REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **B**
DATE OF MEETING:	**28 March 2024**	
REPORT TITLE:	**Minutes of the ICB Board Meetings held on 25 January 2024**	
REPORT AUTHOR:	**Julie Hutchings, Board Secretary and Corporate Governance Lead Officer**	
EXECUTIVE SPONSOR:	**Jonathan Higman, Chief Executive**	
PRESENTED BY:	**Paul von der Heyde, Chair**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☒
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☐
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

PREVIOUS CONSIDERATION/ENGAGEMENT
There is lay representation on the ICB Board.

Executive summary and reason for presentation to Committee/Board	The Minutes are a record of the meetings held on 25 January 2024. They are presented to the ICB Board and are published in the public domain through the NHS Somerset website, to provide clarity and transparency about the discussions and decisions made, and to ensure the principles of good governance are upheld.
Recommendation and next steps	The NHS Somerset ICB Board is asked to **Approve** the Minutes of the meetings held on 25 January 204 and to confirm that the Chairman may sign them as a true and correct record.

Links to Strategic Objectives
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☒ Objective 5: Respond well to complex needs
- ☒ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

Impact Assessments – key issues identified
(please enter 'N/A' where not applicable)

INSERT TITLE OF REPORT

Reducing Inequalities/Equality & Diversity	N/A
Quality	N/A
Safeguarding	N/A
Financial/Resource/ Value for Money	N/A
Sustainability	N/A
Governance/Legal/ Privacy	The Minutes are the formal record of the meetings held on 25 January 2024.
Confidentiality	N/A
Risk Description	N/A

Please keep these front pages to a maximum of three

Minutes of the Meeting of NHS Somerset Integrated Care Board (ICB) held at Wynford House, Yeovil, at 9.45 am **Thursday 25 January 2024**

Present:	Paul von der Heyde	Chair
	Suresh Ariaratnam	Non-Executive Director (Chair of Primary Care Commissioning Committee)
	Dr Berge Balian	Primary Care Partner Member
	Dr Caroline Gamlin	Non-Executive Director (Chair of Quality Committee)
	Professor Trudi Grant	Chief Officer for Population and Public Health
	Alison Henly	Chief Finance Officer and Director of Performance and Contracting
	Jonathan Higman	Chief Executive
	Peter Lewis	Chief Executive, Somerset NHS Foundation Trust (Trust Partner Member)
	Dr Bernie Marden	Chief Medical Officer
	Shelagh Meldrum	Chief Nursing Officer and Chief Operating Officer
	Grahame Paine	Non-Executive Director and Deputy Chair (Chair of Audit Committee)
	Duncan Sharkey	Chief Executive, Somerset Council (Partner Member)
Apologies:	Christopher Foster	Non-Executive Director (Chair of Finance Committee, Remuneration Committee and Somerset People Board)
	Judith Goodchild	Healthwatch (Participant)
In Attendance:	Charlotte Callen	Executive Director of Communications, Engagement and Marketing
	Dr Victoria Downing-Burn	Chief People Officer
	David McClay	Chief Officer for Strategy, Digital and Integration
	Katherine Nolan	SPARK Somerset, VCSE sector (Participant)
	Jade Renville	Executive Director of Corporate Affairs
Secretariat:	Julie Hutchings	Board Secretary and Corporate Governance Lead Officer

ICB 001/24 WELCOME AND APOLOGIES FOR ABSENCE

1.1 Paul von der Heyde welcomed everyone to the meeting of the NHS Somerset Integrated Care Board (ICB). Apologies were received as noted above.

ICB 002/24 REGISTER OF MEMBERS' INTERESTS

2.1 The ICB Board received and noted the register of members' interests, which reflected the electronic database as at 18 January 2024.

ICB 003/24 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

3.1 Under the ICB's arrangements for managing conflicts of interest, any member making a declaration of interest can participate in the discussion of the particular agenda item concerned, where appropriate, but is excluded from the decision-making and voting process if a vote is required. In these circumstances, there must be confirmation that the meeting remains quorate in order for voting to proceed. If a conflict of interest is declared by the Chairman, the agenda item in question would be chaired by the Deputy Chair.

There were no declarations of Interest relating to items on the agenda. The quoracy of the meeting was confirmed.

ICB 004/24 WITHDRAWAL OF PRESS AND PUBLIC

4.1 The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

ICB 005/24 CLOSE AND DATE OF NEXT MEETING

5.1 11.00 am on 25 January 2024, at Wynford House, Lufton Way, Yeovil.

Chairman: Date:

Minutes of the Meeting of NHS Somerset Integrated Care Board (ICB) held at Wynford House, Yeovil, on **Thursday 25 January 2024**

Present:	Paul von der Heyde	Chair
	Suresh Ariaratnam	Non-Executive Director (Chair of Primary Care Commissioning Committee)
	Dr Berge Balian	Primary Care Partner Member
	Christopher Foster	Non-Executive Director (Chair of Finance Committee, Remuneration Committee and Somerset People Board) (virtual - for items ICB 011/24 and ICB 012/24)
	Dr Caroline Gamlin	Non-Executive Director (Chair of Quality Committee)
	Professor Trudi Grant	Chief Officer for Population and Public Health
	Alison Henly	Chief Finance Officer and Director of Performance and Contracting
	Jonathan Higman	Chief Executive
	Peter Lewis	Chief Executive, Somerset NHS Foundation Trust (Trust Partner Member)
	Dr Bernie Marden	Chief Medical Officer
	Shelagh Meldrum	Chief Nursing Officer and Chief Operating Officer
	Grahame Paine	Non-Executive Director and Deputy Chair (Chair of Audit Committee)
	Duncan Sharkey	Chief Executive, Somerset Council (Partner Member)
Apologies:	None	
In Attendance:	Charlotte Callen	Director of Communications, Engagement and Marketing
	Dr Victoria Downing-Burn	Chief People Officer
	Judith Goodchild	Healthwatch (Participant) (Virtual)
	David McClay	Chief Officer for Strategy, Digital and Integration
	Katherine Nolan	SPARK Somerset, VCSE sector (Participant)
	Jade Renville	Director of Corporate Affairs
Secretariat:	Julie Hutchings	Board Secretary and Corporate Governance Lead Officer

ICB 006/24 WELCOME AND APOLOGIES FOR ABSENCE

6.1 Paul von der Heyde welcomed everyone to the meeting of the NHS Somerset Integrated Care Board (ICB). No apologies were received.

ICB 007/24 REGISTER OF MEMBERS' INTERESTS

7.1 The ICB Board received and noted the register of members' interests, which reflected the position as at 18 January 2024.

ICB 008/24 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

8.1 Under the ICB's arrangements for managing conflicts of interest, any member making a declaration of interest can participate in the discussion of the particular agenda item concerned, where appropriate, but is excluded from the decision-making and voting process if a vote is required. In these circumstances, there must be confirmation that the meeting remains quorate in order for voting to proceed. If a conflict of interest is declared by the Chairman, the agenda item in question would be chaired by the Deputy Chair.

DRAFT

There were no declarations of Interest relating to items on the agenda. The quoracy of the meeting was confirmed.

ICB 009/24 CHAIR'S INTRODUCTION/REPORT

9.1 The Chair gave some introductory remarks, noting the following:

- An acknowledgement that all partners in the county continue to be under operational pressure.
- Proactive dialogue has continued with chairs regionally and nationally, together with contact with leaders across our system.
- Attendance of the Council of Governors meeting of Somerset NHS Foundation Trust before Christmas and open discussion about the position across the system.
- Visit from Steve Russell, Chief Delivery Officer at NHS England and colleagues who are looking into how best to make integrated care systems even more successful. They are looking at Somerset as a potential exemplar system for the future.

