 2030 vision.

7.15 Further information about People and OD is given in chapter 6.

Digital

Summary of current services

7.16 The YDHFT IT team currently operates through SSL and comprises 26 colleagues (WTE), while digital change and information services are provided through the Trust with 33 colleagues. SFT's digital team has 180 colleagues (WTE). Both teams provide: IT technical services; project management of new developments; software and system development; application development, support and training, clinical coding, management reporting, business intelligence and digital clinical safety.

YDHFT

7.17 The YDHFT digital team is well established with experience of implementing major systems. The team has specialist advanced programming skills, web and mobile app development skills, and has developed highly automated reporting and information feeds to inform decision-making.

7.18 The team has also developed expertise in population health management through the Symphony Programme, highlighting ‘at-risk’ groups of patients and supporting the development of new care models through the use of data.

7.19 The YDHFT team is small compared to its user base, which constrains delivery and capacity for transformation. The small size of the Trust also limits its purchasing power, particularly for bespoke contracts.

SFT

7.20 SFT has been a Global Digital Exemplar (GDE) - an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information. It is one of the first trusts to complete the 4-year GDE programme. Being a GDE has aided SFT’s digital transformation and supported its pandemic response. The Trust developed the integrated clinical and technical leadership model, and published the national blueprint for the procurement and implementation of electronic prescribing.

7.21 The SFT digital team has a track record of successfully delivering at scale, and strength in working with clinicians to identify clinical needs and ensure successful adoption of new technology by clinical teams.

7.22 The SFT team’s resources are insufficient to meet the increased demand for digital services, given the complexity and size of the organisation, multiple care settings and the need for digital technologies and data to support care decisions.

Both Trusts

7.23 Neither Trust yet has a single electronic care record, and instead both use paper-based medical records, and telephone or letter-based booking systems which carry inherent patient safety and information governance risks. Furthermore, neither Trust’s systems are yet capable of integrating with medical and patient wearable devices which offer benefits such as remote monitoring, influencing patient behaviour and communicating with patients.

7.24 Both Trusts face recruitment and retention challenges given the competitive market for digital skills both within and outside the NHS and, in YDHFT’s case, the limited opportunities for career progression within the team.

Collaborative working to date

7.25 Our Digital teams have worked together since November 2021, and in May 2022 they agreed a joint digital programme of products and services to be rolled out.

7.26 Several digital posts are now shared between the two organisations. The two IT helpdesks now use the same software, and as policies, procedures and standards have come up for renewal, these have been reviewed and re-written jointly.

7.27 A joint strategic outline case for the development of digital capability and the move to an integrated electronic health record was approved by the two Trust Boards in November 2021.

Due diligence

7.28 The Digital due diligence exercise (reported to the boards in September 2022, following earlier reports in February and May 2022) identified the following Red risks:

- Delays in delivery of some elements of the digital programme due to insufficient resource.
- The risk that the user support functions are insufficiently staffed and experienced to meet current needs.

7.29 The mitigations to these risks are set out in the due diligence board updates which are provided as supporting submissions to this Case.

Vision for a single Digital service

7.30 Our vision is to provide digital services that are effective and highly interconnected, and which drive excellent support and care, communication, information, and improved efficiency. We will do this in the following ways:

- **Digitally empowered patients**: Connected digital services which support patients to make informed choices when accessing services; promoting patient self-management and well-being.
- **Digitally enabled colleagues**: Support colleagues with digital skills. All data accessible securely, to all colleagues who need it, system-wide, at all times. Current barriers broken down, better user experience, more efficient working, utilising pioneering systems, automation and advances in artificial Intelligence.
- **Intelligent systems enabling care**: Data-driven insights supporting real-time decision making; rapid system learning and change.
- Care without boundaries: Seamless working across health and care settings and sites, with care supported in neighbourhoods, closer to home.
- **Resilient, secure infrastructure**: Services underpinned by reliable, secure and scalable, fit-for-the-future technologies.
- Innovation: promote a culture of learning to transform and innovate care delivery.
- **Digital inclusion**: Work with system partners to support the people of Somerset to access care without barriers arising from a gap in skills, knowledge or access to technology.
- **Sustainability and performance**: Respond to the evolving needs of the organisation and wider health and care community, supporting both short-term situational resilience, tactical support and long-term goals.

7.31 We developed a new joint draft digital strategy in October 2022. This was clinically-led and will directly support the emerging clinical strategy. Under our strategy we aim to:

- Increase our capacity to generate population health management data to support informed interventions across the Somerset system.
- Develop our automation capability to support operational and clinical processes and improve productivity and quality.
- Invest in the development of digital skills across the merged Trust
- Ensure the interoperability of our systems using national open standards to enable a single view of the patient
- Invest in artificial intelligence to support quicker, more reliable clinical diagnosis
- Continue the drive to paperless solutions to realise efficiencies
- Roll out processes which enable patients to share personally collected data
- Jointly procure digital system replacements which support the creation of a unified electronic patient record and common use of SIDER.[85]
- Support transformation and clinical teams to understand their services' data and improve the merged Trust's performance on Model Hospital benchmarking.

7.32 The draft Digital strategy is provided as a supporting submission to this Case.

Summary of the integration approach

7.33 The Digital workstream has a key role to play in preparing for Day 1. The workstream is focused on ensuring the Trust has safe and functioning digital services on Day 1, such as unified e-mail accounts and underlying technical works. No mergers of core applications are planned prior to Day 1.

7.34 The teams have established a Joint Delivery Board and a Strategic Programme Board to oversee their joint work, which report through to sub-committees of the Trust Boards. Further detail about our Digital integration plans, including Day 1 projects is included in the PTIP.

Enabling the clinical strategy

7.35 The Digital service will support implementation of our clinical strategy through the following:

- **Population health**: using data to understand needs, target resources to reduce health inequalities and enable people to stay healthier.
- **Integrated, personalised care**: enabled by a shared health and care record to support integrated care.
- **Valuing people's time**: using artificial intelligence to enable quicker and more reliable diagnosis.
- **Supporting self-management**: enabling patients to have easy access to their health and care information.

[85] Somerset Integrated Digital Electronic Record

- **Efficiency**: deploying a self-serve booking system to increase responsiveness and control for patients. Implementing an enhanced integrated digital record to improve operational efficiency.
- **Continuous improvement**: using business analytics and intelligence to support the continuous improvement of our services.

7.36 Our Digital teams are working together with the Capital team to ensure our digital transformation aligns with our capital estates programmes.

Estates, Facilities & Capital development

Summary of current services

7.37 The SFT estates and facilities team comprises 462 colleagues (WTE) and provides soft facilities management services including cleaning, catering, housekeeping, portering, and car parking, as well as hard facilities management services: maintenance and minor works, fire, energy and utilities.

7.38 The YDHFT estates and facilities team comprises 201.8 colleagues (WTE) and provides the same services as SFT with the addition of sterile services and health and safety.[86]

7.39 The YDHFT and SFT Capital Development teams have 1 and 14 colleagues (WTE) respectively, providing planning, delivery and reporting on capital projects.

7.40 YDHFT's estates and capital development teams are employed by SSL.

YDHFT

7.41 The YDHFT estates and facilities team is experienced, with many team members being skilled in a variety of trades which offers flexibility in staff deployment. Independent indicators including cleanliness audits, patient feedback, and maintenance response times evidence a good quality of service.

7.42 The estimated value of backlog maintenance at YDH is £21.9 million[87] (2020/21). The key estates challenges at YDH include ageing infrastructure, an old ward model (large wards with 6-bedded bays, no co-located toilets and non-clinical office space on the wards), an under-sized emergency department, and insufficient theatre and diagnostic space to cope with Somerset's growing elective care demand. YDHFT has had no national capital investment in recent years and as a result only has a small capital team. This in turn has created difficulties in progressing large-scale capital plans.

[86] At SFT, sterile services are provided by the surgical directorate and Health & Safety is covered by the corporate governance team.
[87] Excluding 'on costs'.

SFT

7.43 The SFT team includes highly skilled staff from a range of disciplines, with deep knowledge of the Trust. The management team has experience across multiple care settings including acute, community, mental health and primary care. A new Computer Aided Facilities Management system was implemented in 2021 which enables longer term planning and a greater emphasis on preventative maintenance.

7.44 The value of SFT's total backlog maintenance is estimated at £59.3 million.[88] The main estates risk is the ageing infrastructure at MPH. Although investment has been secured to replace the old theatre and critical care facilities, there remains a considerable proportion of the estate which dates back to the 1940s. For example, the maternity, neonatal unit and children's department are in aged estate which is not fit for purpose, is undersized for the current capacity and does not meet modern clinical standards. There are a number of other facilities including ward areas, treatment facilities and screening areas which are also provided in buildings from c.1945 and which require replacement. Although the Musgrove2030 programme will significantly reduce the level of backlog maintenance on the site and address the historic capacity issues and resultant challenges around waiting times, the need for ongoing investment will remain.

7.45 There has been significant investment in SFT's community and mental health estate in the past 10-15 years, although some issues exist which require financial investment.

7.46 An additional ongoing challenge is the dispersed nature of the estate across the north and west of the county, making good response times and a cost effective service harder to achieve.

Both Trusts

7.47 Both teams risk losing critical technical estates skills and corporate knowledge as a result of a combination of local competition for skills from large infrastructure projects such as Hinkley Point C, and the fact that a significant proportion of the teams will reach retirement age within 5 years.

7.48 Both Trusts' Capital Development teams lack sufficient resource bearing in mind the demands placed on them, particularly relating to the 2030 building programmes[89] at each acute site (see paragraphs 2.33-2.35).

[88] Excluding 'on costs'.

[89] Musgrove2030 and YDH2030.

Due diligence

7.49 The Estates due diligence exercise (reported to the boards in September 2022, following earlier reports in February and May 2022) identified the following Red risk:

- the condition of the MPH site is poor with significant backlog maintenance required. This issue is being managed but will not be fully addressed pre-merger. Further information on steps to address this are provided in the Estates strategy.

7.50 YDHFT also has backlog maintenance but it was not rated as a Red risk for merger because the matters requiring attention can largely be addressed using existing capital.

7.51 The mitigations for the 'Red' risks are set out in the due diligence board updates which are provided as supporting submissions to this Case.

Our Vision for estates and facilities

7.52 Our vision for Estates and facilities is to maximise the integration of our Estates and Facilities services to support a safer, more compliant and more cost effective service, which is flexible and leads on innovation for the people of Somerset.

7.53 Our vision for Capital Development is to provide an effective capital development and project management service that leads, integrates and supports the long, medium and short term clinical strategy for the healthcare community of Somerset.

7.54 It is essential that our services are environmentally sustainable, and we aim to be a carbon neutral Trust by 2040. We will focus on the design and operation of our facilities over the next ten years to meet this target, as well as our interim aim to reduce our carbon footprint by 80% by 2030. Our Green Plan is provided as supporting submission to this Case.

7.55 Digital developments will help us reduce our carbon footprint and estates requirements. For example, the impact of remote working on commuting and on-site office space requirements, the potential to coalesce office space into hubs on both sites, and the role of virtual clinics all have the potential to decrease non-clinical space needs and travel associated with healthcare.

Summary of the integration approach

7.56 We have agreed the future operating model for estates delivery, facilities management and capital development across the merged Trust and this involves SFT estates and capital teams continuing to work closely with SSL colleagues as they do now.

7.57 We are developing a joint estates strategy which will reflect our new clinical strategy and our expectations of future demand. The draft Estates strategy is provided as a supporting submission to this Case. The first step is the development of a joint estates design vision which outlines our approach for the design of healthcare environments for the next ten years. Delivery of the strategy will be overseen by our Joint Strategic Estates Board.

7.58 For Capital Development, we established a Joint Capital Delivery group in April 2022 which reports into a single Strategic Estates group. This enables us to prioritise schemes together across the entire estate and take a more strategic view of future demands. We will prepare a single capital plan from April 2023.

Enabling the clinical strategy

7.59 We will use the combined estates of the merged Trust to aid the delivery of our clinical strategy by facilitating the provision of safe, effective, high quality clinical care, support wider work to prevent ill health, and enable care closer to the patient or service user's home.

7.60 The estate and environment in which we provide our services are much more than a place to house our services. The provision of therapeutic environments which are easily accessible and have access to outdoor space, is core to our clinical strategy and there is good evidence of their role in accelerating and supporting recovery.

7.61 We are developing our estates and digital strategies in close conjunction, because the way we use digital to deliver care now and in the future has a strong influence on our estates requirements.

7.62 Merger offers the opportunity to review how we best use our existing properties within the Trusts' combined portfolio. The Estates strategy will reflect the future model of care whilst also addressing short term issues such as critical infrastructure renewal. The agreed principles which underpin our joint Estates Strategy are:

- Ensuring the health estate supports the delivery of safe, effective, high quality care in the most appropriate setting, and enhances health and wellbeing.
- Ensuring that the health estate promotes colleague wellbeing and productivity.
- Ensuring the current health estate is fully and effectively utilised, and reducing estate where it is not required or not cost effective to maintain.
- Ensuring that current health estate is fit for purpose.
- Reducing the running costs of the health estate to enable better use of resources.

Finance

Summary of current services

7.63 The YDHFT finance team comprises 25 colleagues (WTE) delivering: management accounting and business support; costing and income services; contracting; financial services; financial accounting and support; and support for cost improvement programme (CIP) delivery. SFT's finance team has 78.6 colleagues (WTE) providing the same services as the YDHFT team as well as providing payroll, counter fraud and financial support for strategic capital projects for both Trusts.

YDHFT

7.64 The YDHFT Finance team is relatively small and members work flexibly across different finance functions. A third of the team are qualified accountants.[90] The team has embedded Service Line Reporting (SLR) in the Trust, which supports the Getting It Right First Time programme. It also makes good use of Patient Level Information Costing System (PLICS) information.

7.65 Yeovil's relatively remote location makes recruiting to permanent roles challenging, and key positions in the Financial Services team are currently filled by temporary staff.

SFT

7.66 17% of the SFT Finance team (excluding payroll) are qualified accountants. The team has developed its finance and procurement system to support the Trust and has significant in-house expertise in the system which will facilitate and de-risk the migration to one system at the point of merger.

Both Trusts

7.67 Both teams benchmark below the peer group average for costs. Both teams are also very reliant on a small number of key individuals who have the organisational knowledge, skills and experience to ensure the team functions well.

Collaborative working to date

7.68 We have started to align policies and procedures and a single set of Standing Financial Instructions has been agreed in preparation for Day 1. We have supported each other to address resilience and staffing gaps, such as appointing a joint role supporting strategic capital oversight and delivery.

7.69 Our two Finance Committees have been meeting in common since February 2022 which has resulted in improved financial reporting. We have also created

[90] Qualified with a member of the Consultative Committee of Accountancy Bodies.

a single capital envelope and prioritisation process, to ensure a common standard of assets is experienced by patients and staff in the future.

7.70 Our teams have been using the same ledger system since April 2022 which reduces the risk associated with combining our ledgers from Day 1. We have jointly procured our internal and external auditors who will be retained post merger.

7.71 We moved YDHFT's payroll to SFT in October 2021 and will further streamline it once we are merged. We have also recently implemented a common expenses system for colleagues across both Trusts.

Due diligence

7.72 The Finance due diligence exercise (reported to the boards in September 2022, following earlier reports in February and May 2022) identified the following Red risks:

- Work is ongoing to understand the underlying financial position of each organisation, but we know a significant residual underlying system deficit exists.
- The 2022/23 CIP requirement will be challenging for both Trusts to deliver because of continuing pressure on services.

7.73 The mitigations to these Red risks are set out in the due diligence board updates which are provided as supporting submissions to this Case.

The Vision for a single Service

7.74 Our vision for the single Finance service is to:

- Deliver a high performing integrated finance function providing excellent support to the new organisation;
- Ensure best value for money and the most efficient use of resources in the provision of patient care across the whole pathway; and
- Create a team where colleagues feel valued and enabled to provide the best service they can whilst developing their skills.

Enabling the clinical strategy

7.75 To support the clinical strategy, money needs to follow the patient. Budgets and financial structures ought not to be the cause of breaks in pathways of care, or incentivise decision-making that is counter to the interests of patients. Across the health system in Somerset we are striving to work collectively to manage the Somerset pound and make investment and disinvestment decisions that are focused on our clinical strategy ambitions. By working closely together our aim is to deliver more efficient services and pathways by eliminating costs rather than moving the costs between the different sectors. A

benefit of the merger is the removal of the need for contracts or service level agreements between the two Trusts and the associated administrative and managerial costs.

Procurement

Summary of current services

7.76 The 15.4 colleagues (WTE) in the YDHFT procurement team are employed by SSL. The SFT team comprises 40.1 colleagues (WTE). Both teams carry out tendering, sourcing and contract management. They also provide procurement advice and guidance across their Trust and support stock management and replenishment. Both teams conduct spend analysis and benchmarking, and increasingly they are balancing this with supply chain resilience.

YDHFT

7.77 The experienced YDHFT team has low staff turnover but it is very reliant on a small number of individuals. The breadth of expertise required in procurement has become more evident during the pandemic with heightened expectations in relation to Personal Protective Equipment for example. However, retaining such a diverse range of expertise is not possible within such a small team.

SFT

7.78 The SFT procurement team has specialist knowledge across a wide range of portfolio areas but faces capacity pressures. Alongside business as usual activities, the SFT team has a full programme of change to deliver relating to the merger between SPFT and TSFT in 2020. This is expected to deliver significant benefits through standardisation and rationalisation of goods and services but has not progressed fully due to Covid pressures.

Both Trusts

7.79 Both teams face common challenges in the external environment:

- Adopting new Public Contract Regulations, expected during 2023, following the UK's withdrawal from the European Union.
- Implementing new procurement guidance from NHSE as part of the ICS Procurement national programme.
- Inflationary and supply chain challenges in the global economy mean the procurement teams increasingly need to consider continuity of supply and resilience as well as value for money.

Collaborative working to date

7.80 The two Procurement teams have started a contract review, initially focusing on areas of highest priority and urgency. In June 2022 we commenced a joint project to merge our product catalogues as part of phase 2 of Integra, our

purchase to pay system. We have also established a monthly joint procurement meeting to monitor progress against our joint procurement programme and ensure best use of our collective resources.

The Vision for the joint service

7.81 Our vision is to deliver an efficient, resilient service across the merged Trust which:

- supports internal stakeholders in delivering the new clinical strategy;
- ensures products and services are available when and where required;
- delivers excellent value for money;
- creates an environment where colleagues feel valued and are empowered to provide the best service they can whilst developing their skills.

Summary of the integration approach

7.82 The YDHFT team will remain part of SSL, separate from the SFT team for the foreseeable future. However, our teams will work more closely together, conducting procurement activities on behalf of the whole merged Trust and thus reducing duplication of effort and boosting resilience across both teams.

Enabling the clinical strategy

7.83 The clinical strategy is reliant upon the supply of high quality products and services with a system that minimises administrative time. The need to proactively manage risk to ensure delivery continues to be critical. By working together, our teams will provide a proactive service, efficiently procuring across the whole organisation and freeing up resource to work alongside clinical colleagues to respond to future challenges and opportunities.

Clinical Governance support

7.84 The YDHFT clinical governance team and the SFT governance support team provide clinical governance services including: incident reporting and management; risk management; monitoring and assurance; and audit and analysis to support excellent clinical care.

7.85 Both teams have a good range of knowledge and skills, including significant clinical experience, across all areas of governance.

7.86 Both teams are in the bottom two quartiles when benchmarked for resources against other organisations and this presents potential resilience issues, with multiple single points of failure where there is only one subject matter expert.

7.87 Significant changes in the regulatory environment need to be implemented during 2023 relating to key governance elements including incident reporting and investigation. This will place an additional challenge upon already very busy teams.

Vision for a single Service

7.88 Our vision is to create an environment in which excellence in clinical care will flourish, with continuous improvement in the quality of our services and safeguarding the highest standards of care.

7.89 The merger will enable us to create a single governance team that supports and catalyses the quality improvement that the clinical strategy seeks to achieve. We are developing a new single team structure which we will share with our teams for consultation, with a view to implementing it fully by January 2023.

7.90 We have aligned our respective risk registers and have been reporting on clinical quality to a joint Board Level Quality meeting since May 2022 using a common protocol. Further detail on the approach to risk management in the merged Trust is set out in Annex 6.

Corporate Governance support

7.91 The YDHFT and SFT corporate governance teams cover: corporate compliance; the Board Assurance Framework; management of the Council of Governors and it working groups; management of the Trust Board and its committees; oversight of the YDHFT subsidiaries; FT membership and the Trust constitution.

7.92 SFT was rated ‘Good’ for the ‘Well-Led’ category in the most recent published CQC report (2020). YDHFT was rated ‘Requires Improvement’ for Well-led category at the most recent full CQC inspection in 2019, although this was linked to the Trust’s financial performance. Both Trusts received ‘Substantial Assurance’ for governance processes through their respective internal audits.

7.93 We aligned our risk management processes and the Board Assurance Framework in April 2022. Our Trust Board and Board sub-committees (Finance; Quality and Governance; Workforce/People) have been meeting in common in preparation for the merger since early 2022, and the audit committees have been meeting in common since July 2022. Three joint NEDs have been appointed.

7.94 We have also integrated the teams which cover data protection, Freedom of Information, information governance and medical records across the Trusts.

Vision for a single service

7.95 Our integration vision is to create a Corporate Governance Support function that will provide:

- training and guidance to managers and operational staff to undertake their own responsibilities for good corporate governance and the tools to do it;
- an effective framework for good corporate governance to help ensure compliance against the standards within that framework; and
- a single approach to the management of corporate risk that enables the Board and Council of Governors to effectively fulfil their duties.

Improvement and Transformation

Summary of current services

YDHFT

7.96 The YDHFT Transformation team comprises 7 colleagues (WTE) and has core capability in Quality Improvement (QI) methodology and project management. The team has supported improvements in relation to the Model Hospital exemplar and the national 'Getting It Right First Time' (GIRFT) programme. The team also has experience of new models of care through its work with the Symphony programme.

SFT

7.97 The SFT Improvement team has 30 WTE colleagues and provides a range of support to colleagues covering all aspects of change, from deconstructing initial problems, through to trials, measurement, project delivery and spread. The team works with all parts of the organisation, both clinical and non-clinical to spread QI methodology. Team members have experience of merging with another organisation in 2020 and this learning will be used again for this current merger.

Both Trusts

7.98 Demand for support from the teams frequently exceeds the capacity available, and operational pressures mean priorities can change at short notice. The combination of these factors can prevent effective use of the teams to support lasting improvements.

Collaborative working to date

7.99 The teams have had a common QI training delivery and methodology approach since 2017, and the signal of merger has prompted the following additional steps:

- We have now integrated our teams and brought them under single leadership.
- In 2021, we jointly procured PowerHub, a programme management tool which allows a single view of all programmes and projects, benefits, timelines and dependencies. PowerHub is used by all Somerset system partners. Our use of PowerHub has also supported the adoption of a common project management approach across the two Trusts.
- We have baselined all projects across secondary care to assess which can be brought together to exchange best practice and deliver more benefits, sooner. A key example is the GIRFT elective recovery programme – working with clinicians across both organisations to deliver high volume / low complexity procedures more productively.
- Together with Somerset County Council we have created a Collaboration Hub for the ICS. This uses a single source of data to drive population health management and support improvement activities aligned to system priorities.

Vision for a single service

7.100 The vision for the combined Improvement team is to:

- foster a culture of continuous improvement across the merged Trust;
- promote an evidence-based methodology and set of tools tested and developed with those that will be using them; and
- generate a capability to implement changes, based on robust evidence, which delivers sustainable benefits for the population of Somerset.

Enabling the clinical strategy

7.101 An effective Improvement team is a vital enabler to the implementation of our clinical strategy. We have already evidenced the benefit of combining our teams to focus on common challenges such as the GIRFT elective recovery programme. Building the QI capability within our clinical services will enable colleagues to deliver change at scale, making use of the talent and expertise of colleagues throughout the new organisation.

Communications and engagement

7.102 YDHFT and SFT's communications teams both provide a wide range of internal and external communications services. Both teams are experienced and have good relationships with partners and local and regional media. However, each Trust's spend on corporate services, including their communications teams, benchmarks low compared to other trusts. Combining the two communications teams into one will increase resilience, avoid

duplication and enable the team to do more than the two separate teams could do alone.

7.103 The teams have held joint team meetings since late 2021 to respond jointly to media queries, and plan communications content across both Trusts. A review of policies is ongoing, and the teams have already aligned some working practices.

7.104 We appointed a single Director of Communications in September 2022 and our new communication team structure is in development. The teams are currently planning for Day 1, including effective internal communications that supports all colleagues to feel part of the new merged Trust, the development of a single website with a new and distinct visual identity within the NHS brand, and external and stakeholder communication.

The Vision for a single Communications function

7.105 Our aim is to provide a communications function that contributes to the success and development of the new merged Trust and the Somerset ICS. The vision of the integrated communications service is therefore to:

- Effectively tell the story of the merged Trust's work.
- Build effective relationships with all audiences to enable the merged Trust to achieve its mission, vision, aims and objectives.
- Effectively tell the story of the Trust's work within the health and care system in Somerset, supporting the ICS to improve the health of the population of Somerset.
- Engage our staff and empower them to be active members of our Trust.
- Engage our population and patients enabling them to access services safely and appropriately.

Enabling the clinical strategy

7.106 The communications team for the merged Trust will support the implementation of the clinical strategy by:

- building relationships with key stakeholders, communicating and engaging effectively with colleagues and stakeholders to support the merged Trust to achieve its objectives
- positioning the merged Trust effectively with stakeholders within the ICS
- raising the profile of the new Trust and helping to set the tone for a collaborative and positive culture, contributing to improved recruitment and retention
- engaging effectively with patients, families and patient representatives, enabling the telling of their stories
- celebrating the merged Trust's work, reflecting our progress, celebrating success, and telling stories about people for people.

7.107 Further information about our communications work is provided in chapter 11.

Commercial

7.108 The SFT Commercial team covers: contract management including PFI; overseas patient income; marketing; and commercial and business development. YDHFT does not have a dedicated commercial function at present. The lack of a dedicated commercial resource at YDHFT hinders opportunities for further income growth, and SFT's private patient income is hampered by a lack of theatre capacity and bed availability.

7.109 Both Trusts have well-established commercial income streams including:

- a private patients service at both Trusts
- Somerset Cancer Registry owned by SFT which attracts c. £2 million a year
- income to YDHFT from third parties, including other trusts, for:
  - overseas recruitment (see Figure 50)
  - estates and infrastructure services provided by Yeovil Estates Partnership
  - support services provided by SSL.

Due diligence

7.110 The subsidiaries due diligence exercise (reported to the boards in September 2022, following earlier reports in February and May 2022) identified the following Red risks:

- achievability of financial projections for the next three years for Symphony
- high vacancy rate in Symphony, especially for GPs
- staff resilience and wellbeing in Symphony due to prolonged high demand for services.

7.111 The mitigations for the 'Red' risks are set out in the due diligence board updates which are provided as supporting submissions to this Case.

7.112 Merger will help us maximise commercial and income generating opportunities across the new organisation and reinvest the income in frontline services. We appointed a joint Director of Commercial Development in July 2022, and as a result, we have already been able to collaborate on a number of successful funding applications. We have also shared learning between the Trusts to strengthen contract management.

Charities

7.113 Our vision is to bring the two Trusts' charitable funds together to build on the success of the two charities, building the supporter base to make a difference

across our services, whilst maintaining the identity of our locations and communities which form a mainstay of our support.

7.114 We have adopted a 'linked charities' approach for the legal structure of the charities post-merger, with a 'parent brand' and two 'child brands' for the two acute hospitals to help retain loyal local donors. We will have a single team in place led by a Head of Fundraising, focusing on strategic planning and stakeholder management.

8. Benefits

8.1 This chapter sets out the expected non-financial benefits of the proposed merger. The clinical benefits are summarised here and set out in more detail in the **Patient Benefits Case** which accompanies this Business Case. The financial benefits of our merger are set out in chapter 9.

Patient Benefits

8.2 **Figure 44** below summarises the key changes arising from the clinical strategy (set out in chapter 5) and the benefits for patients that we expect to flow from those changes. The benefits are presented in line with our commitment to value patients' and colleagues' time. More detail on the expected patient benefits and how merger aids their realisation is provided in the **Patient Benefits case**.

8.3 The benefits derive from bringing together our clinical services into single teams and the changes that enables such as single waiting lists, improved access to specialist care, streamlined county-wide pathways and a shared electronic patient record. The benefits also derive from our clinical strategy, such as earlier intervention and care closer to home, which merger helps us deliver.

8.4 We know from the merger of SPFT and TSFT that bringing colleagues together into one organisation supports integrated care by creating a culture in which colleagues seek out each others' expertise and find ways to innovative across pathways and services to improve patient care.

