Yeovil District Hospital
NHS Foundation Trust

Somerset
NHS Foundation Trust

Patient Benefits Case

for the merger of

Yeovil District Hospital NHS Foundation Trust and

Somerset NHS Foundation Trust

November 2022

Contents

Table of acronyms

Acronym	Meaning
ACCU	Acute Cardiovascular Care Unit
ACP	Advanced Care Planning
ACS	Acute Coronary Syndrome
AEC	Ambulatory Emergency Care
AHOS	Acute Haematology Oncology Service
ASU	Acute Stroke Unit
BACPR	British Association for Cardiovascular Prevention and Rehabilitation
BANES	Bath and North East Somerset
BME	Black and minority ethnic
BMI	Body Mass Index
BMJ	British Medical Journal
BNSSG	Bristol, North Somerset and South Gloucestershire
CCU	Coronary Care Unit
CCG	Clinical Commissioning Group
CHB	Complete Heart Block
CHKS	Comparative Health Knowledge System
CQC	Care Quality Commission
CRT	Cardiac Resynchronisation Therapy
CST	Community Stroke Team
CT	Computerised Tomography
DCH	Dorset County Hospital
DNA	Did Not Attend
ECG	Electrocardiogram
ED	Emergency Department
EHR	Electronic Health Record
ESD	Early Supported Discharge
FT	Foundation Trust
GIRFT	Getting It Right First Time
GP	General Practitioner
HASU	Hyper Acute Stroke Unit
HCA	Health Care Assistant
HCP	Health Care professional
HDU	High Dependency Unit
HFpEF	Heart Failure with Preserved Ejection Fraction
ICB	Integrated Care Board
ICS	Integrated Care System
ISDN	Integrated Stroke Delivery Network
LMNS	Local Maternity and Neonatal System
MDT	Multi-Disciplinary Team (meeting)
MOU	Memorandum of Understanding
MPH	Musgrove Park Hospital

MRI	Magnetic Resonance Imaging
MSCC	Metastatic Spinal Cord Compression
NACR	National Audit for Cardiac Rehabilitation
NCP_CR	National Certification Programme for Cardiac Rehabilitation
NHSE	National Health Service England
NICE	National Institute for Clinical Excellence
NSTEMI	Non-ST Segment Elevation Myocardial Infarction
OPEL	Operational Pressures Escalation Level
OT	Occupational Therapy/therapist
PA	Programmed activities
PACS	Picture and archiving communication systems
PCI	Percutaneous Coronary Intervention
PCN	Primary Care Network
PDSA	Plan, Do, Study, Act
PET-CT	Position Emission Tomography - Computerised Tomography
POAC	Pre-Operative Assessment Clinic
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RN	Registered Nurse
RUH Bath	Royal United Hospitals Bath
SACT	Systemic Anti Cancer Treatments
SASP	Somerset Activity and Sports Partnership
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SFT	Somerset NHS Foundation Trust
SIDER	Somerset Integrated Digital Electronic Record
SLA	Service Level Agreement
SNICU	Somerset Neonatal Intensive Care Unit
SPFT	Somerset Partnership NHS Foundation Trust
SRU	Stroke Rehabilitation Unit
SSNAP	Sentinel Stroke National Audit Programme
STEMI	ST Segment Elevation Myocardial Infarction
STEP	Somerset Treatment Escalation Plan
STP	Sustainability and Transformation Partnership
SWAST	South West Ambulance NHS Foundation Trust
TIA	Transient Ischaemic Attack
TSFT	Taunton and Somerset NHS Foundation Trust
VF	Ventricular fibrillation
VT	Ventricular Tachycardia
WREN	Women Requiring Extra Nurturing
WTE	Whole time equivalent
YDH	Yeovil District Hospital
YDHFT	Yeovil District Hospital NHS Foundation Trust

1. Introduction

1.1 This Patient Benefits Case sets out the expected benefits for patients, their families and carers of the proposed merger of Yeovil District Hospital NHS Foundation Trust (YDHFT) and Somerset NHS Foundation Trust (SFT). This Case should be read in conjunction with the **Full Business Case** for merger.

1.2 This chapter provides background on Somerset and summarises the current service provision and the clinical strategy for the merged Trust. Further detail on the clinical strategy can be found in Chapter 5 of the Full Business Case for merger. Chapter 2 of this document summarises the patient benefits, both at a cross-cutting level and at service and locality level. The remaining six chapters set out the case studies we have selected to illustrate the detailed patient benefits we expect to flow from merger.

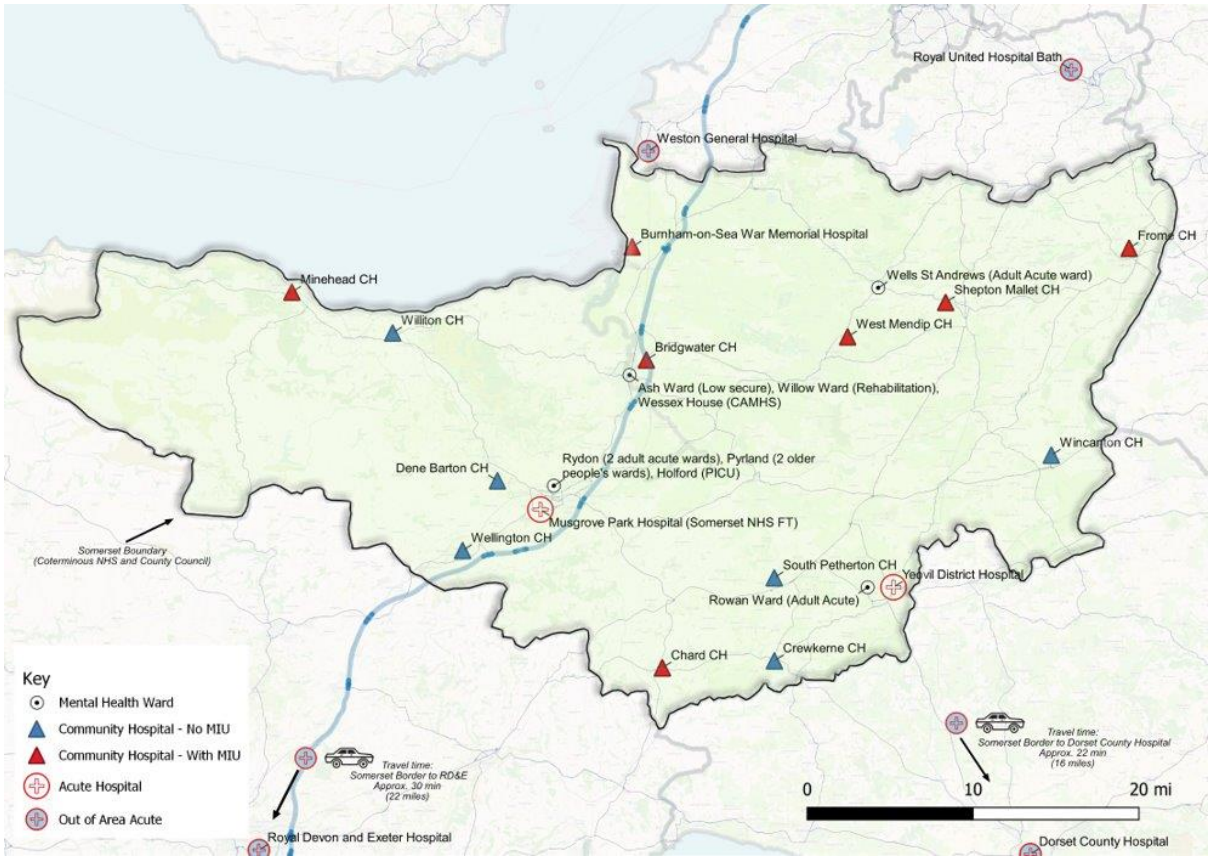
Somerset background

1.3 Somerset is one of the largest counties in England, extending to 1,600 square miles, with relatively low population density[1] and significant distances between population centres. 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 parts of the county which provide community services including mental health care and 7 minor injuries units.

1.4 Travel times across the county are two hours east to west, and one hour north to south. The present configuration of services and the largely rural road network means many residents have long travel times between home and hospital. **Figure 1** below shows the distance between health facilities in Somerset.

[1] Somerset's population density is 1.5 people per hectare, compared to a national average of 4.1.

Figure 1: distances between Somerset health facilities



Note: Travel time from Somerset border to Royal United Hospitals Bath is 26 minutes (10.3 miles).

1.5 48% of people in Somerset live in a rural area,[2] and people with the worst health and the lowest incomes struggle the most to travel to health services.[3] Public transport links in the county are poor, and one in five Somerset residents aged 65 or over has no access to car or van; the proportion is even higher amongst women.[4] This creates challenges around access to our services.

1.6 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, but we are finding it increasingly hard to sustain some services across the county's two relatively small acute hospitals, particularly in light of nationwide shortages for clinicians across a range of specialties.

1.7 **Annex 1** provides further information about the county, in the form of three maps showing population density across the county, household access to a vehicle, and travel times to MPH and YDH.

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

[3] English Longitudinal Study of Ageing 2012/13

[4] 2011 Census

Our vision and current service provision

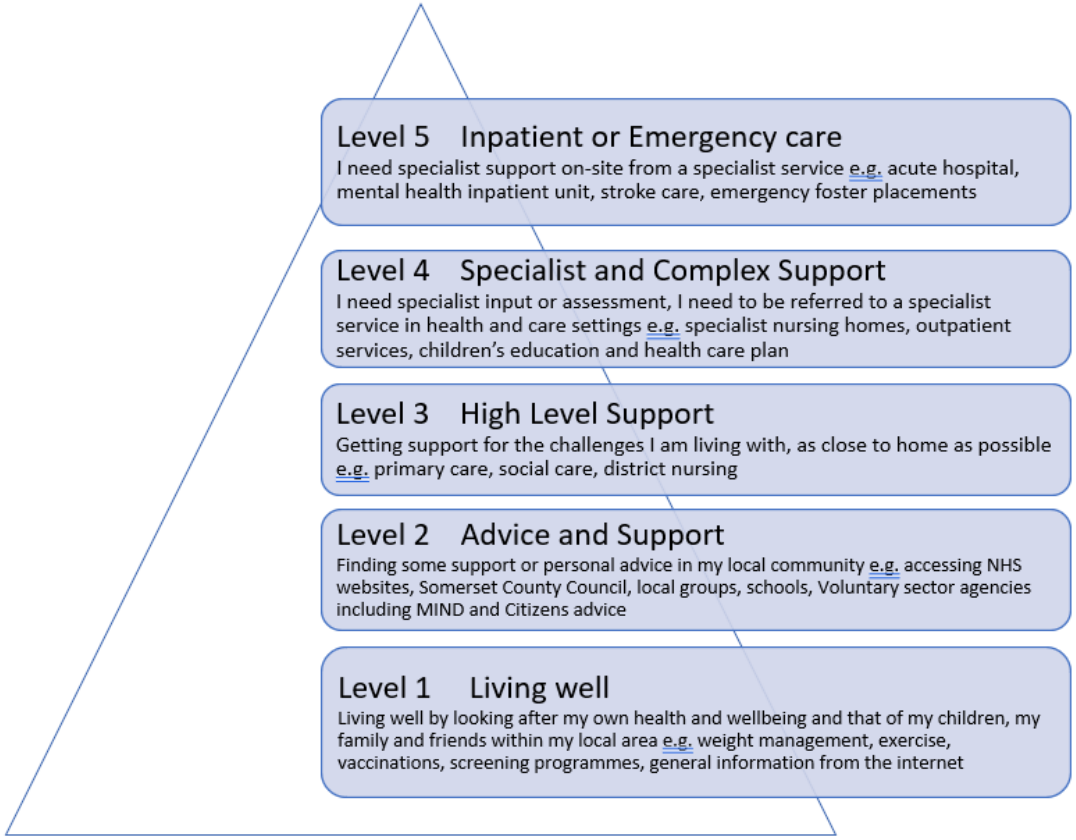
1.8 The Somerset system's shared vision for health and care in the county is:

> "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."[5]

Model of care

1.9 To achieve our 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 only escalating through increasing levels of care if the person's health needs require it, see **Figure 2**. This model of care was agreed following consultation with all system stakeholders, and public and patient involvement.

Figure 2: model of care



[5] Somerset draft integrated care strategy. See also: Building a healthier Somerset together – Fit for my future. (somersetics.org.uk)

Obstacles to achieving our vision

1.10 As a system we have identified the following obstacles to achieving our vision, which lead to sub-optimal patient care in Somerset:

- **Insufficient focus on population health and preventative care:** in line with our system commitment to adopt population health management we need to work as a system to invest more resources in preventing avoidable illness and disability.

- **Fractured and clunky patient pathways:** Many of our patient pathways are disjointed and over-long. Pathways are not integrated between services or across the county. Some pathways involve lengthy referral processes, have high thresholds for access to care, prompt duplicate assessments, or use an approach that focuses on discrete diseases when many people have co-morbidities. This creates delay in patients getting the care they need, leads to poor patient experience and is a poor use of our resources.

- **Too much resource spent on hospital care**: Care in Somerset is weighted towards admission to inpatient beds (both acute and community). Some people are spending time in hospital settings when more accessible local care and support would have been more appropriate had it been available. Inappropriate bed-based care exposes patients 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 causes anxiety and inconvenience.

- **Health inequalities:** The average life expectancies of men and women with a mental health disorder are 20 and 18 years lower respectively than the rest of the Somerset population. In England, people affected by homelessness die on average around 30 years younger than the general population.[6] We need to invest in data and analytics to better understand local health inequalities and inform our actions to address them.

- **Poor coordination of care for people with complex needs:** coordinating care for people who need help from several services remains a challenge, and personalised care has not yet been implemented in all healthcare settings.

5 clinical health and care aims

1.11 To guide our work, the Somerset system has agreed 5 health and care aims which respond to the identified obstacles set out in paragraph 1.10, and which will enable us collectively to deliver our health and care vision. These 5 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.

[6] 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]

- **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.

1.12 As a system, we developed these aims bearing in mind the current and future needs of the Somerset population, and the obstacles Somerset faces in delivering consistently high quality and efficient care.

Clinical strategy

1.13 The merged Trust's clinical strategy sets out how we will play our role in delivering the 5 clinical health and care aims. These aims are summarised below, and further detail about our clinical strategy is in Chapter 5 of the Full Business Case for merger.

Aim 1 - Improve the health and wellbeing of the population

1.14 The intention of this aim is to promote healthiness and independence, avoid illness and harm, and support active self-management and patient empowerment.

1.15 We will increase our work with partners to support prevention, self-management and early intervention to reduce avoidable illness and escalation of health need. For example we will provide more specialist support to primary care and the voluntary sector, give information to people to help them self-manage their health needs, and ensure that at every stage we are taking steps to prevent avoidable illness and disability.

1.16 We will further develop our support for unpaid carers who play such an important role in supporting people with long term conditions. We will also work with our system colleagues to gather and analyse data about the health of the Somerset population.

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

1.17 The intention of this aim is to get the fundamentals of care right and put the people we serve at the heart of their care.

1.18 We will bring together YDHFT and SFT's services into single county-wide services, building on the best from both Trusts as we do so. Working with partners we will streamline and standardise care pathways to remove duplication and inefficiencies, and break down the barriers that exist between services. Each clinical service in the merged Trust will operate to consistent standards across the county, and use a single waiting list.

1.19 We will also ensure people only receive bed-based care when it is right for them, to avoid harms such as deconditioning.

Aim 3 - Strengthen care and support in local communities

1.20 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.

1.21 We will work closely with the 12 neighbourhoods and 13 PCNs in Somerset, both to support their operation but also to provide more care in people's homes and in community settings rather than in an acute hospital.

Aim 4 - Reduce inequalities

1.22 This aim seeks to address health inequalities including those experienced by people with mental health problems, and people who are particularly vulnerable such as people experiencing homelessness.

1.23 We will integrate YDHFT's acute services with SFT's county-wide mental health and community services. This will enable the benefits already felt in the west of the county (where physical and mental health care are already integrated) to be extended to patients in the east of the county.

1.24 Significant data gaps exist and we will also work with our partners in public health to better understand local health inequalities.

Aim 5 - Respond well to complex needs

1.25 This aim seeks to improve patient care and experience through improved coordination and personalised care. Although the aim covers the whole population, the main weight of effort will be directed at those with complex care needs or people living with more than one long-term condition, who spend the most time in healthcare.

1.26 We will implement personalised care for people in Somerset in line with the commitment set out in the NHS Long Term Plan. Working with our partners we will support people to build their knowledge, skills and confidence in managing their health condition and help them to live as independently as they wish.

Valuing time

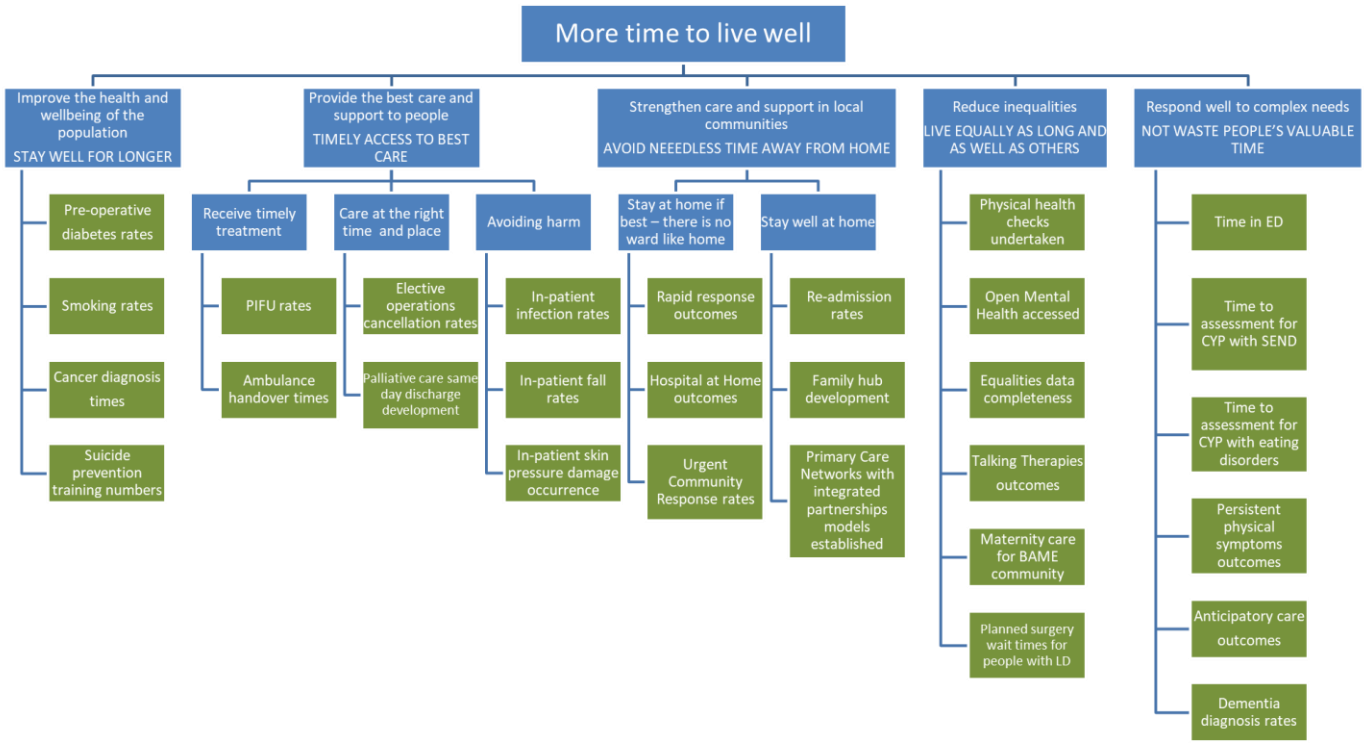
1.27 Valuing time - both patient and colleague time - is a key part of our clinical strategy. For most people the outcome they want from healthcare is to be as well as possible to be able to do the things that matter to them. That means spending as little time as possible in healthcare, and staying healthy for as long as possible. We also want to explicitly value colleague time and make doing the right thing, the easy thing to do. **Figure 3** sets out what we mean in practice by valuing patient and colleague time.

Figure 3: 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 facts 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.

1.28 We will use time as a measure of the success our of clinical strategy. 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. The measures we will use are set out in **Figure 4** below.

Figure 4: measures for valuing time



2. Summary of patient benefits

2.1 This chapter summarises the patient benefits we expect to flow from merger. Merger will enable us to implement our clinical strategy, and realise substantial patient benefits including quicker access to treatment, reduced length of stay in hospital and a better patient experience.

2.2 Both Trusts have some clinical services which are unsustainable in their current form; in many cases this is due to long-standing staffing gaps. Inequities also exist across the county, where some patients can access specialist care more readily than others, depending on where they live. Merger will strengthen our recruitment and retention offers, and help us implement consistent care across the county.

2.3 Although many YDHFT and SFT services are already working closely together e.g. to cover staffing gaps, align policies etc., different IT systems, employment contracts, governance arrangements and budgets hamper this collaboration. Merger offers the opportunity to overcome these barriers and secure significant patient benefits in terms of better care and experience. It also enables us to streamline processes and remove duplication to free up clinicians' time for more front line care and work more effectively with system partners.

Cross-cutting patient benefits

2.4 **Figure 5** set out the cross-cutting benefits we expect to flow from merger. Everyone who has contact with the merged trust will benefit from the changes set out in Figure 5, and the whole population will benefit from our work with partners to intervene early to tackle illness.

2.5 The merged trust will serve the population of Somerset (572,000 people), plus people living in neighbouring parts of Devon, Dorset, Wiltshire, BANES and north Somerset. The number of patient contacts in 2021/22 at YDHFT and SFT were 506,085[7] and 1,838,602[8] respectively. A more detailed version of Figure 5, which includes specific examples of benefits, is at **Annex 2**.

[7] 193,934 individual patients within each type of service (e.g. inpatient, outpatient etc)

[8] 460,091 individual patients.

Figure 5: Cross-cutting patient benefits (summary)

Change as a result of merger	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 • Periods of illness are less acute and recovery is quicker • Improved health trajectory from lasting lifestyle changes • Reduced exposure to risks associated with bed-based care (deconditioning etc.)	• In some cases, shorter length of stay, as illness is less acute when treatment starts • Avoiding delays to surgery
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; back to normal life more quickly. • 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 • 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	• 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 • Frees up colleague time 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	• Improved clinical decision-making leading to better health outcomes as colleagues see wider range of clinical cases, share knowledge and best practice (including via county-wide MDTs), and unwarranted variation is reduced • Removal of duplicate tasks leads to 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 and provide better care for people with rarer conditions	• Less patient time waiting for care as a result of fewer short-term staffing gaps (staff better able to cover colleagues' absence, and fewer planned procedures are postponed) • Planning, delivering, and reporting on national requirements only needs to be done once rather than twice

Change as a result of merger	Benefit	
	More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**
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
Integration of all acute, community and mental health services in the county	Facilitates system-wide work with partners in primary care, social care and the voluntary sector on: • prevention and early intervention to reduce avoidable illness and escalation of health need • population health management, and tackling health inequalities • individual service-level strategies agreed at system level e.g. oncology MOU and the potential reconfiguration of stroke services	• Aids work with partners to streamline and standardise care pathways to remove duplication and inefficiencies
Digital integration including a unified electronic patient record	• Ready access to patients' full clinical history increases patient safety and good clinical outcomes • Lower clinical risk from human error when sharing/re-keying patient information *See also Figure 10.*	• Supports clinicians to provide care more efficiently • Patients only have to share basic facts once *See also Figure 10.*

2.6 The merger of Somerset Partnership NHS Foundation Trust (SPFT) and Taunton and Somerset NHS Foundation Trust (TSFT) in 2020 yielded many benefits for patients, including a more responsive system (as demonstrated by our Covid vaccine rollout), holistic care that meets physical and mental health needs, and more care available closer to patients' homes. Our planned merger of YDHFT and SFT will enable us to build further on these gains and extend them across the whole county.

Potential disbenefits

2.7 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 be delivered from a smaller number or single 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.

2.8 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.

Identification of benefits

2.9 We know that if merger were not to proceed, the obstacles to the delivery of high quality care in Somerset (see paragraph 1.10) would persist, with the associated negative impacts on patients, their families and carers. We also know that some of our services would continue to be subscale, with the attendant quality challenges that brings.

2.10 The following sources are amongst those we have used to identify the patient benefits of our planned changes:

- Analysis done for Fit for My Future, the ICS strategy for health and care in Somerset
- Policy guidance on sub-scale services
- People metrics at both Trusts

Service level benefits

2.11 The remaining chapters of this document consists of our six service level case studies which illustrate the patient benefits we expect to achieve by merging our Trusts. Each case study has a senior level sponsor. The case studies and their sponsors are as follows:

- Maternity (executive sponsor: Hayley Peters)
- Oncology (executive sponsor: Matthew Bryant)
- Cardiology (executive sponsor: David Shannon)
- Stroke (senior sponsor: Dr Meridith Kane)
- Peri-operative care (executive sponsor: Phil Brice)
- Homelessness (executive sponsor: Dr Dan Meron)

Case study selection

2.12 All our case studies are priority areas for change, either because of pressing staffing challenges, or because by coming together we can better serve an underserved cohort of patients.

2.13 We chose to write up these six case studies because they illustrate the breadth of services which the new organisation will provide - spanning acute, community, mental health and primary care. We also selected them to demonstrate the benefits which will

flow from both the horizontal and vertical integration that our merger offers. Finally they also show how we will play our part in delivering the 5 Somerset system health and care aims. **Figure 6** below provides more of the rationale for selection of these services as case studies.

Figure 6: rationale for case study selection

Maternity	The maternity transformation agenda, ensuring high-quality services for women, babies and their families, is a national and local priority. Furthermore, the sustainability of Somerset's maternity services has been subject to scrutiny in recent years. We know that integration will speed up our ability to meet our maternity transformation ambitions by bringing together services delivered in acute and community settings, as well as physical healthcare and perinatal mental healthcare.
Oncology	Oncology services in Somerset have always benefitted from, and relied upon, cross-county collaboration between the two Trusts. However, while some improvements have been made, shared solutions have been hard to broker while we are two separate organisations, and the advent of Covid hampered work to address workforce challenges and inequities of service provision. Both teams are committed to the vision of a single integrated service and have invested in planning their integration and establishing oversight and reporting processes. In addition, early successes such as the Cancer helpline demonstrate the benefits of working together.
Cardiology	Our cardiology services have collaborated closely since the opening of the regional Cardiac Catheterisation Lab in the early 2000s. But while clinical pathways such as STEMI, ACS/NSTEMI are shared, many challenges and inequities remain as a result of the two services having different pathways and service provision. The cardiology teams are eager to realise their ambition for an equitable service in the county and were chosen as a case study to act as an exemplar to other services.
Stroke	There is a history of close collaboration in Somerset along the whole stroke pathway (acute and community and third party providers). The teams have worked in partnership as part of the integrated stroke delivery network to agree a county vision and deliver optimal stroke care in line with national guidance. The TSFT/SPFT merger demonstrated that benefits can be achieved through integration of stroke services (e.g. delivering shorter lengths of stay). This current merger offers the opportunity to optimise use of our combined resources to address rising demand and gaps in the specialist stroke workforce at both providers.
Peri-operative care	Peri-operative care is support to patients before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up As a promising programme of work that was developing in one Trust but would ultimately need to be county-wide, peri-operative care was selected as a priority to become a joint programme, pre-merger.
Homelessness	Reducing health inequalities across our population is one of our system's 5 health and care aims. This case study was chosen to show how sharing our experience, learning and skills from implementing innovative approaches in both organisations will help us improve the health care services provided to Somerset's more vulnerable populations.

2.14 Two of our case studies (Peri-operative care and Homelessness) differ from the others in that they describe work to formulate a county-wide approach to a new form of care, rather than bringing together existing, well-established services (as is the case with the

other four case studies). The vertical integration offered by our merger presents a unique opportunity to integrate care for homeless people and people awaiting surgery along the full extent of patient pathways from primary care through to acute services, and across mental and physical health services, and to do so in a consistent county-wide way. For example, merger helps us link with primary care so surgical patients can get support for modifiable risk factors as early as possible prior to their surgery (see chapter 7). Vertical integration also makes it easier to improve access for homeless people to mental and physical health care tailored to their needs (see chapter 8).

2.15 **Figure 7** below summarises the service-level benefits from our six case studies. These benefits are in addition to the cross-cutting benefits set out in Figure 5.

Figure 7: service-level patient benefits

Change	Benefit to patients	No. of patients benefitting a year
Maternity		
Combining our maternity teams, including WREN team	• Increased scale and ability to implement national requirements (including personalised care)	c. 4,300
	• Improved maternity care and experience for women living in the 'corridor' in the middle of the county, especially those with complex pregnancies or with additional needs	c. 600
Oncology		
Overhaul of psychological support offer	• Better care for the psychological aspects of cancer	c. 550
Improved access to clinical trials	• Earlier access to innovative drugs, closer monitoring during treatment, and improved patient outcomes from trial participation • Enhanced colleague knowledge of leading edge treatments	c. 100-150
Fewer inter-site transfers	• Reduced clinical risk from site transfers • Less discomfort & inconvenience from being transported between sites • Less colleague time spent administrating patient transfers which frees up time for front line care	c. 5
Cardiology		
Amended acute NSTEMI pathway	• Quicker patient access to diagnostics and specialist care leading to improved patient outcomes • Reduced clinical risk from fewer inter-site patient transfers • Less patient time waiting for specialist care and feeling anxious. • Eliminate duplicate investigations which will reduce patient waiting and free up clinical time • Improved use of combined diagnostic capacity, which reduces patient waits • Less patient time (and less discomfort) from being transported between sites • Reduced administrative work associated with inter-site transfers, which frees up colleague time to care for other patients	c. 200

Amended pacemaker pathway, and remote monitoring county-wide	• Right pacemaker first time which reduces risk of heart failure • Quicker identification of deteriorating heart function, which supports early intervention • Fewer pacemaker upgrades which frees up clinical time and catheterisation lab capacity for other patients • Greater patient convenience from not having to attend as many face to face appointments • Greater patient peace of mind from continuous heart monitoring	c. 690
County-wide clinics	• Improved access to care for heart failure patients for mental health aspects of their condition • Improved access to cardiac rehabilitation • Improved access to care which meets both physical and mental health needs	c. 150 for patients with heart failure and angina + c. 50 for patients benefitting from emotional health checks
Stroke		
Combined patient and carer education and support programmes	• Equity of provision of support leading to improved health outcomes • Care better tailored to individuals' needs • Increased patient confidence to self-manage • Healthcare workers' time focused on what only they can do (rather than taking on tasks better done by others)	c. 1,100-1,400 patients + 700-800 carers
Improved use of physical capacity	• More care provided closer to home • Rehabilitation support less likely to be stood down	c. 1,100-1,400
Peri-operative care		
Introduction of a county-wide approach to peri-operative care	• Quicker recovery and fewer complications post-surgery • Better patient experience • Lasting lifestyle improvements which benefit long-term health	c. 24,850
Homelessness		
Introduction of a county-wide approach to care of homeless people	• Intervene early to prevent escalation of health need • Address a significant health inequality in our county • Provide coordinated care which is tailored to the complex needs of this patient cohort	up to c.300-400

2.16 In addition, locality-level benefits will derive from closer working between the merged trust and PCNs/neighbourhoods (see paragraph 2.31-2.33).

Why we need to merge to achieve these benefits

2.17 The case studies presented in this document describe some of the ways in which colleagues have come together pre-merger for the benefits of patients, and how they have succeeded in overcoming organisational barriers in order to collaborate. In this sense, merger is not essential for integration of any individual service - with enough resource, effort and commitment put into implementing workarounds, any team could secure significant benefits for patients through collaboration alone. However, we don't have endless resources, and patients need us to transform services as quickly as we safely can.

2.18 Merger is the key which will unlock systemic integration across all our services, so that we do not need to rely on self-selecting groups of clinicians to drive change. Merger also enables us to pursue integration at the pace required, and to do so in a way that makes best use of our limited resources.

Enablers

2.19 There are a number of key enablers for merger which are set out in greater depth in the Full Business Case (see paragraphs 4.6-4.8 of that document). However, there are two enablers which are key to delivery of our clinical strategy and the changes set out in the case studies. These are:

- digital systems and data, and
- effective working with primary care through Symphony.

Further detail on these is provided below.

Digital systems and data

2.20 Digital systems are key to the implementation of our clinical strategy, and the most important area is unified access to patient data.

Unified EHR

2.21 Patient records are currently held in a range of electronic and paper formats across the two Trusts, see **Figure 8**. In some cases, colleagues have full or read-only access to digital systems in the other Trust; in other cases they have no access at all. This creates challenges and risks for those patients who receive care from both Trusts.

Figure 8: key clinical recording systems in YDHFT and SFT

SFT	YDHFT
• *Maxims* – acute PAS, but only used in some settings e.g. ED; acute wards use paper notes • Community & mental health teams use *RiO* (acute colleagues require a separate login to access RiO)* • *ePRO* used for clinical correspondence, including outpatient appointments • Individual departments also use service-specific digital systems to support patient care	• *Trakcare* – acute clinical record, used as the principle clinical notes for ED and ICU; inpatient wards use paper notes • *Trakcare* - used for outpatient appointments but not to manage patient records (which are held on paper). • *Patient Centre* for patient letters • Individual departments also use service-specific digital systems to support patient care

Note: In addition, primary care uses EMIS, to which staff at both Trusts have read-only access.

2.22 Where patients are being treated by both Trusts and clinicians *do* have access to the other trust's patient record system, delay arises from the need to navigate between systems. There is also a patient safety risk from the potential for mixing up patients' records as clinicians switch back and forth between different systems.

2.23 Where clinicians do not have access to a particular system, they rely on colleagues to email or talk them through the relevant information, before they rekey the information into 'their' system. This uses up valuable clinical time which would otherwise be devoted to front line care, and introduces a risk to patient safety due to transposition errors when information is manually rekeyed. Challenges with different IT system are illustrated in **Figure 9.**

Figure 9: Colleague story – Sharon Cable

Sharon Cable, Operational Service manager oncology and haematology YDHFT

"To support operational pressures in the haematology service we are temporarily moving outpatient appointments from YDH to MPH. At YDHFT we use TrakCare for our outpatient appointment and electronic patient record system which is connected to the NHS spine; MAXIMS is used at MPH which is not connected to the spine. This brings the risk of losing patients when we transfer patients from one system to another.

As the two services are currently using two different electronic patient records, we need to ensure both teams are able to access patient records to continue to care for patients safely. Also for safety reasons, YDH have implemented a change in process where all outpatient haematology appointments are to be recorded within MOSAIQ as well. MOSAIQ is already a shared system between YDH and MPH for delivery of SACT (Systemic Anti Cancer Treatment). The outpatient appointments will continue to be recorded in TrakCare until the transfer is complete. This is not usual practice at YDH (as we collect outpatient data differently to MPH) so it has created additional work for our admin team. We will in total, at a certain point, have each appointment noted three times on three different systems!

We were afraid of losing sight of patients during the transition so we have set up a patient tracking list in the form of a spreadsheet. This will track patients and record all new referrals and also track those already on treatment or under review until a time where all of the referrals are switched off. This has required additional admin support which isn't a good use of resource but there isn't another way round this.

Post-merger, once we have a shared digital system which is connected to NHS spine, we will not have these IT problems."

2.24 In March 2022 the two Trust boards approved a Digital Strategic Outline Case to move to a unified Electronic Health Record (EHR) which will consolidate the three existing Patient Administration Systems and associated digital systems across acute, community and mental health services. Procurement will take place in 2023 and, subject to the necessary approvals, the intention is for deployment of the unified EHR to begin in 2025.

2.25 Moving to a unified EHR will increase patient safety by enabling clinicians to access all of a patient's records via just one login. It will also reduce the risk of mixing up different patient records, or of errors arising when information is rekeyed. A unified EHR will mean that patients' core information will be shared between systems eliminating the need for patients to re-state basic facts. It will also help clinicians improve the quality and efficiency of care, and a unified EHR is essential to our aim of implementing single county-wide waiting lists, see Figure 5.

2.26 Merger offers the following benefits to the procurement and implementation of a unified EHR:

- **Governance**: As a single trust, governance and decision-making for the EHR programme will be significantly streamlined compared to two trusts jointly implementing a shared EHR.
- **Pace**: one team working under single leadership will be able to specify and implement the unified EHR more rapidly than two teams collaborating.
- **Patient safety**: the risk arising from duplicate records which exist for patients treated by both trusts is eliminated once we are one Trust.
- **Cost**: a unified EHR procured by the enlarged trust will be cheaper than it would have otherwise been, because of economies of scale in purchasing and implementation.
- **Design**: clinical services will be integrating at the same time as we specify the unified EHR. This makes it easier to design the EHR to serve single county-wide clinical pathways rather than trying to accommodate different pathways across two organisations.
- **Resilience**: merger offers the opportunity to back up digital systems on different sites e.g. MPH and YDH, which improves resilience.

2.27 Alongside the EHR benefits, merger also offers us other patient benefits in the digital sphere (see **Figure 10**) which we would not be able to secure without merger, either because the costs would be prohibitive, or because we would not have the capacity to implement the necessary changes.

Figure 10: patients benefits deriving from merger-enabled digital change

Digital change enabled by merger	Benefit	
	More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**
Unified electronic health record	• Ready access to patients' full clinical history increases patient safety and good clinical outcomes irrespective of setting	• Patients' core 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

Digital change enabled by merger	Benefit	
	More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**
	• Lower clinical risk from human error when sharing/re-keying patient information • Supports the operation of integrated care pathways and county-wide 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	checking a range of clinical systems to get full patient history, thereby freeing up time to care for other patients
Digitally-enabled support for virtual care and self-management e.g. telecare, remote monitoring, access to own health record etc	• Deterioration in health is identified earlier which aids quicker intervention • Aids the provision of personalised care • Helps people better manage their health and care needs, and feel empowered • Supports the provision of care in the appropriate setting	• Unnecessary appointments are avoided through continuous remote monitoring • DNAs reduced through online ability for patients to change appointments
Intelligent systems (e.g. automation, AI etc)	• Provides real time data to support clinical decision-making	• Supports provision of care in a more efficient manner e.g. through automated processes and/or use of AI
Interconnected systems, and mobile devices to support seamless working across health and care settings	• Supports consistent practice in all settings to maintain high quality care • Enables improved clinical decision-making through ready access to patient records wherever clinicians are. Also aids MDT discussions • Supports the provision of care more quickly, leading to better outcomes	• Supports clinicians to provide care more efficiently • Increased resilience of infrastructure leading to less system downtime.
Shared medication lists	• Improves patient safety by aiding the identification of potentially harmful drug interactions • Helps clinicians tackle problematic polypharmacy and minimise medicines-related harm	• Releases clinical time for front line care, as no longer having to check range of systems for overview of medication

SIDER

2.28 The Somerset Integrated Digital Electronic Record (SIDER) programme aims to provide a shared summary care record accessible by clinicians, GPs, paramedics, out of hours/111, social care and patients across the county. In parallel with the planned

digital changes within the Trusts, conversations are also ongoing with the SIDER programme to link up patient records with relevant partners in the voluntary sector.

Symphony

2.29 Symphony Healthcare Services Limited (Symphony) is a wholly owned subsidiary of YDHFT which operates 16 GP practice contracts across 20 sites. Symphony is an 'at scale' primary care operating company that combines the benefits of scale while preserving the best of the independent nature of primary care.

2.30 The establishment of Symphony Healthcare Services Limited 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.

2.31 As part of the merged Trust, Symphony will help us reduce hospital attendances and support people in their own homes and neighbourhoods to stay well, by building on the work undertaken as part of the vanguard programme and other community transformation plans. Health coaches, introduced under the Symphony vanguard programme also have a role to play in the provision of peri-operative care, see chapter 7.

'Locality' level integration benefits

2.32 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 deliver 'locality' level integration benefits 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.

2.33 For example, with the signal of merger, we have recently created a Community Investigation Unit at South Petherton Hospital that is run by primary care but supports both primary and secondary care. We plan to expand this model in future by providing further diagnostics and extending access.

2.34 The presence of Symphony also enables us to make a stronger contribution to the development of neighbourhoods in Somerset, for example through the provision of staff such as First Contact Practitioners and Mental Health nurses to work in primary care settings (see Full Business Case, paragraph 5.55). The prospect of merger has also enabled us to work closely with four PCNs to run tests of change which aim to identify and optimise patients with diabetes who are referred for surgery (see chapter 7, Figure 53).

Equality impact assessments

2.35 We are aware of our duties under the public sector equality duty and are currently refining our approach to equality impact assessments to ensure they are informed by diverse perspectives and relevant data and research.

2.36 Each programme plan for service integration will include the following steps:

- collecting and interrogating data by protected characteristics to identify any priorities for groups
- reviewing patient feedback bearing in mind protected characteristics and at risk groups
- proactively seeking opportunities to listen to diverse voices and minority groups.

Resources for change

2.37 We want change to be led by the people who run our services, and co-designed with service users. We have a range of support available to help teams plan and implement their change, including the Improvement team, the Clinical Integration Team, support from Service Group Directors and Executive sponsors (see paragraph 2.11). We are also supporting colleagues to lead their teams through change (see paragraphs 6.33-6.36 of the Full Business Case, and the People strategy).

2.38 We are using proven change methodology and a standardised approach to make change as efficient as possible and reduce risk by phasing the change and taking account of interdependencies. We are also prioritising the integration of clinical services as we lack the resources to support all services to integrate at the same time. We are incorporating our change effort into business as usual where we can – e.g. by combining meetings.

2.39 Further detail on our approach to integrating clinical services is contained in the **Post Transaction Integration Plan**.

3. Maternity

Summary

YDHFT and SFT provide comprehensive consultant and midwife-led maternity services including antenatal, intrapartum and postnatal maternity care, as well as community home birth support. Both services are rated 'Good' by the CQC.

Somerset is a large county and around half the population live in a rural area which creates challenges for the provision of care. Despite relatively low birth rates (c. 4,300 deliveries a year), the county has two consultant-led units (in Yeovil and Taunton) to ensure safe care across the large, rural geography. Around 15% of women served (those who live in the middle of the county) receive a blend of care from both Trusts.

The Trusts' maternity teams have collaborated for the last few years as part of the Local Maternity and Neonatal System. However, collaboration is hampered by differing policies and protocols, different IT systems and different governance arrangements.

Under our merger plans we will retain two high performing consultant-led units at Yeovil and Taunton, working under single leadership, governance, and policies.

The patient benefits which will result from combining the two maternity teams include:

- Standardised county-wide protocols and ways of working which will help streamline pathways and improve clinical decision-making, especially for complex patients.
- An increase in maternity care in community settings or at home for low risk births, which will improve patient experience and free up acute resource for more complex cases.
- An integrated digital maternity care record which will help us provide improved patient care and experience, support clinical learning and increase efficiency.
- Merger will increase our scale and ability to implement national strategy, including personalised care.
- An integrated workforce will increase our resilience and enable us to better deploy our combined resources where they are needed most.

Integration of maternity teams is progressing at pace, and we have established a single Maternity Transformation board, chaired by our Chief Nurse and Chief Operating Officer - Neighbourhoods, Mental Health and Families, to oversee implementation of national recommendations and the creation of the single integrated maternity team.

Current service arrangements

3.1 SFT and YDHFT each provide a comprehensive consultant and midwife-led maternity service including antenatal, intrapartum and postnatal maternity care, and community home birth support.

3.2 YDHFT and SFT's maternity services are both rated 'Good' by the CQC.[9] In the 2021 NHS maternity patient survey, both Trusts performed better than or about the same on all questions in comparison with other trusts.

3.3 In this case study, 'maternity services' refers to midwifery and obstetric services. Whilst maternity services are closely associated with other services (e.g. paediatrics and gynaecology) the scope of this case study focuses on the benefits that merger offers to the care of women and babies using our maternity services.

Community care and home birthing

3.4 Both Trusts provide antenatal and postnatal care in community settings, as well as helping women give birth at home where it is clinically appropriate and the woman's preference.

3.5 YDHFT's dedicated community midwifery team provides antenatal and postnatal community care from St Peter's community centre in Yeovil, and a dedicated homebirth team supports women to give birth at home from 37 weeks of pregnancy. The homebirth team operates on a 24/7 on-call basis.

3.6 SFT's community maternity teams provide antenatal and postnatal care from community hubs at Bridgwater, Minehead, Wellington and Chard community hospitals, as well as from Victoria Gate GP surgery in central Taunton. SFT's community maternity teams also staff the Trust's home birth service which operates on a 24/7 on-call basis.

3.7 Both Trusts' maternity teams aim to see all women at home at least once during the antenatal period. The teams also aim to visit all women at home at least once in the postnatal period, with women who require additional monitoring receiving a greater number of visits. Both teams provide postnatal care for up to 28 days,[10] at which point care transfers to a health visitor.

Midwife-led units

3.8 SFT's Bracken Birth Centre is a midwife-led unit at Musgrove Park Hospital. It has two birthing suites (each with a birthing pool and active birth equipment), a postnatal bay, and two multipurpose clinical rooms for admissions, breastfeeding support, and

[9] CQC report on Taunton and Somerset FT (one of SFT's predecessor organisations) published 24 March 2020; CQC report on YDHFT published 8 May 2019.

[10] Postnatal care is provided for up to 6 weeks for women with additional complex care needs.

postnatal care. The Bracken Centre is staffed 24/7 and staff are trained to undertake the new-born initial physical examination.

3.9 SFT also operates a freestanding birth centre (the Mary Stanley unit) at Bridgwater Community Hospital, available to women without antenatal complications. This unit has two birth rooms with birth pools and active birth equipment, and is staffed on an on-call basis.[11] Women can be transferred from Bridgwater to Musgrove Park Hospital (a distance of 19 miles via the M5, taking 30 minutes by 999 ambulance transfer) if obstetric assistance is required.[12]

3.10 YDHFT's obstetrics unit includes midwife-led beds which are used primarily to serve women with low-risk pregnancies whose care is not expected to require a high degree of intervention. Care for these women is provided in two birthing rooms, one of which includes a birthing pool, at the end of the main obstetrics unit which is staffed 24/7.

