Somerset Partnership NHS
NHS Foundation Trust

Taunton and Somerset NHS
NHS Foundation Trust

Strategic Case for merger of Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust

July 2018

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1. Executive summary

Introduction and background

1.1 This 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). SPFT provides community and mental health 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.

1.2 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.

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

1.4 Overall, the Somerset health and care system is very financially challenged. Both Trusts have sought historically to manage their financial position through stretching Cost Improvement Plans (CIP). However, it is now extremely difficult for either Trust to continue to deliver cost efficiencies without changing the way health services are delivered, and the prospects for the Somerset system becoming financially sustainable without transformational change are very slim.

Strategic rationale

1.5 The 2016 Somerset 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.

1.6 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 took the significant step of establishing a joint executive team consisting of Executive Directors from both organisations. In August 2017, the Chairs of the Somerset STP organisations shared with regulators a joint statement setting out their intention to create a single provider organisation with a single Chief Executive for the whole of Somerset.

[1] Now known as an Integrated Care System.

1.7 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 via 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.

1.8 However, there are limits in how far we can go while we remain separate organisations. The different incentives and interests of each organisation can act as a barrier to realising the full potential benefits of integration, particularly where change entails loss to one organisation – financial or otherwise.

1.9 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. For example, in services where integration has already occurred e.g. Safeguarding, day to day operations are slowed down by the need to report separately for each Trust. The current position whereby the joint executive team reports to two boards is also unsustainable in the long term. As one entity with a single vision, budget, and line management structure, the barriers which currently act as a brake on integration and generate undesirable frictional costs would be removed.

1.10 Much of our integration success to date has come about because of the MOU, and the confidence the joint executive team has given staff about the desired direction of travel towards a single organisation. Staff have been given 'permission' to behave differently and work beyond traditional boundaries with colleagues outside their own organisation. However, this pace and staff commitment is likely to unwind if our integrated working is not put on a permanent footing. In the interests of patients, both Boards are very keen to ensure that the momentum for integration built up so far is maintained.

Consideration of options

1.11 Prior to signing the MOU, the two Trusts had considered options for closer collaboration which included a 3-way merger with Yeovil District Hospital NHS FT (YDH) and a Do Nothing option. Merger was discounted on the grounds of complexity and cost, potential competition issues, and YDH's lack of appetite at the time. However, in light of Somerset's increasing financial and operational challenges, the TSFT and SPFT Boards felt the need for transformational change was urgent and, in the interests of patients, could not be delayed. The two Boards concluded that a MOU was the best option on the grounds that it offered the greatest potential benefits in the shortest time, without excessive cost. It also offered a path to subsequent merger (if desired in future).

1.12 In December 2017, the two Boards considered options for the future of their collaboration. The main options considered were to formalise the Alliance with a joint

oversight Board, or pursue a statutory transaction between the Trusts. The Boards concluded that the first option offered only incremental change and was not viable as it was not sustainable for the long term, and therefore statutory transaction was the preferred option.

1.13 At both points, 3-way merger with Yeovil District Hospital NHS FT (YDH) was considered and discussed with YDH but was rejected on the grounds that, at that time, YDH was pursuing a different strategic approach and did not have an appetite for merger.

1.14 Over the last two years, the two Trusts' Chairs have regularly discussed the direction of travel towards potential merger with their fellow Chairs in the Somerset STP, as well as with the previous and current Chairs of NHS Improvement.

Clinical and operating models for merged entity

1.15 The clinical model for the merged entity will adopt a distributed model of care enabling holistic, person-centred care to be provided 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, improved community-based diagnostics, and 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.

1.16 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.

1.17 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.

1.18 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 CCG 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.

1.19 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 work is in hand to harmonise the two Trusts' HR policies and procedures. We are rolling out a joint leadership development programme aimed at creating a culture across both organisations that supports leadership and a culture of feedback at every level.

1.20 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.

Expected benefits

1.21 The primary reason for pursing a merger is our strong commitment to improving the healthcare we provide to the people of Somerset. We will do this through direct improvement to the care and experience provided to patients, carers and families, but also by addressing recruitment and retention challenges and creating a more innovative and financially sustainable merged organisation.

1.22 As one entity with a single vision, budget and line management structure we will remove the disincentives to close working between colleagues in different organisations which currently causes delay and unnecessary frictional costs.

Patient and quality benefits

1.23 The proposed merger will improve patients' care and health outcomes and generate a better experience for them and their families when they use our services. Following transformation of our services benefits to patients will include:

- Holistic care which addresses both their mental and physical health needs
- Ability to access care earlier and closer to home
- No longer having to repeat their story to different healthcare professionals
- Spending fewer nights on average in an acute or community bed than is currently the case, when their condition requires an stay in hospital.

1.24 The ways in which our proposed merger will improve care quality include:

- Standardised clinical and administrative approaches (policies, treatment regimes, governance and risk management) which will support increased compliance and reduce unwarranted variation
- Removal of duplication in integrated pathways – single assessment and care plan supported by a single patient record accessible by all who need to see it
- Sharing of good practice across a wider group of healthcare professionals which will strengthen clinical leadership and improve service quality.
- Increasing the skills of staff by increasing the availability of training e.g. Mental Capacity Act training - an area which CQC said TSFT needs to improve;
- Medicines will be better managed with an integrated electronic prescribing platform, - CQC also identified medicines management as a weakness in their 2017 inspection of TSFT.

Staff benefits

1.25 We expect the following staff benefits to help address current recruitment and retention challenges. As a single organisation we will be able to offer improved career opportunities to existing and potential staff through rotational working in different care settings. Our expanded training offer will draw on the merged organisation's wider base of services to boost staff capability and enhance clinical quality. The merged

organisation's focus on population health management and its broad span of services will offer a research environment capable of attracting the very best national and international studies.

1.26 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.
- Improve their skills, capability and personal resilience through improved training, the sharing of clinical best practice, and experience gained from different care settings.
- Engage in broader research opportunities arising from the wider range of services offered by the merged entity.

Operational benefits

1.27 The proposed merger will boost our resilience by improving our ability to flex our staff and infrastructure resources to respond to temporary or seasonal pressures. The planned changes will also help us improve our performance against NHS constitution standards.

- 4-hour performance: bringing SPFT's Minor Injuries Units and TSFT's Emergency Department together under single clinical leadership will support admission avoidance and redirection of patients to alternative sources of care, thereby helping to manage emergency demand. Increased community-based diagnostics will also help us treat patients more quickly, aiding performance as we move to develop a network of Urgent Treatment Centres across the county.
- Elective care: a single approach to planned care with greater support to primary care and a revised outpatient service that shifts the focus of care to early intervention will help manage demand for elective care.
- Mental health standards: the merged Trust's larger footprint and strong links between mental health and physical health teams will support quicker identification and referral of people who need mental health care thereby supporting achievement of mental health access standards.

System benefits

1.28 The proposed merger strongly supports the STP's strategic objectives of integrated care and strengthened community services for the people of Somerset. It will create a financially sustainable organisation that will help address the Somerset STP's financial challenges. The proposed merger would also be an important first step on the road to creating a single provider organisation in Somerset, and in due course (subject to regulatory agreement and the legal framework in place at the time) an Integrated Care System for the county.

1.29 Our partners in Somerset will benefit from the proposed merger from streamlined, integrated patient pathways, improved support to primary care, and by needing to engage with just one organisation rather than two.

Financial case

1.30 As a result of meeting challenging CIP targets, SPFT reported a surplus in each of the last three financial years which exceeded plan. TSFT reported a deficit in the last three financial years driven in part by rising emergency demand.[2]

1.31 Despite SPFT's track record of strong financial management, future scope to deliver recurrent CIP is very limited unless service provision is modernised and transformed. SPFT has therefore set a CIP target of 1%, but this is insufficient to offset rising pay and non-pay cost pressures. SPFT's financial position is forecast to deteriorate to £5.1 million deficit by 2023/24 if it continues as a standalone organisation.

1.32 TSFT has set a 2% CIP target but the combination of upward pressure on costs and rising demand means TSFT's financial position is forecast to be £8.1 million deficit in 2023/24 if it continues as a standalone organisation.

1.33 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 which is forecast to deliver a surplus from 2019/20 through to 2023/24. Our cost and savings estimates will be developed and refined at Business Case stage.

Transaction execution

Legal route to merger

1.34 This is a merger of equals with the two Trusts coming together for the benefit of the people they serve. The Trusts 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 merger by acquisition, where SPFT acquires TSFT.

Board composition

1.35 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.

1.36 The proposed merged entity will span a wide geography and provide a very broad range of mental health, community and acute services. We will ensure the Board of the new entity has the necessary skills and experience to enable it to provide effective leadership and oversight of the enlarged Trust.

[2] In 2016/17 and 2017/18, TSFT reported operating surpluses but an overall retained deficit.

Plan to deliver transaction

1.37 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. TSFT has well-developed internal expertise in project management and benefits realisation which supports the identification and quantification of tangible and intangible benefits and ensures projects deliver the planned benefits. We are using this expertise to identify benefits and project manage the individual integration projects as well as production of the merger case itself.

1.38 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. Our timetable for merger seeks to balance the need to move at pace for the benefit of local people, while also managing the risk of distraction from business as usual and consequent deterioration in patient care. The draft timetable assumes we do not need to consult publicly on any of our planned changes.

1.39 Where we can we are using in-house resource, to keep costs down and retain ownership and skills. However, we do not have the capacity and capability to complete the Business Case stage in-house, so would need to procure significant additional support if we receive approval to move to the next stage.

1.40 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.

1.41 We have developed an Integration risk register to identify and manage risks associated with integration of the two Trusts. Key risks identified are set out in **Figure 1** below:

Figure 1: High level risks identified

Risk	Mitigation
Risks to achieving merger	
Inability to manage clinical risks	Clinical risks are standing item at Integration Development Board, as well as being discussed at existing forums.
Lack of capacity to undertake due diligence	External legal advisors and staff with relevant knowledge are undertaking due diligence.
Lack of support from stakeholders	Communications and engagement plan in place.
Risks after merger	
Over-optimism regarding benefits / slow progress in achieving benefits	Benefits will be carefully defined, with the input of clinicians and in-house benefits realisation expertise. Board level oversight and challenge will also take place.
Insufficient management time to focus on integration	All the joint executive team are members of the Integration Development Board.
Insuffiicent cultural alignment	People Strategy and culture workstream in place.

1.42 The risk register, which includes mitigations is monitored by the Integration Development Board, and significant risks are escalated to the Trusts' corporate risk registers.

1.43 As a result of Alliance working, the two Trust boards already have an understanding of each other's work. At Executive level, this knowledge is detailed, since every member of the joint executive team has full access to the systems and records of both Trusts within their functional purview. For this reason, the Trusts undertook initial Due Diligence using internal resources, with the exception of initial legal Due Diligence which was completed by our legal advisors Bevan Brittan. We will carry out detailed Due Diligence at Business Case, building on what has been undertaken so far.

Competition considerations

1.44 NHS Improvement has told us the Competitions and Markets Authority does not intend to carry out a review of the proposed merger.

Conclusion

1.45 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 STP 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.

2. Introduction

2.1 This section provides an overview of Somerset Partnership NHS Foundation Trust (SPFT), Taunton and Somerset NHS Foundation Trust (TSFT), the local Somerset health economy and the current challenges it faces.

Overview of the Trusts

SPFT

2.2 SPFT provides a wide range of integrated community health, mental health and learning disability services to the entire population of Somerset. It runs 13 community hospitals including seven minor injuries units across the county, and is commissioned for 222 community beds. The Trust also provides mental health inpatient services from nine mental health wards. The Trust operates four dental access centres in Somerset, as well as providing primary care dental services at three sites in Dorset and four sites on the Isle of Wight[3].

2.3 SPFT provides a very broad range of community services including District Nursing, stroke services, podiatry and diabetic eye screening, community mental health services include Early Intervention in Psychosis, a community eating disorder service, and services for patients with autism and personality disorders. The Trust also provides Learning Disability services.

2.4 SPFT has more than 1.1 million patient contacts each year which take place in a range of settings including community team facilities, GP surgeries, local clinics, and non-NHS settings including patients' homes. Last year there were over 99,000 attendances at Minor Injuries Units, and 1,003 admissions to mental health inpatient wards.

2.5 The Trust employs around 3,200 staff[4], and is rated Good by the CQC. The Trust made a surplus in 2017/18 of £8.7 million, on turnover of £174 million. The Trust is forecasting a surplus of £4.0 million (including £2.3m of Provider Sustainability Funding) for the financial year 2018/19.

TSFT

2.6 TSFT serves a population of over 340,000 across the west, north and centre of Somerset and provides most of its services from Musgrove Park Hospital in Taunton. The hospital has around 700 inpatient beds on 34 wards, 15 operating theatres and a purpose-built cancer treatment centre.

2.7 TSFT provides several services for the whole county, including oncology, haematology, interventional cardiology, neurology, head and neck cancer services, and public health screening. In addition, the Trust provides emergency vascular services for the wider population of Somerset, North Devon and parts of West Dorset (approximately 800,000 people). TSFT is the specialist centre for bariatric surgery in the South West, performing more than 300 procedures a year.

[3] The Isle of Wight service will end on 12 September 2018.
[4] Whole time equivalent staff number.

2.8 Around 71,000 patients attended TSFT's emergency department in 2017/18, and there were around 48,000 non-elective admissions. In the same year, TSFT saw 366,000 patients in outpatient clinics, and carried out day case surgery for nearly 40,000 patients. It admitted 8,000 patients for elective surgery requiring an overnight stay.

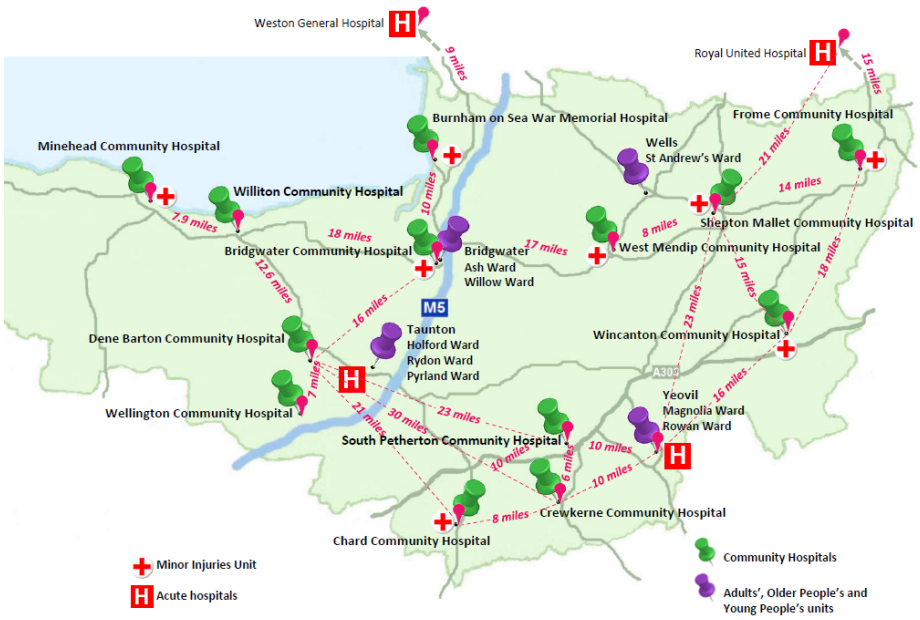
2.9 The Trust employs around 4,300 staff[5], and is rated Good by the CQC. In 2017/18, the Trust reported a deficit of £5.0 million, on turnover of £309 million. The Trust is forecasting a deficit of £3.3 million (including £5.9m of Provider Sustainability Funding) in 2018/19.

