Ashford and St. Peter's Hospitals NHS Foundation Trust

Royal Surrey NHS Foundation Trust

Report title:	ASPH RSFT Collaboration		
Report to:	**Public Council of Governors**		
Date of meeting:	Wednesday, 16 October 2024	**Agenda item:**	
Executive Summary:	This is a joint paper between the chairs and chief executives of Ashford & St Peter's Hospital (ASPH) and Royal Surrey Foundation Trusts (RSFT) which proposes a group model structure between our organisations. The purpose of this proposal is to improve the quality and access to care that we provide our patients. A group model offers us opportunities to improve care more quickly and at greater scale than we could achieve through other ways forward. The paper describes the rationale for the move, desired outcomes and some initial proposals about how and where we will find tangible benefits for our patients, staff and system. Finally the paper describes the process we would need to undertake to our governance structures and proposes a communication plan that we will undertake across our stakeholders.		
Recommendations:	Council of Governors to support the proposal of a group model and agree to progress next steps in establishing this.		
Executive lead:	Chairs and chief executives of ASPH and RSFT		
Report author:	Strategy, governance and communication leads at ASPH and RSFT		

Purpose of report:	**For Noting/Information** ☐	**For Decision** ☒	**For Assurance/Discussion** ☐

Assurance level:	**Significant** ☐ High level of confidence / evidence in delivery	**Acceptable** ☒ General confidence / evidence in delivery	**Partial** ☐ Some confidence / evidence in delivery	**No Assurance** ☐ No confidence / evidence in delivery

Link to Strategic / True North Objectives:	Working with our partners in health and care to ensure provision of a high quality, sustainable NHS, to the communities we serve / With system partners; improve population health and patient experience and reduce per capita costs
Link to CQC Domains:	WELL LED
Link to BAF risks: **(or link to the Significant Risk Register)**	All BAF risks
Next steps:	As detailed in recommendations section
List of appendices:	None

1. OVERVIEW

In 2019 the public level of satisfaction with the NHS stood at 60%. Since then, the challenges we face of demand pressures, workforce shortages, low morale and constrained finances have been further exacerbated by Covid and the 2023 level for patient satisfaction fell to 24%.

RSFT and ASPH are both trusts with strong track records across operational performance, quality and financial metrics but neither are immune from the challenges described above and we need a different approach to continue to serve our communities to our best effect and to improve the quality of care we provide.

Since the publication of the Long Term Plan in 2019 the NHS has been working increasingly toward an architecture which is defined by collaboration and integration, rather than competition, to address the manifest challenges the health and social care economy face. We know from early engagement with the Labour government that the new 10-year health plan that will be published in spring 2025 will continue this theme. We are at a point in the NHS where significant changes must be made and, where they are not, systems risk changes being made to, not by, them.

The direction of current national policy is that if the NHS optimises our services so that they are more closely aligned then we will be able to **eliminate unwarranted variation, standardise best practice (and deliver it every time to patients, first-time) and this will raise the quality and timeliness of care we provide as well as reduce waste in the system, reducing cost**.

2. POSSIBLE WAYS FORWARD

The leadership of RSFT and ASPH have considered three options in considering how we may best rise to the challenges and realise the opportunities we face:

1. **Continue as we are without formal collaboration –** There is a great deal of partnership working across our system already, most obviously in the Trust Provider Collaborative. Despite the good work done here, if we continue as we are we do not believe we can make the changes we need at the requisite scale and pace to best serve our patients and return to financial sustainability. This is compounded by the fact that the permanent ASPH chief executive position is vacant and recruiting to a successor will take many months and they are unlikely to have existing chief executive experience. This will further slow the major changes we need to make to our services.

2. **Move to a group model** – a more formal collaboration between our organisations with a joint / group chair and chief executive but two executive teams, trust boards and councils of governors. This will hasten decision-making and enable some significant benefits of economies of scale but allows both organisations to keep their individual identities and cultures. This does not mean that both trusts get a 'part-time chief executive', this is a full-time chief executive working across the group leading a strong, local executive team at each trust.