ICB 010/24 MINUTES OF THE MEETING HELD ON 30 NOVEMBER 2023

10.1 The minutes of the meeting held on 30 November 2023 were approved as a true and correct record.

10.2 The action schedule was reviewed. No updates were provided.

ICB 011/24 PUBLIC QUESTIONS (PLEASE SEE APPENDIX 1)

ICB 012/24 SOMERSET ACUTE HOSPITAL-BASED STROKE SERVICES RECONFIGURATION – DECISION MAKING BUSINESS CASE

12.1 The Board received the Somerset Acute Hospital-Based Stroke Services Reconfiguration – Decision Making Business Case. David McClay, Julie Jones and Dr Rob Whiting highlighted the following:

- The Decision Making Business Case (DBMC) sets out the future configuration of the acute hospital-based stroke services element, which includes hyperacute stroke and acute stroke services, including transient ischaemic attacks (TIA) and stroke mimics
- The vision for adult stroke care will ensure the provision of acute hospital-based stroke services that are timely, easy to access, high quality and efficient, with stroke experts available 24 hours a day, 7 days a week, 365 days a year.
- This will lead to a quicker diagnosis and faster treatment, resulting in the best possible outcomes for the patient. This includes increased access to thrombectomy services and best use of thrombolysis.
- The current configuration of stroke services creates several risks and issues:
    - inability to deliver the national standards of stroke care consistently to all patients
    - inequity of service, particularly out of hours (OOH)
    - considerable time difference in speed of IV thrombolysis in-hours compared to out-of-hours when delivered by non-stroke physicians
    - limited scope of the current AGWS out-of-hours- physician telemedicine service
    - Yeovil not having a clearly defined Hyperacute Stroke Unit (HASU) or Acute Stroke Unit (ASU) with staffing levels matching the National Stroke guideline recommendations
    - Yeovil District Hospital considerably falling below the 600 patients required annually in order to maintain clinical expertise and ensure

good outcomes within its HASU, as set out within NHSE guidance and with modelling indicating that, despite demographic change, this will not be met over the next 10 years.

- A longlist of nine options was originally developed, with a set of hurdle criteria applied to test each option, using a pass or fail score. A range of experts were asked to rank the longlist and options with more passes than fails were added to the shortlist of six options. These were reviewed by the Stroke Steering Group and reduced to four based on clinical safety. The final four options went to the SW Clinical Senate Review Panel and two options were removed as the recommendation of the Senate was that they were not clinically viable. The remaining two options went out to public consultation.

- Rick Hein, a person with lived experience, talked about his involvement in shaping and designing the proposed future services.

- The 12-week public consultation period ran from January to April 2023 and gathered feedback from people living in Somerset, people using Somerset hospitals, staff and partner organisations impacted by the proposals. The full ORS (consultation feedback) report was included within the appendices of the DMBC.

- Consultation feedback was discussed by the Stroke Programme Team, Stroke Steering Group, Stroke Public and Patient Reference Group, Stroke Project Board and ICB Board

- The themes from the consultation feedback included:

    - Travel and transport – travel times
    - Travel and transport – transport issues for visiting family and friends
    - Clinical risk/quality of care
    - Equality of access
    - Inpatient environment
    - Workforce
    - Alternative models proposed

- The DMBC sets out the actions taken, additional analysis undertaken and how the range of evidence has been considered and taken account of. Travel and workforce have been an area of particular focus within the DMBC. A full copy of the Geospatial modelling was included within the DMBC appendices for reference.

- Following the consultation, further assessment of the two options was undertaken which identified information that was not available prior to the consultation launch. Significant concerns were heard from family and loved ones about the importance of their role in patients' recovery and DCH advised that they were not able to deliver the entirety of option B.

- This was put alongside the strong public opinion about the adverse impact on families and carers if stroke services were to be completely removed from Yeovil. This led to the ICB Board discounting option B at its meeting in November 2023, agreeing to work up option A in more detail as the preferred option.

- The revenue cost to the system of implementing the option A model is estimated at £4.2 million in year 1. The capital cost is estimated at £1.8 million, although the costs will continue to be challenged through any implementation phase. It is assumed that the new model of care will generate non-cashable benefits for the commissioners of £1.0 million from the first full year it is operational. This will rise to £3.5 million by year 10. These savings result from modelling the impact of reduced disability resulting from improvement hyper-acute and acute care.

- An outline implementation plan has been developed with an 18-month timescale, with a go-live date of May 2025 involving close alignment with SFT, DCH and the ambulance service.

- Governance for implementation will be the responsibility of SFT and DCH, however, a Joint Stroke Co-ordination Board (Somerset and Dorset) will be established, which will be convened by NHS Somerset. A formal review of the benefits will be undertaken at 12 months and assurance of the benefits realisation, patient experience etc, will be undertaken by the ICB.

- It is proposed that the ICB Board approve the proposed clinical model:

    - A single Hyper Acute Stroke Unit to be located at Musgrove Park Hospital in Taunton

    - The retention of Acute Stroke Units at both Musgrove Park Hospital, Taunton and Yeovil District Hospital

    - One county TIA service operating seven days a week at Musgrove Park Hospital, Taunton and weekday service at Yeovil District Hospital

12.2 There was discussion and questioning amongst Board members as follows:

- Referring to the new proposal for direct access to specialist consultants from 8.00 am – 8.00 pm seven days a week, clarity was sought on how cover will be provided outside of those times and whether this would this be either local remote advice or linked back to the regional support system. Dr Rob Whiting advised that the plan would be for local advice. The regional AGWS thrombolysis telemedicine network covers a large region from Swindon, Gloucestershire, Salisbury and Somerset and because of covering such a large region, the scope can only be limited to decisions about stroke, thrombolysis and thrombectomy. By having a local team of physicians, it enables better quality decisions and provides an opportunity in terms of education to our local hospitals to improve their knowledge.

- Clarity was sought as to what extent the reconfiguration in Bristol, North Somerset and South Gloucestershire (BNSSG) has affected those in the North of Somerset and whether there will be equity of service if we move to this model. Dr Rob Whiting advised that before the service at Weston General Hospital was changed MPH was starting to see an increased number of patients from North Somerset during evenings and weekends. This is because the Weston service only took patients in working hours from Monday to Friday. Part of the BNSSG business case has resulted in investment in Musgrove Park Hospital, with two additional specialist doctors and one Consultant with an interest in stroke and elderly care medicine, having been recruited to help support a larger stroke unit and a move from four to eight beds.

- Assurance was sought about the trade-off between increased journey times and reduced times once patients arrive at the hospital together with how deliverable the new model is from a workforce perspective. Dr Rob Whiting advised that there are now eight whole time equivalent (WTE) stroke consultants and specialist doctors at Musgrove Park Hospital (MPH) and the Trust is looking to extend senior cover from 9.00 am – 5.00 pm to 8.00 am – 8.00 pm. There is confidence that there is the critical mass of senior physicians to deliver what is set out in the plan. With regard to Dorset County Hospital (DCH), when it comes to providing specialist care around thrombolysis and thrombectomy, in other areas of the country they have been successful in stroke physicians working with acute physicians to implement a rota, with fast ‘door to needle’ times. In Dorset they have a close working relationship with their ED to help deliver thrombectomy and thrombolysis, and whilst this is a different model to that offered at MPH, there are good working relationships and people with the expertise and training to be able to autonomously deliver the treatment. They would need to ensure they are delivering the standards for the HASU, so there is still a need to invest in stroke consultants, which was acknowledged as a risk but

the service has now had investment under a Phase 1 plan (to establish a HASU) in Dorset which makes it more attractive to those looking for a post.

