Somerset Partnership NHS
NHS Foundation Trust

Taunton and Somerset NHS
NHS Foundation Trust

Strategic Case for the merger of Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust: The Short Read

Introduction and background

1. We are ambitious on behalf of the population we serve and want to transform the way we deliver services to improve the health of the population of Somerset. Together with our county partners we want to better meet our patients' mental and physical health needs now and in the future. We will do this by providing integrated, holistic care, closer to patients' homes, with a focus on prevention and early intervention. The two Boards strongly believe that a merger of the two Trusts is an essential enabler to making these planned changes a reality, and at the pace required.

2. Our full Strategic Case sets out the high level case for the merger of Somerset Partnership NHS Foundation Trust (SPFT) and Taunton & Somerset NHS Foundation Trust (TSFT). Subject to receiving the necessary approvals and support from our boards, governors, regulator and local stakeholders, we plan to merge our Trusts by 30 September 2019.

3. SPFT provides community, mental health and learning disability services across the whole of Somerset while TSFT provides acute services in the north, west and centre of the county and beyond. The proposed merger would bring into one organisation almost all of Somerset's NHS community and mental health services and the majority of the county's acute services.

4. Health and care services in Somerset are struggling to meet the increasing demands of an ageing population and a rising number of people with complex or long-term health conditions. The model of care in Somerset is out-dated, with resources focused on bed-based care, rather than community-based services that support early intervention. Some people currently experience poor mental or physical health because the service they need is not available when they need it, which causes a high number of patients to access services in a period of crisis, or to seek urgent care for matters which could have been managed more effectively sooner.

5. All providers in Somerset are facing workforce gaps which make it harder to deliver services that meet NHS constitution standards. Significant nursing and medical staffing gaps have led to high spend on agency staff and the temporary closure of community beds.

6. Overall, the Somerset health and care system is very financially challenged. It is now extremely difficult for either Trust to continue to deliver cost efficiencies without a change in the way health services are delivered, and the prospects for the Somerset system becoming financially sustainable without transformational change are very slim.

Strategic rationale

7. The 2016 Somerset Sustainability and Transformation Plan (STP) acknowledged that the county's health and care services were not keeping pace with the changing needs of local people and that the Somerset system required radical transformation to ensure its financial and clinical sustainability. Partners committed to work together for the benefit of the Somerset

population to provide a place-based, joined-up system of health and social care. The STP also set out the longer-term ambition to create an Accountable Care System[1] in the county.

8. In May 2017, SPFT and TSFT signed a Memorandum of Understanding (MOU) which formalised joint working already taking place between the two Trusts. As part of the MOU, the Trusts established a joint executive team consisting of Executive Directors from both organisations. In August 2017, the Chairs of the Somerset STP organisations set out their intention to create a single provider organisation with a single Chief Executive for the whole of Somerset.

9. Together with our STP partners we have shown that closer working benefits patients and staff, saves money and increases our resilience. For example we are working with partners in the following ways:
   - Reducing admissions and length of stay through several STP-wide projects including Home First and Rapid Response
   - Establishing Complex Care Hubs to provide integrated care for people with complex long term conditions
   - Expanding psychiatric liaison provision to give better care to people experiencing mental health crisis who attend A&E; and
   - Introducing Nurse Associate roles as part of a ‘grow our own’ approach to tackling staffing gaps.

10. However, there are limits in how far we can go while we remain separate organisations. The different incentives and interests of each organisation act as a barrier to realising the full potential benefits of integration, and even where there is board level commitment to make change happen, different line management structures, policies and procedures, staff terms and conditions and cultures create delay and additional cost.

11. Much of our integration success to date has come about because of the MOU, and the confidence colleagues have about the desired direction of travel towards a single organisation. However, this pace and staff commitment is likely to unwind if our integrated working is not put on a permanent footing.

Clinical and operating models for new Trust

12. The clinical model for the merged entity will provide care closer to patients’ homes via more community-based services. We will play a key role alongside STP partners in developing the 14 planned Somerset localities and align our community-based work and inpatient care with them. We will provide increased support and advice to primary care, and will work with partners to support early intervention to prevent escalation of health need. We will also continue to partner with and support local voluntary sector organisations.

13. The clinical model for the merged Trust will improve our support to people living with complex long-term conditions, and offer genuine parity of esteem for mental health and physical health conditions regardless of the setting in which a patient first presents. We will work closely with commissioners to devote a greater proportion of the merged organisation’s budget to community and mental health services in line with the national strategic focus on prevention and care at home, in preference to hospital-based care.

14. As a merged organisation we will integrate and streamline patient pathways spanning community, mental health and acute services. Patients, their families and carers will only have to tell their story once, and clinical and administrative approaches will be consistent to support improved patient and carer experience. We will create a single community-based service for the care of frail, older people, and a single children and families service which will help improve the care of ‘frail families’ in Somerset.