3. **Merge both trusts** – This would require the dissolution of both ASPH and RSFT (due to foundation trust status) and the formation of a new organisation with a single executive, board and governor structure. Undertaking this legal process would take a great deal of time and money. It is not clear at this time that there is a viable NHSE process to do this and there are

very few current merger processes being considered across the NHS. The reason for this is that while mergers can lead to larger economies of scale and quicker decision making than option two there are numerous examples of mergers being unsuccessful (both in the private and public sectors). This is often due to issues of culture, governance and the fact that delivery of any merger takes a large amount of executive and senior team resource and also takes a long period of time.

We believe the best way to make the improvements our staff and population deserve is to move to a group model (option two) such that we work more closely together but not go through the unnecessary disruption and risk of a formal merger. By sharing our talent and resource, taking the best of both organisations and making them better and eliminating unwarranted variation we seek to create an organisation which offers patients better access, experience and outcomes and a sustainable health economy for our system.

Whilst financial considerations are not the main concern of this proposal they cannot be ignored. The Surrey Heartlands system has a large planned financial deficit for the 2024/25 year and (at the time of writing) is already overspent by several millions of pounds against that plan this year. This cannot continue and we must seek any opportunity to reduce cost as we also improve the quality of our care through structural change.

This paper sets out a proposal from the leaders of both trusts as to how we might make some important but simple changes to our governance which will better align our organisations and enable positive changes to be made more swiftly.

3. WHAT IS A GROUP MODEL

Group models are not mergers or acquisitions. They are agreements between providers that enable accelerated, more formal collaboration without the necessity for costly and time consuming legal, transactional changes that alter the organisational integrity and sovereignty of any partner. Trust Boards and Councils of Governors ensure that the needs of members whether they be patients, staff or community representatives of constituent Trusts and the communities they serve are appropriately advocated for.

A number of key joint appointments are usually made to ensure accountability for the programme of collaboration as a whole and to secure the pace and scale of improvement sought. This is balanced and supported by strong local, site-based leadership to ensure that focus and attention continues to be paid to the delivery of business-as-usual activities for each partner.

There is no legal or NHS England (NHSE) definition of a group model which will allow us flexibility to ensure that we develop something which is tailored to best fit our local population's needs. Despite this, there are some commonalities between existing group models which serve as a guide to what we seek to establish. These are:

- **Common leadership** (usually a small number of very senior posts) responsible for vision, strategy and governance of the group's organisations
- **Local senior management of the individual units** with responsibility for delivery, transformation and operational performance. In hospital group models this is usually defined by a 'triumvirate' of a chief operating Officer, medical director and nursing director. This team will also be central to delivering the required changes between both trusts that will develop the opportunities of a group model.

- **Standardisation of process and systems** wherever possible to reduce unwarranted variation and the associated waste, duplication and cost
- **Clinical synergies** are sought between group members however they may be found

This is an increasingly common structure and as of January 2024 there were 211 different NHS trusts run by 154 different chairs and 178 chief executives.

Some recent examples of group models are provided below:

Group Name	Overview	Governance structure
Barts Health and Barking, Havering and Redbridge UHT	Two large trusts in London (£2bn and £0.9bn respectively) have begun work on a group model in late 2023.	Two chairs and boards, one chief exec, some shared non-exec directors and a shared group exec.
St George's Epsom and St Helier Group	Formed in 2022, brings together two large London trusts with a combined turnover of £1.8bn and 17,000 staff.	One chair, one chief exec, some other shared exec posts, two boards and exec teams.
Portsmouth Hospitals UNHST and Isle of Wight Trust	Formed in 2023, one larger Trust, (Portsmouth, £800m income) and one smaller (IOW, £300m income) entered into a group model	One chair, one chief exec and group exec posts with dedicated leadership teams at each trust.
Royal Wolverhampton and Walsall Healthcare	Formed in 2021 between a major teaching trust (Royal Wolverhampton) and a smaller local trust, Walsall. Combined group turnover of £1.2bn.	One chair and chief exec, other shared group exec posts with dedicated leadership teams at each trust.
Dorset County Hospital & Dorset Healthcare	Formed in 2022 - this is an example of an acute trust and a similarly sized mental health trust forming a group of approx. £650m.	One chair and chief exec, other shared group exec posts with dedicated leadership teams at each trust.