- From the floor, Cllr Adam Dance commented if Dorchester have less staff than Yeovil, why are we thinking of dismantling one hospital to build another?

- Assurance was sought as to how the NHS Somerset Board will be assured that Dorchester keep to their programme of delivery and how the Board assures itself as to the quality of the service delivered. David McClay confirmed that there will be an oversight implementation group led by the ICB, comprising representatives from DCH, SFT. Depending on today's outcome, that group will be mobilised within the next six weeks and the membership and terms of reference will be agreed. Detail will be added to the draft implementation plans and a letter of support has been received from the Chief Executive of DCH.

- Questions were also asked about how NHS Dorset ICB will be involved in this to ensure alignment of plans. David McClay advised that there will be two phases. The first is around the Dorset only development of the HASU on the DCH site following agreement of the NHS Dorset plans for Stroke services. There will be a joint interest in the second phase which would see the capacity of the HASU extended to accommodate patients that presently attend Yeovil for their HASU care. Dorset ICB are represented on our Project Board and we have frequent contact with them throughout the process. David McClay acknowledged that this would represent a deepening of cross-border working. Jonathan Higman advised that the Board of DCH have offered a joint conversation with NHS Somerset, so if the proposal is agreed, a Board-to-Board meeting will be arranged with a sub-set of members from this Board.

- There was discussion about the recruitment plan and timescales at DCH and a request for reassurance that the Yeovil HASU would not close until DCH was operational. David McClay provided reassurance that the model currently in place would continue until we are assured that the DCH service is sufficiently expanded to accommodate Somerset patients. Bernie Marden added that with regards to the historic recruitment challenges, a critical element in attracting, recruiting and retaining high performing teams is to have predictability and certainty in what is happening and so a decision taken today will help in all those aspects.

- It was noted that there is a need to think about the intervening period before implementation to keep improving the existing system, which is not currently meeting national standards and not delivering the desired outcomes across the county at present.

- It was noted that neither the HASU or ASU in Yeovil are currently meeting the service standards being delivered at Musgrove. Assurance was requested that the proposals for the new ASU in Yeovil will deliver consistent quality of care to that delivered at Musgrove Park Hospital. Dr Rob Whiting advised that the Clinical Senate set out clear specifications around the definition of an ASU and that this needs to be a geographically defined unit. Currently YDH does not meet that criteria. Getting to an ASU or HASU in a timely manner is a national issue with only about 45/50% managing that nationally and only about 25% of people in Yeovil able to get to a HASU within four hours. The business case looked at how many beds were required, ensuring those beds are ring-fenced with an occupancy level to ensure capacity and flow.

- Trudi Grant highlighted that today is national stroke prevention day and that 80% of cases are preventable. She reflected that whilst this has been a huge piece of work, looking in great detail at the care pathway for strokes, there is a need for a much greater emphasis on preventing strokes in the first place. A commitment was sought from the Board that for any future service reviews, the whole pathway of care is reviewed, together with distribution and emphasis of resources required going forwards. Back in August last year, the Board agreed on a specific system wide focus on

hypertension/high blood pressure as there are 40,000 people in Somerset that are unaware and undiagnosed. More work is required to find those cases and when found, to ensure that medications are optimised to prevent things like stroke. One of the main contributors to 70% of strokes is high blood pressure. A request was also made to double efforts on this work.

- Jonathan Higman agreed that the Board should be looking at the whole pathway and reiterated the need to focus on the work on hypertension to prevent strokes in the first place. If the hyper acute phase is right, the impact on long-term disability is significant. Prevention and the hyper acute and whole reablement pathway that follows, is very important.

- It was noted that while a major focus of discussion today as been on the hyper acute phase only 20% of stroke admissions will be suitable for thrombolysis. The service provides good care to this 20% but this is not consistent through the 24-hour period. For the remaining 80% it is important that they receive care from a specialist team, in a specialist unit and this is not currently being delivered consistently at YDH. It was acknowledged that the team at YDH have worked hard to meet the standards as far as they can but this is not sustainable and increasingly specialist diagnostics and treatment will only make it more difficult to achieve the recommended standards of care.

- Getting people home better, with more functionality for longer, is very important. Assurance for implementation is critical. This is about investment in better outcomes for people.

- Peter Lewis asked how, with an underlying deficit, we are assured that this is the right level of investment and also what the implications are of investing £1.8 million of capital money from Somerset into Dorset. Specific concerns were raised to ensure consistency between the additional cost of delivery across Musgrove Part and Dorset County Hospital.

- Alison Henly reiterated the need to ensure the right standards are achieved and work will continue to review and challenge unit costs as part of the implementation plan. There is also a need to ensure we continue to deliver the benefits set out in the business case. Peter Lewis asked for urgency with this financial work and expressed concern about fully supporting this without seeing this information. Jonathan Higman agreed that this work would be undertaken within the next month with review by the Finance Committee prior to it being presented to the next Board meeting.

- It was noted that the Finance Committee have discussed concerns around capital spend and asked for greater assurance. Assurance is being sought that an assessment of risk to understand what impact the proposal to spend additional capital monies on Stroke will have to the overall capital investment programme. This detail is yet to be worked through but is underway and the Committee would expect to see assurance from colleagues in Dorset, together with an assessment of the overall risk to the capital programme in the coming years.

- Regarding assurance in terms of both delivery of the new model at MPH and at DCH, if approved, the work of the ICB would then move to the next phase of assuring ourselves around that implementation plan, with clear checkpoints along the way and assurance of the delivery of the standards.

Action ICB 012/24: A formal impact assessment on the capital investment and overall financial modelling is to be carried out as a matter of urgency, through the Finance Committee, prior to consideration at the next Board meeting

12.3 The Board unanimously **approved** the Somerset Acute Hospital-Based Stroke Services Reconfiguration – Decision Making Business Case, with the following caveats:-

- that a formal impact assessment on the capital investment and overall

financial modelling be carried out as a matter of urgency and considered at Finance Committee prior to consideration at the next Board meeting.
- that the Board commit to ensuring that for any future service reviews, the whole pathway of care is considered and also to doubling efforts on the current work to tackle hypertension.

ICB 013/23 CHIEF EXECUTIVE'S REPORT

13.1 The Board received and noted the Chief Executive's report. There was particular discussion on the following:

- Operational pressures over the Christmas and New Year period - significant although managed well, particularly when comparing this winter to last winter and within the context of ongoing industrial action. It was acknowledged that major challenges around the level of patients with 'No Criteria To Reside (NCTR)' in our hospitals remain. A positive system workshop took place last Friday with specific actions which now need to be taken forward at pace.

- There has been an opportunity to showcase some of the innovation taking place in Somerset on the BBC Radio 4 Today, BBC Breakfast and also The One Show, focusing on our Brave AI work.

- NHS Somerset operating model and organisational restructure – phase one of the consultation has concluded and is now moving into implementation, with phase 2 structures due to be finalised shortly for consultation.