Figure 44: Patient benefits (summary)

Change	Benefit	
	More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**
Intervening earlier to tackle illness	• Healthcare conditions less likely to escalate to crisis or emergency • Period of illness is less acute and recovery is quicker • Improved health trajectory	• In some cases, shorter length of stay as illness is less acute when treatment starts •
Improved access to specialist care	• Quicker access to specialist care leading to improved health outcomes	• Less patient time waiting for specialist care while in pain or feeling anxious. • In some cases, shorter length of stay from quicker initial access to care
Standardised protocols, and streamlined pathways based on best practice	• Quicker access to diagnosis and treatment - right care at right time in the right place • Equity of care across the county from consistent approach • Improved access to holistic care which meets both physical and mental health needs • Reduced safety risk from clinical mistakes due to multiple pathways • Easier to integrate with the work of partners (primary care, social care, voluntary sector)	• Eliminates wasteful steps in pathways, including duplicate investigations or steps that do not add clinical value • Single set of protocols is easier for colleagues to work with, and supports continuity of care • Smoother transfer between acute, community and mental health settings when all are run by the same Trust • Improved patient and carer experience from pathways which are easier to understand and navigate • Colleague time freed up for front line care
Single county-wide waiting lists	• All patients in county seen in order of clinical priority • Patients may have the choice to be seen more quickly, at a more distant location when waiting times are visible	• Makes effective use of spare diagnostic and treatment capacity wherever it exists in the county which reduces patient waits
Combined teams	• Better health outcomes as colleagues see wider range of clinical cases, share knowledge and best practice across the enlarged team and unwarranted variation is reduced • Greater colleague capacity to implement transformational changes which benefit patients • County-wide clinics (facilitated by a combined team) support equity of care across the county	• Less patient time waiting for care as a result of fewer short-term staffing gaps (staff better able to cover colleagues' absence) • Planning, delivering, and reporting on national requirements only needs to be done once rather than twice
More care closer to home	• Lower patient anxiety and stress from reduced travel which aids recovery	• Greater use of community settings increases patient choice and reduces patient travel time (more convenient & less costly for patients) • Reduces carer travel time for outpatient appointments and for inpatient visiting • Acute resources freed up to care for other patients

Change	Benefit	
	More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**
A single electronic patient record	• Clinicians have ready access to patients' full clinical history which increases patient safety and good clinical outcomes irrespective of setting • Lower clinical risk from human error when sharing/re-keying patient information • Supports the operation of integrated care pathways and county-wider waiting lists • Aids creation of data sets which enable analysis of population health and drive insight into health inequalities • Facilitates the collation of data and the conduct of clinical audits which drive learning and improved patient care	• Supports clinicians to provide care more efficiently • Patients' care information will be shared between systems eliminating the need for patients to re-state basic facts • Reduces staff time spent re-keying information and/or checking a range of clinical systems to get full patient history, thereby freeing up time to care for other patients

Colleague benefits

8.5 The significant workforce challenges faced by both Trusts are set out in Figure 7, and as a single organisation we will be able to improve our recruitment and retention offer. The prospect of merger and integrated services has already had a positive effect e.g. through the recruitment of a substantive oncology consultant to fill a long-standing vacancy. We are currently using a joint YDHFT/SFT consultant group to lead the recruitment of 6 intensivists for YDH's Intensive Care Unit. This model has proved successful in the past, as the consultants use their networks to actively engage with potential candidates and support them through the application process. By creating a larger organisation, merger also means we are able to offer candidates greater flexibility in terms of job planning and accommodating family members.

8.6 **Figure 45** illustrates some of the career benefits for staff who are already employed by one of the two Trusts.

Figure 45: Colleague story, Miriam Wilson

Colleague story, Miriam Wilson, Occupational Therapy (OT) Professional and Service Lead, YDHFT
"In Occupational Therapy we are really keen to look at rotations between services and departments but currently they are difficult to set up due to the need for honorary contracts, financial recharges and mandatory training requirements, and we lose colleagues due to missed opportunities. The merger will enable us to grow and develop these rotation and experiential posts, so colleagues have the opportunity to have different experiences and explore career choices

across acute, community and mental health settings without the need for multiple job applications. This greater understanding of services and pathways and wider knowledge and experience will mean a better experience for our patients through a more robust service, more timely referrals with the person being seen in the right place by the right person, and reduced duplication."

8.7 The benefits for colleagues across the new organisation that we expect to arise from merger are set out in **Figure 46** below.

Figure 46: Colleague benefits

Benefit	How merger helps
Improved colleague satisfaction from: • more varied and engaging career opportunities e.g. rotational posts in a range of clinical settings • increased opportunities for career progression, including moving between care settings, related disciplines or into specialist roles without needing to change employer. • colleagues working at top of their licence more of the time • enhanced training offer which supports professional development • a richer research environment to build professional knowledge and profile • developing skills and confidence in caring for people in different cohorts, e.g. people with mental health issues in acute settings, or physical health issues in mental health settings • A culture which empowers people to innovate and be the best they can be	• Enables rotational posts and cross-site working possible without honorary contracts / information governance concerns • Creates larger teams with a wider variety of roles, across a range of settings • Enables in-house training courses to be run more frequently & makes better use of limited training resources • Makes it economic to invest in developing new capabilities in-house rather than buy them in under contract • Combines our R&D teams and creates larger patient cohort for research • Facilitates the use of innovative roles to fill staffing gaps
Improved colleague wellbeing and motivation from: • More resilient teams, with less time spent firefighting, and staff better able to cover colleagues' absence and respond to surges in demand. • Fewer staff gaps from improved recruitment and retention • Reduced time spent on administration associated with honorary contracts enabling colleagues to access systems and data at the other Trust.	• Enables full integration of services and pooling of team resources • Larger teams increases opportunities for flexible working • Consistent IT systems across all settings increases team efficiency • Removes need for honorary contracts to support cross-site working • Enables changes which improve our recruitment & retention (see above)

8.8 We expect our enhanced staff offer (as set out above) will help improve our recruitment and retention rates and thereby reduce our reliance on agency and locum staff, see **Figure 47**.

Figure 47: Colleague story - Julia Devine, lead Orthoptist, SFT

Colleague story - Julia Devine, lead Orthoptist, SFT
"The SFT Orthoptist team is 9-strong (6.6 WTE) and we work in a wider multi-disciplinary team alongside consultant Ophthalmologists, opticians, specialist nurses and others. There are only 2 Orthoptists at YDHFT (0.9 WTE) and to provide cover across the week they work on different days from each other, which leads to professional isolation. These differences mean that between the SFT and YDHFT teams there are inequities around professional leadership and opportunities to work with a wider group of specialist colleagues. In May 2022, the Outpatient Sister for ophthalmology at YDHFT approached me to talk about the planned merger and bringing our teams together. Since then, we've had lots of conversations, and as teams we've agreed that coming together in November 2022, ahead of the merger is the right thing for patients, and us as Orthoptists. We are looking to provide cross-county cover by both teams, enabling sharing of experience. Integrating our teams means we can provide equitable care across the county, and operate smoother, more efficient patient pathways. For example, an early improvement we want to make is in the management of children with complex eye problems who require a multi-disciplinary approach to their care. Currently, if a child with complex eye problems presents at YDH they are seen by the YDHFT orthoptics team but when the child is referred to the county-wide paediatric ophthalmology MDT based at MPH, many of the initial assessments are repeated as the process, equipment, and staff are different. Once we are a single team these children will have the assessments done only once, meaning fewer appointments and quicker treatment. Initially we've been working to understand each other's services, clinic commitments and roles. This has been an eye opener for some of the SFT team - understanding the benefit of having colleagues working alongside you to chat through eye measurements and asking what they think about complex cases, which our YDHFT colleagues currently don't have. Being a single team will enable sharing of skills, standardisation of equipment, policies and procedures, and all orthoptists will have the opportunity to work alongside consultants across multiple specialist fields enabling a wider skill base. I was fearful about the distances for some of the MPH team to reach YDH, but staff are happy as we've worked to mitigate issues such as car parking and moving clinics to mid-week to avoid weekend traffic. Keeping hold of experienced staff has definitely been a big driver behind the merging of the teams. We had a real risk of losing some really good, experienced people and bringing our teams together has helped us keep those staff.

Benefits to the Trust and wider Somerset system

8.9 In addition to financial benefits (set out in chapter 9), we expect merger to offer benefits to the Trust and wider Somerset system as set out in **Figure 48**.

Figure 48: Benefits to Trust and wider Somerset system

Benefit	How merger helps
Performance Better able to: • respond to rising demand within our existing resources	• facilitates single set of streamlined pathways, operating consistently across the county.

• tackle inequities across the county • redirect resources to where they are needed most	• combines our elective capacity and helps us assemble and manage the dedicated and flexible workforce necessary for elective recovery • single legal entity makes it easier to redirect resources up or down a pathway or into new services
People • Improved recruitment & retention • Increased colleague job satisfaction • Improved colleague wellbeing • Aids succession planning within teams	***See also colleague benefits table above*** • enables us to offer more attractive posts with greater opportunities for flexible working • creates larger teams with broader options for succession planning
Partnerships • Easier for partners to engage with us • Better placed to work with partners to implement new care models which are more responsive, and less bureaucratic & costly • Reduced pressure on primary care • Reduced pressure on social care	• Easier for partners to engage with single entity rather than several • Streamlined referral processes which remove some steps for GPs • More specialist advice & guidance to GPs • MDTs build skills in managing complex long-term conditions e.g. Diabetes • Intervening earlier maintains patient function and reduces social care need
System • Reduces the number of legal entities in the ICS and makes ongoing development of our ICS governance simpler than it would otherwise be. • Improved data to drive better decision-making • Better able to implement population health management and tackle health inequalities • Improved capacity to attract resources into Somerset • Facilitates the use of our combined colleague, estates, digital and improvement resources in pursuit of ICS aims. • Creates further opportunities to align functions and services across Somerset's health and care landscape	• As a single entity data will be created on consistent basis • Creates a single NHS trust provider for Somerset which supports population health management • Creates a larger entity better resourced to bid for national funding and carry risk e.g. pump priming investment into new services
County • Environmental benefits from fewer journeys made leading to a lower Somerset carbon footprint. • Benefits to the local economy from people taking less time off work to attend appointments or support family members to attend appointments.	• Enables us to make better use of SFT's community hospitals, especially in the east of the county • Facilitates implementation of our plan to provide more care closer to home.

Potential disbenefits

8.10 There are already many specialist services that are provided in specific locations in Somerset (e.g. radiotherapy, specialist cardiology services etc). Although our clinical strategy is to deliver services as close to the population as possible, some specialist services or those with a small workforce may over time be delivered from fewer locations in order to maintain safety and ensure the highest level of quality. In these instances increased travel for some patients may result. This reflects the tension we face in our large, rural county between providing care close to home and also maintaining sustainable specialist services. We will ensure that, where possible, appropriate parts of our patient pathways are undertaken locally or through virtual appointments, for example local access to diagnostics and follow-up appointments.

8.11 Related to this is the potential for increased travel time on the part of our colleagues. We are alert to these concerns and any proposed changes to working practices will be subject to the appropriate consultation processes.

Benefits of integrating non-clinical services

8.12 The remainder of this chapter sets out the specific benefits which will be realised in individual corporate services.

People and Organisational Development

8.13 Our integrated People team is now one of the largest People teams of any industry in the south west, and as a significant employer in Somerset providing training and career development and supporting a significant amount of volunteering we will play a strong role in the social and economic development of the county (see **Figure 49**).

Figure 49: Somerset Training Academy for health and social care

The two Trusts are partnering with Somerset County Council and private/voluntary sector providers in a bid to regenerate two vacant buildings in Bridgwater and Minehead and re-purpose them to provide training and other support to health and social care workers.

The former community hospital in Bridgwater town centre is a dilapidated Grade II listed building currently at risk of decay. Under the plan it will be refurbished to provide space for training 2,500 health and care trainees a year. The site will include specialist space for simulation training, an NHS resource centre and an independent living centre. It will also provide trainee and key worker accommodation (to overcome entry and affordability barriers to new health and care employees), and creche facilities for those attending training.

An additional satellite academy will be established in the Seahorse Centre at Minehead which will provide training rooms, an independent living centre, and flexible co-working space.

These developments will help develop the skills of our local health and care workforce, and contribute to our drive to attract and retain staff in Somerset. This programme will also bring buildings back into community use, and help to re-energise and contribute to the economic development of these local communities. The proposed merger means the Trusts are represented by one team and have a stronger, single voice in programme development than they would if we participated as separate Trusts.

8.14 In addition to the general improvements to recruitment, retention and colleague wellbeing outlined above, we also expect merger to offer the following People benefits:

- Building on the success of YDHFT's international recruitment programme (see **Figure 50**), merger will help us increase the number of staff we recruit and the number of other trusts we can assist through the programme, whilst also ensuring it remains profitable.
- creating a Somerset-wide staff bank which will help us increase fill rate and contribute to reduced agency spend.
- enabling delivery of our Leadership and OD ambition to offer a range of coaching, mentoring, work-shadowing and other support to leaders including a programme to embed our new values and behaviours, and the learning from the Messenger leadership review.
- improving the recruitment process across the whole of the new Trust to improve on YDHFT's current performance of 16 days from interview to 'clearance to start', thereby reducing the attrition currently experienced during the recruitment process. This improvement from the 52 days currently experienced at SFT will help to reduce the vacancy rates at both YDHFT and SFT (see Figure 7).
- introducing a single induction process, and using a single set of policies and procedures, reducing the costs of delivering induction and providing induction closer to where people work, reducing travel time.
- creating new specialist roles such as workforce planner which will be increasingly important as we respond to demographic changes both in terms of workforce and demand for our services.
- improved Electronic Staff Record (ESR) data quality from bringing together the individuals who lead on ESR at each Trust, This has already created additional capacity to improve data quality, which in turn has supported better workforce planning.

Figure 50: Overseas recruitment team

YDHFT has developed an innovative overseas recruitment programme which has enabled it to support 30 other trusts across England and Scotland, and place over 2,500 nurses and 100 radiographers in the last 4 years. YDHFT is a centre for recruitment in the south of England and has pledged to deliver a proportion of the 50,000 additional nurses required by the NHS.

The impact of the overseas recruitment programme means that YDHFT generally has very few ward-based nursing vacancies and is also actively recruiting in our specialist areas of Theatres, Emergency Department and ICU. The programme has also helped fill 48 nurse, 1 Midwife, 2 mammographers and 4 radiographer vacancies at SFT.

The programme now has 11 recruitment channels including:

- Adult nurses
- Children's nurses
- Mental health nurses
- Midwives
- Operating Department Practitioners
- Occupational Therapists
- Physiotherapists
- Mammographers
- Radiographers
- Domiciliary care workers
- Laboratory Technicians

Merger would provide a larger pool of clinical staff to undertake interviews and would add credibility to the Mental Health element of the programme. As a bigger team we would also be able to recruit more staff via the programme and use our expertise to support specialist recruitment into our community services which remains a difficult area. We will also have increased capacity to support other Trusts around the country.

Digital

8.15 We expect to realise the following benefits through the creation of a single Digital service:

- By bringing together the diverse skills and experience from the existing teams, we will be able to create an integrated clinical and digital leadership team which is better able to serve the needs of the merged Trust and the wider system through the improved use of digital technology and data, business intelligence and app development.
- Our ability to attract national funding will be increased due to the wider range of services the merged Trust will provide, for example as a test bed for integrated care.
- Operating at greater scale will enable us to reduce our costs. For example, implementation of a single EPR will be more cost-effective by procuring and implementing it once across the new Trust. We will also be able to procure specialist licences at lower cost given our increased size, and reduce the total number of third party support contracts, and the total training required.
- We will be able to reduce duplication in the areas of: systems maintenance; support and licences; national reporting; supporting our new core system; and the scale of our data centres and server rooms which frees up capacity for other work.
- Improved resilience of our systems through the sharing of infrastructure.

Estates and facilities management

8.16 We expect to realise the following benefits through the creation of a single Estates and Facilities management function:

- Merger will enable us to share expertise and resources (whilst maintaining the integrity of SSL) and provide a consistent level of service across all sites in the new Trust. Combining our teams also enables us to provide consistent cover across our wide geography which makes it easier to achieve our desired response times and quality standards.
- We intend to standardise major capital equipment across the new organisation. This will reduce lifecycle costs by having fewer asset types across the new Trust. Where possible, within the constraints of the legal

arrangements with SSL, we will run combined procurements which will yield cost savings and enable procurements to be completed more quickly.

- SSL currently maintains SFT's community and mental health estate and provides medical electronics services to SFT under a service level agreement. Merger enables us to eliminate the significant work involved in managing and reporting under this agreement.

Capital programmes

8.17 We expect to realise the following benefits through the creation of a single Capital Programmes function:

- Merger enables the adoption of a county-wide (rather than Trust level) view for the planning and prioritisation of capital schemes. We will be able to develop a high quality county-wide ICS estates strategy with our ICS partners and a strategic portfolio of works which will strengthen Somerset's chances of securing future capital allocations.
- We will be able to use each hospital to support the other in ways not done previously. For example, we could increase orthopaedic capacity on the YDH site to support county-wide recovery, where previously this would not have been justified by the local position in south Somerset.
- We will develop a common standard for estates, which will reduce variation in the provision of infrastructure in different settings.
- A single procurement approach will remove the existing risk where our two Trusts compete for the same limited supply market. Where external suppliers are required, a common database of tried and tested suppliers will be used across the Trust and SSL ensuring our knowledge of suppliers is shared effectively.
- The merger will enable the combined Capital team, working closely with SSL, to use our collective expertise to manage capital schemes better. It will enable us to create specialist knowledge for different care settings ranging from GP practices to hi-tech solutions in specialist care. As a combined team we can reduce our dependence on external support and combine our training to reduce training costs. The combined team will also have increased capacity to respond to new service requirements.

Finance

8.18 We expect to realise the following benefits through the creation of a single finance function:

- a better service to colleagues: improved financial reporting to support decision making, and improved SLR and PLICS offer which helps teams deliver better value from their services.
- pooling our resources will enable us to conduct long-term planning including workforce and activity modelling which will feed into an integrated activity, workforce and finance plan.

Procurement

8.19 We expect to realise the following benefits through the creation of a joint procurement function serving the merged Trust:

- Combining our teams will enable us to establish category managers who develop expertise in particular procurement types e.g. IT, infrastructure and soft facilities management, to drive better value. We will also be able to improve our contract management using a similar approach, where team members develop specialist sector knowledge and can better hold suppliers to account for service quality.
- Merger will make it easier to implement Atticus as the single stock management system across the new Trust. This will enable us to reduce stock holdings and reduce the waste associated with expired or obsolete products. The Atticus rollout will also improve user experience, support faster deliveries and reduce administrative time for clinical teams.
- Merger will give us greater purchasing power to secure better supplier prices. We will conduct a full review of contracts and product selection in 2023, enabling us to drive more standardisation of products, rationalise products and identify additional savings opportunities.
- Merger will give us increased capacity to undertake risk management. The pandemic, inflation, war in Ukraine, sanctions, Brexit and a stall in economic growth have all increased uncertainty in global supply chains, and proactively identifying the new Trust's exposure to these risks is increasingly important.

Clinical governance

8.20 Bringing together our clinical governance teams will yield the following benefits:

- Increased capacity and resilience from pooling our expertise and resources across the range of governance topics including: claims management; inquests; learning from deaths; risk management: and health and safety. This will help ensure equity of access and support to clinical teams across the new Trust.
- We will be able to support teams to develop better and more joined up systems of governance right along patient pathways.
- We will be able to establish a robust and resilient response to the Patient Safety Incident Reporting Framework to promote organisation and system-wide learning from all forms of adverse events (see also Annex 6).

Corporate governance

8.21 Bringing together our corporate governance teams will yield the following benefits:

- increased capacity and resilience from removing duplication - only having to support a single Trust Board, with a single set of minutes and a single Board Assurance Framework
- a single risk register will ensure investment decisions are informed by knowledge of where risk lies across all our sites in the county.

- sharing our resources to increase FT membership and engagement.

Improvement

8.22 We expect to realise the following benefits from our single Improvement team:

- Our training in QI methodology is already aligned, and we are using the same content and approach in both Trusts. This has enabled us to improve colleague access to training (delivered through both virtual and face to face means) and offer a greater range of training with the same resource. We have now trained 2,000 colleagues in QI methodology. By having a single methodology across the organisation, supported by a single PMO tool, we will be able to train 1,000 colleagues a year. This will help us realise our vision of having 80% of colleagues trained in QI which will empower and equip them to make changes to improve quality and productivity. QI knowledge also improves staff satisfaction by creating a greater sense of ownership and giving staff more control over their work environments.
- Pooling our improvement and transformation resource will enable us to accelerate improvement and the delivery of benefits at system level via the Collaboration hub (see paragraph 5.62).
- Our single approach to project management and QI will streamline our reporting processes, enabling us to provide better quality, timely management information to those responsible for achieving the improvement. It will also allow us to promote networks between people working on similar problems and awareness of other projects throughout the organisation
- Merger will increase our team capacity and resilience by deploying improvement team members to support single Trust-wide projects (rather than two similar projects, one in each Trust). This will enable us to support more change programmes concurrently and enable continuity for assignments both for the individual and respective projects.

Communications and engagement

8.23 We expect to realise the following benefits through the creation of a merged communications function which works closely with People services and the patient engagement function:

- The ability to staff a 24/7 rota which will provide communications support at unexpected times of crisis.
- more consistent communications to colleagues, patients, the public, partners across Somerset, and simplified engagement for our stakeholders. Particularly at a time of transition in the ICS, fewer points of contact will make it simpler for our stakeholders to engage with our new organisation.
- Removing duplication on tasks including: handling media enquiries; website and intranet development and maintenance; briefings; setting of and adhering to policies and procedures; and stakeholder engagement.
- Delivering the 10 principles of people and community engagement in line with national and statutory guidelines.

Commercial

8.24 Merging the Trusts will enable us to create a single Commercial team to identify and deliver opportunities that attract income which we can reinvest in to providing high quality care. Merger will:

- make us more attractive to clinicians who want to provide private practice alongside their NHS workload, thereby improving our clinical recruitment and retention.
- enable us to take a joined up approach to maximising private patient income across the county, including increasing overseas patient revenue
- enable us to widen the use of the Prime Estates Partnership, e.g. by supporting the development of the Community Diagnostics Centre in East Somerset
- help us support Symphony to develop the primary care practices we run.

8.25 Full details of the benefits for each workstream (including smaller workstreams not detailed here) are provided in the Integration Charters which are appended to the PTIP. The PTIP also provides further detail on our approach to benefits realisation, including governance around realisation of both clinical and non-clinical benefits.

9. Finance

9.1 This chapter sets out the financial performance of SFT and YDHFT as single entities, the expected costs and savings from the merger and the forecast performance of the merged Trust compared to the counterfactual. The finance case explores the historic financial positions of the two Trusts and the Somerset system, including the impact of the financial regime that was put in place during the Covid pandemic. The global pandemic has had a significant impact on both Trusts, increasing the underlying deficits and resulting in a demanding operational environment in which it has become harder to deliver recurrent cash releasing savings. Our financial case therefore sets out the synergies that can be delivered in corporate functions as well as the expected strengthened ability to deliver higher levels of recurrent savings through merging.

9.2 The financial model of the proposed merger sits in the context of the overall system recovery strategy which is challenging and will extend over a period of up to five years. The model presented in this Case is based on a level of cost improvement programme (CIP) the Trusts believe can be delivered through normal business as usual productivity and efficiency processes. We are forecasting that the merged Trust does not deliver any additional CIP compared with the counterfactual but that there is a significant increase in the level of recurrent delivery. This will be one component of the Somerset finance strategy, which will be to ensure that the system's underlying deficit does not deteriorate and that together with our partners we start to reduce it over the next five years.

Historical performance and ICS context

Somerset ICS position

9.3 The 2022/23 Somerset combined system plan is to breakeven, however there is a significant underlying system deficit. The underlying deficit has continued to deteriorate as a result of failure to deliver recurring CIP, the recurrent impact of associated Covid expenditure as well as other required investments/unavoidable cost pressures which have been required to address quality, safety and capacity issues.

9.4 Without transformational change to the way health and care services are provided, the deficit position of the system and of individual provider and commissioner partners will continue to deteriorate and the scale of the financial challenge will increase. Tackling the system deficit will require action by the whole Somerset system. Although this merger will help improve the system position it will not, on its own, eradicate the deficit.

9.5 The Somerset system works collectively to manage the financial position, and decisions focus on reducing cost and increasing efficient use of resources, rather than moving the deficit between commissioners and providers. There is a single financial framework in place which has been developed by the Somerset Directors of Finance group.

SFT historical performance

9.6 SFT was formed on 1 April 2020 when Somerset Partnership NHS Foundation Trust (SPFT) and Taunton and Somerset NHS Foundation Trust (TSFT) merged. The recent historical performance of SFT and its legacy Trusts is presented in **Figure 52** below.

9.7 As shown in **Figure 52,** in 2019/20 SPFT had a small surplus of £0.8 million before revaluations and Provider Sustainability Funding (PSF), whilst TSFT had a deficit of £17.4 million before revaluations and PSF. It is difficult to compare the financial performance of the Trust since its creation on 1 April 2020 as the Covid pandemic interrupted business as usual for the duration of 2020/21 and continued throughout 2021/22. As a result of the pandemic, interim financial frameworks were put in place which saw normal commissioning processes and business rules suspended and replaced with a process whereby providers were reimbursed for costs incurred. The changing NHS landscape in 2019/20 and 2020/21 (prior to the Covid pandemic) resulted in a more challenging financial environment for the Trusts within the financial constraints of the Somerset system.

9.8 SFT achieved a break-even position in 2020/21 and in 2021/22 delivered a surplus of £1.9 million. Although the Trust's financial performance was stabilised through the Covid financial framework, it also delayed progress in addressing the underlying affordability of the high level of service demand within the system.

9.9 Whilst a breakeven position is forecast for 2022/23 the Trust has an underlying financial deficit which is driven by a number of factors including diseconomies of scale due to size and rurality, PFI financing costs[91] and an older estate which is more costly to run and maintain. The increasing percentage of CIP delivered non-recurrently is also having a negative impact on the underlying financial position.

[91] The Private Finance Initiative (PFI) financing costs relate The Beacon Centre, SFT's specialist cancer centre in Taunton.

Figure 52: SFT historical performance – Statement of Combined Income & Expenditure

	SPFT 2019/20 £m	TSFT 2019/20 £m	SFT 2020/21 £m	SFT 2021/22 £m	2022/23 Plan £m
Income					
Clinical	175.4	313.9	521.5	596.7	600.9
Other	11.3	54.9	89.5	70.5	34.7
Expenditure					
Pay	(133.7)	(228.5)	(409.7)	(447.8)	(435.9)
Non-pay	(47.4)	(139.9)	(207.8)	(221.9)	(190.2)
Operating surplus/(deficit)	**5.6**	**0.4**	**(6.5)**	**(2.5)**	**9.5**
Gain / (loss) on disposal of fixed assets	0.0	0.0	(0.6)	(0.2)	0.2
Net finance costs	0.2	(1.8)	(1.7)	(1.7)	(1.8)
PDC dividend	(2.5)	(3.6)	(5.7)	(7.1)	(7.5)
Share of profit/(loss) of JVs	0.0	0.2	0.0	0.8	0.0
Gains from transfer by absorption	0.0	0.0	132.5	0.0	0.0
Surplus/(Deficit) for the year	**3.3**	**(4.8)**	**118.0**	**(10.7)**	**0.4**
Impairment reversal	(0.2)	5.8	15.4	12.6	0.0
Less Gain from transfer by absorption	0.0	0.0	(132.5)	0.0	0.0
Technical adjustments	(0.1)	(0.9)	(0.9)	0.0	(0.2)
Less PSF	(2.2)	(18.2)	0.0	0.0	0.0
Adjusted Surplus / (Deficit)	**0.8**	**(18.1)**	**0.0**	**1.9**	**0.2**
Adjusted Plan (before PSF/Other adjustments)	0.5	(17.9)	(14.7)	0.0	0.2
Variance to plan Fav / (Adv)	**0.3**	**(0.2)**	**14.7**	**1.9**	**0.0**

9.10 SFT's balance sheet position improved from 1 April 2020 due to reforms to the NHS cash regime whereby Department of Health and Social Care (DHSC) interim revenue and capital loans in place at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow repayment, see **Figure 53**.

Figure 53 : SFT historical performance – Statement of Financial Position

SFT - SOFP	As at 1/4/20 £m	As at 31/3/21 £m	As at 31/3/22 £m	Forecast outturn 31/3/23 £m
Non-current assets	286.4	308.8	347.9	398.1
Cash	32.6	75.4	58.7	38.7
Current assets	40.2	30.2	26.9	26.4
Current liabilities	(90.3)	(105.0)	(95.3)	(90.4)
Assets less current liabilities	**268.9**	**309.4**	**338.2**	**372.8**
Non-current liabilities	(29.0)	(30.6)	(28.2)	(46.9)
Total assets employed	**239.9**	**278.7**	**310.0**	**325.9**
Financed by				
PDC	127.1	176.7	212.6	236.4
Revaluation reserve	65.6	69.2	77.6	77.6
Other reserves	0.0	0.0	(2.3)	(2.3)
Income & expenditure reserve	47.3	32.8	22.1	14.2
Total taxpayer's equity	**239.9**	**278.7**	**310.0**	**325.9**

YDHFT historical performance

9.11 The historical and current performance for the YDHFT Group is set out in **Figure 54** below. This position includes the Trust's wholly owned subsidiaries. YDHFT has three key wholly owned subsidiary companies.