There are multiple other examples but if we compare the proposal here of RSFT and ASPH coming together we would have a group with a combined staff of about 11,000 and a turnover of around £1bn, making us a mid-size group model.

If we were to establish a group model between RSFT and ASPH, it is of critical importance that we develop and communicate our shared values and a culture of clinical leadership, learning through listening and co-development. As part of this we will strengthen local listening and cultural development tools through our freedom-to-speak-up and equality, diversity and inclusion teams.

This is not to say that this is instead of existing local, place-based cultures of each organisation where they align to our shared values. We recognise that each culture is distinct and will have grown organically over many years and do not seek to impose one single ethos across the group.

The balance between these two will be important in our creating a future defined by best outcomes for patients, listening to and engaging with staff and delivering for our whole population. We must also ensure that sufficient expertise, capacity and focus is given to creating the right conditions for success; with the utilisation of recognised improvement approaches and an early focus on the building of trusted relationships being central pillars to our transformation journey. This is likely to be best achieved through the early development of a central transformation function.

4. HOW A GROUP MODEL WOULD HAVE IMPROVED RECENT JOINT PROJECTS

ASPH and RSFT already collaborate successfully across a large number of different areas, including our shared electronic patient record, many networked clinical services, membership of Berkshire & Surrey Pathology Services (BSPS) and all the work underway through the Trust Provider Collaborative.

Despite this, there are some clear examples where working as a group as opposed to two separate but collaborating organisations would have helped, for instance:

1. **Deployment of Cerner Millennium**

We undertook this programme together but still required multiple duplicative governance processes to approve the business case and the system we ultimately put in to our trusts. Because of this there were (and are) multiple cases where we have deployed the system in a slightly different way which creates unwarranted variation between our organisations.

2. **Community Diagnostics Centres (CDCs)**

Both ASPH and RSFT have opened CDCs - in Woking and Milford. These will be fantastic resources for both trusts and provide a wide range of diagnostics closer to patients' homes and 'one-stop-shop' services across multiple pathways. Our teams have been working independently on this and we recently discovered that we had both been developing the same pathway, separately. This duplication of work is doubtless happening across multiple areas across our organisations. Taking the best of our clinical team's ideas and turning them into services should not only reduce that duplication but result in a better output.

5. WHY WE ARE DOING THIS AND HOW WE MEASURE SUCCESS

The prime reason for this proposal is to improve the quality of care we provide patients and the timeliness with which our population can access that care.

We currently operate in an environment where both trusts acknowledge they have strategic risks in their ability to:

- Offer patients care with consistently high standards of quality, outcome and experience
- Reduce waiting times for our patients
- Ensure stability across all services
- Remain financially sustainable
- Manage executive capacity across multiple local, system and regional transformation programmes

If we do not manage these risks through major change, such as this group model, then we risk longer waits, poorer quality care to patients, poor experience in their care and a concurrent financial situation which may lead to NHSE intervention in the running of both of our Trusts.

The essential case for change is that the ability of RSFT and ASPH to address these risks and make major improvements to the quality of care and outcomes for our population, tackle inequity in health care across our patients and enhance productivity & value for money is significantly strengthened by entering into formal closer joint working.