Obstetrics & neonatal care

3.11 YDHFT and SFT's obstetric units provide specialist consultant-led care for women with complex pregnancies and those who have underlying health conditions requiring greater monitoring, medical intervention, or access to multi-specialist care intrapartum.

3.12 Each Trust has a dedicated ultrasound service to support antenatal clinics, and both run dedicated endocrinology clinics. They also provide specialist support for at-risk pregnancies, substance misuse and teenage pregnancy, as well as counselling for women preparing for birth after previous caesarean section.

3.13 Both Trusts offer intensive and specialised care for premature babies and neonates with health complications. YDH operates a Special Care Baby Unit (level 1) caring for babies born from 32 weeks; this care is provided by the Trust's Paediatric rather than Maternity services. MPH operates a Neonatal Intensive Care Unit (level 2) caring for babies born from 28 weeks, and babies born anywhere in the county needing this level of care are transferred to MPH. Both Trusts transfer babies requiring the most complex, level 3 care to North Bristol Trust (or another tertiary NICU).

3.14 Both Trusts also refer women and babies to allied health services including psychology, physiotherapy and dietetics as needed. SFT provides a county-wide perinatal mental health service.

[11] The freestanding birth centre at Bridgwater has a day midwife rostered to work Monday-Friday until 8pm. After 8pm, the community on-call community midwives (2 per night) are available to come to the unit and continue to care for any woman in labour. If no women are in labour by the time the Day midwife goes home the unit is locked and if a woman rings overnight asking to birth at Bridgwater the labour ward coordinator at MPH calls the community on-call midwives (2) who will open the birth centre and care for the woman until she delivers.

[12] The number of women transferred each year from Bridgwater to MPH is low. The majority of those are transferred after delivery, either because the baby needs extra support or the mother requires further medical attention. There have been no incidents to date where this has impacted on the care or outcome for either mother or baby.

Care of vulnerable women and those with complex needs

3.15 Both Trusts have dedicated midwives supporting vulnerable women with additional needs during their pregnancy. Getting the support right for these families can significantly influence whether a baby remains in their mother's care, as well as the child's later life chances.

3.16 For the last three years, these two teams have been led by a jointly-funded midwife who is also the named midwife for safeguarding in the Somerset Safeguarding team. In January 2022 the two teams became one, see Dawn Sherry's colleague story **Figure 14**. This joint role has enabled a series of joint procedures to be developed, and level 3 safeguarding training previously undertaken only by SFT midwives has been extended to YDHFT midwives.

3.17 In 2021/22, the two Trusts assisted 4,293 women to give birth. **Figure 11** summarises the key elements of maternity provision at the trusts.

Figure 11: summary of maternity provision at SFT and YDHFT in 2021/22

	SFT	YDHFT
Women and babies served in 2021/22	Total number of bookings: 3,663 Of which: Somerset mothers: 3,515 (96%) Mothers from out of area: 148 (4.0%) Mothers who identify as BME 276 (7.5%) Supported to deliver: 2,993 No. of planned caesareans: 431 (14.4%) No. of unscheduled caesareans: 554 (18.5%)	Total number of bookings: 1,476 Of which: Somerset mothers: 1,276 (86.4%) Number from out of area: 200 (13.6%) Number who identify as BME 59 (4.0%) Supported to deliver: 1,300 No. of planned caesareans: 159 (12.2%) No. of unscheduled caesareans: 269 (20.7%)
Consultant-led labour ward deliveries	2,311 (77%) deliveries in 2021/22 • 32 beds - antenatal/postnatal ward • 8 delivery rooms • 1 procedure room – can be used for emergency caesareans if obstetric theatre in use. • 1 obstetric theatre • 3 beds for post operative recovery and HDU care • Dedicated bereavement suite • Dedicated day care / triage for ambulatory obstetrics	1,133 (87.2%) deliveries in 2021/22 • 14 beds - antenatal/postnatal ward • 4 delivery rooms + 2 Induction rooms • 1 emergency obstetric theatre & 1 elective obstetric theatre • Dedicated day care unit for ambulatory obstetrics • Flexible use of bereavement facilities Location: Yeovil District Hospital

	Location: Musgrove Park Hospital	
Midwife-led Alongside Birthing Centre	532 (17.8%) deliveries in 2021/22 2 birthing rooms + 7 beds Bracken Birth Centre, Musgrove Park Hospital	108 (8.3%) deliveries in 2021/22 2 birthing rooms (1 with pool) Yeovil District Hospital
Freestanding midwifery centre	35 (1%) deliveries in 2021/22 Two ensuite rooms with birthing couches and pools. Mary Stanley midwifery unit at Bridgwater community hospital	N/A
Number booked onto a Continuity of Carer pathway	Not currently offered (July 22)	595
Homebirths (number of women helped to deliver in 2021/22)	68 (2.3%) (+ 47 born in transit)	59 (4.5%) This includes 16 born in transit
Neonatal care	Somerset Neonatal Intensive Care Unit (SNICU) Level 2, cares for babies born from 28 weeks 18 cots (4 ITU, 4 HDU & 10 special care) 4 parent bedrooms *(Medical cover under the paediatric service, the nursing care is under the maternity service)* Musgrove Park Hospital	Special Care Baby Unit (SCBU) Level 1, cares for babies born from 32 weeks 8 cots (2 HDU & 6 special care) + camp beds for parents (*Administrated by YDHFT Paediatrics service*) Yeovil District Hospital
Care for vulnerable women or those with complex needs	Juniper team (SFT) and Acorn team (YDHFT) now merged to form single WREN team	

3.18 **Figure 12** shows the location of the two Trusts' maternity services. Somerset is geographically large – travel times across the county are around two hours east to west and one hour north to south at the furthest points.[13] Around 48% of the population live in a rural area[14] and public transport links are poor. This creates challenges for women accessing antenatal and intrapartum care. Rurality also creates challenges to the provision of postnatal care, as midwives need to schedule frequent visits - usually home visits - over a relatively short period of time.

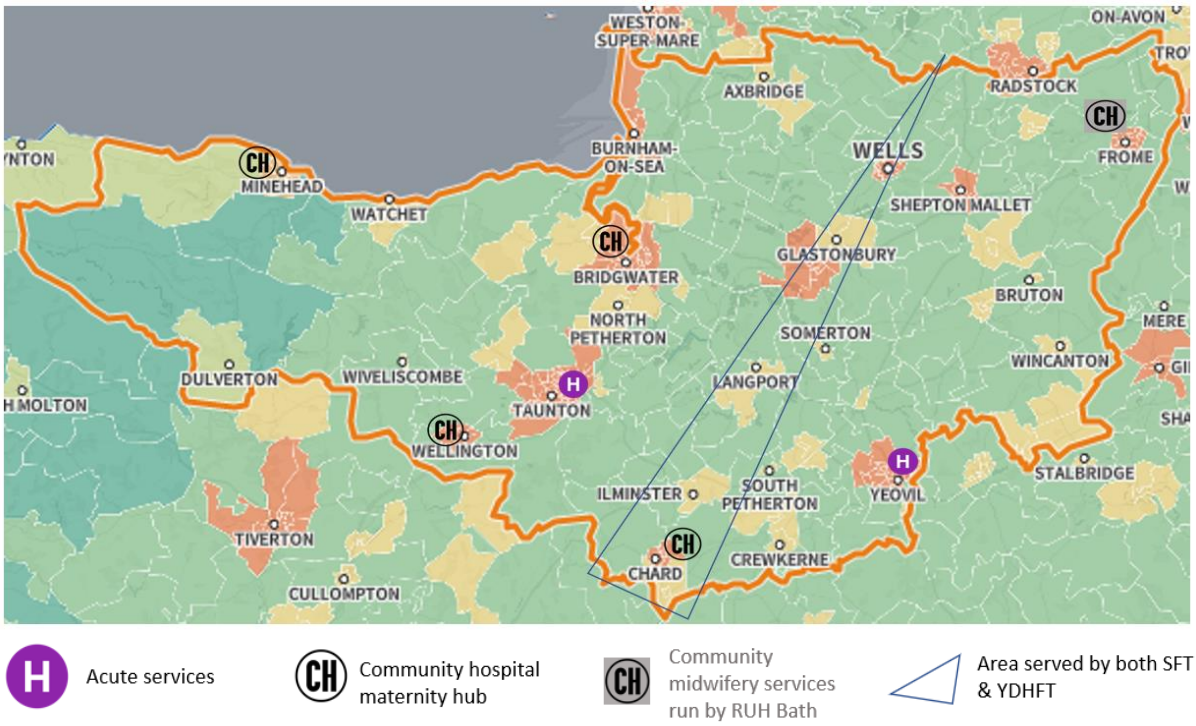
[13] Travel time from the west-most town (Simonsbath) to the east-most (Farleigh Hungerford) is around 96 miles – 2 hours 15 minutes drive in light traffic. North-most Webbington to south-most Tatworth is 40 miles- around hour in light traffic.

[14] Somerset Intelligence. Rurality: Somerset headlines from the 2011 Census. Available from: http://www.somersetintelligence.org.uk/profile-of-rural-somerset-from-the-2011-census.html [Accessed 6th May 2022].

3.19 Around 13% of women who deliver at YDHFT come from out of area – the majority from Dorset, and post-merger we will continue to care for those Dorset-based patients who are in the YDHFT catchment. For SFT the figure is 4% - most of whom come from neighbouring counties of Devon or North Somerset. We do not anticipate merger affecting the current level of activity seen at both sites.

3.20 In some cases, women who live in the area between the two Trusts' catchments receive their maternity care from both Trusts, e.g. antenatal care from SFT but intrapartum care from YDHFT. Around 600 women, or c. 15% of the total number of women who the Trusts help to deliver each year live in this 'corridor' shown in Figure 12.

Figure 12: Map of maternity services in Somerset



3.21 **Annex 1** gives an indication of the travel times for women living in Somerset and neighbouring areas. As a rural county we are not always able to match midwife availability with need, particularly when there are staffing pressures; in these instances, the needs of the labour wards, and women with the highest risk, are prioritised and home births are not supported if there are insufficient staff available. Neither Trust has been able to restart its in-person antenatal preparation groups/parent craft groups (where expectant parents can meet peers for mutual support) following Covid staffing reductions, although virtual support is provided on infant feeding and to help women prepare for labour.

3.22 **Figure 13** shows the maternity workforce at each Trust as at October 2022.

Figure 13: Maternity workforce as at October 2022

	YDHFT			SFT		
	Substantive in post	**Locums**	**Vacancies**	**Substantive in post**	**Locums**	**Vacancies**
Midwives	68.45		-	149.7		7.9
Medical workforce	24.6		4.4	38.3		10.4
Consultants	8.6	-	-	10.8	1	2
Middle grade	8	-	3	7	-	3
Foundation/GP trainee	8	-	1.4	6.89	-	1.46
Support staff	16.13		0	28.7		3.3
Total	**133.78**	-	**8.8**	**241.39**	**1**	**28.06**
Skill mix split	95:5 (MSW band 2 & 3)			80:20 (MSW band 3 & 4)		

N.B. All figures are whole time equivalents.
Midwife to birth ratio - YDHFT: 1:25, SFT: 1:28

3.23 According to the Royal College of Obstetricians and Gynaecologists, a maternity unit which delivers fewer than 3,500 births a year is categorised as 'small'.[15] Using this definition both Trusts' maternity units are classed as 'small'. However, the recommended number of births may not be fully reflective of the needs of a rural setting.

3.24 In 2016/17, the Dorset Acute Services Review with the support of Somerset CCG, examined the case for bringing together YDHFT's and Dorset County Hospital's (DCH) maternity and paediatric services, to improve the sustainability of the services. Ultimately, the integration did not go ahead because commissioners concluded it made more sense for DCH to link with Poole and Bournemouth hospitals (now University Hospitals Dorset) within the Dorset STP, rather than create a network reaching into Somerset.

3.25 Then in 2017/18, Somerset CCG began a review of Maternity and Paediatric services within the county, due to concerns about the services' clinical and financial sustainability. This work was then rolled into a wider clinical services review for Somerset. Although a Women and Children's workstream was established as part of the Acute Settings of Care work, this work was paused with the advent of Covid and has not yet resumed, and there are presently no plans for further reviews of Somerset's maternity services.

3.26 Subscale services are more costly to provide in proportion to the national tariff funding received and some of the deficit in Somerset is due to the sub-scale nature of maternity services at SFT and YDHFT.

[15] maternitystandards.pdf (rcog.org.uk)

3.27 Given Somerset's rurality and poor transport infrastructure, commissioners have confirmed that both the MPH and YDH sites should continue to have consultant-led units to maintain access and safe and equitable maternity care across the county's large geography. Both Trusts support this decision. Even though relatively few births take place at the midwife-led unit at Bridgwater, commissioners have agreed this should remain in order to maintain local access.

National strategic context

3.28 Both Trusts are working on action plans to meet the national requirements set out in the National Maternity Review: Better Births,[16] and the first Ockenden report. This includes Saving Babies Lives v.2,[17] digital information systems and maintaining a skilled workforce.

Ockenden

3.29 Both Trusts are working on delivery of the 'immediate and essential actions' of the Ockenden review and there are now three outstanding areas across the two Trusts.[18] We expect to achieve compliance in these areas by the end of January 2023.

3.30 Initially each Trust's Ockenden actions were overseen by the relevant Trust's quality governance committee, but since March 2022 a joint YDHFT/SFT Maternity Transformation Board has overseen overall progress on national requirements, including Ockenden. Ongoing reporting and assessment of compliance is led by Somerset Local Maternity and Neonatal System (LMNS) and the ICB. The Trusts have also had an NHSE regional insight visit to provide assurance on Ockenden compliance. The Trusts have a non-executive director with an interest in maternity services and women's health.

3.31 The LMNS has a maternity dashboard with an agreed set of national indicators to help track, benchmark and improve the quality of maternity services. The Clinical Quality Improvement metrics are published monthly and the national maternity indicators are published annually drawn from external surveys. Using the July 2022 dashboard, we can, for example, identify areas where one Trust is green and the other red or amber. These show potential areas for learning such as midwife-led births which are green for SFT and amber for YDHFT (year to date), or formal complaints which are green for YDHFT but amber for SFT.

[16] National Maternity Review. Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care: Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf [Accessed 6th May 2022].

[17] NHS England. Saving Babies' Livers Version Two: A care bundle for reducing perinatal mortality. Available from: https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf [Accessed 6th May 2022].

[18] The 3 actions are: obstetric ward rounds which will be in place by 14/11/22; training for the implementation of personalised care plans which will be complete by 31/01/23; rolling compliance audits will be in place by December 2023.

Continuity of Care

3.32 Midwifery continuity of care[19] involves each woman having a named midwife responsible for coordinating her antenatal, intrapartum and postnatal care, supported by a team of up to 8 other midwives, and a named obstetrician. It requires a move away from shift-based rosters to a working pattern where a midwife follows the woman so as to encourage a trusted relationship between the woman and midwife to develop. The model is particularly challenging to implement in large rural settings like Somerset, where there are long travel times across the county.

3.33 Although there is no longer a national requirement to implement continuity of carer, YDHFT has succeeded in creating three continuity of carer teams using staff consultation and contract changes. These teams operate a hybrid way of working which offer continuity of carer to around 40% of the cohort population and they are able to provide full continuity to this group 95% of the time.

3.34 SFT has been unable to implement continuity of carer due to workforce challenges. With the national policy change on continuity of carer, the two Trusts are taking the opportunity to review models of midwifery care and develop a cross-county model which is safe, achievable, sustainable and equitable for all women. However, it is still our ambition to provide antenatal and postnatal continuity of care to all women.

Collaboration to date

3.35 The two Trusts' maternity services have collaborated in recent years, alongside Somerset County Council, as part of Somerset's LMNS. Joint achievements include success in reducing smoking at time of delivery from 11.8% to 10.3%. System partners are also working together to achieve UNICEF Baby Friendly gold status across all domains.

3.36 Somerset has had a single county-wide perinatal mental health service run by SFT since 2019. The perinatal mental health team liaises with acute services at YDHFT, MPH and RUH Bath to meet the needs of the local population. Referral and response processes are the same for all three acute hospitals and the perinatal mental health team runs joint clinics with the relevant obstetric teams at the three sites.

3.37 As part of the LMNS, county-wide posts for maternal bereavement and a public health midwife have been established with more joint posts expected to follow (e.g. practice development lead, safety & quality improvement lead). Separately, the Trusts have also established a joint midwife post for safeguarding.

3.38 With the signal of merger, the two midwifery teams began meeting in 2021 to get to know each other and the respective services. In January 2022, following the retirement

[19] NHS England. Delivering Midwifery Continuity of Carer at full scale: Guidance on planning, implementation and monitoring 2021/22. Available from: https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/ [Accessed 6th May 2022].

of YDHFT's Head of Midwifery, the two Trusts appointed SFT's Head of Midwifery as Director of Midwifery working across both organisations.

3.39 The signal of merger means we have been able to support secondments between the two Trusts which aid staff development. For example, SFT's deputy screening coordinator is currently on secondment to a more senior role as YDHFT's screening coordinator which supports links between the Trusts as well as that individual staff member's professional development.

Challenges

3.40 Despite the achievements that have come about through collaboration, barriers to effective working will continue while the Trusts remain separate legal entities.

Different protocols and policies

3.41 Although the single Director of Midwifery provides professional leadership to the two midwifery teams, team members are nonetheless required to comply with different policies and protocols set by the two Trusts.

3.42 For example, although both Trusts use the perinatal growth assessment protocol to monitor infant growth, it is implemented differently at each Trust. The Trusts' risk assessments for thromboprophylaxis differ; YDHFT use RCOG guidance and SFT have a locally developed pathway, aligned to RCOG but not fully compliant although this is in the process of changing.

3.43 In order to align policies and procedures, changes need to go through the separate governance of each Trust which creates delay to improvement, and alignment cannot be guaranteed if professional opinions within those governance structures differ.

3.44 The teams have recently started looking at the two Trusts' antenatal guidelines and have found many differences they need to resolve, relating to different patient documentation requirements, different oversight arrangements due to different staffing models, and different governance structures. Initially the teams anticipated it would be relatively straightforward to bring these guidelines together, but following review they have realised there is a lot to align (125 guidelines at SFT and 156 at YDHFT).

3.45 Although the maternity teams are in regular contact and share information, the fact that the two Trusts' policies vary and they use different data systems creates challenges in taking forward LMNS work, particularly around data collection. Joint postholders have to work with different processes and protocols at the two Trusts, which creates delay, and the risk of gaps and/or duplication. Colleagues in joint posts also find it hard to secure consensus for key decisions, see Colleague Story **Figure 14**.

Figure 14: Dawn Sherry Colleague story

Colleague story – Dawn Sherry, Named Midwife for Safeguarding YDHFT and SFT, and Head of WREN team

In 2018, I became the joint head of the two Trust teams supporting pregnant women who are vulnerable or have complex needs. I currently report to SFT's Head of Safeguarding as well as both Trusts' maternity teams.

Both teams are really committed to providing equity of maternity care to all women across Somerset, and in particular making sure that women who live in the area between the two Trusts get complex maternity care when they need it.

We had a case where a YDHFT midwife was trying to support a woman who was booked to deliver at YDH but because the woman lived in Chard the midwife was having to ask an SFT midwife to go out and give her lots of support, but the mum was hard to engage with and really difficult to track down. I became aware of this barrier and that was my first nugget of: Could we do something differently about this situation? That was where the idea to become one team came from.

When I took up post, I quickly set up joint meetings between the two teams because I felt strongly from the beginning that working even more closely together wasn't going to work unless the teams were happy to do that, and we've talked a lot about our team vision and overcoming the barriers to what we want to achieve.

In practical terms, understanding the two Trusts' systems has been hard and while YDHFT antenatal records are still on paper it's even more tricky. We store what we can on a shared drive and are now able to access both sites' shared drives without logging into the other site, but just one IT system would be really fab.

It would also be great to have just one governance system to navigate instead of two. At the moment, I'm having to still go through both. One governance structure - that would definitely help.

In January 2022 we officially became a single team called WREN (Women Requiring Extra Nurturing). It's now been 10 months since the Juniper and Acorn teams came together and we have developed a really cohesive single team, including 3 new colleagues we recruited over the summer.

Workforce challenges

3.46 Workforce gaps at both Trusts are set out in Figure 13. The impact of these gaps is that the teams cannot always offer the care to women that they would wish to e.g. in some cases women who want to have a home birth instead have to give birth in hospital as there are insufficient midwives available to support a home birth.

3.47 Greater flexibility to move staff between Trusts would aid our collaboration but there are barriers to staff moving between the Trusts. Differences in roles and responsibilities of equivalent posts, different employment contracts which make rotational posts hard to establish, and the challenges of geography slow down and disincentivise collaboration.

Lack of integrated IT systems

3.48 SFT's current maternity patient record system is partly paper-based and the YDHFT's maternity records are fully paper-based. The lack of an integrated digital maternity care record between the two Trusts negatively impacts patient care and experience

and creates administrative inefficiencies particularly for care of women who live in the middle of the county where the two Trusts' catchments overlap. Around 600 women a year are seen by clinicians from both Trusts (e.g. when YDHFT provides antenatal care to a woman who then gives birth at SFT[20]), and the lack of a single IT system means it is time-consuming for team members to gather information from multiple IT systems and call colleagues in the other Trust to ensure they have the full picture needed to provide the best patient care. Multiple systems and delays creates a safety risk and can impair the care given.

3.49 Although colleagues work closely to coordinate care, the lack of a single care record increases the potential for gaps, duplication or miscommunication and the likelihood that women have to repeat their story which, particularly for women who have experienced complications, can be very distressing.

3.50 It can be especially problematic for women with complex needs - where the trusted relationship between woman and midwife is especially important – to receive care from a maternity team that differs from the team that assists them during labour see **Figure 15**.

Figure 15: Patient story - Sarah

Patient story: Sarah

Sarah smokes and has a BMI of 30. She is pregnant and wants to have her baby at Yeovil District Hospital. However, because she lives in Langport, Sarah's antenatal care will be provided by SFT.

The SFT midwives who see Sarah have to complete two sets of notes which is time consuming: a digital set for SFT, and a paper set for YDHFT. As Sarah comes under the care of YDHFT, the SFT midwife makes a consultant referral to YDHFT.

Because Sarah smokes she needs to have serial ultrasound scans in line with the Saving Babies' Lives bundle. The SFT midwives are aware of the different approaches that the two Trusts have for antenatal fetal growth assessment: at YDHFT the results of Sarah's serial scans would be routinely reviewed by a consultant. However because Sarah is receiving antenatal care from SFT her serial scans are only referred to a consultant if the scan indicates a clinical need to do so.

Sarah's scan at 33 weeks gestation shows that her baby is measuring small. The consultant advises Sarah that they will likely need to induce labour before term if her baby continues to be very small. Sarah has had a good rapport with her midwife but is upset by this news as she had been reassured that all was well.

Sarah gives birth to a healthy baby girl at YDH late on a Friday night, and goes home early the next morning. She has been told to expect a midwife home visit, but 5 days after discharge she has not seen or heard from anyone, and is struggling to feed her baby. She rings her SFT midwife who apologises for the missed visit and says the SFT team were not aware she had had her baby. On investigation the SFT midwife finds the unit had been very busy when Sarah delivered at YDH, and finds the note to alert the SFT community team that Sarah had given birth in the 'to do' tray.

[20] Midwives are aligned to GP practices so women who live in SFT's catchment for antenatal care for example will receive care from SFT but will be offered a choice about where they deliver their baby and they may choose to deliver at YDH.

3.51 The lack of an integrated digital maternity care record places increased demands on colleagues both in terms of inputting information into one Trust's clinical record which may already exist in the other Trust's record, and also the additional communication required with colleagues to brief them on specific cases. These steps carry the risk of human error in miscommunication or recording errors.

3.52 Finally, the lack of an integrated digital maternity record makes it much harder to perform clinical audits, as each Trust needs to request the other Trust's records for any patients who have received care from both. This delays the identification and sharing of learning from clinical audits, which ultimately impacts quality of care. It also means manual work is required in order to report on clinical activity and provide data for local and national reporting.

What will change, and how will patients benefit

Vision

3.53 The planned merger offers the opportunity to secure the benefits of integrating maternity services in a way that Somerset has been unable to achieve until now.

3.54 Under our merger plans we will retain two high performing consultant-led units at YDH and MPH. The single maternity team will provide acute and community antenatal, intrapartum and postnatal care across the county, with single leadership, governance, policies, training provision and ways of working.

3.55 The maternity teams' emerging vision for their integrated team is that all families have access to safe, compassionate and personalised care wherever they live in Somerset. This single vision gives colleagues clarity and confidence about the future direction of the combined service.

3.56 The maternity teams have been developing their transformation plans since April 2022, and have identified nine key elements which are key to successful integration, see **Figure 16**.

Figure 16: key elements of maternity

1. Fully embedding the maternity service user voice	We have begun a programme with colleagues about how to best work with service users, and this includes a funded service user role. The role is hosted by the Evolving Communities stakeholder group to preserve its independence.[21] The postholder will support us to embed personalised care plans and proactively seek diverse voices to ensure the needs of these groups are incorporated into our service provision. The role will also support the development of patient information, our integrated website content and complaint and investigation responses.
2. Team structure & culture	We need a leadership structure and a workforce culture that supports becoming a fully integrated team. Senior leadership roles have been or are being appointed to, with the supporting leadership roles being worked through as opportunities arise through normal workforce

[21] Somerset Maternity Voices Partnership | Evolving Communities

	changes. We have brought together safety champion roles and initiated, from June, joint meetings. Maternity integration champions have been successfully introduced and we have launched a monthly maternity newsletter, a 'day in your shoes' sharing and shadowing opportunities, monthly maternity matters forums and noticeboard presentations. 'Tea trolley' sessions will begin in November alongside local colleague satisfaction surveys to hear what else would support colleagues. From our cross working, we are already seeing the benefits of having an openness to 'fresh eyes' and working together to improve care.
3. Digital	This element is about moving to a single digital maternity care record, by April 2023. Phase 2 is for other interfacing elements to be incorporated and enabling patients to access their record.
4. Governance	Moving to a single governance system includes aligning processes such as risk management, complaints management and learning from deaths, aligning policies and guidance, and developing a single dashboard to give the leadership team a clear view of service delivery.
5. Workforce alignment and wellbeing	This includes mapping current workforce as part of bringing our teams together and to support delivery of Continuity of Carer tailored to the Somerset context. We have set up workshops to bring Obstetrics & Gynaecology colleagues together to identify the opportunities and challenges integration brings ahead of joint action planning. We recognise that consultation may be required to align Terms & Conditions and have planned for this. We are also developing a strategy to support colleague wellbeing.
6. Aligning education and training	We have now reviewed our mandatory training expectations and expect to complete our review of other training by February 2023 in order to standardise the offer. In the meantime, we are jointly delivering our civility and bias training as these were identified as key areas that would be of mutual benefit.
7. Clinical pathways	We have identified the clinical pathways to be reviewed and aligned and allocated leads for the work. It is anticipated that all mapping will be complete by January 2023. This information will feed into planning the next steps to agree county-wide pathways. The actions for Ockenden and maternity continuity of carer are included in this section.
8. Finance	The teams have identified the cost implications of the new joint team structure, and will have a single budget from 1 April 2023.
9. Estates	YDHFT colleagues have had access to SFT's community locations since September 2022. We are currently discussing the standardisation of maternity signage county-wide. Next steps include exploring opportunities to use the estate to offer more options for care closer to home.

Standardisation of protocols and pathways

3.57 Subject to agreed variation to reflect the resources at each site, the combined team will use standardised protocols drawn from existing good practice at both Trusts, and elsewhere. Protocols will be consistent with guidance from the National Maternity Transformation Programme, Royal College of Obstetrics and Gynaecology, Royal College of Midwives, NICE and NHSE LMNS guidance. The implementation of standardised protocols will increase the consistency with which we provide high quality maternity care across the county.

3.58 We will implement standard county-wide pathways. This work has already begun with the creation of a county-wide pathway for fetal medicine which is linked to the Saving Babies' Lives bundle. We will take the best from both Trusts as we do this. For example, SFT has a dedicated twins service, which has improved outcomes for mothers and babies; this will become a shared pathway across both sites. Streamlined pathways will reduce the need for YDHFT to refer fetal medicine cases to Bristol, and instead we will use an MDT approach (using SFT's fetal medicine lead) to support the development of a fetal medicine service at YDH. This will reduce the need to refer complex cases out of the county and cut the associated patient travel.

3.59 Establishing county-wide MDTs e.g. for fetal medicine and perinatal mental health will improve clinical decision-making by giving colleagues exposure to more complex cases. The single cross-county perinatal mental health MDT (to replace the two existing MDTs), will improve our ability to align our workforce with needs, which may reduce the cross-county travel required for psychiatrists and psychologists. Merger also enables us to spread good practice across the Trusts, see **Figure 17**.

Figure 17: YDHFT inequalities training for midwives

In the UK, 7 in 100,000 white women die in childbirth. The figure is 13 in 100,000 for Asian women, 23 in 100,000 for mixed ethnicity women, and 38 in 100,000 for Black women. The death rate for Black women in childbirth is therefore five times higher than for white women, and the death rate for Black women in childbirth is increasing year on year.[22]

Two YDHFT midwives identified that enhanced training could improve the outcomes for families from minority ethnic backgrounds. A comprehensive training package was developed to increase midwives' understanding of providing clinical care in a way that is sensitive to different cultural expectations and norms, and also the impact of bias, stereotyping and microaggression in health care. These are linked to poorer outcomes for women during pregnancy and labour, and also poorer outcomes for babies. Midwives were asked to complete questionnaires before and after the training to establish their understanding and the impact the training had.

Midwife Becky Cocking said: "The responses we received after the training were overwhelming. Our midwives thought that through the training and experience they had gathered over the years, they were culturally aware, but feedback showed that the training gave them a much deeper understanding and opened up conversations, with the team wanting to know more to help break biases. I am so excited to see the positive differences throughout YDH and beyond and exceptionally proud of the work we have done and continue to do."
The merger means that the training will be rolled out to the SFT maternity team to extend the benefits. The teams are also hoping to secure funding to roll out the training across the UK, furthering the skills and knowledge of midwives nationwide.

3.60 As of October 2022, we have a single governance lead in place across both organisations and maternity governance meetings in common are being implemented. One of the benefits this will bring is that mothers choosing a home birth will have reduced risk because unexpected complications can be escalated more smoothly

[22] Black people, racism and human rights (parliament.uk)

within the single maternity team without the potential need to navigate differences in protocol and organisational accountabilities.[23]

3.61 These changes will benefit all women who give birth in Somerset, i.e. around 4,300 a year.

Community hubs and care closer to home

3.62 Although births in Somerset are relatively static, the number of complex, high risk births is increasing.[24] We will continue to meet the needs of women with the highest clinical risk in an acute setting. However, where clinically appropriate and in line with each individual woman's preference, we would like (subject to available staffing) to move high quality maternity care away from acute settings and into a woman's own home (or if the home environment is not appropriate, a community setting e.g. a pop-up birthing centre[25]).

3.63 Merger offers the opportunity to increase the number of low risk births taking place in community settings by giving YDHFT's maternity team access to SFT's community hospitals located in the south of the county (specifically Chard, Crewkerne and South Petherton community hospitals) for use as pop-up birthing centres. The Trusts' maternity teams are also currently considering how they can make use of the community hospital estate to develop midwifery hubs for the provision of antenatal and postnatal care.

3.64 Community maternity hubs support the women we serve by providing a setting in which they can meet other local expectant and new mums. They also help us meet the national and local ambition to improve the 1,001 critical days from conception to age two, which seeks to improve population health and reduce safeguarding concerns.

3.65 The increased use of community settings (for example South Petherton community hospital) will mean more women in south Somerset are able to receive antenatal and postnatal care closer to home; it will also provide greater opportunity for women currently served by YDHFT to give birth in the setting of their choice in line with the national Maternity Transformation Programme[26] and Better Births recommendation. This contributes to our third clinical strategy aim on neighbourhoods, and also helps preserve our acute resource for women with complex needs.

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[23] In 2021/22, 29 (29.6%) of home births assisted by SFT were transferred to the SFT's consultant-led unit. A further 143 (3.3%) were transferred from SFT's midwife led unit to its consultant-led unit. In 2021/22, 17 (28.3%) of home births assisted by YDHFT were transferred to YDH's consultant-led unit. YDHFT's midwife led unit and consultant-led unit are co-located so transfers are not recorded.

[24] Increased interventions - induction and caesarean sections, also increased complications including haemorrhage, sepsis, and increased admission to SNICU etc. We are also seeing a rise in referrals for safeguarding and mental health concerns.

[25] A pop-up birthing centre uses home birthing kit stored at a community hospital which can be set up and used in clinic room. It would operate as a home birth, with the intention for the mother to be home within 2-4 hours of birth. Where facilities are on the ground floor, use of an inflatable birthing pool can extend the offer to water births.

[26] NHS Maternity Transformation Programme. Available from: https://www.england.nhs.uk/mat-transformation/ [Accessed 6th May 2022].

Integrated digital maternity care record

3.66 Merger enables us to implement a single maternity patient record more easily and quickly than would otherwise be the case, which will help improve patient care and experience, and improve colleague productivity. In particular there will be significant benefits in relation to the care of women who live in the area of overlapping catchment in the centre of the county. These women will benefit from more consistent and timely care, lower safety risk (which currently arises from multiple IT systems), fewer handovers and not having to repeat their story.

3.67 The Ockenden requirement for neighbouring trusts to work collaboratively, and the signal of merger from the two Trust Boards acted as a catalyst for the two teams to consider how best to procure a shared maternity care record which works for the whole county. The Trusts have now procured a shared digital maternity records system (BadgerNet) which will go live across the two acute sites and community sites in February 2023.

3.68 Once the shared maternity care record is in place relevant staff will have sight of a woman's record wherever she presents in the county, and at whatever part of the maternity pathway. The new system will meet national data standards for maternity care and will be an enabler to ensuring every pregnant woman in Somerset has a Personalised Care and Support Plan as set out in Better Births. This will help serve our fifth clinical aim of personalised care. Women will also be able to view their record and appointments, see their test results and have online access to information that supports self-care. This will enable us to meet the national target for all women to have access to their health record by 2023/24; it also helps serve our first clinical aim to support prevention and help people self-manage.

3.69 As part of the IT procurement, our digital colleagues will ensure interoperability of the new system with existing clinical systems. The prospect of merger is also enabling YDHFT colleagues, including those on the WREN team, to access RiO (SFT's mental health electronic patient record system); their ability to access mental health records will help improve the care of women with perinatal mental health needs living in south Somerset. This will serve our fourth clinical aim on equity.

3.70 A single digital maternity care record will reduce the administrative burden on colleagues (from re-keying information), thereby freeing up time for clinical work. It will also facilitate the conduct of clinical audits thereby aiding the identification and sharing of learning.

3.71 As part of preparation for the new IT system, the two maternity teams, which includes digital midwives, have mapped the 'as is' and 'to be' patient pathways to make sure the IT system will meet current and future needs. This work not only informs the IT implementation but also helps the work to integrate maternity pathways across the county (see paragraph 3.58).

3.72 The procurement of an integrated digital maternity care record, and investment in supplementary hardware, is an example of a programme which has been heavily

influenced by the prospect of merger. If merger does not proceed and the Trusts remain separate, it is hard to see that they will approach future significant investment decisions in the same way, which would be to the detriment of patients.

Combined response to meeting national strategies

3.73 The increased size of the merged Trust means it will be easier to deliver the requirements of the Ockenden review and the national Maternity Transformation Programme. For example as a combined Trust, we will have just one action plan, with one lead for each action, a single training programme and one audit and assurance process on the action plan, rather than duplication across the two Trusts. In this way, merger frees up resources because action planning, delivery, and reporting on national requirements only need to be done once rather than twice as is currently the case. In addition, the planned single digital maternity record will aid delivery of maternity transformation by reducing safety risk and aiding reporting.

3.74 Merger will make it easier to implement maternity continuity of carer – initially through the sharing of learning from YDHFT's success in this area, but also because as a single team we can work towards a bespoke model of care that aims to deliver the spirit of continuity of care in a way which is tailored to the Somerset context.

Integrated workforce planning

3.75 As a merged Trust we will be able to implement system-wide workforce planning. This will enable us to flex our combined resources and deploy them to where they are most needed. Although there are no plans for wholescale county-wide deployment, some specialist teams will be supported to work county-wide, and we will be able to set different expectations for new staff around work locations and specify that certain roles will be carried out over a range of sites if required.

3.76 The midwifery teams have already identified the need to carry out a workforce review prior to reconfiguring roles and responsibilities. This will identify where specialist roles can be consolidated (in part because some tasks currently done twice will only need to be done once), and which teams can amalgamate, for example, practice development teams, governance teams and smaller specialist teams. This will free up colleagues for other tasks, and it may mean that over time it may be possible to review establishment.

3.77 The midwives who currently cover the geographical area between the two acute sites will be supported to flexibly work across sites when supporting women in labour. Merger will also allow the dedicated homebirth team to expand over a larger area and improve the offer of choice of place of birth. Over time we hope to replicate this model of working across the whole county to better support all women who want to give birth at home.

3.78 Merger will facilitate the sharing of good practice and learning between the wider colleague group, and support upskilling and confidence-building through greater exposure to cases which vary in complexity and setting e.g. via county-wide MDTs. Merger will remove the bureaucracy currently associated with rotational posts, and make it easier to offer these posts to colleagues looking to develop and maintain their skills and experience. Merger also gives us the ability to offer students and qualified staff a wider range of clinical situations.

3.79 Increasing our colleagues' breadth and depth of skills increases the range of roles to which they can be deployed, and therefore improves the resilience of the team; it should also boost colleague satisfaction and aid retention. Fewer staffing gaps will mean our colleagues are better able to give consistently high quality care which meets women's needs and preferences, which serves our second clinical strategy aim.

3.80 The existence of a single combined team with broader skills, and staff rotations which are easier to implement as one Trust, will give us greater resilience in the face of staffing gaps. A stronger, more resilient team, working across a range of settings and case complexity (for example being able to offer student midwives experience on SFT's SNICU and YDHFT's homebirth team) should make us a more attractive employer and aid colleague retention.

3.81 There is good evidence that motivated colleagues who feel well cared for, provide in turn, better care for patients.[27,28] The creation of additional community maternity hubs, alongside those already at Minehead and Chard community hospitals and other community locations, means there will be more places where midwives can meet to counter the negative impacts of lone working. The hubs also provide space for colleagues to meet health visitors and volunteers, such as peer mentors, to share resources and provide early help support.[29]

3.82 Our work to create a single team, including creating opportunities for colleagues to raise any concerns about changes, has involved the following:

- Formal and informal meetings between the two teams to discuss the integration. This included workshops in autumn 2021 with opportunities to share the personal impact of potential changes. The establishment of the maternity transformation board has enabled senior colleagues to get to know each other and build trust.
- The appointment of a single Director of Midwifery facilitated the agreement of a single vision and a plan for integrating the two teams. Colleagues have been appointed to roles which support integration, and midwifery integration champions have been identified. The leadership quadrumvirate is developing, with all roles expected to be appointed to by December 2022.

[27] Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T. Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. NIHR Service Delivery and Organisation programme; 2012. Available from: https://njl-admin.nihr.ac.uk/document/download/2008618

[28] West M, Bailey S, Williams E. The courage of compassion: supporting nurses and midwives to deliver high-quality care. The King's Fund; 2020. Available from: https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives

[29] Somerset County Council. Early Help Services: Early help means providing support as soon as a problem emerges, at any point in a child's life. Available from: https://www.somerset.gov.uk/education-and-families/early-help-services/ [Accessed 6th May 2022].

- The Obstetrics and Gynaecology consultants began joint leadership meetings in autumn 2021 and ran facilitated workshops for the wider team from spring 2022. Colleagues were given time to prioritise attendance in these face to face off site sessions.
- All colleagues have a chance to raise questions and concerns through a variety of routes including:
    - Monthly 'Maternity Matters' webinars which provide updates on integration and include question and answer sessions. These are followed by a newsletter which includes the recording of the session.
    - Weekly walkabouts by the professional midwifery advocates
    - Tea trolley rounds with the maternity integration champions
    - Monthly walkabouts with safety champions
    - Staff side representatives
    - The independent Maternity Voices Partnership (see paragraph 3.88) which regularly engages with staff and feeds back to the leadership team.

Expected benefits

3.83 **Figure 18** summarises how the planned integration of our maternity services will deliver patient benefits.

Figure 18: Patient benefits - maternity

Planned change	More time to live well	
	More time in good health	Making every minute count
Standardisation of protocols	• Streamlined processes based on best practice should reduce health conditions caused by a difficult delivery • County-wide MDTs will improve decision-making for complex patients • Reduced patient safety risk from lower risk of clinical error	• Streamlined processes based on best practice will eliminate wasteful steps in the pathway meaning patients can access care more quickly. • Single set of protocols will be easier for colleagues to work with, and remove risk of confusion between two current approaches (which creates patient safety risk)
Increase in community maternity hubs & care closer to home	• Community maternity hubs create spaces for new and expectant parents to meet and build social support networks; and for colleagues to support VCSE partners and share best practice	• Additional community hubs for antenatal and postnatal care increases patient choice and reduces patient travel time • Less travelling for colleagues in rural communities (by using a community hub rather than the acute hospital as their base) and more time to care
Implementation of integrated digital care record	A single digital system across Somerset will: • Ensure clinicians have sight of patients' full clinical history without delay, which will increase patient safety and good clinical outcomes particularly for women who live in the 'corridor' (600 women/year). • Facilitate the collation of data and conduct of clinical audits which drive learning and improved patient care	A single digital system across Somerset will: • Remove duplication so patients only have to tell their story once • support self-care and help reduce DNAs which ensures NHS resources are available to those who need it • reduce staff time spent re-keying information, and relaying patient information to colleagues, which frees up time for clinical care

Combined response to national strategies	• Improves our ability to implement a continuity of carer style model tailored to the Somerset context which means women are less likely to require clinical intervention and more likely to be satisfied with their care.[30,31,32] • Improves our ability to implement personalised care (a requirement of Better Births) which aims to ensure all time in healthcare is well spent.	• Planning, delivery, and reporting on national requirements will only need to be done once rather than twice as is currently the case, freeing up time for clinical care
Integrated workforce planning	With a combined team there are opportunities for upskilling and sharing of best practice across the enlarged team, e.g. county-wide MDTs which will contribute to better health outcomes.	• A more resilient team with higher retention rate will mean less colleague time spent firefighting and more time developing the service to meet women's needs.

How merger facilitates planned changes

3.84 The signal of merger has brought the two Somerset midwifery teams together in a way that has not been previously possible, and this has already yielded benefits for patients, for example in supporting the creation of single county-wide pathways which improve equity of care across the county.

3.85 However, while the two maternity teams exist within separate legal entities, collaboration can only take us so far. Different policies, protocols, working practices, governance structures, line management arrangements and separate budgets create barriers to joint working, and without the prospect of merger on the horizon the commitment to work around these barriers is likely to wane over time. We now need to move to being a single legal entity to complete the work we have started to standardise protocols and policies, support the movement of staff free from bureaucracy, and enable access to the right information at the right time, so we can improve patient care.

Benefits indicators

3.86 The indicators we will use to show whether the county-wide maternity service is delivering the expected benefits are set out in **Figure 19** below.

[30] Sandall J, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* 2016;4 CD004667. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8663203/pdf/CD004667.pdf

[31] Perriman N, Davis D, Ferguson S. What women value in midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery* 2018;62: 220-229

Figure 19: benefits indicators - maternity

Indicator	Source	Baseline	Target
CQC rating	CQC inspection	Good (both Trusts)	Outstanding by next CQC assessment
NHS maternity patient survey	NHS maternity patient survey	Both Trusts are currently at 'better than or about the same' on all indicators	To maintain all indicators at 'better than or the same', and increase the number of 'better than' indicators
Increase % of home deliveries *(whilst maintaining safety, this is to increase choice rather than avoid hospital settings where needed)*	LMNS dashboard	YTD combined 19/20: 3.6% 20/21: 3.5% 21/22: 3.0%	3.5% by April 2024
Continuity of carer offered in ante and post natal pathways	LMNS dashboard	YTD combined 19/20: 33.6% 20/21: 33.1% 21/22: 44.3%	YTD combined: ≥35% is set by LMNS; however, seek to achieve 50% by April 2024
Workforce review	Workforce review	Underway	Complete by December 2022
Colleague wellbeing Staff to report they are happy at work Reduced staff absence due to stress/anxiety Recruitment and retention	 Staff survey Workforce reports, PMA wellbeing reports Workforce reports	(October 2022) SFT - Score of 45 YDHFT - Score of 64 (Sept 2022) 37% of total absence (October 2022) Turnover rates - 10.7%	 Score of 65 by April 2024 Score maintained by April 2024 < 5% by Sept 2023 < 7% by April 2024
Patient experience Achieving UNICEF gold standard across maternity and neonatal	 Local UNICEF reports	SFT maternity Gold sustainable Neonatal – Level 1 YDH Level 3 Neonatal - intention of commitment	All gold sustainable for both maternity units by 2024 and whole of maternity neonatal care by 2026
Patient experience Complaints Personalised care plans in place (Ockenden action)	 Number of formal complaints (LMNS dashboard) Personalised care plans audit of use	 YTD combined 19/20: 8 20/21: 19 21/22: 17 0%	 YTD combined: 10 for 2023/24 (acknowledging the need to maintain an open culture to receiving complaints) 100% women offered a personalised care plan by April 2023 (evidence suggests uptake will be about 35%)
Digital implementation	Progress against Digital programme plan implementation	Not integrated	Go live as per plan is 22/2/2023
Ensuring safety in change – no increase in safety incidents	Radar / Ulysess	YTD SFT: 100 YDH: tbc	No increase in safety incidents reported

Alignment of policies and guidance	Reports to the Maternity Transformation Programme board	156 to align. 0 complete	95% complete by June 2023

Implementation plans

3.87 Maternity services have been integration trailblazers. The maternity service has taken huge steps forward during 2022, for example with the establishment of the trusted relationships which are a pre-requisite for effective integration, and the creation of single joint posts and maternity integration champions.