---

[1] Now known as an Integrated Care System.

15. We recognise the successful integration of patient pathways requires the involvement of all providers, including primary care and the voluntary sectors. We will ensure our plans to integrate pathways are produced in collaboration with partner organisations. We are also working closely with Somerset Clinical Commissioning Group and Somerset County Council as they develop the Somerset Health and Care Strategy, and will ensure our clinical model and integration plans are closely aligned with the emerging Strategy.

16. We have developed a joint People Strategy focusing on recruiting, retaining and supporting the diverse workforce across both Trusts and forging a common culture. We launched a shared set of values and behaviours in July 2018 and are working to harmonise the two Trusts' HR policies and procedures.

17. We recognise the importance of IT as an enabler to our clinical and operating models and are developing a programme of work to take forward integration of our IT systems in a way that allows our STP partners to link in to our systems. We also continue to work with local partners on development of the Somerset Integrated Digital Electronic Record.

Benefits to patients

18. The primary reason for pursuing a merger is to improve the healthcare we provide to the people of Somerset. We want to support a joined-up approach to care, where integrated patient pathways improve patients' care and health outcomes, and generate a better experience for them and their families when they use our services.

19. When we have transformed our services, patients will:
    - Receive holistic care which addresses their mental and physical health needs, regardless of the health setting in which they first present
    - Be able to access care earlier, to reduce the likelihood that their health needs escalate to crisis or an emergency
    - Have care provided in their own home or closer to home (where clinically appropriate).
    - Receive consistently high quality clinical care with improved health outcomes
    - Spend fewer nights on average in an acute or community bed than is currently the case, meaning faster recovery and lower chance of losing independence.
    - Have increased scope to co-design services spanning the wider range of services provided by the combined Trust.

20. Since April 2018 the two Trusts have had a single patient experience team, which will help patients, their families and carers navigate the newly integrated patient pathways and ensure family and carers have the information they need about an individual's care.

21. In relation to patient, carer and family experience our planned changes will occur alongside the continuation of existing initiatives such as Triangle of Care - a therapeutic alliance between professionals, patients and carers. These joint improvements will mean that patients:
    - Move more quickly along care pathways spanning current organisational boundaries, and experience consistent care and smooth transitions between acute, mental health and community services
    - No longer have to repeat medical history to healthcare professionals at different points of the pathway spanned by the merged organisation
    - Be given a better understanding at the start of their care about their likely routes through the rest of the pathway.

22. **Figure** 1 below explains how one patient's care would change as a result of the proposed merger.

Figure 1: Patient story

Dorothy is 79, frail and lives alone. Her family lives 200 miles away. Dorothy has diabetes and chronic obstructive pulmonary disease (COPD). She has had a few falls in the last 6 months and her GP contacts are increasing. She is struggling with her complicated medication but is fearful of her health worsening which would require a hospital stay.

Pre-merger

Following some falls, the integrated rehabilitation team assess Dorothy in her home environment to identify any possible causes for the falls. Equipment is provided and trip hazards are removed. The team refer to the Pharmacy technician for a medication review and to the falls education group. Dorothy's frailty means she struggles to attend her regular Diabetes outpatient appointments at the hospital 20 miles away. As the appointments only deal with one of her health problems, she wonders if it is worth the struggle to get there.

Dorothy's COPD worsens, and after a particularly bad fall at home she is admitted to TSFT. After several days in hospital Dorothy is pleased to be discharged home. Her recovery is slow and she never quite returns to her previous level of function. Dorothy needs care twice a day and her situation continues to be managed by the individual health care professional teams.

After another fall, Dorothy is admitted to hospital, but fails to recover and passes away during her stay.

Post-merger

Dorothy is identified by her GP as suitable for the Community Frailty Clinic. This is closer to her home so easier to attend. At the clinic, a team comprising of a therapist, pharmacist and elderly care consultant carry out a comprehensive geriatric assessment. Dorothy tells the team what matters most to her and what she is struggling with.

The team develop a care plan which takes into account all of Dorothy's conditions. They simplify her medication regime which reduces risk of falls and is easier for her to manage. Following the clinic, Dorothy has some actions to help take care of herself and a greater understanding of her conditions.

A community pharmacist makes a follow up visit to check Dorothy understands her medication. Her inhalers need adjustment and the community pharmacist can easily get advice from the specialist COPD nurses at the hospital. Dorothy is also visited by a Village Agent who helps her access community support for social contact and get help in the home when needed. Dorothy talks to her GP team about her plans for care in the future, and together they develop her advanced care plan.

Some months later Dorothy falls again. The ambulance service attends and can see her advanced care plan, noting her wish to remain at home. There is no acute injury so the ambulance crew contact the Rapid Response Team which puts in place 72 hours of intensive support enabling Dorothy to stay at home. During this time Dorothy's family drive down to visit and provide support for a few days.