- Minehead Medical Centre – following a recent CQC inspection and interviews that concluded last week, the CQC issued a suspension notice for the registration of Minehead Medical Centre, meaning that it closed to new appointments on Tuesday 23 January. With swift work in the background by the ICB's primary care team and colleagues from SFT, the Medical Centre reopened the following morning under One Medical Group, a temporary solution for the next 12 months whilst a permanent solution for the practice is found. A statement is provided on our website, with a dedicated helpline for concerned members of the public to confirm that the Medical Centre is open for business as usual and services are provided on a like for like basis.

- Measles – Trudi Grant advised that as at a week ago, there were 282 confirmed cases nationally, with this currently being a Europe-wide issue. Most individuals are unvaccinated under 10-year-olds and there is a strong association with areas of deprivation, also amongst a number of health and social care staff. Currently there are no confirmed lab cases in Somerset, although there are 23 in the South West. Work is taking place across the system on increasing uptake of vaccinations, as still below the 95% required for herd immunity. Also working with the Infection, Prevention and Control team and GPs to ensure unvaccinated people are actively followed up, putting in place bespoke arrangements to encourage attendance. Everyone is encouraged to check their vaccination status and have their MMR vaccination through the Evergreen offer, in particular children, teenagers, pregnant women and those born after 1970.

- The second edition of the Somerset ICS newsletter has just been issued and partners are encouraged to share more widely within their organisations.

13.2 There was particular discussion amongst Board members as follows:

- How we are assessing implications of the National Mental Health Commissioning Guidance specifications as this is not currently included in our Integrated Board Assurance Exception Report. Jonathan Higman advised that as the guidance was only issued in November, some actions are being taken but further work is required to fully understand the implications.

Action ICB 013/24: Update on implications of National Mental Health Commissioning Guidance to be considered at future meeting

ICB 014/24 POPULATION HEALTH UPDATE

14.1 The Board received an update on Population Health. Professor Trudi Grant highlighted the following:

- Focus on hypertension – back in late August, it was agreed to take a system wide approach to hypertension. There is now a cardiovascular dashboard in place, with all but two practices feeding all their data into that. This is an interim arrangement until a joint data platform is established.
- Work is being undertaken with a behavioural insights team and communications colleagues to understand what messaging we need to reach specific groups, such as men over 40. Also working with PCNs on what they might be able to do to step up in this space.
- Good progress has been made with pharmacy case finding, linking with practices and also working with Spark and the Voluntary, Community, Faith and Social Enterprise (VCSFE) sector to call employers to arrange blood pressure checks in the work place, especially for men whereby we traditionally have low uptake.
- Reflecting on learning about the balance between having a perfect solution and just getting things going.

14.2 There was particular discussion amongst Board members as follows:

- A communications campaign is being designed to raise the profile and increase understanding of high blood pressure, the fact that testing can be done in pharmacies and libraries and to promote healthy heart habits to bring blood pressure down naturally.
- The importance of using a 'train the trainer' approach.
- Need to consider how to best reach out to those who may not normally engage (e.g., working age men).
- Noted that this is a different way of working and needing to take a test and learn approach, and not to over-medicalise things.
- There is a need to better understand why groups are not engaging, perhaps due to not being willing to change lifestyles with a bite size approach to gradual improvement.
- There is a need to simplify terminology and link use of the word hypertension to blood pressure on GP webpages.

14.3 The Board **noted** the Population Health update.

ICB 015/24 EMERGENCY PLANNING, RESILIENCE AND RECOVERY (EPRR) SELF ASSESSMENT ASSURANCE UPDATE REPORT 2023

15.1 The Board received the Emergency Planning, Resilience and Recovery (EPRR) Self Assessment Assurance Update Report 2023**.** Jade Renville highlighted the following:

- Alongside other agencies, the ICB is a category 1 responder under the Civil Contingencies Act, which means that there are a number of requirements and duties we need to mee through the NHSE core standards for Emergency Preparedness, Resilience and Response (EPRR)
- Each year, self-assessments are completed and go through a rigorous review process.
- NHS Somerset was assessed by NHS England and achieved substantial compliance.
- Somerset NHS Foundation Trust was assessed by NHS Somerset and achieved full compliance.
- Across Somerset, a system approach is taken to how EPRR planning is approached.

15.2 The Board noted the position and unanimously **approved** the statement of compliance contained within the Emergency Planning, Resilience and Recovery (EPRR) Self Assessment Assurance Update Report 2023.

ICB 016/24 FINANCE REPORT – MONTH 8 2023/24

16.1 The Chief Finance Officer and Director of Performance and Contracting presented the finance report, highlighting the following points:

- The Finance Report covers the period 1 April to 30 November 2023.
- Somerset Council's position is now included and reflects an integrated ICS report, recognising that NHS Somerset and Somerset Council report differently, as the Council reports on a forecast position basis. The position in the report is pro-rata to represent the year-to-date position.
- Following the allocation of additional £5.9m funding for industrial action and further budget flexibility, a review of costs for the second half of the year has been carried out. The outcome of this process was that the additional funding supports delivery of a breakeven financial position both on a year to date and forecast basis.
- Somerset Council is showing a forecast deficit of £18.3m for 2023/24. This is largely being driven by pressures in Adult Social Care and Children and Family Services. The Council is focused on addressing the in-year financial plan, with a forward view on the 2024/25 financial plan.
- The report highlights an overspend of £9.1m against the capital allocation. This relates to the cost of additional leases and in year RPI impacts not taken into account in the plans at the beginning of the year.
- The agency control limit has been breached by £4.4m and this is a significant focus for the system. A system review of controls and process has been undertaken and this continues to be a significant area of focus for the Finance Committee.
- As a result of the additional funding received, the number of system risks has reduced and are now focused on winter acute escalation, elective recovery and industrial action.

16.2 There was particular discussion amongst Board members as follows:

- Clarity was sought about treatment of the industrial action costs in the final quarter as we set out our position on the assumption of no further industrial action. Alison Henly advised that for December, we predicted a financial pressure in the financial position relating to industrial action, . The forecast assumed funding will be received and work is ongoing with the national team. Guidance is awaited on how that will be enacted and this will be brought back to this meeting in due course.
- There was a request for sight of the outcomes of the funding provided to contribute towards the Newton Programme for adult social care, in order to understand what the impact was. Alison Henly advised that this was due to be considered at Finance Committee at the February meeting and will be reported back to Board through the Finance Committee report. Jonathan Higman added that as well as the Newton team attending the next Finance Committee, regular touchpoint meetings take place with them. Consideration to be given as to when this will come back to the Board to review progress.

Action ICB 016/24: Review of progress on work with Newton to be considered at future meeting (date to be determined)

ICB 017/24 SYSTEM ASSURANCE FORUM FEEDBACK: INTEGRATED BOARD ASSURANCE EXCEPTION REPORT (IBAR)

17.1 The Board received the IBAR Exception Report for the period 1 April 2023 – 30 November 2023. The Chief Finance Officer and Director of Performance highlighted the following:

The System Assurance Forum met on 18 January 2024. The meeting focused on the following areas:

- Elective recovery – with a focus on the recovery of the long waiters, 62-day cancer performance, six-week diagnostic performance and inpatient activity against the plan.

- The Somerset position against the national performance standards in a number of areas including talking therapies, children and young people access and physical health checks for people with a serious mental illness.