Somerset health system

2.10 Both Trusts are part of the Somerset NHS health system, and are members of the Somerset Sustainability and Transformation Partnership (STP), alongside Yeovil District Hospital FT, Somerset Clinical Commissioning Group (Somerset CCG) and Somerset County Council.

2.11 Somerset is the 7th largest county in England[6], with relatively low population density[7] and significant distances between population centres. Travel times across the county are two hours East to West, and one hour North to South. The largest towns, Taunton and Yeovil, each have a District General Hospital, and there are community hospitals in other localities. The present configuration of services and largely rural road network means many residents have long travel times between home and hospital. **Figure 2** below shows the distance between health facilities in Somerset.

Figure 2: Distances between Somerset health facilities



[5] Whole time equivalent staff number.
[6] 7th largest of the 48 ceremonial counties of England, with an area of 1,610 square miles.
[7] 36th highest population density of the 48 ceremonial counties of England, with a population density of 578 people per square mile.

2.12 At 550,000[8], the population of Somerset is large enough to sustain most specialist health services. However, the model of healthcare in the county is heavily bed-based with resources concentrated in the county's acute and community hospitals.

Somerset system challenges

2.13 Like many local health economies in England, Somerset is grappling with a challenging combination of rising demand, workforce pressures and financial deficit. In addition, historic under-investment in some services in Somerset, specifically mental health and preventive care / public health means resources have not always been aligned with local health needs.[9]

2.14 Some aspects of the county's current healthcare configuration drive care into costly acute settings once health needs have escalated, rather than supporting earlier, more cost-effective healthcare intervention. Pressure over winter 2017/18 was partly caused by the conveyancing of frail elderly patients to the county's acute hospitals because there was no alternative provision available.

2.15 The key challenges facing health care services in Somerset are summarised below. Further detail is provided in **Appendix 2.**

- **Challenging demography**: Somerset's proportion of residents aged over 75 was 30% larger than the average in England and Wales at the last census,[10] and this age group is projected to nearly double in size by 2039[11]. In the year to June 2016, the 65-74 age group in Somerset grew 3.5%, - five times the average growth rate for other age groups in Somerset. Somerset has 10% more overweight and obese people, and a 20% higher prevalence of smoking in priority groups than the national average[12].

- **Deprivation:** Pockets of deprivation exist in the county which create and exacerbate ill health. Around 1 in 7 children in Somerset (15,000) lives in poverty and around 1 in 8 households lives in fuel poverty. Poverty is rising - the number of neighbourhoods classed as 'highly deprived' increased from 14 to 29 in the period 2010-15. The use of foodbanks in Somerset has more than doubled since 2013.[13] Up to 75% of foodbank users suffer from mental ill health, and a similar proportion of users have chronic physical illness.[14] In 2016/17, the percentage of SPFT mental health admissions of homeless patients was 6% - double the national average.

- **Rising demand:** In 2017/18, accident & emergency attendances at TSFT were 10.3% higher than the year before. Specialist mental health referrals to SPFT have increased 23% since 2014/15, and Crisis Resolution and Home Treatment referrals have increased 16% in the same period. Demand is

[8] Mid-year population estimate, Office for National Statistics, 2016.
[9] In 2017/18, Somerset spend on public health was £21.8m. This equated to public health spend per head of £41, compared to an England average of £71.
[10] 10.2% of the Somerset population was aged 75 or over at the 2011 census, compared to 7.8% for England as a whole.
[11] This group is forecast to grow by 84% by 2039 compared to 77% for England as a whole over the same period according to the Office for National Statistics.
[12] Somerset Sustainability and Transformation Plan 2016-21 p8.
[13] www.somersetintelligence.org.uk
[14] The Trussell Trust: Disability, Health and Hunger, 2018.

projected to rise further over the next five years - the Somerset STP predicts rises of 15% for some types of service such as A&E and community services.

- **Historic underinvestment in mental health:** Somerset is in the bottom quartile for Mental Health spend, with £12 million weighted expenditure per 100,000 population, against a mean of £14.8 million for England. This has a knock-on effect beyond SPFT. For example, in 2017-18, almost all 12-hour A&E breaches at TSFT were mental health patients awaiting assessment. A gap analysis of Mental Health provision carried out in December 2017 found gaps across the whole mental health system including provision for Adults of Working age and Older Adults spanning whole pathways from primary care through to secondary care and tertiary services. The priority areas identified as needing investment include adult home treatment / crisis services, personality disorder services and intensive community dementia services. Somerset is also an outlier for suicide rates for people under Mental Health care in Somerset.[15]

- **Gaps in provision for children, young people and families:** The Mental Health gap analysis identified shortfalls in Children and Adolescents' Mental Health Services (CAMHS) available at tiers 1 and 2, including early intervention and prevention, and a lack of sufficient tier 4 provision for more acutely unwell young people. This is particularly problematic for young people with eating disorders who currently have to be treated out of area. Medical CAMHS staffing in Somerset is 2.2 per 100,000 population (compared to a national average of 6), and medical staff per 100 caseload is in the lower quartile nationally. Ofsted has recently rated the county's safeguarding and children's services as Requires Improvement.

- **Community spend skewed to bed-based care:** SPFT has 222 community beds, which is approximately double the average compared to comparator CCG areas. However, overall community healthcare spend in Somerset is comparatively low, at £65 per person compared to £90 per person on average in England. Given the high number of costly community beds, it is clear that expenditure on non-bed based community services in Somerset is comparatively very low. This means opportunities to intervene early to treat health conditions via non-bed based community services are missed, and care is driven towards high-cost bed-based provision.

- **Inconsistent patient experience:** Patients often receive care from multiple organisations. This can entail patients having repeat conversations with healthcare professionals from different organisations to explain their medical history, particularly if they receive care for both physical and mental health needs. Inconsistent clinical and administrative approaches to care can be confusing to patients, and transfers of care can appear un-joined up to the patient and their family.[16]

- **Workforce recruitment and retention issues:** As at March 2018, TSFT had 94 whole time equivalent unfilled nursing posts (17% of the nursing workforce). SPFT had 71 whole time equivalent unfilled nursing posts in community services (12%), and 64 whole time equivalent unfilled mental health nursing

[15] Between 2013-15, the suicide rate in Somerset for people under Mental Health care was 10.48 per 10,000 compared to national median of 7.1 per 10,000. Source: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

[16] The CQC patient survey on Somerset Partnership's community mental health services in November 2017 found that patients were particularly concerned about changes in who they saw for care.

posts (19%). The Trusts also have gaps for certain staff groups for which there is a national shortage including sonographers, radiographers, psychiatrists and pathologists. To maintain safe services, TSFT spent £17.1 million[17] in 2017/18 on temporary staff. SPFT spent £11.1m in the same period. In Autumn 2017, nursing staff shortages forced SPFT to temporarily close community beds at three sites across Somerset on patient safety grounds. Temporary closures remain in place at two sites at the time of writing.

- **Financial pressures:** The Somerset health economy ended 2017/18 with a £19 million deficit, and the system is currently forecasting an £17 million deficit for 2018/19 (including Sustainability Funding). Providers' achievement of CIP targets are becoming increasingly difficult to achieve year on year, and without transformational change to the way services are provided, none of the providers in the Somerset system are likely to be able to return to financial sustainability in the coming years.

[17] In 2017/18, TSFT spent £7.1 million on bank nurses, £3.5 million on agency nursing staff, £4.8 million on medical agency and locums, and £1.7 million on other temporary staff.

3. Strategic context

3.1 This section sets out the strategic context at national, STP and Trust level, and presents Somerset's progress to date in integrating care.

National strategic context

3.2 In May 2018, when speaking about the emerging long-term plan for the NHS, Jeremy Hunt, at the time the Secretary of State for Health and Social Care, said key drivers for improvement are integrated care, improved out of hospital care, and reductions in pressures on Emergency Departments. [18] NHS England's publication *Next Steps on the Five Year Forward View* presents examples where competing provider organisations are working collaboratively as a first step towards becoming an Integrated Care System. It is clear that new care delivery models, spanning whole care pathways, are viewed nationally as the key to unlock efficiencies, and improve patient care, outcomes and experience.

3.3 Lord Carter of Coles' recent report on mental health services and community health services noted the need to strengthen the provision and efficiency of community health services, and supported the model of community hubs hosting a range of health and care services. [19] Lord Carter also noted the challenge of meeting significant levels of unmet demand for mental health services, especially children's mental health services.

STP vision for health and care in Somerset

3.4 The 2016 Somerset STP plan acknowledged that the county's health and care services were not keeping pace with the changing needs of local people and that the system required radical change in the following three years. Partners committed to work together to provide a place-based system of care through joined-up health, social care and wellbeing services. The STP set five priorities:

- Improve the financial sustainability of the county system.
- Focus on prevention to create a more sustainable system.
- Redesign services away from hospitals and into the community and patients' homes.
- Address financially and clinically unsustainable acute hospital services.
- Create an Accountable Care System to plan and deliver integrated services.

3.5 To deliver these priorities, the STP plan committed to redesign the Somerset Health and Care system. This included:

- Ensuring a person-centred, holistic approach which considers people's social, emotional, mental health and physical health together.
- Investing more in primary, community and mental health services as well as prevention, and moving resources away from bed-based care.
- Developing a wider range of services in out of hospital settings, so that more care is available near people's homes.

[18] "Hunt seeks full Health and Social Care integration under new 10 year plans", Health Service Journal, 9 May 2018.
[19] NHS operational productivity: unwarranted variations, mental health services and community health services, Lord Carter of Coles, May 2018.

- Ensuring only those people who are seriously unwell are treated in a hospital and that they are able to return home as soon as possible, with coordinated support from community and primary care services, including support for carers.
- Supporting the development of clusters of GP practices, building on the learning from the Symphony programme[20].

Key Strategic Developments since STP plan

3.6 Since the Somerset STP plan was published, there have been a number of developments relevant to this Strategic Case.

Alliance Memorandum of Understanding

3.7 TSFT and SPFT signed a Memorandum of Understanding (MOU) in May 2017, which committed them to work as an Alliance to improve the quality of care and services for patients and service users. The MOU formalised collaborative working which was already taking place between the two Trusts.

3.8 Under the MOU, the Trusts established a joint executive team in late 2017, made up of Executive Directors from both organisations. The joint executive team, which is still in place, oversees all aspects of the two Trusts' operations, working to a single set of strategic objectives with supporting annual objectives covering acute, community and mental health services. The Trusts retain their own Boards with separate sets of Non-Executive Directors.[21]

Chairs' statement

3.9 In August 2017, the Chairs of all the Somerset STP organisations shared with NHS Improvement and NHS England a joint statement reiterating their commitment to join up health and social care services for the benefit of the people of Somerset. The Chairs committed to improve system sustainability by managing demand and rationalising acute services and back office functions. The statement also made explicit the Chairs' commitment to create a single accountable provider organisation with one Chief Executive for the whole of Somerset in the following two years, and acknowledged the Alliance as a step towards this goal. The text of the Chairs' statement is at **Appendix 3**.

Somerset Health and Care Strategy

3.10 In April 2018, Somerset CCG and Somerset County Council began developing a detailed commissioning strategy to respond to the needs identified in the county. The Somerset Health and Care Strategy is being developed with patients, service users and the public, as well as the voluntary sector and other stakeholders. Members of the two Trusts' joint executive and senior management teams are involved in the development of the Strategy to ensure our integration plans are fully aligned with the emerging Strategy which is expected to be completed in September 2019.

[20] The South Somerset Symphony Programme is an NHS vanguard programme which brings together GPs, hospital clinicians, therapists, social workers and patients to develop care which helps prevent ill health or address potential problems as early as possible.

[21] On 8 May 2018, the SPFT and TSFT Boards approved a proposal to appoint two non-executive directors from SPFT to the TSFT Board and vice versa to enable these non-executive directors to get a better understanding of the other Trust and to share skills and experience. These appointments have since been approved by the Trusts respective Councils of Governors.

3.11 A key element of the developing thinking from the Health and Care strategy is the creation of 14 neighbourhood localities across the county, each consisting of around 30,000-50,000 people. These localities will bring together primary care, community care and the voluntary sector to provide care closer to patients' homes with the aim of preventing ill health and intervening early to prevent escalation of health need.

Joint corporate strategy

3.12 At provider level, and as part of Alliance working, SPFT and TSFT have developed a joint corporate strategy with a mission of 'Working together in our communities to become a healthier Somerset'. The principles of our joint strategy, which is aligned with STP intentions, are as follows:

- Provision of consistent and standardised, more specialist services, organised at scale to meet the needs of the whole population.
- Working together with partners including other providers and primary care to deliver integrated care closer to the communities we serve.
- Provide the right services at the right time in the right place for our patients and carers across Somerset, irrespective of who the provider organisation is.
- Provision of local services organised around groups of GP Practices, with a focus on the health and wellness needs of the population.

Integration achievements to date

3.13 Somerset STP partners have taken forward a significant amount of collaborative work in the last year involving all three Somerset NHS providers (TSFT, SPFT and Yeovil District Hospital NHS FT) . Examples include:

- **Rapid Response Team**[22]: This team will provide GPs and South West Ambulance service with a credible alternative to A&E for frail older people. It has a target to reduce bed numbers by 20 at TSFT, Yeovil District Hospital FT, Royal United Hospitals Bath and Weston Area Health Trust, and reduce ambulance conveyances to an acute setting.

- **Home First**: This Discharge to Assess service was established in 2017 to reduce length of stay and the number of delayed discharges of care. A dedicated team of nurses and allied health professionals assesses patient needs in the patient's home, community hospital or care home, and provides support until an ongoing out of hospital care package is in place. In the period January-April 2018 the service saved an average of 10 bed days per week[23].

- **Psychiatric Liaison Team**: This enhanced, nationally-compliant service means more liaison psychiatrists and psychiatric liaison nurses are available to assess, treat and signpost mentally unwell patients presenting at both TSFT and Yeovil District Hospital to alternative locations for care, such as Crisis Intervention and

[22] The interim service has been allocated £1 million of STP funding, and is intended to be fully operational by December 2018.
[23] 10 days saved on average per week at YDH and TSFT combined, with a saving at TSFT of 5.1 days and YDH of 5 days.

Home Treatment. Its aim is to reduce by 20% the admissions and length of stay for mentally unwell patients presenting at the acute hospitals.[24]

- **Complex Care Hubs**: Eight hubs have been established so far to help treat the increasing number of patients with multiple long-term conditions and enable patients' whole care needs to be assessed and managed in one place. The hubs bring together existing community services with primary care and are located across the county in existing community services localities, with plans to create additional hubs in advance of winter.

- **Better Births:** This £1m project is one of seven nationwide pilots aimed at digitally-enhancing maternity services in line with the recommendations of the Better Births Review. It involves data collection, access to information and records for families and staff, and linking data systems across hospitals and primary care. A new post-natal nurse associate post is supporting this work, providing continuity of care for vulnerable families, as well as offering a new career opportunity for support workers.

- **Nursing Associates:** Nursing Associates provide care and support to patients, addressing a gap in care skills between healthcare assistants and registered nurses. The roles exist in their own right and can be used as a stepping stone to graduate-level nursing qualifications. The third cohort of Nursing Associates is due to start in October 2018, and the initiative enables Somerset providers to 'grow our own' workforce to address skills shortages, with the cost of the training paid for by the national apprenticeship levy.