Over the next few months, Dorothy gradually deteriorates. The community nursing team provide care at home, supported by palliative care services and the GP team until Dorothy's peaceful death at home, as was her wish.

Benefits to staff

23. We intend our improved staff offer to help tackle the recruitment and retention challenges both Trusts currently face. As a result of our proposed merger, current and future staff will have the opportunity to:
    - Derive greater job satisfaction from knowing patients are receiving better care from improved coordination and continuity of care along pathways, and the sharing of clinical best practice from different settings
    - Build capability and competence to recognise and respond appropriately to individuals with mental health needs (if acute staff) and vice versa for mental health staff seeing

patients with physical health care needs, via improved training and in-reach support from colleagues
- Take on more attractive/rewarding roles and pursue more varied career opportunities, including options to rotate in and out of different care settings to broaden skills and professional experience
- Take advantage of a broader range of training opportunities than the two Trusts currently offer, including specialist training developed in conjunction with the planned university in Somerset
- Engage in broader research opportunities arising from the wider range of services offered by the merged entity
- Benefit from the greater resilience of the combined Trust (deriving from the increased ability to flex resources during periods of high demand) and greater personal resilience from broader experience, e.g. through participation in the Integration Pioneers programme.

Quality Benefits

24. Merger will drive improvements in clinical quality in the following ways:

- **Single, harmonised approach**: Standardisation of policies, assessment and treatment approaches will increase compliance, help address unwarranted variation and improve patient outcomes. Duplication will be removed, and the risk that care 'falls between the gap' in the handover between the existing organisations will be reduced. We will also have a single approach to clinical governance and continuous quality improvement. We will have one approach to prevention, assessment and management of certain risks such as pressure ulcers and falls.

- **Sharing good practice**: Sharing practice across a wider group of healthcare professionals in the merging organisations will strengthen clinical leadership and improve service quality.

- **Staff availability:** The shortage of qualified staff currently presents a key risk to quality. Better recruitment and retention from an improved offer to staff will tackle this risk.

- **Staff skills**: Staff will become more highly skilled as education and training that is currently restricted to small groups of staff will be available to more staff, for example Mental Capacity Act training.

- **Single service mind-set**: The merged organisation will benefit from no longer being vulnerable to organisational silo working and protectionism. As part of one organisation, with a single set of values and priorities, previously divided services will come together for patient benefit. For example, increased alignment between TSFT's Emergency Department and SPFT's Minor Injuries Units will support patients to stay out of hospital and receive care closer to home. Improved recording of all patient contacts means we will better understand patients' medical history and their overall needs, which in turn means care plans will better reflect what matters most to individual patients.

- **Filling current service gaps**: Having more highly skilled staff in more closely aligned services supports the development of new services. For example, the merger means some services will be developed which would not otherwise have been possible e.g. a Tier 4 Eating Disorder Service which is currently being scoped.

- **Medicines management**: Medicines will be better managed with an integrated electronic prescribing platform allowing seamless transfer of prescription between sites. This will be alongside a ward accreditation scheme which is being launched to maintain standards across the county.

- **Care closer to home**: Moving care closer to home will improve the quality of care. The Nuffield Trust's report *Shifting the Balance of Care* (March 2017) analysed a large number of projects aimed at moving care from bed-based provision to services provided at home and the community, and found in many instances the projects had begun to significantly improve the quality of care.

25. Merger will also support improvements in performance against NHS Constitution standards. Performance against the 4-hour emergency care standard will be aided by the establishment of a network of Urgent Treatment Centres, and by bringing Musgrove Park's A&E and SPFT's Minor Injuries Units under single clinical leadership. Increased access to diagnostics in the community will mean results are available sooner and appointments are easier for patients to attend. A single approach to elective care, with a reformed outpatient service will help manage demand for planned care. Close working between physical and mental health staff will also help increase access to early intervention for psychosis and psychological therapies.

Benefits to Somerset health and care system

26. Our proposed merger strongly supports the STP direction of travel, and as a combined organisation we will be better able to deliver Somerset CCG's intentions for integrated care and strengthened community services. The proposed merger is fully aligned to the vision of Integrated Care Systems and is a first step towards the STP's stated aim of creating a single provider organisation in Somerset.

27. We believe our partners in Somerset and beyond will benefit from the proposed merger by engaging with just one organisation rather than two. We have a joint strategic aim to have more structured and collaborative engagement with primary care, and the proposed merger will strengthen our relationships with GPs, and provide them with a clearer view of integrated patient pathways beyond primary care to support improved outcomes for patients, carers and families.

Benefits for whole Somerset population

28. Our merger will have wider benefits for the Somerset population by supporting stronger, effective and more resilient health services which are a key part of Somerset's public service infrastructure.