In addition, the Forum undertook deep dives on three other areas:

- Virtual wards – noting the improving picture within the South West position

- A&E 4-hour performance – the Forum noted the 4% increase in A&E attendance since 2020. A further discussion will be included on the March agenda

- No Criteria to Reside – it was noted that a workshop was being arranged on 19 January with colleagues from Newton Europe to update on progress.

The next meeting will focus on a deep dive on the 111 service, an action arising from Board.

17.2 There was particular discussion amongst Board members as follows:

- There was a request to move some of the reporting from activity to outcome and include some key measures about how the population we serve are benefitting from the activities we are driving, to understand where we are making a difference as well as how hard we are working. Alison Henly advised that SPC charts were included within the appendices for the first time and starting to look at where are those areas where we are on a proper exception basis. This will then feed into the SAF agenda, so this circle needs to be completed.

- Attention was drawn to page 6 of the SPC charts which demonstrated the inequality of services we provide for women in Somerset, as our gynaecological and breast 62-day cancer waits are both significantly below our aspirations, whereas all other services are above.

ICB 018/24 KEY MEETING REPORTS

18.1 The Chairs of the Board Committee and System Groups provided written and/or verbal reports of the most recent meetings, as follows:

Board Committee Reports:-

- Finance Committee: written report provided.

- Audit Committee: written report provided.

- Quality Committee: written report provided.

- Primary Care Commissioning Committee: written report provided.

Joint Committee Reports:-

- People Board: written report provided. The last meeting received a paper focusing on workforce productivity to meet the demands over the next 10/15 years and a deep dive will be carried out looking at how we develop the future workforce.

- Children, Young People and Families: The meeting this week discussed the next iteration of the children and young people's plan, which will be

co-produced by the end of the year. There was also an update on the SEND Department of Education (DoE) monitoring visit. There were two areas of significant weakness identified from the written statement of action. The first related to the action taken once an education plan has been produced and they were satisfied with this action, so we anticipate this will be closed when they return in the summer. The second area was about reducing exclusion from schools and whilst positive work has been done with children and young people identified as likely to be excluded, rates are still increasing. The DoE were also interested to hear from us about workforce going forward and financial constraints.

Caroline Gamlin added that Audiology was discussed at Quality Committee, as an issue impacted particularly by Covid. The Senate in the South West has recently looked at the impact of Covid on children' health and services, which might be worth considering.

- Collaboration Forum: written report provided. There is a re-energised focus on No Criteria to Reside and a workshop was held last week, with a set of actions highlighting a redesign of the intermediate care service. Work is now being undertaken to structure this as a programme of delivery across the system. The second priority is around creation of integrated neighbourhood teams. If significant process could be achieved on those two areas, this would be transformational for the system.

  Grahame Paine asked who sits on the Collaboration Forum, which Jonathan Higman advised. This is the forum that translates the strategy into prioritised action for the system.

  Katherine Nolan advised of a VCSFE leaders meeting last week, from which the three main themes were neighbourhood working, the commissioning culture and transparency and elective impact measurement. A big event is being organised in March where commissioners from all parts across the system will meet with the voluntary sector to think about how to work better together.

- Somerset Board: met for the first time on 14 December. This board comprises the ICP and health and Wellbeing Board and is responsible for setting the strategy for the system. The importance of regular and inspiring communication with the whole population was recognised, not least around prevention. The initial priority was housing, care for all ages, prevention and population health. It is a meeting in public, which anyone is welcome to attend.

ICB 019/24 ANY OTHER BUSINESS

19.1 None was raised.

ICB 020/24 CLOSE AND DATE OF NEXT MEETING

20.1 9.30 am on 28 March 2024, at Wynford House, Lufton Way, Yeovil.

Chairman: Date:

APPENDIX 1

ICB 011/24 PUBLIC QUESTIONS

11.1 **From James Farthing, Member of the Public (in attendance):**

"Do bank workers on zero-hour contracts have the same rights as permanent staff?"

11.1.1 Victoria Downing-Burn thanked Mr Farthing for his question and advised that bank workers on zero-hour contracts do not have the same rights as permanent staff. The notable difference is that permanent staff have an obligation to perform shifts that they are required to carry out and have a right to be offered work in accordance with their contracts of employment. In contrast, bank workers have flexibility to choose whether to accept work that is offered to them, and there is no right to be offered work. In addition to having the flexibility to choose whether to accept work, bank workers also have the freedom to work in other organisations.

11.2 **From Mr Roger Marsh, Chair – Patient Participation Group The Grove Medical Centre, Sherborne Dorset:**

"The DMBC states that 56% of the stroke patients (around 255 people) who are currently taken to the HASU at Yeovil District Hospital will in future be taken to the proposed HASU at Dorset County Hospital, Dorchester.

If Dorset County Hospital has not succeeded to recruit the necessary staff to open its HASU within the required two-year window, where will patients from north Dorset be taken for emergency treatment?"

11.2.1 David McClay thanked Mr Marsh for his question and advised that governance for implementation will be the responsibility of Somerset NHS Foundation Trust (SFT) and Dorset County Hospital (DCH).

A joint implementation group will be established (Joint Stroke Co-ordination Board (Somerset and Dorset)) to cover timing and communication of implementation, equity of access and pathways which work across both organisations. The ICB will be a member of this group as involved assurance.

Exceptions to implementation will come back to the ICB for oversight and assurance, including milestones and go/no go gateways before any decisions made before go-live. Since publication of the papers, a letter has been received from Dorset County Hospital reinforcing their commitment to the process and implementation.

11.3 **From Caroline Toll, Former Carer and Volunteer Ambassadors for Carers UK (in attendance):**

"**Provisions suggested for unpaid carers**

It is mostly understood that family members and other unpaid carers supplying emotional and practical support to patients of stroke can help towards good outcomes, quite apart from the essential knowledge that these carers have of the patient which can help the professionals provide appropriate care.
While welcoming the suggestions for supporting unpaid carers' access to the 2 hospitals how can we be sure that these will be seen as an essential part of the decisions made?

It is very easy to take carers for granted but they need to be involved in decisions and supported in their own right in the interests of the patient, after all the essential services that unpaid carers provide has been valued roughly as the same as the cost of the whole of the NHS. At least awareness is improving at last."

11.3.1 Shelagh Meldrum thanked Ms Toll for her question and advised that throughout the programme of work, the engagement with the stakeholder group has always focused on the ability of carers to visit and be with their loved ones. They understand the compromises that need to be made to get specialist stroke care and have made suggestions such as leaflets for relatives and

carers that give them information about options for community transport and the opportunity for open visiting hours to give adequate time for visiting.

There was significant concern heard during the consultation that family and loved ones play an important role in a patient's recovery and the impact not being able to see loved ones could have on the wellbeing of patients and put alongside the strong public opinion heard through the public consultation around the adverse impact on families and carers if stroke services were completely removed from Yeovil, a recommendation was made to the ICB Board to discount Option B (a single hyper acute stroke unit and a single acute stroke unit at Musgrove Park Hospital, Taunton), and to work with Option A as a preferred option.

Having considered the evidence of the impact of additional travel for visiting friends, families and carers, it was felt that the best decision needs to be made for patients and the impact has been mitigated through maintaining an Acute Stroke Unit at Yeovil, limiting the HASU stay to 72 hours and providing technology to connect patients and carers.