3.88 The teams are on schedule to complete the first phase of their integration by April 2023. They will have completed the bulk of the remaining integration actions by April 2024. Key steps which have enabled this rapid progress include a clear steer from the executive team, the appointment of a single Director of Midwifery and the provision of support for integration in terms of project management and other resource. The collaborative working of the multi-disciplinary maternity leadership team with the support of the LMNS has been instrumental in enabling the achievements and success to date.

3.89 The teams have identified the actions needed to integrate maternity services in an integration plan which is provided as a supporting submission to this Case. This integration plan will continue to be developed as part of the ongoing merger programme.

3.90 Since March 2022, progress in planning and delivering an integrated maternity team has been reported to a Maternity Transformation board co-chaired by the Chief Nurse and Chief Operating Officer - Neighbourhoods, Mental Health and Families. This combined board also oversees the implementation of national recommendations (Ockenden and Better Births). This allows us to make efficient use of staff time and appoint a single lead for each workstream across the two Trusts. The Somerset Maternity Voices Partnership (independent ICB-funded patient advocates for maternity) are an active member of the Maternity Transformation Board, bringing the patient perspective to discussions, helping to shape change, and holding service leaders to account. In addition, our Clinical Service Integration Leadership Group will also have oversight of the integration of our maternity services.

4. Oncology

Summary

YDHFT and SFT's oncology services provide systemic anti cancer treatments for a range of solid and haematological tumours, in outpatient, day-case and inpatient settings. SFT is the county's radiotherapy centre.

Both services are well-rated by patients and independent quality assessors alike. Nonetheless, both Trusts are grappling with rising demand, long-term staffing issues and inequities of care across the county. The two teams have recognised for some time that innovative thinking and transformational change are needed to meet these challenges and provide a service that meets patients' needs now and in the future.

In 2020, the Trusts signed a Memorandum of Understanding in which they committed to creating a single county-wide oncology service. However, when clinical demand is high, each team currently has to prioritise the needs of their own organisation which means our collective resources are not necessarily deployed as best they could be.

Under our merger plans the teams will combine and work under single leadership, governance, policies and protocols, and patients will be cared for on one waiting list. YDH and MPH will continue to deliver outpatient care and systemic therapies, and MPH will provide radiotherapy and specialist ward-based care.

The patient benefits which will result from combining the oncology teams include:

- A single, more resilient integrated team better able to cover staffing gaps and drive transformational improvement for patients.
- Better patient access to specialist care, especially out of hours and at the weekends. This will improve patient outcomes and experience, and tackle inequity across the county due to staff shortages and other factors.
- Standardised county-wide pathways and protocols which will reduce patient safety risk, speed up diagnosis and treatment, and improve clinical efficiency.
- Increased outpatient care closer to home, where clinically appropriate, which will reduce patient anxiety caused by travel, and free up acute resources for higher acuity patients.
- Increased opportunity for patients to participate in clinical trials and reap the attendant benefits in terms of better clinical outcomes and experience.
- An integrated electronic health record which reduces clinical risk and increases efficiency.

We have established a joint Oncology Oversight Group to oversee integration progress.

Current service arrangements

4.1 YDHFT and SFT's oncology services provide systemic anti cancer treatments for a range of solid and haematological tumours, in outpatient, day-case and inpatient settings.[33] A summary of services by tumour site is provided at **Annex 3**.

4.2 Both Trusts' oncology services are CHKS accredited.[34] In the National Cancer Patient Survey (2019), over 90% of patients treated by YDHFT or SFT said they were 'satisfied' or 'very satisfied' with the care they received, compared to the national average of 89%.[35,36,37]

Care in acute and community settings

SFT

4.3 Somerset's radiotherapy centre, based at the Beacon Centre, is located at SFT's Musgrove Park Hospital. Prior to the Centre opening in 2009, cancer patients in Somerset had to travel to Bristol, Exeter or Bath for radiotherapy.

4.4 The Beacon Centre has a 14-bed inpatient ward providing 24/7 specialist oncology acute care, an outpatient unit and a day care unit providing systemic anti cancer treatments (SACT) including chemotherapy, immunotherapy, biological therapies and radiotherapy. SFT maintains an active portfolio of oncology clinical trials. SFT has 3 MRI scanners and runs a 24 hour on-call MRI service for emergencies e.g. metastatic spinal cord compression (MSCC).

4.5 During the pandemic, SFT began using Wellington Community Hospital to provide intravenous SACT and supportive treatments for clinically stable patients. This was to help manage rising demand and provide care closer to home. A similar 'hub and spoke' model service is now operating at Bridgwater Community Hospital, and the services at both Wellington and Bridgwater have now become business as usual.

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[33] Diagnosis and surgical interventions are provided by separate Cancer Services.

[34] CHKS accreditation provides independent, expert assessment of quality improvement. Accreditation runs on a 3 year cycle and is supplemented by annual surveillance visits. The Trusts have decided not to continue with the CHKS accreditation for systemic anti cancer treatment and therefore their accreditations will expire on 31 October 2022; other accreditation schemes are being looked into. However renewed CHKS accreditation will be sought for radiotherapy, provided by SFT.

[35] NHS England and NHS Improvement and Picker Institute. National Cancer Patient Experience Survey 2019: National results summary. Available from: https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-National-Report_V1.pdf. [Accessed 21st April 2022].

[36] NHS England and NHS Improvement and Picker Institute. National Cancer Patient Experience Survey: 2019 results. Yeovil District Hospital NHS Foundation Trust: Published June 2020. Available from: https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-Trust-Yeovil-District-Hospital-NHS-Foundation-Trust-RA4.pdf. [Accessed 21st April 2022].

[37] NHS England and NHS Improvement and Picker Institute. National Cancer Patient Experience Survey: 2019 results. Taunton and Somerset NHS Foundation Trust: Published June 2020. Available from: https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-Trust-Taunton-and-Somerset-NHS-Foundation-Trust-RBA.pdf. [Accessed 21st April 2022].

4.6 Following treatment at MPH, some SFT patients, e.g. those with MSCC are transferred to the community hospital nearest to their home where physical assessment and/or rehabilitation support is available.

4.7 Around 1-2 patients a month are referred from YDHFT to SFT for radiotherapy as day cases. A further 5 or so patients a year are transferred from YDHFT to SFT as inpatients to receive emergency radiotherapy for example for MSCC or because of immunotherapy toxicity.

YDHFT

4.8 YDHFT's oncology patients are cared for on YDH's general medical wards, and its acute oncology service is staffed 8.30am-5pm Monday-Friday. At weekends and out-of-hours, YDHFT's general medical staff provide cover, and specialist advice is available by telephone from an on-call oncologist at SFT.

4.9 YDHFT has 2 MRI scanners which operate 9am-9pm Monday-Friday, and 9am-5pm Saturday and Sunday. Emergency cases presenting out of hours (e.g. with MSCC) are either admitted to YDH overnight for scanning the next day, or are transferred to MPH for immediate scanning if the clinical need is urgent.

4.10 The Yeovil Oncology Unit provides SACT day care and additional outpatient cancer care; it does not provide radiotherapy. In May 2020, in order to protect vulnerable patients during the Covid pandemic, the Unit moved, (following a risk assessment) from the main YDH site to a new location in a former hospice in Yeovil (St Margaret's site).

Care at home

4.11 SFT has a range of contracts with third parties to provide cancer therapies at home. The main contract is with Sciensus (previously known as Healthcare at Home), but it also has smaller contracts with other providers on a single drug basis. YDHFT has a contract with Boots to deliver oral anti cancer treatments to patients' homes. However YDHFT is unable to offer intravenous treatments at home due to the small size of the patient cohort which makes it uneconomic to do so.

4.12 Prior to the pandemic, SFT operated a mobile cancer care unit (the 'chemo-bus') which provided c. 1,400 episodes of treatment in 2019/20 across the SFT catchment area. This helped reduce pressure on the Beacon day unit. However, this service was ended due to Covid social distancing requirements (which reduced the number of patients that could be treated) and this reduced the cost-effectiveness of the service. The staff who used to provide care on the chemo-bus now provide oncology care at Wellington and Bridgwater community hospitals (see Figure 27).

4.13 **Figure 20** summarises the key elements of the Trusts' oncology provision.

Figure 20: summary of oncology provision in 2020-21

	SFT	YDHFT
Inpatients	Beacon Cancer Centre, MPH 14 beds 1,977 inpatients on Beacon ward (1,757 emergency cases 22 day cases 198 electives)	551 emergency cancer admissions, patients cared for on YDH general medical wards
Outpatients	• Beacon Cancer Centre, MPH 23-chair chemotherapy service, also radiotherapy, immunotherapy and adjuvant treatments • Wellington Community Hospital chemotherapy and adjuvant treatments 4 chairs, 3 times a week 5,754 oncology outpatient appointments/year at Beacon Centre and Wellington combined	Yeovil Oncology Unit, St Margaret's 9-chair chemotherapy plus adjuvant treatments 4,358 outpatient treatments in 2020/21
Home care (provided by third parties)	Approximately 2,200 patients/year receive cancer therapies at home	

Note: In addition, SFT began providing chemotherapy and adjuvant treatments care at Bridgwater community hospital in 2022, see Figure 27.

Workforce

4.14 **Figure 21** sets out the oncology workforce position at both Trusts. Alongside the posts set out below, the wider oncology workforce includes radiologists, radiographers, speech and language therapists, specialist dieticians and physiotherapists. The teams can also refer patients needing physiotherapy, occupational therapy or social care support to relevant colleagues. Currently, there are no psychologists in post dedicated solely to the care of cancer patients.

Figure 21: Oncology workforce as at September 2022

	YDHFT			SFT		
	In post		Vacancies	In post		Vacancies
	Substantive	Locum/ agency		Substantive	Locum/ agency	
Consultant oncologists	1	2	2	12.82	1	2
Associate Specialist	-	-	-	0.90	-	-
Speciality Doctor	-	1	1	2.65	-	-
Clinical nurse specialists*	4.1	-	2	8.94	-	1
Nursing staff day unit	8.76 (RN)	-	3	18.73 (RN) 12.22 (HCA)	2	-
Administration staff	8.51	-	-	15.94	-	2
Total	**22.37**	**3**	**8**	**72.2**	**3**	**5**

N.B. All figures are whole time equivalents.
* includes SACT (systemic anti-cancer therapy) nurses and AOS (acute oncology service) clinical nurse specialists

Collaboration to date

4.15 The two Trusts' Oncology departments have worked closely together for many years, for example by sharing staff to fill gaps in the short and medium term. However, both teams have also recognised for some time that innovative thinking and transformational change are needed to meet the combined challenges of rising demand, inequity of access, and workforce issues.

MOU

4.16 In February 2020, the teams agreed a Memorandum of Understanding (MOU) which committed to the creation of a single county-wide oncology service with a single management structure, governance arrangements, one set of pathways, policies and standards, and a single waiting list. The teams believe that coming together as a single team will allow them to deploy their collective oncology expertise in a way that ensures an equitable service for patients right across the county, as well as helping them plan the future of the service.

4.17 The MOU was agreed as part of the development of the Fit for My Future health and care strategy for Somerset, a process which was led by Somerset CCG.

4.18 Under the MOU it was agreed that MPH and YDH will both continue to deliver outpatient care and systemic therapies, and that in addition MPH will deliver radiotherapy and specialist ward-based care. The agreed features of the county-wide services are set out in **Figure 22**.

Figure 22: Features of county-wide oncology service agreed under the MOU

- Maintain two distinct sites at MPH and YDH for delivery of outpatient care and systemic therapies to oncology patients in Somerset.
- Maintain MPH as the site for delivering radiotherapy and specialist ward-based care.
- Align clinical practice and delivery of services with joint policies and procedures. Align clinical teams with respect to expertise, training, experience and job plans.
- Share decision-making[38] with respect to patient pathways, best practice, innovation and service improvement.
- Offer equitable training and learning opportunities and access to a supportive pastoral care and wellbeing programme for all oncology staff across the county
- Implement a single triage hub for patients presenting with acute oncological problems to ensure timely access to the correct care.
- Ensure equality of access to all clinical trials offered in Somerset.

4.19 The MOU set out an agreed programme of joint work, split across four workstreams, A further five workstreams were subsequently added to make nine in total, see **Figure 23**.

4.20 The two teams have appointed an overall clinical lead for integration who ensures there is adequate clinical cover and oversight of issues on both sides of county and leads the work to align developments and practice. There are also named leads for each of the nine workstreams and a project manager to help them monitor the programme's progress. The teams have established a monthly oversight group to maintain momentum.

Figure 23: Oncology workstreams

Workstream	Scope	Progress so far
Acute	• Cancer helpline • Policies for acute care • Training for Acute Haematology Oncology Service (AHOS) • Pathway design • Inpatient care	• Cancer Helpline has cross-county cover – led and delivered by designated AHOS Clinical Nurse Specialists with ringfenced time. Now operates Mon-Fri 8am-8pm and weekends/bank holidays 8am-12 noon. Revised operational hours has led to a reduction in out of hours admissions by a third and significant reduction in the impact on primary care. • 20 of 23 policies reviewed and revised for application both at MPH and YDH - all have gone through local governance at MPH and have either gone/are going through YDHFT governance; remaining 3 policies at peer review stage • Neutropenic sepsis pathway - work underway to embed use of patient specific neutropenic sepsis alert cards at YDH - aim to ensure door to needle antibiotic delivery within 1 hour of admission to improve patient outcomes and reduce risk

[38] This include MDTs.

Workforce	• Training/education • Clinical supervision • Clinical nurse specialist cross cover/joint post • Lead cancer nurse role • Team building • Skill mix • Retention/recruitment • Job planning & alignment • Team wellbeing	• Clinical supervision for staff and counselling for patients to commence at YDHFT January 2023 – counsellor and navigator posts appointed to • Leads for systemic anti cancer treatments and Acute Haematology Oncology Service at YDH appointed and dates planned for meeting with leads at SFT for induction and development • SFT SACT study days shared with YDH for attendance of all chemo trained staff from January 2023 • Admin leads on both sites now same banding
Clinical practice	• SACT • Policies on clinical practice • Clinical research • Patient advocate • Capacity/demand • Pathway design e.g. SACT referral pathway	• Onco-geriatrics service is just starting in SFT and learning will be taken forward into the merged Trust • Lead for cross-county oncology trials appointed and they are linking in with wider Research & Development strategy for the merger
Elective	• MDT configuration • Meetings & huddles • Admin teams • Elective pathway design • Day units • Radiotherapy	• Combined clinical team huddles are being rolled out which has resulted in patient cases being discussed by a wider team and ensures best practice is followed • New treatments and chemotherapy regimens have been aligned • Training programmes aligned and joint training sessions in place
Leadership & structure	• Workforce structure	• Early workforce reviews undertaken • Consultation with staff side/unions
Communication & engagement	• Comms and engagement with teams • Patient engagement	• Identified comms lead • Oncology colleagues met to discuss integration work and agree patient benefits • Ongoing submission of data to National Cancer Patient Experience Survey
Digital & contracts	• Digital contracts	• Identified digital leads • Haematology outpatient transfer learning will inform oncology work going forwards
Finance	• Single budget	• Identified finance leads • Early work undertaken to explore what a single budget would look like
Governance	• Oversight of programme • Data collection & measurement	• Monthly Oncology oversight group meetings • Patient benefits indicators agreed and baselining in progress

4.21 Although progress towards the aims set out in the MOU was hampered by the advent of Covid (when teams reverted to focusing on their 'own patients'), both teams remain committed to creating a single county-wide service, and the signal of merger has given them more certainty and confidence to resume their integration planning. For example, in February 2021, the teams brought together their two patient helplines into a single county-wide cancer helpline. Nurses with dedicated triage time now provide a consistent level of triage for all patients across the county, giving direct access to specialist advice and treatment if necessary which helps limit referrals to primary and secondary care.[39]

4.22 Collaboration between the teams has helped staffing gaps to be covered, joint policies to be developed, job planning to be aligned (to support clinics, huddles and administrative tasks), cross-county clinical supervision to take place and the single cancer helpline to be established (see paragraph 4.21, and figure 23).

4.23 However, despite these successes, barriers remain to the delivery of the most effective, equitable care for people across the county. Although the MOU set out a clear statement of intent on the part of both teams, when operational pressures emerge each team has had to prioritise the needs of their own organisation. This retreat to one's own organisation exacerbates inequities in provision across the county, and means the two Trusts' collective resources are not necessarily being deployed as best they might be. The lack of a single digital record also creates challenges for the care of patients who are being treated by both Trusts, see paragraph 4.7.

Challenges

4.24 In recent years, the two Oncology services have faced a range of significant challenges. These are:

- Service sustainability
- Access to specialist care
- Differences in protocols
- Access to clinical trials
- Access to clinical records

4.25 Further detail on these challenges is set out below.

[39] Between October 2021 and February 2022 the countywide Cancer helpline received a high level of calls. But over the period there was a small increase in referrals to secondary care from 16% to 18% and a slight increase in referrals to primary care from 9% to 11%. Clinicians believe this is due to the growing complexity of systemic anti cancer treatments and rising numbers of patients receiving anti-cancer treatment.

Service sustainability

4.26 Over the last decade, incidence rates for all cancers have increased by 4% in the UK.[40] Like the rest of the country, Somerset is seeing rising demand for its oncology services as cancer referrals return to pre-pandemic levels, and because people with cancer are living longer. Despite there being an decrease in activity in 2020/21 due to Covid, when comparing 2019/20 and 2021/22 there is an increase in activity: oncology inpatient activity rose at YDHFT by 30% and at SFT by 10% between 2019/20 and 2021/22. Also, first appointments in oncology rose by 16% at YDHFT and 9% at SFT between 2019/20 and 2021/22.

4.27 In addition, there are shortages of clinical oncology trainees and consultants nationally. Within Somerset there are long-standing vacancies, particularly in the YDHFT team, which reduce team resilience and create single points of failure. For example YDHFT has held a vacancy for an oncology Clinical Nurse Specialist on and off for 4 years due to the rapid turnover of postholders as a result of the high workload. Despite evolving the post to make it more attractive, YDHFT has had no success filling the post on a substantive basis during that time.

4.28 Rising demand in the face of workforce gaps puts pressure on the service and the individuals within it. It also causes patients to have to wait longer for treatment which can lead to poorer health outcomes.

4.29 The cost of agency/locum staff to cover these staffing gaps contributes to financial pressures. Over the past 5 years, owing to recruitment difficulties, the majority of YDHFT's oncology consultants have been either locums or SFT consultants working as visiting consultants at YDHFT under a service level agreement (SLA). In 2021/22, YDHFT spent 80% (£376,333) of its total spend on oncology staffing (£467,673) on locum/agency staff. There are two consultant posts vacant at SFT. In 2021/22, SFT spent 5% (£153,779) of its total spend on oncology staffing (£3,145,507) on locum/agency staff.

4.30 As at September 2022, 80% of YDHFT's oncology Consultant establishment was either vacant or filled by a locum. Also as at September 2022, 33% of YDHFT's establishment of oncology Clinical Nurse Specialists (2 WTE) was unfilled.

4.31 Research has found that locum use creates concerns about continuity of care, patient safety, team function and cost.[41] Both Trusts strongly vet and supervise the locums they use. However, locums take time to learn local systems and processes, and substantive colleagues need to spend time supervising their work. In addition, the regular turnover of colleagues can be unsettling for the substantive team. This creates additional pressure for already stretched teams.

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[40] Cancer incidence statistics | Cancer Research UK

[41] Ferguson, J and Walshe, K. The quality and safety of locum doctors. Journal of the Royal Society of Medicine. 2019;112(11): 462-471. Available from: https://doi.org/10.1177/0141076819877539.

4.32 The teams work hard to cover staffing gaps. For example, 4 SFT oncology consultants each work a day a week, in person, at YDH under an SLA. This is up from 2 consultants working a day a week at YDH during the pandemic. However, the underlying staffing position across the county, coupled with rising demand means that some aspects of the service are currently unsustainable.[42] This is why we are already acting as one service, and treating workforce issues as a priority prior to the merger. **Figure 24** illustrates some of the workforce challenges, including the difficulty of introducing pathway changes which would benefits patients, in a small team with limited capacity and high locum use in senior roles.

Figure 24: colleague story - Sophie Smith

Colleague story – Sophie Smith, acute oncology Clinical Nurse Specialist at YDHFT

"My role involves working with patients who are experiencing complications from their cancer and their cancer treatment as well as advising on new cancer diagnosis, including cancer of unknown primary. The role involves times of high pressure and stress but overall I love my job and the difference it makes to the patients I meet.

Until recently I was the only acute oncology nurse at YDH covering three days a week with the support of a chemotherapy sister four days a week. Being short staffed is challenging and makes it difficult to provide the level of care I aspire to. As a result I often feel I can't do my job properly. Due to clinical demand I often work beyond my hours without breaks and frequently have to cancel clinical development opportunities to ensure the service is covered and care maintained. Furthermore training colleagues to embed pathways such as metastatic spinal cord compression and neutropenic sepsis is often impeded. This pressure is compounded by the lack of an oncology ward or designated area for oncology patients, making it difficult to train/educate colleagues.

The acute oncology role is an autonomous role, I advocate for the patients in my care, acting as the link between oncology and the admitting team regardless of where their treating centre is to ensure patients receive the best possible care. This is very important as in YDH patients are admitted under the medical/surgical teams instead of oncology. I work very closely with the acute oncology team in MPH and I feel the merger will strengthen this bond and help develop new working relationships which will have a positive impact and provide the opportunity for peer support across sites. Whilst the merger causes anxiety amongst many in YDHFT, I feel the merger will help to streamline patient pathways and overcome issues surrounding multiple IT systems which often has a negative impact on patient care. I am also hopeful that the merger will mean I can pursue my professional development which will improve the assessment and management of patients presenting, and also ensure a smoother pathway for patients regardless of where they receive their treatment."

Access to specialist care

4.33 YDHFT oncology patients are cared for on general medical wards around the hospital rather than on designated oncology wards. This makes it harder for YDHFT's small team of oncology specialists to provide the care they would like (see Figures 21 and 24), and in addition nurses on general wards do not have the specialist skills to care for oncology patients.

[42] Examples of elements of the service which are unsustainable are acute oncology and medical oncology cover for gynaecological cancers at YDHFT.

4.34 Although YDHFT colleagues can access advice out-of-hours from the SFT oncologist on call, the clinical decision-making during these times remains with YDHFT colleagues who are not oncologists. And although acute cases are discussed with the oncologist on call, less urgent concerns about patient care often wait until Monday morning when the YDHFT specialists return to work.

4.35 The lack of round-the-clock specialist care at YDHFT creates an inequity of care across the county, because while there are oncology specialists available every day at MPH there is currently no specialist oncology care available at YDH at the weekend. There is evidence that patients who experience a delay in accessing oncology treatment may suffer ongoing pain and discomfort for longer.[43]

4.36 Some YDHFT patients who require emergency radiotherapy have to wait longer for investigations and treatment because they need to be transferred to MPH to receive care, see **Figure 25**, John's patient story.

Figure 25: Patient story - John, radiotherapy

Now

John is 68, retired and lives with his wife in Glastonbury. In 2017 he was diagnosed with superficial bladder cancer for which he receives regular check-ups at Yeovil District Hospital.

In 2021, John experiences a sudden onset of shortness of breath, back pain and cannot walk unaided. He telephones his cancer nurse specialist at YDH and describes his symptoms to the cancer nurse. The nurse suspects John may have developed spinal cord compression as a complication to his cancer. John is conveyed by ambulance to YDH. He is admitted late on Thursday morning where CT scans confirm the cancer had spread to his lungs and spine. The oncologist requests an MRI scan but no slots are available until the following day. First thing the following morning, John has an MRI scan which confirms he has spinal cord compression and requires urgent radiotherapy. As YDHFT does not provide radiotherapy, John requires an urgent transfer to MPH.

Oncologists from both Trusts discuss John's case, including whether he needs a single or multiple doses of radiotherapy. John is transferred on a flat bed by ambulance to MPH, where he receives an urgent single fraction of palliative radiotherapy. John remains at MPH for the whole day receiving a planning scan and then radiotherapy treatment. At the end of the day he is taken back by ambulance to YDH.

Overall, the day is very uncomfortable and stressful for John. He is in pain and very tired by the two cross-county trips he has had to make between YDH and MPH, a journey of c. 50 minutes each way and the many hours he has spent at MPH.

Once he is back at YDH, John returns to the care of a general medic rather than an oncologist over the weekend. Once John is discharged he receives palliative chemotherapy at Yeovil Oncology Unit (St Margaret's site).

Post merger

John is admitted to YDH in the late morning with a sudden onset of shortness of breath, back pain and cannot walk unaided, but when CT scans confirm the cancer has spread to his spine, he is immediately transferred to a specialist oncology bed at MPH with suspected spinal cord

[43] King J, Ingham-Clark C, Parker C, Jennings R and Leonard, P. Towards saving a million bed days: reducing length of stay through an acute oncology model of care for inpatients diagnosed as having cancer. BMJ Quality & Safety. 2011;20(8): 718-24. Available from: doi: 10.1136/bmjqs.2010.044313.

compression. An MRI scan later that day shows John needs urgent radiotherapy, and as he is already on site he receives a single fraction of palliative radiotherapy that same day.

John remains at MPH for the duration of his inpatient treatment, and this reduces the number of journeys he has to endure while very unwell. John remains under the care of an oncologist throughout his inpatient stay which means he has continual access to specialist care.

Once John is discharged he is able to choose where to receive his palliative chemotherapy - YDH or MPH - both of which can be reached in a similar time from Glastonbury.

Psychological support

4.37 The benefits of effective psychological support for cancer patients include reduced depression, anxiety and pain, improved self management and coping skills; these help patients feel more in control and improves their quality of life.[44] In 2015, Macmillan Cancer Support noted that 'better psychological support outcomes offer a significant economic saving by increasing adherence to treatment, reducing take-up of additional services, reducing bed days and improving decision making about treatment choice'.[45, 46]

4.38 YDHFT offers up to level 3 counselling to cancer patients, while SFT offers level 2 to 4 counselling for patients, significant family and friends.[47] However the Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance has identified Somerset as an outlier because although the Trusts provide specialist psycho-oncology support with qualified counsellors, there is no clinical psychologist for cancer services available who could provide additional treatment options such as Cognitive Behavioural Therapy.

Differences in protocols

4.39 There are differences in pathways and protocols between the two oncology services, and given that a number of clinicians work across both Trusts (and therefore move between the two approaches) this creates a patient safety risk as well as being inefficient. For example, the Trusts use different antiemetic medication for some chemotherapy patients: YDHFT prescribes multiple dose antiemetics while SFT prescribes a single dose combination medication. This means colleagues (particularly those who work on the county-wide cancer helpline) need to check patient records carefully to verify what medication the patient is on before advising them. This

[44] Newell, SA, Sanson-Fisher, RW and Savolainen, NJ. Systematic review of psychological therapies for cancer patients: overview and recommendations for future research. Journal of the National Cancer Institute. 2002;94(8): 558-584.

[45] Healthy London Partnership. *The psychological impact of cancer: commissioning recommendations, pathway and service specification on psychosocial support for adults affected by cancer. Transforming Cancer Services Team for London.* Available from: https://www.healthylondon.org/wp-content/uploads/2018/05/Psychological-support-for-people-affected-by-cancer-May-2018.pdf [Accessed 21st April 2022].

[46] The King's Fund. *Long-term conditions and mental health: the cost of co-morbidities.* Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf. [Accessed 21st April 2022]

[47] 'We hear you' is the charity-provided service offered to YDHFT patients and 'HOPE' at SFT.

additional checking takes up valuable clinical time, and the risk of patient or colleague confusion about the different pathways remains.

Sepsis card

4.40 Another difference between the Trusts is the use of the 'sepsis card'. Neutropenic sepsis is a potentially fatal complication for patients receiving systemic anti cancer treatment. Mortality rates range between 2–21% among adults, and the use of aggressive intravenous antibiotics shows a significant reduction in both morbidity and mortality.[48]

4.41 For every hour that neutropenic sepsis is left untreated, patient survival rate declines[49] and for every hour's delay in antibiotic administration, there is a c. 8-hour increase in hospital length of stay.[50] NICE recommends[51, 52] that all patients who present to hospital as unwell post-chemotherapy should receive antibiotics within one hour[53] (and SFT has set a target of achieving this in 90% of cases).

4.42 After chemotherapy at SFT, patients are given a sepsis card detailing the suitable antibiotic prescription in the event of sepsis. If the patient subsequently presents at SFT's emergency department, the admitting team can review the card and without delay administer the correct antibiotics without the need for a new prescription. Between January-July 2022, on average 89% of patients presenting at SFT were treated within one hour, compared to 47% at YDH. SFT's introduction of a sepsis card, which reduced the average time to administer antibiotics, was written up by SFT colleagues and reported in *Acute Medicine*.[54]

4.43 YDHFT introduced a sepsis card in 2022 to realise the benefits for patients. However, due to different governance and professional opinions at the two Trusts, the card was different to SFT's and not recognised at MPH, see **Figure 26**. The Trusts are planning to move to the same sepsis card which will be recognised at both acute sites in early 2023.

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[48] Herbst C, Naumann F, Kruse EB, et al. Prophylactic antibiotics or G-CSF for the prevention of infections and improvement of survival in cancer patients undergoing chemotherapy. *Cochrane Database Syst Rev* 2009:CD007107

[49] NICE: Clinical Knowledge Summaries. *Neutropenic Sepsis: Prevention and Management in people with Cancer*. September 2012.

[50] Gaieski, DF, Mikkelsen, ME, Band, RA, Pines, JM, Massone, R, Furia, FF, Shofer, FS and Goyal, M. Impact of time to antibiotics on survival in patients with severe sepsis or septic shock in whom early goal-directed therapy was initiated in the emergency department. Critical Care Medicine. 2010;38(4): 1045-1053.

[51] Simmons T. *Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients.* National Institute of Health and Care Excellence, 2012. www.nice.org.uk/guidance/cg151/evidence/needs-assessment-pdf-188303583.

[52] National Chemotherapy Advisory Group. *Chemotherapy Services in England: Ensuring quality and safety. A report from the National Chemotherapy Advisory Group.* Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20130104173757/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_104500. [Accessed 21st April 2022].

[53] The time between attendance at ED and the administering of antibiotics.

[54] Botten J, Beard J, Zorzi A, Thompson A. A simple intervention to improve antibiotic treatment times for neutropenic sepsis. Acute Med. 2016;15(1):3-6. PMID: 27116580.

Figure 26: Patient story - Susan

Patient story – Susan, neutropenic sepsis card

Now
Susan who is 71, is retired and lives alone in Wells. She was diagnosed with breast cancer in 2021, and had a mastectomy at YDH. She was subsequently referred for adjuvant chemotherapy at the Yeovil Oncology Unit (St Margaret's site).

During her first cycle of chemotherapy, Susan develops a fever and calls an ambulance which conveys her to Musgrove Park Hospital.[55] Susan has a YDH neutropenic sepsis card, but this is not recognised by the staff at MPH and does not permit the rapid administering of antibiotics under the neutropenic sepsis policy in place at MPH. As the ED is busy, Susan waits 3 hours to be seen by an ED practitioner. While waiting in the ED, Susan experiences slurred speech and worsening pain. She is also confused and increasingly anxious about what is wrong with her.

When the ED practitioner examines her, Susan is diagnosed with sepsis and immediately given antibiotics. She is then admitted and spends 5 days recovering on a general ward at MPH before returning home.

Post merger
As a merged Trust, with a single neutropenic sepsis policy, Susan will have a valid neutropenic sepsis alert card for use if she develops a fever whilst on chemotherapy that is recognised at both YDH and MPH.

When Susan develops a fever and is conveyed to MPH, staff in the ED see the alert card and are able to promptly diagnose and treat sepsis. They give Susan her first dose of antibiotics within the target of one hour. Susan is admitted and spends only 3 days (rather than 5 days pre-merger) recovering on a general ward at MPH before returning home.

Inequitable access to clinical trials

4.44 Patients who are enrolled on clinical trials are more engaged with their care and show increased self-management. They also benefit from earlier access to innovative drugs that would not otherwise be available to NHS patients, and from close monitoring during their treatment which many patients find reassuring. A number of studies show a link between clinical trial participation and improved patient outcomes (including for those patients who do not receive the actual trial drug).[56,57]

4.45 In 2019/20, 354 SFT patients participated in an oncology clinical trial compared to only 15 YDHFT patients. YDHFT's paucity of substantive oncology consultants means it has few staff who can act as Principal Investigator for a clinical trial, and for

[55] Wells is roughly equidistant from MPH, YDH and RUH Bath and patients may be conveyed to all 3 acute hospitals. Ambulance crews will try to take patients to where they are known for their care, but are not obliged to, and if a Taunton crew conveys the patient, they may head to MPH to remain in their patch.

[56] Downing, A, Morris, E, Corrigan, N, Sebag-Montefiore, D, Finan, P, Thomas, J, D, Chapman, M, Hamilton, R, Campbell, H, Cameron, D, Kaplan, R, Parmar, M, Stephens, R, Seymour, M, Gregory, W and Selby, P. High hospital research participation and improved colorectal cancer survival outcomes: a population-based study. Gut. 2017;66(1):89-96. Available from: https://gut.bmj.com/content/66/1/89.long.

[57] Unger, J, M, Cook, E, Tai, E and Bleyer, A. The role of clinical trial participation in cancer research: barriers, evidence and strategies. American Society of Clinical Oncology Educational Book. 2016;35:185-98. Available from: https://ascopubs.org/doi/pdf/10.1200/EDBK_156686.

governance reasons SFT consultants cannot act as Principal Investigator for trials at YDHFT.

4.46 Although YDHFT patients can participate in trials by receiving treatment at SFT, many patients living in south Somerset decline to do so because of the travel involved and because they don't know the clinician leading the trial. So, while SFT has a wide portfolio of interventional and observational trials across all tumour sites,[58] longstanding recruitment difficulties at YDHFT have reduced the opportunity for YDHFT patients to participate in clinical trials.

4.47 Since participating in a trial has patient benefits, the differences in clinical trial enrolment between the two acute sites is leading to an inequity of care. The lack of clinical trials also has a knock-on effect on recruitment at YDHFT as research plays a key role in attracting and retaining high-calibre staff. It also impacts YDHFT's income as the Trust misses out on the income that comes with running commercial trials.

Access to clinical records

4.48 Colleagues from both Trusts have access to the MOSAIQ, PACS and OrderComms systems[59]. However, there is no shared patient record showing the results of investigations and treatments given, prescribing records are separate, and cross-Trust access to patient clinic letters is difficult. Between 1-2 patients a month are transferred from YDH to MPH for radiotherapy. Clinicians treating patients who have been cared for at both YDH and MPH need to log in to up to 10 different systems across the two Trusts, to see all relevant patient information. This is time consuming and increases the risk of patient harm if clinicians confuse patient records when multiple windows are open on the computer.

What will change, and how will patients benefit

4.49 The two teams' vision is to deliver a sustainable, cohesive and patient-focused oncology service that meets the future needs of our population and staff.

Service sustainability

4.50 Merger will allow us to consolidate our workforce into a single team and use our resources where there is greatest need. We have now put in place a single workforce plan, with appropriate PA[60] allocation for consultants across the merged Trust to cover operational requirements. While we do not envisage asking colleagues to change

[58] In 2019/20, 354 patients at SFT were part of 18 oncology clinical trials, while at YDH only 15 patients participated in a clinical trial.

[59] Mosaiq: for prescribing radiotherapy and chemotherapy and maintaining clinical notes. Ordercomms: for requesting radiology (SFT) and results of blood tests and pathology. PACS: imaging

[60] Programmed activities.

permanent base, we will be able to use our combined expertise for the benefit of the total patient cohort, in particular through the virtual sharing of specialist opinion.

4.51 The combined team will have fewer 'single points of failure', be better able to support sub-specialisation, and will facilitate cross-cover during staff absence thereby speeding up access to diagnosis and care (the teams already cover for each other during annual leave). Merger will also free up time by removing duplicate tasks e.g. national reporting, and eliminate the costs associated with the management of the SLA between the Trusts. A more resilient team with more capacity will mean shorter waiting lists than there would otherwise be, greater capacity to make and embed changes that benefit patients, and reduced risk of colleague burnout which helps us sustain a high quality service.

4.52 A county-wide staffing model will increase the opportunities for colleagues to develop their skills through exposure to a wider range of clinical cases, and increase the opportunities for career progression. The merged team will also have improved clinical support and access to specialist opinion. These factors should make the merged Trust a more attractive and rewarding place to work for existing and potential new staff, which in turn will improve workforce sustainability and patient care.

4.53 As an enlarged team we will be better able to respond to new developments, such as the emerging specialty of onco-geriatrics, which is of particular relevance in Somerset given the elderly demographic in the county. As two separate Trusts this work would likely be crowded out by operational pressures.

4.54 Whilst the oncology teams have worked closely for many years, there is a recognition that the planned merger can still cause insecurities and worries for colleagues. Staff on both sites were invited to attend meetings in early 2020, when the two departments were looking to work more closely with each other, to hear about and comment on these potential changes for them and their departments. The clinical workstreams which were subsequently identified have a wide representation of colleagues across the county to ensure everyone has been included and is able to have a voice.

4.55 Colleagues have raised the need for a clear workforce and leadership structure to be identified and this has been programmed into the plan to support the changes to be made.

Improved access to specialist care

4.56 Research shows that timely access to specialist oncology advice and treatment may improve health outcomes and 30-day mortality.[61] Although YDHFT colleagues currently have access to the on-call oncologist out of hours, contact through this route is usually reserved for the discussion of acute cases.

[61] Wallington, M, Saxon, E, Bomb, M, Smittenaar, R, Wickenden, M, McPhail, S, Rashbass, J, Chao, D, Dewar, J, Talbot, D, Peake, M, Perrem, T, Wilson, C and Dodwell, D. 30-day mortality after systemic anticancer treatment for breast and lung cancer in England: a population-based, observational study. Lancet Oncology. 2016;17(9): 1203-1216. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5027226/.

4.57 When we are one team, with shared responsible for a single cohort of patients, trusted relationships will deepen which will support quicker access to specialist advice for a wider range of cases. Peer support will also help build staff knowledge and skills. These changes contribute to our second clinical strategy aim around high quality care.

4.58 Furthermore, as a merged trust with a larger cancer patient cohort, we have a stronger case for the recruitment of a county-wide clinical psychologist to provide specialist psycho-oncology care. Whilst recruitment to a joint post could have been taken forward under the MOU, this would have involved an honorary contract and a recharge of costs. The signal of merger has prompted us to review our offer of psychological support to cancer patients and we are now advertising for a clinical psychologist to work county-wide. We estimate c. 550 patients a year will benefit from this new specialist support.[62] Plans are also underway to merge the counselling provision across the Trusts to address the current inequity in counselling offer. This work contributes to our fifth clinical strategy aim about personalised care.

Standardisation of protocols and pathways

4.59 As an enlarged team working under single leadership and with a single governance structure, it will be easier to plan and implement pathway changes which benefit patients, e.g. implementing a standard county-wide neutropenic sepsis card, and prescribing the same antiemetics during chemotherapy. These county-wide pathways will be tailored to the local context, and draw on existing best practice in the two Trusts and elsewhere to drive improvement in health outcomes. Standardised pathways and protocols will help us remove the risk of confusion that currently exists for colleagues and patients where approaches differ (e.g. different antiemetic drugs) and therefore reduce clinical risk. Streamlined pathways will also support early and faster cancer diagnosis and treatment, especially at the weekends and out of hours. This contributes to our second clinical aim around high quality care.

4.60 Standard pathways and protocols will contribute to equity across the county, and also make it easier for colleagues to cover for each other during staff absence and thereby support continuity of care.

4.61 Patients will be managed on a single waiting list, and we will establish single, larger MDTs for all tumour sites which will mean better outcomes for complex patients from the sharing of learning, and increased colleague understanding of how to treat complex cases.

[62] 200 patients from YDH and 350 from SFT.

Fewer inter-site transfers

4.62 Pathway redesign will help us reduce the number of transfers for very unwell patients such as those with suspected MSCC by caring for them in the best place according to their needs (see Patient story, figure 25).

4.63 Research shows that avoiding patient transfers improves clinical outcomes and overall patient experience, by eliminating the stress and anxiety associated with transfers and reducing length of stay.[63,64] An additional benefit will be a reduction in the clinical and administrative resources used by the Trusts to arrange patient transfers, and an environmental benefit from reduced travel. South West Ambulance Service (SWAST) will also benefit from reduced demand on their services, freeing up their capacity to serve other patients. We estimate that 5 acutely unwell patients a year are likely to benefit from reducing the number of inter-site transfers.

Equitable access to clinical trials

4.64 Once we are merged, an oncology consultant based at either acute site will be able to take on the role of Principal Investigator for an oncology clinical trial. This will improve equity across the county by enabling more patients being treated at YDH to join a clinical trial and thereby reap the benefits of trial participation; this helps serve our fourth clinical aim on equity. Clinical trials across the combined patient cohort will be overseen by a single Research and Development department responsible for managing all the oncology trials as a single portfolio. We estimate that an additional 100 to 150 patients per year in the YDH catchment area will gain access to clinical trials, following merger.

4.65 Both Trusts have good links with the South West Academic Health Science Network, and the National Institute for Health Research's Applied Research Collaboration South West Peninsula (PenARC). 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.

4.66 The merged organisation, with a larger combined patient cohort, would be a more attractive prospect for future clinical trials. We will be able to reach the target number of patients for trials more quickly, enabling trials to be completed more swiftly and the findings implemented sooner. A larger patient pool also increases the likelihood that trials for rare conditions are able to recruit sufficient patients to go ahead.

4.67 Greater depth in oncology research will benefit patients and help attract high-calibre staff by enhancing colleagues' knowledge of leading edge investigations and treatments, and supporting a culture of working to consistent quality standards.

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[63] S.Mueller, E.Shannon, J.Schnipper. *Patient Experience with Inter-hospital transfer: A qualitative study.* 2017. Journal of Hospital Medicine

[64] B.Mortensen, N.Borkowski, S.O'Connor, P.Patrician, R.Weech-Maldonado. *The relationship between hospital interdepartmental transfers and patient experience. J Patient Exp.* April 2020

More care closer to home

4.68 For economic reasons we are unlikely to restart the mobile cancer care unit. However, the mobile unit brought benefits in terms of reducing pressure on the Beacon Day unit and this has prompted us to explore other ways to serve our third clinical aim to provide care closer to home, while also reducing pressure on the acute sites.

4.69 Merger enables us to use the community hospital estate and homecare services to support the equitable delivery of cancer treatments to patients across Somerset. For example we want to explore whether the 'hub and spoke' model for adjuvant therapies currently in use at Wellington and Bridgwater Community Hospitals can be extended to other community hospitals closer to YDH. These include Wincanton, Chard, Crewkerne and South Petherton community hospitals run by SFT, and the Yeatman hospital in Dorset where YDHFT rents clinical space. An extension of the hub and spoke model would support the care provided by both acute sites, and help us better serve people living in the south and the east of the county.

4.70 We know that many patients across the county would benefit from having SACT treatment closer to home[65]. Evidence suggests this would lead to improved patient experience by enabling patients to maintain their independence, and be cared for in a familiar environment. It would also significantly reduce the stress, anxiety and cost associated with travelling to appointments.[66,67]

4.71 We have the opportunity with the proposed transaction to explore the wider use of ambulatory care. Following the merger in 2020 which created SFT, community-based ambulatory care units worked more closely with the Beacon Centre to identify procedures, such as venesection, which could be undertaken at ambulatory care units rather than on the acute site. The provision of care closer to home saves patients the time and inconvenience associated with travel to Taunton. As SFT and YDHFT come together we anticipate that patients in the east of the county could also have access to procedures such as venesection in community locations closer to home, see **Figure 27**.

Figure 27: Colleague Story Emma Wells-Burr, cancer treatments in community hospitals

Colleague story: Emma Wells-Burr, Beacon Day Unit sister

When the pandemic hit we needed to start thinking about how we could safely provide our chemotherapy service in line with social distancing. Initially we needed to consolidate the service in the Beacon Centre at MPH, but the experience of our patients is very important to us and we knew this meant many people would need to travel further than before. We

[65] It is not possible at this stage to quantify the number of patients who would benefit from receiving SACT care closer to home as we need to work through the workforce and estates implications.

[66] Corbett, M, Heirs, M, Rose, M, Smith, A, Stirk, L, Richardson, G, Stark, D, Swinson, D, Craig, D and Eastwood, A. The delivery of chemotherapy at home: an evidence synthesis. Health Services and Delivery Research. 2015;3.14. Available from: https://www.ncbi.nlm.nih.gov/books/NBK285513/.

[67] Evans, J, Qiu, M, Mackinnon, M, Green, E, Peterson, K and Kaizer, L. A multi-method review of home-based chemotherapy. European Journal of Cancer Care. 2016;25:883-902.

therefore started to think about how we could provide these services differently to our local communities.

Firstly, we set up a 4-chair chemotherapy service at Wellington Hospital in July 2021 that operates twice a week – Tuesday and Thursday. And this was followed by another 4-chair service at Bridgwater Hospital, which began in April 2022 – operating three times a week – Monday, Wednesday and Friday. About 10 patients a day are seen at Wellington Hospital and about 13 patients a day at Bridgwater Hospital. The larger Beacon Day Unit at Musgrove Park Hospital sees up to 60 patients a day. The chemotherapy services at both community hospitals are run by colleagues from the Beacon Centre, who rotate through the hospitals.

Every patient who uses our community hospital chemotherapy services will have had their first two treatments at the Beacon centre first. By running services outside of MPH, we can provide vital chemotherapy and supportive therapies closer to people's homes. This change has also enabled us to increase the number of patients we are able to treat by about 25% which is great news, particularly as the healthcare system recovers from the challenges brought about by the pandemic.

This change is especially beneficial for patients who need long treatments and have long journeys to and from MPH, as many people can feel really tired after a spell of chemotherapy. There's free parking at Bridgwater Hospital and there's a cheap council-run car park across the road from Wellington Hospital. As the clinic settings are smaller in the community hospitals our colleagues tend to have that little extra time with patients too.

We've had really positive feedback from patients who've used the service at the two community hospitals, especially when it's for a venesection session, where a unit of blood is taken over 30 minutes. For some people this can avoid a full day off work which they would have had to take if they had had to come into MPH.