- Simply Serve Limited (SSL) commenced operations in February 2018 and provides estates and facilities management and other support services to the Trust and other clients. Its purpose is to enhance the quality and cost effectiveness of services it provides, improve the recruitment and retention of key staff groups, and generate third party income. SSL has a strong financial position and contributes a surplus to the YDHFT Group position.

- Symphony Healthcare Services Limited (Symphony) provides primary care general practice services across 16 practices at 20 sites.[92] It was initially funded through the national Vanguard programme but is now funded through the primary care funding held by Somerset ICB. Symphony contributes to the Somerset system by improving primary care efficiency and productivity, delivering turnaround of challenged practices, and implementing new approaches which reduce demand on secondary care. For 2022/23, Symphony is receiving additional funding from the ICB, resulting in a breakeven plan.

[92] As at April 2022.

- In addition, YDHFT has a third wholly owned subsidiary, Yeovil Property Operating Company Limited, which has minimal transactions. We expect to wind up Yeovil Property Operating Company Limited in advance of the merger.

9.12 NHSE published a Use of Resources inspection of YDHFT in May 2019. The Trust was rated Inadequate for using its resources productively. Following this inspection, the Trust underwent an externally facilitated Financial Governance Review commissioned by NHSE which looked at the Trust's understanding of its financial position and the fitness of its arrangements to deliver continuous improvement. The Trust created three action and delivery plans in response to the recommendations of the Financial Governance Review. These were:

- **2019/20 financial recovery plan** The actions in this plan were completed in 2019/20.
- **Financial governance and control improvement plan** Despite the challenges of Covid all actions have now been completed.
- **4-year financial recovery and sustainability plan to 2023/24** This has been superseded in its original form by the development of the merger and ICS proposals.

9.13 As shown in **Figure 54,** YDHFT had a deficit of £19.3 million in 2019/20 before revaluations and PSF. In 2020/21 the Trust was in receipt of reimbursement and top-up funding due to the financial framework that was put in place for the pandemic which ensured all Trusts delivered breakeven positions.

9.14 For 2021/22, the financial regime was broadly similar to that of 2020/21 and provided block contract income for the majority of Trust services. The Trust delivered a small surplus of £0.3 million. Although NHS Trusts' financial positions were de-risked during the pandemic, the huge operational disruption it caused also delayed progress in addressing the underlying affordability of the high level of service demand within the system.

9.15 Whilst a breakeven position is forecast for 2022/23 the Trust has an underlying financial deficit which is driven by a number of factors including diseconomies of scale due to size and rurality and the underlying deficit position of Symphony as set out in paragraph 9.11. The increasing percentage of CIP delivered non-recurrently is also having a negative impact on the underlying financial position.

Figure 54: YDHFT historical performance – Statement of Combined Income & Expenditure

	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 Plan £m
Income				
Clinical	152.4	175.5	209.0	219.7
Other	42.4	46.0	30.3	33.1
Expenditure				
Pay	(121.9)	(140.7)	(156.0)	(158.1)
Non-pay	(71.5)	(76.9)	(81.0)	(79.3)
Operating surplus/(deficit)	**1.5**	**3.9**	**2.3**	**15.4**
Gain / (loss) on disposal of fixed assets	(0.1)	(0.1)	(0.4)	(0.1)
Net finance costs	(1.5)	(0.1)	(0.3)	(0.78)
PDC dividend	0.0	(1.3)	(1.8)	(2.1)
Corporation tax	0.0	(0.4)	0.0	(0.6)
Surplus/(Deficit) for the year	**(0.1)**	**2.0**	**(0.2)**	**11.8**
Impairment reversal	0.1	0.0	0.1	0.0
Technical adjustments	0.0	(2.0)	0.4	(11.8)
Less PSF	(19.3)	0.0	0.0	0.0
Adjusted Surplus / (Deficit)	**(19.3)**	**0.0**	**0.3**	**0.0**
Adjusted Plan (before PSF/Other adjustments)	**(19.3)**	**(0.5)**	**0.0**	**0.0**
Variance to plan Fav / (Adv)	**0.0**	**0.5**	**0.3**	**0.0**

9.16 YDHFT's balance sheet position improved from 1 April 2020 due to reforms to the NHS cash regime whereby DHSC interim revenue and capital loans in place at 31 March 2020 were extinguished and replaced with the issue of PDC to allow repayment, see **Figure 55**.

Figure 55: YDHFT historical performance – Statement of Financial Position

YDHFT – SOFP	As at	As at	As at	Forecast

	31/3/20 £m	31/3/21 £m	31/3/22 £m	outturn 31/3/23 £m
Non-current assets	70.2	77.5	85.1	166.2
Cash	0.0	24.7	28.5	17.8
Current assets	31.7	19.7	17.2	17.2
Current liabilities	(115.4)	(39.5)	(41.2)	(39.5)
Assets less current liabilities	**(13.5)**	**82.4**	**89.6**	**161.7**
Non-current liabilities	(3.6)	(3.8)	(6.3)	(62.0)
Total assets employed	**(17.1)**	**78.6**	**83.3**	**99.7**
Financed by				
PDC	44.6	138.3	143.3	150.8
Revaluation reserve	13.4	13.4	13.3	13.3
Income & expenditure reserve	(75.1)	(73.1)	(73.3)	(64.4)
Total taxpayer's equity	**(17.1)**	**78.6**	**83.3**	**99.7**

Historic CIP Performance

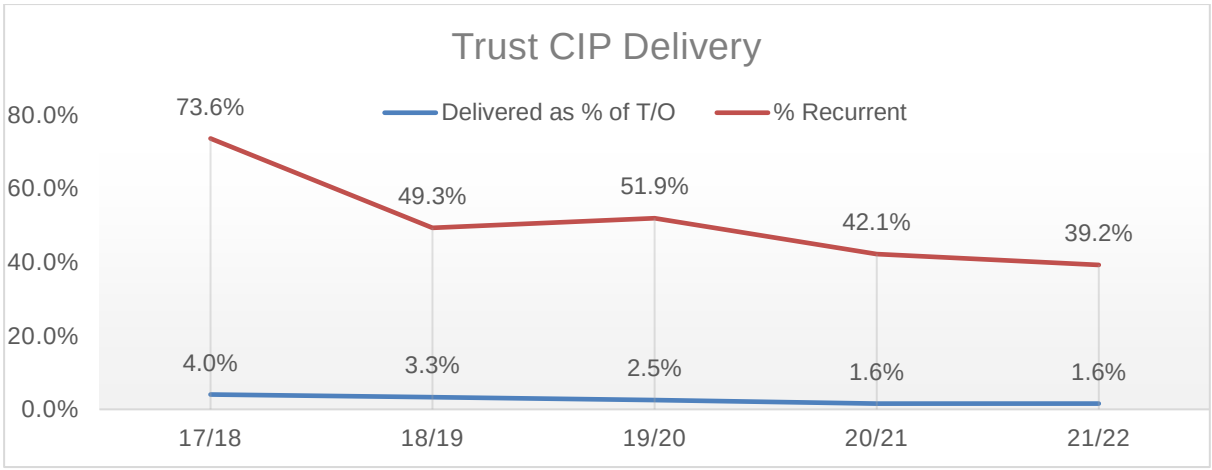
9.17 CIP has largely been based on a tariff model which set an annual efficiency factor into the level of commissioning income received. In addition, both Trusts and the system have set additional savings requirements to fund shortfalls in order to achieve balanced financial plans.

9.18 For both Trusts the delivery of recurrent CIP has reduced over time and was particularly challenging during the pandemic. Economies of scale have been difficult to achieve due to scale, and post-Covid operational pressures mean delivery of CIP continues to be challenging, see **Figures 56** and **57**.

Figure 56: Historical CIP delivery by Trust

	17/18		18/19		19/20		20/21		21/22	
	Total £m	**% of T/O**	**Total £m**	**% of T/O**	**Total £m**	**% of T/O**	**Total £m**	**% of T/O**	**Total £m**	**% of T/O**
SPFT	4.2	2.5%	5.9	3.4%	4.1	2.3%				
TSFT	13.2	4.4%	10.1	3.2%	9.0	2.6%				
SFT	17.4	3.7%	16	3.3%	13.1	2.5%	9.4	1.7%	9.9	1.7%
YDHFT	7.2	4.9%	6.1	3.6%	5.2	2.7%	2.7	1.3%	3.1	1.3%
Total	**24.6**	**4.0%**	**22.1**	**3.3%**	**18.3**	**2.5%**	**12.1**	**1.6%**	**13.00**	**1.6%**

Figure 57: Historical CIP delivery (combined across both Trusts)

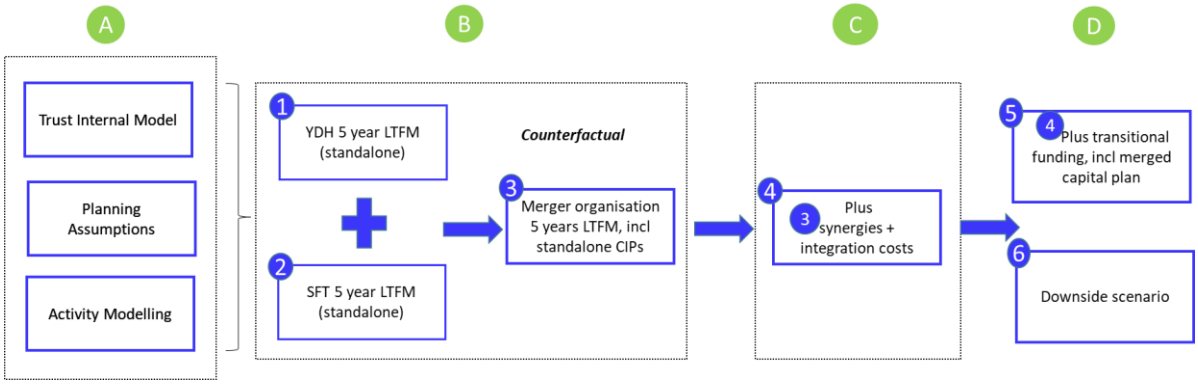


Populating the Finance Template

9.19 The financial information has been input into the model template using supporting data that compares the two Trusts' forecast standalone positions without merger, with the forecast financial position for the merged Trust.

9.20 The detailed template is provided as a supporting submission to this Business Case. We have generated the financial model through the following steps as set out in **Figure 58**.

Figure 58: Steps to generate the financial model



9.21 The historical data in the template comes from the audited financial statements of each Trust. 2022/23 figures are based on each Trust's operating plans which have been approved by the Trusts' Boards and were submitted to NHSE in June 2022. The key assumptions we have applied are detailed below.

Common planning assumptions across both Trusts stand-alone models

Inflation assumptions

9.22 Due to the lack of national guidance on future years' pay and price inflation, the Trusts have taken the decision to use the 2022/23 tariff uplift (less the additional uplift to fund the additional impact of the pay award in 2022/23) as the basis for future years, see **Figure 59**.

9.23 This approach recognises that there is a level of sustained pay and price growth but that pay inflation will reduce in future years. The tariff efficiency element applied to income is part of the cost reduction target applied to contract income from commissioners.

9.24 The financial modelling does not include any impact of potential future years cost increases over and above the pay and price inflation (e.g. CNST premium[93] and pension increases) on the basis there is insufficient detail available at the current time to make a reliable assessment and that the impact of any such costs would be the same in the counterfactual and merged cases.

Figure 59: Inflation assumptions used in the LTFM

	2023/24	2024/25	2025/26	2026/27	2027/28
Pay	3.0%	3.0%	3.0%	3.0%	3.0%
Drugs	0.9%	0.9%	0.9%	0.9%	0.9%
Capital	5.3%	5.3%	5.3%	5.3%	5.3%
CNST	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
Other	5.3%	5.3%	5.3%	5.3%	5.3%
Income	2.4%	2.4%	2.4%	2.4%	2.4%

Demand growth

9.25 Demand growth modelling has been based on the previous Somerset Long Term Plan assumptions. This is before the impact of any Commissioner QIPP[94] and growth rates have been applied to plan 2022/23 activity levels. A common set of assumptions have been used for both standalone Trusts, see **Figure 60**.

[93] CNST: Clinical negligence scheme for Trusts

[94] QIPP: Quality, innovation, productivity and prevention

Figure 60: Growth assumptions

	2023/24	2024/25	2025/26	2026/27	2027/28
Elective admission (ordinary admissions)	3.76%	3.76%	3.76%	3.76%	3.76%
Elective admission (day cases)	3.92%	3.92%	3.92%	3.92%	3.92%
Non-elective admissions (zero length of stay)	13.34%	13.34%	13.34%	13.34%	13.34%
Non-elective admissions (length of stay 1 day and greater)	-0.96%	-0.96%	-0.96%	-0.96%	-0.96%
First outpatient income	5.27%	5.27%	5.27%	5.27%	5.27%
Follow up Outpatient income	2.82%	2.82%	2.82%	2.82%	2.82%
A&E income	7.86%	7.86%	7.86%	7.86%	7.86%
High cost drugs income from commissioners (excluding pass-through costs)	5.00%	5.00%	5.00%	5.00%	5.00%
Other NHS clinical income	5.00%	5.00%	5.00%	5.00%	5.00%
Mental health services	5.00%	5.00%	5.00%	5.00%	5.00%
Community services	5.00%	5.00%	5.00%	5.00%	5.00%
Other	5.00%	5.00%	5.00%	5.00%	5.00%

9.26 Although the growth rates align to the ICS assumptions this does not constitute a contractual settlement with the ICB and therefore this level of modelled income growth cannot be guaranteed. The overall growth required will need to be agreed at ICS level and will be dependent on future ICB allocations and also any change to the future finance regime. Any affordability gap would need to be negotiated at ICS level.

9.27 Equal and opposite cost assumptions have been made against income growth to demonstrate that capacity will be required to manage demand, see **Figure 61**.

9.28 However, this then represents an opportunity for productivity benefits by delivering growth within the existing cost base as part of on-going productivity and efficiency. This therefore provides a route to cash for productivity benefits and will be a key factor in reducing the underlying system deficit.

Figure 61: Cost growth assumptions

	2023/24	2024/25	2025/26	2026/27	2027/28
SFT	5.98%	6.08%	6.19%	6.30%	6.41%
YDHFT	4.10%	4.19%	4.29%	4.38%	4.48%

Cost Improvement Programme (CIP)

9.29 In the standalone financial model, given the current level of operational pressure and backlog waiting lists we have assumed that the maximum cost reduction that can be achieved in a standalone environment by each Trust is 1.6% per annum. This is based on the minimum level of tariff efficiency of 1.1% and an additional 0.5% for those providers who are not in recurrent financial balance, see **Figure 62**. Of this, and based on recent performance, it is assumed that only 50% of annual delivery is achieved recurrently.

9.30 We believe that as a merged organisation the synergies of coming together will enable an increase in the recurrent delivery of 25%, therefore increasing recurrent delivery to 75% annually. Overall financial delivery is not modelled to increase in the merged organisation.

Figure 62 : CIP assumptions

	2023/24	2024/25	2025/26	2026/27	2027/28
Efficiency in tariff	1.10%	1.10%	1.10%	1.10%	1.10%
Additional efficiency requirement	0.50%	0.50%	0.50%	0.50%	0.50%
Total	**1.60%**	**1.60%**	**1.60%**	**1.60%**	**1.60%**

Forecast financial performance standalone organisations

9.31 As part of the assessment of the transaction, a Long Term Financial Model (LTFM) for each organisation has been prepared based on a set of common assumptions in lieu of any formal guidance at this point in time.

9.32 The impact of Covid is now largely embedded within organisational plans. Covid has had a significant impact on the recent financial performance of both Trusts and will continue to have an impact on future years due to:

- Changes to the recurrent cost base through changed ways of working and responding to Covid measures
- The impact on capacity and productivity due to social distancing and increased cleaning regimes
- An increased waiting list and backlog due to cancellation of elective surgery
- Surges in urgent demand post-Covid
- Uncertainty over the future funding regime

9.33 The ongoing recovery of elective performance has been excluded from all models. It has been assumed that the ongoing and any future cost of delivering elective recovery will be funded through additional earned income as is the case currently.

SFT standalone

9.34 On the basis of the assumptions set out above, SFT's standalone position (i.e. without merger) is set out in **Figure 63**, alongside the bridge in **Figure 64**. It

shows that the SFT financial position is forecast to worsen over the period. This deterioration is driven primarily by the level of non-recurrent CIP.

Figure 63: SFT forecast standalone position – Statement of Combined Income and Expenditure

SFT	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
	£m	£m	£m	£m	£m	£m
Income						
Clinical	600.9	639.5	685.3	734.8	788.0	845.5
Other	34.5	35.43	36.2	37.0	37.9	38.8
	635.4	**674.9**	**721.5**	**771.8**	**825.9**	**884.32**
Expenditure						
Pay	(435.9)	(461.7)	(493.2)	(527.2)	(564.0)	(603.9)
Non-pay	(190.2)	(204.3)	(220.4)	(238.1)	(257.5)	(279.09)
	(626.1)	**(666.0)**	**(713.6)**	**(765.3)**	**(821.5)**	**(882.9)**
Finance costs	(9.1)	(9.6)	(10.1)	(10.6)	(11.2)	(11.8)
Surplus/(Deficit)	**0.2**	**(0.7)**	**(2.2)**	**(4.1)**	**(6.8)**	**(10.4)**

Figure 64: Counterfactual SFT standalone forecast – bridge from 2022/23 to 2027/28

SFT	2022/23	Income growth/ marginal cost (Net)	ICB income reduction (Growth inc = costs)	CIP	N/R CIP	Impact of infl/tariff	2027/28
	£m	£m	£m	£m	£m	£m	£m
Income							
Clinical	**600.9**	211.5	(59.8)			92.9	**845.5**
Other	**34.5**	-	-			4.3	**38.8**
	635.4	211.5	(59.8)	-	-	97.1	**884.23**
Expenditure							
Pay	**(435.9)**	(106.45)	-	43.3	(21.7)	(83.2)	**(603.9)**
Non-pay	**(190.2)**	(45.3)	-	14.4	(7.2)	(50.7)	**(278.9)**
	(626.1)	(151.7)	-	57.7	(28.9)	(133.9)	**(882.9)**
Finance costs	**(9.1)**					(2.7)	**(11.8)**
Surplus/(Deficit)	**0.2**	**59.8**	**(59.8)**	**57.7**	**(28.9)**	**(39.4)**	**(10.4)**

YDHFT standalone

9.35 On the basis of these assumptions set out above, YDHFT's standalone position (i.e. without merger) is set out in **Figure 65**, alongside the bridge in **Figure 66**. It shows that the YDHFT financial position is forecast to worsen over the period. This deterioration is driven primarily by the level of non-recurrent CIP.

Figure 65: YDHFT forecast standalone position – Statement of Combined Income and Expenditure

YDHFT	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
	£m	£m	£m	£m	£m	£m
Income						
Clinical	219.7	232.9	247.0	261.9	277.8	294.7
Other	21.3	21.8	22.3	22.8	23.4	24.09
	241.0	**254.7**	**269.3**	**284.78**	**301.2**	**318.76**
Expenditure						
Pay	(155.3)	(163.7)	(172.3)	(181.5)	(191.3)	(201.8)
Non-pay	(82.12)	(87.87)	(93.9)	(100.5)	(107.87)	(115.6)
	(237.4)	**(251.4)**	**(266.2)**	**(282.0)**	**(299.1)**	**(317.4)**
Finance costs	(3.5)	(3.7)	(3.9)	(4.1)	(4.3)	(4.6)
Surplus/(Deficit)	**0.0**	**(0.4)**	**(0.8)**	**(1.4)**	**(2.2)**	**(3.3)**

Figure 66: Counterfactual YDHFT standalone forecast – bridge from 2022/23 to 2027/28

YDHFT	2022/23	Income growth/ marginal cost (Net)	ICB income reduction (Growth inc = costs)	CIP	N/R CIP	Impact of infl/tariff	2027/28
	£m	£m	£m	£m	£m	£m	£m
Income							
Clinical	**219.7**	51.7	(9.1)			32.4	**294.7**
Other	**21.3**					2.7	**24.0**
	241.0	51.7	(9.1)	-	-	35.1	**318.7**
Expenditure							
Pay	**(155.3)**	(26.4)	-	15.7	(7.8)	(28.0)	**(201.8)**
Non-pay	**(82.2)**	(16.2)	-	6.4	(3.2)	(20.34)	**(115.6)**
	(237.5)	(42.6)	-	22.1	(11.0)	(48.3)	**(317.4)**
Finance costs	**(3.5)**					(1.0)	**(4.6)**
Surplus/(Deficit)	**0.0**	**9.1**	**(9.1)**	**22.1**	**(11.0)**	**(14.43)**	**(3.3)**

Combined Trust counterfactual

9.36 The combined counterfactual position is set out below in **Figure 67**. This shows a deterioration in financial performance from the balanced position in the current year to a projected deficit of £13.7 million in 2027/28. This is driven by the issue that inflation and cost pressures are funded through the achievement of non-recurrent CIP.

Figure 67: Combined forecast standalone position – Statement of Combined Income and Expenditure

Combined (YDHFT+SFT)	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
	£m	£m	£m	£m	£m	£m
Income						
Clinical	820.6	872.5	932.3	996.7	1,065.9	1,140.2
Other	55.8	57.1	58.5	59.8	61.2	62.7
	876.4	929.6	990.8	1,056.5	1,127.1	1,202.9
Expenditure						
Pay	(591.2)	(625.4)	(665.5)	(708.7)	(755.4)	(805.8)
Non-pay	(272.3)	(292.1)	(314.3)	(338.76)	(365.2)	(394.54)
	(863.5)	(917.54)	(979.8)	(1,047.4)	(1,120.6)	(1,200.2)
Finance costs	(12.7)	(13.3)	(14.0)	(14.7)	(15.5)	(16.4)
Surplus/(Deficit)	**0.2**	**(1.2)**	**(3.0)**	**(5.6)**	**(9.0)**	**(13.7)**

9.37 **Figure 68** below sets out the bridge for the counterfactual combined position from 2022/23 to 2027/28.

Figure 68: Combined counterfactual standalone forecast – bridge from 2022/23 to 2027/28

Combined (YDHFT+SFT)	2022/23	Income growth/ marginal cost (Net)	ICB income reduction (Growth inc = costs)	CIP	N/R CIP	Impact of infl/tariff	2027/28
	£m	£m	£m	£m	£m	£m	£m
Income							
Clinical	820.6	263.2	(68.8)	-	-	125.2	1,140.2
Other	55.8	-	-	-	-	6.9	62.7
	876.4	263.2	(68.8)	-	-	132.1	1,202.9
Expenditure							
Pay	(591.2)	(132.8)	-	59.0	(29.5)	(111.2)	(805.8)
Non-pay	(272.3)	(61.6)	-	20.8	(10.4)	(71.0)	(394.4)
	(863.5)	(194.4)	-	79.8	(39.9)	(182.2)	(1,200.2)
Finance costs	**(12.7)**	-	-	-	-	(3.7)	(16.4)
Surplus/(Deficit)	**0.2**	**68.8**	**(68.8)**	**79.8**	**(39.9)**	**(53.8)**	**(13.7)**

9.38 The counterfactual model effectively assumes that the impact of non-recurrent CIP achieved in year (set out in **Figure 69** below) is added back to the cost base of the standalone Trusts in the following year and ICB income is rolled forward and inflated for tariff uplift and growth as set out in the counterfactual modelling above.

9.39 This essentially perpetuates the current system funding mechanism whereby gaps in Trusts' funding to achieve break-even in year is met non-recurrently by additional system top-up funding and/or restricting how growth money can be invested. There is a real risk this situation will not continue as the system's ability to provide this bridge funding is reduced the longer it is required to make it available.

9.40 It is reasonable to assume that, notwithstanding other system pressures, bridge funding may not be available from 2025/26 onwards and therefore unless the standalone Trusts can reduce their cost base and/or increase other sources of income to compensate the standalone deficits will increase from those modelled in the counterfactual.

Figure 69: Non recurrent CIP delivery bridge from 2022/23 to 2027/28

	Non recurrent	% recurrent
2023/24	7,379	50%
2024/25	7,667	50%
2025/26	7,967	50%
2026/27	8,280	50%
2027/28	8,606	50%
Total	**39,899**	

Projected financial performance of merged Trust

9.41 The proposed merger will bring together all of Somerset's acute, community, mental health and learning disability services, and around a fifth of primary care into a single NHS Foundation Trust.[95] The merged Trust will be in a unique position to provide truly integrated mental and physical health care, spanning whole patient pathways and will be the only NHS trust provider within the Somerset ICS; however, there are a number of financial impacts of coming together in terms of both transactional costs and benefits.

Synergies of Integration

9.42 The original merger Strategic Case cited a number of areas where benefits would be explored in coming together as one organisation. The integration programme has established a number of workstreams to understand how integration will impact on services with a number of objectives to meet in developing the post integration plans. One of these objectives was to identify the synergies in coming together and any financial benefits from integrating corporate functions and combining organisational overheads.

9.43 The workstreams have been able to test the initial assumptions in the Strategic Case and further develop the areas in which the targeted savings will be delivered. This has enabled the savings targets to be tested to provide credibility to the assumptions in the financial case for the merged organisation. Savings in corporate costs make up the large majority of cash releasing benefits of the merger.

Clinical Integration

9.44 As part of the merger, we expect to secure efficiencies and cost savings from the transformation of a number of clinical services as we bring the two teams together across multi-site pathways. However, we also need to recognise that sufficient resource is needed to manage services safely across both acute sites.

9.45 Therefore, the clinical workstream savings are currently limited to a modest reduction in medical agency spend through investment in the substantive workforce.

9.46 The transformation and consolidation of clinical services is expected to be the major driver of the increased recurrent CIP delivery set out in the merger case. The overall level of CIP delivered is not planned to change as a result of the merger, but the value of recurrent CIP is expected to increase by 25% (to 75%) in each year following merger.

Corporate savings

9.47 There will be synergies in corporate and some clinical support services by reducing duplication, adopting best practice across both sites and formally

[95] Proportion of primary care by list size.

joining teams where it is applicable do so. All corporate areas have worked on plans through their Integration Charters which show how they will integrate and reduce cost through merger.

9.48 Savings of £22 million will be achieved through the integration of corporate functions and will be realised through a combination of workforce redesign and reduction in overall workforce numbers.

Medical Agency reduction

9.49 The enlarged Trust will create a more attractive proposition for both the existing and prospective workforce which, it is anticipated will improve the recruitment and retention of colleagues. There is an expectation that the merger will help to improve medical recruitment in hard to fill specialties. The assumption is that through more successful recruitment of substantive doctors, the current reliance on agency can be reduced. Through investment of £1.3 million in substantive posts, an overall reduction in agency expenditure of £1.9 million is anticipated, giving a net reduction of £0.6 million in premium costs. These plans are summarised in **Figure 71** below.

Figure 71: Medical agency savings through merger

	In year						Cumulative Total £000's
	2023/24	2024/25	2025/26	2026/27	2027/28	Total	2027/28
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Medical workforce	100	100	100	100	100	600	1,600

Increased recurrent CIP

9.50 We expect, through merger, to be able to accelerate the transformation and consolidation of clinical services (as set out in chapter 5). This work has already begun and will gather pace, supported by the development and implementation of the system finance strategy (which is provided as a supporting submission to this Case).

9.51 The overall level of CIP being delivered as result of the merger will not increase but crucially, we expect to increase the level of recurrent CIP by 25% to 75%, thereby improving the trend in recent years of declining achievement. This increased recurrent delivery will improve the underlying financial position of the merged organisation and system compared with the counterfactual. The impact of this is shown below in **Figure 72** and also later in the chapter.

Figure 72: Increased recurrent CIP impact

	In year						Total savings over 5 years
	2023/24	2024/25	2025/26	2026/27	2027/28	Total	2027/28
	£m	£m	£m	£m	£m	£m	£m
Improved recurrent CIP	3.8	4.0	4.5	5.0	5.6	22.9	64.1

Integration costs (incl. transaction costs)

9.52 We recognise that integrating two organisations is a complex programme of work that does not end once the transaction date is met. There are non-recurrent costs to support the creation and delivery of the Full Business Case and accompanying post transaction integration plans, but there are also likely to be longer term recurrent costs to ensure investment is made in the organisational development team needed to bring two different organisations together safely and cohesively. Through the programme workstreams these costs have been identified and have been built into the merged organisation financial case.

9.53 The integration costs incurred in the lead up to merger have been absorbed within existing funding. The expected non-recurrent and recurrent pay and non-pay costs are shown below, see **Figure 73**.

