

REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: D
DATE OF MEETING:	28 November 2024	
REPORT TITLE:	Progress report on the implementation phase of the Somerset Stroke reconfiguration	
REPORT AUTHOR:	Julie Jones, Senior Programme Manager	
EXECUTIVE SPONSOR:	David McClay, Chief Officer for Strategy, Digital and Integration	
PRESENTED BY:	David McClay, Chief Officer for Strategy, Digital and Integration	

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

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

PREVIOUS CONSIDERATION / ENGAGEMENT

This report leads on from the items previously presented at Board, in relation to the Decision-Making Business Case (January 2024) and the financial case review (March 2024). This report is informed by the work of the Joint Stroke Co-ordination Board (see 2.1, below). There have been a range of related discussions and engagement events as part of this reconfiguration project. These have included with staff, patients and public and MPs and other stakeholders. These discussions continue, as appropriate.

REPORT TO COMMITTEE / BOARD

This paper sets out the progress made since the Board approved the proposed clinical model for stroke services in Somerset and recommended that the programme of work was moved to the implementation phase.

1. Introduction

1.1. At the January 2024 meeting, the NHS Somerset Board approved recommendations contained within the Decision-Making Business Case (DMBC) to improve stroke services in Somerset. The plans mean changes to:

- Hyper acute stroke services, with the establishment of a single Hyper Acute Stroke Unit (HASU) at Musgrove Park in Taunton, providing 24/7 emergency treatment.
- Ongoing hospital treatment, with acute stroke units at both Musgrove Park Hospital, Taunton and Yeovil District Hospital (YDH), Yeovil.
- Patients would be taken to their nearest HASU. This could be out of Somerset, if it was closer, such as Dorset County Hospital, Dorchester.

2. Current situation

2.1 A Joint Stroke Coordination Board (JSCB) has been established with representation from:

- Somerset and Dorset ICBs,
- Dorset County Hospital Foundation Trust (DCH),
- Somerset Foundation Trust (SFT),
- Southwest Ambulance Service Foundation Trust (SWASFT),
- Healthwatch.

2.2 The JSCB is working well with good buy in. The purpose of the board is to coordinate the specific implementation plans, oversee and review progress against the implementation plans and provide oversight and assurance to ensure milestones and go/no-go gateways are in place before any decision is made for the proposed changes to go-live. The most recent meeting of the JSCB was on 19th November 2024.

2.3 This meeting reviewed updated implementation plans owned by the two trusts, the project risk register and a draft refreshed communications plan.

2.4 The Stakeholder Reference Group has been re-established with the addition of representatives from Dorset and clinical staff from SFT (Taunton and Yeovil) and DCH.

The purpose of this group is to share lived experiences and comment on, and inform on, changes to pathways, advise on the development of information for patients and carers and to receive updates on implementation progress.

The Chair of this group is a manager within Healthwatch Somerset.

2.5 Within the JSCB, the work has been chunked into the following areas:

- Workforce – to have clarity of the staffing model and standards used and the recruitment against the required staffing model and any gaps.
- Clinical pathways – ensuring that Somerset patients have access back into Somerset services when they move out of county for their hyperacute care.
- Joint communications – a separate monthly communications catch up has been set up.
- Estates and Finance - being clear on the assumptions and the capital money phasing.
- Critical path – ensuring a focus on having clear assumptions across all sites and the timeline for implementation.

2.6 The ICB has received further correspondence from a local clinician and the JSCB will consider this and work with SFT on assessing the new information within the correspondence.

3 Background

3.1 The DMBC vision for the adult stroke services in Somerset is to 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.

3.2 The case for change laid out the reasons for needing to reconfigure stroke services in Somerset:

- Workforce sustainability - Neither Yeovil nor Taunton has the number of specialist staff needed to provide the hyper acute stroke units with 24/7 consultant cover.
- Clinical Outcomes - We are failing to meet several national performance targets in relation to hyperacute and acute stroke care which have a negative impact on clinical outcomes.
- Equity of service - There is currently variation and inequitable provision of hyperacute and acute stroke care across the county, especially over weekends and out of hours where it takes significantly longer for patients to receive treatments such as thrombolysis.
- Financial stability - There is currently a poor correlation between the money spent on stroke and the outcomes achieved.

3.3 Final approval was granted by the ICB Board at the March 2024 meeting, having considered an update following the review of the financial case, to provide assurance around the affordability of the revenue and capital case in terms of maximising value for money (see ICB Board Paper, March 2024).

The Board approved the recommendation from the Finance Committee that the questions raised at the board meeting in January 2024 had been answered sufficiently in terms of providing assurance around the affordability of the case and maximising value for money.

3.4 In May 2024, correspondence was sent to the Chief Executive Officers at SFT and DCH, transferring the responsibility for implementation to the two provider trusts, working in collaboration with NHS Somerset.

3.5 Both providers have a Senior Responsible Office in place for the delivery of the implementation plan and SFT and DCH have developed detailed draft implementation plans.

3.6 The implementation plans meet the core assumptions made in the DMBC that:

- Best practice principles will be applied.
- Interdependencies will be carefully planned and closely managed to ensure alignment and a smooth transition.
- Implementation planning will involve SWASFT.
- Pathways will be closely aligned to ensure effective and timely patient flow is in place and tested before the service goes live.
- Implementation timescales will be closely aligned.

4 Assessment

4.1 During October, representatives from the ICB and DCH completed site visits to both Taunton and Yeovil stroke services.