We will measure the success of this collaboration by our ability to:

- **Improve patient access** by reducing waiting times for care by sharing our joint assets more effectively.
- **Improve clinical outcomes** for our patients by sharing best practice and eliminating unwarranted variation
- **Reduce inequalities** of care our patient population experience by delivering the two outcomes above
- **Increase patient satisfaction** as they experience higher quality care more quickly
- **Reduce substantive vacancy rates** through improved workforce retention
- **Increase staff satisfaction** by offering our people (and those that may wish to work for us) a larger organisation with more opportunities for career development across multiple specialities and disciplines
- **Meet our financial targets** through better planning, utilising economies of scale and improved buying power
- **Improve our research and development** offering to patients and staff
- Become a **centre of excellence for education** across the region

As we progress the work on this transformation we will ensure that these outcomes are at the heart of both our delivery plans and also our assessment of success.

Key to that success will be strong, experienced shared leadership and the development of a management and governance structure which enables clinical leadership to set the future of the group. Establishing a culture of listening amongst our clinicians will foster collaboration to achieve our aims.

To ensure this can happen a joint transformation board will be set up between the two trusts which will be accountable for ensuring the right clinical environment and conditions for future collaboration and change.

6. CLINICAL CASE FOR CHANGE

As above, the major reason we are considering this move is to improve our ability to serve patients in challenging circumstances. **Specifically we are seeking to directly improve patients' access to care, the quality of care they receive and the experience they have.**

There is a much larger and more detailed piece of work to be done to develop the opportunities further which will include a '100-day Plan' for the group's inception. The plan will address the development of our longer-term clinical vision and how that will improve the lives of our patients and staff whilst living within our financial means. As always, any strategic process will involve the voices of our stakeholders including patients and staff.

As noted previously, there are already many significant examples of our clinical teams working together including providing care on each other's sites (oncology, dermatology, gastroenterology

amongst others) and there are some obvious areas where accelerated and deeper collaboration would help us achieve our goals:

1. Elective Care pathways

RSFT has a significant number of long waiting patients and this is exacerbated by its status as a tertiary cancer centre (where cancer surgery takes priority over benign). ASPH has complementary clinical skills and interests and, particularly with the new elective centre at Ashford Hospital being established later this year, there is a unique opportunity to align our assets to increase capacity and improve access to elective care for our populations. This is also highly beneficial for our staff – we know there is nothing more frustrating to them than having an operation planned which gets cancelled at late notice.

The further, more exciting, opportunity to reduce inequality and eliminate unwarranted variation, align pathways and clinical practice and create expertise and specialism in both cancer and benign elective care will offer our patients higher quality care with better access and at lower cost to the system.

2. Unsustainable Services

ASPH and RSFT are both medium-sized trusts and, as such, some of our more niche services lack the critical mass required for them to be sustainable – which we can address as a group. An example of this is spinal surgery where ASPH has a robust service with three consultants whilst RSFT only has one (who has retired and returned). In part due to this, RSFT send many patients to St George's for surgery. This is clearly worse for our patients who have to travel to South London for operations and rehabilitation and also for our system as Surrey Heartlands funding goes out of our area. The opportunity here is to bring the services together, offer higher quality, more sustainable access to care closer to home for our patients. With a larger clinical team we can also offer staff more opportunity to see a greater variety of patients and thus specialise further within the spinal field. There are other services where the principles described here are also true, such as neurology and paediatric surgery.

3. Maternity

Maternity care across the NHS has been under incredible scrutiny in recent years due to a number of high-profile national instances of very poor care. Overall, the birth rate in Surrey is decreasing but this is not affecting providers equally as the activity of RSFT is actually increasing as women choose to have their care out of their local area. ASPH has had some issues with maternity provision following a CQC inspection and there is the potential to raise our standards and access to care across both providers so that we offer a best-in-class service. We can do this through strengthened leadership capacity, joint recruitment across staff we know are hard to attract (for example sonographers and midwives) and better use of existing assets including our estate and shared maternity digital platform, Badgernet. One example of this would be better alignment around the regional level three Neonatal Intensive Care Unit at St Peter's which can act as a fixed point through which our group could accelerate work to build seamless pathways for all women regardless of their risk presentation.