Figure 73: Integration costs

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Cuml Total
Property conveyancing	-	-	10	-	-	-	-	10
External support	323	342	225	-	-	-	-	890
Branding/Communications	20	55	25	25	-	-	-	125
Internal backfill	144	144	-	-	-	-	-	288
Revenue Integration costs	585	1,000	1,300	-	-	-	-	300
Sub-total NR	1,072	1,541	1,560	25	-	-	-	4,198
Recurrent transaction costs								
Pay alignment	-	500	500	500	500	500	500	3,000
Pay	729	1,444	1,700	500	500	500	500	5,873
Non pay	343	597	360	25	-	-	-	1,325
Total	**1,072**	**2,041**	**2,060**	**525**	**500**	**500**	**500**	**7,198**

Summary of merger impact

Figure 74: Merger impact on Statement of Combined Income and Expenditure

Combined Trust	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
	£m	£m	£m	£m	£m	£m
Income						
Clinical	-	-	-	-	-	-
Other	-	(7.8)	(8.3)	(8.7)	(9.2)	(9.6)
	-	**(7.8)**	**(8.3)**	**(8.7)**	**(9.2)**	**(9.6)**
Expenditure						
Pay	-	5.6	10.0	15.0	19.6	23.8
Non-pay	-	7.3	10.1	11.6	13.1	15.1
	-	**12.9**	**20.1**	**26.6**	**32.7**	**38.9**
Finance costs	-	-	-	-	-	-
Surplus/(Deficit)	-	**5.1**	**11.8**	**17.9**	**23.5**	**29.3**

9.54 The merger has a positive impact on the income and expenditure position of the standalone organisations. There is a net improvement in each year, see **Figure 74**. The detailed bridges are shown in **Figures 75** and **76** below.

Figure 75: Merger impact – in year & cumulative bridge from 2022/23 to 2027/28

	In year							Cumulative impact on recurrent budgets					Total of cumulative savings over 5 years
	2023/24	2024/25	2025/26	2026/27	2027/28	Total		2023/24	2024/25	2025/26	2026/27	2027/28	
Increase Rec CIP	3.7	3.7	3.7	4	4.1	19.2		3.7	7.4	11.1	15.1	19.2	56.5
Corp	2.7	1.0	1.3	0.3	0	5.3		2.7	3.7	5	5.3	5.3	22
Med agency	0.1	0.1	0.1	0.1	0.2	0.6		0.1	0.2	0.3	0.4	0.6	1.6
Inflation	0.2	0.5	0.9	1.1	1.5	4.2		0.2	0.7	1.6	2.7	4.2	9.3
Total	**6.7**	**5.3**	**6.0**	**5.5**	**5.8**	29.3		**6.7**	**12**	**18**	**23.5**	**29.3**	**89.5**

9.55 A detailed explanation of the merger benefits shown in Figure 75 above is set out below:

- **CIP – improved recurrent performance** The CIP target for the 5 year period 20/23/24-2027/28 has been maintained at 1.6%, 75% recurrent delivery at this level actually equates to a 1.2% CIP target with 100% recurrent performance and is therefore greater than the levels which would normally support a breakeven position (1.1%). The cumulative impact results in the improvement seen in the table.
- **Corporate services** The recurrent, phased savings expected to be achieved through the integration of corporate support services through merger.
- **Medical Agency** Targeted recruitment into vacant posts, reducing agency spend by £1.9 million with £1.3 million being reinvested to cover the costs

of substantively employed doctors. This is likely to equate to approximately 9-10 consultants. Not all of these posts would be filled in year 1. A prudent approach splits the total £0.6 million reduction in overall cost over the 5 years, thus there is additional £0.12 million saving per year so that by 2027/28, the reduction to that year's expenditure compared to counterfactual is £0.6 million.

- **Inflation** If the recurrent improvement on CIP was not delivered across the 5 year period (per the counterfactual) expenditure would be higher and this would incur additional inflation costs each year. In the merged case the higher recurrent CIP brings a cumulative benefit in reducing expenditure and therefore reducing the cost of inflation.

Figure 76: Merger impact – bridge from 2022/23 to 2027/28

Combined (YDHFT+SFT)	2022/23	Improved recurrent BAU CIP ratio	Corporate Savings	Medical Agency Savings	Impact of tariff	Inter Company Trading	2027/28
	£m	£m	£m	£m	£m	£m	£m
Income							
Clinical	-	-	-	-	-		-
Other	-	-	-	-	(2.2)	(7.4)	(9.6)
	-	**-**	**-**	**-**	**(2.2)**	**(7.4)**	**(9.6)**
Expenditure							
Pay	-	14.3	5.3	0.6	3.7	-	23.9
Non-pay	-	4.9	-	-	2.7	7.4	15.0
	-	**19.2**	**5.3**	**0.6**	**6.4**	**7.4**	**38.9**
Finance costs	-	-	-	-	-	-	-
Surplus/(Deficit)	-	**19.2**	**5.3**	**0.6**	**4.2**	**-**	**29.3**

Merged Trust financial position

9.56 The financial forecast for the merged Trust is shown in **Figure 77** below. This uses the projected counterfactual standalone financial plans for both organisations and then incorporates the integration costs and expected savings from the merger to produce the post consolidation or merger financial plan.

Figure 77: Merged Trust - Statement of Combined Income and Expenditure

Combined Trust	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
	£m	£m	£m	£m	£m	£m
Income						

Clinical	820.6	872.5	932.3	996.7	1,065.9	1,140.2
Other	55.8	49.2	50.2	51.1	52.1	53.1
	876.4	921.7	982.5	1,047.8	1,118.0	1,193.3
Expenditure						
Pay	(591.2)	(619.7)	(655.5)	(693.7)	(735.9)	(781.9)
Non-pay	(272.3)	(284.8)	(304.2)	(327.1)	(352.1)	(379.4)
	(863.5)	(904.5)	(959.7)	(1,020.8)	(1,088.0)	(1,161.3)
Finance costs	(12.6)	(13.3)	(14.0)	(14.7)	(15.5)	(16.4)
Surplus/(Deficit)	**0.2**	**3.9**	**8.7**	**12.3**	**14.5**	**15.6**

9.57 The bridge from 2022/23 to 2027/28 is shown in **Figure 78** below. This demonstrates an improvement from a small surplus in 2022/23 to a projected £15.6 million surplus in 2027/28.

9.58 The financial forecast for the merged Trust demonstrates an improvement in every year post merger.

Figure 78: Merged Trust – bridge from 2022/23 to 2027/28

	2022/23	Income Growth and marginal cost (Net)	Inc from ICB reduction (Growth inc = costs)	CIP	N/R CIP	Inter company trading	Improved recurrent BAU CIP ratio	Corporate Merger savings	Medical agency reduction	Impact of inflation / tariff	2027/28
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income											
Clinical	**820.6**	263.2	(68.8)	-	-	-	-	-	-	125.2	**1,140.2**
Other	**55.8**	-	-	-	-	(7.4)	-	-	-	4.7	**53.0**
	876.4	263.2	(68.8)	-	-	(7.4)	-	-	-	129.9	**1,193.3**
Expenditure											
Pay	**(591.2)**	(132.8)	-	59.0	(29.5)	-	14.3	5.3	0.6	(107.5)	**(781.8)**
Non-pay	**(272.3)**	(61.6)	-	20.8	(10.4)	7.4	4.9	-	-	(68.3)	**(379.5)**
	(863.5)	(194.4)	-	79.8	(39.9)	7.4	19.2	5.3	0.6	(175.8)	**(1,161.3)**
Finance costs	**(12.7)**	-	-	-	-	-	-	-	-	(3.7)	**(16.4)**
Surplus/ (Deficit)	**0.2**	**68.8**	**(68.8)**	**79.8**	**(39.9)**	**-**	**19.2**	**5.3**	**0.6**	**(49.6)**	**15.6**

9.59 The merged Trust will be in a surplus position each year. Under the current contractual arrangements across the system, funding is effectively based on the cost of providing commissioned activity. Where costs exceed the recurrent funding available, non-recurrent solutions are deployed to manage the overall system financial position.

9.60 Assuming this arrangement continues, and we do not return to a payment by results or cost and volume based contracting framework, the merged Trust would reasonably be expected to achieve a breakeven position. If this continues to be the system requirement moving forward, we expect the level of ICB

funding to reduce and in turn reduce the in-year surplus. This would improve the system financial position and create funding capacity to reduce the system underlying position and invest in service developments, service expansion and improve quality all of which is currently very limited due to the highly constrained financial position of the system.

9.61 We have not modelled this reduction in surplus so we can clearly demonstrate the benefit of the merger transparently. Although we expect the current financial and contractual arrangements to continue, this is not certain and will be subject to any future changes and/or conditions of future planning rounds. This issue would equally apply to the counterfactual scenario.

Financial benefits to the wider system

9.62 The improved financial position of the merged Trust through a combination of synergy cost reduction and increased recurrent efficiencies will reduce the significant pressure on ICS finances. Although not eliminated, the underlying deficit is materially reduced through merger by 2027/28.

9.63 Furthermore, the counterfactual assumes there is a non-recurrent or bridging solution to manage the ongoing financial pressure caused by the high level of non-recurrent savings being achieved (c.£40 million). This will continue to place huge strain on system finances, being the first call on any growth thereby diverting funding from new investments to meet capacity and safety needs. Use of other non-recurrent funding flexibilities is not a realistic prospect beyond one or two years.

9.64 Finally, the merger will create additional opportunities to maximise efficiency and productivity through the transformation and consolidation of clinical pathways and services. Although this will be a factor in the improved recurrent efficiency of the merged Trust as set out in the merger case, we expect to go further as we implement the wider ICS clinical and financial strategy as it emerges.

Capital plan for merged Trust

9.65 Capital envelope allocations are already at an ICS level. These allocations have been based on a calculation reflecting the asset base and depreciation levels of both organisations along with some recognition of backlog maintenance requirements and previous surpluses.

9.66 The capital programme is jointly planned and is based on:

- Prior commitments from previous years
- Previously agreed business cases or strategic plans
- An allowance for backlog maintenance, medical equipment and IT refresh programmes

9.67 The joint Capital Delivery Group and joint Strategic Estates Group ensure risk is balanced within the available resources and there is a spread of investment across Acute, Mental Health and Community settings.

9.68 There is no additional capital requirement as a result of the merger.

Downside Scenarios and Sensitivities

9.69 The assumptions around future funding regime, levels of demand and growth funding are common across the do-nothing standalone models and the merger case. Therefore, the sensitivities are concerned with the ability to deliver the merger benefits as set out in this chapter. Three downside scenarios have been modelled and these are described in **Figure 81** below.

Figure 81: Downside risks

Downside risk	Why this is a risk	Risk modelled
Reduced level of corporate savings	Slippage in plans and some plans are not yet fully developed	Under achievement of 25%
No medical agency benefit	Benefits are reliant on substantive recruitment which is hard to predict into future years	No savings achieved
Recurrent CIP shortfall	Recognition that the increased recurrent CIP delivery in the merger case is a step change from current performance	Only 50% of the extra recurrent is achieved (i.e. 12.5% improvement from counterfactual)

9.70 These risks have been quantified below, see **Figure 82**, estimating the impact on the merged Trust's income and expenditure position. Calculations have been based on the risk occurring in isolation and how it impacts the 'baseline' forecast position for the merged Trust. No attempt has been made to consider a number of risks happening in combination, but it is considered that the analysis is adequate to broadly show the extent to which each risk or multiple risks would affect the bottom line and to test the robustness of our plans.

Figure 82: Estimated impact of downsides on merged Trust

			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
1.	Merged plan	Surplus/(Deficit)	0.2	3.9	8.7	12.3	14.5	15.6
	BAU CIP recurrent improvement - reduce from 75% to 62.5%		-	(2.2)	(4.6)	(7.2)	(10.1)	(13.4)

	Revised plan	**Surplus/(Deficit)**	**0.2**	**1.7**	**4.1**	**5.1**	**4.4**	**2.2**
2.	Merged plan	Surplus/(Deficit)	0.2	3.9	8.7	12.3	14.5	15.6
	Medical agency reduction removed		-	(0.1)	(0.1)	(0.3)	(0.5)	(0.6)
	Revised plan	**Surplus/(Deficit)**	**0.2**	**3.8**	**8.6**	**12.0**	**14.0**	**15.0**
3.	Merged plan	Surplus/(Deficit)	0.2	3.9	8.7	12.3	14.5	15.6
	Corporate savings @ 75% of planned level			(0.7)	(0.8)	(1.1)	(1.2)	(1.2)
	Revised plan	**Surplus/(Deficit)**	**0.2**	**3.3**	**7.9**	**11.2**	**13.3**	**14.4**

9.71 The merger case has not considered any upside scenarios. The redesign and consolidation of clinical services will afford opportunities to reduce cost and/or improve efficiency and productivity. It is assumed these will initially reinforce the delivery of increased recurrent CIP as set out above.

Impact of previous merger

9.72 The business case for the merger of SPFT and TSFT detailed benefits that would be achieved from bringing together mental health, community and acute services into one organisation. These benefits were classified as patient benefits, colleague benefits and financial benefits.

9.73 The start of the pandemic in March 2020 has had an impact on some of the clinical pathway changes that were envisaged in the business case. This delay has had a two-fold impact in that either efficiencies have not been possible to deliver or that it is very difficult to evidence the level of efficiency due to the evolving operating context that health services are working in.

9.74 A post-merger review has been undertaken to review the benefits set out in the last merger case. The financial benefits have been categorised as follows:-

- Achieved
- Delayed – but may still possible without merging with YDHFT so included in counterfactual financial model
- Delayed – still possible if merger with YDHFT proceeds
- No longer achievable
- Delayed – maybe still possible but will form part of ICS clinical/finance strategy as not enough detail known to include in merger case

9.75 The review concluded that value of efficiencies achieved recurrently was £3.7 million and this is predominantly through corporate consolidation of £3.1 million with £0.6 million for clinical areas. The savings are embedded within the SFT financial position already and are therefore not double counted in this merger case.

9.76 The review concluded that £7.5 million of savings were no longer achievable and that no further savings were possible in the counterfactual scenario (i.e., without the YDHFT merger).

9.77 The review concluded that £8.1 million of the original expected efficiencies may still be achievable through merger but that the detail of how this will be achieved is not currently sufficiently well developed. The savings originally modelled (primarily emergency growth containment and outpatient efficiency) will be developed as part of the work to deliver the ICS clinical and financial strategy.

10. Transaction execution

10.1 This chapter sets out our plan to complete the transaction (i.e. to go live). Further detail about our plans to integrate the two Trusts is contained in the **Post Transaction Implementation Plan** (PTIP).

Transaction delivery

Merger governance

10.2 The Senior Responsible Owner for merger planning is David Shannon, Executive Director of Strategy and Digital Development for the two Trusts. David oversees the transaction Programme Management Office (PMO) which is headed by a Director of Integration.

10.3 The joint executive team has established a Merger Programme Board (MPB) consisting of all nine joint executive directors. The MPB is chaired by the Chief Executive and reports to both Trust Boards. It has oversight of the overall integration of the two Trusts, including the case for merger.

10.4 Key decisions relating to the proposed merger are taken by the Trust Boards, and the Boards have been provided with updates on merger progress at every meeting since submission of the Strategic Case in April 2021. We have also kept both Councils of Governors informed of progress, at both their individual meetings and joint sessions of both Councils.

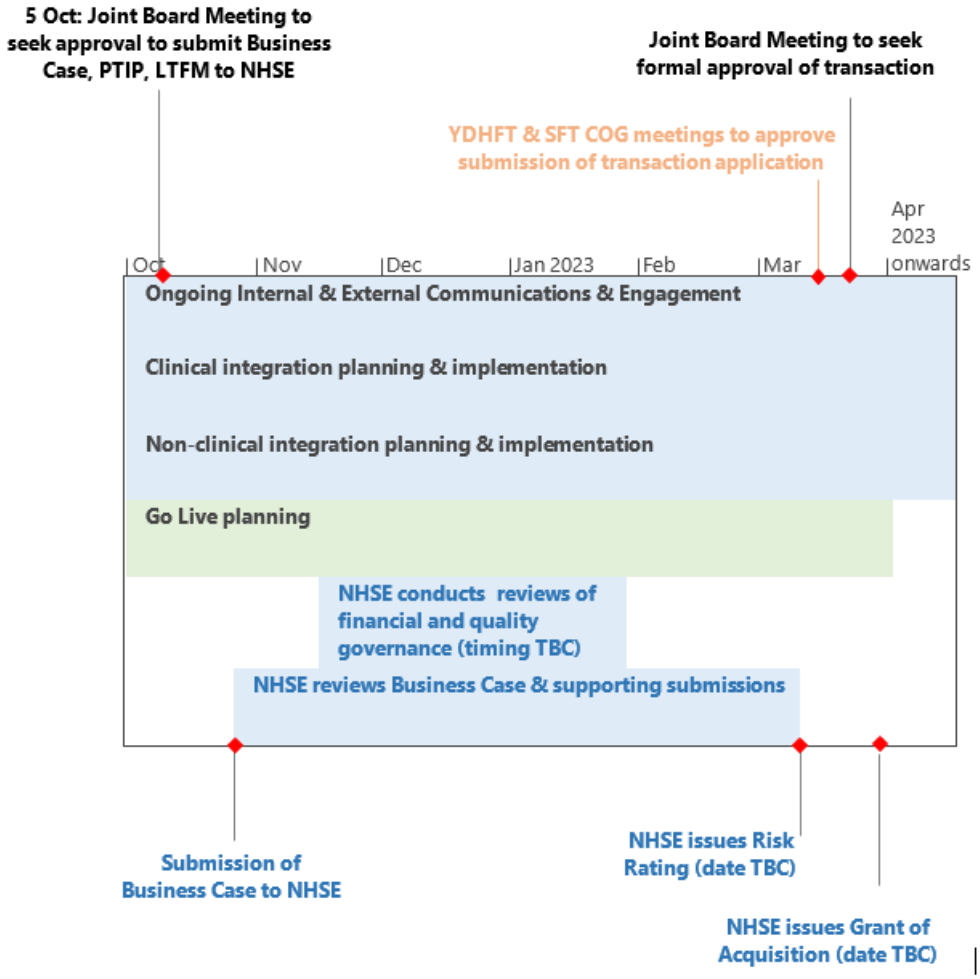
10.5 We have used a workstream approach to develop the Business Case and support our planning for the date of merger and beyond. Each workstream has a senior responsible owner and specified projects determined by the workstream's key deliverables. We have also developed an integration risk register which identifies the key risks relating to the transaction and the associated mitigations.

10.6 Further detail on merger governance and risk management is set out in the PTIP. The PTIP also sets out the resources that will be in place post-transaction to ensure the benefits (as described in the Patient Benefits case and chapter 8 of this Business Case) are realised.

Transaction timeline

10.7 Key milestones in the period up to the merger are set out in **Figure 83**.

Figure 83: Transaction timeline



10.8 Provided we secure the necessary support and approvals from our Boards, Governors, stakeholders and NHSE, we intend to 'go-live' with the merger on 1 April 2023.

10.9 We have set out a timetable for merger which seeks to move at pace while also recognising that sufficient senior management time needs to be devoted to maintaining high quality care for our patients.

10.10 At Strategic Case stage we said we intended to merge in spring 2022. However, in July 2021 we reset our timeline because the extraordinary operational pressures created by Covid meant we needed more time to develop our integration plans. In February 2022, the Trust Boards agreed a further reset of the timeline to April 2023, in response to the challenging operational situation and to allow more time for colleague and stakeholder engagement.[96]

[96] In late 2021/early 2022, discussions with the NHSE national transactions team gave us an informal understanding of the likely content of the revised transactions guidance (not published at that point), which included an increased focus on cultural integration, staff engagement and readiness for transformational change.

Formal consultation

10.11 Our proposed transaction is a change to organisational form and will not entail any immediate significant service change. The Trust Boards have therefore concluded that there is no requirement to engage in formal consultation on the merger itself. Nonetheless, the Trusts have engaged with a wide range of stakeholders about our intention to merge and we have incorporated stakeholder feedback into our detailed plans (see paragraphs 5.241-5.253 and 11.13-11.15).

10.12 Although we ultimately expect the geographical location of some of our services to move - to provide care closer to patients' homes - we do not believe these proposals meet the threshold for public consultation. If, as our clinical services develop their detailed plans, it becomes clear that a significant service change is intended which meets the threshold for public consultation, we will work closely with Somerset ICB to carry out a formal consultation in line with NHSE guidance.[97]

10.13 A 2019 review of stroke services in Somerset recommended further consideration of the way that hyper acute stroke services are provided in the county, and a system-wide review of this care is currently underway. This review is separate from our merger plans. It is possible that proposals for change will emerge from the review of hyper acute stroke services which will require public consultation. If that is the case, Somerset ICB will lead the public consultation which will take place in late 2022, with the development of a decision-making Business Case shortly thereafter.

Public sector equality duty

10.14 The public sector equality duty requires us to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people.

10.15 We are committed to building inclusion into all our services and ways of working, see paragraphs 6.23-6.26. As part of this, we are currently refining our approach to equality impact assessments to ensure they are informed by relevant data and research and diverse perspectives. Further information about the equality impact assessments we have carried out for our clinical case studies is contained in the Patient Benefits Case.

[97] Planning, assuring, and delivering service change for patients, NHSE, 2018.

Due diligence

10.16 The Trusts undertook a due diligence exercise to identify and evaluate the risks inherent in each Trust, identify mitigating actions, and support effective integration planning. The due diligence exercise covered all key lines of enquiry set out in NHSE's transaction guidance for trusts undertaking transactions, including mergers and acquisitions. The scope of our due diligence review was the same for each Trust with the exception of some of the legal due diligence which was tailored to the legal nature of the transaction (see paragraphs 10.24-10.25).

10.17 The due diligence exercise included review of the two active subsidiaries at YDHFT: Symphony Healthcare Services Ltd and Simply Serve Limited.

10.18 As a result of the MOU between the Trusts and the existence of a joint executive team, the two Trust Boards already have a very good understanding of each other's work. We therefore chose to carry out most of the due diligence using internal staff resource, with the exception of legal due diligence which was carried out by Bevan Brittan.

10.19 We carried out the Business Case stage due diligence in autumn 2021, building on the due diligence work carried out at Strategic Case stage (March 2021). This review identified 18 'red' rated issues, the majority of which applied to both Trusts.[98]

10.20 The due diligence review was subject to external scrutiny by Deloitte LLP to give the Trusts' Boards and Governors assurance about the robustness of both the process and the conclusions reached. Our NEDs have also reviewed the evidence underpinning the due diligence reports.

10.21 Since the main due diligence exercise carried out in autumn 2021, the Trust Boards have received quarterly due diligence updates on progress to address the issues identified, and any new risks. At the September 2022 update, the number of 'red' rated due diligence issues was 14. Further detail on these issues is provided in chapter 7.

10.22 We have created specific projects within our integration plans to address the red and amber issues identified by due diligence, with the exception of issues identified as 'business as usual' matters, e.g. operational performance, which are managed through existing, well-established processes.

10.23 The Boards will continue to receive due diligence updates up to the transaction date. All our due diligence board reports are provided as supporting submissions to this Case.

[98] Ten red rated risks applied to both Trusts; two applied solely to SFT, and six applied solely to YDHFT.

Legal form of transaction

10.24 The proposed transaction is a merger of equals, with the two Trusts voluntarily coming together for the benefit of the people we serve. However, the Boards are mindful that effecting the transaction through statutory merger (s.56 of the NHS Act 2006[99]) is slower and more expensive than if one Trust were to legally acquire the other (using s.56A of the NHS Act 2006).

10.25 After considering the merits and demerits of the available legal routes (and after taking legal advice from Bevan Brittan), the two Trust Boards agreed in February 2021 that their preferred option was to pursue merger by acquisition, using s.56A, with SFT legally acquiring YDHFT. This choice was made on the grounds of cost and time, as the expected cost of transferring YDHFT's assets to SFT is lower than transferring SFT's assets to YDHFT, largely because of the number of properties involved.

10.26 Our legal advisers, Bevan Brittan drafted the Heads of Terms which the Board Chairs signed in September 2022. Bevan Brittan also drafted the Transaction Agreement which the Boards will sign closer to transaction date. The draft Transaction Agreement has been reviewed by the Boards and is provided as a supporting submission to this Case.

Name of merged Trust

10.27 The name of the newly merged organisation will be Somerset NHS Foundation Trust.

10.28 In June/July 2021 we asked colleagues, Governors, and stakeholders of both Trusts to suggest names for the newly merged organisation. After checking the suggestions met the naming conventions for NHS trusts, we agreed a shortlist of three names: Somerset Healthcare NHS Foundation Trust, Somerset County NHS Foundation Trust, and Somerset NHS Foundation Trust.

10.29 In February/March 2022, we asked colleagues, patients, members of the public, partner organisations and other stakeholders which of the three shortlisted names they thought would be best for the merged Trust. We received 1,921 responses of which 78.5% favoured Somerset NHS Foundation Trust as the new name.

10.30 Staff at both Trusts responded in similar proportions (c.14-15% of staff at each Trust responded), with 56% of YDHFT colleagues and 86% of SFT colleagues favouring the name Somerset NHS Foundation Trust. Reasons people gave for preferring this name were that it is simple, short and to the point, covers

[99] Subsequently amended by the Health and Care Act 2022.

the whole county, and will save resources on signage and templates when we bring the two organisations together.

10.31 We are mindful that the merged Trust will have the same name as one of its predecessor Trusts. We have developed a new set of values and behaviours for the merged Trust, (see Figure 12), and are developing a new visual identity to help signal a new beginning and foster a sense of belonging for colleagues from both YDHFT and SFT. We also have a significant amount of communications planned for Day 1 to herald our new organisation.

Subsidiaries

10.32 At the point of merger, ownership of Symphony Healthcare Services Ltd and Simply Serve Limited will transfer to SFT as the legal acquirer. Oversight of the performance of Symphony Healthcare Services Ltd and Simply Serve Limited is carried out by their respective Boards of Directors. These Boards of Directors include members of the board of the merged Trust.

11. Communications and stakeholder engagement

11.1 This chapter describes the communications and engagement undertaken as part of our merger planning to date, and our future communications and engagement plans.

11.2 Our plans for an integrated communications function that works closely with patient engagement and People Services are set out in chapter 7.

Communication and engagement strategy

11.3 We have developed a high level communications and engagement strategy for the merger which sets out our communications and engagement aims, objectives, principles and key messages. The strategy also identifies key audiences, and methods of communication and engagement with those audiences.

Aims

11.4 Our communications and engagement aims are to:

- effectively tell the story of the merger of our two Trusts
- engage and communicate with colleagues and stakeholders, and
- seek colleague input and comment on the merger of our two organisations.

11.5 We will do this by:

- providing regular communications about the work that SFT and YDHFT are doing jointly, helping to create an environment of one team working together across Somerset to better meet the needs of our population.
- supporting the proposed merger with communications and appropriate engagement at each stage of the process including the creation of our future merged organisation
- communicating, informing and engaging appropriately about what a potential merger means for SFT and YDHFT.
- communicating, informing and engaging appropriately about the joint work of the Trusts and our route to merger in the context of the development of the ICS.

Objectives

11.6 Our communications objectives are as follows:

- Colleagues at both Trusts, our stakeholders, patients and the public receive regular, open and timely communications about the joint work that SFT and YDHFT are undertaking that describes:

    - the reasons for the merger with specific focus on the benefits to patients, carers and communities
    - what the changes will mean for colleagues, patients and services
    - developments and our progress to create a new organisation
    - how the new Trust is building the best from both legacy Trusts, and decisions are made in the interests of continuing excellent patient care.
- Our communications support the engagement activity that is taking place around the merger of the Trusts.
- Colleagues at both Trusts are provided with opportunities and mechanisms to input into the creation of the new organisation and are able to feedback on our communications.

Colleague and governor engagement

11.7 Our objectives for engagement with colleagues and governors are to:

- create awareness and understanding about why we are proposing to merge our two Trusts.
- provide opportunities to be listened to and share their feedback on the proposed merger.
- provide opportunities to contribute to the development of the vision and values for the new organisation
- create a sense of belonging to the new organisation, and
- show that feedback has informed and influenced our plans and our approach to engagement.

Stakeholder engagement

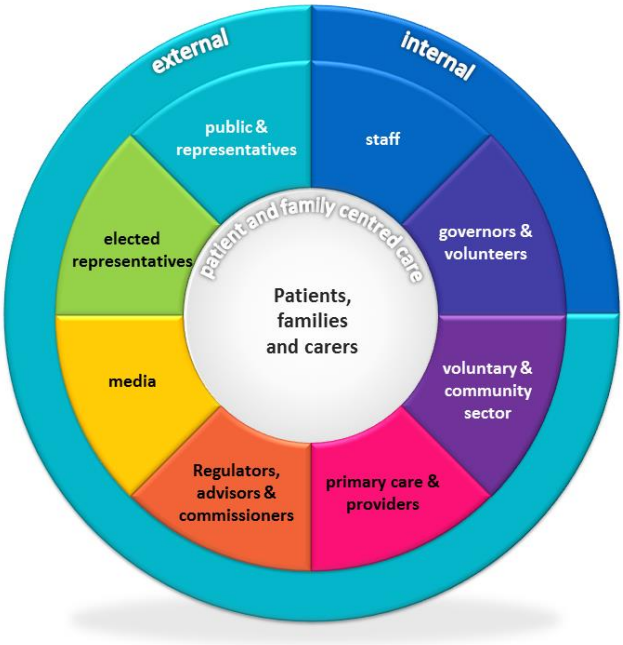
11.8 Our engagement objectives for stakeholders and the public are to:

- provide the public and stakeholders with meaningful opportunities to understand the reasons we are proposing to merge our two Trusts.
- provide the public and stakeholders with differentiated opportunities to share their feedback on our proposed merger.
- work with partner organisations to provide a networked approach to engagement which makes the best use of available capacity and expertise.
- evidence that the feedback provided has informed and influenced our plans and the ways in which we engage.