29. Levels of deprivation in Somerset are growing. There are pockets of poverty which lead some people to have poorer health, lower quality of life, lower life expectancy and reduced life chances. Effective health and social care supports people to improve their own lives. Our increased focus on early intervention, improved support to children and families and closer links with primary and social care will help deliver a healthier Somerset, and consequently support the population of Somerset to prosper.

Financial benefits

30. The estimated cumulative savings released by merger over the 5 years 2019/20 to 2023/24 are £51 million (£21 million from support services and £30 million from clinical services). The estimated costs of the transaction are £4.1 million, which we will fund from the two Trusts' budgets. The proposed merger is projected to create a financially sustainable organisation through to 2023/24.

Legal route to merger

31. This is a merger of equals with the two Trusts coming together for the benefit of the people we serve. The Trust boards have carefully considered the options for effecting their merger (including taking legal advice) and, for time and cost reasons, have decided that their preferred legal route is to create the new organisation by transferring TSFT's business into SPFT.

Board composition

32. The merged Trust will have a new name and revised constitution at the point of transaction. Its reconstituted Board will have Non-Executive Directors drawn from the legacy SPFT and TSFT's boards. We intend to hold elections to the Council of Governors of the merged entity shortly after transaction date to ensure representation from the constituencies sets out in the revised constitution. The Trusts' existing joint executive team will transfer to the merged entity.

Merger delivery

33. We have developed a detailed plan to deliver the transaction, which is owned by a named Executive Director and managed by a Programme Management Office. We have identified a wide range of projects focused on integrating individual clinical and support services across the two Trusts. We are using TSFT's existing expertise in project management and benefits realisation to support the individual integration projects, as well as production of the merger case itself.

34. The joint executive team is overseeing the progress of the proposed transaction through an Integration Development Board. Key decisions relating to the proposed merger are made by the two Trust boards. The two Councils of Governors are sighted on progress via regular joint meetings. STP partners are kept informed via monthly Alliance Development Committee meetings, as well as other STP meetings.

35. We have developed an Integration risk register to identify and manage risks associated with integration of the two Trusts. The risk register is monitored by the Integration Development Board, and significant risks are escalated to the Trusts' corporate risk registers.

Glossary of terms

Term	Definition
Accountable Care System	As part of an Accountable Care System, NHS providers, commissioners, the local Council and other partners work together to plan and commission care for the local population, and provide leadership across all organisations.
Acute services	Services provided to patients who require active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.
Alliance Development Committee	The Committee overseeing the development of plans for the proposed merger, made up of senior staff from both organisations and other key stakeholders.
Community services	Services provided to patients in their own homes, or in places like clinics or community hospitals. These could be for short-term issues such as a minor injury, or they could be for long-term/ongoing care needs.
Complex Care Hubs	Locations from where a variety of services are provided, to ensure that patients with complex care needs get the best care.
Home First	A service providing packages of home-based care to enable patients to leave hospital and return home quicker, thereby minimising hospital stays.
Integration Pioneers	Members of staff such as nurses, who are amongst the first of our colleagues to work across both Trusts. For example, some acute nurses are working in community hospitals, and vice-versa, to gain further clinical experience and see for themselves the opportunities afforded by merging.
Memorandum of Understanding	An agreement signed by both Trusts, confirming the two Boards' joint will to work together as an Alliance.
NHSI	NHS Improvement – the body responsible for overseeing and regulating NHS providers. We need NHSI approval before our two Trusts can formally merge.
Nurse Associate	A member of the nursing team who provides care to patients, but is not a registered nurse. The role provides a bridge between registered nurses and healthcare assistants.
Place –based care	Healthcare services designed to meet the specific needs of a geographical location. In Somerset, for example, this means health care services designed to reflect the fact that our population is older than average.
Rapid Response	A round-the-clock service which provides additional short-term support for patients at home or close to home when they need it, to avoid a hospital admission.
Somerset Clinical Commissioning Group	The clinically-led body responsible for planning and commissioning NHS services in Somerset.
Somerset County Council	The body responsible for providing adult social care and children's services to Somerset (as well as other services such as libraries, parks and roads maintenance), overseen by elected Councillors.

Somerset Integrated Digital Electronic Record	Also known as SIDER, this aims to link up all clinical and social care IT systems so that patients and professionals can see all care records in one place. This can include recent appointments, hospital stays, care plans, medication etc.
Somerset Partnership NHS Foundation Trust (SPFT)	The provider of NHS community and mental health services in Somerset.
Staff offer	The types of jobs, working conditions and benefits that we can offer our staff.
Sustainability and Transformation Plan (STP)	Place-based plans for future healthcare services, produced jointly for each area of England by NHS providers and commissioners, and the relevant local Council(s).
Taunton and Somerset NHS Foundation Trust (TSFT)	The provider of hospital inpatient and outpatient care to the north and west of Somerset.