We aren't stopping here as we want to extend our community chemotherapy service and are looking at how we could set up a additional services in the near future."

4.72 Merger would also facilitate the extension of SFT's existing homecare contracts across the whole county – so that patients in the YDHFT catchment can receive chemotherapy and adjuvant therapies (including intravenous therapies) at home rather than having the stress, cost and inconvenience of travelling to YDH for this care.

Single electronic health record

4.73 Moving to a unified Electronic Health Record (see chapter 2) will increase patient safety by enabling clinicians to access all of a patient's records via just one login and removing the risk of mixing up different patient records. It will also reduce the administrative burden associated with multiple systems which frees up time for front line care (see paragraph 4.48).

Patient benefits

4.74 The patient benefits we expect to realise from these changes are set out in **Figure 28**. These benefits were identified at meetings of the two teams in early 2022.

Figure 28: Patient benefits - oncology

Planned change	More time to live well	
	More time in good health	**Making every minute count**
Sustainable service	• Better patient health outcomes as colleagues increase their skills and share best practice across the enlarged team (e.g. via combined MDTs)	• Eliminating duplicate tasks means the team is better able to cover staffing gaps so patients have shorter waits. • A more resilient team will mean less colleague time spent firefighting and more time to drive transformational change which benefits patients
Improved access to specialist care especially out of hours	• Quicker access to specialist care leading to improved patient outcomes e.g. via single cancer helpline • Access to specialist psycho-oncology support to help patients deal with psychological aspects of cancer.	• Less patient time waiting in pain for specialist care, (e.g. introduction of weekend clinical nurse specialists at YDH who are able to access specialist opinion at weekend from SFT)
Standardisation of protocols and pathways	• Streamlined processes based on best practice will increase speed of diagnosis and treatment (e.g. county-wide neutropenic sepsis card) • Countywide MDTs will improve decision-making for complex patients <u>Fewer inter-site transfers</u> • Reduced clinical risk from fewer inter-site patient transfers e.g. MSCC patients	• Streamlined processes based on best practice will eliminate wasteful steps in the pathway. • Single set of protocols will be easier for colleagues to work with, and remove risk of confusion between two current approaches e.g. standardising antiemetic medications <u>Fewer inter-site transfers</u> • Less patient time spent being transported between sites (less discomfort & inconvenience) • Less colleague time spent on patient transfer administration
More care closer to home	Lower patient anxiety and stress from reduced travel (more care at community hospitals or at home via extension of homecare contracts)	• More use of community settings increases patient choice and reduces patient and carer travel time
Equitable access to clinical trials	Improved clinical outcomes from more patients participating in clinical trials	• Participation in clinical trials supports colleague adherence to consistent and efficient processes
Single patient record	Ensures clinicians have ready access to patients' full clinical history which will increase patient safety and likelihood of good clinical outcomes	• Supports clinicians to provide care more efficiently by reducing staff time spent checking a range of clinical systems to get full patient history.

4.75 We do not expect the changes set out here will have a significant impact on other providers within or beyond the Somerset system.

How merger facilitates planned changes

4.76 Despite the MOU, and colleagues' commitment to collaborate for the benefit of patients, operational pressures linked to Covid meant some of the planned integration work, initiated in 2020, stalled temporarily. However the signal of merger, which will formally bring the two existing teams into one, means this work has now resumed.

Retreating to one's own organisation when operational pressures increase will no longer be an option, as the challenges facing both services will become everyone's responsibility. When colleagues are 'all in it together' we will be better able to apply our combined resources to drive out the inequities in access and outcomes that currently exist. Merger also gives us the scale to take forward improvements which would be harder without merger e.g. employing a clinical psychologist to work county-wide.

Benefits indicators

4.77 The indicators that the oncology teams will use to assess their progress in realising the expected benefits are set out in **Figure 29** below.

4.78 These indicators were identified at an off-site Oncology workshop in September 2022, which brought together colleagues from both organisations.

Figure 29: benefits indicators - oncology

Measure	Source	Purpose	Baseline		Target
			SFT	YDH	
Neutropenic sepsis	Trust audits	To reduce inequity of access to antibiotics within 1 hour	89% (Jan-July 22)	47% (Jan-July 22)	90% within 1 hour of arrival to hospital by 1 April 2023
Metastatic spinal cord compression	Trust audits	To reduce inequity of access to spinal MRI within 24 hours	99%	Not collected currently	100% of patients with suspected MSCC having spinal MRI within 24 hours by 1 April 2023
Metastatic spinal cord compression (MSCC)	Trust audits	To ensure prompt management of MSCC within national guidelines	100%	Not collected currently	100% receive definitive treatment within 24 hours of receiving a confirmed diagnosis of MSCC by 1 April 2023
Clinical research trials	Edge, CPMS, recruitment/ screening logs	To reduce inequity of cancer recruitment to trials	TBD	TBD	To increase cancer recruitment to trials by 25% within a year across the county.
Reduce locum / agency spend	Finance	To reduce locum usage	5% (£153,779)	80% (£376,333)	To reduce combined locum expenditure by 25% by Dec 2024
Reduce staff turnover	Workforce report	To ensure staff are retained and have job satisfaction	8.6% (July 22)	23.1% (July 22)	<3% by 1 April 2024
Access to clinical supervision within oncology	In house	To ensure all colleagues have equitable access to clinical supervision in line with SFT's current provision	100%	37%	All oncology staff (YDH and SFT) will be offered restorative clinical supervision by 1 April 2023

Implementation plans

4.79 The teams are relatively far advanced in their integration planning bearing in mind the agreement in 2020 of the oncology MOU and the subsequent development of the nine joint workstreams. Senior colleagues are developing well-established trusted relationships, and the issues that need to be addressed are well known.

4.80 In July 2022, the teams came together to refresh their integration plan and after a series of workstream meetings the plan was updated and re-shaped. In September 2022 the teams met face to face to sign off the plan, discuss risks and issues and agree the benefit indicators.

4.81 The Oncology Oversight Group established as part of the MOU to oversee progress was paused due to Covid but resumed in October 2022. This oversight group is the platform where risks and issues arising within the workstreams are discussed. In addition, like all clinical services in the Trusts, the integration of Oncology services will be overseen and supported by the Trusts' overarching Clinical Service Integration Leadership Group.

4.82 The latest draft of the oncology integration plan is provided as a supporting submission. This plan will continue to be developed as part of the ongoing merger integration programme.

5. Cardiology

Summary

YDHFT and SFT's cardiology services provide acute inpatient and outpatient care as well as cardiac rehabilitation.

Both services are facing rising demand and a shortage of skilled staff. There are inequities between the services, including those of scale, meaning patients receive different care depending on where in Somerset they live. Although the teams collaborate on specific pathways (e.g. care of urgent NSTEMI patients), operational pressures and workforce challenges have, until recently, acted to limit the extent of integrated working.

The signal of merger has given the two cardiology teams more confidence to come together, and since October 2021 they have met with energy and commitment to plan their integration. The teams have now agreed their vision for a single countywide service, and begun reviewing current services and staffing, and exploring pathway improvements.

The patient benefits which will result from bringing the cardiology teams together include:

- Streamlined pathways (e.g. for urgent NSTEMI patients and people needing pacemakers), which will speed up patient access to diagnostics and specialist care (including out of hours), lead to improved patient outcomes and experience and reduce the time spent in hospital
- A single, more resilient team working across the county, better able to meet national standards for specialist staffing, with increased capacity to drive transformational improvement for patients and able to support a high quality sustainable cardiology service in both acute hospitals.
- Equitable care across the county for patients who need an echocardiogram, mental health support, cardiac rehabilitation or specialist care for rarer cardiac conditions.
- Combined digital systems which will reduce clinical risk and increase efficiency, thereby freeing up more clinical time for front line care.

The teams have identified the detailed workstreams by which they will integrate, and recently established a joint Cardiology Oversight Group to oversee progress of their integration.

Current service arrangements

5.1 YDHFT and SFT provide acute inpatient and outpatient cardiology services as well as cardiac rehabilitation. Somerset residents requiring tertiary cardiac care, including cardiovascular surgery are treated out of county at the Bristol Heart Institute.

Acute care

SFT

5.2 SFT provides level 2 cardiology care as defined by GIRFT, alongside primary Percutaneous Coronary Intervention (PCI) procedures (level 3). It has a 9-bed Coronary Care Unit (CCU) with 24/7 consultant cover, and three catheterisation laboratories which are open 5 days a week (and at weekends for emergency cases), accompanied by six recovery beds. The service has a cardiac MRI scanner, four echocardiography laboratories, a 12-bedded day case unit with a radial lounge, and dedicated outpatient facilities.

5.3 As well as covering CCU, SFT's cardiology consultants also help supervise the care of cardiology inpatients whose condition is not serious enough to require care on CCU, or those who have a heart condition alongside the condition for which they were admitted.[68]

5.4 SFT's cardiology service serves both STEMI[69] and NSTEMI[70] patients. SFT hosts the county's catheterisation laboratories, so all STEMI patients in Somerset are conveyed by South West Ambulance Service (SWAST) directly to SFT's Musgrove Park Hospital (MPH), including those patients who live in the east of the county.

5.5 SFT's service performs both basic and complex pacing procedures. It also runs specialist clinics for Adult Congenital Heart Disease, Inherited Cardiac Conditions, and Sudden Cardiac Death, which are supported by a dedicated genetic nurse specialist.

5.6 SFT's consultants operate a 1:6 interventional cardiology rota, and a 1:8 non-interventional cardiology on-call rota.

YDHFT

5.7 YDHFT's cardiology service provides GIRFT level 1 acute inpatient care, outpatient cardiology care and cardiac rehabilitation.

5.8 YDHFT has an 8-bedded Acute Cardiovascular Care Unit (ACCU) which is used for acute stroke and cardiology patients.

[68] These patients are cared for on Fielding ward which is located close to the CCU.

[69] ST-elevation myocardial infarction. In 2021/21 SFT admitted 271 patients with STEMI. YDHFT does not treat patients with STEMI.

[70] Non-ST elevation myocardial infarction. In 2021/22 SFT admitted 376 patients with NSTEMI, and YDHFT admitted 198.

5.9 CT coronary angiograms and basic (Brady) pacing procedures are carried out in YDH's interventional radiology suite. Dobutamine stress echocardiograms are done in a clinical investigation room. The Trust's cardiology consultant and Associate specialist in cardiology work a 1:2 on-call rota for emergency temporary pacing only. YDH does not have a catheterisation lab on site.

5.10 As well as covering the ACCU, YDHFT's cardiology consultant and Associate specialist in cardiology also supervise the care of lower acuity cardiology inpatients who are cared for on a 31-bed cardiology ward.[71]

5.11 Unstable NSTEMI patients, or those requiring angioplasty or a stenting procedure, are assessed and stabilised at YDH until they can be transferred to the catheterisation laboratory at SFT where they receive the necessary intervention and are then conveyed back to YDH. (STEMI patients are transferred directly to SFT as noted in paragraph 5.4).

5.12 YDHFT's cardiology consultant provides on-site care Monday-Friday 9am-5pm. At weekends and out-of-hours, YDHFT's general medical staff (a medial registrar) care for cardiology patients, and can draw on specialist advice from the on-call cardiologist at SFT when needed.

5.13 YDHFT runs a specialist clinic for Adult Congenital Heart Disease, and refers patients with Inherited Cardiac Conditions to the Bristol Heart Institute (part of University Hospitals Bristol and Weston NHS Foundation Trust).

Cardiac rehabilitation

5.14 YDHFT provides cardiac rehabilitation for patients recovering from heart attack or cardiac surgery, as well as those with angina or heart failure. Patients have the choice of exercising at home with a rehabilitation DVD developed by the Trust, or attending exercise classes at YDH. YDHFT offers four phases of cardiac rehabilitation: inpatient; pre-exercise period following discharge from hospital; exercise and education; and maintenance.[72] The fourth phase is optional, and some patients chose instead to return to their previous gym or exercise regime.

5.15 SFT provides cardiac rehabilitation only to patients recovering from heart attack or cardiac surgery, and the service covers only three phases: the inpatient period, pre-exercise period following discharge, and exercise and education. Pre-pandemic, SFT offered a choice of exercise at home with the heart manual, or face-to-face classes at five community sites across the county.[73] In summer 2020 (due to Covid) SFT reduced its support to the heart manual with telephone support, the heart app, or signposting to the British Heart Foundation DVD. Face-to-face classes have since resumed (in July

[71] Ward 8A

[72] Patients are asked for a donation to attend the fourth phase (maintenance) although the donation is not obligatory, and the income is put back into patient care.

[73] Taunton, Bridgwater, Minehead, Wells and Frome.

2022) to meet the needs of patients who value in-person support. SFT patients with angina or heart failure are not offered cardiac rehabilitation unless they live sufficiently near to YDH, in which case they can access YDHFT's cardiac rehabilitation.

Mental health care

5.16 Anxiety is common in patients with cardiovascular disease, such as coronary artery disease, and has been associated in some cases with the progression of cardiovascular disease.[74] The previous merger in Somerset which created SFT brought together the mental health services run by Somerset Partnership NHS Foundation Trust, and the acute services provided by Taunton and Somerset NHS Foundation Trust. That merger enabled SFT to establish clinics at which patients with heart failure or an implantable complex device can receive a heart health check from a physiologist or cardiac nurse specialist, directly followed by an emotional health check with a Talking Therapies practitioner. This type of clinic enables SFT to more easily care for patients holistically, addressing both physical and mental health needs in one appointment. At YDHFT, mental health support is provided by a counsellor paid for from charitable funds. With the signal of merger, SFT's Talking Therapies team now accepts referrals to see YDHFT cardiology patients; these sessions take place virtually or by phone as there is currently no available clinic space at YDH.

Summary of cardiology provision

5.17 **Figure 30** summarises the key elements of the Trusts' cardiology provision. Further information is provided at **Annex 4**.

Figure 30: summary of cardiology provision 2021/22

	YDHFT	SFT
Inpatients	8-bedded ACCU & 31-bed cardiology ward 901 inpatients a year (emergency)* 36 inpatients a year (elective)	9-bed CCU & Fielding ward 2,113 inpatients a year (emergency) 133 inpatients a year (elective))
Outpatient appointments	21,074 outpatient appointments a year (7,461 new, 13,613 follow ups)	35,097 outpatient appointments a year (19,818 new, 15,279 follow ups)
Day cases	c. 340 a year	c. 1,300 a year
Cardiac Rehabilitation	c. 400 patients supported annually	c. 600 patients supported annually

* an additional 427 patients were admitted under General Medicine and looked after by a consultant with a main specialty of Cardiology.

[74] Celano CM, Daunis DJ, Lokko H, Campbell KA, Huffman JC. Anxiety disorders and cardiovascular disease. Current Psychiatry Reports 2016;18(11): 101. doi: 10.1007/s11920-016-0739-5.

Workforce

5.18 **Figure 31** sets out the cardiology workforce position at both Trusts.

Figure 31: Cardiology workforce as at September 2022 (WTE)

	YDHFT			SFT		
	Substantive	**Locum**	**Vacancies**	**Substantive**	**Locum**	**Vacancies**
Consultants	1	1	1	14.62	0.2	-
Associate specialists	1			-	-	-
Doctors (registrars/ clinical fellows / junior)	8	-	-	13.5	-	-
Cardiology nurse consultant	1	-	-			
Physiologists	7.18	-	3	16.86	10.6	8.71
Specialist cardiac nurses inc cardiac rehabilitation	7.92	-	-	17.56	-	-
Admin / support staff	3.66			31.02	-	3.96
Total	**29.76**	**1**	**4**	**93.56**	**10.8**	**12.67**

Note: All figures are whole time equivalents.

Inflows and outflows

5.19 Around 30% of YDHFT's cardiology patients live in Dorset. Around 9.5% of SFT's cardiology patients come from out of county (either Devon, Bath or North Somerset).

5.20 Somerset and Dorset residents in the YDHFT catchment area requiring ablation or cardiac surgery are treated at the Bristol Heart Institute. Patients referred to Bristol for cardiac surgery are shown in **Figure 32** below.

Figure 32: patients referred to Bristol Heart Institute

	From MPH	From YDH
2019	69	23
2020	38	23
2021	50	17

5.21 After cardiac surgery patients are referred back from Bristol to either SFT or YDHFT for cardiac rehabilitation. Both Trusts also provide some cardiac rehabilitation to patients who are referred by their GP for cardiac surgery to RUH Bath but choose to have their rehabilitation in Somerset (around 80 such patients a year go to SFT for cardiac rehabilitation, and 2 a year to YDHFT).

Collaboration to date

5.22 The Trusts have a history of collaboration stretching back to the opening of the county's cardiac catheterisation laboratories at MPH in the early 2000s. Since then, the Trusts have shared some clinical pathways, including for STEMI and ACS/NSTEMI patients.

5.23 In addition, it used to be the case that YDHFT patients requiring an invasive angiogram were treated by a YDHFT consultant who visited MPH once a week to treat YDHFT patients in the catheterisation laboratories. If these patients also required a stenting procedure, they were referred to SFT and the procedure would be carried out by an SFT cardiologist at MPH at a later date. The signal of merger has prompted the teams to work differently: YDHFT and SFT patients needing invasive angiograms or stents are now managed on shared waiting lists which ensures patients are seen in order of clinical priority. YDHFT patients who need an invasive angiogram and stent now receive their treatment as one procedure at MPH. This is more convenient for patients (one hospital trip rather than two), and consolidating two procedures into one improves patient safety, as each procedure performed carries a small risk of stroke, heart attack or death.

5.24 Despite effective pathway collaboration between the SFT and YDHFT cardiology teams, practical challenges exist to deeper collaboration. For example, different IT systems, the lack of a single rota, and the legitimate pride of both teams in the high quality care provided and a consequent fear of potentially diluting areas of excellence at both sites. Furthermore, psychological factors such as a fear that two teams of unequal size would not come together as partners with an equal 'voice', and the challenge of releasing clinician time to focus on service development during the pandemic and operational pressures, have acted as barriers to deeper collaboration between the teams.

5.25 However, the announcement of the proposed merger was a turning point, providing a clear signal of intent which has enabled the two cardiology teams to engage with much greater confidence, and since October 2021 (with the ability to meet face-to-face again post-pandemic) the teams have regularly come together with energy and commitment to plan their integration.

5.26 Initially the teams met weekly at six workshops during October and November 2021 at which they discussed clinical pathways and identified where there were inequities, challenges and areas for change which would realise patient and colleague benefits. Each workshop had a planned area of focus which allowed the relevant clinicians from both organisations to attend. They also held a summary workshop in December to review the outputs from the workshops and agree next steps.

5.27 Further engagement with colleagues brought about the cardiology programme plan and timeline which was discussed with colleagues at a face to face meeting in July

2022, at which the teams' confidence to deliver integration and risks and issues were also discussed.

5.28 The teams have appointed a clinical lead, Dr Mohammad Sahebjalal, to lead the integration of cardiology services. The teams have agreed their vision for the combined service, which is to create a sustainable, equitable and patient-focused service that helps prevent cardiovascular ill-health, and provides rapid and equitable interventions when cardiac disease is identified, whilst continuing to provide high quality, safe core local cardiology care close to patients' homes where appropriate. This will require timely diagnostics, invasive intervention, support for self-management and effective inpatient services.

5.29 The teams have begun reviewing current services and staffing, and exploring pathway improvements. For example, since the teams began discussing their integration they have agreed that one slot a day at MPH will be ringfenced for unstable NSTEMI patients transferring from YDH, to help address the inequity in the order in which patients are seen. Whilst the teams have historically worked well together, the rapid progress the teams have made to plan their integration is highly unlikely to have occurred had it not been for the signal of merger, see **Figure 33**, Ashley's Colleague Story below.

Figure 33: colleague story - Ashley Davidson

Colleague story – Ashley Davidson, Cardiology Nurse Consultant, YDHFT

"I have worked in Cardiology at YDH for 27 years and have invested heavily of my time and emotion into the excellent service that we provide to our patients. Despite the fact that we have worked on many cross-county projects over the years, traditionally Musgrove Park Hospital has been seen as the 'bigger brother' of YDH and has been seen as a threat to our precious services.

When the Trust merger and the series of meetings between the cardiology teams was announced I was very nervous and even considered whether I could continue to work in a joint organisation. I decided to engage with the meetings and see how they felt before making any rash decisions. The meetings have been clinically led with fairness, and due consideration has been given to the strengths and weaknesses of services on both sides of the county.

I can honestly say that I now feel very positive about the work that has begun and look forward to being involved in the ongoing workstreams that will allow access to excellent services for all patients across the whole county."

Challenges

5.30 In recent years, the two Cardiology services have faced significant challenges relating to sustainability of the service and inequity of care across the county. These challenges are made worse by a lack of integrated digital systems. Further detail on these challenges is set out below. These are:

- Sustainability of services

- Inequity of care
- Lack of integrated digital systems.

Sustainability of services

Rising demand

5.31 Between 2011/12 and 2016/17, cardiac referrals nationally rose by an average of 3.7% per year.[75] Within our two Trusts, overall demand has not yet gone back to pre-covid levels. However, emergency cases in 2021/22 have surpassed 2019/20 levels with emergency demand up by 8% at SFT and 1% at YDH in the two-year period, see **Figure 34**.

Figure 34: cardiology activity at both Trusts, last 3 years

Cardiology activity	2019/20	2020/21	2021/22
YDH			
Inpatients	1,821	1,263	1,865
of which emergency	1,686	1,038	1,708
Outpatients	22,035	19,031	21,074
TOTAL (inpatients + outpatients)	**23,856**	**20,294**	**22,939**
SFT			
Inpatients	5,202	4,768	4,997
of which emergency	3,351	3,470	3,628
Outpatients	38,611	26,564	34,973
TOTAL (inpatients + outpatients)	**43,813**	**31,332**	**39,970**

5.32 Demand for Heart Failure care in 2020/21 rose by 10% at YDH and 14% at SFT compared to the previous year. This rise in demand (and a lack of heart failure nurses) mean the criteria for referral for heart failure care at SFT had to be increased in order to manage demand (see paragraph 5.48).

5.33 The impact on patients of rising demand is that they have to wait longer for care. It also means staff do not have the capacity to implement transformational changes which would improve patient care and experience. YDHFT and SFT cardiology staff are, in some cases, having to do tasks for which they are overqualified, e.g. specialist nurses are delivering cardiac rehabilitation, in order to maintain services.

Staffing

5.34 The national shortage of physiologists across all cardiology disciplines is reflected in Somerset, and we find many cardiology roles (including consultants and specialist nurses) hard to recruit to. Both Trusts aim to train staff in-house, to 'grow our own'. We also look to innovate in our staffing models, for example YDHFT has a cardiology nurse consultant who works at the top of her licence and triages referrals (a task which

[75] cardiology-elective-care-handbook.pdf (england.nhs.uk)

at SFT is done by a consultant). Nonetheless, at least 14% of the cardiology staff base at both Trusts is either currently vacant or filled by locums.

5.35 In 2021/22, SFT spent 14% (£619,694) of its total cardiology pay budget (£4,477,320) on locum/agency staff. SFT currently has a locum consultant who works 2 days a fortnight, and more than 10 locum physiologists (which represents more than a third of the physiologists in post at SFT). SFT also uses external companies to provide additional capacity to carry out echocardiograms.

5.36 At YDHFT, one of the 3 cardiology consultant posts has been filled by a locum for the last 12 months and other consultant post is vacant. In 2021/22, YDHFT spent 22% (£440,943) of its total cardiology pay budget (£2,006,744) on locum/agency staff. Alongside the financial impact of premium payments for temporary staff, high locum use makes it harder to innovate and embed quality improvements, and this ultimately impacts patient care.

5.37 With no cardiology consultants now undertaking an out of hours cardiology on-call rota, YDHFT's medical staffing position is not in line with the national guidance which indicates there should be 24/7 access to cardiology specialists at hospitals receiving acute cardiology admissions.[76] (Out of hours and at weekends YDHFT's general medical staff can access specialist cardiology from the on-call team at SFT.) Furthermore, whilst YDHFT provides strong core cardiology services, it lacks the full breadth of expertise that a modern cardiology service could offer (e.g. skills in complex pacing (see paragraph 5.51 below).

5.38 These staffing challenges are not limited to YDHFT; SFT has just one genetic nurse which means referrals for genetic testing, results and follow-ups are delayed when she is on leave.[77] Furthermore, neither Trust currently employs the GIRFT recommended number of heart failure specialist nurses.[78]

5.39 Lack of specialist staff also means care in Somerset for some rarer conditions (e.g. sudden cardiac death) is currently only available at MPH. This in turn means patients in the east of the county have to travel to Taunton (MPH) or Bristol to receive care for these conditions.

Inequity of care

Unstable NSTEMI patient pathways

5.40 As YDHFT does not have a catheterisation laboratory, patients admitted to YDH with unstable NSTEMI presentation are transferred to MPH for treatment. These patients need to be stabilised and reviewed at YDH before they can be transferred to MPH. In 2021, 273 patients with cardiac-related conditions (which included unstable NSTEMI, unstable angina, heart failure and patients awaiting inpatient surgery) were transferred

[76] Layout 1 (gettingitrightfirsttime.co.uk)

[77] Genetic testing helps identify whether there is a genetic element to a patient's heart disease.

[78] GIRFT recommend 3-4 heart failure specialist nurses per 100,000 population.

from YDH to MPH,[79] and were subsequently conveyed back to YDH after their treatment.

5.41 The time taken to stabilise these patients at YDH and then transfer them to MPH introduces avoidable delay in these patients receiving potentially life-saving care. It also means YDHFT patients who transfer to MPH are less likely to be seen in order of clinical priority because of the delay involved in transporting them to MPH.

5.42 Research has shown that delays in treating NSTEMI patients (even within the 72-hour period recommended by NICE) increases the risk of poor health outcomes and results in longer length of stay; high risk patients have significantly improved outcomes following early intervention (at an average of 14 hours) compared with patients whose intervention takes place c. 50 hours after admission.[80]

5.43 YDHFT cardiology consultants estimate it takes up to two hours for unstable NSTEMI patients to be assessed and for their transfer to MPH be arranged and completed[81]. Furthermore, YDHFT patients cannot be transferred until a recovery bed is available at MPH. In 2021, unstable NSTEMI patients admitted first to YDH had a median wait time to treatment of 62.5 hours compared to 52.7 hours for patients presenting first at MPH[82].

Timely access to specialist care

5.44 As at September 2022, the average waiting time for a stress echocardiogram was 4 weeks at YDHFT and 12 weeks at SFT. This delay in diagnosis has a knock-on impact on timely access to specialist care. The wait time for insertion of a simple pacemaker was 1 week at YDHFT but 6 months at SFT, as at September 2022.

5.45 Although YDHFT colleagues can access advice out-of-hours from the SFT cardiologist on call, the clinical decision-making during these times remains with YDHFT team who are not cardiologists. This means some YDHFT patients do not have timely access to a specialist cardiology review, which may delay diagnosis and initiation of treatment, potentially increasing the risk of poorer health outcomes.

5.46 Non-urgent NSTEMI patients who attend YDH at the weekend have to wait until Monday morning for clinicians in the two services to discuss the next steps in their care.

[79] Around 200 of these patients were unstable NSTEMIs.

[80] Mehta SH, Granger CB, Boden WE, Steg PG, et al. Early versus delayed intervention in acute coronary syndromes, *New England Journal of Medicine* 2009;360: 2165-2174. doi: 10.1056/NEJMoa0807986. at Appendix 103

[81] We estimate it takes on average between 30-45 minutes to agree the referral, write up and email over the notes and imaging, and arrange the transport for each unstable NSTEMI patient transferred from YDH to MPH. In addition the journey between YDH and MPH takes around 50 minutes.

[82] Door to procedure time.

Differences in care for heart failure

5.47 In 2019/20, SFT admitted 741 patients with heart failure, and YDH admitted 375. Although YDHFT does not have a designated heart failure consultant, the Trust 's heart failure nurse specialist (with input from the YDHFT cardiology consultant) runs a rapid access clinic for patients with possible heart failure.

5.48 Due to high demand the SFT heart failure specialists have had to introduce access criteria[83] which mean they only see about 50% of heart failure patients, going against national recommendations. The remaining heart failure patients at SFT (those with HFpEF[84]) receive a management plan to support care in the community with their GP or are followed up in general cardiology clinics. This creates the risk of poorer outcomes for that group as they are not being seen by a heart failure specialist.[85] Following a successful pilot, a rapid access heart function clinic started at MPH in October 2022. SFT also holds weekly MDTs for complex heart failure patients with the input of renal and palliative care specialists.

Differences in cardiac rehabilitation

5.49 YDHFT offers cardiac rehabilitation to patients with angina or heart failure, while SFT does not (historically SFT was not commissioned to provide cardiac rehabilitation while YDHFT was). Furthermore, YDHFT's programme provides support in the 'maintenance' phase of rehabilitation whereas SFT's does not. The cardiac rehabilitation offer therefore differs for patients across the county depending on where they live, which is likely to lead to differences in patient outcomes.

5.50 The British Association for Cardiovascular Prevention and Rehabilitation (BACPR) has set 7 standards for cardiovascular prevention and rehabilitation[86]. In 2021, both Trusts' cardiac rehabilitation offers were rated 'Red' by The National Certification Programme for Cardiac Rehabilitation (NCP_CR) against the BACPR standards because of an inability to report accurately due to multiple IT systems. In late 2022, YDHFT's rating was upgraded to 'Amber'; both teams are currently working to achieve 'Green' status

[83] SFT heart failure nurses only have capacity to see patients with an ejection fraction of 40% or less (HFrEF).

[84] Heart failure with preserved ejection fraction (symptoms of heart failure but normal or near normal left ventricle ejection).

[85] Heart failure patients cared for on general medical wards have a 10.2% mortality compared to 6% for patients cared for on specialist cardiology wards. Furthermore, patients reviewed by Heart Failure specialists have a lower mortality: 7.9% compared with 14.9% with no specialist Heart Failure review. NHFA: National Institute of Cardiovascular Outcomes Research (NICOR) . National heart failure audit 2022 summary report (2020/21 data). NHFA-DOC-2022-FINAL.pdf (nicor.org.uk)

[86] British Association for Cardiovascular Prevention and Rehabilitation. The BACPR standards and core components for cardiovascular disease prevention and rehabilitation. 3rd edn. London: BACPR; 2017.
https://www.bacpr.org/__data/assets/pdf_file/0026/39437/BACPR_Standards_and_Core_Components_2017.pdf

Differences in pacemaker care

5.51 Although YDHFT cardiology consultants fit basic (Brady) pacemakers, they do not have the specialist skills or access to the necessary facilities (a catheterisation lab) to fit complex pacemakers, which is undertaken at SFT. SFT also runs a pacemaker MDT.

5.52 The number of patients requiring a complex pacemaker is increasing, and a small number of YDHFT patients a year require a pacemaker upgrade. These patients have to be referred to SFT where the upgrade procedure is carried out in a catheterisation laboratory by one of the two SFT consultants with specialist skills in fitting complex pacemakers.

5.53 With a larger team, SFT has been able to make the change to readable pacemakers, and implement remote pacemaker monitoring. YDHFT's monitoring of the basic pacemakers inserted at YDH is carried out face-to-face as YDHFT lacks the capacity to support monitorable devices (this would require a change to digital hardware and the devices currently used are not compatible with remote monitoring). This creates another inequity across the county; remote monitoring is more convenient for patients and supports early identification of any decline in heart function. This is an example of an area where merger enables us to build on what already exists to bring about patient benefits.

Support for mental health aspects of cardiology

5.54 Face-to- face clinics of the sort described in paragraph 5.16, which bring together physical and mental health practitioners to provide holistic care are currently only available to patients in the west of the county, and not the east, due to a lack of available clinic space at YDH.

Lack of integrated digital systems

5.55 YDHFT's systems for cardiology patient information and imaging (EchoPac and Imagevault) are outdated and in need of replacement as they do not have the capability to communicate with the Change Healthcare system (previously named Medcon) which SFT uses. As a result, patients who are transferred from YDH to MPH have to be sent with their Echocardiogram report. The signal of merger meant when upgrade was being discussed, it was logical to upgrade to a joint system (Change Healthcare) as opposed to two separate systems able to 'see' each other.

5.56 Until the joint system is in place, the lack of a unified IT system means cardiology colleagues need to email patient information and images between the Trusts. This creates a patient safety risk associated with human error and is an inefficient use of valuable clinical time. The different data systems involved in the patient pathway also makes it difficult to gather data for purposes such as the National Audit for Cardiac Rehabilitation (NACR).

What will change, and how will patients benefit

5.57 The proposed merger will enable improvements to be made which help us meet national requirements and address the current inequities across the county. Further detail is set out below.

Combining and streamlining pathways

5.58 We have prioritised two key pathways for change as part of our integration. They are the pathway for unstable NSTEMI patients and the care of patients requiring a pacemaker. In the coming year the teams will also review the heart failure pathway, with work due to start on this in late 2022. These changes will help deliver our second clinical aim around high quality, effective care as well as our fourth aim on equity.

Pathway for unstable NSTEMIs patients

5.59 Post-merger, all higher acuity and less stable NSTEMI patients who are currently stabilised at YDH before transfer to MPH, will instead be conveyed directly to MPH for their procedure (see **Annex 5** for further details). Research has shown that high-risk patients have significantly improved outcomes (in terms of lower risk of death, subsequent heart attack or stroke) when they receive early intervention (see paragraph 5.42).[87] Capacity at MPH will be created for this change by moving from the current 1:8 on-call rota for non-interventional cardiology to 1:10 staffed by cardiologists from both sites, and a 1:6 on-call rota for interventional cardiology. Once the detail has been agreed by the two teams, changes to ambulance protocol will be discussed with SWAST. The extra capacity created at YDHFT could be used for longer length of stay patients e.g. those with long-term heart failure, although this is subject to further discussion.

5.60 As well as enabling this cohort of patients from the east of the county to be seen more quickly, this change will also reduce the number of handovers and ensure all patients are seen in order of clinical priority - both of which will lower clinical risk.

5.61 Alongside the health benefits set out above, patients and their families will have an improved experience from quicker diagnosis and treatment, a reduced overall hospital stay, and reduced anxiety; the latter is particularly important since increased anxiety is linked to poorer outcomes for people with cardiovascular disease,[88] see Peter's story, **Figure 35**.

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[87] Mehta SH, Granger CB, Boden WE, Steg PG, et al. Early versus delayed intervention in acute coronary syndromes, *New England Journal of Medicine* 2009;360: 2165-2174. doi: 10.1056/NEJMoa0807986.

[88] Celano CM, Daunis DJ, Lokko H, Campbell KA, Huffman JC. Anxiety disorders and cardiovascular disease. Current Psychiatry Reports 2016;18(11): 101. doi: 10.1007/s11920-016-0739-5.

5.62 After their procedure, this cohort of patients will either go directly home if they are well enough, or be conveyed to YDH to receive ongoing care. The cardiology teams are currently working through the impact on bed requirements of this change.

5.63 Reducing inter-site transfers, and the merger itself will also reduce the administration associated with discharging patients from one hospital and admitting them to another. For the c. 200 annual transfers of acute NSTEMI patients, this equates to c. 130 hours a year of nurse practitioner or junior doctor time which will be freed up for front line care.

Figure 35: Patient story - Peter

Patient story – Peter

Now

Peter is a 68 and diabetic. He develops chest pain one Friday night (which is determined by paramedics to not be a STEMI) and he is conveyed by ambulance to YDH's emergency department where he has an electrocardiogram (ECG). His ECG and blood tests indicate Peter has suffered a heart attack. He is given stabilising medication and transferred to YDH's Acute Cardiovascular Care Unit at 6.30am.

As his pain and overall condition settle, Peter manages to get a few hours rest. On Saturday morning Peter is assessed by a medical consultant. Peter is listed for inpatient angiography (a type of x-ray used to check blood vessels) to be done at the MPH catheterisation lab on the next available weekday slot because angiography is not available at YDH. Peter is anxious as he has not yet seen a cardiologist and does not have a planned date for his treatment.

Monday comes, but there are no available slots at MPH's catheterisation lab. Peter waits anxiously for another day and is then transferred to MPH on Tuesday where he has his intervention. Peter's angioplasty goes well and he is able to return home directly from MPH on Tuesday evening, 4 days after his chest pain began.

Post merger

When Peter develops chest pain on Friday night, he is conveyed by ambulance directly to SFT's emergency department, in line with revised protocol agreed with the ambulance service. Peter's ECG and blood tests indicate he has suffered a heart attack.

Peter is seen by a consultant cardiologist who recommends an inpatient angiogram and angioplasty. Peter is reassured to have been seen by a specialist so quickly. Peter remains under the care of a cardiologist 24/7 over the weekend, who monitors Peter's condition for any signs of deterioration. However, Peter remains stable and he has his procedure as planned on Monday, after which he returns home, 3 days after his chest pain began.

Pathway for patients needing pacemakers

5.64 As part of our merger planning, we will establish a joint pacemaker MDT which will support better and quicker decision-making and ensure patients get the right pacemaker device the first time. When we are one team, pacemaker patients in the east of the county will have improved access to specialists in cardiac devices, and

additional investigations at the MPH site (e.g. PET CT scanning) in line with European Society of Cardiology guidelines (2021). [89]

5.65 This will increase the likelihood of patients receiving the most suitable cardiac pacemaker at the first fitting, and therefore fewer pacemaker upgrades will be required. This is better for individual patients, but also frees up clinical time and catheterisation laboratory capacity for the benefit of others. Fitting the right pacemaker first time – which in some cases will be a complex pacemaker – will potentially reduce admissions for heart failure by 40% and reduce mortality for certain cohorts of patients.[90]

5.66 We will also be able to offer remote monitoring for all pacemaker patients, so that patients receiving simple pacemakers at YDH will not need to attend YDH in person, saving both their time and that of clinicians. Remote monitoring supports the earlier identification of decline in heart function which improves health outcomes, and provides greater peace of mind for patients. Based on 2020 figures, these changes to care of people needing pacemakers will benefit around 690 people a year.[91]

5.67 **Figure 36**, Sharon's Patient Story below illustrates the expected patient benefits from these planned changes.

Figure 36: Patient story - Sharon

Patient story – Sharon

Now

Sharon, a 56-year-old care worker from Sherborne, attends Yeovil District Hospital after she experiences difficulty breathing and collapses at work. An echocardiogram (heart scan) at YDH shows she has mild to moderate reduced heart function and her cardiologist concludes she needs a pacemaker.

Sharon has a basic (Brady) pacemaker inserted at YDH, and she subsequently attends regular face to face clinics at the hospital to have her pacemaker monitored. Sharon becomes increasingly breathless and two years later she is again admitted to YDH where, following an echocardiogram, she is diagnosed with heart failure. Sharon is anxious about her health and this anxiety is heightened by the fact that her breathlessness means she has had to reduce her responsibilities at work which impacts her pay. Sharon receives medical therapy, but unfortunately her condition continues to deteriorate, and after a further year Sharon can only walk 100 yards without stopping.

At this point Sharon is referred to MPH for consideration of an upgrade of her pacemaker to a CRT device (which is not available at YDHFT). Her pacemaker upgrade is done as a day case and over

[89] Michael Glikson, Jens Cosedis Nielsen, Mads Brix Kronborg, Yoav Michowitz, Angelo Auricchio, Israel Moshe Barbash, José A Barrabés, Giuseppe Boriani, Frieder Braunschweig, Michele Brignole, Haran Burri, Andrew J S Coats, Jean-Claude Deharo, Victoria Delgado, Gerhard-Paul Diller, Carsten W Israel, Andre Keren, Reinoud E Knops, Dipak Kotecha, Christophe Leclercq, Béla Merkely, Christoph Starck, Ingela Thylén, José Maria Tolosana, ESC Scientific Document Group, 2021 ESC Guidelines on cardiac pacing and cardiac resynchronization therapy: Developed by the Task Force on cardiac pacing and cardiac resynchronization therapy of the European Society of Cardiology (ESC) With the special contribution of the European Heart Rhythm Association (EHRA), *European Heart Journal*, Volume 42, Issue 35, 14 September 2021, Pages 3427–3520, https://doi.org/10.1093/eurheartj/ehab364

[90] Ibid.

[91] In 2020, SFT implanted / revised 499 devices, and YDHFT performed 191 pacemaker procedures and renewals.

the following year her heart function and symptoms improve. Sharon is issued with a home monitor, enabling her pacemaker to be monitored remotely so she doesn't need to travel regularly from Sherborne to MPH.

Post merger

Once we are a single trust, Sharon will have improved access to specialists through a county-wide pacemaker MDT. As part of a countywide cardiology team, the cardiac device specialists will review investigations such as cardiac MRI, PET CT scan and genetic testing results to identify the right pacemaker for her at the earliest opportunity. Sharon will have a CRT device (complex pacemaker) inserted much sooner, leading to quicker optimal treatment and a quicker recovery than she experiences in the pre-merger scenario.

Sharon will be also issued with a heart monitor to enable remote monitoring of her pacemaker. This saves her the inconvenience of travelling to regular face to face appointments, and will give early warning of any decline in her heart function which gives her peace of mind and reduces her anxiety.

5.68 Although in theory these pathway changes could happen without the merger, we will be able to implement these planned changes more quickly and easily when we have a single management team with an overview of the capacity and demand across both sites, working to a single waiting list.

Staffing

5.69 Practical challenges associated with maintaining effective communication and clear accountability across two management and clinical teams, mean it would be difficult to operate a single rota in the absence of merger. However, post-merger we want to work towards providing 24/7 countywide access to specialist care by consolidating the consultant team, and moving to a 1:10 non-interventional cardiology on-call rota and a 1:6 interventional cardiology on-call rota. We will also be able to implement innovative staffing approaches across the enlarged team, such as the cardiology nurse consultant role currently used at YDHFT. We will also ensure all colleagues are working at the top of their licence; for example, we are currently exploring the merits of echocardiologists rather than cardiologists running heart valve clinics, and such a change would free up consultants to see more complex cases.

5.70 Making better use of our skilled staff will increase patient access to specialist care which will improve patient outcomes and provide better patient experience. Merging the teams will also increase team resilience, and reduce single points of failure. It will create capacity to make transformational improvements which benefit patients, and help us maintain full breadth of specialist expertise. Team members will not necessarily travel more, although potentially some MPH cardiologists will go to YDH to do some procedures. We will make best use of technology and MDT meetings to ensure patients receive the best care in the most appropriate place with the fewest steps in their pathway.

5.71 The teams recognise that change can be unsettling and have created opportunities at face to face meetings for concerns to be shared (see paragraph 5.27), and listening to

and responding to colleague issues and concerns is part of the remit of Cardiology integration oversight group.

5.72 These changes will help deliver our second clinical aim around high quality, effective care.

Inequity of care

5.73 We have a range of planned changes, set out below, which will help deliver our fourth clinical aim on equity.

Timely access to specialist care

5.74 As a single team, working to a single waiting list, we will be able to reduce waiting times for outpatient angiograms and basic pacing procedures by making best use of the interventional radiology suite at YDH and the catheterisation laboratories at MPH.

Care for heart failure patients

5.75 Merger will enable us review the two models and associated staffing currently in place at YDH and MPH for people with heart failure, and determine the best future model for county-wide care for this cohort.

5.76 Since mid-2021, the heart failure teams have been meeting to develop a county-wide heart failure pathway, which will enable patients with all types of heart failure to be seen at both acute sites. This will bring equity of care for heart failure patients and will benefit the 20% of people with pacemakers who are dependent on their pacemaker.[92] The team's vision is to create a one-stop heart failure clinic at each site to provide more timely diagnosis and management of patients, and improve efficiency. A single heart failure pathway will also support changes to cardiac rehabilitation which is currently not available to SFT heart failure patients. Heart failure care will also be part of a test and learn pilot within Hospital@home (see Full Business Case, chapter 5).

Improved access to echocardiograms

5.77 Once merged, we will be able to make better use of our combined resources. For example, around 15% of referrals to SFT for an echocardiogram are for people resident in south and east Somerset. As a merged Trust, with a combined staff pool we will be able to direct people in this group to YDH (or potentially in future South

[92] Link, M.S., Hellkamp, A.S., Estes, N.M., Orav, E.J., Ellenbogen, K.A., Ibrahim, B., Greenspon, A., Rizo-Patron, C., Goldman, L., Lee, K.L. and Lamas, G.A., 2004. High incidence of pacemaker syndrome in patients with sinus node dysfunction treated with ventricular-based pacing in the Mode Selection Trial (MOST). *Journal of the American College of Cardiology*, *43*(11), pp.2066-2071.

Petherton or Chard community hospital) so they can receive an echocardiogram more quickly and locally. This will help keep waiting times equitable across the county and help us meet any flex in demand at one site or another. In addition, working as one team will bring opportunities for staff to expand their knowledge and skills in other fields of cardiology. Furthermore, as a single trust, with a single cardiology imaging system, it will be easier for echocardiogram images to be shared between clinicians across the county (rather than being emailed), which will speed up diagnosis and reduce clinical risk.

5.78 The Trusts have a joint programme to create Community Diagnostic Centres which has already established a Community Diagnostic Centre at Blackbrook Park in the east of Taunton. There are further plans to create a second East Somerset Diagnostic Centre in 2023/24 on the YDH site. These centres will create additional capacity for echocardiograms, reducing waiting times still further.

5.79 None of these improvements, which will speed up patient diagnosis, would be possible if we were not merging.

Equitable cardiac rehabilitation

5.80 Research reported in the BMJ found patients who participate in community cardiac rehabilitation have improved self-management of their condition, improved psychological wellbeing and quality of life, and reduced mortality and hospital readmission.[93]

5.81 Merger provides an opportunity to consolidate the existing cardiac rehabilitation programmes into a streamlined, standardised offer that is equitable across the county, and meets BACPR[94] standards. Coming together will enable us to improve provision for SFT's patients by widening the group to whom rehabilitation is offered, i.e. by including patients with angina and heart failure.

5.82 Patients will be offered a range of options including self-directed exercise programmes or face-to-face classes. We are scoping venues for face-to-face classes in Bridgwater, Taunton, Yeovil, and Wells to ensure good geographical spread. Patients for whom face-to-face classes are not appropriate or who are unable to attend in person, will be offered home exercise options including the heart manual, DVDs or web-based platforms with exercise classes and educational content. As part of the work to integrate the cardiac rehabilitation offer, the teams are planning to work with patients to co-produce a patient experience/satisfaction measure.