Key audiences

11.9 Our strategy has identified the stakeholder groupings, see **Figure 84** below. For each communications and engagement opportunity we consider the broad range of stakeholders who should be targeted, and communications and engagement is altered accordingly.

Figure 84: Merger stakeholders



Key messages

11.10 We have tailored our key messages as the merger programme has progressed (and to reflect the focus of each key stakeholder group). The key messages have included:

Why we are merging our two Trusts

- We are working to create one provider trust for Somerset that provides community, mental health, learning disabilities, acute hospital services and some primary care services.
- We are doing this because we believe that we will be better able to support the health and care needs of the people of Somerset, and to provide consistent and accessible services across the county, as one merged organisation.
- The aims of our merger are to:
    - Develop health and care services that meet the changing needs of our population.
    - **Patient and population benefits** - provide better care for the population with everyone enjoying access to the same high quality care and support no matter where they live in the county.
    - **Benefits for services and staff** - build a more resilient workforce and more responsive services across the entire county.
    - **Benefits for the Somerset health and care system** – understand the whole needs of a person and work more easily and effectively with our partners to support health and wellbeing.

    - **Financial benefits** – improve the financial health of the NHS in Somerset.
- Many colleagues from both Trusts are involved in different aspects of our planning, for example in the development of our clinical strategy. Together we want to create an organisation that combines the best from both our Trusts and that can only be achieved with input from colleagues across both organisations.
- One mechanism that we have established to do this is our engagement champions. Over 80 colleagues from a wide variety of different services have stepped forward to become engagement champions to support the upcoming merger of our two organisations.

Principles guiding our merger

- We have overarching principles that guide our merger.
    - We are committed to meeting the needs of the local population. This will include maintaining two vibrant hospitals in Yeovil and Taunton, which are fully integrated with our mental health, learning disabilities, community and primary care services. We want to ensure all services feel part of a single organisation from Day 1.
    - As we become one Trust, we will:
        - Listen to the views of our colleagues and patients
        - Work constructively together and ensure interactions are respectful, appreciative, compassionate and kind
        - Bring to life our shared vision to improve population health with a focus on our five clinical strategy aims
        - Deliver benefits for patients, carers and colleagues and the wider population
        - Take the best from both Trusts and look outwards to learn from elsewhere
        - Recognise our role in the Somerset Integrated Care System and, in partnership, think creatively to transform services for our local population
        - Live within our means and, by making best use of available resources, help put Somerset back on a more sustainable financial footing.

Development of our clinical strategy

- The clinical strategy is one of the foundations of our merged Trust and has been developed with the input of teams across both Trusts and the wider Somerset system.
- The clinical strategy aims are:
    - **Population health** - enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management
    - **Pathways** - ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting

    - **Neighbourhoods** - provide support in neighbourhood areas with an emphasis on self-management and prevention
    - **Equity** - value all people alike, address inequalities and give equal priority to physical and mental health
    - **Complexity** - improve outcomes for people through personalised, co-ordinated support.

- We will do this by ensuring:
    - everyone plays their part by fostering co-production and dissolving barriers to develop services which promote healthy, connected communities
    - we have trusting and collaborative relationships enhanced by a sense of belonging
    - engaged colleagues drive innovation from within high performing teams with strong supportive leadership
    - our processes and systems make it easy for us to get it right first time
    - we focus on, and measure things that matter to patients, carers and colleagues
    - we structure our estates, organisation and system to develop and deliver our transformation plan.

- If we deliver this strategy effectively, people will have more time to live well and do what matters to them. We will enable people to have more time in good health and eliminate wasted time in healthcare.
- We will measure this across all aspects of the quadruple aim: improving health outcomes, better patient experience, increased colleague satisfaction and lower costs. Treasuring the time of our patients, carers and colleagues will drive the delivery of our clinical strategy.

Bringing our services together

- To implement our clinical strategy and realise our aims, services are coming together as we merge our two Trusts.
- We are supporting services in both Trusts to get to know each other and discuss the opportunities that exist once we merge. Our aim is for all services to feel part of one Trust when we merge.
- Integrated services will have:
    - one service vision and transformation plan
    - a single operational structure which includes a unified governance structure, single waiting list (for clinical services), unified policies, report as one service, shared information and a single budget.

Creating our future merged Trust

- Together we have an opportunity to create an organisation that we can all be proud of that builds on the best of both Trusts. To do that we need to hear colleagues' views, aspirations and concerns as part of the planning process to merge.

- The network of engagement champions is one way that we are linking in with colleagues. Staff side representatives, Speaking Up guardians and our colleague networks are other routes that we are using to ensure we consider and are in touch with colleagues' concerns and aspirations.
- Over 80 engagement champions have stepped into the role across both Trusts. They are:
    - Helping colleagues stay informed about our merger
    - Providing an informal link between colleagues and the joint leadership team
    - Working with us to improve the methods and language we use to engage colleagues to make this as useful and accessible as possible
    - 'Myth busting' and provide an additional channel for staff to raise queries or concerns
    - Helping us identify the vision and values of the new Trust.
- We want all colleagues to feel part of our new Trust when we merge and that our organisation reflects what is important to colleagues and is a place where they feel supported and nurtured.
- We are inviting as many colleagues as possible to shape the values that will define our new organisation when SFT and YDHFT merge.
- Both Trusts have values that guide culture and behaviour. We now want to create new values, learning from the best in both our organisations, that will guide and inform the culture of our new organisation and how we behave. We will embed our values into everything we do, including how we recruit, appraise, develop, reward and recognise people; how we make decisions; how we give and receive feedback safely and how we resolve poor behaviour, discrimination and bullying.
- We encouraged colleagues from all areas of both Trusts to get involved by either attending a workshop or by taking part in the colleague culture survey.

Engagement and communications to date

11.11 Communications and engagement activity to date is set out below.

Colleague communications

11.12 We are providing continual and regular communications via a combination of the following:

- Communications to all colleagues using each Trust's communications channels.
    - For SFT – weekly Staff News, front page of intranet, merger intranet section, electronic messages on computer desktops, and content on corporate social media channels

    - For YDHFT – weekly CONECT bulletins; intranet content including dedicated merger section; messaging on computer desktops; website content, including case studies; social media channels; hardcopy communication materials for harder-to-engage groups.
    - Joint communications channels – regular webinar led by chief executive and, weekly chief executive messages, which also provide an opportunity for colleagues to ask questions about our merger plans
- Communications and discussion at leadership meetings (for SFT - Senior Operational Management Team; for YDHFT - Hospital Leadership Group)
- Communications and discussion at SFT colleague networks forum, staff-side forums and equality and diversity steering group
- Regular communications and discussion with governors and Trust Board members via weekly briefings and regular meetings.

Colleague engagement

11.13 Our engagement with colleagues about merger includes the following activities:

- Colleague roadshows: executive-led open meetings held across our sites at which colleagues can ask questions about our merger plans. These will start in November 2022 and take place monthly.
- Leadership forums: events for senior decision-makers across the Trusts to hear about our plans and give their feedback. These events also provide an opportunity to socialise the new Trust values. These forums will start in October and take place quarterly.
- Engagement and involvement of colleagues from both Trusts to develop the merged Trust's values via workshops and a cultural survey (c.1,000 colleagues participated). Feedback was also sought from colleagues on the draft values.
- Engagement with colleagues about the clinical strategy for the merged Trust (see chapter 5)
- Engagement with leadership and senior colleagues from both Trusts on the operating model for the merged Trust
- Engagement with colleagues to gather views on the most appropriate name for the merged Trust
- Ongoing monthly meetings since late 2021 with our c.80 engagement champions to share merger news, hear how people are feeling about merger and receive feedback. Through this forum we heard that YDHFT colleagues did not feel they had a voice and in response we ran face-to-face sessions for YDHFT colleagues to understand their concerns.
- Merger surveys – carried out in November 2021 and another in July 2022 (on culture) for colleagues from both Trusts.

Stakeholder engagement

11.14 Our engagement with stakeholders about merger includes the following activities:

- Engagement with patients and system partners to inform the development of the clinical strategy for the merged Trust (see chapter 5).
- Engagement with primary care Patient Participation Groups (PPGs) on the rationale for merger and to establish ongoing opportunities for engagement.
- Engagement with Healthwatch Somerset to enable a networked approach to engagement.
- Engagement with the public via an online survey (see Figure 85).
- Engagement with the Somerset Engagement Advisory Group (SEAG) to update partner organisations in the local voluntary sector about the proposed merger and to establish opportunities for ongoing engagement with their audiences.
- Engagement with local elected representatives including Members of Parliament, the Somerset Local Medical Council and Local Pharmaceutical Committee to provide regular updates on the progress of our merger plans and provide opportunities for ongoing engagement.
- Engagement with patients, partners, stakeholders, and the public to gather views on the most appropriate name for the merged Trust
- We have also briefed Trusts in neighbouring counties on our merger plans via our existing operational links and formal correspondence.

11.15 **Figure 85** describes the results of a public survey we carried out with the support of Healthwatch Somerset about merger.

Figure 85: Results of survey of public about our merger

Public survey about merger

Between June and September 2022, we ran a public survey about the planned merger, with the help of Healthwatch. 490 people responded to the survey which asked about their experience of NHS services in Somerset, and what they thought our priorities should be as we bring together YDHFT and SFT.

Respondents told us the priorities we should focus on as we bring our organisations together are:

- Maintaining high quality of care
- Improving access to services, and reducing waiting times
- Improving access to GP and primary care services
- Improving communication between the Trusts and patients/carers (and between NHS organisations themselves)
- Joining up IT services
- Reducing waste and improve efficiency

The majority of respondents see the merger as a positive move, although they have limited knowledge of - or interest in - the merger itself. Where there are concerns they are around the potential for reduced services in people's local area and the consequent impact of travelling further

for care. Concerns were also expressed about the impact of cost savings, although there was support for a reduction in bureaucracy.

Future communication and engagement

11.16 We are continually developing our communications and engagement activity in line with the communications and engagement strategy set out above. The next phase of communication for colleagues in both Trusts will focus on:

- further examples of the implementation of the clinical strategy and its benefits for patients, colleagues and services
- progress to formally merge our Trusts
- creation and Day 1 of the Trust that reflects the shared values we have developed.

11.17 As we approach Day 1, we will increase the frequency and reach of engagement with stakeholders and the public, providing ongoing opportunities for individuals and groups to share feedback on our plans via a range of digital and physical methods. We will make greater use of opportunities for engagement via existing networks established by system and third sector partners.

Annex 1: SFT and YDHFT performance against national standards

1. This annex sets out the performance of YDHFT and SFT against national performance standards. Both Trusts currently provide acute hospital services, and are measured against national standards for waiting times in A&E, for diagnostic tests and for cancer and elective surgical treatment. SFT also provides community, mental health and learning disabilities services, with further performance standards for these services.

2. Since the beginning of the Covid pandemic, performance against national standards has been volatile. There have been periods of unprecedented high demand, and times when we have seen far fewer patients than usual. The impact of measures to prevent the spread of Covid has also made it much more challenging to deliver performance which meets national standards, as has been the case at other trusts across the country.

3. This annex provides information on current performance and trends, as well as performance prior to the pandemic, to give insight to the underlying performance of the organisations.

4. SFT was created on 1 April 2020. The historic information for SFT refers to the performance of Taunton and Somerset NHS Foundation Trust (TSFT) and Somerset Partnership NHS Foundation Trust (SPFT), which were SFT's predecessor Trusts.

Acute hospital services

Accident and Emergency

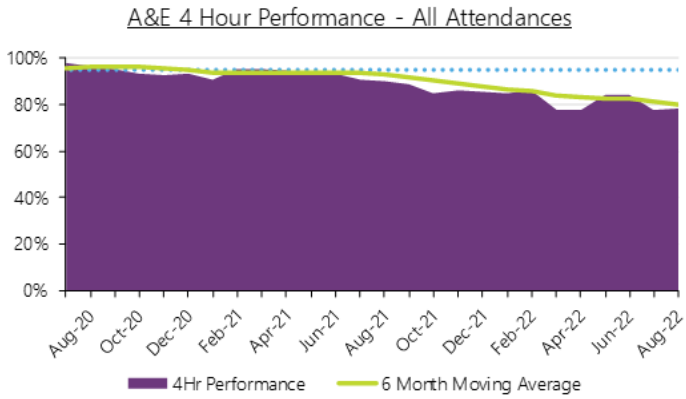
5. The Accident & Emergency (A&E) four-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 95% of patients will wait less than four hours in the Emergency Department.

YDHFT performance

6. Prior to the pandemic, YDHFT was achieving the national target of seeing 95% of patients within four hours. Performance has fallen in the last two years, and as at August 2022 stands at 78.19%. Although this performance is below the national standard, it compares favourably to the national average performance of 58%. YDHFT has seen a steady increase in A&E demand, which rose by 4.8% in the year to April 2022. In 2020, average A&E attendances per day were around 100, but are now over 150 per day. Performance has also been affected by issues with patient flow, and an increase in patient acuity.

7. YDHFT's A&E four-hour performance is shown in the graph below, **Figure 86**

Figure 86: YDHFT 4 hour A&E performance against target



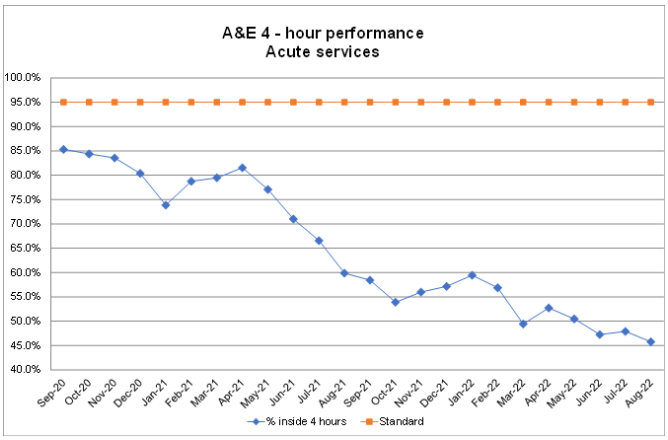
SFT performance

8. In early 2020, prior to Covid, TSFT A&E performance was around 90%. Performance was hampered by increases in demand, which had grown by 2.3% since 2019.

9. Current performance for SFT (as at August 2022) is 45.8%, against a national average performance of 58%. Performance has been on a downward trajectory over the last 18 months. We have a recovery plan in place, with a focus on ED triage and patient flow, and changes to pathways including a new Surgical Decisions Unit.

10. SFT's performance against the 4-hour standard is shown in the graph below, **Figure 87**.

Figure 87: SFT 4-hour A&E performance against target



Cancer performance

11. The national standard is for 93% of patients across eleven tumour sites to receive a first appointment within two weeks of a GP referral for suspected cancer, or if they are exhibiting the symptoms of breast cancer. A separate standard requires that 85% of patients should start their first definitive treatment within 62 days.

YDHFT performance

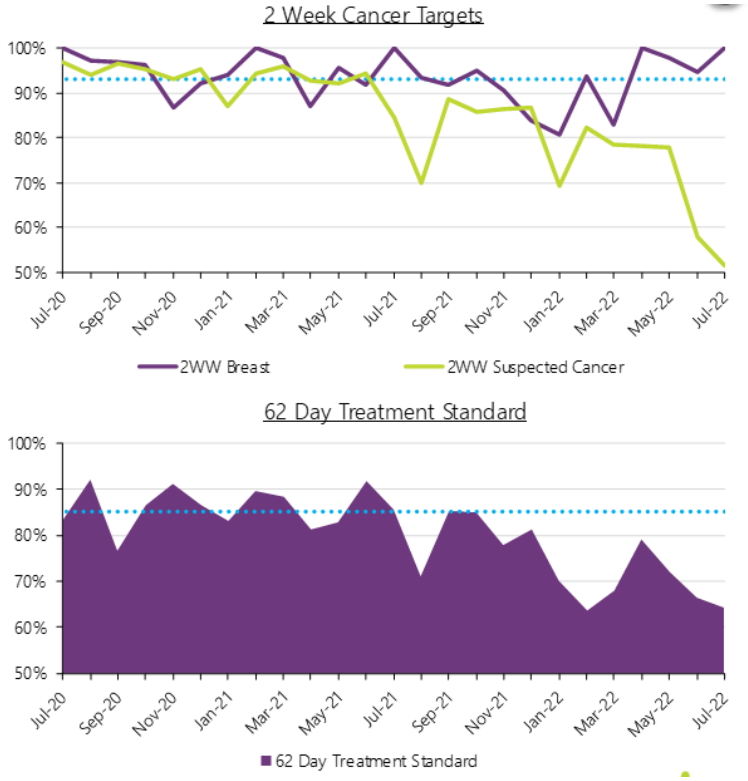
12. YDHFT performance against the two-week standard was 51.47% in July 2022 for suspected cancer, and 100% for breast cancer. Performance has been variable for

much of the last year, but below the national standard, although it has fallen sharply this month due to delays in Skin, Lower GI and Endoscopy.

13. Current performance on beginning definitive treatment within 62 days stands at 64.23% (as at July 2022). This is significantly lower than historic performance levels which, although variable, regularly exceeded the national standard up to 2021.

14. YDHFT's performance on cancer standards is shown in the following graphs, **Figures 88 and 89.**

Figures 88 and 89: YDHFT performance against the 2 week cancer wait standard and the 62 day cancer treatment standard

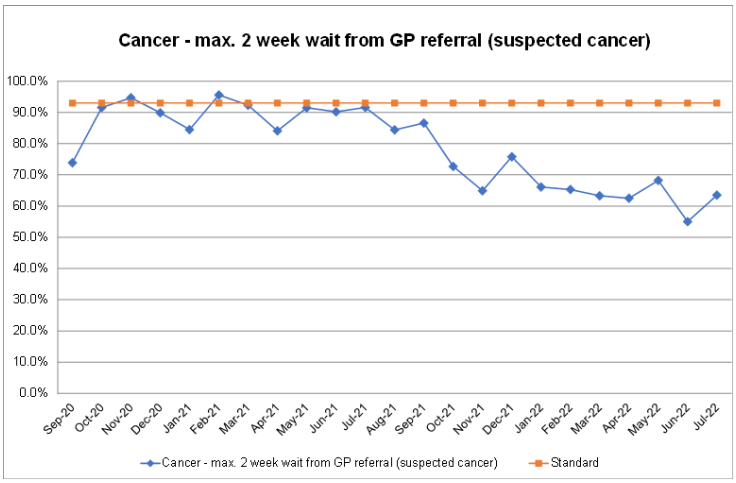


SFT performance

15. Performance against the two-week wait standard was consistently at or around standard in the years before Covid. Performance fell during the first phase of the pandemic, but was recovered in late 2020. However, performance has recently declined. Performance as at July 2022 is 63.5%. This is an increase from 55% in June, and approximately in line with performance throughout the rest of 2022.

16. Performance against the target for the two-week standard is shown in **Figure 90** below.

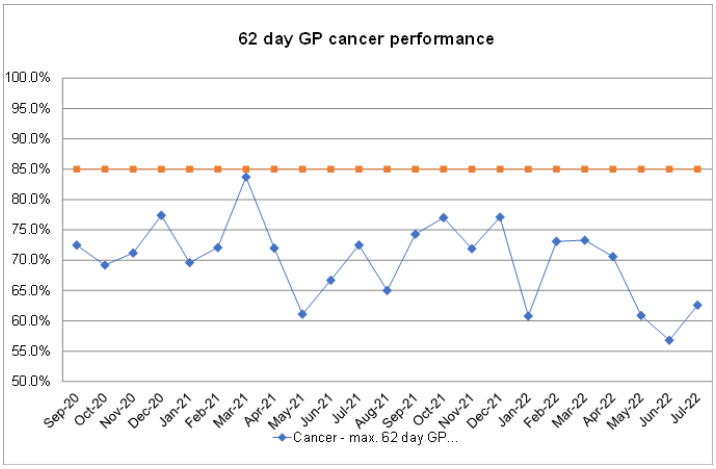
Figure 90: SFT performance against the two-week cancer wait standard



17. The Trust did not meet the 62-day cancer standard of 85% in the years before Covid. This has remained the case in recent times, with performance ranging from around 60% to just below the target level. Performance as at July 2022 was 62.6%, which is an improvement on performance in June, but lower than in spring 2022.

18. SFT performance against the 62-day cancer standard is shown in **Figure 91** below.

Figure 91: SFT 62-day cancer performance



Referral to Treatment (RTT)

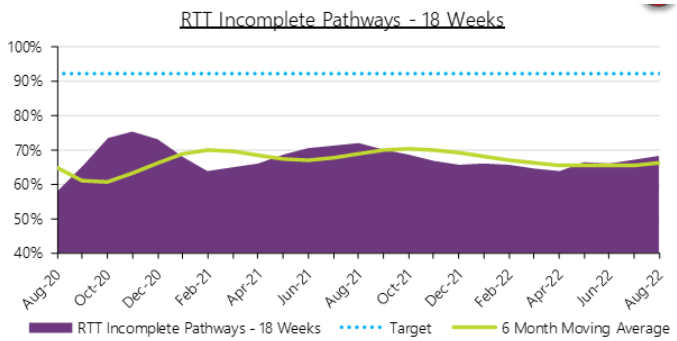
19. The national standard is for treatment to occur within 18 weeks of referral for 92% of patients.

YDHFT performance

20. YDHFT has not met the national standard for a number of years. Current performance (as at August 2022) is 68.37%. The current level of performance is significantly worse than pre-pandemic performance. In April 2019, for example, performance was over 89%. The same pattern can be seen in terms of the numbers of patients waiting over 52 weeks for treatment. Three years ago YDHFT had no such patients, whereas in August 2022 there were 799 patients waiting more than a year.

21. Action plans are in place to improve performance, but performance continues to be hampered by non-elective pressures within the hospital. Performance is shown in **Figure 92.**

Figure 92: YDHFT performance against the 18 week Referral to Treatment target

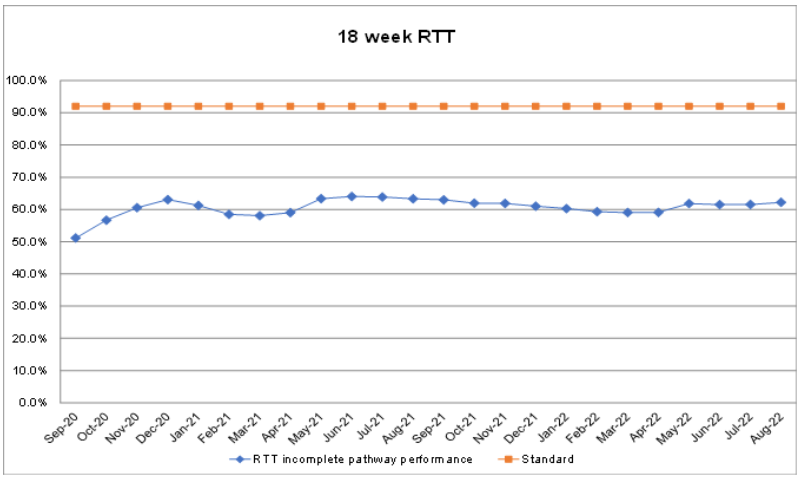


SFT performance

22. TSFT's performance on RTT did not meet the standard of 92% for several years before Covid, with performance between 70-80% in early 2020. Performance fell significantly during Covid, to below 40% in mid-2020. Since then performance has improved, and has been at around 60% since December 2020. Current performance as at August 2022 is 62.2%.

23. SFT's performance against the standard is shown in **Figure 93** below.

Figure 93: SFT performance against 18 week Referral to Treatment standard



Diagnostic 6-week wait

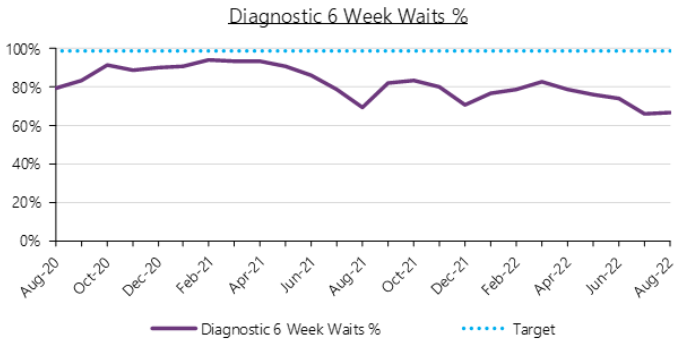
24. The national target is for 99% of patients to receive a diagnostic test within six weeks of referral.

YDHFT performance

25. YDHFT is not meeting the national target, with current performance (as at August 2022) at 66.54%. Performance has fallen slightly in recent months, having recovered

from around 40% at the start of the pandemic. There are particular pressures in Echocardiology and Audiology. Performance is shown in **Figure 94** below.

Figure 94: YDHFT performance against six-week diagnostic standard

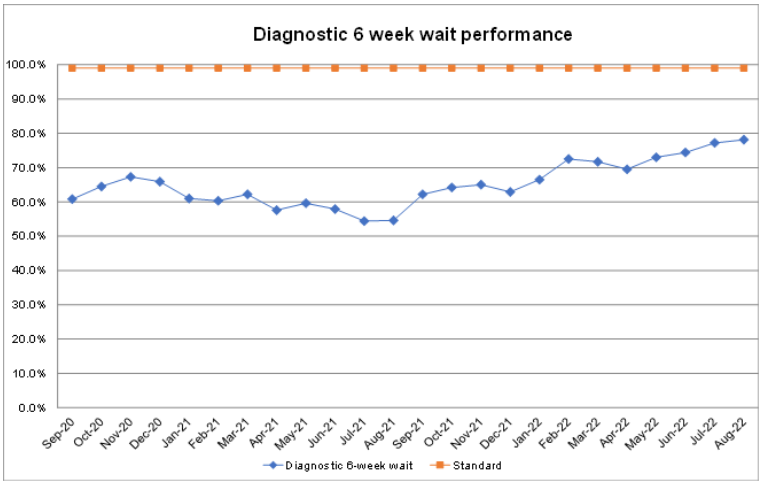


SFT performance

26. TSFT did not meet the diagnostic national standard in the pre-Covid years. Performance was around 85% in the months running up the pandemic, and it fell significantly in the early part of the pandemic. Since then it has recovered steadily, and was 78.1% in August 2022. This was the fourth consecutive month of improved performance, and performance is now higher than at any time since before Covid.

27. SFT's diagnostic six-week wait performance is shown in **Figure 95**.

Figure 95: SFT performance against 6 week diagnostic wait standard



Patient safety performance indicators

28. Both Trusts monitor a range of patient safety indicators to ensure performance continually improves, and that the potential for harm is minimised. These indicators include information on Falls and Pressure Ulcers

YDHFT performance

29. **Falls:** In August 2022 there were 87 patient falls, of which six caused harm. This is a rate of 7.42 per 1,000 occupied bed days. Rate of falls rose during 2021, and although the August rate is higher than recent months, it is lower than for most of 2021.

30. **Pressure Ulcers:** There were 10 pressure ulcers reported in August 2022. This represents a decrease from levels seen in late 2021 and early 2022, but is still higher than rates through most of 2021.

SFT performance

31. **Falls:** In August 2022 232 falls were recorded, of which 56 caused harm. This is a rate of 7.96 per 1,000 occupied bed days. The rate has risen slightly in recent months but is significantly lower than in 2021.

32. **Pressure ulcers:** There were 19 pressure ulcers in the Musgrove Park hospital in July 2022. This is the highest level since procedures were updated in April 2021.