(Bernie Marden to respond to both questions 11.4 and 11.5 collectively – see response in 11.5.1)

11.4 **From Kris Smith, Member of the Public (in attendance):**

"The case for change as promised by the trust cites workforce sustainability was the principal reason for change, highlighting the fact the current stroke consultant is due to retire and recruitment for the post has not been successful. The Trust have much responsibility for that situation having questioned the Yeovil Stroke units continued existence since 2018.

However, now in 2024, we have two additional stroke consultants and a nurse stroke consultant and the head of department has delayed his retirement plan. Hence the principal reason for change is no longer valid!

The second reason for change sets a figure of 500 patients per year to maintain expertise and good clinical outcomes. From 2018 to 2021 Yeovil averaged 441 and Taunton 651. Yeovil is only 59 patients off the minimum and will undoubtedly reach 500 per year in the short term due to the ageing population in Somerset. The audited performance of Yeovil and Musgrove units does not show significant difference in SSNAP tables. The second reason for change is no longer valid.

The third reason, money! In the PCBC The trust state "NHS Somerset has an underlying financial deficit in the region of £70million. This means that to balance the books we have no choice but to look to radical ways to deliver services more efficiently and effectively while still maintaining quality and safety of care." Will the dismantling of an established HASU save £70million pounds? If not the three reasons for change are no longer valid, do you agree?"

11.5 **From Tareth Casey, Member of the Public (in attendance):**

"**Viability of a HASU at MPH and YDH**

While we welcome Somerset ICB recently agreeing the need to retain the ASU at YDH, there is still huge concern over the intention to close the YDH HASU. In NHS Somerset's Documents (appendices page 26) it states one of the challenges is that "Services are not set up to maximise the skills and experience of staff. Currently, Yeovil District Hospital does not see the minimum recommended number of stroke patients (500–600 per year) for staff to maintain their skills and build expertise".

The NHS Somerset proposal to close the YDH HASU includes the use of the proposed HASU facility at DCH in Dorset which is currently being developed to open next year to provide a service for stroke patients in North and West Dorset. The business case is yet to be made to extend the HASU for a further 255 stroke admissions per year from Somerset, should the HASU at YDH be

closed. Therefore this proposal is making decisions based on pure assumptions rather than clear evidence that this is achievable long term and fails to take into consideration long term growth and ageing population.

With the closure of the Weston General Hospital HASU and that service relocated to MPH the expected capacity for the MPH HASU under this proposal will be in the region of 815 patients. With this capacity and the 255 NHS Somerset are proposing to outsource to Dorset and the total number of Stroke patients for Somerset is 1070. Based on patient numbers between the two Hospitals (YDH and MPH) this makes 2 HASUs in the county a viable proposition, if care is balanced between the two.

Somerset's ageing population means demand for stroke care will increase (page 26 of the appendices docs). Current trends predict within 3 years, more than a third of Somerset's population will be aged 65 or over. Additionally, the population for Somerset and Dorset is expected to continue to rise considerably as can be seen from SC housing model for the coming years. Stroke treatment will be a growth industry. The need for two HASUs in the county is clear.

What is the difference between Somerset and Dorset? Let's look at Dorset - a county with much the same geography and population as Somerset and with two Hospitals much the same distance apart - in fact the only difference between the two counties is the number of stroke patients where Dorset has far less than Somerset. But while NHS Dorset have seen fit to increase their HASU capacity to an extra hospital (DCH), so in future Dorset has two key HASU Units, NHS Somerset sees fit to remove their secondary large HASU unit and go to just a single Unit across the county.

Surely, now is the time for NHS Somerset to develop BOTH existing HASUs at Yeovil and Taunton, especially as YDH has recruited two new stroke consultants, and is therefore a very viable unit which is desperately needed to meet the developing need. How can this proposal be justified given the projected demand?"

11.5.1 Bernie Marden thanked Kris Smith and Tareth Casey for their questions and advised that the situation now is slightly different than when we started: at the start we were faced with a YDH inability to recruit any substantive stroke consultant staff for 10 years despite multiple attempts; and it is true that YDH has been able to recruit two consultants, however there would need to be considerably more than two or three stroke consultants on the YDH site to deliver the same 7-day 8am- 8pm cover at MPH and YDH.

The stroke configuration support guide published by NHS England sets out that the total number of strokes each year, per unit, to ensure that a hyperacute stroke unit should see no less than 600 patients per year. They advise that fewer than 600 strokes per year would not be sufficient to ensure staff would have enough clinical experience and institutional learning experience to maintain their experience. The minimum of 600 strokes per year was also a threshold endorsed by the Midlands and East stroke review. Ten years' activity modelling shows that Yeovil would not meet the 600 patients per year.

With regards finance, the PCBC mentioned the underlying deficit across the health system however the proposed model signals an investment in the inpatient phase of stroke care. The economic modelling shows that this investment should herald better outcomes for patients and therefore less investment needed in ongoing support and long-term care.

The outputs from the refreshed modelling and additional analysis are summarised in the DMBC including the impact on other hospitals.

The option to keep two HASU units with a single team of stroke specialists covering both HASU units was one of the options that was discussed with the South West Clinical Senate as part of the assurance process. The clinical senate advised that this option should not be taken forward as they could not provide assurance on the model of care and deliverability. One of the main concerns was the ability to recruit sufficient consultants to staff a HASU at

Yeovil (National Stroke Guidelines recommend a minimum of 6 consultants). The clinical senate were also concerned about the deliverability of recruiting and retaining sufficient consultant staff to make an acute stroke unit in Yeovil a viable option. The recent stroke consultant appointments help to preserve the viability of maintaining an acute stroke unit in Yeovil. However, they fall short of the number of consultants required to sustainably staff a HASU that meets the required standards.

11.6 **From Gerry Smith, Member of the Public (in attendance):**

"In September 2023 opinion research services submitted a feedback report to Somerset NHS Trust detailing the widespread opposition of the public and NHS staff to the closure of the Yeovil HASU. This report has been suppressed by the Trust, and was not made available to the ICB decision makers for their meeting on the 30th of November. The report was not disclosed to the public or decision makers until the very last minute on the 18th January the decision makers having less than five working days to examine 177 pages of report, 271 pages of appendices and to reference the many other reports within those documents. This reprehensible behaviour by the Somerset NHS board requires explanation, apology and reassurance that no further misconduct in public office is committed by trust staff and that the ICB decision makers adjourn today's meeting until all ICB board members have at least four weeks to digest the detailed information deliberately kept from them by the board.

Who will apologise today for the boards disgraceful conduct?"

11.6.1 Jonathan Higman thanked Mr Smith for his question and confirmed that the ORS report was provided to NHS Somerset, rather than Somerset NHS Foundation Trust (SFT) as it is NHS Somerset that has the statutory duty to consult on major service changes like this. This was an independent report written by ORS consolidating the wealth of feedback received during the public consultation. Following receipt, it was shared widely with the Stroke Team, Stroke Steering Group, Stroke Public and Patient Reference Group and Stroke Project Board.

A number of meetings and workshops were organised to ensure that the consultation responses were shared and evaluated. This included at an NHS Somerset Board development session in September, where the Board had an opportunity to review the report and ask questions to ORS who presented their findings at the session. A summary report detailing the major themes from the feedback was also shared with stakeholders including both the Somerset and Dorset Adult Health Scrutiny Committees. The summary report was also published and formally considered by this Board at its meeting in November 2023.

Feedback from the consultation has been used to inform the business case and associated recommendations that will be considered later. We have published the full report alongside the DMBC so that the two could be read together but the feedback has been widely considered by decision makers in parallel to this. I would acknowledge that the full report is long but would assure you that the findings have been widely considered by decision makers.