5.83 Working as one team will provide an opportunity for cardiac rehabilitation colleagues to work flexibly across the county so exercises classes can be maintained. It will also support the resilience and sustainability of this important area of care. This change will

[93] Dakak HM, Doherty P, Taylor RS. Cardiac rehabilitation. BMJ 2015;351: h5000. doi: 10.1136/bmj.h5000.

[94] British Association for Cardiovascular Prevention and Rehabilitation

help deliver our first clinical aim on prevention and self-management, and also our third clinical aim on care closer to home. This change will benefit c. 150 patients a year with heart failure and angina.

Equitable mental health care

5.84 The signal of merger has already prompted conversations about how we can extend the face-to-face SFT clinics providing physical and mental health care to cardiac patients across the whole county, and we hope to introduce these prior to merger subject to being able to find clinic space at the YDH site. This will ensure the same access to timely holistic care for patients regardless of where they live in Somerset. This will benefit c. 50 patients a year.

Countywide pathways for rarer conditions

5.85 Merger will enable us to draw on the skills of the combined team to run clinics for Sudden Cardiac Death. These clinics will enable all Somerset residents to be seen in county (rather than having to travel to Bristol as some YDHFT patients currently do). We are exploring whether these clinics could take place in a central location such as South Petherton Community Hospital (centrally located) to reduce pressure on space in the acute hospitals. As part of our workforce planning we are also looking to train another genetic nurse specialist to support these clinics. These changes serve our third clinical aim of care closer to home.

Integrated digital systems

5.86 Moving to a unified Electronic Health Record (see chapter 2) will save valuable clinical time by enabling colleagues to see patient records regardless of where they are. This will remove the need for colleagues to email patient information between sites and chase up results (which reduces the risk to patient safety). It will also reduce duplicate tests which reduces the risk to patient safety and frees up clinical time to see other patients.

5.87 In anticipation of the merger, a single records and imaging system across both sites is in the process of being implemented (Change Healthcare). The joint procurement of a single system would not have happened without the signal of merger. The single system will enable clinicians to see investigation results at both acute sites. This will support quicker access to care, a reduction in duplicate tests (and a corresponding gain in the associated resources), a reduction in clinical risk and improved patient experience. Combined digital systems will also support submission of data to the National Audit for Cardiac Rehabilitation.

5.88 **Figure 37** below summarises the patient benefits of bringing together the cardiology teams into a single service. The teams identified these benefits at a series of workshops in late 2021 and 2022.

Figure 37: Patient benefits - cardiology

Planned change	Valuing time	
	More time in good health	Making every minute count
Change NSTEMI pathway	• Quicker patient access to diagnostics and specialist care leading to improved patient outcomes • Reduced clinical risk from fewer inter-site patient transfers	• Less patient time waiting for definitive specialist care and feeling anxious. • Less patient time (and less discomfort) from being transported between sites • Eliminate duplicate investigations which will reduce patient waiting and free up clinical time • Improved use of combined diagnostic capacity, which reduces patient waits • Reduced administration associated with inter-site transfers, which frees up colleague time to care for other patients
Amend pacemaker pathway	• Right pacemaker first time which reduces risk of heart failure <u>Remote monitoring extended to patients in the east</u> • Quicker identification of deteriorating heart function, which means fewer complications and aids early intervention	• Fewer pacemaker upgrades which frees up clinical time and catheterisation lab capacity for other patients <u>Remote monitoring extended to patients in the east</u> • Greater patient convenience from not having to attend face-to-face appointments. • Greater patient peace of mind from continuous monitoring of their heart • Better use of face-to-face outpatient appointment time
Combined team	• Patient access to specialist cardiology care 24/7, leading to improved patient outcomes • Better clinical decision-making from combined MDTs, leading to better health outcomes	• Less patient time waiting for specialist care and feeling anxious. • More resilient team, better able to cover staffing gaps and provide timely care • Colleagues working at the top of their licence more of the time • Greater colleague capacity to enact transformational change

Countywide clinics	• Improved access to care for patients in east Somerset who need support for mental health aspects of heart failure and cardiac rehabilitation, leading to reduced patient anxiety
	• Wider group of patients in the west of Somerset who can access (and reap the benefits of) cardiac rehabilitation - reduced anxiety and greater ability to manage own long-term condition
	  • For heart failure patients – reduced readmission to hospital
	  • For angina patients – increased exercise tolerance
		• More resilient team, better able to cover staffing gaps and ensure cardiac rehabilitation exercise classes go ahead

Combined digital systems	• Ensures clinicians have ready access to patient information which reduces clinical risk	• Reduces duplicate diagnostics, which speeds up access to treatment, frees up clinical time and gives better patient experience

How merger facilitates planned changes

5.89 Despite the cardiology teams working together for some years (e.g. on care of urgent NSTEMI patients), clinicians at the two Trusts have necessarily had to stay focused on the care of patients on their own waiting lists. This is particularly the case given the long-term staff shortages, and more recently Covid pressures. This has meant that the incentives and opportunities to address inequities in care were weak, while the barriers to close working (both practical and psychological) have historically been high.

5.90 By bringing colleagues together into a single team, and patients together into a single waiting list, we can create the situation where it is everybody's business to ensure equitable cardiology care across the county. The signal of merger has already helped overcome some of the psychological barriers (see Ashley's story, Figure 33), and merger also enables us to address practical barriers such as IT systems and staff rotas. By combining our teams we put ourselves in a better position to drive through the changes needed to achieve our vision of a sustainable, equitable and patient-focused service.

Benefits indicators

5.91 The indicators that the teams will use to assess their progress in realising the expected benefits of integration are set out in **Figure 38**. These were developed by the team in summer 2022.

Implementation plans

5.92 Building on the integration planning done to date, the cardiology teams have now identified 10 detailed integration workstreams.[95] The leads for these workstreams will link in with Digital, Finance and People team colleagues as required. The teams have also set a timeline for coming together and we have recently appointed a project manager who will work with the cardiology teams to help them plan their integration. Developing plans will be informed by the findings of the upcoming GIRFT review at SFT which is planned for December 2022.

5.93 The teams have agreed to establish a monthly oversight group to drive forward their integration work and the first meeting took place in November 2022. Our trust-wide Clinical Service Integration Leadership Group will also have oversight of the integration of the cardiology teams, alongside all other clinical services which are coming together.

5.94 The latest draft of our cardiology integration plan is provided as a supporting submission to this Case. This integration plan will continue to be developed as part of the ongoing merger programme.

[95] The workstreams are Workforce; Governance; Cath lab & ACS transfer; Cardiac rehabilitation; Pacing (remote monitoring); Heart Failure; Valves; Specialist clinics (ACHD, ICC); CT/MIR; Echo (including TOE and Medcon).

Figure 38: benefits indicators - cardiology

Pathways	Source	Purpose	Baseline (Sept 2022)		Target
			MPH	YDH	
NSTEMI door to procedure time	External	To reduce the inequity of times	52.7 hours	62.5 hours	To achieve equity by Dec 2024
		To increase % receiving PCI <48 hours	68%	47%	90% receive PCI <48 hours by Dec 2024
Waiting time Diagnostics:					
ECHO	In-house	To reduce the inequity of waiting times	8 weeks	8 weeks	6 weeks by Jan 2023
Stress ECHO	In-house		12 weeks	4 weeks	6 weeks by Feb 2023
Transoesophageal echocardiogram (TOE)	In-house		8 weeks	4 weeks	6 weeks by Jan 2023
Waiting time Interventions:					
Pacemaker - simple	In-house	To reduce the inequity of waiting times	26 weeks	1 week	<4 weeks 31/12/23
Pacemaker complex	In-house		26 weeks	NA	<6 weeks 31/12/23
Angiogram	In-house		16 weeks	NA	<4 weeks 31/12/22
Angiogram +/- PCI	In-house		16 weeks	NA	<6 weeks 31/12/22
Length of stay:					
NSTEMIs	Data Analysts	To reduce length of stay (LOS)	6.7 days	6.7 days	72 hours (average) by 31/12/23
Pacemaker ALL	In-house		8 days	6.3 days	6 days by 31/12/23, 4 days by 31/12/24
Workforce:					

Reduce locum/agency	Finance	To reduce overall locum/ agency spend	£619,694 (20/21)	£440,943 (20/21)	Reduce by 30% by Dec 2023
Clinical Pathways:					
Cardiac Rehabilitation	RiO/ Trak	To ensure Phase 2 calls within 3/7	48%	100%	100% of Phase 2 calls made within 3/7
	NACR	Compliance with NACR submission	RED	AMBER	To be fully compliant by October 2023
	In-house	Patient satisfaction	TBD	TBD	To devise a bespoke patient satisfaction measure

6. Stroke

Summary

Both YDHFT and SFT's stroke services provide hyper-acute and acute stroke care, post-stroke support and education. In addition, SFT provides community and inpatient rehabilitation care (including in people's own homes) for all stroke patients across the county.

Local demand for stroke care is increasing and both Trusts have struggled for some time to recruit the specialist staff they need. The care currently provided is inequitable across the county, and both stroke teams face constraints arising from lack of physical capacity. Although the teams have worked together for some years, different systems and processes at the Trusts create additional barriers to effective joint working.

The stroke teams are now revisiting their work to devise a single stroke pathway to ensure it fits the current and future context. The teams have agreed their vision for a single county-wide service, and are now developing the workstreams by which they will deliver their team integration.

The patient benefits which will result from bringing the Stroke teams together include:

- Improved patient outcomes and experience from a single, streamlined county-wide stroke pathway which will speed up patient access to specialist care (especially out of hours), and better access to rehabilitation support.
- A single, more resilient team which is better able to meet national standards for specialist staffing, and has increased capacity to drive transformational improvement for patients.
- Equitable post-stroke education and care across the county, provided in more community locations.
- A single electronic patient record which will reduce clinical risk and increase efficiency, thereby freeing up more clinical time for front line care.

The Trusts have appointed a clinician to lead the work to implement a single county-wide stroke pathway and have established a steering group to plan and oversee their integration.

Current service arrangements

Acute care

6.1 YDHFT and SFT each provide specialist stroke treatment and intervention. Both acute sites (YDH and MPH) have a Hyper-Acute Stroke Unit (HASU) providing critical care, and an Acute Stroke Unit (ASU).

SFT

6.2 MPH has a dedicated stroke unit with 4 high dependency (HASU) beds and 19 ring-fenced acute stroke beds (ASU) to which all patients in the hyper-acute phase may be admitted. There are a further 6 step-down beds on an adjacent ward, managed by the stroke team, which are used to manage demand. The SFT team aims for all acute stroke patients to be admitted to the HASU in the first instance.

6.3 Consultant-led HASU ward rounds take place twice daily, Monday-Friday and once daily at weekends; daily consultant-led ward rounds for other stroke patients take place 7 days a week. SFT has 24/7 access to stroke opinion for new presentations that require complex decision-making or a thrombolysis opinion – this is accessed via the regional thrombolysis network. SFT also has 24/7 access to a suitably trained healthcare professional e.g. a medical registrar or HASU nurse, supported by an on-call general medical consultant for out-of-hours advice.

6.4 SFT runs separate consultant-led clinics for Transient Ischaemic Attacks (TIA) and for 6-week follow-ups Monday-Friday, plus a weekend clinic for high-risk patients.

YDHFT

6.5 YDHFT has a merged 24-bedded ward for stroke and general medicine, of which 12 beds (which form the ASU) are for stroke patients. YDHFT's 4 high dependency stroke beds (HASU) are located on a separate ward which is shared with coronary care. YDHFT only admits patients to its HASU if they are thrombolysed, have had an intracranial haemorrhage, or have complex acute medical needs.

6.6 Ward rounds are led once a day Monday-Friday by either a stroke consultant or consultant nurse; at weekends a medical registrar reviews patients once a day with input from the stroke consultant who performs a virtual ward round by telephone. YDHFT has 24/7 access to stroke opinion for new presentations that require complex decision-making or a thrombolysis opinion – this is accessed via the regional thrombolysis network. YDHFT also has 24/7 access in the form of a stroke-trained medical registrar, supported by an on-call general medical consultant for out-of-hours advice.

6.7 YDHFT runs a combined clinic Monday-Friday for TIAs and 6-week stroke follow-ups. Patients presenting at YDH on weekends/bank holidays with suspected TIA and who

are assessed as high risk are either admitted or seen by a stroke clinical nurse specialist available 9am-5pm at weekends. Low risk patients with a suspected TIA are seen and discharged with a TIA clinic referral which is triaged by the YDHFT stroke consultant on Monday morning.

Thrombolysis and other acute stroke care

6.8 Both Trusts provide thrombolysis 9am-5pm Monday to Friday. Out of hours, clinicians who are not trained in specialist hyper acute stroke care can access telephone advice from the regional thrombolysis network;[96] two SFT consultants and one YDHFT consultant participate in this network.[97]

6.9 SFT's vascular service runs outpatient clinics at both YDH and MPH, and stroke patients requiring carotid surgery are operated on at MPH. Patients at both YDHFT and SFT who require thrombectomy are referred to North Bristol NHS FT.

6.10 Both acute stroke teams also input to the care of patients on non-stroke wards who have had a stroke in the past but whose current condition for which they have been admitted is not stroke.

Community care and rehabilitation

6.11 Rehabilitation begins immediately post-stroke and is performed in all settings: acute hospital, community stroke rehabilitation units, other community settings, residential care, or at home, either by YDHFT's rehabilitation team (acute setting only) or by SFT's acute and community stroke teams.[98]

6.12 SFT has two stroke rehabilitation units (at Williton and South Petherton community hospitals), which provide community and inpatient rehabilitation care for all stroke patients across the county. The integrated community stroke service includes a stroke-specific Early Supported Discharge (ESD) team which provides rehabilitation in people's own homes for all Somerset stroke patients. SFT's community stroke team (CST) carries out the SSNAP[99] reviews for all stroke patients 6 months after discharge from an acute setting.

Support after stroke

6.13 The two Trusts currently offer different support to patients and their carers following a stroke. YDHFT's ASPIRE programme (which was paused during Covid but has now restarted) is a face-to-face 12-week tailored programme providing one hour of exercise

[96] The thrombolysis network covers Yeovil, Taunton, Salisbury, Gloucester, Bristol, Swindon, Hereford and Worcester.

[97] Merger will not have a negative impact on our ability to participate in this network.

[98] YDHFT patients who are registered with a Dorset GP are handed over to the Dorset Early Supported Discharge team for the community and rehabilitation phase of their care.

[99] Sentinel Stroke National Audit Programme. SSNAP measures the quality and organisation of stroke care in the NHS.

plus 30 minutes of advice about lifestyle change and how to prevent a secondary stroke, each week. The programme takes place on the YDH site. Trained volunteers who have been through the programme also provide peer support.

6.14 Prior to the pandemic, SFT ran three support groups, although all groups were paused during Covid due to staffing pressures and visiting restrictions, and have not restarted. These groups were:

- Carers support group: open to carers whose relative was on the acute stroke ward at MPH; run by a clinician and volunteer from the Stroke Association.
- Life after stroke group: 10-week programme run by stroke coordinators at South Petherton and Shepton Mallet community hospitals offering one hour of exercise and one hour of education and stroke prevention advice a week. The programme also offered peer support.
- Aphasia[100] communication support groups: run by speech and language staff in a range of settings across Somerset.

6.15 Resumption of these groups is on pause due to staffing gaps and rising demand. Development of the county-wide stroke education and support offer will be taken forward under the Training and Education workstream, see paragraph 6.102.

Inflows

6.16 30% of the stroke patients treated by YDHFT are registered with a Dorset GP.[101] 5% of the stroke patients treated by SFT live in Devon, North Somerset or North East Somerset.

Outflows

6.17 15% of the people who have a stroke in Somerset are treated out of county, either by Royal United Hospitals Bath NHS FT, or University Hospitals Bristol and Weston NHS FT.

Summary of stroke provision

6.18 **Figure 39** summarises the key elements of stroke provision at the Trusts.

Figure 39: summary of stroke provision in 2021/22

	SFT	YDHFT
Hyper acute stroke unit (HASU)	4 bed unit (+ 2 escalation beds*) c.680 patients admitted/year	4 bed unit (shared with coronary care) c. 100 patients admitted/year (Admission criteria: Thrombolysed stroke, Labetalol infusion required, intracranial bleed or high risk of further event or deterioration)

[100] Aphasia is difficulty with speaking and understanding others

[101] Dorset currently has a plan to consolidate its three HASUs into two, with one at Dorset County Hospital in Dorchester and the other at Royal Bournemouth Hospital.

Acute stroke unit (ASU)	19 bed unit (+ 6 step down beds managed by stroke team on an adjacent ward) All patients from HASU step down to ASU before discharge	12 bed unit c. 350 patients admitted/year**
Stroke Rehabilitation Units (SRUs)	• South Petherton community hospital, 16 stroke beds c. 200 inpatients admitted/year • Williton community hospital, 19 stroke beds c. 170 inpatients admitted/year (commissioned for 11 stroke beds + small amount of temporary funding for additional therapists & rehabilitation assistants)	
Early supported discharge team	c. 370 patients supported/year	
Community stroke rehabilitation team	c. 410 patients supported/year Plus completion of 6-month post-stroke assessments (& ongoing case management if required) for c. 1,050 patients/year	
Support groups	*Pre-Covid the following groups ran, although all are now paused* • Carers support group Drop in • Life after Stroke groups c. 200 patients/year • Aphasia support groups c. 120 patients/year	ASPIRE programme c. 250 patients and carers/year

*: MPH's '+2' HASU escalation beds are only opened when the hospital is at OPEL 4. However, recent operational pressures mean MPH has frequently been at OPEL 4. The beds are not ringfenced for stroke and may be used for non-stroke patients.

**: These patients are in addition to the 100/year admitted to YDH's HASU.

Notes:

1) During 2021/22 (to which the data in this table relates), Covid was still depressing the number of patients coming forward for care. SSNAP data showed a national decrease in stroke patient admissions to hospital and reduced activity at TIA and stroke clinics during this time (although the reduction was more pronounced in the early part of the year).
2) The number of admissions to each hospital for stroke will be higher than the number of patients recorded in SSNAP data. This is because patients are not recorded in SSNAP if they do not meet the submission eligibility criteria set nationally, or because they have been transferred from another hospital e.g. from Weston-Super-Mare or Bristol.

6.19 Both Trusts' stroke teams are multi-disciplinary, consisting of stroke consultants, specialist nurses, rehabilitation support staff, occupational therapists, speech and language therapists, physiotherapists, psychologists, dieticians and community

pharmacists. The teams also work closely with adult social care on discharge planning e.g. for patients requiring a nursing home placement following a catastrophic stroke.

6.20 **Figure 40** summarises the workforce position at each Trust. YDHFT has had a vacancy for a substantive stroke consultant since 2018. The Trusts issued a joint advert in 2020 to recruit a stroke consultant across YDHFT and SFT but this was unsuccessful due to the national shortage for stroke consultants. YDHFT's substantive consultant has returned from retirement, and the second substantive post is currently filled by a locum working on a rolling basis (free to leave at any point). As of October 2022, there are vacancies for two WTE stroke consultants at SFT. These gaps are currently being covered in the main by the existing stroke consultants, as locums are in short supply in this specialty. Further detail on staffing is set out in **Annex 6**, which shows that at many grades the national recommended staffing levels are not being met at either Trust.

Figure 40: Summary of stroke workforce

	In post		Vacancies/ gap from budget
	Substantive	**Locums**	
YDHFT			
Medics (consultants)	0.95*	1**	0.05
Medics (other than consultants)	4.8	1	-
Consultant stroke nurse	0.4	-	-
Specialist nurses / practitioners	2.6	-	-
Nurses (incl. HCAs)	24.41	-	1.4
Allied health professionals (incl. assistants)	5.61	-	0.70
SFT acute			
Medical: consultants	4.8	-	2.0
Medical: doctors in training	4	-	-
Specialist nurses / practitioners	3	-	-
Nurses (incl. HCAs)	43.99	-	-
Allied health professionals and psychologists (incl. assistants)	14.85	-	1.3
SFT Community SRU, ESD & CST			
Medical: consultants	(0.4WTE - included in acute *WTE)*	-	-
Medical: specialty doctors	2.0		
Consultant Therapist	1.0	-	-
Specialist nurses / practitioners	0.8	-	1.0
Nurses (inc HCAs)	63.54	-	7.71

Allied health professionals and psychologists (incl. assistants)	43.51	-	2.2

*: The substantive stroke consultant at YDHFT is physically at YDH 3 days a week and is available by phone for his remaining hours.

**: The locum stroke consultant at YDHFT is on a rolling contract rather than fixed term and may leave at any time.

Notes:
1. All figures are whole time equivalents.
2. All nurses complete general and stroke-specific inductions which includes stroke specific training e.g. The Stars training as well as spending time with MDT members to support training on stroke-specific needs.

Review of hyper acute stroke provision

6.21 There is strong national evidence that providing hyper acute stroke care 24/7,[102] and centralising that care into a smaller number of well-equipped and staffed hospitals saves lives and leads to better patient outcomes.[103] Even though 65% of stroke cases are admitted out of hours, Somerset is unable (for staffing reasons) to provide 24/7 access to consultant level opinion for all stroke patients, and hyper acute care is spread across two sites.

6.22 A 2019 review of stroke services in Somerset recommended further consideration of the way that HASU and TIA services are provided in the county, and a system-wide review of HASU and TIA care in Somerset is currently underway. Any changes which emerge from this process will align with national policy on integrated stroke delivery networks and integrated community stroke services. This work includes an equality impact assessment.

Collaboration to date

6.23 YDHFT and SFT's stroke services have collaborated for a number of years, alongside local social care and voluntary sector partners, to improve stroke patient care and experience, and respond to rising demand. This collaboration has succeeded in reducing the average length of stay in Somerset's acute and community stroke rehabilitation units.[104] At the time of the previous merger (which created SFT), TSFT and SPFT engaged with YDHFT to ensure that changes made to the interface between acute and community stroke care/ESD did not disadvantage YDHFT patients.

6.24 At an operational level, other existing areas of joint work include:

[102] The hyperacute phase of care is the first 72 hours after the patient arrives at the hospital.

[103] Stroke Association. *What we think about: reorganising acute stroke services. Rebuilding lives after stroke.* 2019. https://www.stroke.org.uk/sites/default/files/new_pdfs_2019/our_policy_position/psp_-_reorganising_acute_stroke_services.pdf. [Accessed 27th July 2022].

[104] The average length of stay at MPH's acute stroke unit fell from 10.6 days in 2019/20 to 7.6 days in the period July-December 2020 (data gathering was paused from April to June 2020 due to Covid-19). The average length of stay at YDH's acute stroke unit fell from 10.9 days in 2019/20 to 6.8 days for the period April -December 2020. The average length of stay in SFT's two community stroke rehabilitation units fell from 40.9 days in 2019/20 to 33.6 days for the period April 2020-Jan 2021.

- a daily call between the two acute stroke units and the ESD team to help manage patient flow
- the development and use of a shared stroke proforma covering the whole patient journey from acute stroke units to community stroke rehabilitation units
- SFT provides speech and language therapy across all sites, including at YDH
- combined specialist nursing education in stroke and neurology
- joint development of patient literature
- close working between data administrators to share SSNAP records, support the collection of additional data for patients cared for by both Trusts, and generate information on patient outcomes.

6.25 A history of close working means teams have been able to act collegiately to support patient safety. For example, in response to staff shortages at YDHFT, SFT stroke consultants are available by phone to support YDHFT registrars treating stroke patients whenever there are gaps in consultant cover at YDHFT. However, this is not a long-term solution, especially for the care of hyper-acute patients.

6.26 As part of the development of Somerset's Fit for my Future strategy, led by Somerset's Integrated Care Board (and its predecessor, Somerset CCG), the Trusts have worked with local partners to develop a model for shared acute services in Somerset, which includes stroke.

6.27 Prior to the pandemic, the stroke teams mapped the desired single, streamlined stroke pathway for the county. However, new ways of working introduced during Covid (e.g. community MDT meetings via Microsoft Teams) and staffing changes mean the mapped pathway no longer fits the current context. In addition, the prospect of merger means there will be a single team, rather than separate teams collaborating which has implications for the pathway (for example, differences such as TIA provision at the weekend which might continue if the teams were collaborating will now be replaced with consistent county-wide processes). Current differences in approach (e.g. different staffing and differences in stroke education offer) need to be reconciled in order to achieve a single county-wide approach. NHSE published the National Stroke Service Model in 2021 and the Integrated Community Stroke Service Specification in 2022 and the merger also offers the ideal opportunity for services to review their provision against these updated models.

6.28 With these factors in mind, stroke colleagues have recently resumed their pathway redesign work to ensure it fits the current and future context, and covers the full breadth of the pathway from the point of stroke/TIA through to support at home and education/advice post-stroke.

6.29 Ongoing workforce challenges (see paragraph 6.20 and Figure 40) prompted the two teams to establish an emergency workforce planning group in April 2022. This group has been able to look at the combined stroke medical workforce position rather than workforce at individual trust level, and the group has agreed emergency, medium and short term plans to safely staff the two acute stroke departments. Although gaps in substantive consultants at both Trusts mean consultants are currently unable to cross-

cover for each other, the teams have been able to share their experience to develop a plan that ensures safe care by thinking creatively about how tasks can be better distributed amongst the wider multi-disciplinary team in ways other than like-for-like replacements.

6.30 For example, YDHFT has had to develop innovative staffing approaches in the face of enduring staff shortages and at YDHFT 6-week reviews following stroke are carried out by a stroke consultant, consultant stroke nurse or clinical nurse specialist as part of the combined stroke/TIA clinic. At SFT these reviews are currently carried out only by stroke consultants or associate specialists, although the SFT team are now exploring the feasibility of specialist nurse-led TIA clinics.

6.31 In the colleague story below, (**Figure 41**) Caroline Smith sets out her experience of the challenges of joint working.

Figure 41: Colleague story, Caroline Smith

Colleague story – Caroline Smith, Consultant Stroke Nurse at YDHFT

"I'm a consultant nurse and have worked in stroke care for 20 years. I spend my time on ward rounds, running clinics and supporting junior team members of all disciplines.

All clinicians, regardless of discipline bring different elements to the team and the fact that I am a nurse is not important - I introduce myself by my name, not my title and if I feel out of my depth I ask for help, the same way colleagues do who come to me for advice or support. I do not consider myself to be a stroke physician, but a clinician who has decades of stroke experience, and who wants to work in an organisation where patients are at the heart of all we do.

At a time when there's a national shortage of stroke physicians, I think exploring other roles is important. Within both the YDHFT and SFT stroke teams there are colleagues working in innovative ways and taking on different roles to enhance patient care and experience. These roles have evolved differently in each of our organisations. I feel that the merger will enable us to share and build on these experiences to create a stronger more robust workforce and to further develop these roles.

In Somerset we have already been working collaboratively on a single stroke pathway, but that involves delivery by different organisations with different processes and systems. This can be incredibly frustrating when patients are transitioning between organisations. It is not uncommon for patients to deteriorate in the community hospital and be transferred to YDH for their acute illness despite their initial stroke management being at MPH.

The challenges of this go beyond not knowing the patient and their family. Currently, we aren't able to quickly access medical notes, test results and other important information and our two teams have to use valuable time doing a patient handover. This takes up clinical time and has the potential to delay the patient's acute treatment. It also leads to poor experience for the patient and their family. Knowing that the merger will result in a review of the digital systems and ideally provide a single IT system is extremely reassuring, as that will have an incredibly positive effect on my ability to provide safe, timely patient care."

Learning from Covid

6.32 During the pandemic, joint working increased with both teams taking a system-wide view and working more flexibly along the entire patient pathway. For example,

communication between the acute teams and the community team increased to aid patient flow. This increase in collaboration and flexibility was aided by technology, particularly Attend Anywhere, patient follow-ups by phone and the use of Microsoft Teams to coordinate patient care.

Limits of collaboration

6.33 Despite working closely together for a number of years, collaborating while we are separate organisations has limitations. The existing stroke teams (and the Trusts of which they are a part) face different issues and pressures. There are no current arrangements for cross cover in-person, and in operational terms the two teams runs separate stroke services although they adhere to the same guidelines. The teams are also structured differently and use different practices, e.g. tasks are carried out by different staff roles at the two Trusts. It is no coincidence that the area of deepest collaboration to date has been around handovers/transfers of care, since this area poses the fewest challenges to existing processes. Furthermore, practical barriers such as IT differences also hamper collaboration.

Challenges

6.34 For a number of years, the two stroke services have faced a range of significant challenges. Rising demand,[105] enduring workforce gaps and the multiple staff grades at which national staffing requirements cannot be met mean neither stroke service is sustainable in its current form. The consequences of this include poorer patient care, inequity of care across the county, and a lack of capacity to implement change that would benefit patients.

6.35 In addition, colleagues have to work around different systems and processes between the two Trusts. Alongside sufficient workforce, other resources including bed capacity and space for rehabilitation are also needed to deliver the right care at the right time. Further detail on these challenges is set out below.

Workforce and rising demand

6.36 There is a national shortage of stroke specialists and in particular stroke consultants. In Somerset this challenge manifests in difficulty filling posts substantively.

6.37 It is 5 years since YDHFT had a full complement of budgeted substantive stroke consultants. The single substantive stroke consultant at YDHFT has retired and returned to work to ensure YDH has a consultant physician presence. The inability to successfully recruit a second substantive stroke consultant has made it impossible to provide specialist medical assessment and care, including specialist ward rounds, 7

[105] Data on annual number of strokes in Somerset: 1,429 in 2019 (actual); 1,658 in 2025 (predicted); and 1,858 in 2030 (predicted) – a 30% increase on the 2019 position.

days a week at YDH. Even securing locum consultants is difficult, and historically there has been significant turnover in locum consultants at YDHFT.

6.38 Likewise, SFT has gaps at consultant level. SFT struggles to ensure sufficient medical cover for its Stroke Rehabilitation Units[106] during periods of leave, and there are frequent periods when these Units have to rely on remote consultant support to nursing staff.[107] Both Trusts have difficulty recruiting therapy staff, in particular occupational therapists. These workforce gaps impact daily on the care of stroke patients, for example in a lack of capacity to implement pathway improvements such as taking forward the intent to create a county-wide stroke education offer.

6.39 In Somerset 40% of people with hypertension are undiagnosed; this equates to 61,000 people. Around 2,000 people in Somerset have atrial fibrillation and are unaware of it. Health checks in Somerset have identified that 25% of people examined have a sedentary lifestyle, and 60% are overweight or obese.[108] These are all risk factors for stroke.

6.40 In line with the national trend, the incidence of stroke in Somerset is expected to rise as a result of an ageing population with more complex health needs. Stroke admissions in Somerset are projected to rise by 30% over the next 10 years, from 1,400 a year in 2019 to c. 1,800 a year by 2030. Responding to stroke mimics alongside diagnosed strokes also contributes to the burgeoning workload of both acute teams. Furthermore, the Bristol, North Somerset, and South Gloucestershire (BNSSG) system estimates that planned changes to the stroke care in that system will result in an additional 3.8 patients a week on average (c. 200 a year) needing acute stroke care at MPH.

6.41 As demand increases over time, the workforce requirement to meet that demand will rise too. However, recent experience shows how difficult it is to attract stroke specialists to work in Somerset, and there is concern that the current precarious staffing position risks undermining colleague retention and making future recruitment into Somerset even more challenging than it already is.

6.42 Alongside our internal workforce challenges there are workforce issues in adult social care. Adult social care plays a critical role in ensuring flow of stroke patients: up to a third of patients in our stroke rehabilitation beds are currently awaiting adult social care provision or onward care. The Trusts are working with partners at ICS level to try to address these specific issues (see Full Business Case, chapter 6).

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[106] The British Association of Stroke Physicians (BASP) standards recommend at least twice weekly Senior Medical stroke specialist ward rounds. This is achieved in South Petherton Hospital but not at WIlliton where there is only one weekly session to cover MDT and ward round.

[107] Regional thrombolysis rota: two SFT consultants and one YDHFT consultant participate in this network.
Day rota at MPH: each day one of the SFT stroke consultants will cover the thrombolysis bleep and provide advice and guidance to other staff e.g. at YDH / community hospitals. There is no out of hours stroke rota, but stroke trained medical registrars can seek advice from the general medical consultant on call out of hours

[108] All data from Somerset Long Term Plan, November 2019

Inability to meet national requirements

Acute setting

6.43 The National Clinical Guidelines for Stroke, issued by the Royal College of Physicians (RCP), require stroke units to provide 24/7 consultant cover. Both Trusts meet this standard for newly-presenting stroke patients needing complex decision-making or a thrombolysis opinion (by drawing on advice from the regional network). However, neither Trust currently has the number of stroke consultants needed to meet this requirement for *all* stoke patients and this has consequences for quality of care.[109] When medical registrars assess patients for stroke thrombolysis out-of-hours (with support from the regional network) they take longer to assess the patient and thus the time taken to administer thrombolysis ("door-to-needle time") is longer than can be achieved when a stroke consultant is present in person. The difference can be up to 30-40 minutes in some cases. Research shows that each minute saved in administering thrombolysis leads to an additional 1.8 days of extra healthy life.[110]

6.44 In addition, neither Trust meets the NICE requirement[111] that all patients with a suspected TIA are seen by a stroke specialist within 24 hours. Lack of staff also means neither Trust is currently able to offer the necessary level of rehabilitation to patients on acute stroke units.

6.45 The 2018 GIRFT review found that although both Trusts' stroke services perform relatively well against many key national indicators for the whole stroke pathway, they perform less well against the hyper acute and acute phase standards, for example rapid assessment by stroke nursing and medical teams. This is largely driven by staffing gaps at both Trusts and, in the case of YDHFT, the lack of a facility exclusively for stroke patients.

Community settings

6.46 A lack of sufficient skilled staff in the community stroke service run by SFT means it is not meeting NICE guidance, Royal College of Physicians (RCP) guidelines, the National Stroke Service Model, or standards set by the British Association of Stroke Physicians.[112]

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[109] Both Trusts participate in an out-of-hours rota of stroke consultants across the Avon-Gloucestershire-Wiltshire-Somerset (AGWS) network. However, this is for a limited number of scenarios (e.g. patient presenting with an acute stroke requiring specific specialist decision-making about whether or not to administer thrombolysis or to refer for thrombectomy) rather than all patients presenting out-of-hours. The network consultant can only discuss the case by phone and review the brain scan; there is no facility for the stroke consultant to actually review the patient. Thus our current out-of-hours provision using the AGWS network does not meet the RCP recommended standards (e.g. no video-telemedicine with capability for the remote stroke specialist to observe the clinical examination; no ability for the remote stroke specialist to talk to the patient or family).

[110] Stroke Thrombolysis (ahajournals.org)

[111] Stroke and transient ischaemic attack in over 16s: diagnosis and initial management NICE guideline Published: 1 May 2019 www.nice.org.uk/guidance/ng128

[112] The British Association of Stroke Physicians (BASP) standards recommend at least twice weekly Senior Medical stroke specialist ward rounds. This is achieved in South Petherton Hospital but not at WIlliton where there is only one weekly session to cover MDT and ward round.

6.47 Effective rehabilitation and support for recovery in the first 6 months is key to regaining function and quality of life after a stroke,[113] but a lack of sufficient specialist nursing and therapy staff across the pathway is impairing SFT's ability to provide this essential element of stroke care. For example, due to lack of staff, the community stroke team is currently unable to meet patients' therapeutic needs as set out in the national service model for integrated community stroke service. This impairs patient outcomes and increases length of stay. The lack of sufficient therapy staff at South Petherton Stroke Rehabilitation Unit is having a significant impact on staff morale and potential retention of staff. **Annex 7** presents SSNAP data which shows that while referrals to the community stroke team and the ESD team are increasing, the average number of minutes of therapy that patients receive a day has declined, because the number of therapists has not risen to keep pace with rising demand.

SSNAP performance

6.48 For the period April-June 2022, SFT's acute and community stroke services were both rated 'C' according to SSNAP criteria.[114] Although performance against some indicators is good (e.g. Somerset performs well above national average on completion of 6-month post-stroke reviews), SFT did not fully meet the standards for that period due to lack of availability of community care, an increased number of patients not arriving at the acute stroke ward within four hours,[115] and a lack of available (and therefore timely) therapy and nursing intervention on stroke rehabilitation units.[116]

6.49 In April-June 2022, YDHFT's acute stroke service was rated D. This was the third quarter since 2014 that the Trust rated so low.[117] The challenges driving YDHFT's rating were primarily Covid-related, and include a lack of:

- access to specialised senior clinical decision makers (caused by staffing gaps);
- specialist stroke beds;
- capacity elsewhere in the hospital to take patients following their hyper-acute phase;
- access to specialist therapy (for patients cared for on outlying wards); and
- packages of care to enable timely discharge from hospital.

6.50 As at June 2022, SFT was SSNAP rated 'D' for thrombolysis, and YDHFT was rated 'D'. This is comparable to ratings from other organisations across the south west. Further information about the Trusts' SSNAP performance is at Annex 7.

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[113] NHS England. *National service model for an integrated community stroke service*. 2022. https://www.england.nhs.uk/wp-content/uploads/2022/02/stroke-integrated-community-service-february-2022.pdf. [Accessed 27th July 2022].

[114] Summary Results (Apr-June 2022), Format: .XLS, Dataset: Sentinel Stroke National Audit Programme Clinical results 22/23

[115] The percentage of patients admitted to MPH's acute stroke unit with 4 hours was 48.8% and to YDHFT's acute stroke unit was 32.1% in the period April-June 2022 (SSNAP data).

[116] SFT's policy is to admit patients directly to the stroke ward out of hours. However, it has become increasingly difficult to deliver this because of increased attendances at A&E and because patient flow is hampered by the lack of availability of social care. Also, in some instances, acute stroke beds have to be used temporarily for other acute medical patients. Timely access to specialist care has been shown to improve patient outcomes, hence the standard.

[117] Prior to the pandemic and up to Jul-Sep 2020, YDHFT's SSNAP rating was consistently B. In Oct-Dec 2020 it was between a C and B.

Inequity of care

6.51 Staffing gaps lead to inequity of provision across the county because some elements of care cannot be provided in all locations. For example, YDHFT patients do not have on-site access to a stroke consultant at the weekends, which can have a negative impact on patients (see paragraph 6.43). There is also inequity in the stroke education programmes - YDHFT has a programme in place but SFT currently does not; this difference is driven in part by staffing gaps and higher demand at SFT.

Lack of capacity to implement change

6.52 The workforce position at both Trusts is such that colleagues do not have the capacity to implement pathway (and other) changes even when they know these would benefit patients. For example, there is a desire to further develop an equitable stroke education programme across the county which builds on the success of YDHFT's ASPIRE programme. However, colleagues do not currently have the capacity to take this work forward, at the same time as providing front line care.

6.53 Many patients report a strong feeling of abandonment following their discharge from NHS services if they are not given effective support to help to adjust to living with the long-term conditions associated with stroke.[118,119] This support is broader than the NHS can offer as it may need to encompass financial support, community transport, housing support, social opportunities, emotional support[120] and meaningful activity. It is important that NHS services are able to work seamlessly with third sector organisations to smooth the transition for patients following discharge. However, neither Trust's stroke service currently has the capacity to take this work forward.

Different systems and processes

6.54 The two Trusts' systems and processes differ, and this creates difficulties for clinicians treating patients who receive care from both organisations. For example:

- There is an intention to give YDHFT staff read and write access to RiO (the patient record system used by the community services which are run by SFT), but due to a lack of colleague time to undertake the required training, some do not yet have access in practice. This means when patients are transferred from the acute stroke unit to the Early Supported Discharge team or the Community Stroke Rehabilitation Team run by SFT, acute colleagues have to send information by email which the receiving colleague in SFT's community team then uploads to RiO. This is time-consuming and leads to reduced patient information

[118] Stroke survivors' and informal caregivers' experiences of primary care and community healthcare services – A systematic review and meta-ethnography | PLOS ONE

[119] anefs_report_web.pdf (stroke.org.uk)

[120] feeling_overwhelmed_final_web_0.pdf (stroke.org.uk)

being provided. Even for those colleagues who do have access, this is still another clinical system with a separate login which creates a clunky process. This affects about 50-60 patients/year for ESD, and 60-70 patients/year for Community stroke rehabilitation.

- Patient records are held in multiple electronic and paper formats depending on where they are captured in the stroke pathway (systems include RiO, EPro, Trakcare, Maxims, written patient notes etc). Accessing the various patient record sources creates delay for clinicians caring for patients being treated by both Trusts (see Caroline's colleague story, Figure 41).

6.55 In the absence of real time data on bed status, the community stroke team spends a significant amount of time locating beds for stroke patients. This creates a high number of calls between the acute stroke units and the community stroke team to understand caseload and current activity.

6.56 The two Trusts record their data differently which means it cannot be compared between YDHFT and SFT at system level. Also, a significant amount of clinical time at MPH is devoted to SSNAP data entry,[121] whereas YDHFT has a full time SSNAP data administrator to manage SSNAP data, produce reports and highlight areas of concern.

Stroke education programmes

6.57 Even prior to Covid, the provision of post-stroke education programmes was inequitable across the county, with different support available in different areas. SFT paused its education programmes during Covid and now lacks the staffing capacity (in the face of rising demand, see **Annex 8**) to resume them, which has exacerbated the inequity in this area of care. In addition, some YDHFT patients find it hard to travel regularly to YDH to participate in the ASPIRE programme.

Physical capacity constraints

6.58 Space limitations at YDH mean the Trust has had to introduce criteria for admission to its HASU beds. Stroke patients who do not meet these criteria are cared for on the ASU or on an outlying ward. YDH's hyper acute stroke unit shares space with Coronary Care, and its ASU shares bed capacity with general medicine. This means that the nurses caring for patients on these units do not specialise solely in stroke care.

6.59 As YDH lacks a dedicated ward solely for stroke care, there is an increased likelihood that stroke patients may initially be admitted to other wards. It is harder for the YDHFT stroke team to give patients specialist stroke care on outlying wards, and care on an outlying ward leads to poorer outcomes. Stroke patients who receive organised inpatient care in a stroke unit are more likely to be alive, independent, and living at

[121] SFT has 1 WTE data coordinator for community stroke care and 12 hours per week of a band 2 for acute stroke care. The remaining work associated with inputting/coordinating data for acute stroke care is done by band 7 stroke practitioners.

home one year after the stroke.[122] In the two years January 2020-December 2021, 30% of YDHFT's stroke patients (239) were initially admitted to an outlying ward not on the stroke unit.[123]

6.60 Although MPH has a dedicated 19-bed stroke ward, 18% of SFT's stroke patients (240) in the period January 2020-December 2021, were initially admitted to an outlying ward.[124,125] Although some outliers were due to Covid social distancing, stroke patient outliers were an issue for both Trusts prior to the pandemic, and outliers at both trusts continue to be higher than the national average.

6.61 Both Trusts' stroke services lose the space they use for rehabilitation during periods of escalation (e.g. when the Trusts are in OPEL 4). Lack of access to equipment and space for life skills therapy (e.g. kitchen assessments) means patients' cognitive and physical recovery is impaired, and those patients will either get better more slowly, or their ability to fully recover function will be reduced.

What will change, and how will patients benefit

Vision

6.62 Our stroke teams want to create a service where stroke patients receive rapid and equitable assessment and diagnosis, and appropriate care and rehabilitation regardless of where they live in Somerset.

6.63 To achieve this, the teams will create a single stroke service, with single leadership, an agile workforce and a combined bed base which enables the provision of high quality, comprehensive and equitable stroke care across the county.

6.64 The merged team, with single leadership, will have a single set of agreed priorities and move away from site-based interests towards pathway-based solutions, enabling faster decisions which can be implemented more quickly.

6.65 Our plans are aligned with the west of England integrated stroke delivery network workplan hosted by NHSE.

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[122] Langhorne, P, Ramachandra, S and Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke: network meta-analysis. Cochrane Database of Systematic Reviews. 2020; Apr 23;4(4):CD000197. Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000197.pub4/epdf/full.

[123] This figure excludes 3% of patients requiring critical care who were admitted directly to ITU. YDHFT data for April 2021 -March 2022 show 39% of stroke patients (177) were initially admitted somewhere other than the Stroke Unit, which is an increase from 30% in the 2 years from January 2020-December 2021. The teams believe this increase is due to issues with patient flow.

[124] The driver for outliers is that demand is outstripping capacity. MPH has 4 step down stroke beds on the neighbouring ward which is the first stage of the escalation; these are manged by the stroke consultant and specialist nurses and therapy team, but are nursed by the existing ward staff. The patients that go into these beds are either more stable, or have a plan in place and are awaiting transfer to the stroke community unit or ESD . All stroke patients are aimed to be repatriated to the stroke unit as soon as possible.

[125] SFT data for April 2021 -March 2022 show 32% of stroke patients (229) were initially admitted somewhere other than the Stroke Unit, which is an increase from 18% in the 2 years from January 2020-December 2021. The teams believe this increase is due to issues with patient flow.

Workforce

6.66 Merger alone will not solve the profound workforce issues our stroke services face. However, it will enable us to make changes which improve the position, and move us towards our aim of creating a great stroke service in Somerset where staff enjoy their work and are supported to deliver high quality care.

6.67 Merger will allow us to consolidate our workforce into a single team and apply the single team's resources flexibly. For example we aim to be able to provide Consultant level specialist opinion 24/7 via an out-of-hours stroke on-call rota for all stroke patients in the county not just those requiring complex decision-making or thrombolysis decisions (as is currently the case).

6.68 During Covid the teams built trust as colleagues helped each other. For example SFT's clinical specialist occupational therapist supported junior occupational therapists at YDHFT when the senior YDHFT occupational therapist was on maternity leave during the pandemic. YDHFT also brought complex cases to the complex cases MDT for community patients. The rapid roll-out of Microsoft Teams assisted this close working by enabling virtual support between the teams.

6.69 Working as a single county-wide stroke service we will be better able to engage with primary care and support GPs to tackle risk factors for stroke such as undiagnosed atrial fibrillation, high blood pressure and diabetes. This will help us address rising demand because up to 90% of stroke cases are preventable by improving key risk factor management.[126]

6.70 Combining the teams will improve the efficiency of transfers between acute and community settings and support continuity of care. This will serve our second aim on high quality care, and our fifth clinical aim on personalised care.