4.2 Discussions focussed on future workforce models across both hyperacute and acute stroke units to ensure that there was consistency across Somerset and Dorset, and they were making planning assumptions, as a minimum, to the 2016 national staffing standards used in the DMBC.

- 4.3 On all three sites, discussion with clinicians about the details for the staffing model and the estate is ongoing and this engagement will continue throughout the implementation phase.
- 4.4 The Yeovil site has received a notice that will require them to get Building Safety Regulator sign off for any work on the site due to new legislation. There has also been asbestos identified at the YDH site so these two things may well affect the refurbishment of Ward 8b and introduce some slippage on the implementation timeline.
- 4.5 The intention was to aim to implement within eighteen months of the decision which, if taken from the approval at the March 2024 ICB Board meeting, would mean implementation by October 2025.

This is still under review as SFT and DCH continue to refine their implementation plans and how the legislation and asbestos issues at YDH may impact the timeline.

- 4.6 There will be a visit to the DCH site in December.
- 4.7 It is worth noting that the ICB is yet to hear from the Secretary of State as to whether he will call in the decision, in response to requests received.

5 Recommendation

- The potential slippage on the overall timeline due to the estates plans will be managed through the JSCB.
- Brief updates should be brought to the ICB Board meetings through 2025 as the implementation date approaches.
- A verbal update is given at today’s meeting from the Chair of the Stakeholder Reference Group.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED
(please enter ‘N/A’ where not applicable)

Reducing Inequalities/Equality & Diversity

An Equality Impact Assessment (EIA) has been completed and can be found in the appendices of the DMBC.

The EIA has been reviewed and updated throughout the process, supported and enabled by both the public engagement and consultation has been an integral part of the reconfiguration programme and commenced from the outset of developing the Somerset Stroke strategy in 2019, and our ongoing engagement and consultation activities.

The EIA identified that in the preferred option, there will be a negative impact on those carers/relatives who are older people or live in rural areas and more deprived areas in the south of the county (who would normally travel to YDH for their stroke care) as there would be increased travel during the first 72 hours of care whilst receiving Hyper Acute Stroke Care.

It is not possible to mitigate all the negative impacts on protected groups which have been identified in this EIA. The impacts that remain are predominantly:

	<ul style="list-style-type: none"> • For patients who will have an increased ambulance travel time following a stroke. This will be mitigated by an improved clinical model of care which will improve outcomes for stroke patients. • On carers/relatives who are older people, those who live in rural areas and those who are in the more deprived areas in the south of the county (who would normally travel to YDH for their stroke care). This is because a proportion of patients' carers/relatives would experience an increased travel during the first 72 hours to visit loved ones in a HASU which is different from the current HASU in YDH. <p>The programme will reduce health inequalities by delivering equitable access to timely specialist interventions proven to reduce mortality and morbidity and best practice long-term rehabilitation support to optimise the quality of people's lives after stroke, regardless of where they live.</p>
Quality	<p>By centralising our hospital-based stroke services, we will be better placed to follow best practice national guidance and deliver improved outcomes for people who use Somerset services. This will include 24/7 services, address workforce issues and provide treatment in a more timely way</p>
Safeguarding	<p>Safeguarding has been considered as part of the process of developing the pre consultation business case. It has been considered that safeguarding does not directly impact the shortlist of options but will be an integral part of any future implementation.</p> <p>We are committed to following the Mental Capacity Act and engaging with robust capacity and best interest assessments. As any changes to services are implemented, due regard will be given to ensure the services meets our responsibilities outlined in the MCA including Deprivation of Liberty safeguards and Liberty Protection Safeguards as well as our statutory safeguarding duties.</p>
Financial/Resource/ Value for Money	<p>The cost to the system of implementing these proposals has been estimated at £4.2m per year. This includes a one-off transitional cost to the system of £0.2m to cover the costs of agency premiums whilst recruitment to therapy roles is completed.</p> <p>The estimated cost of capital required to implement these proposals are estimated to be £1.843m, however more work is required to confirm the final requirement.</p> <p>The delivery of benefits relating to a reduction in long term health and care needs relating to stroke care will enhance productivity and value for money</p>
Sustainability	<p>Consideration has been made to increased travel times for carers and family being part of and supporting rehabilitation after having a stroke which is key to recovery and was consistently noted in the consultation feedback</p>
Governance/Legal/ Privacy	<p>The programme is being overseen by NHSE under the service change guidance and is subject to the associated assurance</p>

	<p>processes. This has included a Clinical Review Panel by the Southwest Clinical Senate.</p> <p>Legal advice was taken in relation to public consultation, completion of the PCBC, further option assessment and completion of the DMBC.planning-assuring-delivering-service-change-v6-1.pdf (england.nhs.uk)</p> <p>There is a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:</p> <ul style="list-style-type: none"> • Section 242, of the NHS Act 2006, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate. • Section 244, of the NHS Act 2006, requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees). • The NHS Act 2012, Section 14Z45 places a duty on ICBs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways): <ul style="list-style-type: none"> • in the planning of the commissioning arrangements by the integrated care board; • in the development and consideration or proposals by the integrated care board for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; • in decisions of the integrated care board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact. <p>There are no information sharing implications of this report.</p>
Confidentiality	N/A
Risk Description	<p>Somerset holds a corporate risk regarding the risk of reputational damage to organisations from legal challenge brought by members of the public, either a Judicial Review and/or Independent Reconfiguration Panel.</p> <p>There are several risks to implementation which are contained within the programme risk register.</p>