The release of papers for today's meeting is in line with the terms of reference for this Board and we extended the normal deadline for public questions by 2.5 days following a request from an Interest Group.

11.7 **From Raymond Tostevin, Quicksilver Community Group (Chair) and Somerset NHS Foundation Trust Member (in attendance):**

"Looking through the Appendices, alongside the bundle of documents before you today, reveals widespread opposition to the proposed closure of the Yeovil HASU.

Nearly six out ten (58%) of residents disagreed with the proposal to deliver hyper acute stroke services from just one hospital site in future.

From NHS staff members working in stroke services, nearly half (47%) agreed with the proposal to deliver hyper acute stroke services from one HASU in Somerset. BUT, a marginally greater proportion (49%) disagreed.

Among other groups, more than half (54%) of stroke survivors, opposed the plans. Views among family members and carers of stroke survivors were even more negative, with nearly three quarters (73%) disagreeing with the one HASU model.

We also note the letter from Dr. Khalid Rashed, MBE, Consultant Stroke Physician, at Yeovil Hospital, writing to the ICB chair, Paul von der Heyde. In his concluding paragraph Dr Rashed states: The stroke services at MPH and YDH are in desperate need for extra investment, good organisational support, and strong leadership. Work force problems can be solved with an appropriate recruitment drive and strong leadership.

Without this, says Dr Rashed, the current proposal in front of the ICB to remove YDH HASU will have catastrophic effect on the community, will not guarantee delivery of better services and will be more costly to the health and social care system.

Do the ICB seriously intend to override the overwhelming negative views of the public and staff - and ignore the professional advice of its most senior consultant stroke physician?”

11.7.1 Jonathan Higman thanked Mr Tostevin for his question and commented that it is important to recognise that a public consultation is an important and vital opportunity to gather a range of insights, views and feedback on proposals before any decisions are made and to inform the decision-making case. MHS Somerset do appreciate the strength of feeling that many people have and are pleased that so many local people took the time to give their views during the consultation. The views of the public have been considered and will be weighed against the other considerations set out in the business case as part of today's decision. The plans brought today have been developed by a team of clinicians, people working in stroke services, other local stakeholders and people with lived experience of stroke.

All the feedback received has carefully been considered. In the decision-making business case, concerns raised are outlined together with how these have been taken into account in developing these recommendations. The public feedback was also considered in the decision at the last meeting to discount option B. Concerns that we heard that family and loved ones play an important role in a patient’s recovery during the acute phase of their care and the impact that not being able to see loved ones could have on the wellbeing and recovery of patients were recognised. The DMBC also outlines the modelled impact on travel times for patients and carers.

As already touched upon earlier, NHS Somerset has been in dialogue with Dr Rashed and a series of meetings have taken place with him, including a meeting with other senior medical leaders from across Somerset to understand his concerns in more detail. The alternative suggested model put forward by Dr Rashed was explored and it was concluded that this was essentially one of the options rejected at an earlier stage of the process following review by the SW Clinical Senate. It is not possible to comment on your final statement as the Board has not yet considered the proposal but the Board look forward to a full discussion which balances all the information before us.

APPENDIX 1

11.8 **From Eva Bryczkowski, Member of the Public (in attendance):**

"The original concerns put forward by NHS Somerset at the Health and Wellbeing Scrutiny Committee have been mostly dealt with regarding staffing levels at YDH acute stroke unit, including the delayed retirement of the lead consultant.

Are you going to take into account the will of the people, the above information and keep Yeovil hospital acute stroke ward open?

Are you going to avoid a similar disaster like the Horizon Post office scandal?

Are you going to do the moral thing, see the wood for the trees amid all your research and keep it open?"

The work undertaken is robust. Thinking about horizon and following the suicide of a headteacher after being rated inadequate during an Ofsted inspection which they said was robust, please can you vote with your heart and your conscience and do the honourable thing to keep Yeovil open and undiluted. This is about possible brain damage and people giving up work to care 24/7 for people and regarding the business model, we are not just numbers and this can happen to any of us.

Regarding the equalities issue and the cost-of-living crisis, when I had downbeat nystagmus and living in Glastonbury and unable to drive, community transport quoted me £30 to get there. I was over two hours in outpatients and this doubled to £60.

Regarding the consultation, I think more people would have voted no because at the end of the Health and Wellbeing Scrutiny Committee, I asked how many had heard of or voted in the consultation and only about three hands went up. Whilst I know you have really worked hard to do the consultation, please bear in mind this is about the will of the people and to quote Pascal, "The heart has its reasons, which reason knows nothing of". This is not just about numbers or sustainability or all the wonderful research you have done, this is about listening to your heart and your conscience and thinking about if it was your loved one or it was you, that lived really far away from Yeovil. We know about drive times, we know about emergency assistants on £11.11 an hour trying to save lives because paramedics are burnt out, so it is a long drive time."

11.8.1 David McClay thanked Ms Bryczkowski for her question and advised that the proposal in the decision-making business case is that the acute stroke unit in Yeovil District Hospital will be kept open. Furthermore, there will be investment in the Yeovil acute stroke unit to ensure that it meets the standards of a stand-alone acute stroke unit as was recommended by the South West Clinical Senate.

11.9 **From Rick Beaver, Quicksilver Community Group (in attendance):**

"In summarising the proposal NHS Somerset state "A single hyper acute stroke unit (HASU) at Musgrove Park Hospital (MPH), Taunton would mean that most people in Somerset would receive their first 72 hours of stroke care at MPH, Taunton". The word "most" here is important: From the figures in this proposal only 71% of Somerset stroke victims will be treated at the single MPH HASU. Significantly, with the closure of YDH HASU 255 Somerset stroke patient will not receive treatment at MPH HASU, but at DCH, that is almost a quarter of Somerset stroke patients. NHS Somerset claims that one centralised hyper acute stroke unit can increase the number of patients receiving high-quality specialist care and meet the standards for providing stroke care in line with national clinical guidelines, seven days a week. But evidence is weak that this would be the case for the 255 who are sent to DCH.

MPH in Taunton is the 'preferred site' for the HASU in Somerset because:

- It has access to a wider range of scans to enable doctors to make quick treatment decisions;

- It would utilise the existing direct admission pathways to the stroke unit and increased specialist stroke staff.
- It has an onsite neurology service which helps with prompt diagnosis and treatment for patients with a stroke mimic condition.
- It has a vascular surgery team which assists in rapid assessment by vascular surgeons.

Throughout the proposal there has been little detail offered about the provision at DCH, other than broad statements of intent. It does not exist as yet. All that can be said is that "Dorset County Hospital NHS Foundation Trust has been involved throughout the process of options development and appraisal, is supportive of the proposed changes, and has given assurance that the DCH HASU is able to manage any increased demand if the proposed changes go ahead. This is not a convincing improved service for the 255 Somerset patients who would receive their initial treatment at DCH HASU under this proposal. DCH told us in a meeting of 7/11/23 that they currently have no dedicated stroke consultant and expect to provide consultants to support the HASU from existing DCH consultants in other areas e.g. ED. Indeed, they do not expect to be able to recruit specialist stroke consultants. We also note that the NHS Somerset recent proposal to retain the ASU at YDH (put to the last ICB meeting) followed DCH, (relatively last minute), indication that it was their view that the ASU should be retained in Yeovil. This does not seem like DCH and NHS Dorset have been working in long term close cooperation with NHS Somerset on this proposal, as is claimed.

