Meeting of Board of Directors

Report Summary Sheet

Report Title	Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust.					Agenda item		
Date of meeting	22nd July 2024							
Purpose	Note		Agree X		Inform		Assure	
Authors, contact for enquiries	• Ian Green, Chair SFT, Chair AHA Committees in Common • Liam Coleman, Chair GWH, Chair AHA EPR Joint Committee • Alison Ryan, Chair, RUH, Chair AHA-BSW Communities Together Programme • Lisa Thomas, Interim Chief Executive, SFT • Jon Westbrook, Interim Chief Executive, GWH • Cara Charles-Barks, Chief Executive, RUH, AHA SRO • Ben Irvine, Programme Director (ben.irvine@nhs.net)							
Appendices	• *Appendix 1: Draft Joint Committee Terms of Reference*							
This report was reviewed by	• AHA Committees in Common							
Executive summary	Our collective commitment in the NHS is to make a difference for the people we serve. We aim to improve quality and access for the people of BSW, while enhancing opportunities for our staff and responding to the unprecedented financial environment we now face. We know we need a different response to the changing needs of our communities, and we believe that working more closely together, sharing our combined talents and resources, is the best way to do that. We believe we need to be dynamic in response to current challenges and cannot assume significant change in the national NHS and public services economic position. In this context, our report sets out a joint proposal by the Chairs and Chief Executives of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust, to make some changes in the leadership & governance of the three Trusts. We are seeking to better connect our organisations, as simply as possible, to better support front line staff in their delivery of care.							

	Our three Trusts have been working increasingly closely since 2018. We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. However, our collective and individual Trust local performance, present a very challenging position. Increasingly, in relation to performance, we are reviewed and assessed by SW Region and NHSE as a system – e.g. for 4-hour delivery and financial balance and so, it is important that we have governance and management structures that reflect this. We believe it is the right time to accelerate and broaden our collaborative work, increasing our focus on fully realising the benefits of working at scale, reducing unwarranted variation, transforming services for the future, by delivering the opportunities described in the *Case for Collaboration* report, shared with Private Boards in May/June. With this shared ambition we intend to be proactive not reactive; in this paper we are signalling our strategic intent to establish a 'Group'. The report describes: • The case for collaboration and change • Proposed group leadership & governance, developments • Eight Recommendations The realisation of the significant benefits identified in the *Case for Collaboration* will require development in leadership and governance arrangements. Our proposed areas of change in the collaborative leadership, governance, and development of the Trusts are included in the recommendations set out below. • We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Foundation Trust will retain its own sovereign board, committed to an agreed roadmap for the Group; this change would not represent a merger of the Trusts. Each Trust will also have a Deputy Chief Executive to support the single CEO. • We will establish a Joint Committee, from September, to enable joint decision-making across GWH, RUH and SFT. This Joint Committee will oversee the plan for realising the case for collaboration, the subsequent delivery programme, and development of the proposed Group model. • In-year priorities and an associated concrete delivery plan will be agreed by executive teams in September, ensuring they enhance and

	align with the 2024/25 operational plan. The Joint Committee will hold Executives accountable for the delivery of this plan. What does this mean for our organisations? • These changes are designed to accelerate successful delivery of transformed sustainable excellent clinical services, in service of the BSW population. We believe that a joint leadership model will improve the delivery of care to local communities. • In establishing a Group, we will maintain three Trusts with their own Governors, Boards and Non-Executive Directors. Each of the hospitals will maintain their own identities reflecting the services they provide and the local population they serve. • GWH, RUH and SFT will provide the main interface with our patients and respond to the needs of our diverse population by ensuring equitable and high-quality safe care. • We are not recommending a merger or change in legal structure, as we do not think such a change would offer value for money or be in the best interests of our populations. The following timeline is proposed and will see vital involvement of Governors and Trust teams in helping shape our next steps: • July. Progress Initial recommendations. Remuneration Committees to convene to confirm process for appointment of Joint-Chief Executive. August-October. Establish Joint Committee to oversee Joint Development Phase. Engagement with Council of Governors regarding move to Joint Chair. Develop delivery plan for in-year priorities. • September-January. Joint Development Phase. Trusts develop target operating model, and strategic framework. Begin delivery of in-year priorities. Appointment of Joint-Chair. • January 25. Joint Committee and Three Boards consideration of proposed Operating Model and Strategic Framework • Q4 – Q1 Implementation of agreed Operating Model.
Equality Impact Assessment	An Equality Impact Assessment of proposed changes been completed.
Recommendation(s)	Boards are invited to approve the following eight recommendations: • *Recommendation 1.* We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Trust will retain its own board and this change would not represent a merger of the trusts. Each site will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and