3.14 As part of our Alliance working, SPFT and TSFT have also taken the following steps to integrate support services:

- **Human Resources**: SPFT and TSFT's Human Resources departments came together in 2017, and now operate as a fully-integrated single function serving both Trusts. Having a single function has supported the development of a joint People Strategy focused on recruiting, retaining and supporting the diverse workforce across both Trusts and forging a common culture. A shared set of values and behaviours was launched in July 2018 and a programme of work is underway to harmonise the two Trusts' HR policies and procedures, including staff terms and conditions. Cost savings have been generated by moving to single processes (e.g. a single, streamlined recruitment process) and by extending to SPFT some of TSFT's in-house training for which SPFT used to pay an external provider.

- **Communications:** The two Trusts previously operated independent communications teams but now have a single Head of Communications overseeing communications for both Trusts, with combined internal communications channels, including a weekly staff newsletter and monthly face to face all staff briefings from Executive Directors.

- **Data protection**: There is now a single Data Protection Officer managing the two Trusts' information governance and records teams. This reduces pay costs

[24] A 20% reduction in admissions would mean 817 fewer admissions generating a notional saving of 5,678 bed days, and a notional financial saving of £766,530 to the CCG. A 20% reduction in length of stay would mean a reduction of 3,404 Occupied Bed Days and a notional saving of £459,540.

and is also more efficient as some tasks are now done only once – e.g. development of common policies and addressing GDPR requirements.

- **Governance:** Systems and processes for the completion of risk registers, policy approval and provision of health and safety advice are being harmonised to ensure consistency between the two Trusts, support the sharing of good practice, and minimise duplication. The two teams will merge in the coming months.

- **Estates maintenance**: SPFT's properties in the Mendip area were previously maintained under contract by Great Western NHS FT. This service has now been transferred to TSFT generating a cost saving of £24,000. We intend to integrate the two Estates and Facilities functions in the coming months.

- **IT**: The two Trusts' IT teams have standardised their IT networks so that staff from both Trusts can work in the same manner anywhere in the county; they are also in the process of aligning technical policies and are co-ordinating their work on cyber security to reduce risk. The Informatics teams have adopted a single task management system which has improved efficiency, and SPFT's clinical coding function has been moved from an external company to TSFT generating a £21,000 saving. In the absence of change in organisational form, further integration of IT systems is challenging because of information governance issues.

3.15 Further work is planned to integrate TSFT's and SPFT's other support services with the aim of improving efficiency and generating savings.

Limitations of current position

3.16 It is clear that integrated working between STP partners has yielded benefits for patients and the Somerset system e.g. a reduction in bed usage through faster discharge. Furthermore, formal collaboration between TSFT and SPFT, including the creation of the joint executive team, has removed some organisational barriers and generated cost savings where services have been integrated.

3.17 However, despite good progress to date, there are limits in how far the two Trusts can go in integrating services while organisations within the STP remain separate legal entities. Each organisation continues to be accountable to its own Board, Council of Governors and population, and differing organisational interests and incentives can act as barriers to realising the full potential benefits of integration.

3.18 Where win-win opportunities are identified, change can be relatively straightforward. But where one organisation will 'win' while another may 'lose' (be that income, performance, staff, prestige etc.) change is much harder to progress in the time scale required, even where there is Board level commitment to make change happen. The challenges of different line management structures, policies, procedures, IT systems and cultures present barriers to implementing change and generate delay and unnecessary cost to the system in realising benefits.

3.19 An example is the highly specialist inpatient treatment of children with eating disorders, for which there is a national shortage of available provision. These patients require combined specialist paediatric mental health care and inpatient physical health care, usually provided in an acute setting. While we are two separate organisations, the challenge of finding a location at Musgrove Park Hospital (which

would displace other acute services), and the likely monetary recharge from SPFT to TSFT, act as barriers to making the necessary change to improve care for these patients. As a merged organisation the new Trust would have all the necessary specialist capabilities to deliver this care to this high priority group of children, and would offer this service across the county and the region, helping other acute providers such as YDH.

3.20 Much of our integration success to date has come about because of the Memorandum of Understanding, and the confidence the joint executive team has given staff about the desired direction of travel towards a single organisation. Staff have been given 'permission' to behave differently and work beyond traditional boundaries to help colleagues outside their own organisations. However, this pace and staff commitment is likely to unwind if our integrated working is not put on a permanent footing. The provision of peri-natal care is a case in point, see **Figure 3** below.

Figure 3: Peri-natal care

Case Study – Peri-natal care

Peri-natal care has previously been identified as a system risk in Somerset. Pregnant women with a history of post-natal depression, or showing signs of mental ill-health were at risk of having no appropriate mental health support, as there were no formal links between primary care, community mental health services and maternity services.

As a result of collaboration between TSFT, SPFT and Primary Care, GPs now have the opportunity to undertake peri-natal mental health training. Via a GP referral, women now have access to early intervention from the peri-natal mental health team provided by maternity services. This collaboration means midwives are better informed about mental health issues, and women receive better and more holistic care. Women whose mental health is particularly vulnerable are given additional support, and there are now specialist outreach workers from the Devon Mother and Baby Unit able to provide further assistance where required.

These improvements have only come about as a result of the Alliance between SPFT and TSFT, and because staff feel they have the permission to collaborate beyond organisational boundaries and are confident about the direction of travel towards a single organisation.

3.21 Where we have moved to integrated services, the need to report separately on behalf of each entity creates inefficiencies. An example is the integrated Safeguarding team established by SPFT and TSFT, which is required to report twice to the CCG and twice to the Somerset Safeguarding Adults Board and Safeguarding Children Board (once for each Trust).

3.22 In addition, separate budgets make our desired reallocation of resources within patient pathways (i.e. away from acute services towards community services) more challenging, and fully flexible use of the combined estate is hampered while we are separate organisations.

3.23 Finally, on a practical level, the current position for TSFT and SPFT, whereby we have one joint executive team serving two Boards leads to duplication and is costly and inefficient, placing additional and unsustainable demands on limited Executive time. The SPFT/TSFT Alliance was created to improve services for patients but was not intended as a permanent position and is unsustainable for the long-term.

4. Strategic options analysis

4.1 This section sets out the options considered by the two Boards for the future collaborative relationship between the two Trusts, and the justification for the selection of merger of TSFT and SPFT as the preferred option.

4.2 The Boards' consideration of options was informed by two independent reports, the first prepared in May 2017 by 4D Consulting Ltd on options for collaboration between the two Trusts, and the second in December 2017 by Deloitte LLP on options for the future of the Alliance.

4.3 In 2016, the Somerset STP set out its long-term aim to join up care across different parts of the health system and create an Integrated Care System in the county[25]. The STP document set out the steps to achieve this aim, including closer provider collaboration in the interim. Subsequently, in August 2017, the STP Chairs made clear their intention to create a single provider organisation in Somerset with a single Chief Executive.

Options considered when Alliance created

4.4 TSFT and SPFT have historically had a close working relationship which has supported high quality care for the Somerset population. Examples are the Somerset Wide Integrated Sexual Health service, (which included the transfer of some TSFT staff to SPFT), and the orthopaedic surgery pathway to prepare patients for their hospital stay and enhance their recovery.

4.5 In May 2017, the Boards of SPFT and TSFT considered how the two Trusts might collaborate more closely, given the agreed STP vision. Yeovil District Hospital FT (YDH) was not involved at the time as its strategic focus was on developing a new care model involving collaboration with primary care, as part of the national Vanguard programme. YDH was also exploring the possibility of combining some of its services with Dorset County Hospital, in the Dorset STP. However, in light of Somerset's increasing financial and operational challenges, the TSFT and SPFT Boards felt the need for transformational change was urgent and, in the interests of patients, could not be delayed.

4.6 The two Boards considered the following options for closer collaboration between their two Trusts:

- Do nothing: no continued effort around collaboration or closer relationships.
- Formal collaboration on specific pathways: underpinned by individual contracts which are overseen by a programme Board but little further joint management or governance.
- Joint management with single executive team: governed by an overarching group Board and committees in common, all given effect through an MOU.
- Merger, dissolving the two Trusts and creating new integrated Trust.
- 3-way collaboration/merger (or 4-way with social care).

[25] When the STP plan was written the term Accountable Care System was used.

4.7 The criteria that the Trusts employed to evaluate the options were:

- Impact on patient care and clinical sustainability, including ability to unlock transformational change.
- Impact on financial sustainability.
- Alignment with STP direction of travel.
- Appetite/capacity of other partners.
- Time and effort to achieve/potential distraction from business as usual.
- Costs and risks.
- Ease of unwinding the arrangement.

4.8 The Trusts' consideration of these options was informed by a report prepared by 4D Consulting Ltd which explored the advantages and disadvantages of each option in detail, and which are set out in **Figure 4** below.

Figure 4: Options analysis

Option	Strengths of this approach	Weaknesses of this approach	Ability to unwind
Do Nothing Organisations continue with some collaboration, on an ad hoc basis, but no closer relationship than now.	• Low effort • Allows focus on internal organisational improvement	• Does not address sustainability, demand or care issues or STP requirements. • May cause regulatory intervention (because of lack of action/delivery). • Joined up care does not improve for patients.	Nothing to unwind
Formal collaboration on specific pathways Continue as separate entities with some formal collaboration groups pulled together on specific pathways or support areas but little in the way of joint management or governance.	• Potential to prove concept of changes on a small scale with some associated benefits. • Low risk from a change perspective. • Continues good relationships.	• Limited positive impact for patients • Collaboration only likely on items that are directly beneficial • Continues to be 'in addition to' the day job for executives and managers so unlikely to get their best attention. • Unlikely to unlock significant transformation because of remaining organisational barriers. • Potential to break down quickly when there is conflict/disagreement.	Easy within the constraints of any contracts
Joint management with single executive team Executive operates as one team with aligned objectives and communication channels. Governed by some form of overarching Board (Group Board/Programme Board) and creation of committees in common – all given effect through an MOU.	• Allows increased scope of transformation and pathway review therefore identifying and delivering patient benefits. • Can be implemented quickly (3-6 months). • Creates single point of leadership and alignment of objectives • Opportunity to share workforce and people/career development. • Develops system leadership. • Likely to drive more significant cost savings/efficiencies. • Provides mechanism to resolve conflict in the system's interest through Committees in Common. • Removes the need for individual contracting on each collaboration • No statutory change so no need to consult/seek permission.	• Bureaucracy of two Boards remains • May disenfranchise individual Boards due to the work of the Group Board (or equivalent) and committees in common. • Some uncertainty/insecurity over roles (for a time). • Requires further change (either merger or • unwinding) at a later date as organisational governance unlikely to be sustainable in the medium/long term. • May cause adverse reaction amongst other partners if not handled well. • Those who are sceptical of the benefits of integration may feel backed into a corner.	Possible with some difficulty. Establishment of previous governance arrangements and Executive Teams
Merger	• Benefits as "Joint Management" above plus:	• Cost and time effort	Difficult

Option	Strengths of this approach	Weaknesses of this approach	Ability to unwind
Dissolution of both existing Trusts and creation of a new single Trust, new Board and Executive team	• Simplest end point in terms of organisational governance and minimised bureaucracy. • Maximises benefits and minimises duplication (Board overheads etc.).	• Complex regulatory and consultation process which can be derailed by external parties/factors. • Transaction could distract from change effort and business as usual delivery (jostling for position). • Significant uncertainty for a time amongst teams	
3-way or 4-way merger Rely/support/enable STP process to deliver a 3 (or 4 with social care) way collaboration/merger. Same range of options as above but applied more broadly	• Unlocks a county-wide fully integrated system with all associated benefits.	• Disadvantages as "Merger" above, plus • Extremely complex, costly and unwieldy to deliver in one step. • Lack of appetite/capacity from other partners. • Apparent inability of STP system process to deliver.	Very Difficult

4.9 On 25 May 2017 the SPFT and TSFT Boards agreed to sign an MOU to support ongoing collaboration and create a joint executive team. This was the preferred option on the grounds that it offered the greatest potential benefits in the quickest time, without excessive cost. It also offered a clear path to merger if that was desired, but could be unwound if necessary.

4.10 Board members were informed of the discussions held with partners and regulators to explain the rationale for an Alliance between the two Trusts, and of the supportive responses that had been received confirming the proposed Alliance was wholly congruent with the intent of the Somerset STP.

Options considered for Alliance development

4.11 In December 2017, when the Alliance had been in place for seven months, the two Trust Boards commissioned a second options appraisal report from consultants Deloitte LLP about the future of their collaboration. The report presented a range of potential models including management contract and accountable care organisation. However, given the strategic context and the position and objectives of the Trusts, the report considered that only two options were viable (see below) and therefore only these options were explored in detail as part of the review:

- Formalise the Alliance with an oversight Board
- Statutory transaction between the two Trusts

4.12 These options were considered against the following criteria:

- Board and committee arrangements.
- Impact on staff.
- Quality and operational effectiveness considerations.
- Financial implications.
- Impact on broader system working and fitness for the future.

4.13 Deloitte excluded YDH from their review for two reasons: YDH was not within their engagement brief, and it was considered likely that regulators would require the benefits of merging two organisations to be realised before considering a third entity.

4.14 The SPFT and TSFT Boards met in December 2017 and agreed that the option to formalise the Alliance with an oversight Board was not a viable option as it offered only incremental change and Alliance work could not be sustained in the long term. The two Boards concluded that a statutory transaction may bring benefits in the medium to long term if: a clear vision and benefits plan were defined and work was undertaken to address feedback from staff and stakeholders. Following this meeting, the Trusts initiated a range of merger-related activities including developing a staff and stakeholder communications and engagement plan, holding more executive drop-in sessions, sharing a monthly 'merger special' briefing with staff and providing weekly updates to governors and Board members.

4.15 At the joint Board session on 31 January 2018 the Boards agreed that the Alliance arrangements should progress to the next stage and gave approval to proceed with the development for the Strategic Case for merger, which included the outline clinical model. The Boards believe that becoming one organisation will allow us to realise fully the potential benefits of integrating our two Trusts by:

- Allowing vertically integrated clinical models to be established which improve patient outcome and experience.
- Signalling to staff and other stakeholders the permanence of the change, and underscoring our commitment to realise the maximum benefits.
- Underpinning our shared vision, goals, values and behaviours and driving a consistent culture.
- Supporting aligned staff terms and conditions and avoiding the potential for a two-tier workforce.
- Enable fluid movement of resources across existing organisational boundaries to better meet clinical need.
- Removing the cost of maintaining two organisations (two Boards, two sets of accounts).
- Allowing full integration of back office services.

Consideration of merger with Yeovil District Hospital

4.16 It is important to be clear in this Strategic Case why we are not proposing either an acute-to-acute merger with Yeovil District Hospital (YDH), or a 3-way merger between our two Trusts and YDH.

4.17 SPFT and TSFT are mindful of the STP's commitment to create a single provider organisation, and still believe this is the right long-term solution for the people of Somerset. The Boards are also aware of the urgent need to a drive transformational change in the Somerset health system to improve care for patients and address issues of financial sustainability.

4.18 The Boards believe the proposed merger of SPFT and TSFT is a pragmatic first step on the road to creating a single provider in the county, given the pressing need to initiate transformational change, the existing groundwork already done under the Alliance, and the two Boards' willingness to move to the next stage. Our partners are involved in our work towards merger via the Alliance Development Committee. The final legal form of a single integrated provider organisation in Somerset would depend on the outcome of local system discussions and the legal and regulatory framework at the time. However, we are confident that our merged organisation would fit into any future model for integrated accountable care.