We believe this Stroke Service reconfiguration while detailing how MPH HASU can be developed, fails a significant part of the Somerset population by directing them to a not yet existing DCH HASU where they are unable to provide any real detail about the provision and only at the late stage have they had to acquiesce to DCH wanting the YDH HASU to be retained. We are concerned that DCH provision will be overseen through NHS Dorset so NHS Somerset will have little role in the quality assurance of provision for a significant proportion of its population. How will the ICB safeguard the satisfactory treatment of 255, (a quarter of), Somerset stroke residents under this proposal?"

11.9.1 David McClay thanked Mr Beaver for his question and advised that the decision was taken at the November Board meeting to retain an ASU at Yeovil on the basis of the DCH feedback but also the feedback received through the public consultation. The ICB facilitated a meeting between the Quicksilver group and DCH on 7 November at which the DCH team went through the phases of their plan, which are set out in the DMBC. Since the release of the DMBC, a further letter of assurance has been received by the ICB from DCH which outlined their commitment to the development of the HASU at DCH. The oversight of implementation will be detailed in today's presentation.

(Bernie Marden to respond to questions 11.10, 11.11 and 11.12 collectively – see response in 11.12.1)

11.10 **From Marion Tibbitt, Member of the Public (in attendance):**

"Being a stroke patient from the east of the county (nr Wincanton) my concern is the transit time to Taunton. I had to wait an hour for an ambulance to arrive but was in Yeovil resus in 25 mins. If I had to travel on to Taunton it would have taken at least an hour. As we are told time is the major factor in stroke damage every extra moment is a serious concern. Therefore Yeovil & Taunton should be kept.

I would like to reinforce the consideration for travel, not just for carers but for the patient themselves, as Yeovil especially is growing and more and more people will need services, I feel that splitting the sites is the best option as two hours is too much for those this side of the county.

11.11 **From Graeme Pidgeon, Member of the Public (in attendance):**

"With journey times up from 22 to 45 minutes under the proposals, an additional 60 minutes potentially, before any HASU assessment or needle time

and 34% of the population seeing journeys of some 35 Km. Your own projections indicate that in ten years, there is a projected increase in need of 47%.

Are the proposals in the report, a good outcome for stroke patients, or acceptable collateral damage, with a complete disregard for patient outcome?"

11.12 **From Marion Davies, Member of the Public (in attendance):**

"Why do you think in 2024, it's O.K. for the people in South Somerset to be denied the swiftest HASU intervention as would be denied under your proposal?

I don't understand how you reached a decision, that is so at odds with well publicised national information, that absolutely emphasises how imperative it is that medical intervention be carried out urgently on a stroke victim.

Yet, you keep suggesting the transportation time delay doesn't matter, as long as you eventually get to the right place in the end.

I passionately believe it does matter and I implore you to think again!!"

11.12.1 Bernie Marden thanked Marion Tibbitt, Graeme Pidgeon and Marion Davies for their questions, recognising the concern.

As part of the process, the national guidance and research and evidence from implementing this guidance in other areas, was considered.

It was agreed that the options for change should be in line with the draft National Stroke Service Model and address the current inequalities in stroke care provision across Somerset.

The evidence is strong that being admitted to a specialist stroke centre with access to stroke expertise 24 hours a day, seven days a week, results in better outcomes than being managed without these resources.

The impact of changes in travel time to the hospital need to be weighed against, and can be mitigated by, anticipated improvements in the speed of treatment when a patient arrives at the hospital (the "door-to-needle" (DTN) times. The purpose of reconfiguring stroke services in Somerset has been to realise our vision that for adult stroke care we will ensure the provision of acute hospital-based stroke services that are timely, easy to access, high quality and efficient, with stroke experts available 24 hours a day, 7 days a week, 365 days a year.

It has been recognised that it is not possible to eliminate all aspects of current inequity and that in some rural areas, compromises might need to be made. Achieving a well-staffed unit working 24/7 that is also within a 45 – 60-minute drive in a blue light ambulance might not be possible.

Taking the example in Marion's question rather than travel to Taunton from Wincanton it is likely that the ambulance would convey you to Dorset County Hospital, increasing the journey time by 17-20 minutes compared to travelling to Yeovil District Hospital. Evidence from the reorganisation of stroke services in Northumbria, a rural area like Somerset, demonstrated a significant improvement of 26 minutes in average Door-to-needle times after the reorganisation. A thrombolysis audit performed at MPH shows that it a realistic expectation that the preferred model could improve local DTN times by a similar amount. In practice this should mean that the increased time spent travelling is offset by a quicker response once you would arrive at DCH. This very concern has been raised through other channels in recent weeks and we know that the public within Yeovil and to the East of Yeovil will require reassurance over this very issue, and this will be done as part of the implementation.

A significant amount of work has been undertaken by the Somerset stroke steering group (a partnership of clinicians, people with lived experience of

stroke and other health and social care staff from across Somerset as well as colleagues from Dorset) to design a new model for acute hospital-based stroke services that meets both clinical best practice and one that is grounded in what matters most to people and delivers the best outcomes for patients.

11.13 The Chair thanked everyone for the comprehensiveness of the questions and for the detail in the answers, which will all inform the discussion and decision to follow and expressed gratitude for everyone expressing their thoughts so clearly and passionately.

ICB ACTION/DECISION LOG

Committee Name: ICB Board

Item No or Type (Action/Decision/Issue/Risk)	Date Raised	Item	Decision/Actions/Comment	Lead	Update	Status (Complete/Ongoing/ Approved/Endorsed)	Date Action Closed
ICB 109/23	30/11/2023	Quarterly Corporate Risk Register	Names of Executive owners for risks to be included within the quarterly corporate risk register report, with a deep dive of current risks to be carried out to establish whether these are all live risks or if some are statements of fact to be picked up via another route	Jade Renville/Kevin Caldwell	16/01/24: Names of Executive owners will be included in the next report. Deep dive is underway and teams have been given until 22 February to complete the task 18/03/24: Names of Executive owners for risks have been included within the quarterly corporate risk register report. A deep dive of current corporate layer risks has been carried out to establish whether these are all live risks and to ensure they all meet the same format.	Complete	15/03/2024
ICB 012/24	25/01/2024	Somerset Acute Hospital-Based Stroke Services Reconfiguration – Decision Making Business Case	A formal impact assessment on the capital investment and overall financial modelling is to be carried out as a matter of urgency, through the Finance Committee, prior to consideration at the next Board meeting	Alison Henly	05/03/24: Finance Committee on 21 February considered the 2024/25 capital programme, which is within the national tolerance level for capital programmes. Finance Committee on 20 March is reviewing the overall financial modelling within the DMBC. Item also included on agenda for 28 March Board meeting.	Complete	15/03/2024
ICB 013/24	25/01/2024	Chief Executive's Report: National Mental Health Commissioning Guidance	Update on implications of National Mental Health Commissioning Guidance to be considered at future meeting	Shelagh Meldrum	15/03/24: No update as yet	Ongoing	
ICB 016/24	25/01/2024	Finance Report - Month 8 2023/24	Review of progress on work with Newton to be considered at future meeting	Jonathan Higman	21/02/24: An update was provided to the Finance Committee meeting on 21 February, which will feed back to the Board via the Key Meeting Report	Complete	21/02/2024