Friends and Family Test

33. Both Trusts record their performance against the national Friends and Family Test. This records how patients feel about their care, giving patients the chance to provide simple and anonymous feedback before they leave hospital about how likely they are to recommend the hospital to their friends and family. Performance levels as at August 2022 are as indicated in **Figure 96** below:

Figure 96: Latest Friends and Family Test performance

Service Area	% of patients providing a positive response ("Extremely Likely" or "Likely")	
	SFT %	YDHFT %
A&E	66.7	97.33
Inpatients	95.4	97.49
Maternity	100	93.85
Outpatients	94.7	97.49

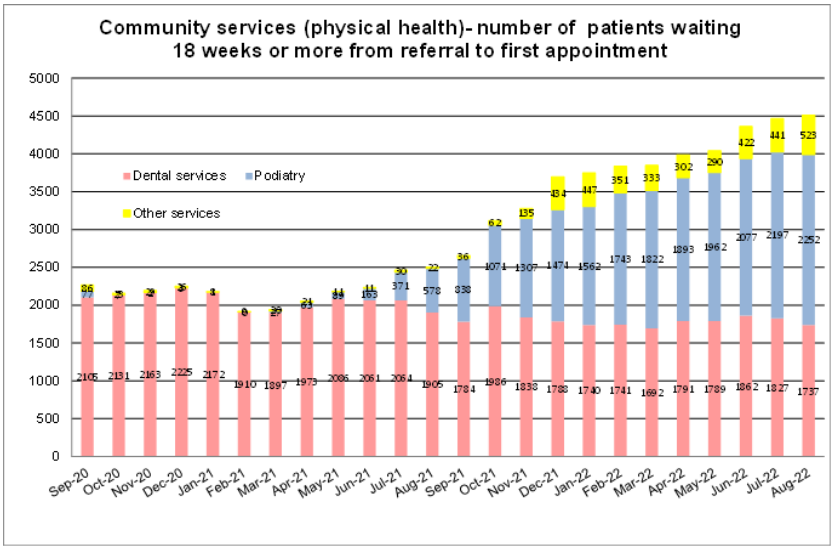
Community Services - SFT only

34. There has been a significant increase in the number of patients waiting longer than 18 weeks for their first community physical health appointment at SFT.[100] The number waiting more than 18 weeks has increased from fewer than 1,000 patients at the start of the pandemic, to 4,512 patients (as at the end of July 2022). There are particular problems in community dental and podiatry services, which make up the vast majority of patients waiting beyond 18 weeks. The dental waits include particular issues for children requiring dental procedures under general anaesthetic. Podiatry waits are predominantly caused by the significant national recruitment issues in podiatry.

35. Performance against this indicator is shown in **Figure 97** below.

[100] This is a locally agreed standard.

Figure 97: Numbers of patients waiting longer than 18 weeks for community physical health services



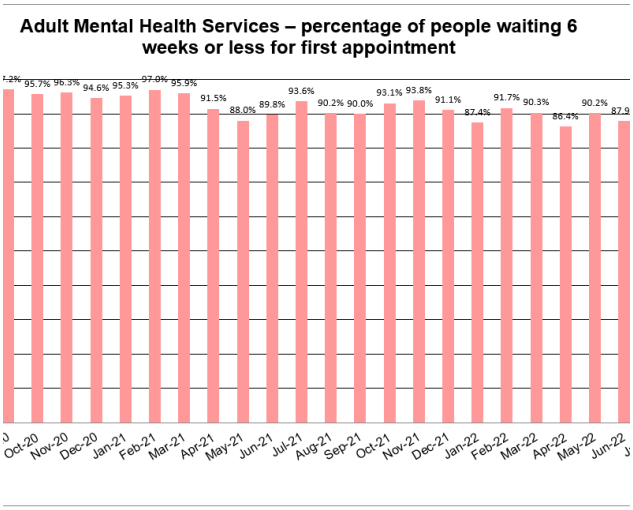
Mental health services – SFT only

Waiting times for treatment

36. SFT aims to see at least 90% of people referred to its community mental health services within six weeks of referral. Performance has been at or above this target level throughout the pandemic, and is currently at 93.6% as at August 2022, even though referrals have grown significantly in recent years, and are now 35% higher than two years ago.

37. Performance against the standard is shown in **Figure 98** below:

Figure 98: Performance against six-week wait standards for mental health services

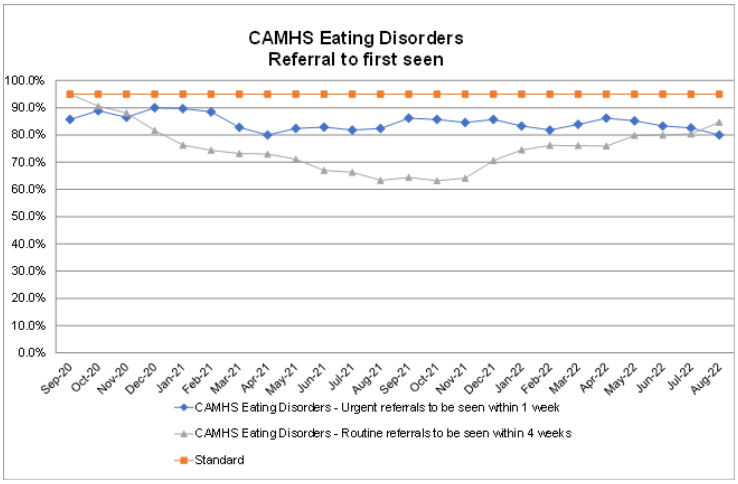


Child and Adolescent Eating Disorder services

38. SFT has a local standard for 95% of urgent referrals for eating disorders to be seen within one week, and for 95% of routine referrals to be seen within four weeks. For urgent referrals, performance has been between 80% and 90% for most of the last two years. For routine referrals, performance dipped to around 65% during 2021, but has since improved to around 83% as at the end of August 2022.

39. Performance against this standard is shown in **Figure 99** below.

Figure 99: Waiting times for child and adolescent eating disorder services

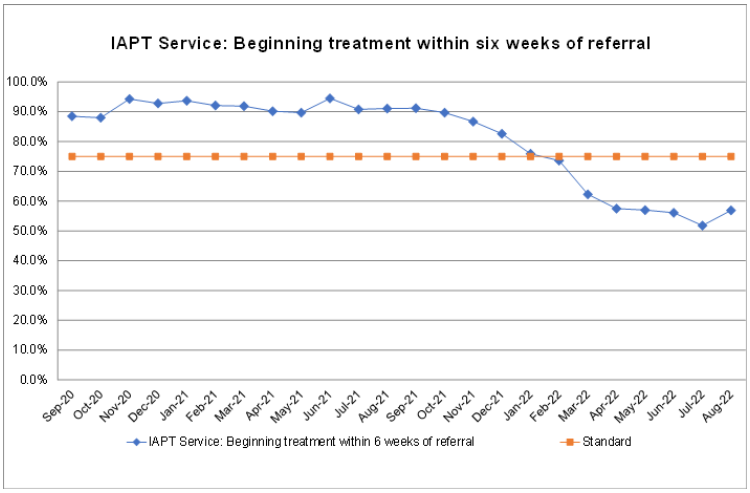


Increasing Access to Psychological Therapies

40. For Increasing Access to Psychological Therapies (IAPT), SFT exceeded the standard of 75% of people waiting 6 weeks or less from referral to entering a course of talking treatment throughout 2020 and 2021. However, there has been a decline in performance in 2022 and as at August 2022 the Trust achieved 56.9%. Performance is slightly higher than July, but still low by historic standards and has declined to due a combination of significantly increased demand, and capacity shortfall due to a number of unfilled vacancies in the service.

41. Performance against the standard is shown in **Figure 100** below.

Figure 100: Patients waiting six weeks or less to access talking treatments



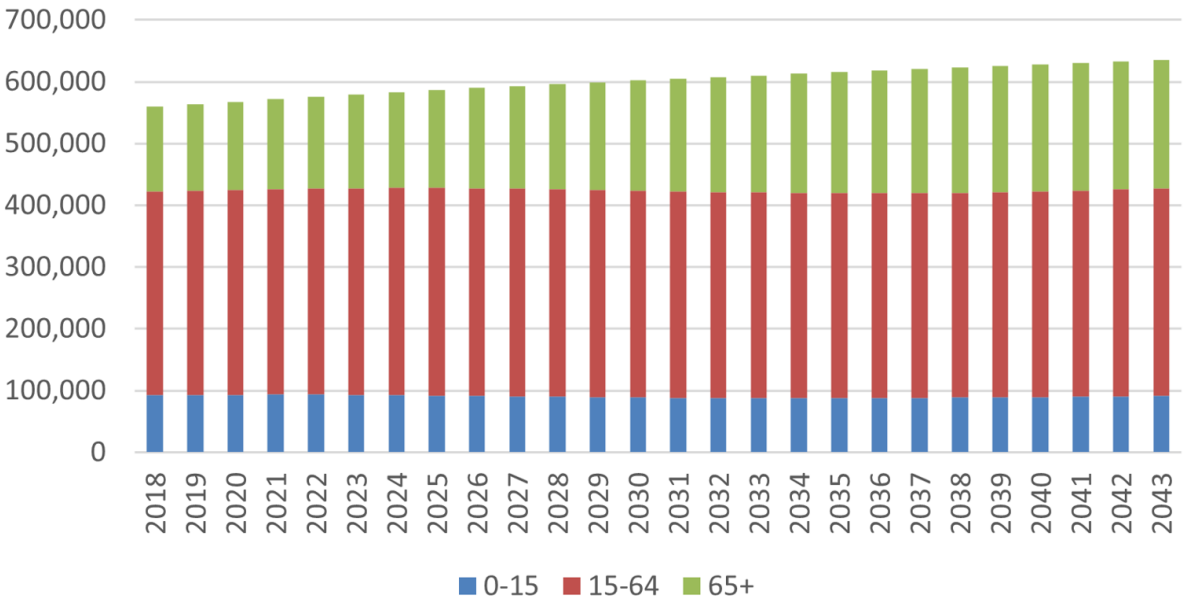
Annex 2: Somerset health and care key challenges

Demography – an ageing population

1. The 2021 census indicates that the current population of Somerset is around 572,000.[101] The Office for National Statistics (ONS) estimates that 24.8% of Somerset residents (c. 142,000 people) are aged 65 or over. This is significantly higher than the average for England of 18.6%.[102]

2. By 2043, the ONS predicts that the Somerset population will rise by around 13% to 635,000. At this point, the percentage of over 65s in Somerset is predicted to account for 33% of the total population, against a national average of 24%, and the number of people over 75 in Somerset will have nearly doubled to 121,000. [103] In parts of West Somerset and Burnham-on-Sea, more than half the population is expected to be aged 65 or over by 2033[104]. **Figure 101** shows Somerset population projections by age.

Figure 101: Population projections by age, Somerset 2018-2043



Source: ONS population predictions

3. **Figure 102** below shows ONS population estimates for 2018 illustrating that Somerset's proportion of older age residents is higher than the England and South West averages. It also demonstrates the relative under-representation in the county of people aged 20 to 44.

[101] Population and household estimates, England and Wales: Census 2021 - Office for National Statistics (ons.gov.uk)
[102] Population and household estimates, England and Wales: Census 2021 - Office for National Statistics (ons.gov.uk)
[103] Office for National Statistics 2018-based population projections, March 2020.
[104] http://www.somersetintelligence.org.uk/older-people/

Figure 102: Somerset age profile (as at 2021 census)

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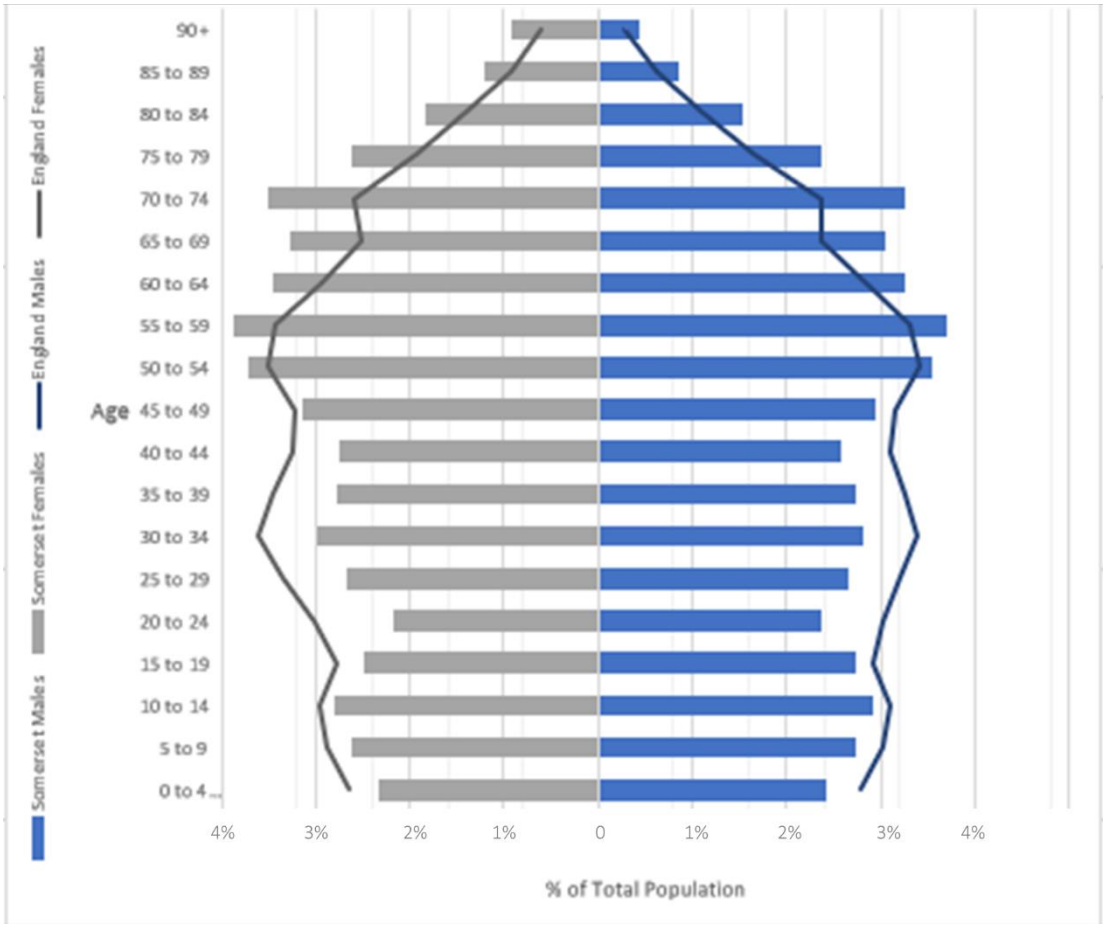

4. Across England, 15% of those aged 65 or over are moderately or severely frail.[105] Older people make greater use of health care services than people of working age. This means the demands on the Somerset health and care system are proportionately greater than in a comparable region with the same total population but a more balanced demography. Because Somerset has a below average proportion of working age residents compared to England as a whole, this is likely to reduce the number of adults able to provide unpaid care for a close friend or relative.

5. The gap between a) life expectancy at birth and b) healthy life expectancy at birth in Somerset is 16 years for males and 18 years for females.[106] Time spent in poor health puts pressure on healthcare services.

6. Life expectancy for males has fallen slightly in Somerset in recent years.[107]

105 https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf
106 Public Health Outcomes Framework - Data - OHID (phe.org.uk)
107 http://www.somersetintelligence.org.uk/life-expectancy.html

Complex needs

7. People with one or more long-term conditions now make up 30% of the population of England. They account for 50% of all GP appointments, 64% of all outpatient appointments, and occupy 70% of hospital beds.[108]

8. By 2035, two-thirds of adults in England are expected to be living with multiple health conditions, and 17% will have four or more conditions.[109] In Somerset 4% of patients account for 50% of all health expenditure.

Inequalities

9. At the 2011 census, 19% of the Somerset population said they had a long-term condition or disability.[110] Data from the Symphony programme indicates that around 4% of people in Somerset have two or more long-term conditions.[111]

10. The number of children in England with profound and multiple learning difficulties has increased by 40% since 2004. More than 15% of young people in Somerset have special educational needs or a disability.[112]

11. Somerset is in the worse quartile nationally for rate of suicide.[113] The hospital admission rates for people who have self-harmed or have misused alcohol are higher than benchmark,[114] which either indicates greater rates of mental distress in the county or that we are missing opportunities to intervene sooner with these groups.

12. 66.1% of adult Somerset residents are overweight or obese compared to an England average of 64.6%.[115] Latest data (from 2016) indicate 12% of the adult population of Somerset are smokers.[116] Smoking is the single largest cause of preventable premature mortality in Somerset.

13. The life expectancy of women in Somerset with a mental health disorder is 17.5 years lower than for women without serious mental illness; for men in Somerset the difference is 19.7 years.[117] This discrepancy is replicated around the country and is

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108 https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

109 https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

110 2011 Census profile for Somerset, via www.somersetintelligence.org.uk

111 http://www.somersetintelligence.org.uk/files/JSNA%202017%20Ageing%20Well%20Summary.pdf

112 Hidden Somerset, Somerset Community Foundation https://www.yumpu.com/en/document/read/63829959/hidden-somerset-unseen-youth

113 https://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132696/pat/6/par/E12000009/ati/102/are/E10000027/iid/41001/age/285/sex/4/cid/4/page-options/ine-vo-0_ine-yo-1:2015:-1:-1_ine-ct-39_car-do-0_car-ao-0

114 Public Health England fingertips data https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000042/pat/6/par/E12000009/ati/102/are/E10000027/cid/4

115 http://www.somersetintelligence.org.uk/obesity.html#:~:text=The%20Somerset%20District%20with%20the,or%20obese%20(NCMP%202016).

116 http://www.somersetintelligence.org.uk/smoking.html#:~:text=12.3%25%20of%20the%20adult%20population,of%20them%20in%20middle%20age.

117 *Making the Case for Integrating Mental Health and Physical Healthcare,* Midlands and Lancashire Commissioning Support Unit, May 2017.

attributed mainly to cardiovascular disease and cancer, rather than the underlying mental health condition.

14. In England, people affected by homelessness die on average around 30 years younger than the general population; drug or alcohol misuse, cardiovascular disease and suicide are the leading causes of death.[118] In summer 2022 there were around 365 people sleeping rough or in temporary accommodation in Somerset. The charity Crisis has predicted that homelessness will rise by a third on 2019 levels as a result of the steep rise in energy bills and the end of Covid eviction bans.[119] People affected by homelessness often have complex health needs and are much more likely than the general population to experience depression, substance misuse and require emergency hospital admission.

Socio-economic position

15. Although Somerset has lower overall deprivation than the England average, pockets of deprivation exist which create and exacerbate ill health, and deprivation is worsening. The number of neighbourhoods classed as 'highly deprived' rose from 25 to 29 in the period 2015-19, and around 47,000 people now live in such neighbourhoods.[120] The most deprived area of Somerset is the Highbridge South West area of Sedgemoor.[121]

16. The gap in life expectancy at birth between most and least deprived areas of Somerset is 6.5 years for males and 5.1 years for females.[122] The gap in *healthy* life expectancy at birth for men living in the most deprived parts of Somerset is 8.9 years lower than for those living in the most affluent areas. The difference for females is 8.0 years.[123]

17. Many long-term conditions are more than twice as common in adults from lower socio-economic groups, and mental health problems are also more prevalent.[124] Around 1 in 10 households in Somerset is in fuel poverty, often living in damp, cold conditions which cause and exacerbate health problems.[125]

18. 13% of children in Somerset are growing up in a low-income household,[126] and childhood poverty is linked to premature mortality and poor health outcomes in adulthood.

19. Food bank use in the South West rose 74% between 2014/15 and 2021/22[127] and there are clear links between foodbank use and poor health. Research in 2018 found that 19% of people using foodbanks have a disability, 23% have a long term health condition, and 38% suffer from mental ill health.[128]

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118 https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf

119 Homelessness Monitor 2022 | England | Crisis UK

120 http://www.somersetintelligence.org.uk/files/English%20Indices%20of%20Deprivation%202019%20-%20Somerset%20summary.pdf

121 English Indices of Deprivation 2019 www.somersetintelligence.org.uk

122 Public Health Outcomes Framework - Data - OHID (phe.org.uk)

123 https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000049/pat/6/par/E12000009/ati/102/are/E10000027/cid/4/tbm/1

124 https://www.bma.org.uk/media/2084/health-at-a-price-2017.pdf

125 https://www.gov.uk/government/statistics/sub-regional-fuel-poverty-data-2020

126 http://www.somersetintelligence.org.uk/cyp/ 14,300 children of 110,000.

127 https://www.trusselltrust.org/news-and-blog/latest-stats/end-year-stats/

128 The Trussell Trust: Disability, Health and Hunger, 2018

20. Use of food banks rose during the pandemic - according to The Trussell Trust, 50% of people using food banks at the start of the pandemic had not needed one before. Food bank use is rising further still due to the cost of living crisis – usage increased nationally 29% between April/May 2021 and April/May 2022.[129]

Geography

21. Somerset is geographically large and one of the most rural counties in England with a population density of 1.5 people per hectare (compared to a national average of 4.1).[130] 48% of people in Somerset live in a rural area.[131] People with the worst health and the lowest incomes struggle the most to travel to health services.[132] One in five Somerset residents aged 65 or over has no access to car or van; the proportion is even higher in amongst women,[133] and public transport links in the county are poor. This creates challenges for access to our services. Furthermore, rurality contributes to social isolation and is linked to digital poverty.

Rising demand – acute care

22. Independent forecasting by consultants Factor 50 suggests aggregate projected growth in elective demand through to 2024 will be 1.6% per year. Forecasts by service are below (**Figure 103**).

Figure 103: Demand growth forecasts by RTT treatment function

RTT treatment function	Clock starts year to end 2020	2019-24 percentage expected growth in Somerset per year
Trauma & Orthopaedics	26,443	1.0
General surgery	24,697	2.5
Ophthalmology	20,234	1.4
Other	24,278	0.9
Ear, Nose & Throat	14,186	0.9
Gynaecology	12,640	3.5
Dermatology	9,838	3.6
Urology	9,717	1.5
Gastroenterology	9,257	0.9
Cardiology	9,049	1.6
Thoracic Medicine	4,958	1.4
Neurology	3,794	0.6
Rheumatology	3,521	1.6
Geriatric Medicine	2,225	2.2
General Medicine	1,565	1.1
Plastic surgery	1,346	0.9

[129] Gousto partners with food bank in response to cost of living crisis (foodmanufacture.co.uk)
[130] https://www.yumpu.com/en/document/read/63829671/hidden-somerset-rural-isolation
[131] http://www.somersetintelligence.org.uk/profile-of-rural-somerset-from-the-2011-census.html
[132] English Longitudinal Study of Ageing 2012/13
[133] 2011 Census

Neurosurgery	385	1.1
Cardiothoracic surgery	206	1.1

Uncertain demand – Community services

23. Our best estimate of direct referrals for community physical health services is set out below. The pandemic has made it extremely difficult to forecast referral levels, in part because the level of demand in 2020/21 was so unusual compared to previous years. The projections below are based on demographic growth forecasts, recent changes observed in demand, and service directors' views about the likely future impact of Covid and the cost of living crisis on their respective services, see **Figure 104**. Whilst we saw referrals in 2020-21 fall as a result of the pandemic, demand rose back to pe-Covid levels in 2021-22 and we expect demand will rise again in 2022-23.

Figure 104: Demand growth projections for community physical health services 2019-20 to 2022-23

	Direct referrals				
	2019-20	**2020-21**	**2021-22**	**2022-23 *projected***	**2023-24 *projected***
Community physical health services	127,540	104,268 (-18% year on year)	127,788 (23% year on year)	129,941 (1.7% year on year)	132,150 (1.7% year on year)

Rising demand - mental health community services

24. Our best estimate of direct referrals for community mental health services in Somerset is set out below. The pandemic has made it extremely difficult to forecast referral levels, in part because the level of demand in 2020-21 was so unusual compared to previous years. The projections below are based on demographic growth forecasts, recent changes observed in demand, and service directors' views about the likely future impact of Covid and the cost of living crisis on their respective services, see **Figure 105**.

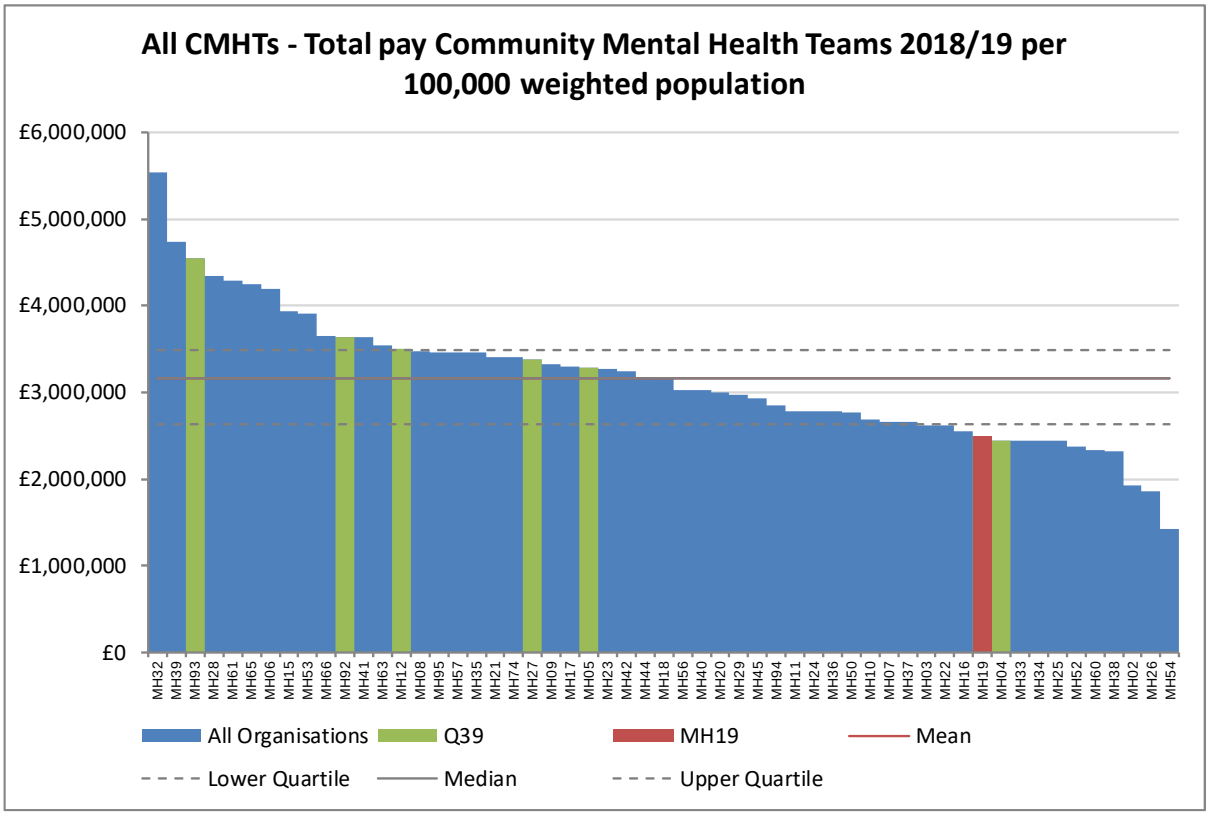
Figure 105: Demand growth projections for community mental health services

	Direct referrals				
	2019-20	**2020-21**	**2021-22**	**2022-23 *projected***	**2023-24 *projected***
Community mental health services	56,080	66,015 (18% year on year)	77,148 (17% year on year)	82,934 (7.5% year on year)	83,559 (0.8% year on year)

Historical underinvestment in community mental health services

25. Data from the NHS Benchmarking Network's 2021 Mental Health benchmarking project shows that Somerset's number of adult inpatient mental health beds is around the national average. However, funding for our adult community mental health services is in the lowest quartile nationally according to the 2019 benchmarking data (see **Figure 106**).

Figure 106: Comparative spend on community mental health services



N.B. Somerset FT is shown in red MH19.

26. The historical lack of investment in mental health creates pressure on other parts of the system. For example, the number of admissions to adult mental health inpatient beds per weighted head of population is amongst the highest in the country (6th highest of 56 mental health trusts benchmarked). At their last inspection of YDHFT the CQC expressed concern about the admission of children with mental health problems where there were no beds available for them in specialist mental health services. This underinvestment is particularly worrying given the observed and expected rises in mental health need.

Resources focused on bed-based care

27. Benchmarking analysis done in 2016 of the number of community hospital beds per 100,000 population in South West counties and other CCG areas with characteristics similar to Somerset found an average of 34 community beds per 100,000. More recent benchmarking data on the number of community hospital beds is not available, but we do know that since 2016 the number of acute beds has fallen nationally, as has the number of mental health and learning disabilities beds. With the introduction of new

care models, it is reasonable to believe that the average number of community beds nationally has fallen too.

28. The number of community beds in Somerset is currently 218 (down from 222 a few years ago), which equates to around 38 community beds per 100,000 population. This would suggest the number of community beds in Somerset is at best now around benchmark but more likely above benchmark if we are correct in our assumption that the number of community beds elsewhere has fallen.

29. A recent set of clinical reviews[134] performed in January-February 2021 found that 91 of 136 patients in Somerset's community hospitals did not require bedded care and would have been better cared for in other settings such as nursing care. YDH and MPH routinely have 150-200 patients who do not meet the criteria to reside in an acute hospital. Therefore, we know that there are still many people in bedded care who do not need to be there, and there is scope to further reduce our reliance on bed-based care.

Workforce recruitment

30. Somerset faces challenges around the recruitment of nursing and medical staff across a wide range of roles and specialties. The fact that Somerset has a below average proportion of residents of working age compared to England as a whole exacerbates the recruitment challenges in the county. Workforce gaps make it harder to deliver services that meet constitutional standards.

31. As at July 2022, SFT had 191.4 whole time equivalent unfilled registered nurse posts which represents a vacancy rate of 7.7%. As at June 2022, YDHFT had 19.6 whole time equivalent unfilled registered nursing posts (2.1% vacancy rate).