4.19 Three-way merger was considered in May 2017 and discussed with YDH but rejected on the grounds that there was a lack of appetite from YDH and because of the complexity and cost of a 3-way merger. The Boards continue to test this position. For example as part of joint Board discussions in May 2018, the two Boards again discussed the merits of a 3-way merger with YDH, but noted the associated complexity and risk.

4.20 The Board also noted the need to involve the Competition and Markets Authority in a 2- or 3-way transaction involving two acute Trusts and the delay this would introduce. Concerns were also noted that 2- or 3-way merger with YDH might raise regulatory "red flags" given YDH's financial position and CQC rating of Requires Improvement. Informal board discussions have further noted that the development of integrated pathways across the county (enabled by the proposed merger of TSFT and SPFT) is likely to drive larger population health benefits than an acute-acute merger.

4.21 The Boards are clear that the proposed merger of SPFT and TSFT does not preclude ongoing close working with YDH, or further strategic change in the STP which could, for example, see YDH join the merged organisation at a later date. The involvement of YDH's Chairman and Chief Executive in the Alliance Development Committee (alongside representatives from Somerset County Council and the Somerset GP board) ensures YDH stays abreast of merger developments and can play a role in shaping it.

Support from Somerset STP

4.22 Over the last two years, the two Trusts' Chairs have regularly discussed the direction of travel towards potential merger with their fellow Chairs in the Somerset STP, as well as with the previous and current Chair of NHS Improvement.

4.23 We have engaged with our local STP partners as our plans for joint working have taken shape – initially on informal collaboration, then formal collaboration as the Alliance, and now our proposed merger. We have the support of our partners in the Somerset health and care system for our proposed merger, namely Somerset Clinical Commissioning Group, Somerset County Council, Yeovil District Hospital FT, and GP representatives. The letter of support from the STP is provided as a supporting submission to this Case.

5. Clinical and operational models

5.1 This section sets out the outline clinical and operational models, and how they will help the merged entity play its role in addressing the challenges set out in **Part 2**.

Outline clinical model

5.2 As a merged Trust we will play a key role alongside STP partners in developing the 14 planned Somerset neighbourhood localities which will see care currently delivered in acute settings provided in future from settings much closer to patients' homes. This will improve patient experience and support financial sustainability. As a rural county, Somerset has strong local identities and working with our social care partners we aim to build the resilience of these local communities.

5.3 We will align our community-based work and inpatient care with the planned localities and provide acute services support (including diabetes support and geriatric expertise) to the localities and Primary Care. Both our Trusts are already managing and providing clinical services to some Primary Care practices, and we expect this to continue and develop in the future.

5.4 The following are key features of the planned clinical model:

- Holistic care
- Integrated pathways
- Person-centred care
- Reduced bed-based care
- Improved use of infrastructure and assets

Detailed development of the clinical model will take place at Business Case stage. However, the outline model and developments to date are set out below.

Holistic Care

5.5 We will develop our services to address both mental and physical health conditions regardless of the setting in which people first present. Work already underway and planned includes:

- **Support to staff**: By the end of 2018 we will have established ward buddy and clinical shadows arrangements enabling mental health and acute care nurses to gain experience in different care settings. These arrangements, together with placement rotations and enhanced staff training[26], improve staff capability in managing challenging behaviour on physical healthcare wards, and the treatment of physical health conditions in mental health patients. They enable staff to develop a network which they can draw on as necessary. Early pilot work showed that upskilling nursing staff through on-the-job training dramatically reduced the need for temporary staff to care for patients with unfamiliar care needs.[27]

[26] We have begun training mental health staff in intramuscular injections, allowing them to perform a task traditionally performed by physical health staff.

[27] Reliance on agency Registered Mental Health Nurses to treat patients with mental health needs on TSFT's Conservators Ward fell to zero after staff had the opportunity to learn from colleagues working on SPFT's mental health wards.

- **Mental health support for patients with physical health conditions**: SPFT's psychological therapies service now offers an Emotional Health Check[28] for musculoskeletal, podiatry and diabetes patients. Depending on the outcome, patients can be offered self-help, group intervention or be signposted to community agencies to support better mental health. In future we want to extend these services to patients with cancer, heart failure, chronic obstructive pulmonary disease and medically unexplained symptoms.
- **Improved care for patients with dual diagnosis**: We have plans to explore with voluntary sector partners how we can provide improved therapeutic care for patients with a dual diagnosis, for example those who are mentally unwell and who also have physical health care needs caused by alcoholism.

Figure 5: Patient story

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.

[28] An Emotional Health Check is a rapid assessment of how anxiety or low feelings might be affecting a patient living with a serious physical health condition.

Integrated pathways

5.6 We will integrate and streamline patient pathways which span community, mental health and acute services to remove duplication, support seamless care along the pathways, and improve patient care and experience.

5.7 We recognise that successful integration of primary, community, acute and social care requires the involvement of all providers, including the voluntary sector. We will ensure our plans to integrate pathways are produced collaboratively with partner organisations.

5.8 Examples of planned integrated pathways include:

- **Admission to community hospital from acute**: Our two Trusts have already improved the pathway for admission from acute to community hospitals by creating a joint management post and establishing new working arrangements between the two teams. Together with *Home First (*Somerset's Discharge to Assess service), these changes have largely eliminated waits for community hospital beds at the point of discharge from the acute hospital.[29]

- **Frail elderly pathway**: We will create a distinct pathway provided by expert old people's multi-disciplinary teams based in the community to provide care for the frail elderly in their homes or close to home. These teams will provide comprehensive geriatric assessment (covering both physical and mental health) including intensive dementia support, old age psychiatry and other mental health support, rapid next-day clinics, and specialist out of hospital older people's services e.g. to treat UTIs and falls prevention. We want to create local teams that are truly person-centred, who know the individuals in the community they serve. We will also explore opportunities for direct admission to community hospital for frail elderly people who require lower acuity care, to reduce acute admissions. See **Figure 5**.

- **Stroke pathway**: Work to integrate the Stroke pathway is already well advanced. The neuro-psychology and stroke-psychology teams have merged, and joint nurse handover protocols are in place to facilitate transfers of care from the acute to community setting. The joint team has mapped existing pathways as well as a 'perfect pathway' for which a supporting IT tool is being developed. Next steps include rotating stroke nurse placements between acute and community settings. We also want to explore opportunities for rapid hyper-acute treatment in the hours immediately following a stroke, and closer ties to rehabilitation services currently provided by SPFT in the community.

- **Adult mental health services**: There will be further enhancement of the psychiatric liaison service, including further Night Assessor resource for people in crisis out of regular hours. This investment will help reduce admissions and provide a support framework to aid earlier discharge.

- **Children, young people and families services**: There is county-wide acknowledgement that services for children, young people and families need to

[29] In April 2018 there was just one delayed discharge of a Home First patient, of a cohort of 56 patients on the pathway for discharge to a community hospital.

improve. We will join up paediatric mental health and physical health services and link in the unified team with local authority and primary care partners.

- **Safeguarding**: Together with partners we have recently established an integrated service covering safeguarding for children, adults and maternity, as well as specialist areas including consent, the Mental Capacity Act, Deprivation of Liberty Safeguards, and multi-agency safeguarding arrangements. The combined service working across the two Trusts has generated annual cash-releasing savings of £90,000- £100,000. The model is underpinned by a 'Think Family' model of safeguarding, which aims to ensure staff can identify vulnerabilities in patients or in other people that our patients may care for.
- **Eating Disorders**: Exploratory work is already underway to create a tier 4 CAMHS specialist eating disorder service which would provide a much needed local facility for young people, thereby avoiding out of area placements, see **Figure 6**.
- **Peri-natal care**: We want to build on work already started to provide enhanced care to expectant mothers and new mothers, by providing better training to community midwifery staff in mental health matters, helping them spot mental health issues early and signpost women to community mental health teams and other psychiatric support services as needed.

- **Additional pathways**: We have identified more than 30 further clinical areas for integration, including Urgent and Emergency Care, Therapies and minor surgery.

Figure 6: Patient story

Jessica is 14. She has a serious eating disorder which has weakened her physical health to the point that she now requires inpatient care. She has completed the 3-week acute pathway for children who require intensive feeding support, but her condition has not improved and she now needs specialist inpatient care.

Pre-merger
The nearest eating disorder unit is in Birmingham. Jessica finds it traumatic to be separated from her family and routines, the travel to support their daughter is difficult for Jessica's family, and staff know that going against the therapeutic Family Based Treatment approach to care may make Jessica's recovery harder. However there is no alternative. The two Trusts are working collaboratively where possible and developing an enhanced pathway, but as two separate organisations the scope and pace of improvement is not as it would be if we were one organisation.

Post-merger
When combined, the two Trusts are able to make the case for a specialist Tier 4 facility in Somerset. Without a merger, neither organisation would have the combined clinical expertise to deliver the necessary combination of mental and physical health care to support such a unit. Receiving her care closer to home speeds Jessica's recovery, enabling a quicker step down to community treatment. It also makes things easier for her family and helps them support her. Jessica is now cared for by a single team, who care for all aspects of her health according to a single care plan which is easier for Jessica and her family to understand and engage with.

Person-centred care

5.9 We want to remove the boundaries between organisations which can lead to patients and their families having to repeat their story, experience inconsistent care, and feel they are engaging with a system that is not joined up. We also want patients to feel their symptoms are taken seriously even if they are medically unexplained.

- **Consistency of approach:** We want to move to a consistent clinical and administrative approach across pathways which includes a single care plan to avoid repeat clinical assessments and changes in care regime as patients move from the care of one organisation to another.

- **Medically unexplained symptoms**: We will explore how to provide enhanced psychological support and pain clinic care for patients with medically unexplained symptoms which are particularly common in neurology, cardiology, gastroenterology and gynaecology. Increased mental health support is particularly pertinent for this patient group, as between 40-50% of all outpatient appointments for Medically Unexplained Symptoms have a mental health element.[30]

- **Transition from children to adult services**: Many young people and their families face difficulties when they transition from paediatric to adult services at age 18, especially those with complex long-term conditions. For example a person with Down's Syndrome is more likely to have a range of physical conditions such as a heart condition, vision problems or a hearing impairment alongside their learning disability, and each condition is currently treated by a different adult specialty. We want to create a service for patients with complex long-term needs which enables a single clinician to oversee all their care, in much the same way a geriatrician works with frail elderly patients[31].

Reduced bed-based care

5.10 The clinical model for the new organisation will be based on the principle that patients should not be in hospital unless necessary.

- **Reallocation of resources**: Working closely with commissioners, and using the unified budget of the merged organisation, we want to devote a greater proportion of our resources to community services and mental health provision.

- **Support to primary care:** We will also work with partners including primary care and the voluntary sector to support early intervention, with the aim of preventing healthcare needs escalating and helping patients stay out of hospital when they do not need to be there. A pilot project placing physiotherapists into GP surgeries has reduced onward musculoskeletal referrals into secondary care.
- **Reducing admissions:** We will align the practice at TSFT's Emergency Department and the Minor Injuries Units run by SPFT. Nursing and medical input, including mental health specialists will be provided to both settings which will offer a range of alternatives to hospital presentation and admission.

- **Reducing length of stay**: We will build on work already started to help inpatients (in both acute and community beds) recover faster and have a shorter length of stay.
    - **Improved outpatient service**: Wherever possible a distributed model of care will be in place, using a modernised community infrastructure,

[30] Carson et al "Do medically unexplained symptoms matter? A prospective cohort study of 300 new referrals to neurology outpatients", *Journal of Neurology, Neurosurgery & Psychiatry, 68*, 207–210.
[31] A development of the versitalist staffing model whereby a clinician is trained in a variety of fields to meet the range of care needs that a specified subset of patients might present with (akin to geriatric or paediatric practice).

supported by an integrated electronic care record and local diagnostic facilities. We want to provide as much access to diagnostics and supporting advice as possible to primary care and community care; where referral to secondary care is necessary services will be provided as a 'one-stop' shop. Follow up care will be supported by technology, with remote consultation and email advice provided directly to patients and primary care teams. Improving our outpatient service requires significant work not just between the two merging Trusts but also with our partners in primary and social care, and for that reason we expect improvements to our outpatient model to take longer to develop than our inpatient services.

Improved use of infrastructure and estates

5.11 We want to make more flexible use of the combined acute and community bed base to accommodate peaks in demand, and make more effective use of the available estate to provide care out of hospital and closer to patient homes.

- **Creation of Ambulatory Emergency Care**: In advance of next winter we plan to temporarily move TSFT's outpatient physiotherapy service to SPFT's Dene Barton site so we can create an Ambulatory Emergency Care unit next to the Emergency Department at Musgrove Park Hospital. This will free up space for 18 additional escalation beds which will boost our resilience at times of pressure.

- **Community Diagnostics**: We will improve utilisation of community diagnostics facilities and at the same time provide the service closer to patients' homes.

Outline operating model

5.12 We are at the early stages of considering the merged Trust's operating model, which will support the clinical model outlined above. We have agreed the following high level principles which will be used to inform the operating model for the merged Trust:

- Holistic approach to care which supports physical and mental health needs across Somerset.
- Care in the Right service, Right place, Right time: to support integrated working across health and social care we will align our work with the 14 geographical localities agreed by the STP. This will involve assessing the community needs in each locality, and determining which services can be delivered locally and which require a specialist setting.
- Equity of access for patients, carers and families.
- Reflect the rurality of Somerset with a need to consider the lack of public transport aligned with longer travel times for patients and our colleagues.
- More effective use of resource with consideration of the challenges currently being experienced in recruitment and retention.

5.13 We plan to develop these principles further and consider options for the operating model with input from clinical colleagues in the coming few months.

People strategy

5.14 Our joint HR function has developed a joint People Strategy focused on recruiting, retaining and supporting the diverse workforce across both Trusts and forging a common culture.

Recruitment and retention

5.15 Our recruitment and retention approach will be tailored to the role and service where there are challenges. We will target both passive and active candidates through a variety of innovative recruitment channels. Key actions include:

- aligning and streamlining processes to provide an efficient and positive candidate journey.
- providing a proactive recruitment approach which is forward thinking rather than reactive and bureaucratic.
- implementing effective and robust action plans with all services to ensure the approach to attraction is targeted, using a range of resourcing methods. including headhunting for hard-to-fill vacancies.
- providing comprehensive reporting on all stages of the recruitment lifecycle with developed KPIs, enabling the Trust to report on its vacancy position at all times.
- introducing innovative, modern and effective advertising channels, including cluster advertising, social media and bespoke CV databases.

5.16 As a larger and more diverse merged organisation we will be able to develop new career opportunities for existing and potential staff including opportunities to rotate around different care settings. For example, our new Integration Pioneer programme offers acute care nurses the chance to work for six months in the community setting, which enables them to develop new experience and builds personal resilience, see **Figure 7**.

Figure 7: Staff story

Staff story: Kristina Renshaw

I've worked at Musgrove Park Hospital for ten years as a Junior Sister on Dunkery ward. I wanted to be an Integration Pioneer as I'm always keen to expand my knowledge and love sharing skills and things I've learnt.

I'm currently based at Bridgwater Community hospital where I've experienced the challenges of working in a community hospital and seen a different way of nursing. It's so rewarding to see patients being discharged home after intense rehabilitation in a community setting following a long stay in the acute. I've been able to share some of my skills with my new colleagues and explain how acute Trusts work and the different pressures we face. The management team at Bridgwater have also listened to my ideas about how to improve our service here.