6.71 As part of their integration, the two teams are carrying out a workforce review of the combined team to look at how we can use our combined resources more effectively. The review will ensure colleagues are working at the top of their licence[127] and that rotational posts are in place across the different sites within the service. Rotational posts, particularly for band 5 and band 6 therapists, will help plug some current staffing gaps. They will also help improve therapists' understanding of the whole patient pathway and therefore improve the care they provide. The implementation of rotational posts will be enabled by the consistent ways of working and shared governance and management which will come from merging.

6.72 The workforce review will also explore changes to ways of working, for example the county-wide use of consultant stroke nurses in the acute units, and optimising the use

[126] B0850-RightCare-Stroke-Toolkit_July-2022.pdf (england.nhs.uk)

[127] Examples of a colleague working at the top of their licence would be a clinical nurse specialist making an independent decision to thrombolyse a patient, prescribe medication or clerk in a patient.

of advanced clinical practitioners, stroke practitioners, and specialist stroke nurses and AHPs who currently do similar but slightly different roles. This will help us focus consultant time on the most complex work, and distribute other tasks to other skilled members in the team, including carving out time to implement transformational change which benefits patients now and in the future. We can then align our training offer to support the right people in the right posts. Plans are also in place to employ physician's associates in stroke medicine to support the team.

6.73 Combining our teams strengthens the options we have to cover staffing gaps – by thinking creatively about which specialist does which job, and this in turn will increase team resilience and improve patient care. This will serve our second clinical aim on high quality care. Consolidating our workforce will also help us get closer to meeting national recommended staffing levels.

6.74 The merged team will offer increased opportunities for professional development and career progression, and will aid succession planning. As one team we will be able to secure efficiencies from developing and implementing a single training strategy across the combined team, which will be in line with the national Stroke Specific Education Framework. As a combined team we will be able to make a more attractive offer to existing and potential new staff, which will contribute to the provision of high-quality care that meets national requirements.

6.75 To continue to build trust and ensure concerns and fears about change are aired and worked through the teams have done the following:

- All clinical, managerial and administrative stroke leads from both Trusts (and across the whole pathway) met in May 2022 at a neutral site for an engagement day to discuss what is working well, what the issues are and what the vision should be moving forward. A key element of this day was to discuss the post-acute part of the stroke pathway (the hyperacute and acute phases have recently been mapped as part of the ICS-led project). The group agreed their vision, identified work that needs to be undertaken to achieve the vision and people stepped forward to lead the work. Risks, issues and colleague concerns were heard and acknowledged.
- Operational and clinical leads from both Trusts meet weekly as a steering group to develop the integration programme of work and to progress this alongside maintaining safe clinical services in the face of ongoing capacity challenges. Specific regular meetings are held to manage the fragility of the position regarding YDHFT stroke consultant cover.
- Acknowledging the potential impact of changes on colleagues, the stroke leads have asked the Trusts' organisational development team to support the stroke teams as they take forward their integration.
- Extensive engagement with colleagues, service users and the public is also underway as part of the review of hyper acute stroke and TIA provision in the county.

Systems and processes

Pathways and processes

6.76 The teams will redesign the stroke pathway by taking best practice from the two Trusts and elsewhere. They will also ensure the new integrated stroke pathway is in line with the National Stroke Service Model, the national service model for integrated community stroke services[128] and the emerging model from the review of Somerset's stroke service see paragraph 6.22. We will also ensure that we understand and minimise the impact of our planned changes on the patients we serve who live in Dorset.

6.77 A single integrated stroke care pathway will improve timely access to care, further reduce length of stay on acute and community stroke rehabilitation units and improve patient experience. The combined team will work to a single waiting list and be able to optimise use of the stroke beds county-wide. Colleagues will have a better understanding of the whole patient journey and be able to provide smoother and more tailored care for patients.

6.78 Being one Trust will remove the administration associated with inter-site transfers, and discharge from one Trust and admission to the other. This is the case, for example, for patients who transfer from YDH acute stroke unit to SFT's community stroke service (see Figure 41).

6.79 Standard pathways and protocols will contribute to equity across the county, and make it easier for colleagues to cover for each other during staff absence and support continuity of care. This helps serve our fourth clinical aim around equity.

6.80 Merger will facilitate this work because although some pathway redesign took place pre-Covid, the work to redesign and implement a new pathway will be easier when we are one team rather than two. In addition, key decisions about HASU and TIA care in Somerset have yet to be made, but with a single stroke team we will be better placed to implement the outcome of the Somerset HASU review (whatever that outcome is), and ensure a smooth transition (if one is needed) which does not impair patient care.

6.81 As we review our pathways (including end of life and catastrophic stroke pathways), we will take the opportunity to harness technology to support the provision of remote expert care, for example to support virtual follow-up reviews and blood pressure monitoring at home. We will also build on the use of digital technologies which were implemented during Covid (see paragraph 6.32).

[128] NHS England. *National service model for an integrated community stroke service.* 2022. https://www.england.nhs.uk/wp-content/uploads/2022/02/stroke-integrated-community-service-february-2022.pdf. [Accessed 27th July 2022].

6.82 Our pathways changes will benefit the whole stroke patient cohort of around 1,100-1,400 patients a year.[129]

Impact on people living with disability as a result of stroke

6.83 In 2017/18, there were 13,335 people[130] living in Somerset diagnosed as having had a stroke, although the actual figure may be higher; many of these people will be living with a disability which creates a burden not only on those individuals and their families but on health and social care providers too.

6.84 By making pathway changes that improve rapid and equitable access to stroke interventions, we also have an opportunity to reduce the impact of long-term disability both in terms of wellbeing and financial cost. Although these impacts largely do not fall on the Trusts, they are shouldered by our patients and their families, and the local public and voluntary sector. In this way our planned changes will help deliver the ambition of the NHS Long Term Plan to reduce the burden stroke places on families and carers and on the health and social care system.

Digital integration

6.85 The unified Electronic Health Record which, subject to the necessary approvals will be in place by 2025/26, will increase efficiency especially around transfers between stroke settings. It will also improve patient safety by reducing transcription errors.

6.86 Being one Trust with one data system will save time spent collating and reporting data for national purposes e.g. ISDN,[131] and SSNAP data sets. Merger will also allow us to review and consolidate the resources devoted to SSNAP data entry and the production of reports, thereby freeing up clinical time for front line care, especially at MPH.

Stroke education programmes

6.87 Merger offers the opportunity to review our stroke education and support programmes to consider what stroke education should be offered, where, and by whom in order to create a comprehensive and equitable offer for stroke patients in Somerset.

6.88 We want to ensure patients have access to an evidence-based, person-centred range of programmes which empowers them to live well after a stroke and supports their families, see **Figure 42**. We will focus more on working in partnership with the third

[129] The estimate is based on the number of people in Somerset who attended hospital for a stroke. In 2019/20 this was 1,430. Figures for 2021/22 showed 1,130 people were admitted for a stroke; the fall between 2019/20 and 2021/22 is believed to be related to Covid – e.g. fewer people coming forward to seek medical help following a TIA.

[130] Circulatory Diseases - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations

[131] Integrated Stroke Delivery Networks

sector (both stroke and non-stroke specific third sector providers[132]). The new offer will be in line with the stroke specifications from the NHSE central policy unit.

6.89 We will work with third sector partners to meet individuals' needs and provide people with a choice about where they attend programmes (including non-medical venues). We also want to make sure healthcare workers are not doing the work that others are better placed to deliver. We will facilitate peer-to-peer connections and provide online support for people who prefer not to attend groups. We also want to support more of this work to take place in community rather than acute settings, which will support our third clinical aim of care closer to home.

6.90 When we are a combined team, we will have increased capacity to take forward this work, by removing duplicate tasks. It will also be easier for third sector organisations to engage with us when we are one trust rather than two, with a single set of county-wide pathways. This will help not only the provision of stroke education, but will also help social care and third sector organisations who support people after they have been discharged from our care (see paragraph 6.84).

6.91 This work supports our first clinical strategy aim around prevention and self-management, our third aim around equitable care, and also our fifth aim around tailored care. Changes to our stroke education programmes will benefit around 1,100-1,400 patients a year.[133] In addition, we estimate that our improvements to carer support would benefit 700-800 carers a year.

Figure 42: Patient story – Freda and Maisie

Patient story: Freda and Maisie

Now

Freda and Maisie live in Somerset, and both had a stroke in 2019.

Freda

Freda is 72 and enjoys gardening at her home in Porlock, west Somerset where she lives with her husband, Peter. Freda had a stroke in February 2019 and while she was being cared for on SFT's Acute Stroke Unit, Freda's husband attended SFT's family/carer stroke support group. The group helped Peter understand what had happened to his wife, particularly regarding her aphasia (difficulties with speaking and understanding others). He was also able to meet other relatives in the same situation which brought him comfort.

When she left the ASU, the early supported discharge team gave Freda rehabilitation support to help her regain her independence at home. However, Freda felt less confident talking to people outside the house.

The stroke co-ordinator directed her to the local stroke club. Freda enjoyed the social aspect of the stroke club and hearing from others about how they had overcome difficulties.

[132] E.g. Stroke Association, Different Strokes independent stroke clubs, Age UK, Somerset Activity Sports Partnership and other local community groups.

[133] The estimate is based on the number of people in Somerset who attended hospital for a stroke. In 2019/20 this was 1,430. Figures for 2021/22 showed 1,130 people were admitted for a stroke; the fall between 2019/20 and 2021/22 is believed to be related to Covid – e.g. fewer people coming forward to seek medical help following a TIA.

However, stroke-specific communication groups were not available locally which meant she was reliant on her husband to help her communicate with others.

Maisie

Maisie is 70 and a widow who lives in Martock, south Somerset. Maisie had a stroke in July 2019 and was treated at YDH. After discharge from hospital, Maisie was invited to join YDHFT's 12-week ASPIRE programme. On the programme Maisie learnt how to reduce her risk of a further stroke and she regained her confidence in doing physical activity. However, as she lives alone and was unable to drive, Masie was reliant on friends or patient transport to get to YDH where the programme takes place. On two occasions patient transport was not available due to service pressures which meant she was unable to attend all 12 sessions - she missed out on sessions about managing her medicines and diet advice. On other occasions she had to fit around her friends' schedules and was dropped off an hour before the appointment and had to wait a long time for her ride home which lengthened her day and was exhausting.

Post merger

We will have an equitable county-wide support service run in conjunction with third sector providers which offers face-to-face and virtual education and peer support for people who have had a stroke.

Freda

Alongside the local stroke club, Freda is also signposted to a local 'talking café' which she attends with her husband. At this group Freda is able to practice the communication techniques she learnt during rehabilitation, and rebuild her confidence in talking to strangers. She eventually becomes a volunteer at the stroke club and is able to share her experience with others who have had a stroke.

Freda's husband is directed to a local carer's group for ongoing peer support. Freda is also signposted to a local gardening group run for people who have had a stroke. This makes her feel there is life after stroke and gives her hope for the future.

Maisie

Maisie is invited to attend a stroke education and peer-support programme at South Petherton community hospital which is closer to her home. Although she is still reliant on friends and local hospital transportation to get to and from the sessions, the distance is shorter so she is less exhausted. This enables Maisie to join every session of the programme, so she gets the maximum benefit.

Maisie meets people who attend the local walking group which gives her the confidence to go along, and this has helped to improve her mobility and mood.

Improved use of our physical capacity

6.92 As a merged trust we will be able to explore increased use of the 13 community hospitals to deliver elements of the revised patient education programme, for example by providing guidance on how to manage blood pressure or diabetes in order to prevent a further stroke.

6.93 For example, in July 2022, with the signal of merger, the ESD/CST teams increased the number of face to face clinics taking place at community hospitals; these now take place at South Petherton, Bridgwater, Williton and Shepton Mallet community hospitals. Patients who might suit a clinic are identified by staff in the ESD/CST teams.

Patient feedback indicates that people like the opportunity to come out of the home, and the treatment they receive is appropriate in this setting.

6.94 This work aligns with our vision for the use of community hospitals (see Full Business Case, chapter 5). This will relieve pressure on highly sought-after space at the two acute sites, and serves our third clinical strategy aim of providing care closer to home.

Patient benefits

6.95 **Figure 43** below summarises the patient benefits from integrating the stroke teams.

Figure 43: Patient benefits - Stroke

Planned change	More time to live well	
	More time in good health	Making every minute count
Combined workforce	• Quicker access to specialist care (including access to specialists out of hours, and rehabilitation support) leading to improved outcomes	• Colleagues will spend more time working at the top of their licence, thereby optimising the care we provide • Increased colleague capacity to implement changes which benefit patients • Doing things only once – e.g. training provision, national data reporting etc which frees up time for front line care
Single set of pathways & processes, and single electronic patient record	• Quicker access to care leading to improved functional and quality outcomes • Greater equity of access to care regardless of where patient lives • Improved patient safety from clinicians having ready access to patients' full clinical record	• Shorter length of stay from quicker access to specialist care • Improved patient and carer experience from streamlined pathway • Quicker inter-site transfers e.g. YDH acute to community stroke team • Greater efficiency and reduced risk of confusion from single set of protocols and pathways.
Combined patient and carer education and support programmes	• Equity of care leading to improved health outcomes • Care tailored to individuals' needs • Increased patient (and carer) confidence to self-manage from access to appropriate support programmes	• Healthcare workers' time focused on what only they can do (rather than taking on tasks better done by others)
Improved use of physical capacity	• Rehabilitation support less likely to be stood down thereby retaining services for patients	• More care provided closer to home so less travel and inconvenience for patients

How merger facilitates planned changes

6.96 Discussions about a shared stroke service in Somerset have been ongoing for some years[134] and pre-date our planned merger. However, historically there has been some scepticism about whether the teams would ever actually come together.

6.97 The announcement of the planned merger has given a strong and clear signal of intent that this time things are different. Creating a single team within one Trust is much easier than trying to create a simulacrum of a single team spread across two Trusts, (which previous efforts sought to do). The work will also be aided by the collective corporate intent to merge the organisations, which was not present during previous attempts to bring the stroke teams together.

Benefits Indicators

6.98 **Figure 44** below sets out the indicators we propose to use to measure achievement of the expected benefits.

6.99 To minimise the burden on colleagues, we will use data already collected to assess our integration progress. These indicators either come from SSNAP indicators (which are nationally collected because they benefit patients) or are locally collected data sets for which there is evidence of patient benefit e.g. access to life after stroke education programmes.[135] These measures include an outcome measure in the form of a self-assessed, health-related, quality of life questionnaire given to stroke patients, which has recently been added to the SSNAP dataset.[136]

Figure 44: benefits indicators - stroke

Indicator	Source	Baseline	Target
Therapy intensity in acute setting (SSNAP rating)	SSNAP data	June 2022 Physiotherapy (YDH: C SFT: C) Occupational Therapy (YDH: B SFT: B) Speech & Language Therapy (YDH: D SFT: C)	B level SSNAP rating across all disciplines by March 2024 A level SSNAP rating across all disciplines by March 2025

[134] Discussions relate at least back to 2016 with the publication: Bigger, better, faster? - An options appraisal for the reconfiguration of emergency heart attack and stroke services for the South West of England, by the South West Cardiovascular Strategic Clinical Network April 2016.

[135] 2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx (strokeaudit.org) page 113

[136] The EQ-5D-5L questionnaire measures self-assessed quality of life on a 5-component scale including mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.

Therapy intensity in community service (minutes)***	SSNAP data (mean minutes)	June 2022 Physiotherapy: 14.7 mins OT: 10.5 mins SLT: 10 mins Psychology: 4.1 mins	<u>Physiotherapy</u>: 17.5 minutes per day by March 2024 20 minutes per day by March 2025 <u>OT</u>: 13 minutes per day by March 2024 15.5 minutes per day by March 2025 <u>SLT:</u> 12.5 minutes per day by March 2024 15 minutes per day by March 2025 <u>Psychology:</u> 6.5 minutes per day by March 2024 9 minutes per day by March 2025
Length of stay – acute**	SSNAP data (median days)	Jan-Jun 2022 YDH: 6.8 days MPH: 8.5 days	Median LOS MPH 8 days by March 2024 Median LOS MPH and YDH 6 days by March 2025
Length of stay – Stroke rehabilitation units**	SSNAP (median days)	Jan--Jun 2022 44.5 days	Median LOS 40 days by March 2024 Median LOS 35 days by March 2025
% patients access to education programme	Local data	4%	50% by March 2024 90% by March 2025
% carers access to education programme	Local data	0%	50% by March 2024 90% by March 2025
Overall SSNAP rating – bed based care	National SSNAP data set	June 2022: SFT: Acute: C SFT: SRUs: C YDH: Acute: D	B rating across bed-based locations by March 2024 A rating across bed-based locations by March 2025
% patients with improved mRS of the EQ-5D-5L at 6 month	SSNAP data	*New data set* *Need to establish baseline*	Statistical improvement in EQ5D-5L score by March 2025 10% increase in patients showing improved mRS by 6 months by March 2024 20% increase in patients showing improved mRS by 6 months by March 2025

* All targets are subject to realisation of efficiencies with additional resource secured via approved business cases as required.

** Length of stay targets are subject to influence by the availability of adult social care provision. Stroke services will work with colleagues across the ICS for innovative solutions to care crisis.

*** Increase in therapy intensity will depend on ability to increase community staffing resource.

Implementation plans

6.100 Work was progressing on the integration of the SFT acute and community teams (following the merger of SPFT and TSFT in 2020) when the proposed merger with YDHFT was announced. The teams wanted to make plans mindful of the second proposed merger to avoid doing things twice. Although the pandemic temporarily diverted attention away from stroke service integration, this work is now resuming. There has also been a change in the management of the stroke services and other clinical staff within both organisations which has meant integration has needed a reset. This reset was initiated in May 2022 with the engagement day (see paragraph 6.75).

6.101 The Trusts have now appointed a single clinical lead to work across both organisations to lead the hyper acute stroke transformation work and inform work on the wider county-wide pathway. In addition, each organisation has nominated a consultant lead who has oversight of operational delivery at each Trust. Further work is needed to determine the single leadership team for the service, develop the county-wide pathway, and plan the transition to the new arrangements.

6.102 The steering group has identified nine workstreams which each has a lead. These are:

- Clinical pathways
- Workforce
- Leadership and culture
- Service users' voice
- Governance
- Training and education
- Digital
- Finance, and
- Estates

6.103 The stroke steering group is defining the scope of the workstreams and has set a timeline for coming together. The teams are prioritising service improvement projects prior to merger, and they expect to complete their transition to a single team and governance structure post-merger. A project manager from the Trusts' improvement team is assisting in the development of a robust programme plan and progress reporting. The latest draft of the stroke integration plan is provided as a supporting submission to this Case.

6.104 Examples of work that has been undertaken already within the workstreams are as follows:

- A full review of stroke medical staffing has been carried and this has resulted in a business case being developed to respond to rising demand.

- Teams have developed a proposal for a temporary reconfiguration of the community stroke beds in line with staffing capacity at the two sites (South Petherton and Williton) to provide equity of care in both rehabilitation units.
- A review of stroke education programmes has begun.
- In recognition of the significant amount of work needed for the full integration of all services the stroke, neurology and neuro-rehabilitation services have come together to look at pathway mapping and establishing a combined training strategy across these services as there is significant overlap. This links in with the ICS's ongoing reviews of stroke and neuro-rehabilitation provision.

6.105 Alongside the stroke steering group, the Trust-wide Clinical Service Integration Leadership Group will also have oversight of the integration of stroke services.

7. Peri-operative care

Summary

Risk factors for poor outcomes after surgery include older age, multi-morbidity and the effects of lifestyle, such as physical inactivity, smoking or alcohol intake. One in five people experience complications after surgery,[137] and the risk of this happening is more closely correlated to the individual's condition before they came into hospital rather than the specific surgery they have.[138]

Peri-operative care is the comprehensive management of patients before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up.[139] The benefits of peri-operative care include quicker recovery, fewer complications post-surgery, better patient experience and lasting lifestyle improvements. Effective peri-operative care also plays an important role in helping us address the Covid-related elective backlog.

Neither Trust has a peri-operative service, but each has relevant skills to bring to the creation of a county-wide approach to peri-operative care. YDHFT has existing anaemia and substance misuse services, and SFT has allocated senior clinical time (a Consultant Anaesthetist) and improvement expertise.

With the signal of merger the Trusts' surgery/planned care teams have identified 14 workstreams which will help us turn passive surgical waiting lists into active preparation time, during which we will support people to optimise their physical and mental health prior to surgery.

Working together to create a single county-wide approach enables us to capitalise on our respective strengths, implement more quickly, ensure equity of care across the county, and pursue a greater level of ambition than we could as separate Trusts. Creating a single approach also allows us to secure economies of scale, and build a resilient service which has more effective links with partners.

Merger helps us create a single county-wide approach because it removes barriers that would otherwise hamper this work. The prospect of merger means:

- The nascent peri-operative programme has a higher profile and has attracted resources from both Trusts
- We are all on the same team which speeds up decision-making
- There is a single set of elective pathways, single line management, and a single set of budgets which all make it easier to implement a county-wide approach to peri-operative care.

A peri-operative care steering group oversees the programme. Key next steps include determining the operational model for the county-wide approach based on the results of our tests of change, and agreeing the governance arrangements.

[137] Ghaferi AA, Birkmeyer JD, Dimick JB. Variation in hospital mortality associated with inpatient surgery. New England Journal of Medicine 2009;361(14):1368-75.

[138] Story, D.A., Leslie, K., Myles, P.S., Fink, M., Poustie, S.J., Forbes, A., Yap, S., Beavis, V., Kerridge, R. and (2010), Complications and mortality in older surgical patients in Australia and New Zealand (the REASON study): a multicentre, prospective, observational study. Anaesthesia, 65: 1022-1030. https://doi.org/10.1111/j.1365-2044.2010.06478.x

[139] Overview | Perioperative care in adults | Guidance | NICE or What is Perioperative Care? | Centre for Perioperative Care (cpoc.org.uk)

Introduction

7.1 The risk factors for surgery include older age, multi-morbidity and the effects of lifestyle, such as physical inactivity, smoking or alcohol intake.[140] One in five people experience complications after surgery,[141] and the risk of these happening is more closely correlated to the individual's condition before they came into hospital rather than the specific surgery itself.[142]

7.2 Peri-operative care focuses on providing multidisciplinary, patient-centred care before, during and after surgery, from the moment surgery is contemplated right through to recovery and long-term follow-up. Peri-operative care is appropriate for all patients who are waiting for an operation or procedure performed under general anaesthetic.

7.3 NICE guidance (2020) advises that clinicians work with individual patients to identify their risk factors early and proactively manage them as part of the surgical pathway.[143] NICE also advises that the risks and benefits of surgery and the impact of lifestyle modification are clearly discussed with patients. [144]

7.4 The benefits of effective peri-operative care include quicker recovery, fewer complications post-surgery, better patient experience, and lasting lifestyle improvements. The Centre for Perioperative Care notes examples where optimising co-morbidities prior to surgery has reduced complication rates by 50%.[145] Consideration of surgery can also be a 'teachable moment', where people are more receptive to lifestyle changes that will improve their longer-term health trajectory.

7.5 Alongside the benefits to individual patients, effective peri-operative care also helps reduce waiting lists. This is because people for whom the identified risks are considered too high will not be listed for surgery, and some other people (who see a significant improvement in their health during the pre-operative period) may not need surgery at all.[146] Reducing waiting lists leads to quicker access to surgery for those who remain on the list.

7.6 In line with the national picture, YDHFT and SFT have seen elective waiting lists rise as a result of the Covid pandemic. Between March 2020 and May 2022, SFT's elective

140 Loogman, L, de Nes, LCF, Heil, TC, Kok, DEG, Winkels, RM, Kampman, E, de Wilt, JHW, van Duijnhoven, FJB, COLON Collaborative, COLON Collaborators and Affiliations Collaborators. The association between modifiable lifestyle factors and postoperative complications of elective surgery in patients with colorectal cancer. Diseases of the Colon & Rectum. 2021;64(11):1342-1353. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8492187/pdf/dcr-64-1342.pdf.

141 Ghaferi AA, Birkmeyer JD, Dimick JB. Variation in hospital mortality associated with inpatient surgery. New England Journal of Medicine 2009;361(14):1368-75.

142 Story, D.A., Leslie, K., Myles, P.S., Fink, M., Poustie, S.J., Forbes, A., Yap, S., Beavis, V., Kerridge, R. and (2010), Complications and mortality in older surgical patients in Australia and New Zealand (the REASON study): a multicentre, prospective, observational study. Anaesthesia, 65: 1022-1030. https://doi.org/10.1111/j.1365-2044.2010.06478.x

143 Perioperative care in adults (nice.org.uk)

144 Ibid.

145 https://cpoc.org.uk/sites/cpoc/files/documents/2019-11/Integrated%20Care%20Systems%202019.pdf (page 17/18)

146 For example, an obese patient listed for a knee replacement may no longer need the knee replacement if they lose a significant amount of weight.

waiting list increased in size by 38.1%.[147] For the period May 2020 to May 2022 YDHFT's elective waiting list increased 16.7%.[148] Implementing effective peri-operative care is not only the right thing to do for individual patients awaiting surgery, it is also an essential part of our work to deliver elective recovery.

7.7 Peri-operative care is an important adjunct to our other merger work as it helps services make best use of their combined elective resources. A single approach to peri-operative care will help clinical services respond to rising demand by contributing to a shorter average length of stay (a clear peri-operative pathway delivers on average a 2-day reduction in hospital stay[149]), lower acuity post-surgery and, in some cases, it removes the need for surgery altogether.

7.8 The main focus of the work described in this case study is care prior to surgery, as our teams believe this offers the greatest potential for patient gains and they have therefore prioritised it. We already have well-established improvement work at SFT around the period of an operation itself and immediate recovery while in hospital. We will move to consider care in the post-hospital phase once the work described in this case study has moved to implementation phase.

Current provision

Current pre-operative assessment

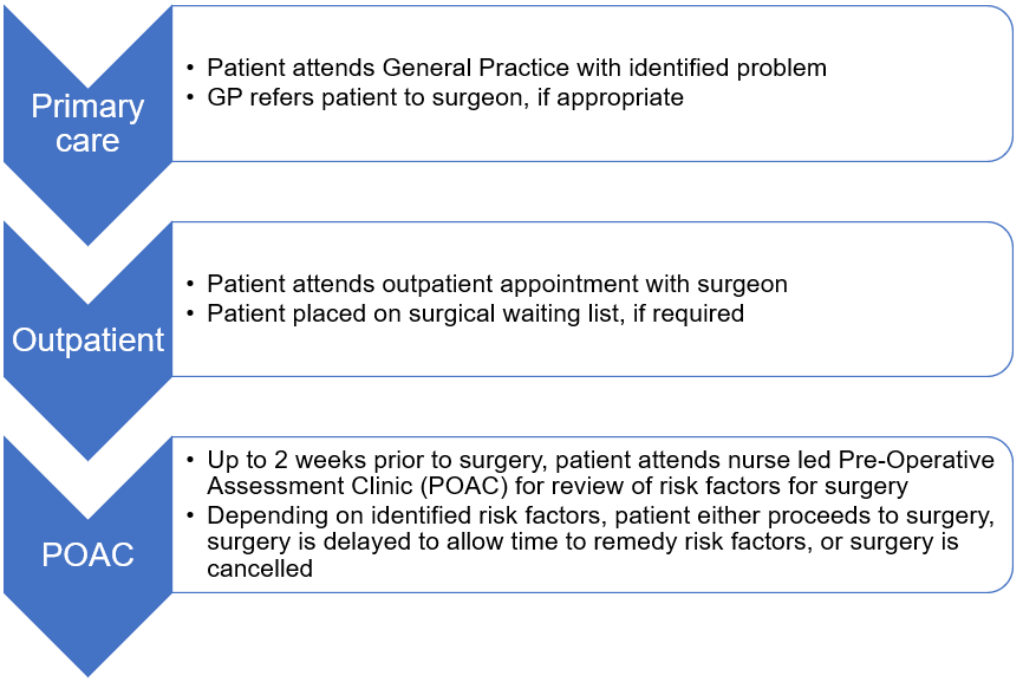
7.9 The pre-surgery pathways currently in place at YDHFT and SFT follow the traditional high level model: from GP referral to surgeon, listing for surgery, and a pre-operative assessment shortly before surgery, see **Figure 45**. This approach is reactive, with minimal consideration of a patient's wider physical or mental health at the point at which surgery is first considered. However, each Trust's detailed approaches to pre-operative assessment and care differ - for example YDHFT offers anaemia support but SFT does not.

[147] On 16/3/20, SFT had 5,800 undated patients on its Elective Waiting List, compared to 8,007 (as at 23/5/22) - a 38.1% increase.

[148] On 26/5/20, YDH had 7,058 undated patients on its Elective Waiting List, compared to 8,236 (as at 23/5/22) - a 16.7% increase.

[149] Centre for Perioperative Care. *Impact of perioperative care on healthcare resource use: rapid research review.* Available from: https://cpoc.org.uk/sites/cpoc/files/documents/2020-09/Impact%20of%20perioperative%20care%20-%20rapid%20review%20FINAL%20-%2009092020MW.pdf. [Accessed 19th May 2022].

Figure 45: Current pre-surgery pathway in Somerset



POAC workforce

7.10 The current Pre-Operative Assessment Clinic (POAC) workforce at both Trusts is set out in **Figure 46**. Both teams work closely with anaesthetists, surgeons and GPs. POAC appointments (face-to-face, virtual or by telephone) are with either a pre-surgery assessment sister or a consultant anaesthetist. We are not aware of any national recommendations on the optimal size of a POAC workforce in terms of whole time equivalents (WTE).

Figure 46: POAC workforce as at July 2022

	YDHFT		SFT	
	In post	**Vacancies**	**In post**	**Vacancies**
Manager	1.0	-	1.5	-
Registered Nurses	6.6	-	10.81	-
Healthcare Assistants	2.0	-	4.0	-
Administration staff	3.72	-	3.6	-
Total	**13.32**	**-**	**19.91**	**-**

N.B. All figures are whole time equivalents.

7.11 Under the traditional pre-operative pathway shown in Figure 45, risk factors for surgery e.g. anaemia or diabetes are often not identified until attendance at the pre-operative assessment clinic, which takes place shortly before surgery. In some cases, this means there is insufficient time to take remedial action to address the identified health issues, and the planned surgery has to be rescheduled.[150] This introduces delay and means patients experience greater pain, anxiety and restrictions on their normal activity than they would if their surgery had been able to go ahead as planned.

7.12 Even where underlying health conditions are not present, some people's physical and mental health deteriorates while they wait for surgery such that when their turn for surgery arrives, the operation cannot safely go ahead and has to be rescheduled. This is particularly disappointing for people who have already waited a long time for surgery.

7.13 The need to reschedule surgery is not only bad for patients, it is inefficient and time consuming for the Trusts: dates for operations have to be rescheduled and some theatre slots remain unused if replacement cases cannot be found for late notice cancellations. This was particularly the case during the pandemic when theatre slots went unfilled because potential replacement patients had not had a Covid test in time.

Pre-cursors to a peri-operative approach

7.14 POAC is a service which provides final sign off and preparation of the patient prior to surgery, for example what medications to stop, what the patient should bring to hospital and plans for discharge. It is not set up to put in place optimisation programmes from the point of referral which is what peri-operative care does.

7.15 Neither Trust has yet implemented a peri-operative approach to all its surgical pathways. However, we do have some excellent building blocks in place that we will draw on as we develop the county-wide approach to peri-operative care, and which has been given momentum by the prospect of merger. These include the following:

- **YDHFT anaemia service**: this service offers anaemia support for all elective surgical pathways referred through YDHFT. Currently there is no anaemia service at SFT, but YDHFT's anaemia clinical specialist lead is developing a county-wide model for peri-operative anaemia care.
- **YDHFT alcohol and substance misuse service**: we will build on YDHFT's existing service and expertise to design a county-wide peri-operative care model for patients with alcohol and substance misuse issues. A similar service has

[150] Healthwatch in Somerset noted in 2021 that: 'A large proportion of people told us they had experienced one or more of the following due to waiting for surgery in Somerset: - Their condition had deteriorated. - Their mobility had reduced during their wait, and this had impacted on their ability to carry out everyday tasks. - They had experienced changes in their daily mood.' HWS-RTT-report-Nov2021-finalr.pdf (healthwatchsomerset.co.uk);

recently been given the go-ahead at SFT and will have peri-operative care as part of its remit.

- **SFT leadership resource**: Since September 2021, SFT has allocated 2 PAs a week to Dr Tom Teare, (a consultant anaesthetist) to act as clinical lead for the development of the county-wide approach to peri-operative care (see **Figure 47**, Colleague Story below).
- **SFT improvement expertise**: SFT has allocated improvement advisors, project managers, clinical integration and project coordination colleagues to support the development of the joint peri-operative programme.

Figure 47: Colleague Story, Dr Tom Teare

Colleague story – Dr Tom Teare, consultant anaesthetist at SFT, and Clinical Lead for Transformation of Peri-operative medicine in Somerset

"We're designing our approach to peri-operative care in an integrated, county-wide way from the outset, and have developed relationships across both acute hospitals, mental health services, and community partners including GPs and the voluntary sector. These contain many silos of excellent peri-operative care but are separated by geography and operate in (or support) only one specialty, or one Trust.

To me, the value of the merger is that instead of dual-working - or indeed in some cases unproductive competition - we can bring these disparate elements together to give all our patients the same standard of high-quality care no matter where they live or what surgery they require.

As well as benefitting our patients, the merger also means our staff can support each other by sharing expertise and learning from different settings and services as part of our routine work. I look forward to seeing peri-operative medicine achieve maturity across the county."

Vision

7.16 Both Trusts are committed to developing an effective county-wide approach to peri-operative care. We want to make better use of the time patients spend waiting for surgery and turn passive waiting lists into active preparation time during which we will support them to optimise their physical and mental health. This will help reduce the number of planned surgeries which are postponed because patient ill-health means their surgery cannot proceed. Good peri-operative care will support better patient health outcomes and quicker patient recovery.

7.17 A key element of our vision is to start peri-operative support as close to primary care as possible, so that patient risk factors are identified up front. We want to start the work to optimise the patient for surgery as soon as possible, thereby maximising the window for action. We also want to help patients to 'wait well' for their surgery even when they have no underlying health conditions at the point of referral, and support

shared decision-making between the patient, surgeon and multi-disciplinary team, see **Figure 48**.

Figure 48: Patient Story- Ralph

Patient story – Ralph

Before the peri-operative service is established
Ralph is 84 and visits his GP about a stiff and painful knee. His GP refers Ralph to the OASIS service[151] which in turn refers him on for a surgical opinion. Following an assessment with the surgeon Ralph goes onto SFT's waiting list for surgery for a total knee replacement and waits for a pre-operative assessment clinic (POAC) appointment which takes place in the month before surgery. Ralph has heart failure, type 2 diabetes, rheumatoid arthritis and is overall quite frail.

In the 5 months that Ralph is on the waiting list, his general mobility reduces further and his exercise tolerance and strength diminish. He also feels quite fatigued, with a lack of energy. When he attends his POAC appointment, the team identify that iron deficiency (anaemia) was likely causing his fatigue and lack of energy. Ralph's surgery has to be delayed while he receives intravenous iron to correct the deficiency.

After the peri-operative service is established
In the future, when our anaemia peri-operative care is operating county-wide, Ralph's deficiency will be picked up and corrected at the point he is referred for surgery regardless of where he first presents. This prevents Ralph feeling so fatigued and avoids postponement of his surgery, which means Ralph can get back to doing what he enjoys much sooner.

Progress to date

7.18 In October 2020, SFT formed a working group to develop peri-operative care at SFT. This group gathered data and good practice, and initiated the first test of change for exercise optimisation on the hip and knee replacement pathway. In August 2021, the group was reformed as the peri-operative care steering group, chaired by Dr Tom Teare, as clinical lead. With the signal of merger, the group invited colleagues from YDHFT and Somerset CCG to join, and the group expanded its ambition to focus on creating a county-wide approach to peri-operative care. In February 2022, the first joint meeting of the group agreed its purpose was to:

- support the development of peri-operative care in Somerset by enabling ideas to be tested, and tests of change to be spread
- bring together stakeholders from across the system to influence the shape of peri-operative care in Somerset, and build on existing services and resources
- receive reports from the peri-operative projects and support decisions about their future, and
- drive the development of a peri-operative approach that sits between primary care and secondary care at the start of the surgical pathway.

[151] OASIS: Orthopaedic Assessment Service in Somerset.

7.19 The group meets fortnightly to oversee and coordinate the peri-operative programme, receiving regular reports from the 14 workstreams (see Figure 51). All workstreams have a workstream lead drawn from one of the two Trusts.

7.20 Improvement advisers, a full-time project manager and a project coordinator working 2 days a week are supporting the steering group and the workstream leads, (see **Figure 49**, Jacqui Wilson's Colleague Story below). We are applying the seven steps of improvement methodology to the development of all the peri-operative workstreams. There are around 30 pilots/PDSA analyses underway across the workstreams. The working group uses a programme plan to help monitor progress.

Figure 49: Colleague Story, Jacqui Wilson

Colleague story - Jacqui Wilson, Project Coordinator for Peri-operative programme (employed by SFT)

"I'm the project coordinator for the 14 peri-operative workstreams. I'm excited by the opportunity this work has to change lives. The idea that we can help patients have better outcomes from their surgery, and also make a difference to their overall health and wellbeing is humbling and feels fundamentally the right thing to do.

It's been a fascinating journey for me learning about the existing areas of excellence within YDHFT, SFT, Primary Care, Public Health and voluntary sector services. Knowing the merger is coming has enabled SFT colleagues to embrace and learn from the mature provision already in place at YDHFT, namely the Anaemia and Alcohol/Substance Misuse services.

YDHFT's expertise in peri-operative care combined with SFT's capacity, experience and Quality Improvement support will enable us to quickly and intelligently build an effective system-wide peri-operative approach."

7.21 The peri-operative care programme is currently led by the surgical directorate (SFT) and the Planned Care division (YDHFT) which have set up a series of workshops with ICS and primary care colleagues to develop and agree the operational model for peri-operative care across the county. The ambition is to bring peri-operative interventions close to the GP decision for surgical referral, without creating extra work within primary care. It is anticipated that eventually some of our existing POAC resources, will move closer to primary care to facilitate the implementation of the agreed peri-operative care model. However, work is at an early stage and we are using pilots with selected GP surgeries to test ideas before finalising the model and spreading it (see Figure 53 for an example).

7.22 We are aiming to roll-out peri-operative care into each existing surgical pathway (around 12-15 specialties, the largest of which is Trauma and Orthopaedics) rather than creating a new stand-alone peri-operative service.

7.23 The team has worked with three 'patient voice partners' to help develop the peri-operative programme. These partners all have experience of the surgical pathway either personally or as a carer, and they have helped shape elements of the programme, see **Figure 50**. For example, following feedback from patient voice partners we made changes to a smoking cessation leaflet and an exercise video we produced with Somerset Activity and Sports Partnership (SASP). We are delighted that one of our patient voice partners has now agreed to join the programme steering group. We have also sought feedback from patients as part of each of the PDSA cycles, learning from their experience to inform the next test of change.

Figure 50: Patient voice partner story, Joyce Standring

Joyce Standring, patient voice partner and retired nurse

"I have edited many pieces of literature from leaflets to a policy, and on occasion you have asked my opinion from a patient as well as a professional perspective (as I'm a retired nurse).

During the last few weeks I've helped James (cancer workstream) with his website, introduced Sam (the new lead for the frailty workstream) to the MPH Frailty team as she wanted to know how they worked and what they do so that she would be able to look at the whole of the county.

I'm going to discuss the Talking Therapies workstream with Jacqui (peri-operative project coordinator) to see if there is any way in which I might be of any assistance (I have an advanced diploma in Trauma Management and worked as a volunteer for a Therapy/Counselling charity). And after the last meeting I suggested to Tom Teare the clinical lead that when he was trialling his new policy he used me as a 'guinea pig' before trialling it on actual patients. He thought it was a good idea."

7.24 Digital systems have an important role to play in helping us deliver peri-operative care both in terms of triggering the required interventions and prompting patient actions to self-manage. The team has recently procured the Pathpoint system to help both Trusts' POACs identify patients with surgical risks. We are also an NHSE volunteer site for the 'HOPE' pilot programme - a supported face-to-face and virtual self-management exercise programme for patients on the hip and knee surgical pathway. We also plan to use community resources e.g. Spark iT[152] that supports people to increase their digital literacy, to ensure equity of access to the digital solutions being developed.

Developing plans for single approach to peri-operative care

Workstreams

7.25 Our joint peri-operative care programme has developed from the building blocks already in existence at both Trusts (see paragraph 7.15). The programme team have identified 14 workstreams, see **Figure 51**, all of which have a role to play in turning waiting lists into preparation lists, and optimising people for surgery by targeting their modifiable risk factors. Further detail about the workstreams is set out in **Annex 10**.

[152] Spark iT aims to promote digital inclusion in Somerset and help people to access online health care services through the provision of a free IT helpdesk, 1-2-1 support an a device loan scheme.

7.26 We will ensure our approach to peri-operative care is in line with NICE guidance (2020)[153], guidance from The Royal College of Anaesthetists,[154] and recommendations from the Centre for Perioperative Care[155] and the Perioperative Quality Improvement Programme.[156]

7.27 The 14 workstreams differ in purpose and maturity. Some aim to further develop an existing service (e.g. anaemia), while others focus on developing an entirely new element of peri-operative care (e.g. Digital). In many cases we are seeking to build on what already exists in one or both Trusts, and take learning from our own and others' experience.

Figure 51: 14 Peri-operative programme workstreams

Workstream	Aim	Maturity
Advanced care planning (ACP) and Somerset Treatment escalation plan (STEP)	Offer all patients undergoing surgery an advanced care planning conversation and create a STEP	ACP referral is already in place but the opportunity exists to build this referral into peri-operative care and widen the occasions when an ACP/STEP is offered to people
Alcohol and Substance misuse	Develop a county-wide model of peri-operative care for people with alcohol and substance misuse issues	The alcohol and substance misuse at YDHFT receives some referrals from YDHFT's POAC and provides pre and post surgery assistance to patients listed for surgery with alcohol or substance misuse issues. Next steps is to develop a county-wide model.
Anaemia	Create a county-wide anaemia service with a strong focus on proactive identification and management within surgical pathways, which yields benefits for surgery and also benefits wider health.	Service already exists at YDHFT (see Figure 52)
Cancer pathways	Ensure the pre-habilitation programme for patients requiring surgery for cancer which is currently under development aligns with our peri-operative care ambitions.	Links between the cancer and peri-operative programme have been established and tests of change agreed
Development and digital	Test and implement digital systems to aid understanding of what peri-operative support a patient needs and help advise patient on actions to optimise their health prior to surgery. This workstream also includes cross-cutting elements such as: - support for risk assessment conversations between clinician and patient, and other tools for outpatient appointments (co-developed with surgeons)	Early development

[153] National Institute for Health and Care Excellence (NICE). *Perioperative care in adults: NICE Guideline [NG180].* 2020. https://www.nice.org.uk/guidance/ng180/resources/perioperative-care-in-adults-pdf-66142014963397 [Accessed 1st July 2022].

[154] The Royal College of Anaesthetists. *Perioperative care. The pathway to better surgical care.* 2015. https://www.rcoa.ac.uk/sites/default/files/documents/2019-08/Perioperative%20Medicine%20-%20The%20Pathway%20to%20Better%20Care.pdf. [Accessed 18th August 2022].

[155] Centre for Perioperative Care. Guidelines. https://cpoc.org.uk/guidelines-resources/guidelines [Accessed 18th August 2022].

[156] Perioperative Quality Improvement Programme. https://pqip.org.uk/Content/home [Accessed 18th August 2022].

Workstream	Aim	Maturity
	- embedding data collection into peri-operative care to support continuous improvement	
Diabetes	Identify people with diabetes on a planned surgical pathway and optimise their diabetes prior to surgery	Pilot/testing (see Figure 53)
Emotional support	Optimise patients psychologically prior to surgery, especially those expected to have a long wait	Work is underway to develop the peri-operative role of the existing Somerset-wide Talking Therapies team within surgical pathways, with a pilot in orthopaedics. This will test whether a conversation with the Talking Therapies service immediately following the discussion with the surgeon about possible surgery aids psychological optimisation.
Exercise	Optimise patients physically prior to surgery i.e. improve muscle strength, endurance and cardiovascular capacity	Pilot/testing
Frailty	Improve care of frailer, older people referred for surgery.	Early development - in October 2022 we appointed a frailty nurse with a remit to develop the peri-operative frailty programme for Somerset
Health Coaches	Identify patients on the surgical pathway who would benefit from health coaching to improve their health and wellbeing prior to surgery	Health coaches or similar already exist in some form in the PCNs. The current test of change is about how we identify relevant patients early on and refer them in - currently not all health coaches have a remit to take on this work.
Nutrition	Identify and support patients who need to optimise their nutritional status prior to surgery.	With the exception of specific pathways such as bariatrics there has been limited focus to date on peri-operative dietary care. However, the dietetics teams have recently helped to develop a peri-operative nutrition webinar and have secured funding for a new dietician role to develop peri-operative dietetics care to address this gap.
Pain management for opiate users	Identify patients with existing high opiate usage to help them manage their pain before and after surgery	The existing Somerset pain service operates county-wide. There are relatively few patients with high opiate use, and work to identify the right patients to refer to the Somerset Pain service is at an early stage.
Smoking cessation	Support patients to quit smoking prior to surgery and to continue to refrain post-surgery	Pilot/testing
Weight management	Develop and test a model for peri-operative weight management, which can be rolled out across all Somerset PCNs.	Early development

7.28 Further details about the benefits of peri-operative anaemia and diabetes care are set out in **Figure 52** and **Figure 53**.

Figure 52: Peri-operative anaemia care

Peri-operative anaemia care

Being anaemic (having low haemoglobin) can result in deferral of treatment and surgery, a longer hospital stay and higher risk of re-admission.[157] Recognising and treating anaemia at the earliest opportunity significantly reduces these burdens, and in most cases treatment for anaemia is low risk, highly effective and readily available.