32. Both Trusts also have medical workforce recruitment challenges. At July 2022, SFT had 40.87 whole time equivalent consultant vacancies, representing a 11.3% consultant vacancy rate. YDHFT had 14.95 WTE consultant vacancies as at June 2022, representing 14.3% of the consultant establishment.

33. Staff absence at SFT as at July 2022 was 4.9% and staff turnover at SFT in July 2022 was 11%. Staff absence for the YDHFT group as at June 2022 was 4.7% and staff turnover for the YDHFT group in July 2022 was 19.9%.

34. SFT spent £19.904 million[135] in 2021/22 on temporary staff. YDHFT spent £19.495 million in the same period on temporary staff.[136]

Financial pressures

35. Both Trusts have underlying financial deficits driven in part by diseconomies of scale due to size and rurality. SFT and YDHFT are forecasting to end 2022/23 at breakeven. However, these positions include exceptional Covid funding, so do not reflect the true underlying financial positions.

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[134] Practice development forums.

[135] SFT spend in 2021/22 was split £8.624 million on medical temporary staff, £8.167 million on nursing temporary staff, and £3.113 million on other temporary staff

[136] YDHFT spend in 2021/22 was split £7.949 million on medical temporary staff, £8.492 million on nursing temporary staff, and £3.054 million on other temporary staff.

36. Providers' achievement of CIP targets is becoming increasingly difficult to deliver year on year, and neither of the Trusts nor the ICB in Somerset is likely to be financially sustainable in the coming years without transformational change to the way health services are delivered.

Annex 3: How our merger fits with national strategy

1. The following two tables (**Figures 107** and **108**) show how our merger fits with national strategy as set out in the NHS Long Term plan and the objectives of the NHS Integrating Care paper.

Figure 107: How our merger meets NHS Long Term Plan objectives

NHS Long Term Plan chapter	NHS Long Term Plan objectives	How our merger delivers the Plan objective
Chapter 1 – A new service model for the 21st Century	Boost 'out of hospital' care, further integrate primary and community services, reduce pressure on acute emergency services, and focus on population health – moving to Integrated Care Systems everywhere.	Somerset became an ICS in December 2020. The clinical strategy for the merged Trust takes a population health approach and will provide person-centred equitable care, closer to people's homes via more community-based services. The merged Trust will play a key role alongside our ICS partners in further developing the 12 Somerset neighbourhoods and supporting the 13 Primary Care Networks (PCNs) by aligning our community-based services and inpatient care with them, (see Aim 3 of the clinical strategy, chapter 5).
Chapter 2 – More NHS action on prevention and health inequalities	Strengthened contribution to prevention and tackling health inequalities.	Aim 1 of the clinical strategy sets out how we will provide increased support and advice to primary care, and support prevention and early intervention to prevent escalation of health need. Aim 4 of the clinical strategy focuses on tackling health inequalities, including treating mental and physical health conditions equitably, regardless of the setting in which a person first presents (see chapter 5).
Chapter 3 – Further progress on care quality and outcomes	The Plan confirms the need to continue to address the biggest killers and disablers of the population, with a particular focus on cancer, mental health, multi-morbidity and healthy ageing including dementia, while intensifying the focus on children's health, cardiovascular and respiratory conditions, learning disability and autism.	Aim 2 of the clinical strategy sets out our work to ensure our services are high quality, sustainable, and person-centred. Our merger plans include the creation of county-wide services which will help reduce overall waiting times and facilitate the sharing of learning and best practice within and between services. Aim 5 of the clinical strategy sets out our work to introduce personalised care, which will help people build their knowledge, skills and confidence in managing their health condition and ensure their care is focused on the things or outcomes that matter most to them (see chapter 5).
Chapter 4 – NHS staff will get the backing they need	The Plan recognises that in the past decade workforce growth has not kept up with the increasing demands on the NHS, which has led to NHS staff feeling the strain. The Plan also recognises that the NHS has not been a sufficiently flexible and responsive employer.	As a single organisation we will be able to offer improved career opportunities to existing and potential colleagues through rotational working in different care settings. The merged organisation's increased patient volumes and wider base of services will enable us to boost colleague capability, enhance clinical quality, and offer a richer and more attractive research environment. The enlarged Trust will have increased team resilience with less risk of colleague burnout, and we will be able to offer greater opportunities for flexible working and a more comprehensive colleague wellbeing package (see chapters 6 & 8).
Chapter 5 – Digitally	The Plan recognises that virtually every aspect of	Our merger enables us to roll out a unified electronic health record across the merged Trust to ensure all

NHS Long Term Plan chapter	NHS Long Term Plan objectives	How our merger delivers the Plan objective
enabled care will go mainstream across the NHS	modern life has been impacted by the digital revolution, but that the NHS has not yet been subject to a similar wholesale transformation. It provides a framework for investment in digital technologies for the future transformation of NHS services.	clinicians have ready access to the patient information they need. We will also roll out digitally-enabled solutions to support self-management and the provision of virtual care e.g. remote monitoring, patient access to their own health record etc. We continue to work with colleagues across the Somerset system on the Somerset Integrated Digital Electronic Record (SIDER) programme which aims to provide a shared summary care record accessible by clinicians, GPs, paramedics, out of hours/111, social care, patients and voluntary sector partners to support joined up care. See chapter 7.
Chapter 6 – Taxpayers' investment will be used to maximum effect	The Plan recognises the need to continue to drive efficiencies in the NHS in order to meet the increasing demands of the growing and ageing population, within the agreed funding settlement.	Our aim to provide care closer to patients' homes, where clinically appropriate, is better for patients and reduces costly bed-based care. The merger will also enable us to deliver a level of support service savings which we could not achieve as separate entities. The estimated cumulative savings released by merger up to 2027/28 are £87.6 million, see chapter 9.

Figure 108: How our merger meets NHS Integrating Care objectives

Integrating Care objective	How our merger delivers the objective
Improving population health and healthcare	Somerset ICS has committed to a model of care which focuses on population health. As a merged entity we will be in a better position to work with our ICS partners to drive improved population health and redirect our collective resources to the areas of greatest need.
Tackling unequal outcomes and access	Tackling health inequalities is the 4th aim in our clinical strategy – see chapter 5. Under this aim we will address disparities in health outcomes for disadvantaged groups and health differentials arising from socio-economic factors and rurality.
Enhancing productivity and value for money	We forecast that our merger will generate cumulative savings of £87.6 million up to 2027/28 (see chapter 9). Alongside these quantified savings we will increase productivity by removing interventions of low clinical value, and support colleagues to work at the top of their licence. We are investing in a unified electronic health record across the merged Trust which will save clinical time. We are also investing in artificial intelligence to support quicker, more reliable clinical diagnosis, and paperless solutions to realise efficiencies, including automated self-service processes (see chapter 7).
Supporting broader social and economic development	Our clinical strategy values patient time and seeks to reduce the collective patient time spent in poor physical or mental health (see chapter 5). This will promote the ability of the Somerset population to lead socially active and economically productive lives. The merged Trust will be a major employer in Somerset and will offer rewarding employment, including apprenticeships, with good career prospects and the opportunity to gain a professional qualification. We will continue to offer volunteering opportunities which help people develop new skills and remain socially engaged (see chapter 6).

	The merged Trust will be a major owner of estates and, through its ongoing estates redevelopment programmes, will create local employment and contribute to economic development (see chapters 7 and 8). As a merged Trust we aim to reduce our carbon footprint by 80% by 2030 and be a carbon neutral Trust by 2040. Fewer healthcare-related journeys as a result of our clinical strategy will lead to environmental sustainability and health benefits, and a lower carbon footprint for Somerset (see chapter 8).

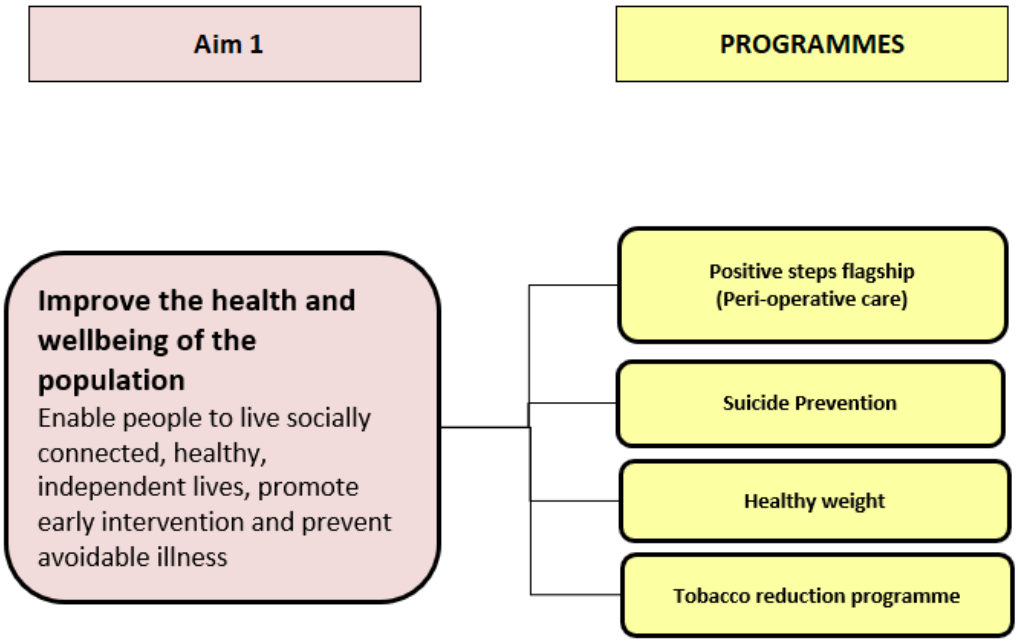
Annex 4: Trust programmes for delivery of the 5 clinical health and care aims

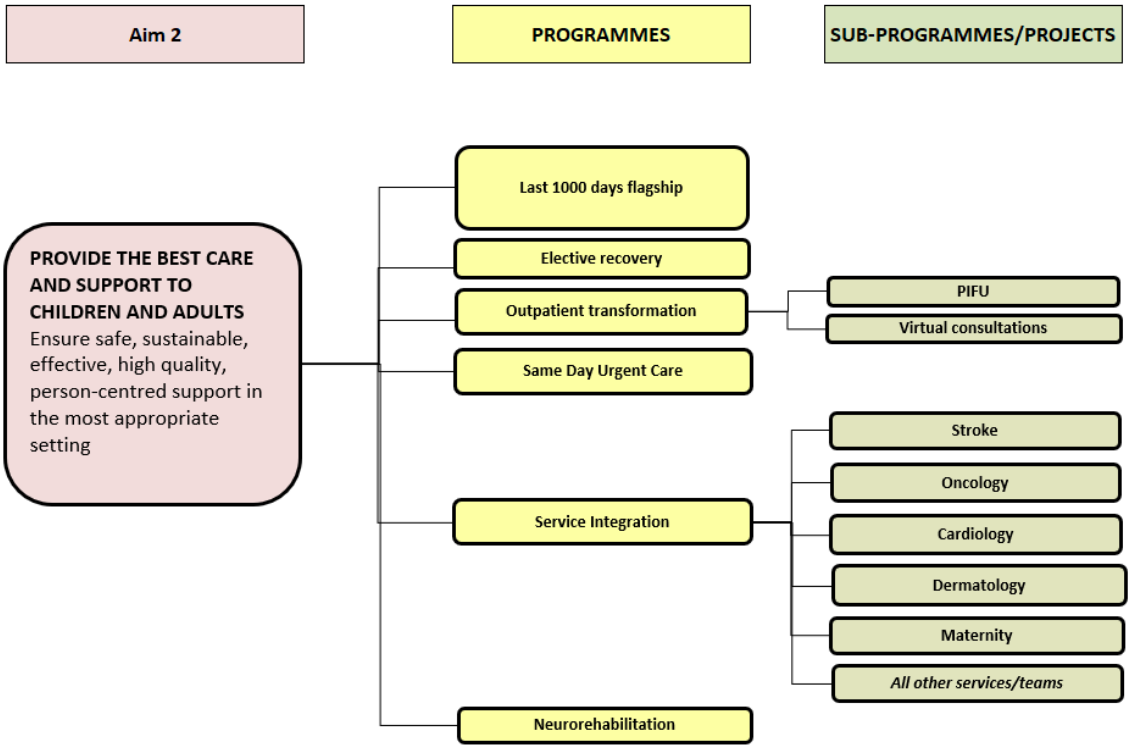
1. Under each of the county's five clinical health and care aims we have identified a flagship programme which embodies the aim and illustrates the changes we will make as a merged Trust. These flagship programmes are as follows:

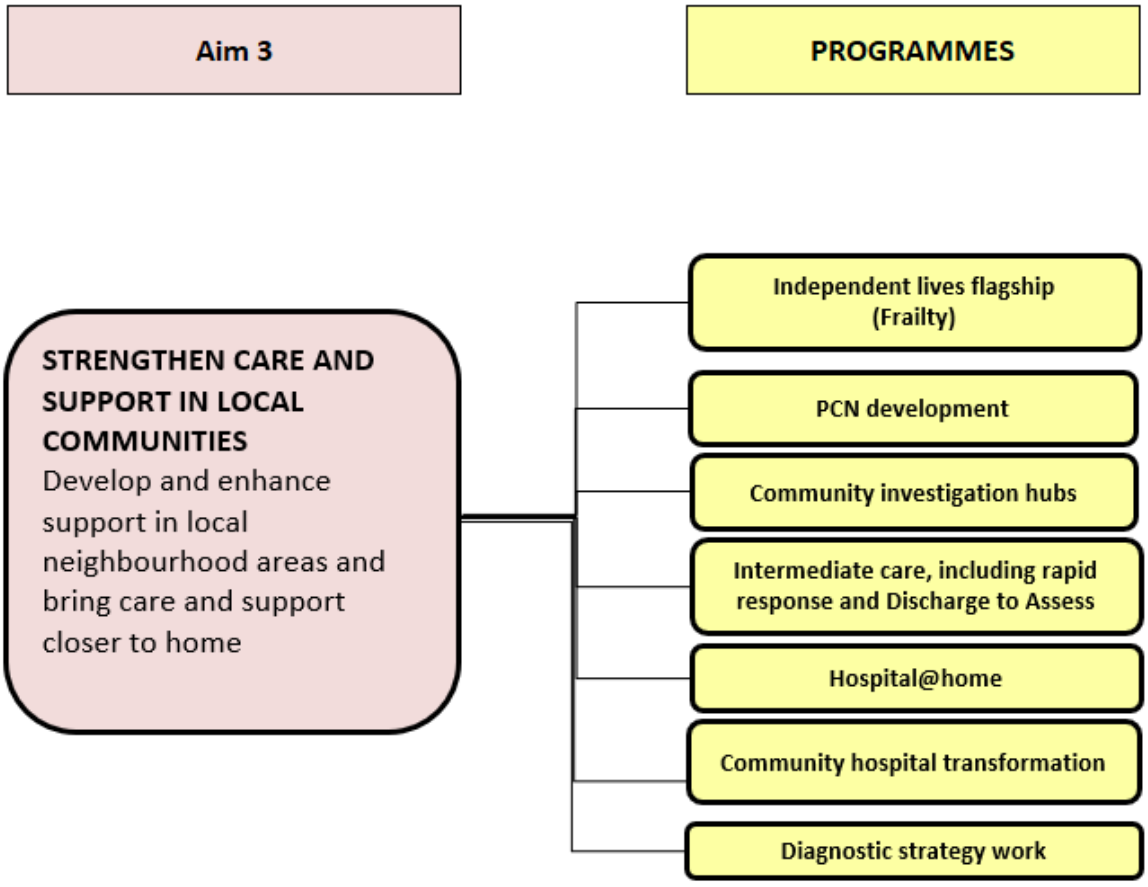
    - Aim 1: **Positive Steps** – Using the time waiting for surgery to optimise people's health and wellbeing now and in the future (peri-operative care)
    - Aim 2: **Last 1,000 days** – Valuing people's precious time in the last chapter of life
    - Aim 3: **Independent Lives** – Helping older people love as they wish, giving them time to do what is important to them
    - Aim 4: **Stolen years** – Helping people with mental health conditions live longer lives
    - Aim 5 (adults): **Connecting Us** – Using time well by working together to focus on what matters to people with complex needs
    - Aim 5 (children): **Function First** – Improving life chances for children by increasing their time in school.

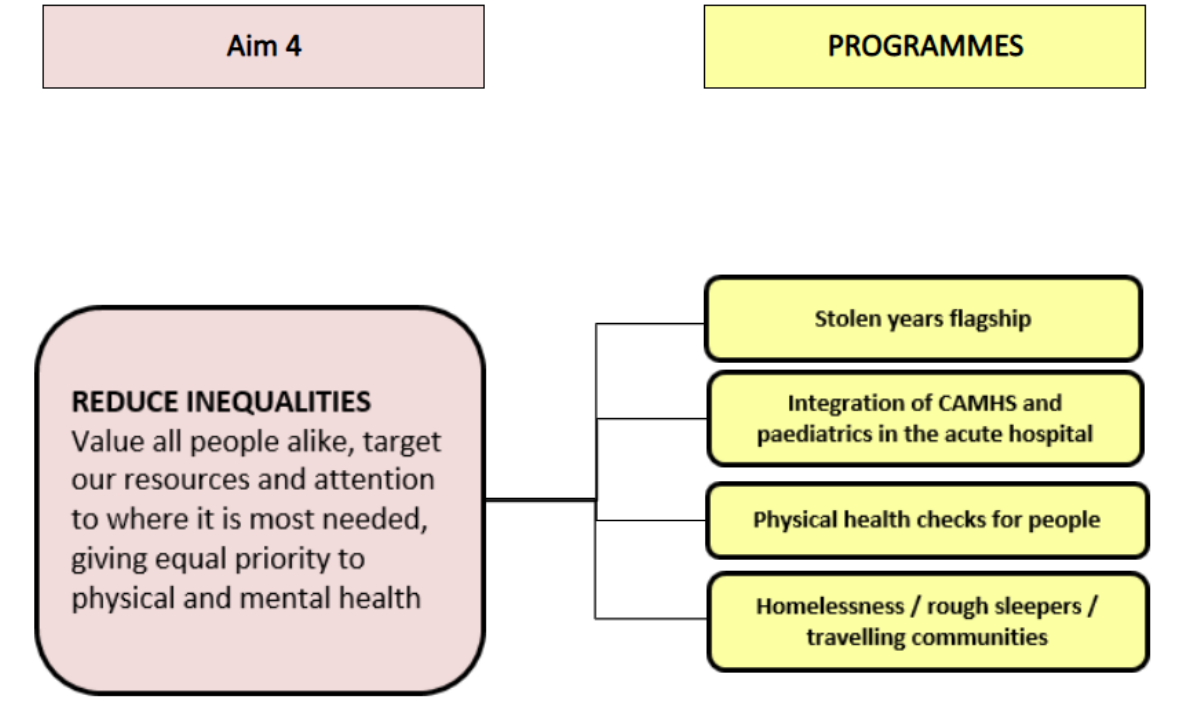
2. The following graphics (**Figure 109**) set out some of the key programmes by which the merged Trust will contribute to the delivery of the Somerset system's five health and care aims. These are our priority areas for reporting to the board of the merged Trust about our contribution towards the five aims. However, these graphics do not capture the whole of the merged Trust's work towards the aims as they do not include the work at service group level or individual service which is under development and will take shape in the coming months and years.

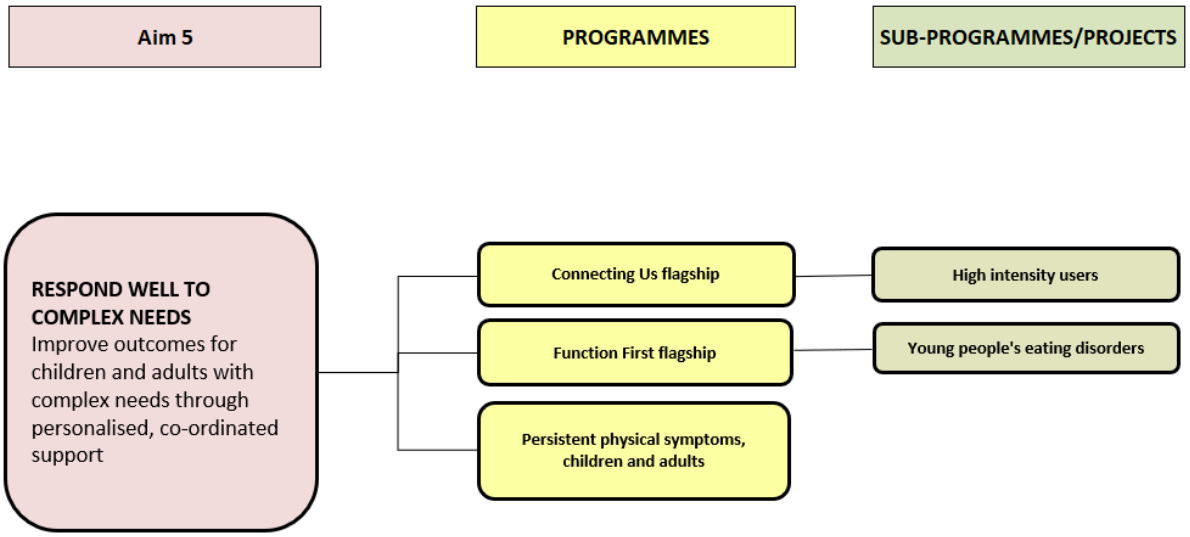
Figure 109: key programmes by aim




Aim 2
PROGRAMMES
SUB-PROGRAMMES/PROJECTS
PROVIDE THE BEST CARE AND SUPPORT TO CHILDREN AND ADULTS
Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting
Last 1000 days flagship
Elective recovery
Outpatient transformation
PIFU
Virtual consultations
Same Day Urgent Care
Service Integration
Stroke
Oncology
Cardiology
Dermatology
Maternity
All other services/teams
Neurorehabilitation


Aim 3
PROGRAMMES
STRENGTHEN CARE AND SUPPORT IN LOCAL COMMUNITIES
Develop and enhance support in local neighbourhood areas and bring care and support closer to home
Independent lives flagship (Frailty)
PCN development
Community investigation hubs
Intermediate care, including rapid response and Discharge to Assess
Hospital@home
Community hospital transformation
Diagnostic strategy work


Aim 4
PROGRAMMES
REDUCE INEQUALITIES
Value all people alike, target our resources and attention to where it is most needed, giving equal priority to physical and mental health
Stolen years flagship
Integration of CAMHS and paediatrics in the acute hospital
Physical health checks for people
Homelessness / rough sleepers / travelling communities


Aim 5
PROGRAMMES
SUB-PROGRAMMES/PROJECTS
RESPOND WELL TO COMPLEX NEEDS
Improve outcomes for children and adults with complex needs through personalised, co-ordinated support
Connecting Us flagship
Function First flagship
Persistent physical symptoms, children and adults
High intensity users
Young people's eating disorders

Annex 5: Levels in the model of care

1. The Somerset clinical model of care (see Figure 13) sets out how as a system we will deliver health care and support to our population. To achieve our shared vision, we have agreed as a system that we will provide care at the lowest level appropriate for a person's needs, starting with self-management and escalating through increasing levels of support and care if the person's health needs require it. As we rise through the levels, the number of people served at each level should decrease and the merged Trust's role increase. Further detail on this model is given in **Figure 110**.

Figure 110: detail on levels in the model of care

Level	Detail	Examples	Who's involved?	Merged Trust contribution (examples)
Level 1 Living well Living well by looking after my own health and wellbeing and that of my children, my family and friends within my local area	Focus is on prevention, reducing avoidable illnesses, and promoting self-management, achieved through easy access to good quality health and support information in own community or own home.	• Online resources & national and local literature giving health advice e.g. on weight management • Local support groups and classes • Vaccinations • Screening programmes	• Primary care • Voluntary sector • National NHS website • Pharmacists • Merged Trust	• Screening programmes e.g. diabetic eye screening • Offering good quality, accessible patient information in leaflets, Trust website and open access webinars • Health on the high street offer • Farmers' market offer • Open Mental Health contribution
Level 2 Advice & support Finding some support or personal advice in my local community	Local support for a specific need e.g. help for anxiety, support to carers, improving physical wellbeing	Local support for: • Stress and anxiety • Carers' cafes • Dementia cafes • Zing Somerset programmes	• Somerset County Council • Open Mental Health alliance • Neighbourhood groups • Voluntary sector e.g. MIND and Citizens' Advice Bureau, • Somerset Carers support service • Merged Trust	• Our contribution to Open Mental Health • Vision for community hospitals

Level 3 High level support Getting support for the challenges I am living with, as close to home as possible	Skilled advice and care from GP, or a healthcare professional e.g., district nurse, social care worker coming into own home or within neighbourhood setting.	• Routine care for longer term condition management • Early assessment for additional support required e.g. provision of aids to support independent living • Mental Health support into schools	• Primary care • Somerset County Council (social care) • District nurses • Schools (mental health provision) • Merged Trust	• District nursing team support for wound dressing and insulin injections • Hosted roles within the PCNs • Community teams (physical and mental health) • Secondary care advice & guidance to primary care
Level 4 Specialist and complex support I need specialist input or assessment; I need to be referred to a specialist service in a health and care setting	Care and support for people with more complex needs that can be provided within their own home or outpatient community setting.	• Complex Care teams in neighbourhoods • Specialist outpatient services e.g. CAMHS, Speech and language therapy, podiatry • Specialist residential settings, e.g. learning disabilities placements for people with autism.	• Merged Trust • Nursing homes • Somerset County Council (education service) • 111 • Community physical health services	• Community and outpatient teams (physical and mental health) with input from acute colleagues as needed, and care co-ordination as needed
Level 5 Inpatient or emergency care I need specialist support on-site from a specialist service	Care for people who require emergency or inpatient care to meet their time-critical needs.	• Acute inpatient care e.g. stroke care • Mental health inpatient setting e.g. Pyrland ward for dementia care. • Emergency foster care placement	• Merged Trust • Somerset County Council (foster care)	• Secondary care specialists (physical and mental health) • Emergency department including minor injuries units, urgent treatment centres

Annex 6: Quality governance arrangements in the merged Trust

1. We recognise the importance of having effective quality governance arrangements in place across the merged Trust from Day 1. This annex describes the key elements of the proposed quality governance framework for the merged Trust and the rationale for adopting this approach. Chapter 6 sets out overall governance in the merged Trust (see paragraphs 6.37-6.64).

2. The Trusts' Quality Governance Framework for the merged organisation is based on our current working model which has been tested jointly since April 2022 and developed through the merger which created SFT. It has been reviewed and supported through a range of internal audits on governance and two CQC Well-Led inspections.

3. The merged Trust will support over 11,000 WTE colleagues and operate from 75 sites across Somerset and Dorset. It will be unique in its depth and breadth of service – running services from two acute hospitals, mental health and learning disability services, community-based services, community hospitals, and a quarter of Somerset's GP practices. As a result, the Trust's Quality Governance has to be based on a devolved, three lines of defence model with operational and service quality overseen through service and service group governance and assurance, and central assurance oversight.

Committees

4. The Trusts' Quality and Governance/Governance and Quality Assurance Committees have met jointly since April 2022 and will become a single Quality and Governance Assurance Committee (QGAC) in the merged Trust. Every second meeting is a planning meeting, alternating with a detailed formal meeting. This provides an opportunity for Board members and senior clinical colleagues to review a wide range of information relating to patient safety, clinical effectiveness and patient experience and identify significant areas for detailed focus at the formal meetings.

5. The Committee is a sub-Committee of the Boards and is chaired by a Non-Executive Director. The two Chief Operating Officers, Chief Medical Officer, Chief Nurse, Director of People and OD and Director of Corporate Services are members alongside the Director of Integrated Governance, Director of Infection Prevention and Control, Medical Director for Acute Services and other senior clinical colleagues. The Chair of the Committee provides an assurance report to the Board following each meeting. This report sets out the assurances received by the Committee and any areas of concern or risk as well as providing oversight and assurance on the delivery of the strategic objectives in the Trust's clinical strategy (as part of the Board Assurance Framework).

6. SFT's Integrated Quality Assurance Board (IQAB) and YDHFT's Quality Assurance Group (QAC) have both been chaired, since February 2022, by the Director of Corporate Services who has overall responsibility for integrated governance across both organisations. Both IQAB and QAC report to the Joint Quality and Governance Assurance Committee (a sub-committee of the two Boards). It is planned that IQAB and

QAC will be combined from January 2023 and a single Quality Assurance Group established within the merged Trust.

7. The Quality Assurance Group (QAG) will work within a single framework of governance topics for assurance reporting, representing the full scope of compliance requirements across all services, including clinical governance, information governance and health and safety. Each of these areas is supported by a specialist group which is responsible for policy development, approval and compliance and escalation of risks and issues to QAG or direct to the Executive Team, if appropriate. The framework lists the topics, how they map to legislative requirements, the topic lead and the governance support link. Each topic report will report to QAG on an annual basis using a standardised template with in-year exception reporting.