I've now begun working with some of the specialist teams at both Trusts, such as the staff bank and Learning and Development to share my perspective as someone who's worked in both acute and community settings. On a personal level, this opportunity has been invaluable to me as a developing leader. As an Integration Pioneer, I was offered the chance to do an L5 ILM leadership apprenticeship which is providing me with good leadership skills. I'm looking forward to returning to Musgrove, to share how community hospitals work and encourage other staff to take up the opportunity to learn, develop and share like I have.

5.17 We will expand our training and research offers to staff to draw on the wider base of services that the merged organisation will deliver. This will include working with the planned university in Somerset to develop bespoke educational offers for healthcare students. The merged organisation's focus on population health management and

broad reach across the health continuum will offer a research environment capable of attracting the very best national and international studies.

5.18 The merged Trust will become the only provider of integrated acute, community and mental health services in Somerset, Devon and Cornwall. It will also have the highest income and employ the largest number of staff in the three counties. For staff seeking to be at the cutting edge of the NHS, we believe we will be an attractive provider to work for.

Harmonising culture

5.19 We are mindful of the importance of harmonising culture across the two Trusts in order to deliver a successful merger. We have a good understanding of the cultural differences between the two Trusts based on a number of sources including the NHS staff survey (specifically staff engagement score), Pulse survey results and feedback from other sources e.g. Freedom to Speak Up, internal audits, employee relations cases and informal feedback to senior managers and the HR team.

5.20 The top 5 key findings from the staff surveys in the two Trusts indicate that SPFT is more effective at preventing physical violence and bullying and harassment experienced by colleagues, while TSFT is rated more highly in areas involving effective team working, staff feeling valued, and the support staff get from their line managers.

5.21 The NHS staff survey found that overall employee engagement at SPFT was 3.77 and 3.91 at TSFT. We are developing plans to improve leadership and engagement across both Trusts to help improve our engagement scores, and will draw on the complementary strengths of both Trusts to do so. Progress will be monitored through Pulse surveys at both Trusts every 6 months.

5.22 We have consulted staff on a joint set of values and behaviours for both Trusts and these are currently being rolled out. We are also reviewing our performance management approach, induction and training to ensure the new values and behaviours are well-embedded.

5.23 We are developing a Joint Leadership Development Programme which we will start to roll out at the end of July 2018. The Programme aims to create a culture across both Trusts that supports leadership and a culture of feedback at every level. Our intention is that in the coming 12 months all staff at band 7 and above in both Trusts will participate in the Programme, and in the two years following we will enrol all other staff with supervisory roles on the programme.

IT as enabler to clinical and operating model

5.24 IT integration will be a critical enabler to the effective operation of our planned clinical and operating models as they will rely on the secure sharing of patient and corporate data between staff at multiple locations and across all parts of patient pathways. IT integration is one our key corporate integration projects given its importance to our ability to implement service transformation.

5.25 Our IT teams are looking at options for increasing integration across the Alliance to maximise efficiency, achieve economies of scale from standardisation and automation, and give better digital support to patient pathways in Somerset. We will ensure the

right clinical system is selected to support the best clinical outcome and we will approach IT integration in a way that allows our STP partners to link in to our systems.

5.26 Both Trusts are playing a leading role in the development of the Somerset Integrated Digital Electronic Record (SIDER), which will provide a single electronic patient record accessible by GP surgeries, ambulance staff, Out of Hours/111 service, social care, community, mental health and acute Trusts, and patients themselves. The expected benefits of SIDER are:

- Improved information sharing at the point of care.
- Improved safety, care efficiency and effectiveness.
- Less duplication of effort, recording and tests requested.
- Patients do not have to repeat their story to every care professional.
- Timeliness of access to information.
- Reduction in serious untoward incidents and near misses.
- Optimised use of existing technology investment.
- Better preparedness for changes to models of care and organisational structures.

How the merged organisation will address Somerset healthcare challenges

5.27 **Figure 8** below sets out how the challenges in the Somerset health economy, (presented in **paragraph 2.15**) are addressed by the clinical and operating models described above.

Figure 8: Challenges and how they are to be addressed

Challenge (from paragraph 2.15)	How addressed
Challenging demography Ageing population, above average incidence of obesity and smoking	• Creation of specialist Frail Elderly pathway with much more provision provided in community rather than acute setting • Re-allocation of resources away from acute into early intervention in community to prevent escalation of ill health.
Deprivation Pockets of poverty with associated physical and mental health issues	• Locality-based care, including hubs providing tailored support near to people's homes. • 'Think Family' approach to Safeguarding to improve support to vulnerable people who use our services.
Rising demand: High increases in demand for emergency care and mental health care; demand projected to rise further over the next five years	• Development of out-of-hospital care pathways to re-focus hospitals on acute/emergency patients. • Increase in early intervention care provided from locality hubs to reduce escalation of need to emergency/crisis.
Mental health services Historic underinvestment in mental health, identified gaps in mental health provision	• Holistic approach to support better mental health for those with physical health conditions – e.g. new service planned for medically unexplained symptoms. • Improved dual diagnosis, CAMHS and peri-natal mental health services
Gaps in provision for children, young people and families: Shortfalls in CAMHS tiers 1 and 2; lack of sufficient tier 4 provision for more acutely unwell young people, particularly those with eating disorders; care for vulnerable children and families.	• Improved CAMHS services, including provision of Tier 4 eating disorder service. • Improvements to Safeguarding services • Improved services for 16-18+ patients with complex care needs transitioning to adult services.

Challenge (from paragraph 2.15)	How addressed
Community care: provision skewed to costly bed-based rather than non-bed based community care which would help prevent escalation of need and need for hospital stay.	• Increase in community-based care provided from locality hubs to reduce requirement for inpatient admission • Improved community diagnostics services. • Smoothed admission to community hospitals from acutes.
Inconsistent patient experience repeat patient conversations with healthcare professionals from different organisations; inconsistent clinical and administrative approaches to care can be confusing; transfers of care can appear un-joined up	• Holistic care model delivered by a single organisation with a single care record system. • Integrated pathways with a single clinical and administrative approach.
Workforce recruitment and retention gaps and agency costs	• Better career development opportunities through rotational roles and a wider portfolio of services. • Better training and skills-sharing. • Wider service mix creating enhanced research opportunities. • Large employer able to offer more flexible roles.
Financial pressures: All Somerset providers expected to be financially unsustainable in the next 1-2 years without transformational change to way services are provided.	***See Part 7*** • Savings arising from pathway changes, reduced reliance on bed-based care. • Savings from rationalisation of support services.

6. Expected benefits of merger for patients, Trust and local health economy

6.1 This section sets out the expected benefits of the proposed merger for patients, staff, the merged organisation and the Somerset health and care system.

Benefits to patients

6.2 The primary reason for pursuing a merger is to improve the healthcare we provide to the people of Somerset. There are examples of inequity of access across the county, with some people currently experiencing poor mental or physical health because the service they need is not available when they need it. This lack of access causes a higher number of patients to have to enter services in a period of crisis, to seek urgent care for matters which could have been managed in a better way, or to re-enter services due to lack of support when they have been discharged. We also 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.

6.3 In relation to patient care this means that once we have transformed our services in the way we plan to, 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 less decompensation.
- Have increased scope to co-design services spanning the wider range of services provided by the combined Trust.

6.4 SPFT provides carers' services across Somerset, and since April 2018 the two Trusts have had a single patient experience team. This team will help patients, their families and carers navigate newly integrated patient pathways and ensure that family and carers have the information they need about an individual's care.

6.5 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 will:

- 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.

Benefits to staff

6.6 We intend our improved staff offer to help tackle the recruitment and retention challenges both Trusts currently face.

6.7 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 Integration Pioneers programme (see **Figure 9**).

Figure 9: Staff story

Staff story: Penny Earl

I've been a staff nurse at Musgrove Park since 2000, and always thought of myself as an acute nurse, in the thick of things, facing the unknown most days. I never once thought that I would get – or even want – the opportunity to go to a community hospital to experience something new.

What was an Integration Pioneer anyway and what - some of my colleagues at Musgrove Park Hospital asked - would I possibly learn? Wouldn't I get bored?

How wrong I was. I began my 6 month secondment in March 2018 and realised by April that I wanted to stay!

The nursing profession actively encourages us to be autonomous, put patients (and their relatives) first, and deal with each case individually. This is no more evident than in a busy community hospital when you have no Doctor after 5pm on a Friday, patients arrive without the adequate (and essential paperwork), medications may not have been sent with the patient, and the handover isn't always a true reflection of the actual person in front of you.

Communication is a basic, fundamental aspect of good, effective nursing care and I'm proud to say I've witnessed excellent communication throughout my entire secondment to Exmoor ward. All the staff here have their patients' best interests at heart and actively question and challenge decisions they feel may affect the patient they're looking after.

This experience has completely revitalised me. It's given me new-found pleasure in my work and encouraged me to continue with my much beloved profession (even though retirement was an option I'd been considering). I hope my experience will encourage more staff to come and witness, and be part of, the amazing work that a community hospital can provide for our elderly, frail and sometimes, demanding population.

Benefits to the merged entity

6.8 Benefits to the merged entity lie in a number of areas. Benefits to quality, performance, and improved organisational resilience are set out below. Financial benefits are set out in **Part 7**.

Quality Benefits

6.9 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 to harm 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. Merger presents a significant opportunity to strengthen clinical leadership across community and mental health settings during a time of significant service transformation, including by development of triumvirate leadership.

- **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. CQC identified this as an area in which TSFT needs to improve.

- **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 MIUs 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 where gaps exist and there is local need. For example, the merger will mean that 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. CQC identified medicines management as a weakness in their 2017 inspection of TSFT.

- **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.

6.10 Further information on the quality performance of both Trusts, including information on CQC and Well-led reviews, can be found at **Appendix 4.**

Performance benefits

6.11 Merger will drive improvements in performance against NHS Constitution standards in the following ways:

- **4-hour emergency care**: Patients will be better able to access emergency care, due to the establishment of a network of Urgent Treatment Centres (UTCs) providing community-based urgent care. This will lessen demand on TSFT's Emergency Department and ensure that patients receive the right care in the right place sooner. SPFT's Minor Injuries Units will be fully integrated for the first time with TSFT's Emergency Department service, under single clinical leadership.

- **Diagnostics:** More care will be delivered in community locations which will have increased access to diagnostics. Greater convenience for patients (through care closer to home) will mean there will be fewer 'Did Not Attends' for diagnostics and other outpatient appointments, and the results of diagnostic tests will be available more quickly.

- **Elective care**: Post-merger, there will be a single approach to planned care, including a reformed outpatient service **(see paragraph 5.10)**, which will see the focus of care shifted to early intervention through greater community care and support to primary care. This will help manage demand for planned care and ensure that doctors, nurses and other clinical staff can focus more on an improved patient experience.

- **Increasing access to Psychological Therapies**: this performance standard requires 15% of the eligible population to have access to the service. The combined patient contacts of the two Trusts will provide a higher volume of eligible patients who can be directed to the service.

- **Early Intervention in Psychosis**: although most psychosis referrals are made by a patient's family or GP, some people experiencing a psychotic episode attend A&E. Close working relationships between A&E staff and mental health staff in the combined entity will support prompt referral of patients with psychosis thereby supporting achievement of the two-week access standard.

6.12 Further information on the performance of the two Trusts can be found at **Appendix 5**.

Organisational resilience

6.13 The merger will make us more resilient by improving our ability to flex our staff and infrastructure resources to respond to temporary or seasonal pressure. Our plans to focus on streamlining pathways, providing more out of hospital care and making service efficiencies will also help 'futureproof' our services against forecast demographic changes, specifically the rising number of over 75s with complex care needs expected in the coming decades.

Improved governance

6.14 The merger will allow us to make improvements to our governance processes in response to the findings of the recent Well-Led reviews. These reviews highlighted areas for action including the need to further develop a shared vision and objectives for the joint executive team, and the need for further sharing of good practice across the two organisations. Work has already begun to address these issues, and will be made significantly easier and more effective after merger, with single teams delivering against our single vision and set of objectives.

6.15 Further information on the members of the joint executive team, and the Non-Executive Directors who make up the current Boards of the two Trusts can be found at **Appendix 8.**

Benefits to Somerset health and care system

6.16 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.

6.17 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. **Figure 10** below sets out how the proposed merger fits with the STP priorities.

Figure 10: Fit of merger with Somerset STP priorities

STP priority	How is it served by the merger?
Improving the financial sustainability of the county system	The merger will improve the financial efficiency of the Somerset healthcare system via efficiencies from clinical pathway redesign, intervening earlier to reduce escalation of need/ demand for emergency care and reduce our reliance on bed-based care. Savings will also be secured through combining support services and some clinical teams.
Focus on prevention to create a more sustainable system	We will work with partners to improve our focus on and investment in preventative care to help reduce demand particularly for mental health, cardio-vascular services, cancer, respiratory disease and musculo-skeletal services.
Redesigning services away from hospitals and into the community and patients' homes	A key aim of the merger is to work with our commissioner and primary care to refocus our resources away from acute services and into mental health and community services so we can provide care for patients in their own homes or close to home.
Address financially and clinically unsustainable acute hospital services	We continue to work with neighbouring acute Trusts to identify solutions to unsustainable acute services, either by consolidating acute services or by developing out of hospital models of care.
Creating an Accountable Care System.	We see the proposed merger as a first step on the road to creating a single provider organisation in Somerset, and subsequently an Accountable Care System.

6.18 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.

Fit with Somerset Improving Lives Strategy

6.19 The Somerset Improving Lives Strategy (formerly the Somerset Health & Wellbeing Strategy) has four strategic priorities:

- A county infrastructure that drives productivity, supports economic prosperity and sustainable public services.
- Safe, vibrant and well-balanced communities able to enjoy and benefit from the natural environment.
- Fairer life chances and opportunity for all.
- Improved health and wellbeing and more people living healthy and independent lives for longer.

6.20 The proposed merger will contribute in particular to the first objective (sustainable public services) by improving the financial sustainability of the Trusts, and the fourth objective (improved health and well-being) by supporting early intervention to reduce escalation of need and care provided closer to patients' homes.

Benefits for whole Somerset population

6.21 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.

6.22 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.

7. Finance

7.1 This section sets out the financial performance of SPFT and TSFT, the expected costs and savings from the merger and the forecast performance of the merged entity compared to the counterfactual.

SPFT Financial Performance

7.2 SPFT's recent and current performance is set out in **Figure 11** below. SPFT has historically achieved a surplus each financial year by delivering challenging cost improvement plans. Following the integration of community and mental health services in 2011 the way services were delivered was reviewed and the Trust was able to generate significant savings in 2015/16.

Figure 11: SPFT current financial performance

SPFT	Actual			Plan
	2015/16	2016/17	2017/18	2018/19
	£000	£000	£000	£000
Clinical income	155,773	159,508	162,846	164,098
Other income	7,195	10,336	11,366	10,883
Pay	(121,422)	(122,123)	(123,743)	(124,854)
Non-pay	(46,821)	(38,938)	(38,212)	(42,507)
Operating Surplus/(Deficit)	**(5,275)**	**8,783**	**12,257**	**7,620**
Gain/(loss) on disposal of fixed assets			(2)	
Net finance costs	(31)	(30)	(6)	(5)
PDC dividend	(3,358)	(3,556)	(3,587)	(3,588)
Retained Surplus/(Deficit)	**(8,664)**	**5,197**	**8,662**	**4,027**
Revaluation (exceptional)	9,174	(1,857)	(4,620)	0
STF/PSF	0	2,616	2,868	2,303
Retained Surplus/(Deficit) before exceptional items & STF/PSF	**510**	**724**	**1,174**	**1,724**
Plan (before STF/PSF)	**253**	**684**	**1,135**	**-**
Variance from plan	**257**	**40**	**39**	**-**

Note: the data in this table is presented to ensure consistency with the reported financial position and to reconcile with the audited accounts. It does not include adjustments made by NHSI for the purposes of control total reporting which was introduced in 2016/17.