At YDH, the average length of stay for a non-anaemic patient is 2.8 days compared to 10 days for anaemic patients.[158] As at March 2022, 33.4% of all female patients and 37.3% of all males at YDH and MPH were anaemic. YDHFT has found that treating anaemia also reduces re-admissions to hospital by 11.8%.

YDHFT currently runs an anaemia service which seeks to proactively identify anaemia in patients listed for surgery and optimise their condition prior to surgery. With the support of SFT's business planning and Quality Improvement team, we are now jointly designing the future county-wide service and preparing a joint business case so that support and advice from a specialist anaemia nurse is available to all services in the merged Trust as well as GPs in Somerset. The service will ensure patients are fully informed and 'expert' in their condition to help them drive their anaemia care.

Many anaemia patients struggle with the symptoms of iron deficiency for many years in the absence of appropriate blood tests, treatment and monitoring. Educating patients about their anaemia empowers them to maintain their physical health, which in turn also supports good mental health. It also prevents further deterioration and possible inpatient admission. Patient-driven care enables investigations and treatments to be undertaken in a timely and efficient way without the need for the patient to see the GP to secure a referral when their symptoms return e.g. using PIFU for those who require regular iron infusions.

[157] The effect of deficiency anaemia on length of stay and re-admissions is well documented with multiple research and studies worldwide.' Use reference: Kotze A, Carter LA and Scally AJ (2012) Effect of a patient blood management programme on preoperative anaemia, transfusion rate and outcome after primary hip or knee arthroplasty: a quality improvement cycle. British Journal of Anaesthesia 108 (6): 943-52

[158] This relates to all inpatients, not just surgical patients.

Figure 53: Peri-operative diabetes care

Diabetes pilot

11% of MPH patients attending POAC, and 6.6% of YDHFT patients attending POAC have diabetes. Furthermore, 10% of those patients with diabetes across both trusts have had their surgeries deferred due to sub-optimal diabetes control.

The 2020 GIRFT national report for diabetes,[159] noted that up to 20% of all hospital beds in England are occupied by patients with diabetes. According to GIRFT, people with diabetes spend on average c. 3 days longer in hospital post-surgery than those without diabetes.[160]

Pilot

SFT's Diabetes team has recently secured further funding from NHSE to extend its Diabetes pilot project which aims to identify and optimise patients with diabetes who are referred for surgery. This additional funding enables us to increase staff from a 0.6 WTE Band 6 Diabetes Specialist Nurse and 0.46 WTE Band 2 administrative support to 1.2 WTE Band 6 Diabetes Specialist Nurses and 1.0 WTE Band 3 administrative support.

The signal of merger prompted early re-design of this pilot so that it aligned with our ambitions for a county-wide approach to peri-operative care. We are now testing ideas in both the east and west of the county. The pilot is currently running in 4 GP practices in Yeovil, Taunton and Bridgwater with plans to extend the pilot to additional practices in the coming months, with the help of the additional staff.

A national project (IP3D) reported a reduction in length of stay by 1.5 days following support from a Diabetes Specialist nurse and discharge planning.[99] Although our project differs from the IP3D project, - we are starting support at the point of referral for surgery rather than POAC - we are hoping to achieve a comparable length of stay reduction. Canadian research on bariatric patients showed that it may be possible to optimise twice as many patients if support begins at the point of referral rather than later. [100]

This project is led by a specialist Diabetes nurse, who is working with patients and training practice nurses to support patients with diabetes who are referred for surgery. We are using quality improvement (QI) methodology to test the following change ideas:

- an EMIS alert which will flag people with diabetes who are referred for surgery, so practice nurses can provide them with diabetes support
- development of a diabetes pre-operative passport which helps patients monitor and control their diabetes. The passport also advises on blood pressure and lipid management. We are seeking feedback from patients (including the independent patient forum) and clinicians as we develop the passport. The passport is currently paper-based but if the pilot is successful, we will create a digital alternative.
- Process mapping work to ensure all eligible patients are captured by GP practices
- Silver QI methodology is being used to plan the roll-out of diabetes clinics in GP surgeries and to design wider system 'spread'
- Further change ideas include virtual shared clinics, upskilling practice nurses and development of an e-Referral form.

[159] Getting it Right First Time. *Diabetes. GIRFT Programme National Specialty Report.* 2020. https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2022/01/GIRFT-diabetes-report.pdf. [Accessed 18th August 2022].

[160] Getting it Right First Time. *Improving the perioperative pathway for patients with diabetes*. Available from: https://www.gettingitrightfirsttime.co.uk/improving-the-perioperative-pathway-for-patients-with-diabetes/. [Accessed: 29 November 2021].

Why a single approach to peri-operative care is better for patients in Somerset

7.29 We believe we can provide better patient care by working together to create a single county-wide approach to peri-operative care. Working together enables us to pursue an increased level of ambition, capitalise on our respective strengths, implement more quickly, and ensure equity of care across the county. Creating a single approach service also allows us to secure economies of scale, and build a resilient service which has more effective links with partners. More detail is provided in **Figure 54**.

Figure 54: why a single countywide approach to peri-operative care is better than separate services

Factor	Detail
Capitalise on our complementary strengths	The two trusts have complementary strengths to bring to the development of a peri-operative service. For example, YDHFT has expertise in peri-operative support for anaemia and alcohol & substance misuse, while SFT has improvement expertise which we can use to drive through this broad and complex programme (see paragraph 7.15). To create a successful service requires a range of skills, and by drawing on what the Trusts already have, we avoid reinventing the wheel or duplicating effort.
Economies of scale and greater resilience	Pooling our resources means we will create a more resilient service and can secure economies of scale. For example, together we will have a wider range of clinical skills to draw on and a larger team to run the service.
Increased scale of ambition	Coming together enables us to offer a broader range of peri-operative support and pursue increased ambition than we could achieve alone. For example, YDHFT's existing anaemia care service focuses on inpatients. A business case is currently under development to provide anaemia care earlier in the surgical pathway and to extend provision to the west of the county.
Equity across the county	By working together to develop a single approach we can implement a consistent, equitable offer across the county, from which all patients benefit.
Faster pace of implementation	As a combined trust we will be able to implement peri-operative care at a faster pace because we will have a larger team to take the work forward. As one team, everyone will be involved from the start, jointly owning the process and we will be able to talk about learning in real time and spread innovation quickly.
Supports effective partnership working	Peri-operative care depends on effective partnership working with others, including primary care, public health and voluntary sector organisations. It is easier for partners to engage with one trust with a single set of referral pathways and processes, rather than work with two trusts operating different systems (e.g. it is easier for GPs to refer into one set of pathways rather than two). When we are one Trust, partners will not have to split their limited resources between two sides of the county - for example public health can make more efficient use of their smoking cessation budget by working with just one single county-wide approach.

How merger helps the creation of a single approach to peri-operative care

7.30 Without the signal for merger, it is likely that each Trust would have developed its own peri-operative service independently. These services would have developed at different paces, and be built from different starting places (e.g. YDHFT building on its work on anaemia and SFT building on its diabetes work). The end or steady state of each service would likely look different, and patient inequities between the two services would exist. Experience of the development of services prior to the signal of merger suggests that without merger it is likely there would have been a competitive or siloed approach rather than a collaborative, collective aim, which builds on each Trust's current strengths.

7.31 Merger helps us create a single county-wide approach to peri-operative care (with all the benefits that brings as set out in Figure 54) in the following ways:

- **Shared responsibility** The creation of a single countywide approach to peri-operative care is a large transformation programme, and although both Trusts have wanted for a while to develop their own peri-operative care, at directorate level it was too difficult to get off the ground. However, the signal of merger has given the work higher internal priority and profile, and has enabled resources from both Trusts to be freed up to take the programme forward.
- **All on the same team** The prospect of merger has freed us up to identify a single clinical lead and a shared team to take the work forward. If we were pursing a single approach in the absence of merger we would very likely have two clinical leads who would need to seek joint agreement at every step, which would be very time consuming. The prospect of merger has enabled us to put organisational interests to one side and move forward with our shared endeavour at a faster pace than would otherwise be possible.
- **Different pathways** If the Trusts were not merging, different elective pathways would continue to exist across the county which would make it harder to implement a county-wide approach to peri-operative care.
- **Line management** It is more difficult to implement change when colleagues are working in different line management structures. This is especially the case for cross-cutting programmes such as peri-operative care which involve multiple acute services.
- **Budgets** Pooling budgets is harder to do while we are two Trusts, in part because of the associated reporting and accountability requirements. For example, business cases for investment currently have to be approved by both Trusts. Where disagreements arise, this can mean progress slows, or comes to a halt entirely.

How surgical patients will benefit from merger

Benefits of peri-operative care

7.32 As noted in paragraph 7.4, the general benefits of peri-operative care include quicker recovery, fewer complications post-surgery, better patient experience, and lasting lifestyle improvements.

7.33 Effective peri-operative care serves three of our clinical health and care aims:

- Aim 1: peri-operative care helps prevent avoidable illness by reducing complications from surgery and promoting lasting lifestyle improvements
- Aim 2: by diagnosing modifiable risk factors early on, peri-operative care helps to reduce surgical risk. Shared decision-making reduces the risk of regret post-surgery, and increases the likelihood that surgery meets the patient's objectives
- Aim 5: peri-operative care is personalised to the needs of the individual, and seeks to support people to adopt healthier life choices by understanding their individual drivers.

7.34 In Somerset, around 24,850 people[161] a year have an elective procedure, see **Annex 9**. This entire elective surgical cohort has the potential to benefit from peri-operative care because all surgical patients will be impacted by at least one of the 14 workstreams, and the majority of patients are likely to be impacted by more than one.

7.35 The benefits of implementing a peri-operative service in Somerset are set out in **Figure 55** below. These benefits were identified at a series of meetings of the core Peri-operative care group.

Figure 55: Patient benefits – peri-operative care

Key change	Valuing time		Key workstreams
	More time in good health	Making every minute count	
Identify modifiable risk factors early	Patients with undiagnosed conditions e.g. diabetes and anaemia will have their condition picked up more quickly, leading to less time in poor health Patients will have the opportunity to improve their overall health and ensure a quicker recovery post-surgery	Diagnosing health conditions and modifying health behaviours sooner makes it more likely surgery can proceed as planned, rather than being deferred	• Anaemia • Diabetes • Cancer pathways • Digital
Provide support for modifiable risk factors, so patient is optimised for surgery	Reduces safety risk going into surgery and leads to fewer health complications arising from surgery. This is linked to better health outcomes and more time in good health	Shorter length of stay in hospital due to swifter recovery Shorter period with restrictions on normal daily activity Fewer re-admissions to hospital post-surgery	• Advanced care planning • Alcohol & substance misuse • Anaemia • Cancer pathways • Diabetes

[161] Average for years 2016/17 to 2019/20 (i.e. excludes covid years)

	Time spent waiting for surgery is invested in optimising health (e.g. stopping smoking, lowering BMI, or reducing alcohol intake) which for some people will be lasting lifestyle improvements		• Emotional support • Exercise • Frailty • Health coaches • Nutrition • Pain management • Smoking cessation • Weight management
Help people to 'wait well' both physically and emotionally	Time spent waiting for surgery is invested in optimising health (e.g. building muscle strength) and supporting lasting lifestyle improvements (e.g. increasing exercise) Reduced anxiety about ill health and impending surgery from psychological support	Shorter length of stay in hospital due to swifter recovery Shorter period with restrictions on normal activity Fewer re-admissions to hospital post-surgery	• Advanced care planning • Alcohol & substance misuse • Anaemia • Cancer pathways • Diabetes • Emotional support • Exercise • Frailty • Health coaches • Nutrition • Pain management • Smoking cessation • Weight management
Shared, informed decision-making	Ensures patients are full informed about the benefits and risks of surgery, thereby increasing patient empowerment Fewer instances of patient regret post-surgery	Ensures the care provided is aligned with each patient's personal goals, including the decision about whether or not to proceed with surgery Shorter waiting lists (as only those who are ready for surgery will be listed)	• Advanced care planning • Cancer pathways • Digital • Emotional Support • Frailty • Health Coaches

Benefits indicators

7.36 The indicators we will use to show whether the county-wide approach to peri-operative care is delivering the expected benefits are set out in **Figure 56** below.

7.37 Our Trusts are early adopters of the relatively new concept of peri-operative care and hence there is no true benchmarking data available, other than research on peri-operative care implemented by other health systems. We are working with NHSE to help develop guidance around, for example, how effective peri-operative care can aid elective recovery.

Figure 56: benefits indicators – peri-operative care

Indicator	Source	Baseline (October 2022)	Target
Number of patients on surgical pathway who we have identified as having risk factors (prior to POAC)	Pathpoint (in process of being implemented) EMIS / Maxims /Trakcare	50 patients	100 by April 2023
Number of patients identified with risk factors who are	Pathpoint	50 patients	100 by April 2023

referred into appropriate interventions	EMIS / Maxims / EPRO		
Number of patients identified with risk factors who have achieved goals prior to surgery	Pathpoint	zero	200 by November 2023
Number of workstreams with community and VCSE collaboration	Peri-operative steering group	Four	Nine by November 2023
Length of stay (LOS)	Information teams	Elective in-patients, annual average LOS (based on data from 2016/17-2021/22) SFT: 2.67 days YDHFT: 3.88 days	* see note
Number of readmissions	Information teams	Elective inpatients, annual average readmission rate (based on data from 2016/17-2021/22) SFT: 7.25% (301 patients) YDHFT: 10.67% (12 patients)	* see note

*: The peri-operative steering group has not set a target for LOS or re-admissions as it is currently unclear what impact our interventions will have on these indicators (e.g. it is possible as we move more patients from inpatient stays to day cases that LOS increases as we will only have the most complicated patients remaining). We will therefore monitor this data without setting a target until we have a better understanding of potential impact and there are sufficient patients on peri-operative pathways to see an impact.

Future plans

7.38 The POAC teams at both acute sites are aware that POAC will develop into peri-operative care, and the POAC leads at YDHFT and SFT are working out what the merged structure for POAC/peri-op looks like at both sites. It is probable that the existing POAC teams will form part of a coordinating group for peri-operative care, sharing peri-operative expertise and guidance with surgical services and managing links with the PCNs, as well as providing final pre-operative checks as they do now, but this has yet to be decided.

7.39 The programme plan sets out the workstreams, steps and timelines for our peri-operative programme. The current priorities as at October 2022 are:

- Monitor through the steering group the progress and issues within each of the workstreams to ensure development of the peri-operative pre-surgery phase.
- Agree the peri-operative operating model and develop a plan to implement it. This includes determining the role of the existing POAC teams in the leadership and management of peri-operative care, and developing the governance structure for peri-operative care in collaboration with partners in primary care and community partners e.g. SASP.

- Finalise and submit the next phase of the business case (the first phase funded the clinical lead, clinical service manager and project coordinator time, plus the frailty practitioner time).
- Acknowledging that diabetes and anaemia have largest number of patients with greatest benefit from optimisation, develop business cases for long term resourcing as a priority.

7.40 Service level oversight of the programme will continue to sit with the peri-operative care steering group, reporting to the Elective care delivery board within the ICS. The programme team has prepared a peri-operative programme plan which is provided as a supporting submission to this Case.

8. Homeless and rough sleepers

Summary

People experiencing homelessness are often vulnerable and have complex health needs. They can find it harder to access care, and some resist coming to hospital because of a fear or mistrust of authority. The transient nature of this group makes it harder to attend appointments, which can lead to health deterioration and further acute presentations.

SFT runs a community-based intensive, outreach nursing service for people experiencing homelessness who have a physical and/or mental health need. YDHFT has a substance misuse team serving all inpatients and outpatients, and this team specialises in meeting the needs of homeless people as part of their wider roles.

Around 300-400 people in Somerset are affected by homelessness. Although a small cohort, the annual cost of unplanned care for homeless people is eight times that for housed people. Homeless people are also overrepresented amongst frequent attenders at ED.

Effective, targeted care for homeless people means more equitable access to healthcare, and fewer acute physical or mental health needs.

Our teams want to develop a county-wide approach to the care of people experiencing homelessness which focuses on early proactive care to prevent ill health and which reduces the health inequalities this patient group face. It will be delivered, where possible, via outreach, bringing care to people rather than expecting them to attend healthcare settings.

Working together to create a single approach enables us to capitalise on our respective strengths, prevent avoidable admissions and ensure equity of care across the county. Creating a single approach also allows us to create a service which has more effective links with partners.

Merger helps us create a single county-wide approach because it removes barriers that would otherwise hamper our work. Merger enables:

- A single set of pathways which help us roll out consistent county-wide care (including ‘shortcuts’ for some conditions e.g. access to care for deep vein thrombosis or leg ulcers)
- Joined up digital systems (particularly important for the care of a transient population)
- Stronger, consistent links between the outreach team and both acute sites.

Progress is being overseen by a steering group. Next steps include taking forward work on the identified workstreams and building on our work to support other vulnerable groups such as prison leavers.

Introduction

8.1 The underlying causes of homelessness include poverty and deprivation, domestic violence, addiction, trauma, mental illness and discrimination. People experiencing homelessness often have complex physical and mental health needs alongside social care needs that may both contribute to becoming homeless as well as being a consequence of homelessness.

8.2 In England, people affected by homelessness die on average around 30 years younger than the general population.[162] Drug and alcohol disorders are common amongst the homeless population and account for just over a third of all deaths amongst this cohort.[163] Homeless people are also more than nine times more likely to complete suicide than the general population.[164]

8.3 In July 2022, local data indicated that in Somerset there were c. 325 single adults in temporary accommodation (hostel, YMCA, bed & breakfast or sofa surfing etc.) and a further c. 40 people sleeping rough.[165] Although the number of people who are homeless or sleeping rough in Somerset is relatively small, patients in this cohort are often vulnerable and have complex health needs. The annual cost of unscheduled care for homeless patients is eight times that of the housed population, and homeless patients are overrepresented amongst frequent attenders in Emergency Departments (EDs).[166] For this reason, as well as the significant health inequalities outlined above, it is important that we get care right for this group of people.

Current provision for homeless and rough sleepers

8.4 Both Trusts have, until recently, developed their provision for homeless people and rough sleepers separately.

SFT

8.5 SFT has a community-based intensive, targeted outreach nursing team serving homeless people and rough sleepers with a physical or mental health need.[167] The service has a registered nurse and a band 4 support worker for each of the 4

[162] 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]

[163] Ivers J, Zgaga L, O'Dibighue-hynes B, Heary A, Gallwey B, Barry J. Five-year standardised mortality ratios in a cohort of homeless people in Dublin. *BMJ Open* 2019;9:e023010. doi: 10.1136/bmjopen-2018-023010

[164] Thomas B. *Homelessness: A silent killer: A research briefing on mortality amongst homeless people.* Crisis. 2011

[165] It is hard to identify homeless people from patient records alone as individuals often give the name of a hostel or a friend's address.

[166] Hewett N. (ed.) Homeless and inclusion health standards for commissioners and service providers. Faculty for Homeless and Inclusion Health. 2018. https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final.pdf [Accessed 29 July 2022]

[167] The team serves anyone who is living on the street or does not have a permanent home, is living in temporary accommodation (including a hostel or YMCA) or has recently been released from prison. They also support travellers and Gypsies.

'localities' in Somerset.[168] The team is relatively new, having been piloted in 2021 and then made substantive at the beginning of 2022.

8.6 The team offers general health assessments, wound care and dressings, GP registration, vaccinations, mental health first aid and a range of health testing and health promotion on an outreach basis. If a service user needs specialist mental health care the team will refer them to the Neighbourhood specialist mental health team. The team also refers people into other services (including acute services), and coordinates support for more general health needs. All members of the team are safeguarding trained to the top tier and link in with the Trusts' joint safeguarding team when needed.

8.7 The service operates Monday to Friday across the whole county, serving rough sleepers and people in temporary accommodation in the catchment of both acute hospitals. The average caseload as of June 2022 was 187. This represents a 45% rise from the average caseload in April 2022 (129).

8.8 The outreach service has close links with homeless hostels across the county and they attend hostels[169] on a set day at least once a week so homeless people and hostels workers know when healthcare workers will be there. The team also visit places where homeless people tend to stay, and on some visits they are accompanied by colleagues from Somerset County Council's homeless and rough sleepers initiative team, and together they walk local areas talking to rough sleepers to understand their needs, and recording numbers.

8.9 The community outreach team receives direct referrals to its email inbox from a number of sources: the homeless and rough sleepers initiative team at the Council, homeless hostels, YMCA, minor injuries units, GPs, probation, and police. The team also proactively identifies individuals needing help via their drop-in sessions at hostels and attendance at meetings such as the ED high intensity users group, Somerset homeless sub-cell, case review meetings with charities e.g. Home group in Yeovil, Mendip priorities meeting and prison release meetings.

8.10 The team aims to provide accessible, targeted care that recognises and treats mental and physical health needs before they become acute. By working closely with the Council they seek to provide a joined up service focused on addressing the causes and impacts of homelessness. The service fills a gap not covered by other services, see **Figure 57**. The outreach team was recently shortlisted for the Royal Society of Public Health's Health and Wellbeing Awards 2022, in the Health Equity category.

[168] The four 'localities' in Somerset are: Somerset west & Taunton, South Somerset, Mendip, and Sedgemoor. They contain the following PCNs: Somerset west & Taunton (South Taunton, North Taunton, Central Taunton, West Somerset) South Somerset, (South Somerset East, South Somerset West, CLIC, Yeovil), Mendip (East Mendip, West Mendip, Frome), Sedgemoor (Bridgwater and North Sedgemoor).

[169] Homeless hostels in Somerset are run by charities e.g. Shelter, YMCA, Julian House etc.

Figure 57: filling a gap in existing services

Filling a gap in existing services - community outreach team, Karen George

"The feedback that we've received from the other agencies we work alongside has been outstanding – they've told us that our team is joining up the gaps where nursing care wasn't previously being provided.

One example of someone we've recently provided healthcare to was a middle aged gentleman with end stage cancer who was rough sleeping. Due to a multitude of different issues, he was unable to live in the local homeless hostel. Our nurse took healthcare to him on the streets, joined multiple agencies together, and was eventually able to secure him a safe, comfortable place to end his days. This case is one of many our team has on its caseload and has highlighted the complexities of the people we see.

There has been a lot of interest from other areas in the country and I have met, both in person and online, other services who are keen to learn from our experiences."

8.11 SFT has no dedicated substance misuse team, although the Trust has recently recruited three alcohol abuse specialist nurses. SFT currently refers patients with identified drug abuse problems to third sector providers.

YDHFT

8.12 YDHFT has a substance misuse team, operating 9am-5pm Monday-Friday which supports all inpatients and outpatients across YDHFT with alcohol or drug problems. This service developed from a successful pilot run with the assistance of YDHFT's gastroenterology service and then became a substantive team within that service. Shortly after it was created in 2004 the service won the South West Strategic Health award for advances in clinical practice.

8.13 The team's work includes helping to assess and manage people in ED with substance misuse problems, titrating methadone for intravenous drug users and overseeing patients on alcohol detoxification regimes. They support ward staff to manage the complications that substance abuse can cause with some medical conditions, and aid discharge by inputting to patients' support management plans.

8.14 As part of their work, the team specialise in meeting the needs of homeless people within the wider cohort of patients with substance misuse problems that the team serves. The team also links in with SFT's community outreach nursing team to ensure ongoing care for YDHFT patients discharged from YDH and to gather information on admission.

8.15 In 2021, the team had c. 280 contacts with homeless people.[170] Approximately half of these contacts were with patients presenting at YDH's ED and the remainder were referred to the service prior to surgery or other interventions. The YDHFT team also

[170] In 2021, the team saw 934 inpatients with drug or alcohol issues and an additional 252 people in the outpatients clinic.

signpost to other services where appropriate, e.g. to SFT's community mental health team or the council's Housing service.

8.16 YDHFT does not have a separate dedicated homeless team.

Workforce

8.17 **Figure 58** shows the current workforce across the two Trusts working with Homeless people and rough sleepers.

Figure 58: Homelessness & rough sleepers workforce as of July 2022

SFT community outreach nursing team		
	In post	**Vacancies**
Clinical lead (a non-medical prescriber with experience in ED, substance misuse, forensic nursing, and training in dual diagnosis)	1	-
Registered Nurses (with experience in ED, forensic nursing, mental health and safeguarding)	4	-
Band 4 Support Workers (with experience of working with this client group)	4	-
Admin	1	-
Total	**10**	

Notes:
1. All figures are whole time equivalents.
2. Mental health expertise: one of the registered nurses is a mental health nurse by background, and the clinical lead is dual diagnosis trained. The teams are also able to seek specialist support and advice from SFT mental health colleagues and make referrals to them.

YDHFT substance misuse team		
	In post	**Vacancies**
Clinical lead	0.8	-
Specialist Registered Nurses	2.0	-
Total	**2.8**	-

Notes:
1. All figures are whole time equivalents.
2. As a rough estimate the team spend c. 5% of their time with patients who are homeless, as part of the wider cohort of all patients presenting at YDH with substance misuse problems who the team serves.

Challenges

8.18 Colleagues providing care for homeless people in Somerset face a number of challenges, which are set out below.

National standards

8.19 The service provided by SFT's community outreach team is compliant with the relevant NICE guideline.[171] However wider healthcare services in Somerset do not currently

[171] Overview | Integrated health and social care for people experiencing homelessness | Guidance | NICE

meet the Faculty for Homeless and Inclusion Health's 'Homeless and Inclusion Health standards for commissioners and service providers'[172] (which sets minimum standards for planning, commissioning and providing healthcare for homeless and other excluded groups) in terms of the provision of accessible and equitable services for all. This is largely because many services (e.g. dental care, physiotherapy, podiatry, eye care, palliative care and other services) are not currently set up to serve people who lack a fixed address. Further work at system level is needed to address this.

Rising demand

8.20 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.[173] We have seen demand rise in Somerset (see paragraph 8.7) and this places additional pressure on the existing small teams.

Inequity

8.21 The relevant services at both Trusts (i.e. YDHFT's substance misuse team and SFT's community outreach team) have developed independently and this has led to different areas of focus and inequity across the county. For example, the lack of specialist drug abuse support at MPH means homeless people currently admitted sometimes discharge themselves prematurely as they do not always receive support for their addiction while at MPH, (and the YDHFT substance misuse team does not currently have the capacity to help MPH inpatients with substance abuse problems), see **Figure 59**.

8.22 Furthermore, different processes in each acute (e.g. cardiology pathways) make it more challenging for the community outreach team - which works across both Trusts - to operate.

Figure 59: Patient story - Ben

Patient story – Ben

Pre-merger

If Ben is admitted to YDH
Ben is 30, homeless and a heroin user. He is found unconscious and brought into YDH's ED where he is diagnosed with endocarditis and admitted to CCU for a six-week course of intravenous antibiotics.

Because of his heroin use, Ben is seen on arrival by the YDHFT substance misuse team who already know him. The team brief their ED colleagues on Ben's fuller medical history and personal circumstances, which enables quicker development of a comprehensive management plan. The substance misuse team assess his opioid dependency and titrate methadone to his need.

[172] Version-3.1-Standards-2018-Final.pdf (pathway.org.uk)

[173] Homelessness Monitor 2022 | England | Crisis UK

While he is an inpatient, Ben receives a daily dose of methadone and this supports him though his course of antibiotics. The substance misuse team engage with Somerset Drug & Alcohol Service (SDAS)[174] to ensure Ben's methadone prescription continues in the community after he is discharged. The team also hand over Ben's case to the community outreach team who maintain contact with Ben to help him attend his planned outpatient appointments and continue with methadone rather than heroin purchased on the street.

If Ben is admitted to MPH
If Ben is admitted to MPH, there is no substance misuse team to work alongside ED colleagues, and supervise the titration of Ben's methadone, so unless the clinician treating Ben has the expertise to titrate methadone he will not receive it (or may not receive it in a timely way). Without methadone, Ben chooses to discharge himself early so he can access heroin, and he does not complete his course of antibiotics.

Back on the streets, Ben's condition quickly worsens. He becomes acutely unwell again and unresponsive. He is taken back to ED where he re-starts antibiotics, but his prognosis is affected by the repeat infections. Ben is fearful of remaining in hospital as he is not supported to manage his drug dependency and again discharges himself early. The cycle repeats.

Post-merger

Ben will receive support to help manage his addiction regardless of which acute hospital he is admitted to. This support will come from specialists in substance misuse but also from ED and ward staff who understand his particular needs. Ben will also receive support at discharge and beyond to help him attend any follow-up appointments.

Access

8.23 Despite national policy which entitles people without a fixed address to healthcare, homeless people can still find it hard to access care (e.g. to see a GP, or attend an outpatient appointment) for a range of reasons. These include:

- **Lack of knowledge**: some homeless people do not know they are entitled to healthcare without a fixed address
- **Mistrust**: some rough sleepers and homeless people resist seeing a GP or attending hospital because of fear and/or a mistrust of authority. Trusted relationships between client and healthcare professional are essential when supporting this cohort, and when a trusted relationship can be established people are much more likely to accept care either directly or coordinated by the healthcare professional with whom they have a rapport.
- **Means to access care**: poor literacy, lack of transport or a lack of a mobile phone means some homeless people do not have the means to book or attend an appointment or understand healthcare correspondence and literature. Furthermore, in Somerset there is a lack of access to specialist services for substance abuse and homelessness outreach at weekends and out of hours.
- **Transient lifestyle**: The transient nature of this population makes it harder for people to attend outpatient appointments, which can lead to further health deterioration and additional acute presentations.

[174] SDAS is a third sector organisation.

- **Unable to comply**: sometimes homeless people discharge themselves before they are medically fit because they are unable to comply with their treatment within the confines of a hospital setting (see Figure 59).

'Did not attends' (DNAs)

8.24 Although attendance at appointments varied by outpatient service, an analysis of SFT data for January 2019 to September 2020 showed that 40% of the 6,200 appointments booked for homeless people in that period resulted in a DNA.[175] The costs of such non-attendance is significant.[176]

Discharges

8.25 Sometimes colleagues are reluctant to discharge homeless people back on to the street even though they are medically fit, but this disempowers the patient. In other cases, patients are discharged without their particular needs being taken into account, e.g. the need for a safeguarding assessment to be carried out for a vulnerable person at risk of harm from a county lines drugs gang.

Digital systems

8.26 Multiple patient record systems are used across the Somerset system. SFT's ED uses Maxims, but paper notes are used on wards, and ePRO is used for outpatient appointments. YDHFT uses Trakcare and paper notes, and patient letters are stored on Patient Centre. GPs use EMIS to which Trust staff only have read access. SFT's community outreach team uses RiO which is cumbersome for acute colleagues to access (it requires a separate login). Multiple digital systems are time-consuming and in some cases clinicians do not have the time to review all clinical systems before making a decision about patient care (this applies to all clinicians but is especially the case for ED clinicians).

Vision

8.27 The teams want to support the health and care needs of homeless people and rough sleepers in Somerset by ensuring safe and equitable access to neighbourhood services, reducing the inequalities that this client group faces, and working collaboratively with clients and partner organisations to deliver a county-wide approach that promotes coordinated care, see **Figure 60**.

8.28 The teams (SFT's community outreach team and YDHFT's substance misuse team) aim to achieve this by:

[175] Appointments where the patient does not attend

[176] The average cost for an acute service face-to-face outpatient appointment or procedure at MPH in 2021/22 was £136 per attendance. 40% of 6,200 appointments at £136 each = £337,280.

- Providing earlier, proactive interventions which prevent ill health and reduce acute physical and mental health presentations
- Where possible, bringing care to where homeless people are, via outreach, rather than expecting them to attend health care settings
- Providing accessible, targeted care to reduce current health inequalities, and improve health outcomes.

8.29 Bearing in mind many homeless people's fear or mistrust of authority (see paragraph 8.23), our model is one where the community outreach team uses trusted relationships to provide proactive care, with the aim of minimising onward referrals into acute services. Where referrals *are* needed, the outreach team will link in with acute colleagues, support the homeless person, and provide community-based follow-up e.g. taking blood for testing when it is safe to do so.

8.30 Alongside the county-wide community outreach team devoted to the needs of homeless people, a wide range of other services will be involved in the delivery of our vision. The outreach team will lead the county-wide approach to care for homeless people in three ways:

- Providing direct care to homeless people in hostels and community settings, in a manner akin to 'hospital at home'
- Providing support, training and advice to specialist colleagues in acute services on how to respond to the needs of homeless people.
- Coordinating the care provided to homeless people by other colleagues including GPs and acute services.

Figure 60: Colleague story - Karen George

Colleague story – Karen George Clinical lead for the homeless and rough sleepers community outreach team

"Earlier in my career I worked in ED. I also worked for Avon and Somerset Police as a forensic nurse practitioner. More recently I was a member of the substance misuse team in YDHFT, and then in January 2022 I became clinical lead for the SFT community outreach nursing team. I absolutely love it. I feel like my whole nursing career has led to me being here and it just feels right.

My move from YDHFT to SFT was quite smooth. There were little hiccups like mandatory training which doesn't transfer, and the frustration of losing clinical time to repeat that training. When we merge, removing duplications like that will free up more time to care for our patients. The lack of access to patient information because the Trusts have different IT systems has been a real eye-opener for me. Once we've merged, the same processes, governance and IT systems will mean that we can share patient information without the need for honorary contracts for the community teams which will be a real step forward.

Currently there are inequities in the services that are provided by the Trusts. In YDHFT there is a substance misuse team but no similar service in MPH. It's frustrating when a patient who has stabilised on methadone is transferred to MPH and there's no continuity of care. When I was on the YDH team I couldn't just pick up the phone and speak to someone at MPH who understood substance misuse and was on my wavelength. As part of the merger, we're

working to ensure there ***is*** equitable access to specialist care for substance misuse, including for people who don't have a fixed address or who aren't registered with a GP.

I think the merger can only be a positive step. It will mean we have one organisational view, and a single set of priorities and services caring for vulnerable people, which will improve the health of the clients we see. I think it might take a while to get there though because of the difficulties with the multiple digital systems, and because we need to change people's perceptions of how to help this vulnerable group."

Progress to date

8.31 The signal of merger has prompted us to begin to address inconsistent links between the community outreach team and the two acute sites. For example, the YDHFT substance misuse team have already begun handing over inpatients to SFT's community outreach team upon discharge, thereby improving the link between acute and community care in the south and east of the county.

8.32 The community outreach team includes three nurses with ED experience and this has aided the team's close working with the EDs at Yeovil and Taunton. Staff at both EDs now alert the community outreach team if a homeless person attends ED, and they provide the outreach team with a copy of the discharge summary to enable them to proactively follow up with the individual. The community outreach team also attends the regular meetings about high intensity users at each ED. Conversations are in hand to set up similar arrangements with the EDs at RUH Bath and Weston General Hospital.

8.33 The outreach team has worked with ambulatory care teams at both Trusts to enable experienced nurses on the team to refer homeless people with certain conditions (e.g. cellulitis, leg ulcer, suspected deep vein thrombosis or abscess) directly into the Same Day Emergency Care (SDEC) service at SFT or the Ambulatory Emergency Care (AEC) service at YDH without the service user having to be seen by ED or a GP first.

8.34 The outreach team provide support to hospital staff at both YDH and MPH in dealing with homeless patients who display challenging behaviour while on a ward. If needed, the team attend ED with clients to provide information and support, and provide help if there are known behavioural issues. They also help service users attend outpatient appointments which helps to reduce DNAs. A combination of community outreach, diversion to SDEC or AEC, and pro-active follow up helps to reduce ED attendances for this cohort.[177]

8.35 The community outreach team and dual diagnosis team[178] have begun to co-ordinate their days at The Gateway drop-in centre in Yeovil to make mental and physical healthcare for homeless people available as a one-stop-shop. Following early success

[177] The average cost of an ED attendance for a complex patient is £265 per visit.

[178] The dual diagnosis team serves those who have severe mental health problems and drug or alcohol addiction.

of this approach, the community outreach and dual diagnosis teams hope to roll it out to other areas.

8.36 The community outreach team is also starting to expand its work to support other vulnerable groups. For example, it is working with prison release hostels across the county to make sure prison leavers get the healthcare they need, which includes referring people into specialist services at both acute hospitals as required.

Incorporating user feedback into service design

8.37 It is harder to carry out formal co-design with this cohort of patients for a variety of reasons. Nonetheless the outreach team gathers feedback from service users at the time of care or gives service users with a mobile phone a QR code to use to provide feedback. This feedback informs operation of the team and future changes.

Links with system partners

8.38 Our Homeless integration work is linked into wider system work for homeless and rough sleepers. For example, the community outreach clinical lead attends the Somerset Homelessness sub-cell meeting which is the county-wide forum for tackling homelessness. She also sit on working groups (e.g. the Gypsy, Roma and Traveller Working Group) which plan and implement county-wide initiatives targeted at vulnerable groups, and which encompass all public service provision in Somerset, not just healthcare.

8.39 The community outreach team also works with GPs who have allocated time to care for homeless people. There is currently a GP in 3 of the 4 ‘localities’ in Somerset: Yeovil, Taunton, and the Mendip area, each spending between 1-1.5 days a week meeting the needs of local homeless people in their area. This includes attending homeless hostels alongside members of the community outreach team. The fourth locality, Sedgemoor, does not yet have dedicated GP time for care of homeless people although the public health team are looking at options to address this gap.

Developing plans to care for homeless people

8.40 To help deliver our vision of accessible, targeted care for homeless people across the county, the teams have identified five workstreams, which are described below, see **Figure 61.**

Figure 61: workstreams – homelessness

Workstream	Content
Workforce	This workstream will consider the capacity of the community outreach service in light of rising demand and other vulnerable groups whose needs also need to be meet. It will also consider the capacity of colleagues in inpatient settings to support the complex care needs of this cohort. A key priority of this workstream is to look at recruiting additional mental health expertise to the team. As part of this workstream there is a focus on ensuring equitable access for all homeless people who need substance misuse support whether they are inpatients, outpatients or attending an ED/minor injuries unit. In particular we want to make sure specialist care for substance misuse is provided for homeless people in all acute bedded settings in the county, so that SFT inpatients with drug addictions are as well served as YDHFT inpatients currently are. This work will be aided by SFT's recent recruitment of 3 alcohol abuse specialist nurses who will work with colleagues to bring learning from YDHFT's case management approach into MPH and other bedded settings. Although these specialist nurses have initially been recruited to help care for people with alcohol addiction, they will move to incorporate drug misuse into their portfolio in a phased way over time.
Our approach	Homelessness is not a health condition but people who are homeless can experience a wide range of healthcare needs. This cohort therefore needs support to access a wide range of acute and other services. Many of the existing pathways currently differ between the Trusts. This workstream is about agreeing a single set of pathways for care of rough sleepers and homeless people, and ensuring they can access the right care whatever the setting. Elements of this workstream include: • developing solutions to the challenges around booking outpatient appointments for people with no fixed address • agreeing a smoother, single discharge approach across both acutes which supports both patients and staff. This will be achieved through better links between ward staff and the community outreach team, in particular by ensuring that discharge letters for patients with no fixed address are shared with the community outreach team. • further developing the care provided in the community, including support to homeless people to attend follow-up appointments. • ensuring equity of provision by working with emergency departments not just at YDH and MPH, but also RUH Bath and Weston General Hospital.
Training	This workstream will deliver county-wide training for ward-based colleagues (and potentially outpatient clinic colleagues) about the specific needs of homeless people and people with addiction. This training will draw on the expertise of the YDHFT substance misuse team, the community outreach team and the Dual diagnosis team and will be based on national standards. It will also prepare guidance on how to signpost people to other local services.
Policies & procedures	This workstream will integrate policies and procedures e.g. addiction policies, policies on homelessness, and incorporate the needs of homeless people into ED and discharge checklists.
Digital	This workstream will initially focus on how to streamline use and access to existing digital systems. However, the aim is to work towards having one digital health and social care plan for homeless and other vulnerable people that is accessible by all relevant professionals, which we hope can be achieved as part of the ongoing development of the SIDER programme.

8.41 The provision of health care to this particular cohort of patients requires the coordinated action of a range of clinical teams across and beyond both Trusts. To understand the impact of our developing plans on services and individuals we have actively engaged through workshops and individual conversations to ensure all key stakeholders' thoughts and concerns are heard so they can be taken into consideration as plans are made.

Why a single approach to care of Homeless people is better

8.42 We believe we can provide better patient care by working together to create a single county-wide approach to the care of homeless people. Working together enables us to capitalise on our respective strengths, prevent avoidable admissions and ensure equity of care across the county. Creating a single county-wide approach also allows us build more effective links with partners. More detail is provided in **Figure 62**.

Figure 62: Benefits of a single county-wide approach to care for Homeless people

Factor	Detail
Capitalise on our complementary strengths	The Trusts have complementary strengths to bring to the development of a county-wide approach to caring for homeless people. YDHFT has expertise in using a case management approach for substance misuse and providing specialist support to inpatients who are homeless. SFT has expertise in community outreach which helps to reduce the frequency with which homeless people and rough sleepers require unplanned care.
Equity across the county	By working together to create a single approach to the provision of care for homeless people we can ensure a consistent offer across the county which provides equity of access and provision. For example merger makes it easier to: • bring consistency to pathways and strip out unnecessary elements, and to make those changes more quickly • ensure equitable access to all secondary care specialist services through consistent referral pathways.
Supports effective partnership working	Homelessness has multiple causes and consequences. Public sector and voluntary sector services are better able to meet the multiple needs of homeless people if we work together. It will be easier for partners (e.g. GPs, and voluntary sector organisations) to engage with a single approach and a single set of referral pathways and processes, rather than working with two Trusts operating different systems.

8.43 An effective approach to the care of homeless people meets all of our five clinical health and care aims, but three in particular:

- Aim 1: our community outreach team helps prevent avoidable illness by intervening early with homeless people to avoid escalation of health need
- Aim 4: the development of a county-wide approach to care of homeless people is a key plank in our work to address a significant health inequality in Somerset.

- Aim 5: our approach to the care of homeless people recognises their complex needs and seeks to take care to where homeless people are rather then expecting them to come to us. Our intention to train colleagues in how to adapt their service to respond to the needs to homeless people, and the care coordination role the outreach team will play are further ways we are tailoring care to the needs of people experiencing homelessness.

How merger aids the creation of a single approach to care for homeless people

8.44 The signal of merger has prompted YDHFT's substance misuse team and SFT's community outreach team to work together, which they are unlikely to have done otherwise. Merger helps us develop a single county-wide approach to the care of homeless people in the following ways:

- **Pathways**: Being part of the same single organisation will smooth the links between YDHFT's acute services and the community services currently run by SFT. A single set of pathways will be easier for patients and colleagues to navigate, and will smooth access to care. It will also make it easier to maintain continuity of care for transient service users who move around the county, and make it easier for the outreach team to make direct referrals to other services (like we have already done for direct referrals to SDEC and AEC, see paragraph 8.33). Stronger links with the acutes and a consistent county-wide approach will contribute to the efficiency of the community outreach team.
- **Access to information**: merger removes information governance concerns and enables us to bring our many clinical records systems together (see paragraph 8.26). Joined up records are especially important when caring for a transient population. Joined up systems also reduce administrative work by cutting out duplicative work.
- **Care in the right place**: Now that SFT's outreach team has stronger links into both acutes, including with specialists in substance misuse, we are better able to give care in the right place, for example through community monitoring of patients recently seen in an acute setting, which prevents unnecessary admissions/re-admissions to hospital.
- **Sharing of practice**: merger is making it easier to share practice e.g. SFT is learning from the case management approach used by YDHFT's substance misuse team. Stronger links between the outreach team and acute specialists improves the outreach team's understanding of acute services and they can take that knowledge back to their work with clients in the community.
- **Openness to new possibilities**: the signal of merger has prompted changes to take place that would not have otherwise happened. These include the ability of the community outreach team to refer into SDEC/AEC at both acutes, improving the discharge of homeless people, and the plan to initiate colleague training (beginning with ward staff) about the particular needs of homeless people.

How homeless patients will benefit from merger

Benefits of effective care for homeless people

8.45 The benefits of a county-wide approach to care for homeless people include more equitable access to healthcare, and fewer acute physical or mental health needs due to prevention work and early intervention, see **Figure 63** below. These benefits will be felt by the whole cohort of homeless people in Somerset (which is c. 360) whenever they require healthcare. These benefits were identified through a combination of: the pilot project that preceded the homeless and rough sleepers outreach service being made permanent; and workshops initiated as part of merger planning involving key stakeholders in both Trusts. Next steps include work to develop indicators which we will use to measure our progress in delivering these benefits.