4. Research & Development (R&D)

Both our trusts have significant assets and a strong track record in R&D for both national projects and commercial trials. Our research efforts reflect our complementary clinical expertise and thus span multiple specialities and a combination of early and later phase trials. There are also

opportunities to better utilise the networks we have across both academic and commercial partners which include Royal Holloway, University of Surrey, Google Health and funding from EU sources.

A group offers us the potential to create a step-change in R&D capability across both trusts with access to a greater population and therefore greater range of research studies available to our staff. This will make us a more attractive site to potential research projects and improve our ability to bid for studies and resource to deliver them from national funding sources. This in turn will enable us to attract more staff who currently seek a larger R&D element to their role and also explore synergies in our R&D delivery and support teams.

More R&D in our trusts will also bring more income to our health economy and most importantly, offer our patients access to life-changing treatment that is not available elsewhere.

5. Education

ASPH and RSFT have substantial expertise in teaching across numerous disciplines and both our trusts will be part of the new University of Surrey Medical School. This will see us hosting undergraduate students from Surrey in September 2025. Whilst both trusts currently host students from other medical schools, the opportunity to be part of a core medical school programme offers us the benefits of becoming a major hub for multi-professional education in the South East England. We would be able to offer students and teaching staff access to multiple specialities with significant clinical expertise and academic and research opportunities. Combined with the proposed changes to R&D we can build an academic hub for research and education which offers us further potential for income generation, staff retention and improvement in patient experience.

6. Digital and data

As noted above, both trusts have Cerner Millennium as our main clinical administrative system. Whilst there are many areas where this supports our ability to collaborate these systems are not the same and do not currently offer the same functionality. We are still working to optimise the system and the quality of data available to our teams remains both an issue and risk. Whilst we are collaborating well on this work a group model with a single data quality standard and reporting structure available to our teams will facilitate alignment pathways and reduction of patient inequality.

7. People

As mentioned above, attracting, recruiting and retaining the best staff to our trusts will be enhanced by the opportunities of a group model described in this paper. Some of these will be gained as staff are attracted to the improved clinical offering we can make and some can be gained through better managerial controls around areas such as bank and agency spend. A group model would also present opportunities to share resource and expertise in relation to learning and development opportunities as well as potential collaboration in developing job roles and career pathways. Being able to offer staff (or potential staff) a group which has three major hospital sites which encompass a host of expertise across specialist and local services with associated opportunity to specialise, undertake research, education and so forth will set us apart from other trusts they consider working for.

7. PROPOSED INITIAL GOVERNANCE OF GROUP

The proposed group model for ASPH and RSCH is an agreement to formally collaborate while maintaining two independent trusts. Therefore, there would be no legal change to either organisations' establishments or constitutions, and each trust would maintain separate governance

structures. This includes councils of governors, boards of directors, executive teams (noting the recent recruitment of one executive to RSFT and two to ASPH), internal organisational management structures, and reporting and assurance pathways.

However, the trusts may establish group director posts and joint committees / working groups across the two organisations, to provide effective central leadership and governance, ensure accountability for the full programme of collaboration, and ensure the appropriate clinical environment and conditions for effective future collaboration and change. The initial proposals and principles of governance around these aspects are outlined below.

1. Group director posts

In accordance with both trusts constitutions, group posts may be established to provide effective central leadership and drive progress toward a shared vision. A group chair and group chief executive will be established to provide strong central leadership from the outset. It is proposed that the group chief executive be the current chief executive of RSFT. Further group posts may be established as the process progresses, based on the needs of the group (as opposed to an individual trust). All group posts must be agreed by both trusts in accordance with their constitutions and reservations of powers.

Any group director post must have a clearly defined role profile and person specification, approved by the appointing group(s), before the appointments process begins.

The governance pathway for establishing and appointing to such posts differs depending on the role in question, as follows:

Role	Appointing group(s)
Chair & non-executive directors	Both councils of governors, on recommendation from their respective nominations committees.
Chief executive	Both councils of governors, on recommendation from individual committees consisting of the chair and the other non-executive directors of each trust.
Executive directors	Individual appointments committees of each trust comprising the chair, other non-executive directors, and the chief executive.