TSFT Financial Performance

7.3 TSFT's recent and current performance is set out in **Figure 12** below.

Figure 12: TSFT current financial performance

TSFT	Actual			Plan
	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Clinical income	243,281	259,428	268,339	275,623
Other income	26,319	40,442	40,560	30,269
Pay	(163,258)	(171,850)	(186,171)	(184,407)
Non-pay	(110,398)	(126,531)	(121,993)	(119,090)
Operating Surplus/(Deficit)	**(4,056)**	**1,489**	**735**	**2,395**
Net finance costs	(1,727)	(1,802)	(1,783)	(1,724)
PDC dividend	(3,996)	(3,942)	(3,967)	(4,000)
Retained Surplus/(Deficit)	**(9,779)**	**(4,255)**	**(5,015)**	**(3,329)**
Revaluation (exceptional)	(855)	5,033	1,981	0
STF/PSF	0	8,838	6,712	5,872
Retained Surplus/(Deficit) before exceptional items & STF/PSF	**(10,634)**	**(8,060)**	**(9,746)**	**(9,201)**
Plan (before STF/PSF)	**(11,000)**	**(9,015)**	**(7,671)**	**-**
Variance Actual/Plan	**366**	**955**	**(2,075)**	**-**

Note: the data in this table is presented to ensure consistency with the reported financial position and to reconcile with the audited accounts. It does not include adjustments made by NHSI for the purposes of control total reporting which was introduced in 2016/17.

7.4 TSFT has been in deficit since 2015/16[32] which marked the start of a particularly challenging period financially. Rising demand for acute medicine and emergency care meant the Trust needed more staff, and income-generating elective surgery had to be de-prioritised so emergency patients could be treated. Following CQC inspection and peer review, additional costs were incurred to provide more doctors and nurses in the Emergency Department and Maternity, with no matching increase in income due to the block nature of the contract with commissioners.

7.5 In 2015/16 TSFT submitted a reforecast year-end position with an increased deficit of £11.5m during the year, and as a result of the deterioration in its financial position was placed under improvement action by the regulator Monitor (now NHSI). A turnaround advisor was appointed to work with the Board of Directors to implement further financial controls and improve the financial position.

7.6 The financial position continued to be challenging in 2016/17, a fact recognised nationally by the sustainability and transformation funding made available to trusts which achieved their financial and performance plans. The Trust also reverted to a Payment by Results (PbR) fully variable contact in 2016/17, generating additional

[32] In 2014/15 TSFT recorded a small surplus of £0.07m.

income through the delivery of increased levels of activity, and offsetting the costs of delivery it had been unable to offset in the previous year. The Trust made a £1.5m operating surplus in 2016/17.

7.7 In 2016/17, the Trust participated in the Financial Improvement Programme (FIP), working with external advisors to identify the opportunities to improve overall financial performance and sustainability. Following FIP, the Trust has continued to ensure it has solid financial governance, and that there are robust grip and control measures embedded across the organisation.

7.8 TSFT's challenging financial position has depleted cash resources, and in 2016/17 it had to secure a revolving working capital facility and drew down cash to support its operations. This was later converted to an interim loan of £4.4m which is repayable in 2020.

Assumptions for projected counterfactual performance

7.9 The assumptions used to build the financial plans for future years if the Trusts were to remain as standalone entities (the counterfactual case) are set out in **Figure 14** below:

Figure 14: Inflation assumptions for counterfactual performance

	SPFT	TSFT
Pay	2.0%	2.0%
Non-pay	2.0%	2.0%
Clinical income	0.1%	1.5%
Non clinical income	0.0%	1.0%

CIP assumptions

7.10 TSFT has assumed 2% CIP delivery over the next five years, of which 70% is recurrent and 30% non-recurrent; this is based on the average delivery profile in recent years.

7.11 SPFT has assumed 1% CIP delivery in the coming five years. CIP delivery in 2018/19 is assumed to be 80% recurrent, and from 2019/20 onwards to be fully recurrent.

Capacity assumptions

7.12 TSFT has assumed capacity investment of £750,000 per year will be required from 2019/20 to cover the step change in costs related to expected increases in demand. This will need to be more accurately modelled and aligned with the Somerset Health and Care Strategy once that strategy is complete.

7.13 SPFT has not assumed any additional investment in capacity is needed over the period covered by the financial modelling as in the past this has been fully funded by Somerset CCG so there is no net impact to the financial plan.

Provider sustainability funds

7.14 We have assumed both Trusts will receive provider sustainability funds in future years at the same level as is included within their 2018/19 plans.

Projected counterfactual financial performance

7.15 **Figure 15, 16 and 17** below present the financial performance of each Trust, and then their aggregated performance, in a scenario where they do not merge. It should be noted that these forecasts assume:

- the Trusts continue to deliver business as usual CIPs as set out above
- the Trusts would revert to the pre-Alliance state i.e. costs are included to re-establish separate Executive teams at each Trust.

7.16 For the period 2018/19 to 2020/21, organisations within the Somerset STP have agreed to manage to the collective control total and suspend PbR as the contractual payment mechanism. A Memorandum of Understanding underpins the cost-based contractual agreement for the period 2018/19 to 2020/21 and defines the rules and actions the STP partners will need to consider before any financial adjustments are made.

SPFT financial forecast – no merger

7.17 **Figure 15** below sets out SPFT's forecast performance in a no merger scenario.

Figure 15: SPFT forecast performance as a stand-alone Trust

SPFT	Plan	Forecast				
	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000
Clinical income	164,098	159,326	159,567	159,807	160,048	160,290
Other income	10,883	10,883	10,883	10,883	10,883	10,883
Pay	(124,854)	(123,731)	(126,286)	(128,893)	(131,551)	(134,263)
Non-pay	(42,507)	(42,112)	(41,222)	(40,314)	(39,389)	(38,445)
Operating Surplus/(Deficit)	**7,620**	**4,366**	**2,942**	**1,483**	**(9)**	**(1,535)**
Net finance costs	(5)	(5)	(5)	(5)	(5)	(5)
PDC dividend	(3,588)	(3,588)	(3,588)	(3,588)	(3,588)	(3,588)
Retained Surplus/(Deficit)	**4,027**	**773**	**(651)**	**(2,110)**	**(3,602)**	**(5,128)**

7.18 Whilst SPFT has a track record of strong financial management, the ongoing opportunities for delivering services more efficiently are minimal, and continuing to deliver annual CIPs of 2% or 3% is not realistic unless service provision is modernised and transformed. SPFT has therefore assumed a 1% CIP for the next five years. The financial modelling through to 2023/24 shows that if the Trust were to remain standalone then its financial position would deteriorate to a deficit of £5.1 million.

7.19 SPFT's historic generation of surpluses has enabled it to invest significantly in its estates and IT. It is likely that the Trust will be unable to generate sufficient cost

improvements to fund inflationary pressures in the future, and this will erode the Trust's cash balance, eventually leading to the Trust needing a loan to support working capital requirements.

TSFT financial forecast – no merger

7.20 **Figure 16** below sets out TSFT's forecast performance in a 'no merger' scenario. The financial position of TSFT continues to be challenging. CIP delivery of 2% (of which only 70% is assumed to be recurring), combined with the upward pressure on costs and the need to continue to invest in capacity to meet demand means a worsening financial outlook. Under the 'no merger' scenario the Trust would require further interim loans to support working capital requirements.

Figure 16: TSFT forecast performance as a stand-alone Trust

TSFT	Plan	Forecast				
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000	£000	£000	£000	£000	£000
Clinical income	275,623	279,757	283,954	288,213	292,536	296,924
Other income	30,269	30,572	30,877	31,186	31,498	31,813
Pay	(184,407)	(187,030)	(191,548)	(196,156)	(200,858)	(205,653)
Non-pay	(119,090)	(120,040)	(121,734)	(122,946)	(124,170)	(125,406)
Operating Surplus/(Deficit)	**2,395**	**3,260**	**1,549**	**297**	**(993)**	**(2,321)**
Net finance costs	(1,724)	(1,824)	(1,824)	(1,824)	(1,824)	(1,824)
PDC dividend	(4,000)	(4,000)	(4,000)	(4,000)	(4,000)	(4,000)
Retained Surplus/(Deficit)	**(3,329)**	**(2,564)**	**(4,275)**	**(5,527)**	**(6,817)**	**(8,145)**

Aggregated financial forecast – no merger

7.21 The aggregated counterfactual position for both Trusts with 'no merger' is shown in **Figure 17** below.

Figure 17: aggregated forecast performance if the Trusts did not merge

Aggregated counter factual No Merger	Plan	Forecast				
	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
	£000	£000	£000	£000	£000	£000
Clinical income	439,721	439,083	443,521	448,020	452,584	457,214
Other income	41,152	41,455	41,760	42,069	42,381	42,696
Pay	(309,261)	(310,761)	(317,834)	(325,049)	(332,409)	(339,916)
Non-pay	(161,597)	(162,152)	(162,956)	(163,260)	(163,559)	(163,851)
Operating Surplus/(Deficit)	**10,015**	**7,626**	**4,491**	**1,780**	**(1,002)**	**(3,856)**
Gain/(loss) on disposal of FA	0	0	0	0	0	0
Net finance costs	(1,729)	(1,829)	(1,829)	(1,829)	(1,829)	(1,829)
PDC dividend	(7,588)	(7,588)	(7,588)	(7,588)	(7,588)	(7,588)
Retained Surplus/(Deficit)	**698**	**(1,791)**	**(4,926)**	**(7,637)**	**(10,419)**	**(13,273)**

7.22 **Figure 18** shows a marked deterioration in the aggregate financial position, from £0.7m surplus in 2018/19 to £13.3m deficit in 2023/24 for the two Trusts in a 'no merger' scenario. This is largely driven by the impact of achieving lower CIPs in future years and the requirement to make further investment in capacity at TSFT which is not fully offset by increased income. The level of CIP included in future years falls to reflect the expected ongoing demand pressures and because of the reduced ability to cut costs further without significant structural change.

7.23 There is a significant cumulative CIP requirement of £40.4m by 2023/24 in part to offset inflationary and activity pressures. This would have to be achieved by each Trust individually and, without the transformational change or infrastructure of the merged organisation, even this level of CIP would be very challenging to deliver. The CIP expectation is set out in **Figure 18** below.

Figure 18: Business as usual CIP requirement

	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	Cumulative total £000
SPFT	1,702	1,704	1,704	1,704	1,704	**8,518**
TSFT	6,207	6,297	6,388	6,481	6,575	**31,947**
Total	**7,909**	**8,001**	**8,092**	**8,185**	**8,279**	**40,465**

7.24 Even at modest levels (1% for SPFT and 2% for TSFT) the level of planned CIP is below the level needed to offset rising pay and non-pay cost pressures. The opportunity to identify and deliver recurrent savings is becomingly increasingly more challenging and will necessitate difficult choices around further rationalisation of services. TSFT will continue to rely on non-recurrent savings which will do nothing to reduce the underlying financial deficit of the Trust. It is clear from the delivery of the programme in 2017/18 that delivery of recurrent savings will be a challenge while demand pressures continue.

Projected financial performance of merged Trust

7.25 The financial forecast for the merged Trust is shown in **Figure 19** below. This uses the projected standalone financial plans for both organisations and then incorporates the investments required and expected savings from the merger to produce the post consolidation financial plan. The savings and investments are set out in more detail later in this section.

7.26 Base assumptions in terms of inflationary pressures, cost growth and business as usual CIPs are as they were in the standalone financial plans of each organisation.

Figure 19: Forecast performance for the merged Trust

Merged Trust	Plan	Forecast				
	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000
Clinical income	439,721	439,083	443,521	448,020	452,584	457,214
Other income	41,152	37,027	37,332	37,641	37,953	38,268
Pay	(309,261)	(305,187)	(308,587)	(312,502)	(318,017)	(324,945)
Non-pay	(161,597)	(160,997)	(160,769)	(160,323)	(160,422)	(160,514)
Operating Surplus/(Deficit)	**10,015**	**9,927**	**11,497**	**12,836**	**12,099**	**10,024**
Net finance costs	(1,729)	(1,829)	(1,829)	(1,829)	(1,829)	(1,829)
PDC dividend	(7,588)	(7,588)	(7,588)	(7,588)	(7,588)	(7,588)
Retained Surplus/(Deficit)	**698**	**510**	**2,080**	**3,419**	**2,682**	**607**

7.27 The Income and Expenditure position for the merged Trust shows an improvement of £13.9m from the counterfactual deficit of £13.3m to a surplus of £0.6m by 2023/24. This is driven by:

- Clinical reconfiguration savings: £30 million (cumulative)
- Corporate/back office support savings: £21million (cumulative)
- Business as usual CIP delivery of £40.5 million
- Transaction costs of £3.9 million[33]

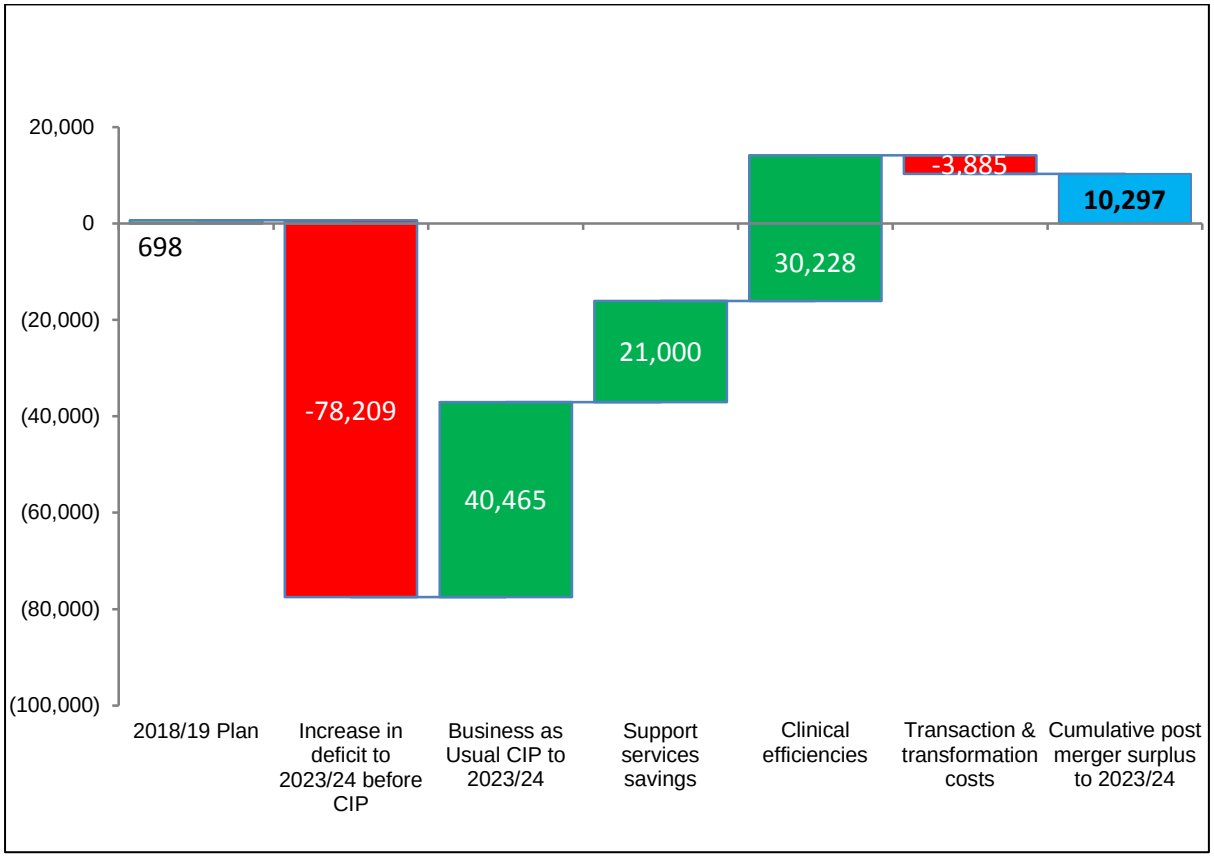
7.28 Detailed work on sensitivities and scenarios, including the development of a downside model, will be carried out at Business Case stage.