8. Service Groups have responsibility for operational quality assurance. Each Service Group has its own governance structure and reports bi-monthly through a Quality Outcomes Finance and Performance (QOFP) meeting, in line with the Performance Management Framework. On quality and patient safety, Service Groups will report to the QAG on an annual basis on whether core governance requirements are being adequately met. The QAG, QOFP and governance topic framework will continue to operate in the merged organisation. Issues are reported by exception to the QGAC.

Quality impact assessments

9. Quality Impact Assessments (QIA) for CIPs are assessed at Service Group level. Teams are supported by the Governance Support Team to ensure risks are appropriately identified and assessed. Any QIA that scores 12 or above, involves the removal of a post or saves more than £25,000 is subject to review by the Chief Medical Officer and Chief Nurse and any areas either not supported or identified as significant risk are reported by exception to the QGAC.

Incidents

10. The merged Trust will have a harmonised incident reporting policy in place from Day 1. Currently SFT uses the RADAR incident reporting system and YDHFT uses Ulysses. To meet the new requirements for reporting to the national Learning from Patient Safety Events system, the Trusts will move to a single risk management software system for the merged Trust from Day 1.

11. Following publication of the new Patient Safety Incident Response Framework (PSIRF) in August 2022, the two Trusts have begun to develop a joint plan to prepare the merged Trust to implement PSIRF by August 2023 in line with nationally mandated timescales. PSIRF requires a fundamental change to how the NHS responds to, and learns from, patient safety incidents and the key focus for the merged Trust will be on reviewing our incident management process to ensure we deliver its four key aims:

    - Compassionate engagement and involvement of those affected by patient safety incidents

- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

12. Until PSIRF is implemented, the merged Trust will consider incidents in three tiers, initially based on the actual impact of the incident, moderated by the governance support team:
    - Low harm incidents will be managed by the local team who will lead any investigation that is deemed necessary by the local team. The governance support team will not be involved in this process;
    - Moderate harm incidents will be fully investigated by the relevant Service Group who will develop and monitor action plans. The governance support team will provide support as required but Service Groups will retain accountability for the incident process; and
    - Serious incidents will be subject to central oversight by the governance support team and associated governance.

13. Both Trusts have weekly Serious Incident Review Groups, which will be brought together from April 2023 and remain in place until PSIRF is fully implemented. These Groups reports to the QGAC and consider serious incidents, serious complaints, inquests and any concerns arising from the mortality review process. In respect of serious incidents, the Group reviews the root cause analysis and themes, and escalates any concerns to the Governance and Quality Assurance Committee or Board. During the implementation of PSIRF, the role of the Serious Incident Review Group will change significantly and it will eventually be replaced with new structures for sharing learning.

14. The governance support team is responsible for external reporting of incidents to NHSE (currently via the Strategic Executive Information System (StEIS) and the National Reporting and Learning System, but due to change to the Learning from Patient Safety Event System (LfPSE) from April 2023). The team also shares details of serious incidents with the CQC.

Complaints

15. The combined Trusts' PALS and complaints teams have been led by a single Head of Patient Experience since February 2022 who has responsibility across both organisations.

16. The Trusts currently use different systems to manage complaints (RADAR at SFT and Ulysses at YDHFT). We have developed a plan to train staff at each Trust in the other system to allow the teams to operate as a single team pre-Day 1. We have started developing a joint complaints policy which we aim to have in place from January 2023.

17. Both Trust Boards receive a report on a quarterly basis which includes numbers of complaints, complaint response times and trends. The merged Trust Board will receive a single report covering all services from Day 1.

18. In addition, a quarterly report is provided to a group (the Quality and Patient Experience Group at SFT which reports into the Council of Governors, and the Patient Care Group at YDHFT) which reports to the Hospital Leadership Group. This report covers numbers and themes of complaints, Patient Advice Liaison Service (PALS) areas of concern and any Parliamentary and Health Service Ombudsman (PHSO) cases, as well as Friends and Family test data and other patient feedback. We are aligning these groups to form a single Patient Experience Group which will report to the QGAC from Day 1.

Patient experience

19. The Trusts' patient experience teams have also been working together since January 2019.

20. The QGAC currently receives regular reports on patient experience, covering both Trusts. The reports cover the Friends and Family Test, details of service user involvement, volunteering data and any other patient experience information such as national and local patient and carer surveys.

21. The Trusts have merged their resources to support carer involvement and the SFT Triangle of Care Group oversees the commitment to shared involvement of patients, carers and healthcare professionals in service delivery and development.

22. The Trust will develop an Engagement Strategy by April 2023 to meet the requirements of the NHSE guidance "Working in Partnership with People and Communities".

Responsibilities under the Mental Health Act (MHA)

23. SFT provides support to YDHFT to meet its responsibilities under the Mental Health Act (MHA) via a Service Level Agreement. This has included ensuring training is in place and that there is effective working with local authority and other system partners, in line with the Mental Health Act Code of Practice. A new scheme of delegation has been developed, setting out responsibilities of key staff in the merged organisation in line with MHA requirements; this will be implemented from Day 1.

24. Compliance with the Mental Health Act and assurance on the effectiveness of our services for detained patients is overseen through the Mental Health Act Committee which is a sub-committee of the Board and will continue to operate at this level in the merged Trust. SFT's inpatient service is regularly reviewed by the CQC's MHA compliance team.

Risk management

25. Both Trusts have effective processes in place for the identification, reporting and management of clinical and non-clinical risks, supported by their governance teams. The risk management processes in each Trust are based on the Australian / New Zealand

risk management standard (further developed by the National Patient Safety Agency in 2008) and apply to both clinical and non-clinical risks.

26. Both Trusts currently use separate systems to record and monitor risks. As described in paragraph 10 above, the Trusts are procuring a new incident reporting system to be in place from Day 1 and this will also be used for risk management.

27. All risks are assessed and evaluated using a standard form and scoring system, allowing direct comparison of all risks. There has been a single Head of Risk working across both Trusts since April 2022. The Head of Risk has reviewed the risk scoring tools in each organisation and developed a standardised risk scoring tool to ensure risks in each organisation are being scored consistently. From this evaluation, risks are categorised into one of three accountability levels, and responsibility for the control and monitoring of the risk is allocated to the appropriate department, Service Group or the Trust executive team, depending on the level identified. Responsibility for completing actions is allocated to an individual manager, with monitoring carried out by the relevant Service Group or Trust committee.

28. In autumn 2022 the Trusts will develop a risk management strategy for the merged Trust to ensure that patients, visitors, employees, contractors and other members of the public are not exposed to unnecessary risks. This strategy will be supported by a single risk matrix and risk register template.

29. Work has been undertaken with both Boards in 2022 to develop a risk management vision statement, strategic aims, risk appetite and tolerance to inform the development of the strategy.

30. The corporate risk registers, which include all of the highest risks in each organisation, are reviewed on a monthly basis at the key operational committees in each organisation and quarterly by the Boards, with the overall process for management of risk being overseen by the Audit Committees, and this will be the approach in the merged Trust.

31. The proposed structure for the governance support team includes a single risk manager post to work across the merged Trust and support effective risk management.

Ward to Board reporting

32. Our planned merged performance management function will be able to provide information at Trust, Service Group and specialty level. The function will also consider reporting by theme where appropriate, for example on falls or pressure sores.

33. From September 2022, post-pandemic, the Trusts are re-introducing a rolling Leadership Walkaround programme involving both Executive and Non-Executive Directors and covering all service areas. This programme will continue in the merged Trust. Any concerns that are identified are fed into the relevant quality governance structures.

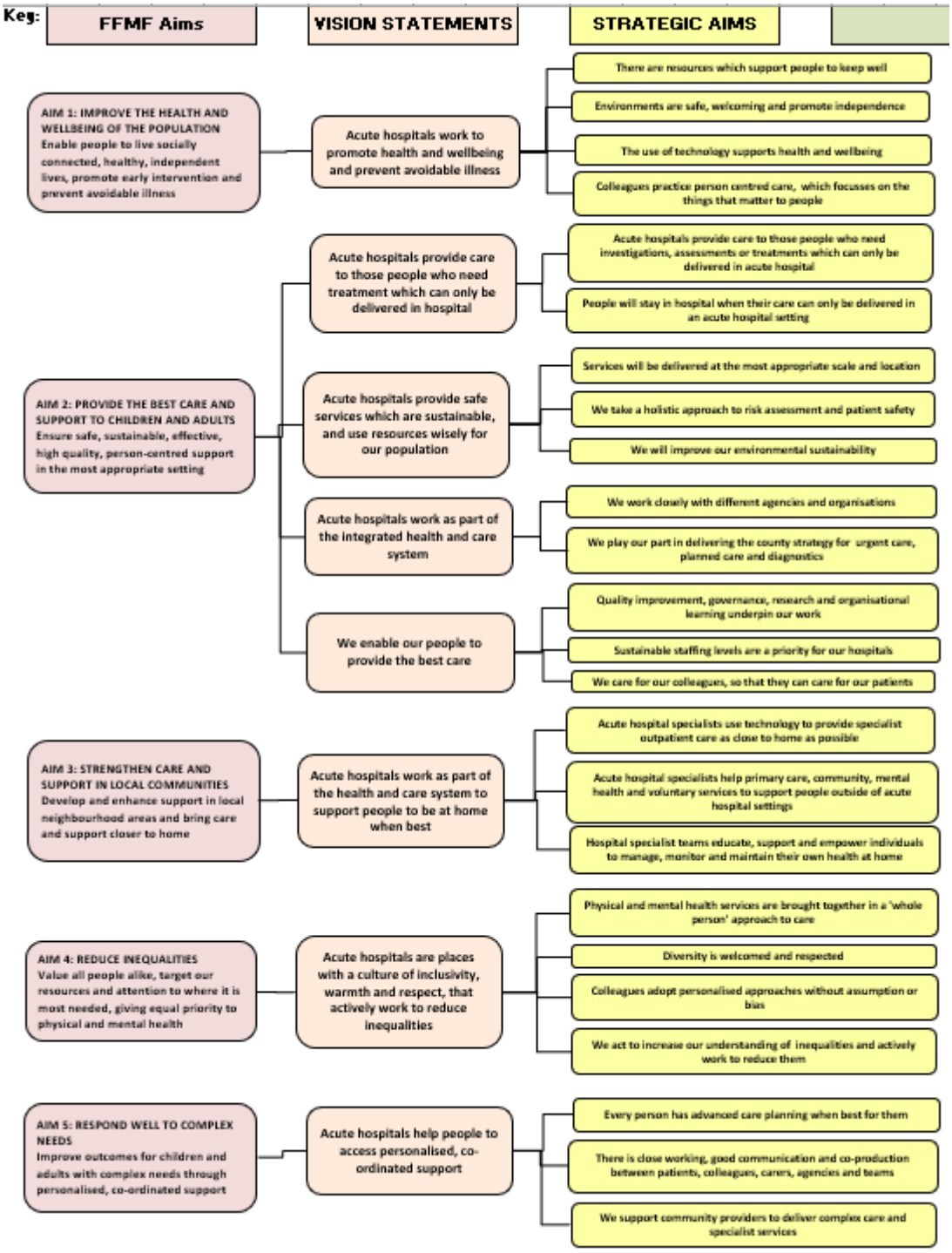
34. Both Trusts have quality assessment programmes in place. In SFT we have a comprehensive quality improvement programme for inpatient wards and departments,

this is our ward accreditation programme. There is a detailed roll out that now includes YDH wards. Mental health inpatient services are subject to an external accreditation process (AIMS). Once we have embedded inpatient ward accreditation we will move onto the development of accreditation for non-inpatient services across the new organisation.

Annex 7: Strategic aims for acute hospitals

1. **Figure 111** below sets out our aims for the use of acute hospitals, YDH and MPH.

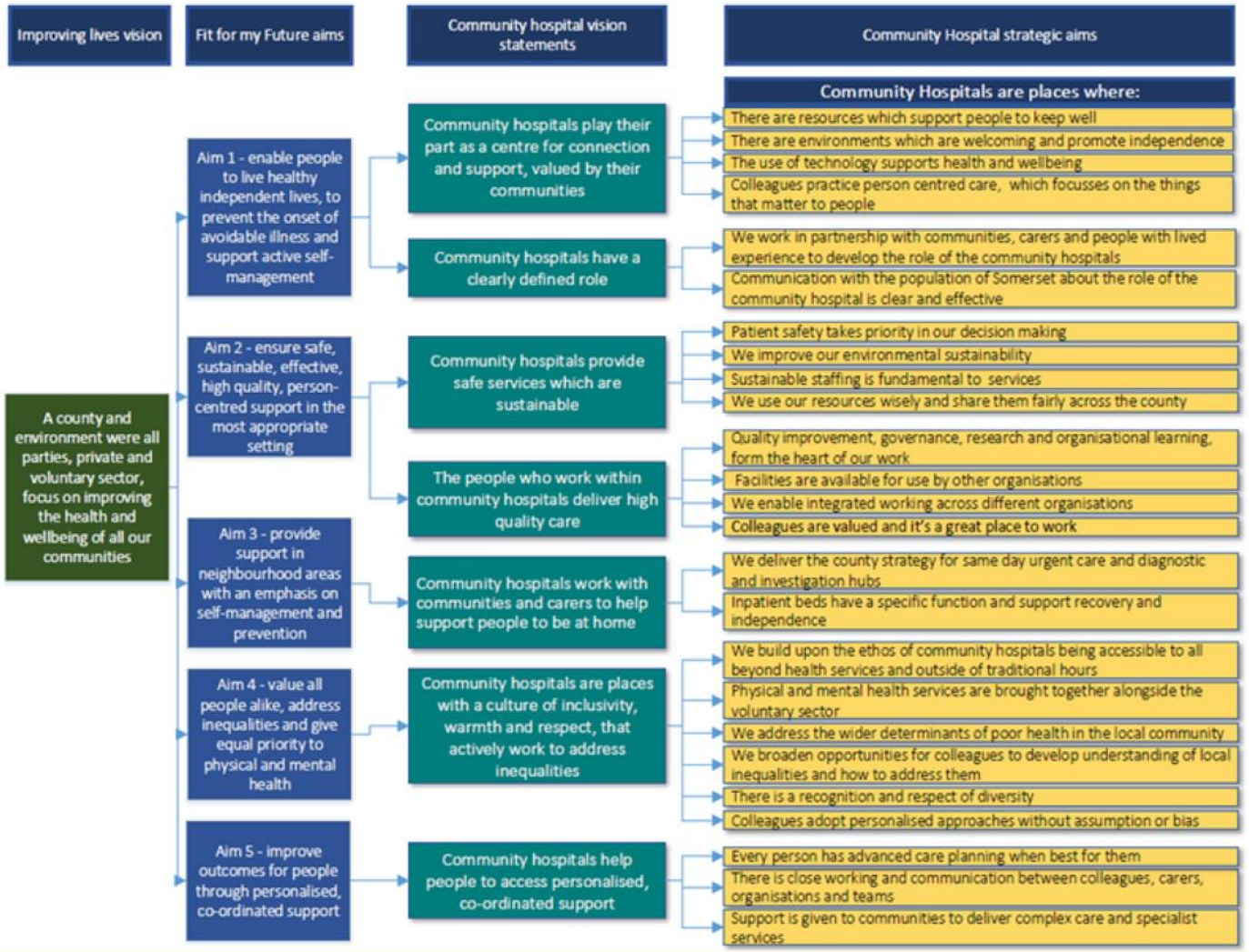
Figure 111: Strategic aims for acute hospitals



Annex 8: Strategic aims for community hospitals

1. **Figure 112** below sets out our agreed Somerset system aims for the use of community hospitals.

Figure 112: Strategic aims for community hospitals



Annex 9: Biographies of proposed members of merged Trust Board

This annex provides background on the proposed members of the Board of the merged Trust. All come from one or both of the legacy Trust boards.

Non-Executive Directors

Colin Drummond OBE, DL (currently Chairman and Non-Executive Director at SFT, observer to the YDHFT Board)

Colin was appointed chairman of SFT on 1 April 2020 following the merger between SPFT and TSFT. He was chairman of TSFT from 2014 and pro-chancellor and chair of governors of the University of Plymouth from 2016-2022.

From 1992 to 2013 Colin was chief executive of Viridor, one of the UK's leading recycling, renewable energy and waste management companies, and an executive director of Pennon Group PLC. He was then chairman of Viridor until the end of 2014. Prior to joining Pennon, Colin was chief executive of Coats Viyella Yarns Division, an executive director of Renold PLC, a consultant with the Boston Consulting Group and an official with the Bank of England. Colin was chairman of the Government's 'Living with Environmental Change' Business Advisory Board from 2009 to 2015 and of the Environmental Sustainability Knowledge Transfer Network from 2007 to 2013. He is master of the Worshipful Company of Water Conservators for 2022/23 (as previously in 2007/08) and was chair of the 'WET 10' City Livery Companies from 2008 to 2013. From 1997 to 2015 he was a trustee, and is now honorary vice president, of the Calvert Trust Exmoor.

Colin holds an MA from Oxford University and an MBA from Harvard Business School where he held a Harkness Fellowship. He was appointed an OBE in the Queen's Birthday Honours 2012 for services to technology and innovation, and a Deputy Lieutenant (DL) of Somerset in 2016.

Jan Hull (currently Non-Executive Director and Deputy Chair at SFT, Non-Executive Director at YDHFT)

Jan spent the early part of her career with Unilever, in an international perfumery business covering sales, marketing and general management roles, including two years in the USA.

She has over 20 years' experience of the NHS in Somerset, initially in public health and later as deputy chief executive for NHS Somerset, until she became managing director of the South, Central and West Commissioning Support Unit. Jan retired from this post in 2016.

Jan has worked at senior level with all of the major health and social organisations in the county, including primary care, local authorities and the voluntary sector. She also has significant experience of structural change, having led the merger of three commissioning support units in 2015.

Dr Kate Fallon (currently Senior Independent Director and Non-Executive Director at SFT, observer to the YDHFT Board)

Kate was appointed as a non-executive director on 1 July 2015 and came to TSFT, a predecessor of SFT, with significant experience in the strategic direction and transformation of services within the NHS. She established a completely new NHS Trust in 2010, which trebled in size and became the first community Trust to be licensed by Monitor as a Foundation Trust in November 2014. Previously Kate transformed her own general practice, taking it from a traditional reactive business to a forward-planning, innovative 'beacon site', with a sustained Investors in People accolade.

Kate is currently Chair of the Skills for Justice Awards. Her daughter is a Consultant at SFT. In 2015 she was included in HSJ's list of "Top 50 NHS Chief Executives" for her approach to service transformation and the integration of NHS services.

Martyn Scrivens (currently Chairman and Non-Executive Director at YDHFT, and Non-Executive Director at SFT)

Martyn joined the YDHFT Board in April 2018.

Martyn is a Fellow of the Institute of Chartered Accountants and chairs the Institute's Internal Audit Advisory Panel. He has 40 years of experience in audit and risk management, operating at board level with both the public and private sector. Over the last 15 years he has led the internal audit functions first at a major UK bank and then at a global investment and wealth management bank. From 2010 to 2012, he was a Board member of the East Kent Hospitals NHS Trust. Martyn chairs YDHFT's Financial Resilience and Commercial Committee.

Graham Hughes (currently Non-Executive Director at YDHFT and observer on SFT Board)

Graham Hughes joined the YDHFT Board in April 2018.

Graham has over 40 years of experience in the financial and legal sectors and was previously an Executive Director of Bank and Clients PLC. Prior to this, in his capacity as Managing Partner and latterly Chairman, he developed a legal practice to a multi-office large employer. He has a deep understanding of commercial and risk management within the financial sector together with a thorough knowledge of the core strategic principles of heavily regulated and competitive sectors.

He has also been involved in change management, developing policies for large and complex organisations including Whistleblowing, IT Security and Data Protection and People policies. Graham chairs YDHFT's Remuneration and Workforce Committees and is a member of the Financial Resilience and Commercial Committee.

Paul Mapson (currently Non-Executive Director at YDHFT and observer on SFT Board)

Paul joined the YDHFT Board in March 2020.

After an NHS career spanning 41 years, including 17 years as Director of Finance and Information at University Hospitals Bristol NHS Foundation Trust, Paul retired in June 2019.

He is Chair of YDHFT's Audit Committee and member of the Trust's Financial Resilience and Commercial Committee.

Barbara Gregory (currently Non-Executive Director at SFT, observer to the YDHFT Board)

Barbara Gregory has worked at senior management level in the NHS since 1993, including 15 years at Board level in a number of organisations in different parts of the health system – including as Director of Finance in an NHS organisation providing community and mental health services. She has an excellent working knowledge gained from first-hand experience of the health and social care system and has also been involved in the Strategic Transformation Programme in Cornwall.

Barbara has also worked closely with senior colleagues from the Local Authority on the integration of provision and commissioning and the opportunities for the devolution of expenditure to providers as part of the potential development of Accountable Care organisations/systems.

Alexander Priest (currently Non-Executive Director of SFT, Non-Executive Director of YDHFT)

Alexander is Chief Executive of Mind in Somerset, the mental health charity, a role he has held since January 2016. Many of the people that Mind in Somerset supports are, or have been in the past, supported by SFT. He is also a Non-Executive Director of the Bath & Wells Multi-Academy Trust, a Director of the Somerset Mental Health Hub, and a Board Adviser to Seedrs Ltd, an equity crowdfunding business. Before joining the third sector Alexander practised as an intellectual property lawyer.

Professor Sube Banerjee (currently Non-Executive Director of SFT, observer to the YDHFT Board)

Professor Sube Banerjee was appointed as an Associate Non-Executive Director of SFT from 1 May 2021 and became a Non-Executive Director in July 2021. He is Executive Dean of the Faculty of Health and Professor of Dementia at the University of Plymouth and an Honorary Consultant in Psychiatry at Plymouth University Hospitals NHS Trust. Sube brings an extensive knowledge and understanding of dementia and older people's health. He has worked on health policy and strategy internationally with the World Health Organisation, and led the development of the National Dementia Strategy for England. He has extensive strategic and research experience at board level in the NHS and the university sector as an executive and clinical director.

Executive Directors

Peter Lewis, Chief Executive

Peter joined TSFT, a predecessor of SFT, in 2005 as Director of Finance and Performance. He became Deputy Chief Executive in 2008 and took on the responsibility of Chief Operating Officer in 2010, before becoming Chief Executive in September 2017. Prior to joining the Trust, Peter was a Director of Performance at Dorset and Somerset Strategic Health Authority and has also worked in both commissioning and provider organisations prior to that. Peter is a Fellow of the Chartered Institute of Management Accountants.

Dr Daniel Meron, Chief Medical Officer

Dan joined TSFT, a predecessor of SFT, as Chief Medical Officer in 2019. Previously, he worked in Hampshire as Chief Medical Officer of Solent NHS Trust, which provides mental health, community, and primary care services in Southampton, Portsmouth and the Isle of Wight. Dan was also Deputy Medical Director at University Hospitals Southampton NHS Foundation Trust, a large acute teaching hospital providing secondary and tertiary services in Hampshire. Dan combines his wide-ranging experience of clinical board-level leadership with clinical work as a Consultant in Psychiatry, research, and teaching. Dan has a passion for service integration and leadership development. He provided medical leadership in SFT throughout the pandemic, and through the completion of the merger between SPFT and TSFT which created SFT.

Hayley Peters, Chief Nurse

Hayley has over 25 years of experience in the NHS and joined TSFT, a predecessor of SFT, in July 2013 as the Deputy Director of Nursing. Prior to that, Hayley worked in senior clinical leadership roles in the south west, London and the south east. Hayley became Acting Director of Nursing at SFT in September 2015, and then Director of Patient Care in December 2015.

Hayley's early professional career centred on critical care, first as an intensive care nurse and later, following a period of training at Birmingham Medical School, as one of the very first Physician's Assistants to practise in the UK.

As a senior nursing leader in the south west, Hayley has developed an interest in nursing and enabling elderly and frail people to stay safe and reach their full potential through personalised care and service integration. Hayley is passionate about excellence in patient care and aspires at every opportunity to improve patient safety, quality and patient experience. Hayley is an active local and national patient safety champion.

Andy Heron, Chief Operating Officer (neighbourhoods, mental health and families)

Andy joined SPFT, a predecessor of SFT, in January 2014, and has worked in health and social care for 27 years having originally qualified as an Occupational Therapist (DIP.COT). Having initially worked clinically in Cornwall and North Somerset he went on to manage mental health services there. He then managed mental health services in Bristol from 1999-2006 where he took a central role in integrating NHS and social care services and a modernisation programme that included complete service redesign and the comprehensive re-provision of the mental health estate in the city.

Following this Andy gained a broad range of experience in London and the South West in senior commissioning and provider roles in the NHS and also in social care where he worked at the level of Service Director with responsibility for services to people with physical and sensory impairment, learning disabilities and mental health problems. Prior to joining SPFT in 2014 he was Director of Projects for a successful mental health and community NHS Foundation Trust in East London with portfolio responsibility for service modernisation and commercial and business development.

Andy maintains a strong interest in care pathway redesign and service integration and is also Lead Director for Restrictive Interventions.

Matthew Bryant, Chief Operating Officer (hospital services)

Matthew has been Chief Operating Officer at Musgrove Park Hospital since 2015, and in January 2021 he also took on the role of Chief Operating Officer at YDHFT following the departure of the incumbent.

Matthew has worked in the NHS in the South West since 1998, managing medical and surgical services at the Royal Devon and Exeter Hospital, and being part of the management team when that Trust became one of the country's first foundation trusts. He led the Trust's

delivery of new models of care for older people, which included a strong focus on integration with services outside hospital.

He helped establish the Peninsula Medical School in Exeter, of which he became an Honorary Fellow, teaching undergraduate medical students about healthcare management. He was also involved in the commissioning of specialist services and the development of joint working for health authorities across Devon and Cornwall. Matthew joined the NHS on the national general management training scheme, after graduating from Oxford University. He is also a Trustee of Hospiscare, the palliative care provider for Exeter, East and Mid-Devon.

Isobel Clements, Chief of People and Organisational Development

Isobel started her career at TSFT, a predecessor of SFT, in 1988 and held several senior human resources and organisational development management roles, including at associate and deputy level, until she became Director of People for the Trust in 2014.

She has played a key role in developing our joint system of distributed leadership, and ensuring that our shared values are brought to life in everyday behaviour.

Isobel is a Fellow member of the Chartered Institute of Personnel and Development.

Pippa Moger, Chief Finance Officer

Pippa joined the NHS in 2002 as a management accountant at South Somerset Primary Care Trust where she remained employed until the restructuring of Primary Care Trusts in 2007 by which stage she had been promoted to Assistant Director of Finance. In 2007 Pippa joined NHS South West as Assistant Director of Finance responsible for strategic development of costing and Payment by Results for the South West. During her time at NHS South West a secondment opportunity arose in NHS Wiltshire to head up the Commissioning Team for 6 months.

In March 2009 Pippa joined YDHFT as Assistant Director of Finance and on leaving the Trust in 2013 became Interim Director of Finance at SPFT (a predecessor of SFT). Pippa has a passion for ensuring that NHS resources are used in the most efficient and effective way whilst ensuring patient safety is not compromised.

Pippa is a fellow of the Association of Chartered Certified Accountants (ACCA).

David Shannon, Director of Strategy and Digital Development

David joined the NHS in 1998 on its graduate financial management training scheme. His career developed within the Midlands including University Hospitals of North Staffordshire and Nottingham University Hospitals. In 2014 he relocated to the south west when he was appointed Director of Operational Finance at North Bristol NHS Trust, and he joined TSFT (a predecessor to SFT) in 2016 as Director of Finance.

David was appointed Director of Strategic Development at TSFT in October 2017 with responsibility for integration, digital services, strategic planning, and transformation.

David is a member of the Chartered Institute of Management Accountants and holds a BA(hons) in Accounting and Finance.

Phil Brice, Director of Corporate Services

Phil Brice joined SPFT (a predecessor to SFT) in 2012, having joined the NHS in 2000, working for Somerset Health Authority before becoming Director of Corporate Services for Taunton Deane Primary Care Trust and then Director of Corporate Services and Communications for NHS Somerset from 2006-2011. He previously worked for the Treasury Solicitor's Department, the Parliamentary and Health Service Ombudsman and AXA PPP healthcare.

Phil holds a BA (Hons) in English Literature and an MSc in Comparative and General Literature.

Annex 10: List of supporting submissions

1. Patient benefits case
2. Post-transaction Integration Plan (PTIP)
3. Finance template
4. Board certification
5. Due diligence Reports
6. Signed transaction Heads of Terms
7. Draft Transaction Agreement
8. Board skills gap analysis
9. Constitution of merged Trust
10. Board performance reporting format for merged Trust
11. Stakeholder engagement log
12. Communications & Engagement Strategy
13. People strategy
14. Digital strategy
15. Draft Estates strategy
16. Green plan
17. System Finance strategy
18. Governance topic framework
19. SFT cultural maturity audit
20. YDHFT cultural maturity audit
21. Register of proposed Directors' interests
22. 2-year review of TSFT/SPFT merger
23. Merger programme plan
24. Latest CQC reports for YDHFT and SFT
25. CQC action plans for YDHFT and SFT
26. Corporate risk registers for YDHFT and SFT