Practical considerations are also required to ensure that any group directors are able to fulfil their duties and responsibilities to both trusts. Our corporate governance teams are currently aligning the two governance structures and meeting patterns, to produce a feasible schedule for the smooth transition of any individual into a group post, and ensure that their time is balanced appropriately to manage responsibilities across both trusts.

2. Joint committees / working groups

In accordance with both trusts constitutions, the boards may make arrangements for the exercise of any of their functions by a committee of directors of the trust. A joint transformation committee will be formed by the boards of directors to exercise functions on their behalf, comprising non-executive directors and executive directors from each board, to enable joint decision-making across the trusts with adequate independent scrutiny. Other joint committees or joint working groups may be also established for joint focus on strategy and / or operations in particular areas as the process progresses.

Any joint committee or working group must have a clearly defined terms of reference detailing its purpose, duties, terms of authority, membership, chairmanship, quorum, pattern of meetings, and channels of communication and accountability. This must be ratified by the constituting group(s) before a formal meeting can take place and decisions can be made, for example, with approval from both trust boards.

Where the boards wish to delegate authority to a joint committee or working group, this must be stated in both trusts reservations of powers and formally approved at respective public board meetings.

8. COMMUNICATIONS APPROACH

The formation of a group model between RSFT and ASPH is a major change for stakeholders and will require a robust communications and engagement strategy. This section proposes a high level approach to this and detailed plans for both organisations will be formed.

This will be led in collaboration by the RS Associate Director of Communications, Marketing and Engagement and the ASPH Director of Communications and Engagement, working when necessary with system and regional communications colleagues as well as our teams to deliver this plan.

We will take insight and learn from communications and engagement colleagues who work at trusts that have already formed group models, which will inform our plan and approach.

Key Aims and Principles:

- Identify key stakeholders and how best to communicate with different audiences in a clear, concise and consistent way.
- Create a core set of messages to explain what a group model is (and isn't), the clinical case for change and potential benefits and opportunities it will create.
- In doing so, ensure that areas of good practice across both organisations are recognised and celebrated. Allay fears of a 'merger' or 'acquisition' and focus upon the joining of successful services.
- Ensure that all messaging has the right tone and feels authentic – positivity is important but so is recognition of the challenges and uncertainty change can create.
- Create a sub identity to accompany core messaging to be used across both trusts business-as-usual internal and external communication channels, so people recognise and differentiate when engaging with group model communication and news.
- Ensure that 'one voice' is used across both trusts and the same messages are shared in the same timescales and through similar channels
- Identify the likely challenges and concerns for stakeholders at an early stage and prepare responses to these (FAQs etc.).
- Ensure everyone is aware of the key timescales and kept informed throughout the process.
- Create equitable opportunities across both trusts for stakeholders to ask questions, share their views and concerns with senior leaders. Ensure this feedback is captured and considered and the communications and engagement approach amended accordingly.
- Alongside this, ensure bespoke communication and engagement tools are on hand for each individual Trust and the various stakeholders as and when appropriate.

- Create a 'day one' launch plan for the new model and 'first 100 days' plan to introduce new leaders across the group.

Key Stakeholders:

A detailed stakeholder mapping will be undertaken across both organisations. The following shows the key groups of internal and external stakeholders this will likely consider.

Internal	External
• Staff and volunteers • Non-exec directors and governors • Members • Subsidaries and affiliated companies and charities • Unions	• Patients • Patient groups and community leaders • NHS partners including GPs • Borough and district councils • Voluntary sector • MPs • Healthwatch • Media

Examples of key messages:

A full set of key messages, tailored to different audiences, will be created for use across both trusts. An example could be:

"The landscape across the NHS is changing and group models are becoming increasingly common. They enable organisations to benefit from each other's expertise and best practice to deliver better outcomes for patients, as well as provide new opportunities for staff"

"Both trusts' have incredible strengths and by working more collaboratively and sharing skills, expertise and resources in some areas, we can maximise our combined efficiencies and be in a better position to take on the challenge of growing demand on our services."