Financial bridge

7.29 **Figure 20** below illustrates the principal movements between: the 2018/19 financial plans as they are currently agreed for each Trust; the 'do nothing' 2023/24 aggregate position; the 2023/24 counterfactual case position and the Merged Trust's 2023/24 position. The savings figures are reported cumulatively across the period.

[33] Transaction costs for years 2019/20 to 2023/24.

Figure 20: Financial bridge from 2018/19 plans to the 2023/24 merger case



Expected merger savings

Support services savings

7.30 The estimated support services savings expected from the merger are £21 million. All savings are assumed to be cash releasing. These are high level estimates which will be developed in greater detail at Business Case stage. Whilst savings have been achieved to date through amalgamation of support services, the ability to achieve further savings are limited whilst there remain two separate legal entities because of statutory requirements e.g. around information governance.

Clinical service delivery savings

7.31 As part of the merger we would expect to secure efficiencies and cost savings from the transformation of a number of clinical services. Overall, we will be adopting a clinical model that is less reliant on costly bed-based care. In the context of rising demand we are unlikely to be able to reduce the absolute number of acute beds. However, we believe we can make lower use of bed-based care than would be the case without merger.

7.32 Evidence suggests[34] that whilst reducing hospital activity and increasing community-based care does not save money in all circumstances, the most positive evidence for cost saving comes from changes to services which are targeted to particular groups of patients e.g. improved end of life care in the community and condition-specific rehabilitation, and we will focus on areas such as these as we develop our detailed plans.

7.33 The expected timescale for making changes to clinical services and securing the associated savings is two-three years, and in some cases may be longer. The estimated savings are set out below. These are high level estimates which will be developed in greater detail at Business Case stage.

7.34 The key clinical savings will come from the development of new integrated pathways of care, building on initial integration work to date. Financial savings will come from reduced length of stay in community and acute beds and better demand management, from teams working in a clinically and operationally aligned way. Although a level of savings could potentially be achieved purely through more collaborative working, the alignment of priorities and singular focus on the delivery of integrated care models within a single organisation is more likely to ensure delivery of the identified opportunities in a rapid, cost-efficient and sustainable way.

7.35 Both trusts are currently developing Patient-Level Information and Costing Systems which report the cost of events relating to individual patient care. This data will enable us to monitor and report the savings delivered by clinical integration.

7.36 Some of the expected savings will accrue to the combined organisation and some will accrue to other parts of the Somerset health and social care system. In the interests of patients and taxpayers we are taking a system-wide view and, subject to discussions with partners, we are exploring all savings opportunities regardless of the organisation in which the financial benefits may initially land. Savings are summarised in **Figure 22** below.

[34] BMJ March 2017, and Nuffield Trust "Shifting the Balance of Care" 2017.

Figure 22: Clinical services savings

Clinical savings	Total £000	Cumulative total £000	Cash Releasing
Paediatrics	**525**	1,575	Y
A&E and MIU (Reduction in demand and consolidation of clinical pathways)	**300**	1,200	Y
Consolidation of diagnostic & clinical support pathways	**625**	1,875	Y
Pharmacy	**250**	950	Y
Workforce - reduction in agency premium spend	**2,000**	8,000	Y
Workforce - cost reductions from altered staffing mix (Increased use of non-registered staff in community settings)	**500**	1,500	Y
LOS reductions - Acute beds frailty and stroke	**2,100**	8,200	Y
LOS Reduction - Community Beds	**1,106**	3,179	Y
Other Savings identified via model hospital Acute and Community Services	**1,250**	3,750	Y
Sub-total cash releasing	**8,656**	30,228	
Reduction in demand into acute & community services	**4,500**	13,500	N
Reduced OPs & community interventions through reduced duplication & improved pathways for medically unexplained symptoms	**1,125**	3,125	N
Sub-total non-cash releasing	**5,625**	16,625	
Clinical services Total	**14,281**	46,853	

Opportunities identified through benchmarking

7.37 Benchmarking data indicates scope for the combined entity to improve its position through changes to both corporate and clinical services. Further work will be required to determine whether these savings are realisable and to quantify them. Nonetheless they indicate areas we would review in detail if we receive approval to move to Business Case stage.

Corporate services opportunities

7.38 In corporate services, the 2016/17 benchmarking review by the NHS Benchmarking Network highlighted the following areas where there are potential savings:

- **Management accounts costs** (relative to turnover): TSFT's costs per £100m turnover are £136,000, the 4th lowest of 86 comparator Trusts. Although SPFT's costs at £327,000 per £100m turnover are about average, this is still over double the TSFT cost so bringing SPFT's costs down to a similar level represents a savings opportunity of around £300,000 per annum.
- **Internal audit costs**: SPFT internal audit costs are low at £263 per day against an average of £469. SPFT are the 5th lowest in their comparator group of 74 Trusts. TSFT costs were not included in the benchmarking exercise, but given SPFT's good performance it is likely that there is potential for savings.
- **Procurement costs** (relative to turnover): SPFT's costs are below average at £110,600 per £100m turnover while TSFT's costs are the 7th highest in their comparator group at £265,000 per £100m turnover. Integrating our procurement functions is one of our high priority integration projects and could generate savings of £250,000 per annum.
- **Learning and Development**: SPFT's Learning and Development cost per employee was £236. TSFT's cost per employee was £199, which was slightly above the national average of £191. Bringing both Trusts down to the average would save over £200,000.

Clinical services opportunities

7.39 In clinical services, there are also savings opportunities if the two Trusts change their service model to better reflect more efficient comparator organisations. For example:

- **Community hospital beds**: Provision of community beds is significantly above average in Somerset with around 47 community beds per 100,000 population, compared to a mean of around 23 beds. As noted in **Part 1** we want to change the way these beds are used in future to improve patient flow and support peaks in demand for acute services.
- **CAMHS services**: SPFT's CAMHS costs are higher than the average mean and median levels per patient, at around £4,200 per patient on caseload compared to a mean of around £3,200. By integrating acute and community CAMHS services with each other and with physical paediatric services, we believe there is scope for savings.
- **Mental health inpatient costs**: The NHS Benchmarking Network's 2016/17 mental health data set indicates SPFT admitted around 190 mental health inpatient per 100,000 weighted population per year, against an average of around 160. Reducing this to the mean level by redesigning pathways and increasing out of hospital support will provide a better experience for patients as well as lowering costs. This will require support for investment in community mental health services.
- **Acute Hospital Services:** A range of opportunities has been identified through the Getting it Right First Time programme (GIRFT) across a range of specialties which could improve clinical effectiveness and deliver savings.
- **Model Hospital Savings:** There are a number of items identified within the model hospital for acute services (some linked to the GIRFT items above) which are being progressed, and we will explore opportunities for efficiencies as we develop our clinical model.

Transaction and transformation costs

7.40 We propose to cover the full cost of the proposed merger from the two Trusts' budgets, and are seeking to keep costs low by minimising external advisers and using in-house resources as far as possible. This approach has the additional advantage of ensuring ownership and retention of the developing thinking and planning. Existing operational and transformation teams will be used to supplement the additional resource.

7.41 The Trusts have included £0.7 million non-recurrently within their 2018/19 plans specifically for merger support. In addition, £0.15 million has been assumed to be available in 2018/19 and 2019/20 from existing budgets to support the transaction. The full transaction costs are included within the financial model outlined above. Estimated transaction and transformation costs are set out in **Figure 23** below:

Figure 23: Estimated transaction and transformation costs

Non-recurrent Transaction costs	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Internal Team including PMO and project management and benefits realisation support to integration projects	442	380	206	-	-	-	**1,028**
External Support (Legal advice & Due Diligence, independent expert opinions, consultancy support)	538	362	-	-	-	-	**900**
Property conveyancing	-	45	-	-	-	-	**45**
Revenue integration Costs	-	250	250	-	-	-	**500**
Branding and Communications	50	150	100	-	-	-	**300**
Less Already Funded Costs	(850)	(150)	0	0	0	0	**(1,000)**
Sub-total Non-recurrent costs	**180**	**1,037**	**556**	**-**	**-**	**-**	**1,773**
Recurrent Transaction costs							
Pay alignment	-	292	500	500	500	500	**2,292**
Total Transaction costs	**180**	**1,329**	**1,056**	**500**	**500**	**500**	**4,065**
Pay	(408)	522	706	500	500	500	**2,320**
Non-pay	588	807	350	0	0	0	**1,745**
Total	**180**	**1,329**	**1,056**	**500**	**500**	**500**	**4,065**

8. Transaction execution plan

8.1 This section sets out our outline plan to deliver the proposed merger.

Legal form of transaction

8.2 The proposed transaction is a merger of equals, with the two Trusts voluntarily coming together for the benefit of the people they serve. However, the Boards are mindful that effecting the transaction through statutory merger (s.56 of the NHS Act 2006) is slower and more expensive than if one Trust were to legally acquire the other (using s.56A of the Act).

8.3 After considering the merits and demerits of the available legal routes, (and after taking legal advice) the two Trust Boards have agreed that their preferred option is to pursue merger by acquisition, using s56A, with SPFT legally acquiring TSFT. This choice was made on the grounds of cost and time, as the expected cost of transferring TSFT's assets to SPFT is lower than transferring SPFT's assets to TSFT, largely because of the number of properties involved.

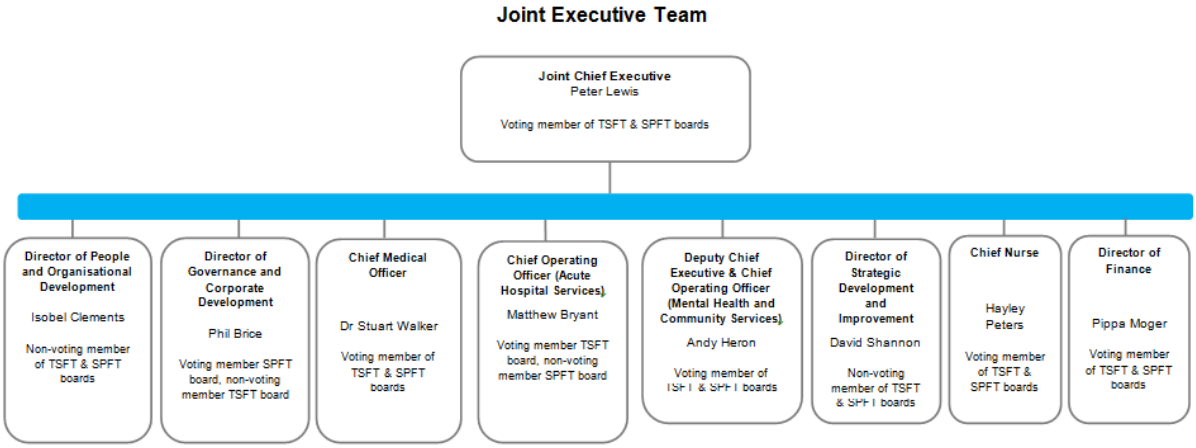
New name

8.4 At the point of transaction we intend the merged Trust to have a new name. We propose to consult stakeholders on a shortlist of options for the new name to inform the two Boards' final decision.

Board composition of merged Trust

8.5 In the MOU signed in May 2017, the two Trusts committed to establishing a joint management team comprising executive directors from both Trusts. The full joint team consisting of 8 Executive Directors under the joint Chief Executive Peter Lewis has been in place and working across both Trusts since September 2017 (see **Figure 24** below). Appointments to the joint executive team were made through competitive processes. The existing members of the joint executive team will transfer to the executive posts in the merged entity.

Figure 24: Composition of joint executive team



8.6 Currently each Trust maintains its own separate Board. Both Trust Boards have 7 Non-Executive Directors including the Chair. In June 2018, two non-Executive Directors from each Trust were appointed to join the Board of the other to aid understanding and collaboration and support our work on the proposed merger.

8.7 At the point of transaction we intend the merged Trust to have a reconstituted Board with Non-Executive Directors drawn from both legacy Trusts. We also plan to hold elections to the Council of Governors shortly after transaction date to ensure representation from the constituencies set out in the revised Trust constitution. We will create joint working groups of Governors in advance of merger to ensure their views are fed into merger planning. We will also create a joint governors' working group on the revised constitution for the merged Trust.

8.8 The proposed merged entity will span a wide geography and provide a very broad range of mental health, community and acute services. We are mindful that the Board of the new entity needs to have the necessary skills and experience to enable it to provide effective leadership and oversight of the enlarged Trust.

Plan to deliver transaction

8.9 We have developed an initial plan covering the period up to the merger which is provided as a supporting submission to this document. Assuming we receive the necessary approval to move to stage 2, we will further refine this plan early in the Business Case stage, in consultation with NHS Improvement.

8.10 The risk of adverse impact on business as usual is very real, and to manage this we have set out a timetable for merger which seeks to move at pace while also recognising that sufficient senior management time needs to be devoted to ensuring high quality care continues to be provided to our patients.

8.11 Key milestones set out on the transaction delivery plan are as set out in **Figure 25** below. Provided we secure the necessary support and approvals from our boards, governors, stakeholders and regulator, our intended 'go-live' date for the merger is 30 September 2019.

Figure 25: Key milestones in transaction delivery plan

Date	Milestone
August/September 2018	NHSI complete review of Strategic Case and indicate whether or not proposed transaction may move to Business Case stage
August 2018 to April 2019	Trusts develop Business Case, including benefits realisation plan, Long-Term Financial Model, post-transaction implementation plan, full due diligence, revised constitution and negotiate transaction agreement
March 2019	Boards' initial feedback on draft Business Case
May 2019	Trusts submit final Business Case to NHSI following approval from Boards and with agreement of Councils of Governors
July/August 2019	NHSI Board meeting with both Boards
August 2019	NHSI issues transaction risk rating
September 2019	Boards and COGs formally approve transaction
September 2019	NHSI formally grants transaction and Trusts merge

8.12 Further detail on the proposed timeline is included at **Appendix 7.**

8.13 The draft timetable assumes there are no service changes requiring public consultation.

8.14 If the timetable were to slip this would increase costs, prolong the disruption to the Trusts while the merger process is completed and delay realisation of expected benefits. This risk and mitigations are included in the Integration risk register (see **paragraph 8.26**).

Outline transaction governance

8.15 We have a number of governance mechanisms to oversee progress of the proposed transaction. The joint executive team has established an Integration Development Board which has oversight of the overall integration of the two Trusts including the case for merger. The minutes of these regular meetings are shared with both Trust Boards.

8.16 Key decisions relating to the proposed merger are taken by the Trust Boards, and the Boards are provided with regular progress updates. The Councils of Governors of both Trusts are also kept informed about progress, via regular joint sessions of both Councils.