Figure 63: Patient benefits - homelessness

Key change	Valuing time	
	More time in good health	**Making every minute count**
Single set of pathways & processes, and single electronic patient record	• Improved provision of care, including targeted 'shortcuts to care' for Deep Vein Thrombosis, leg ulcers etc., leading to improved health outcomes. • Improved access to specialist care even when no fixed address • Equity of care across the county for homeless people, regardless of where they present • Reduced patient safety risk from records spread across multiple systems	• Single set of pathways will be easier for service users and colleagues to navigate • Less time spent by colleagues on administration associated with multiple digital systems
Stronger outreach service with focus on prevention and early intervention	• Improved access to care from outreach model leading to improved health outcomes. • Assistance to attend outpatient appointments leading to better health outcomes	• Fewer ED attendances which frees up colleague time to see other patients • Fewer inappropriate hospital admissions for monitoring purposes which frees up colleague time to care for other patients • Fewer acute referrals due to prevention/early intervention
Improved inpatient care for homeless people	• Support for substance misuse problems in all bedded settings leading to better health outcomes	• Support to ward colleagues for inpatients who exhibit challenging behaviours • Ward colleagues have greater confidence in meeting the needs of homeless people, leading to better patient experience
Improved discharge processes through training of ward staff and discharge processes	• Any safeguarding issues considered prior to discharge	• Patients not kept in hospital longer than medically required

Future plans

8.46 Next steps include taking forward work under each of the five identified workstreams, see **Figure 64**.

Figure 64: next steps

Workstream	Next steps
Workforce	• The outreach team have recently secured NHSE funding to pilot the addition of two mental health practitioners, a dual diagnosis worker and two mental health peer support workers to the outreach team. • Although the outreach team has discussed with partners how they can bring health care to other groups that are at risk of homelessness e.g. prison leavers, and other vulnerable groups e.g. sex workers, travellers and seasonal farm workers, additional resources need to be sought so this work can be embedded and rolled out consistently across the county. The outreach lead is drafting a proposal detailing the staffing and other resource requirements needed to extend the outreach service to these other vulnerable groups.
Our approach	• The teams are currently mapping the patient journey at each acute site from ED through to acute services using a typical patient narrative. Working with a wide group of colleagues, and informed by service user feedback the aim is to agree the ideal patient pathway with standard processes to help services access support to care for this patient group. • There is ongoing work to support homeless people while they are inpatients and to look at transitions of care, particularly discharge planning from all our bedded care units back to the place people call home. • Exploring possible new areas of work for the outreach team such as the feasibility of using femoral stab techniques for taking blood in difficult-to-access veins (common in intravenous drug users), and whether suturing, stapling and mobile ECGs can be taken into community settings which would benefit clients as well as relieving pressure on acute colleagues. • The community outreach team is building relationships with staff at RUH Bath and Weston General Hospital to help provide better care for homeless people in Somerset who are conveyed to those hospitals, and ensure those patients are not disadvantaged by where they are based. Links are being built with the equivalent homeless team based in RUH Bath to work towards aligning services and accessing relevant patient information.
Training	• The substance misuse team and community outreach team are drawing together a training programme, initially to support ward staff to manage the often complex issues associated with caring for homeless people e.g. complex safeguarding issues and post discharge care planning. • The substance misuse team and community outreach team also plan to work with dual diagnosis colleagues to create training that will be available to all social and health care staff to raise awareness of the rights of vulnerable groups, the issues associated with their care, and services available to help them. This training will be based on the national inclusion standards, see paragraph 8.19. • Instigation of team training days to ensure colleagues are up to date with relevant information and best practice.
Policies & procedures	• To produce a standard operating procedure for the support of homeless and rough sleepers whilst accessing health care services

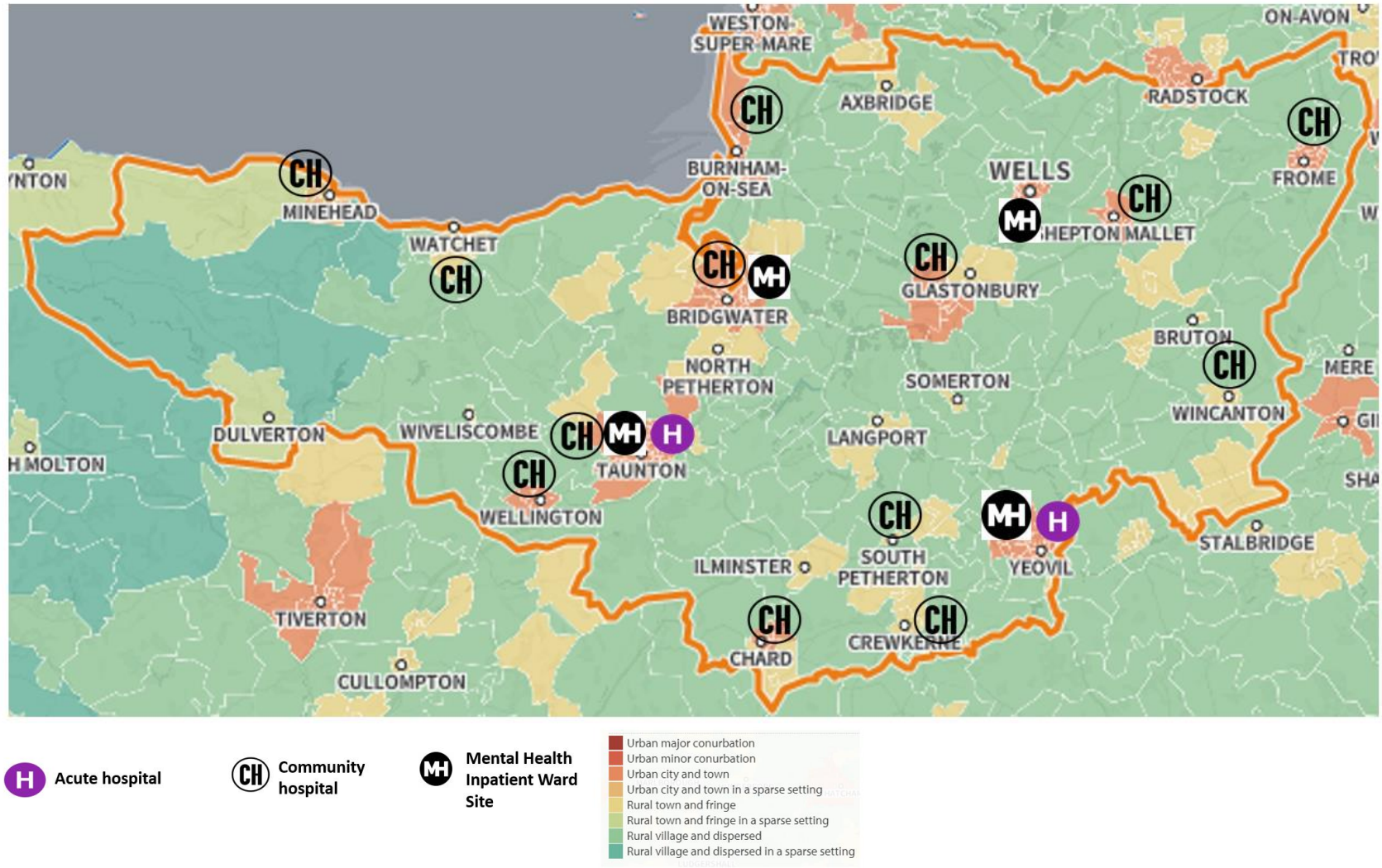
	• To work with medical specialties e.g. gastroenterology to develop standard policies for the management of substance misuse disorders across acute, community and mental health.
Digital	• Link with the SIDER team to discuss how the summary care record could support the care of homeless people by providing access to professionals in relevant organisations.

8.47 The teams have set up a steering group to oversee the work to bring their support for homeless people together. Workstream leads have been appointed from the current teams and improvement advisers and a project manager are supporting their work.

Annex 1: Rurality

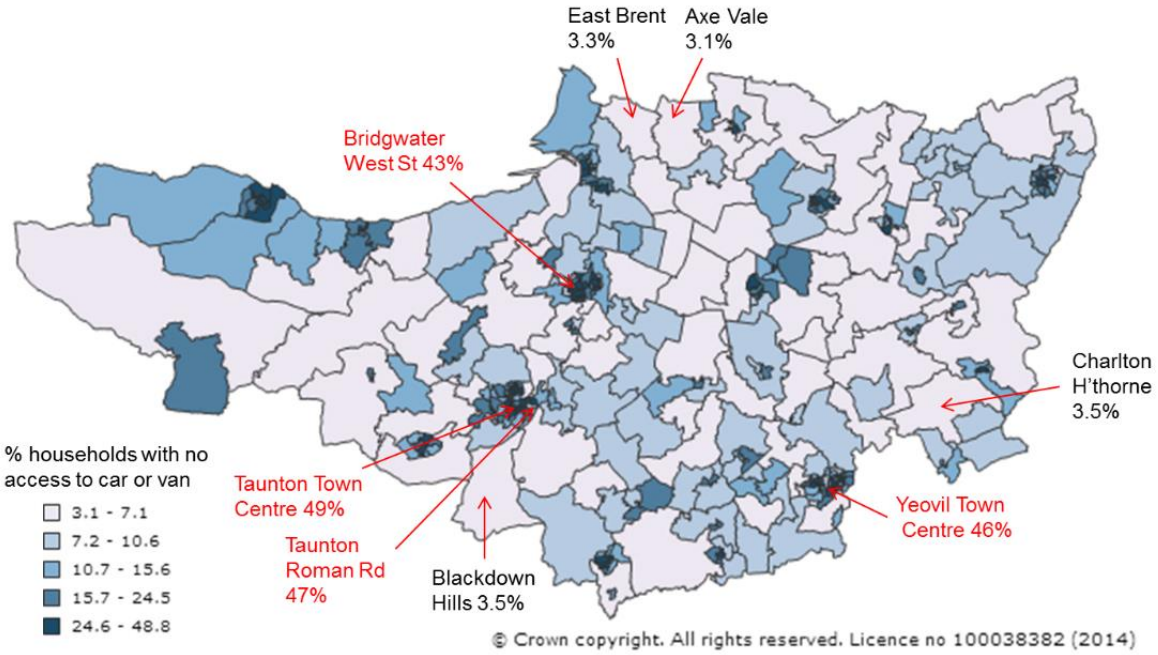
1. **Figure 65** below shows the population density in Somerset in relation to our key sites.

Figure 65: population density in Somerset



2. **Figure 66** below shows the proportion of households in Somerset with no access to a car or van, as at the time of the 2011 census.

Figure 66: proportion of households with no access to car or van



3. **Figure 67** below gives an indication of the travel times across the county.

Figure 67: map of travel times by car to acute hospitals in Somerset

Annex 2: Overview of patient benefits

1. The table below, **Figure 68**, sets out in detail the cross-cutting patient benefits we expect from our merger.

Figure 68: Patient benefits of merger

Change	How merger helps	Benefit		E.g.
		More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**	
Intervening earlier to tackle or prevent illness/ adverse health behaviours	• When we are one Trust it will be easier to partner with others (e.g. GPs, VCSE, social care) to prevent illness by intervening early and offering support for health behaviour change.	• 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 • Reducing delays to surgery caused by modifiable risk factors	• Homeless care • Peri-operative care
Improved access to specialist care out of hours	• Facilitates pathway changes which speed up access to specialist care • Supports development of trusted relationships between clinicians on different sites which aids exchange of advice.	• 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	• Cardiology • Oncology
Standardised protocols, and streamlined pathways based on best practice	• Easier to agree and implement single set of protocols and pathways when we are one Trust	• 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	• 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	• All services

Change	How merger helps	Benefit		E.g.
		More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**	
		• Easier to integrate with the work of partners (primary care, social care, voluntary sector)	• Improved patient and carer experience from pathways which are easier to understand and navigate • Colleague time freed up for front line care	
County-wide MDT meetings	• Easier to schedule county-wide MDTs when we are one Trust • Stronger MDTs due to a wider pool of expertise	• Improved clinical decision-making for care of complex patients	• Efficient use of valuable clinical time	• Maternity • Oncology • Cardiology • Homelessness /ED
Single county-wide waiting lists	• Facilitates introduction of single IT systems which support operation of single waiting lists	• All patients in county seen in order of clinical priority under single waiting lists • 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	• All services
Combined teams	• Brings clinical teams together into single teams rather than just collaborating (or at worst working in silos)	• Better health outcomes as colleagues get exposure to wider range of clinical cases, share knowledge & best practice across the enlarged team and unwarranted variation is reduced • Greater colleague capacity (from stripping our duplicate tasks) 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	• All services
More care closer to home	• Aids use of SFT's community hospitals to support acute	• Lower patient anxiety and stress from reduced travel which aids recovery	• Greater use of community settings increases patient choice and reduces patient	• Maternity • Oncology • Stroke

Change	How merger helps	Benefit		E.g.
		More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**	
	services at YDH and MPH where appropriate		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	
Greater & more equitable access to clinical trials	• Larger combined patient cohort, across acute, community and MH settings under the governance of a single trust is more attractive prospect for clinical trials. • More clinicians able to act as Lead Investigator.	• More patients benefitting from participating in a clinical trial (including improved clinical outcomes) • Larger patient pool increases likelihood that trials for rare conditions are able to recruit sufficient patients to proceed	• Participation in clinical trials supports colleague adherence to consistent quality standards and efficient processes	• Oncology
Fewer inter-site transfers	• Supports pathway changes which reduce inter-site transfers	• Reduced clinical risk from fewer inter-site transfers	• Less patient time spent being transported between sites (less discomfort & inconvenience) • Reduced administrative work for colleagues associated with inter-site transfers	• Oncology • Cardiology • Stroke
Recruitment of specialists	• Larger patient cohorts create stronger case for creation of specialist roles	• Better health outcomes due to receipt of specialist care		• Oncology (clinical psychologist role)
A single electronic health record	• Cheaper and easier to procure and implement a single EHR across one Trust rather than two	• Clinicians have ready access to patients' full clinical history wherever they are which increases patient safety and good clinical outcomes • Lower clinical risk from human error when sharing/re-keying patient information	• Supports clinicians to provide care more efficiently • Patients' 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	• All services

Change	How merger helps	Benefit		E.g.
		More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**	
		• Supports the operation of integrated care pathways and county-wide 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	checking a range of clinical systems to get full patient history, thereby freeing up time to care for other patients	
Implementation of digital solutions e.g. wearable devices to support remote monitoring, virtual consultations etc	• Cheaper and easier to procure and roll out digital solutions than would otherwise be the case	• Earlier detection of patients requiring clinical support resulting in more timely care.	• Greater patient convenience from not having to attend face to face appointments when not required • Greater patient peace of mind from remote monitoring • More effective use of face to face outpatient appointment time	• All services
Intelligent systems (e.g. automation, AI etc)	• Cheaper and easier to procure and roll out intelligent systems than would be the case if we remained separate Trusts.	• Provides real time data to support clinical decision-making	• Supports provision of care in a more efficient manner e.g. through automated processes and/or use of AI	• All services
Interconnected systems, and mobile devices to support seamless working across health and care settings	• Cheaper and easier to procure and roll out interconnected systems than would be the case if we remained separate Trusts.	• Supports consistent practice in all settings to maintain high quality care • Enables improved clinical decision-making through ready access to patient records wherever clinicians are	• Supports clinicians to provide care more efficiently • Increased resilience of infrastructure leading to less system downtime.	• All services

Change	How merger helps	Benefit		E.g.
		More time in good health (better health outcomes)	**Making every minute count (eliminating wasted time in healthcare)**	
		• Supports the provision of care more quickly, leading to better outcomes		
Shared medication lists	• Cheaper and easier to procure and roll out single EPMA than would otherwise be the case	• Improves patient safety by aiding the identification of potentially harmful drug interactions • Helps clinicians tackle problematic polypharmacy and minimise medicines-related harm	• Releases clinical time for front line care, as no longer having to check range of systems for overview of medication	• All services
Improved ability to work with partners	• Brings all acute, community and mental health services in the county into one organisation, and makes it easier and simpler to work with partners in primary care, social care and the voluntary sector to integrate our collective care and support offer, as we'll have one leadership team and a single set of referral pathways and processes, rather than two.	Facilitates system-wide work on: • prevention and early intervention to reduce avoidable illness and escalation of health need • population health management • individual service-level strategies agreed at system level e.g. oncology, stroke.	• Aids work to streamline and standardise care pathways to remove duplication and inefficiencies	• All services, but Hospital@home is a particularly good example

Annex 3: Oncology and cancer services by tumour site

1. The table below (**Figure 69**) sets out oncology and cancer services at each Trust by tumour site.

Figure 69: Oncology and cancer services by tumour site

Tumour site	Oncology services (non-surgical treatment)		Cancer surgery		Comments
	SFT	YDHFT	SFT	YDHFT	
Breast	Yes	Yes	Yes	Yes	
Colorectal	Yes	Yes	Yes	Yes	
Gynaecology	Yes	Yes	Yes	Low risk	YDHFT provides diagnostic service and surgical treatment of low-grade cancers, and ovarian cancer chemotherapy.
Lung	Yes	Yes	No	No	YDHFT patients are referred to SFT for radiation therapy. SFT and YDHFT patients are referred to University Hospitals Bristol and Weston NHS FT for surgery.
Skin	Yes	No	Yes	Yes	Both Trusts operate on skin cancers including melanoma; complex cases requiring reconstruction go to Royal Devon and Exeter NHS FT
Sarcoma	No	No	No	No	YDHFT and SFT patients are referred to North Bristol for surgery and University Hospitals Bristol and and Weston NHS FT for systemic treatment. Radiotherapy may be offered at SFT on a patient by patient basis.
Paediatrics	Yes	Yes	No	No	YDHFT and SFT patients are referred to University Hospitals Bristol and Weston NHS FT for surgery.
Urological	Yes	Yes	Yes	No	YDHFT patients are referred to SFT or University Hospitals Bristol and Weston NHS FT for surgery.
Head and Neck	Yes	No	Yes	No	YDHFT patients are referred to SFT for treatment or to Dorset County Hospital (depending on where the patient lives), and for surgery to either SFT or University Hospitals Bristol and Weston NHS FT

Brain	No	No	No	No	YDHFT and SFT provide Palliative Care but refer patients to University Hospitals Bristol and Weston NHS FT for Neurosurgery.

Annex 4: Cardiology - current services at YDHFT and SFT

1. The table below (**Figure 70**) sets out cardiology services at each Trust.

Figure 70: cardiology services at YDHFT and SFT

Specialty and sub-specialty provided	YDHFT	SFT
Echocardiography	√	√
Cardiac CT	√	√
Cardiac MRI	x	√
Cardiac monitoring	√	√
Invasive angiography and angioplasty	x	√
Brady pacemakers	√	√
Complex (CRT) pacemakers	x	√
Inherited cardiac condition	√	√
Adult congenital heart disease	√	√
Sudden cardiac death	X	√
Cardiac Rehabilitation:		
Post MI	√	√
Post PCI	√	√
Angina	√	X
Post Coronary Artery Bypass Graft	√	√
Post Valve surgery	√	X
Heart Failure	√	X
Other cardiac conditions	√	X

Note: Both trusts refer patients to the Bristol Heart Institute for valve and Coronary Artery Bypass Graft surgery, electrophysiology, and genetic testing.

Annex 5: Cardiology patients to be treated at Musgrove Park Hospital

1. Following merger, YDHFT patients with the following conditions will be taken directly (or transferred if they make their own way to YDH) to Musgrove Park Hospital for their cardiology care, see **Figure 71**.

Figure 71: cardiology patients to be treated at MPH

1.	NSTEMI with dynamic ECG changes/ongoing chest pain
2.	Malignant ventricular arrhythmia
3.	New diagnosis of acute heart failure/pulmonary oedema
4.	Cardiogenic shock
5.	Cardiac tamponade
6.	CHB – unstable patient requiring pacing
7.	Pacemaker malfunction – requiring immediate pacing
8.	STEMI
9.	VT/VF requiring pacing, Cath lab

Annex 6: Stroke workforce

1. **Figures 72** and **73** below set out the stroke workforce at each Trust as at October 2022.

Figure 72: Stroke workforce at YDHFT as at October 2022

	In post		Vacancies/ gap from budget	National recommended levels** (based on 12 ASU and 4 HASU beds)
	Substantive	**Locums**		
Acute (HASU & ASU)				
Stroke consultants	0.95	1.0	0.05	**NOT MET** HASU: 24/7 consultant availability ASU: Ward round 5 days/week
Other stroke medics	4.8 *(4.0 Juniors and 0.8 Registrar)*	1 *(for current additional support – not a fixed post)*	-	
Consultant Nurse (*Consultant level nurse included in consultant HASU & ASU activity)*	0.4	-	-	
Clinical nurse specialists/ stroke practitioner nurses/ Advanced nurse practitioners	2.6	-	-	
Physiotherapists (including Rehabilitation Assistants)	*2.0* *Adjusted WTE to cover stroke workload/beds (~50%)*	-	0.6	**NOT MET** **2.6** HASU: 0.58 ASU: 2.02
Occupational therapists (including 1.13 Rehabilitation Assistants)	*2.21* *Adjusted WTE to cover stroke workload/beds (~50%)*	-	0.1	**NOT MET** **2.48** HASU: 0.54 ASU: 1.94
Ward nurses (including HCAs)	HASU: 9.14 ASU: 15.27 *Adjusted WTE to cover stroke beds only (4/12)*	-	HASU: 0.9 ASU: - *Adjusted WTE to cover stroke beds only*	**NOT MET** HASU: 11.6 *(80:20 Registered: Unregistered)* ASU: 16.2 *(65:35 Registered: Unregistered)*
Speech & language therapists	1 *(works under an SLA from SFT)*	-	-	**NOT MET** **1.23** HASU: 0.27 ASU: 0.96
Stroke specialist dietician	0.4	-	-	**NOT MET** **0.48** HASU: 0.12 ASU: 0.36
Total	**38.77**	**2**	**1.65**	

N.B. All figures are whole time equivalents.
* Consultants provide daily weekday cover for TIA service
** Based on National Clinical Guideline for Stroke - figure Table 2.1. 2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx (strokeaudit.org)

Figure 73: Stroke workforce at SFT as at Oct 2022

	In post		Vacancies	National recommended levels** (based on 19 ASU and 4 HASU beds)
	Substantive	**Locums**		
Acute (HASU & ASU)				
Stroke consultants	4.8***	-	2	**NOT MET[##]** **HASU: 24/7 consultant availability** **ASU: Ward round 5 days of week**
Other stroke medics	4 *(Junior Doctors)* 1x Physician Associate 1x Medical Support Worker	**-**	**-**	
Clinical nurse specialists/ stroke practitioner nurses/ Advanced nurse practitioners	3	-	-	
Physiotherapists (including 2.0 WTE Assistant Physiotherapists)	6.0	-	0.6	**MET – for 5 day working** **3.77** HASU: 0.58 ASU: 3.19 **MET – for 7 day working** **5.29** HASU (Adj for 7 day working): 0.8176 ASU (Adj for 7 day working): 4.4688
Occupational therapists (including 2.55 WTE assistant OTs/*apprentice assistant)*)	6.25 *(Band 6s work rotationally in Neuro and Stroke)*	-	0.5	**MET – for 5 day working** **3.62** HASU: 0.54 ASU: 3.08 **MET – for 7 day working** **5.07** HASU: 0.7616 (Adj for 7 day working) ASU: 4.3092 (Adj for 7 day working)
Ward nurses (inc. HASU, ASU Nurses and Band 2-4 nursing staff)	43.99	-	-	**MET** HASU: 11.6 *(80:20 Registered: Unregistered)* ASU: 25.65 *(65:35 Registered: Unregistered)*
Speech & language therapists	2.0	-	-	**MET (5 day)** **1.79** HASU: 0.27 ASU: 1.52
Dietitian	0.6	-	0.2	**MET** **0.69**

				HASU 0.12' ASU: 0.57
Community stroke care				
Stroke consultant therapist (works across acute & community)	1	-	-	
Community stroke rehabilitation units**				
Consultant	(0.4WTE included in acute consultants staffing above)	-	-	
Physician	2.0 Associate Specialists	-	-	
Clinical nurse specialists/ stroke practitioner nurses/ Advanced nurse practitioners	0.8 at South Petherton community Hospital	-	1.0 at Williton Community Hospital	
Nurses *(inclusive of Band2-Band7)*:	South Petherton CH – 33.52 (inclusive of 20.3 Band 2-4) Williton CH – 26.02 (inclusive of 15.26 Band 2-4)	-	5.58 2.13	**MET** 1.35 WTE per bed 47.25
Physiotherapists	4.3	-	-	**NOT MET** **5.88** 0.84 / 5 beds weekdays only 7 day working 1.176 / 5 beds
Occupational Therapists	1.4	-	1.0	**NOT MET** **5.67** 0.81 / 5 beds weekdays only 7 day working 1.134 / 5 beds
Speech and Language Therapists	1.7	-	-	**NOT MET** **2.8** 0.40 / 5 beds weekdays only
Rehabilitation Assistants	4.0		-	Mitigates shortfall of OT and PT staff to a degree
Community stroke team and Early Supported Discharge****				
Physician				**NOT MET** 0.1 WTE per 100 referrals/year 1.0 WTE
Nurses	3.2	-	-	**NOT MET** **4.68 WTE** 0.6 WTE per 100 referrals/year
Physiotherapists	8.1	-	0.6	**MET** **7.8**

				1 WTE per 100 referrals/year
Occupational Therapists	7.48	-	-	**NOT MET** **7.8** 1 WTE per 100 referrals/year)
Speech and Language Therapists	1.4	-	-	**NOT MET** **3.12** 0.4 WTE per 100 referrals/year
Rehabilitation Assistants	12.33	-	-	**MET** **7.8** 1 WTE per 100 referrals/year
Clinical Psychologists###				
Clinical Psychologists (include support role)	2.8 *(split 1.8 qualified and 1.0 unqualified)*	0	0.6	**Not MET** ***MPH: 0.92*** ***YDH: 0.64*** ***SRCs: 1.4*** ***ICSS: 1.5-3.0*** ***Recommended = 4.46-5.96***
Total	**180.69**	**0**	**14.21**	

N.B. All figures are whole time equivalents.
** Based on National Clinical Guideline for Stroke - figure Table 2.1. 2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx (strokeaudit.org) and https://www.england.nhs.uk/wp-content/uploads/2022/02/stroke-integrated-community-service-february-2022.pdf

*** Consultants provide daily cover for TIA service and community stroke rehabilitation units.

****Based on National service model for integrated community stroke service – Feb 2022 - https://www.england.nhs.uk/wp-content/uploads/2022/02/stroke-integrated-community-service-february-2022.pdf

##: Consultant care is available 7 days a week, but not 24 hours.

Clinical Psychologists work flexibly across the whole pathway and as such their hours are not split between the different services.

The ICSS recommends 0-0.5 WTE social worker for the MDT. Currently the community team liaise with Somerset Adult Social Care on a patient-by-patient basis. A dedicated social worker integral to the team could be more efficient and can be explored as the ICS develops.

Annex 7: Trusts' SSNAP performance April – June 2022

1. **Figures 74** below set out the Trusts' SSNAP performance data.

Figure 74: Trusts' SSNAP performance data, April-June 2022

Routinely Admitting Teams		Number of patients		Overall Performance				Team Centred Data										
Trust	Team Name	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	TC KI Level
South England - West of England																		
Gloucestershire Hospitals NHS Foundation Trust	Gloucestershire Royal Hospital	223	173	B↑↑	A↑↑	A↑	B↑	A	B↑↑	B↑	B	A↑	A↑	E↓	C	C↑	D↓↓	B↑
Great Western Hospitals NHS Foundation Trust	Great Western Hospital Swindon	157	157	B	A	A	B	A	E↓	D↓	D	A	B	C	C	A	A↑	B
North Bristol NHS Trust	North Bristol Hospitals	186	235	B	A	B↓	B	A	E	C	B	B	B	B	B↑	B	A↑	B
Royal United Hospitals Bath NHS Foundation Trust	Royal United Hospital Bath	163	162	D↓↓	A	A	D↓↓	C↓↓	E	D↓	C	D↓	D↓	C↓↓	D	B	A	D↓
Salisbury NHS Foundation Trust	Salisbury District Hospital	78	87	C↑	B↓	A↑	C↑	A↑	E	D↑	D↑	B↑	C	A	B↑	C↓	A↑	C↑
Somerset NHS Foundation Trust	Musgrove Park Hospital	134	149	C↓	A	A	C↓	A	D↑	D	C	B	C↓	C↓	B	B	A	B
University Hospitals Bristol and Weston NHS Foundation Trust	University Hospitals Bristol Inpatient Team	98	95	D	C↓	B↓	D	B	E	E↓	E	C	B↑	C↓	D↑	B↑	A	D
University Hospitals Bristol and Weston NHS Foundation Trust	Weston General Hospital	39	54	C↑	A	B↓	C↑	A↑	E	B↑↑↑	B	C↓	D↓	D↑	C	A	A↑	C
Yeovil District Hospital NHS Foundation Trust	Yeovil District Hospital	81	89	D	A	A↑	D	B↓	E	D	D	B↑	C	D↓	E↓	C	A	D

SSNAP Key:

A	Over 80%
B	Between 70 and ≤80
C	Between 60 and <70
D	Between 40 and <60
E	Less than 40

Key

D1. Scanning = 3 Key Indicators related to time of scans (e.g. clock start to first scan time)
D2. Stroke Unit = 3 Key Indicators related to arrival time and length of stay on stroke unit
D3. Thrombolysis = 5 Key Indicators related to patient receiving thrombolysis (e.g. door to needle time)
D4. Specialists Assessments = 6 Key Indicators related to assessments such as swallow, nurse and consultant assessments.
D5. Occupational Therapy = 4 Key Indicators related to compliance against therapy target taken from NICE
D6. Physiotherapy = 4 Key Indicators related to compliance against therapy target taken from NICE
D7. Speech & Language = 4 Key Indicators related to compliance against therapy target taken from NICE
D8. MDT Working = 8 Key Indicators related to MDT e.g. goals agreed within 5 days, receipt of all therapy and nursing input
D9. Standards by Discharge = 3 Key Indicators (i.e. patients received nutrition screening, continence planning and mood and cognition screening)
D10. Discharge Process – 4 Key Indicators (health and social care plan, % discharge with ESD, % patients in AF on medication and patients discharged with a named contact)

TCKI: the score for the team against the standards (D1 to D10 combined)

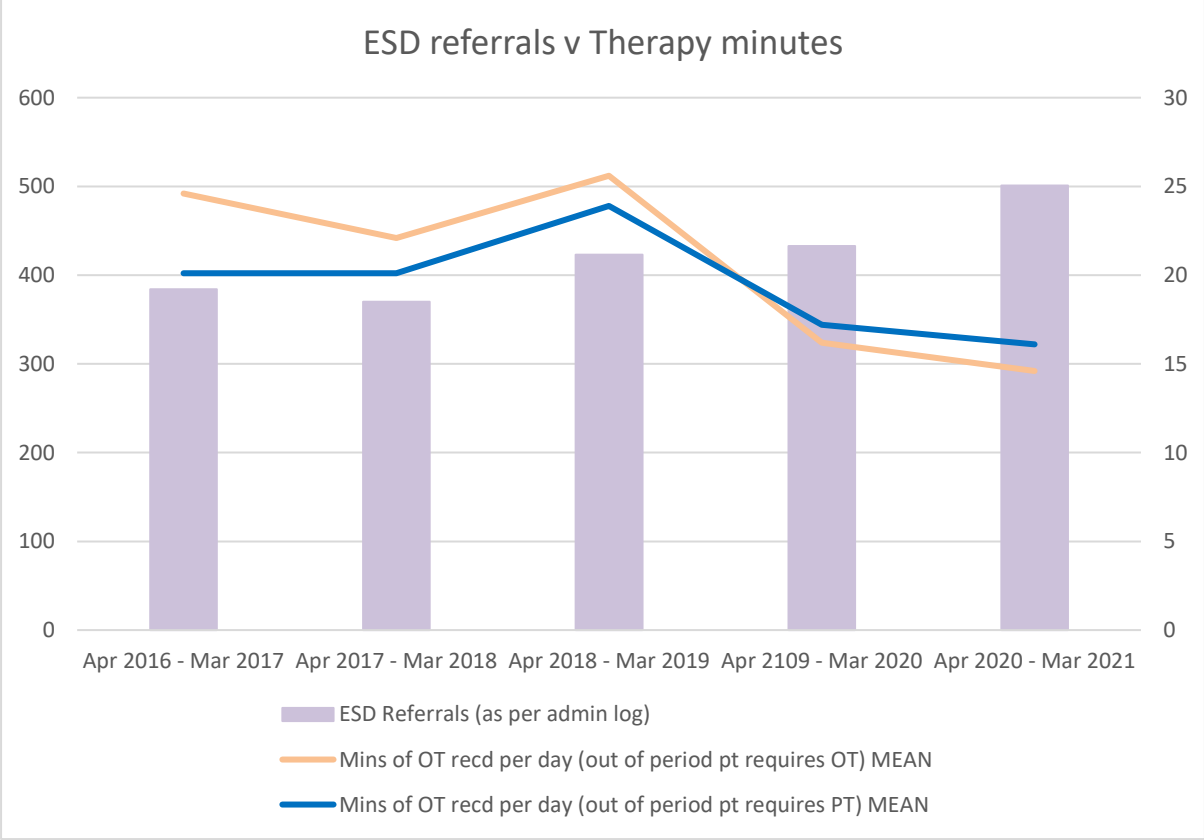
Combined KI level: the result for the combined score of patient centred Key Indicators score and team score.
CA: Case Ascertainment (the number of records reported upon by the Trust compared to the number SSNAP expects to be reported based on HES data.
AC: Audit compliance

Annex 8: Stroke - community & ESD referrals v. therapy minutes

1. **Figures 75** and **76** below show that referrals to the community stroke team and ESD have risen over the last five years, while the mean number of minutes of therapy patients received each day has declined over the same period. This is because the number of therapists has not increased in line with the rise in referrals.

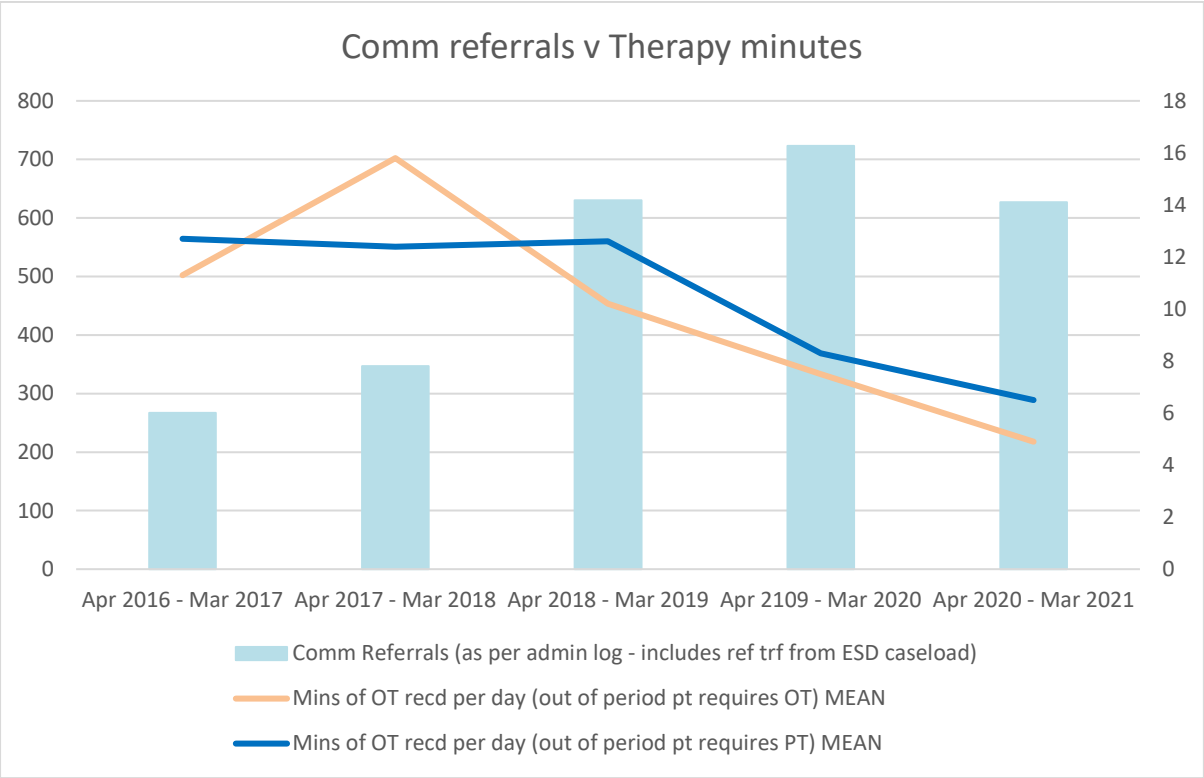
2. Neither the community stroke team nor the ESD team are currently able to provide patients with the recommended number of minutes of appropriate therapies a day as recommended by national guidance.

Figure 75: Early Supported Discharge team referrals v therapy minutes



Source: SSNAP data

Figure 76: Community stroke team referrals v therapy minutes



Source: SSNAP data

N.B. Community stroke team data includes patients transferred from the ESD team. Approximately 50% of patients transfer from the ESD team to community stroke team a year.

Annex 9: Peri-operative - elective surgeries 2016/17 to 2020/21

1. The table below, **Figure 77**, shows the total number of elective surgical cases for each of the last six years at YDHFT and SFT. The annual average number of elective surgical cases over the last six years is 21,862. Excluding 2020/21 and 2021/22 (due to the impact of COVID), the annual average is 24,851.

Figure 77: number of elective surgery cases at the two Trusts 2016/17 to 2021/22

Year	SFT	YDHFT	Total
2016/17	18,509	7,650	**26,159**
2017/18	16,993	7,287	**24,280**
2018/19	17,107	7,122	**24,229**
2019/20	16,967	7,769	**24,736**
2020/21	8,720	4,297	**13,017**
2021/22	13,892	4,857	**18,749**
Annual average	**15,365**	**6,497**	**21,862**
Annual average excluding 2020/21 & 2021/22 (covid)	**17,394**	**7,457**	**24,851**

Annex 10: Peri-operative care programme – summary of the current workstreams

1. The table below, **Figure 78**, provides further detail on the 14 peri-operative workstreams, each of which has a role to play in helping optimise people for surgery by turning waiting lists into preparation lists.

Figure 78: peri-operative workstreams - detail

Workstream	What already exists at SFT/YDH	What we've done so far	Next steps	How merger helps
1. Advanced care planning and Somerset Treatment escalation plan (STEP) Offer all patients undergoing surgery an advanced care planning conversation and create a STEP	A programme supporting the roll-out of ACP and STEP across Somerset already exists. We now need to link this work with peri-operative care and support peri-operative referrals to the ACP service where appropriate.	Reviewed options for using planned surgery as an opportunity to understand what is important to individuals, and to put in place an ACP/STEP where appropriate	Test referrals from the surgical waiting list to the Marie Curie ACP service for volunteer-led 'what matters to me' conversations	Joint design for planned surgical pathways, will avoid variation in the experience for patients Merger enables one individual to represent both Trusts, which is more efficient
2. Alcohol and Substance misuse Develop a county-wide model of peri-operative care for people with alcohol and substance misuse issues	Alcohol and Substance misuse is already an established service in YDHFT. SFT has recently recruited 3 alcohol abuse specialist nurses who will work with colleagues to bring learning from YDHFT's case management approach into MPH and other bedded settings. Although these specialist nurses have initially been recruited to help care for people with alcohol addiction, they will move to incorporate drug misuse into their portfolio in a phased way over time.	Discussed plans for peri-operative care with leads of the YDHFT service	Develop the new SFT posts with input from YDHFT colleagues.	Signal of merger means the new SFT posts incorporates cross-county collaboration

Workstream	What already exists at SFT/YDH	What we've done so far	Next steps	How merger helps
3. Anaemia Create a county-wide anaemia service with a strong focus on proactive identification and management within surgical pathways	An anaemia service is well-established at YDHFT; currently no similar service at SFT	SFT improvement team are helping the YDHFT clinical specialist lead to develop a case for change to develop a county-wide peri-operative anaemia pathway	Submit business case for additional staff to enable anaemia to be consistently identified and treated preventing any delays for surgery.	Facilitates the coming together of YDHFT's anaemia specialist with SFT's improvement team to develop business case for submission Dec 2022 and, (subject to approval) plan the anaemia peri-operative model.
4. Cancer pathways Ensure alignment of existing prehabilitation programme for patients requiring surgery for cancer, with our peri-operative care ambitions	SFT operates a prehabilitation programme for all cancer patients in Somerset requiring surgery	Appointed a project manager to lead this workstream; initial scoping meetings set up.	Engage key stakeholders to secure support for the project. Identify patients for first PDSA cycle[179].	A large number of YDH cancer patients who are currently seen and treated at SFT will benefit from peri-op interventions identified for pre-surgical optimisation
5. Development and digital Test and implement digital systems to aid understanding of what peri-op support a patient needs and help advise patients on actions to optimise their health prior to surgery. Support for risk assessment conversations with patients and other tools for out-patient appointments	Neither trust has a digital peri-op system in place. Together, we are learning from others e.g. the Prepwell programme developed by South Tees Hospital and Public Health South Tees.	We have procured a digital system 'pathpoint' for SFT and have a quote for extending to YDH. Pathpoint will enable us to send out patient questionnaires to gather information on key areas such as smoking, diabetes, frailty etc. This will allow us to move from a paper-based to electronic system, to easily identify patients' needs so tailored actions to be taken. Currently also testing provision to patients of other online resources which support health and wellbeing prior to surgery.	To evaluate the digital systems once in place. To evaluate the impact of the online resources offered.	Reduces 'silo' and duplicate purchasing of digital packages across the system e.g. only need to develop one website and will procure one system to meet the needs of the Somerset peri-operative service function from GPs into surgery.
6. Diabetes	SFT's Diabetes team secured NHSE funding to run	The pilot project is now running in 4 GP surgeries in	Based on the results to date, the ICB has	Signal of merger prompted re-design of the pilot in line with

[179] Plan, Do, Study, Act.

Workstream	What already exists at SFT/YDH	What we've done so far	Next steps	How merger helps
Identify people with diabetes on the planned surgical pathway and optimise their diabetes prior to surgery	a 1-year pilot to identify and treat patients with diabetes who are referred for surgery	the east and west of the county, to test whether we can identify and help optimise diabetic patients from the point the GP suggests surgery. We have appointed a specialist Diabetes nurse and coordinator to this project. We have recently secured additional funding from the ICB for this pilot for a further year (to December 2023).	confirmed it would like the pathway to become standard practice and is supporting roll out to all GP practices. We will spend the next year collecting further data on outcomes and refining the model. Regular updates are shared with the steering group, ICB and NHSE.	the ambition of the joint peri-operative programme and also prompted test of ideas in GP practices in both the east and west of the county.
7. Emotional support To optimise patients psychologically prior to surgery - especially for those expected to have a long wait	Talking Therapies is a existing Somerset-wide service.	The workstream has tested 'Talking Therapies' letters sent with 'Safety Netting' letters to people who have been waiting a long time. SFT provided the resource to run this test and learn.	Complete test and learn and review results. We may modify our approach if pilot is unsuccessful. We have begun testing in one Orthopaedic clinic a patient conversation with the Talking Therapies service immediately following the discussion with the surgeon about possible surgery.	Merger helps us spread the support of Talking Therapies to patients in the east of the county
8. Exercise Optimise patients physically prior to surgery i.e. improved muscle strength, endurance and cardiovascular capacity	Although there are pockets of exercise support in formal services such as physiotherapy or social prescribing, there isn't an offer currently available to slot into the peri-operative model.	An early test of change was undertaken between SASP (Somerset Activity and Sports Partnership) and a lead physiotherapist from OASIS (the county-wide musculoskeletal service) to offer a pre-surgery exercise programme both virtually and where possible (considering	Design the model for peri-operative exercise care, building on resources already available in Somerset including walking groups, guided gym sessions and learning from the pre-habilitation cancer programmes etc	Merger is facilitating the joint working in this project, which involves SFT offering improvement resource, clinical expertise from both SFT and YDHFT, and input from the third sector (SASP).

Workstream	What already exists at SFT/YDH	What we've done so far	Next steps	How merger helps
		COVID-19 restrictions) face to face. Learning has been shared within the steering group, SASP and OASIS colleagues.		
9. Frailty Improve care of frailer, older people referred for surgery.	Frailty services exist at both SFT and YDHFT but do not currently include any element of peri-op care (current focus more on post-surgery care)	Recently established this workstream with the input of frailty clinicians and specialist nurses from both trusts. In October 2022 we appointed a frailty nurse whose remit is to develop the peri-operative frailty programme for Somerset	To identify where there is potential for improvements and the best areas to focus on and then scope out PDSA cycles	Without merger we would have likely developed separate peri-op frailty support. Merger facilitates the involvement of frailty clinicians and specialist nurses from both trusts, aided by the recent joint appointment of frailty nurse for peri-operative care.
10. Health Coaches Identify patients on the surgical pathway who would benefit from health coaching to improve health and wellbeing prior to surgery	Establishing joint links into the PCNs health coaching offers	Secured agreement in summer 2021 to signpost patients identified on the peri-operative pathway to health coaches (for those PCNs that have them)	Evaluate the process for referral and the impact on issues such as smoking cessation, weight management, nutritional status and exercise participation to inform our thinking about the desired model for peri-operative care	Merger enables us to bring together the benefits of YDHFT's links with primary care via Symphony, and SFT's existing link with PCNs through its community services
11. Nutrition Identify and support patients who need to optimise their nutritional status prior to surgery.	Dietetics services exist in both YDHFT and SFT	Dieticians from YDHFT and SFT are collaborating to release resource to support this workstream, which is in early development. A webinar has been developed and tested ready for use. We have recently secured funding for a joint peri-operative dietician post.	This workstream may amalgamate with either health coaches or weight management, depending on progress.	The prospect of merger has facilitated the release of resource for this joint project i.e. one colleague leading for both Trusts rather than both Trusts fielding someone.

Workstream	What already exists at SFT/YDH	What we've done so far	Next steps	How merger helps
12. Pain management Identify patients with existing high opiate usage to help them manage their pain before and after surgery	The Somerset pain service (run by SFT) is well established	The Somerset pain service is working with the peri-op team to understand how to best identify and support patients who will require pain management	Test our chosen method for identifying appropriate patients	Merger allows easier rollout of the pathway that will be recommended for peri-operative pain management as relationships are well-established as a consequence of joint working.
13. Smoking cessation Support patients to quit smoking prior to surgery and beyond	Smoking cessation is delivered by public health services. SFT has recently appointed a Tobacco Reduction Programme Manager with a remit across both Trusts.	Early results of signposting to existing Smoking Cessation service showed we needed to be more directive. The SFT POAC team co-designed a patient leaflet with service users about the benefits of stopping smoking prior to surgery. For a separate cohort of patients, we are testing a personalised letter, with follow-up call.	Outcomes are being collated to understand the impact of current tests of change, in terms of patient behaviour change and resource required from colleagues. These tests will help us identify the best approach bearing in mind cost/benefit, which will then be developed as part of peri-operative support. With the appointment of the Tobacco Reduction Programme Manager, the team are now testing direct follow up with identified patients in the peri-operative stage.	Joint working to take forward the best options for supporting patients to give up or reduce smoking prior to surgery.
14. Weight management Develop and test a model for peri-operative weight management, which will ultimately be rolled out across all Somerset PCNs.	Links made with South Somerset West PCN to support a related weight management programme initiated by the PCN.	Workstream formed and Quality Improvement project set up with key stakeholders from within the PCN such as health coaches and community services e.g. SASP	The team will start work on prioritised tests of change	With the South Somerset West PCN offering the leadership and drive, SFT are offering improvement resource and clinical expertise from both SFT and YDHFT. SFT are unlikely to have been involved without merger.