Timeline and phasing

September	Develop detailed communications and engagement plans for both trusts Draft and agree key messages and FAQs, including external stakeholder briefings and reactive media responses Begin staff engagement, including briefing sessions, and prepare for wider engagement with key stakeholders post private board and council of governors meetings
October	Continue engagement with key stakeholders and share regular updates on the process
November	Ongoing engagement and agreement of formal announcements ready for final decision

December	Issue announcements to key audiences and prepare detailed 'go live' communications and engagement plan
January	Launch 'day one' and 'first 100 days' plans and agree new ways of working across communications and engagement going forward

Tactics and channels:

Full tactics will be included in the detailed communications plan as these will differ across both organisations but will likely include:

- Regular internal communications issued via usual channels– all staff newsletters, weekly chief executive message, all staff briefing sessions
- Specific staff engagement opportunities – town hall events across both trusts, lunch with the chief executive etc.
- Specific community/patient engagement opportunities – development of a group model stakeholder reference group / citizen panel, roadshow of drop-in events across our communities
- Development of detailed internal and external FAQs and video interviews of common questions that can be shared
- Produce case studies around the clinical case for change and benefits to patients and staff of a group model – for example patient pathways and team collaboration/ways of working
- Creation of group model resource centre linked to both trust intranets
- Members Q&A sessions
- Stakeholder briefing document to share with MPs, HealthWatch etc.
- Long form and short form copy for inclusion on trust websites and in external newsletters – GPs, members etc.
- Media handling plan including agreement of proactive press opportunities and reactive statements.

9. RISKS

The leaders of ASPH and RSFT are in agreement that the approach described in this paper will markedly improve the quality of patient care and experience but it is acknowledged that it is not without risk.

The major risk that the Group faces is the potential for distraction of key managers and clinicians away from the key focus on quality of care, safety and sustainability of our services.

We have already described in this paper the steps that will be taken to ensure that the focus of the group leadership is on improving care for patients but in acknowledging this risk before entering into a group we will seek to manage it before any formal changes take place.

There are already some factors which should mitigate the risk - both trusts for example have executive teams which are fully recruited to as we enter the group. Whilst there will be some senior leaders who are reasonably new into post, the new chief executive will not need to build any of the team from scratch.

Finally, we understand the important role of robust, clear governance in ensuring the success of the new group. Through our preliminary work on this we have spoken to multiple groups and will learn from their mistakes and successes in creating our governance model.

We recognise that, if approved, the move to a successful group model will be a long-term, iterative process and this is no quick fix to the patent challenges the NHS faces currently. With this said, it is also clear that we cannot continue as we are and that there are no quick fixes that will enable the kind of major and rapid changes we need to improve the quality of care and stabilise our financial position for our population.

10. RECOMMENDATIONS

Recognising the context in which we operate and the requirement for major and rapid changes, both Boards have agreed the following recommendations for the Councils of Governors to agree:

1. Form a group model between ASPH and RSFT;
2. Appoint a group chief executive across both ASPH and RSFT – proposed to be the current chief executive of RSFT;
3. Appoint a group chair across both ASPH and RSFT*
4. Establish a joint transformation committee as a sub-committee of both boards.

*In relation to item 3, the ASPH Board agreed this recommendation subject to an open recruitment process.

The agreed next step in this regard is a meeting of representatives from the NEDs and Nominations Committees of both Trusts, facilitated by Senior Independent Directors and supported by Directors of HR and Governance Leads, to agree the nominations process.

Subject to agreement by both Councils of Governors, the next steps in the process would be to:

5. Begin the process to appoint a group chair and group chief executive;
6. Constitute a joint transformation committee to drive group activity;
7. Formation of case for change (led and assured by the joint transformation committee) and associated delivery plan and operating model to be in place to align with planning guidance for 2024/25 and submission to trust boards in January 2025;
8. Agreement and delivery of the joint communication plan.