8.17 In July 2017, a Group Board was established, comprising the Chief Executives of both Trusts, the Deputy Chief Executive (joint appointment), the two Chairs and vice-Chairs. After the first meeting, membership was expanded to include the Chair of the Somerset GP Board, and the Leader of Somerset County Council. The Group Board

became the Alliance Development Committee in October 2017 and Yeovil District Hospital joined the Committee in January 2018. We keep our county partners updated with progress on the proposed merger via the Alliance Development Committee, which meets monthly, as well as other Somerset STP meetings.

Resources and Programme management

8.18 The Senior Responsible Owner for merger planning is David Shannon, Executive Director of Strategic Development and Improvement for the two Trusts. David oversees the transaction Programme Management Office (PMO) which is headed by a Director of Integration seconded from NHS Improvement.

8.19 If approval is received to move to Stage 2, the PMO will require significantly increased internal resources and external support to develop the Business Case. A workstream approach will be used to develop the Business Case and support the planning for the day of merger and beyond. Each workstream will have a senior responsible owner and specified work packages determined by the key deliverables. We will have separate workstreams as indicated in **Figure 26** below:

Figure 26: Merger workstreams

Workstream	Executive lead(s)	Scope
Clinical and operating model redesign	Stuart Walker & Hayley Peters	• Clinical model & patient benefits • Delivery of clinical integration projects • Integration of Research & Development function • Clinical service strategies • Operating model for new entity
Corporate Strategy	David Shannon	• Corporate strategy • Support services strategies
Finance	Pippa Moger	• Long term financial model • Quantification/finance team support to integration projects • Integration of Finance and Planning function • Integration of Performance function • Integration of Procurement function
IT, estates & infrastructure	David Shannon	• Integration of IT function • Integration of Estates & facilities function • Integration of Capital planning function • Integration of Improvement Team • Integration of HQ services • Integration of Corporate Operations
Governance	Phil Brice	• Clinical governance framework for new organisation • Corporate governance for new organisation • Plan for transition to single Board and Council of Governors • Revised constitution • Integration of information governance function
Communications	Phil Brice	• Staff and stakeholder communications
Workforce & Organisational Development	Isobel Clements	• Cultural harmonisation plan, including Leadership training • Staff engagement • Workforce planning • TUPE transfer of staff • Completion of HR integration • Integration of Training and Education function
Merger Case and Programme management	David Shannon	• Business case drafting and supporting submissions • Transaction plan to Day 1

Workstream	Executive lead(s)	Scope
		• Post-Transaction integration plan • Overarching Benefits Realisation Plan • Heads of Terms and Transaction Agreement • Commissioning 4 x independent expert opinions • Coordination of Due Diligence • Integration risk management • Coordination of Programme of integration projects • Coordination of integration workstreams

8.20 We want to use in-house resources to deliver the transaction as far as possible, so as to maintain ownership, retain skills, and keep costs down. However, we do not have sufficient in-house capacity and capability to complete the Business Case on our own. Alongside expert legal advice we also intend to procure specialist consultancy support to help us prepare the Business Case, for example to help develop the post-transaction implementation plan and the long-term financial model. Expected costs of the transaction are set out in **Part 7**.

8.21 We have identified a range of clinical and corporate integration projects (see **Appendix 6**), which will deliver the benefits identified in **Part 6** for patients, staff, the merged entity and the wider Somerset health economy. We have carried out an initial prioritisation exercise of our integration projects portfolio and are focusing our dedicated internal project management resource on the highest priority projects.

8.22 TSFT has developed a bespoke project management methodology which the Trusts are applying to the transaction itself and to all our integration projects. Our approach ensures projects are consistently managed and reported, and all have a senior owner with agreed timelines and progress indicators. Progress on every integration project will be overseen either by an existing joint Improvement Board or by the Integration Development Board **(**see **paragraph 8.15)**.

High-level benefits realisation strategy

8.23 TSFT has well-developed internal expertise in benefits realisation which supports the identification and quantification of tangible and intangible benefits and ensures projects deliver the planned benefits.

8.24 We are already applying this expertise to a small group of the highest priority integration projects which span the two Trusts, including the Stroke pathway, and Emergency Department and Minor Injury Units integration, as well as to the production of the case for merger. This work has helped to inform the benefits set out in **Part 6**.

8.25 Further details on our benefits realisation methodology is provided as an supporting submission to this Strategic Case.

Risk assessment and management

8.26 We have developed an integration risk register identifying key risks related to the proposed transaction and the associated mitigations (see **Figure 27** below). The integration risk register is provided as a supporting submission to this Strategic Case.

Figure 27: Summary of risks and mitigations

Key Risk related to proposed transaction	Impact	Likelihood	Mitigation
Risks to achieving merger			
Inability to manage new and existing clinical risks during the integration	4	3	Clinical risks are a standing item at the Integration Development Board. Trends in incidents and new risks are reported at Executive level.
Inability to manage non-clinical 'business as usual' risks during the integration	3	3	Continuing performance, financial and CIP monitoring takes place via existing forums. Operational or financial challenges resulting from integration is a standing agenda item on the Integration Development Board agenda.
Lack of capacity to undertake effective due diligence	3	3	External legal advisors are undertaking the legal due diligence. Staff with relevant knowledge are carrying out Due Diligence
Lack of support from patients, staff, CCG, or other partners	3	4	Close engagement with STP partners, Governors and staff, as per the Communications and Engagement plan.
Risks after merger			
Overly optimistic approach to defining benefits of integration	3	3	Internal project management expertise is being deployed to ensure planned benefits are clearly defined with realistic timeframes. Detailed benefits are being framed by clinical and support service colleagues, rather than being centrally defined. Board level oversight and challenge will also take place.
Slow progress or failure to achieve the expected benefits of the integration	3	4	Robust planning for the merger via detailed Business Case, integration projects and implementation plans, with oversight from Integration Development Board.
Insufficient management time to focus on integration	3	3	Integration Development Board meets monthly – all members of the Joint Executive Team are members.
Different financial positions of the two Trusts, and challenging CIPs	3	4	CIP plans are in place; single Director of Finance manages financial decisiond aimed at balancing service needs.
Aligning cultures from two different organisations to create a single positive culture	3	3	People Strategy in place; work already begun on culture workstream.
Costs of aligning IT systems	3	3	Further work is ongoing to fully understand the costs and create mitigation strategies to reduce them.

8.27 The integration risk register is a live document which will be kept updated as we move through the merger process, including to take account of risks identified through the Due Diligence process. The integration risk register has been considered by a Board committee of each Trust, and consideration of risks is a standing item at Integration Development Board meetings.

8.28 The two Trusts' corporate risk registers are monitored by the Trust Boards and their sub-committees. The integration risk register is also considered by the Board and its sub-committees and any significant risks relating to integration and the proposed

transaction will be incorporated into the two corporate risk registers as necessary. Both Trusts' corporate risk registers are provided as supporting submissions to this Strategic Case.

Legal advice sought

8.29 Both Trusts have engaged legal firm Bevan Brittan to provide legal advice and support during the merger process. Bevan Brittan is carrying out the legal Due Diligence for both Trusts. They have also advised us on the potential legal routes to merger.

8.30 If we receive approval to move to Stage 2, we would expect to take legal advice at Business Case stage on matters including TUPE transfer of staff, the transaction agreement, and, if relevant, public consultation on any significant changes to services.

Initial due diligence

8.31 As a result of our Alliance working, the two Trust Boards already have an understanding of each other's work. At executive level this knowledge is detailed, since every member of the joint executive team has full access to the systems and records of both Trusts within their functional purview. For this reason, the Trusts decided to undertake most of the initial Due Diligence using internal staff resource. The exception to this was the initial legal Due Diligence which Bevan Brittan conducted on behalf of both Trusts.

8.32 The two Trust Boards agreed that, at Strategic Case stage, the same level of initial Due Diligence would be carried out for each Trust. We have provided assurance to the Boards regarding the objectivity of internal Due Diligence by asking middle managers from across the Trusts to complete the detailed due diligence submissions. These submissions were then reviewed by the relevant executive director(s) to validate the content and judgements.

8.33 We have carried out initial due diligence under nine workstreams:

- Clinical
- Financial & Tax
- Legal
- HR
- Contracts
- Commercial
- IT
- Estates & Environmental
- Health & Safety

8.34 The findings of the initial Due Diligence are set out in a supporting submission to this Strategic Case.

8.35 At Business Case stage we will carry out detailed Due Diligence, including further work on contracts and commercial due diligence, and further clinical and financial due diligence arising out of developments in the clinical and financial models for the merged entity. We will also refresh any areas where there has been material change

since initial Due Diligence. We will continue to update our Due Diligence right up until the proposed merger receives final approval.

Competition analysis

8.36 NHS Improvement has liaised with the Competition and Markets Authority (CMA) on behalf of the two Trusts in relation to our Alliance and proposed merger. NHS Improvement has told us the CMA does not intend to carry out a review of the proposed merger, and that we do not need to take any further action to inform the CMA about the proposed merger[35]. We understand the CMA retains the right to undertake a review if it further relevant information comes to light.

Stakeholder communications and engagement

8.37 Our ability to deliver the planned benefits of merger depends on each of our clinical and corporate integration projects delivering their specified benefits. This requires close working with staff at all levels, and for clinical projects we will need strong clinical engagement.

8.38 We have established a group of Integration Champions – staff drawn from across both Trusts who have volunteered to play a role in supporting integration. This group is helping us develop and convey messages to the wider colleague group. See **Figure 28**.

Figure 28: Integration Champion view

Quote from Integration Champion (Health Care Assistant)

"Our Integration Champion meetings give us the opportunity to share thoughts, feeling and ideas from grassroots levels of care as we move forward as a group. It's great to see that everyone is united in their goal of having the patient at the heart of everything.

I think it's important for us to realise that the challenges that we and the NHS as a whole are being subjected to are like nothing that we have ever faced before. In order to adapt to and endure the increasing demands that are placed upon us, we have to evolve into something greater, realising and unleashing the full potential of each and every member of our alliance."

8.39 We have developed a communications and engagement plan to support the move towards merger. Key elements of the plan are set out below.

Aims and Objectives

8.40 Our stakeholder engagement strategy aims to ensure that all colleagues and key stakeholders:

- understand the reasons for the merger with specific focus on the benefits to patients, carers and communities of joined up working and services

[35] Email from Georgina Brett to Victoria Keilthy, 23 March 2018

- are kept updated on developments and progress and misinformation is rebutted quickly
- understand what the changes will mean to staff, patients and services
- feel empowered and involved and know how they can take part in shaping the new Trust
- are confident that the new Trust is building the best from both legacy Trusts, and decisions are made in the interests of continuing excellent patient care.

8.41 To maintain the trust of all those we communicate with, messages need to be consistent and include any which are difficult as well as those which provide the benefits of the move to merger.

8.42 Staff engagement will be critical to the success or otherwise of the proposed merger and our ability to deliver the planned benefits. We have kept the Trades Unions and staff side updated as our merger plans have developed.

8.43 We will develop our new service models with clinical colleagues and other partners including Primary Care. In line with the stakeholder engagement strategy we will alos ensure ongoing engagement and co-production with patients and carers. Although we expect the geographical location of some of our services to move – to be provided closer to patients' homes - we do not believe our integration proposals are likely to require public consultation. However, should it become clear that any of our proposals require public consultation, we will amend our plans accordingly.

Key Messages

8.44 Overarching messages will be developed and tailored according to key milestones as the merger programme progresses. The focus may be tailored for each key stakeholder group but will include:

For the two Trusts:

- Our aim is to make health and care services better and more accessible for patients within the local population to receive the right care in the right place at the right time. By working together we can avoid duplication as well as avoid gaps in services which are frustrating for patients, their carers and families and costly for the NHS. This will also include streamlining our support services and reducing management costs to release money for the front line.

For commissioners:

- We want to work with other partners and providers across the whole county to deliver quality services, aligned to better relationships with primary care in support of the Health and Social Care Strategy.

For the public:

- We want to keep local services sustainable and continue to improve the range of care available to the population we serve across Somerset.

For patients:

- We want to deliver more joined-up care to support patients, their families and carers where they only have to tell their story once, and information on their care is available to all who are involved in looking after them. The changes will provide a more holistic approach to care with emphasis on prevention. When care is needed, it is delivered closer to home and where possible out of hospital.

For staff:

- We want to provide a more attractive and rewarding place to work where it is possible to work in different care settings and expand the potential career opportunities of the people who work for us.
- We want to improve retention and recruitment and provide broader training and research opportunities.
- We learn best and achieve most when we work to understand each other and adopt each other's best practice.
- Our collaborative approach cannot be exclusive and will include closer working with primary care, Yeovil District Hospital and other district general hospitals in Bath and Weston super Mare, social care and the voluntary sector.

For primary care:

- We want to work much more closely with partners and providers to deliver quality services that better support primary care.
- We will look to develop services more locally focussed on 14 clinical groupings across the county which will serve patient populations of between 30,000 to 50,000 patients.
- We will be working more locally with primary care colleagues to understand what the local need is and how this can be best served, with our focus being delivering the right care in the right place at the right time.

8.45 Audiences and communication channels/products are as summarised in **Figure 29** below.

Figure 29: Audiences and channels of communication

Audience	Channels of communication
Trust-wide staff from both Trusts:	• Integration Champions • Staff news • Staff rumour buster • Chief Executive's video blog • Videos • Trust intranets • Team meetings supported by senior managers, Executives and Programme Team
Senior Trust staff	**SPFT:** • Senior Management Team • Senior managers' away days **TSFT:** • Executive committee • Managers' briefing **All** – provision of support packs for managers to cascade messages and brief

Audience	Channels of communication
	teams more personally
Clinicians	• C2C (consultants only) • Proposed engagement programme including development of clinical strategies across all services
Council of Governors	• Governors' briefing • Council of Governors meetings • Away Days/Development sessions • Proposed engagement programme
Somerset Clinical Commissioning Group	• STP meetings
Primary care	• GP Board chair is member of the Alliance Development Committee • Engagement via Trust Joint Medical Director of Integrated Care • Text for CCG newsletter and GP bulletin • Proposed engagement programme aligned to development of clinical strategy
Other NHS partners/providers: • Yeovil District Hospital • South Western Ambulance Trust • NHS111 provider (currently Devin Doctors but in procurement) • Devon Doctors (GP Out of Hours) • Care UK	• YDH – member of the Alliance Development Committee • Care UK – via Joint Venture • Others – phone and face to face contact as needed • All - Proposed engagement programme
Local council partners: • Somerset County Council • Parish/town councils • District councils • Health and Well Being Board • District and County Somerset Overview and Scrutiny Committee	• SCC Leader is member of the Alliance Development Committee • All: Contact via phone calls, emails and letters as issues arise • Attendance at public meetings • Proposed engagement programme
Patient representative/ advocacy groups: • Health Watch • PPGs	• Text supplied for Healthwatch bulletins and website • Text for PPG bulletin • Issue-based PPI contact
Voluntary/third sector groups: • Hospital Leagues of Friends • Love Musgrove • Other charity organisations	• Leagues of Friends Forum • Somerset County Council VCSE forum • *Love Musgrove* – through charitable funds committee
Local MPs	• Proposed engagement programme • Westminster based briefing on full business case
Staff representative / advocacy groups: • Staff Side / Trades Unions	• Proposed engagement programme • Briefings when key milestones met
Media including: • local, regional and national broadcast and print media • national media health specialists • trade press including medical, nursing, scientific and management publications.	• Specific briefing when key milestones met • Case studies and patient stories aligned new ways of working