	timetable. We would like our Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role in the first quarter of 2025. • *Recommendation 2.* In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair. • *Recommendation 3.* We believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration, and improving quality. We will create a Joint Committee, from September, to oversee our work together. There will be a clear articulation of the topics overseen by the Joint Committee and those overseen locally; refer Appendix 1, initial Joint Committee Terms of Reference. • *Recommendation 4* We will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, stabilisation of the services we deliver and our financial position,* so in coming months we will bring executives and non-executives together to identify collective opportunities to work more efficiently and eliminate unnecessary duplication. An associated concrete delivery plan will be agreed by executive teams in September, ensuring they enhance and align with the 2024/25 operational plan. The Joint Committee will hold Executives accountable for the delivery of this plan. • *Recommendation 5.* Also in 2024-25, we will develop a Group Operating Model that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work, ensuring access, improvement & innovation, embracing standardisation, all in an effective and agile governance environment. • *Recommendation 6.* We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with *joint clinical strategy and associated workforce and digital strategies*, we will confirm our transformation programmes for clinical and corporate services. • *Recommendation 7.* We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*, identifying those areas where we work together most effectively at place or neighbourhood and those where partnership working across BSW delivers added benefits to the populations we serve. • *Recommendation 8.* We recognise that the changes of the scale we are proposing will be hard to achieve and that support will be essential as our leaders, teams, non-executives, and governors help

	shape our future together; Organisational Development support for coming years will be secured.							
Risk (associated with the proposal / recommendation)	High		Medium		Low x		N/A	
Key risks	The development of our BSW provider collaborative is in line with national policy and strategic direction on provider collaboration. The eight recommendations in this proposal are designed to address the following risks: • Quality of and access to planned and urgent care we deliver for BSW and local population. There is a risk that we fail to deliver the potential benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. • Financial sustainability of our acute services. There is a risk that our Trusts fail to deliver the potential financial benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. • Performance & oversight environment. There is a risk that if the case for collaboration benefits are not pursued as proposed, there will be a decrease in local control owing to deterioration in performance (financial and access to services), leading to great scrutiny, classification in SOF4 leading to mandated external support. • Capacity of Executives to engage in system working. The capacity of executives and senior managers in Trusts is constrained, with competing pressures from what can be irreconcilable internal and system-wide activities. Risk of proceeding with proposed recommendations: • Uncertainty for our staff. Changes may create uncertainty for some staff. *Mitigation and Management*: A comprehensive shared and well-resourced communications and engagement strategy and organisational development programme will be required. • Local ownership. There is a risk that local stakeholders perceive a loss of local ownership or influence at organisation or place level. *Mitigation:* Our communication and engagement plan will be clear that these changes offer the benefits of scale in service of local delivery.							
Impact on quality	The developments proposed are designed to enhance the quality and resilience of health services for the population in BSW.							
Resource implications	Establishment of a group will better enable GWH, RUH and SFT to deliver the benefits identified in the Case for Collaboration, thereby supporting the three							

	Trusts to improve the efficiency and value for money of our services. During the proposed *Joint Development Phase* - Q2 and Q3 2024-25 - a group operating model, with detailed resource implications will be developed by Trust leads, for consideration by Boards.
Conflicts of interest	None known.
This report supports the delivery of the following BSW Integrated Care Strategy Objectives:	☒ Focus on Prevention and Early Intervention ☒ Fairer Health and Wellbeing Outcomes ☒ Excellent Health and Care Services

Title: Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust:

1. Introduction and Context

Our collective commitment in the NHS is to make a difference for the people we serve. We aim to improve quality and access for the people of BSW, while enhancing opportunities for our staff and responding to the unprecedented financial environment we now face. We know we need a different response to the changing needs of our communities and we believe that working more closely together, sharing our combined talents and resources, is the best way to do that. We believe we need to be dynamic in response to current challenges and cannot assume significant change in the national NHS and public services economic position.

In this context, our report sets out a joint proposal by the Chairs and Chief Executives of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust, to make some changes in the leadership & governance of the three Trusts. We are seeking to better connect our organisations, as simply as possible, to better support front line staff in their delivery of care.

Our three Trusts have been working increasingly closely since 2018. We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. However, our collective and individual Trust local performance, present a very challenging position. Increasingly, in relation to performance, we are reviewed and assessed by SW Region and NHSE as a system – e.g. for 4-hour delivery and financial balance and so, it is important that we have governance and management structures that reflect this.

We believe it is the right time to accelerate and broaden our collaborative work, increasing our focus on fully realising the benefits of working at scale, reducing unwarranted variation, transforming services for the future, by delivering the opportunities described in the *Case for Collaboration* report, shared with Private Boards in May/June.

With this shared ambition we intend to be proactive not reactive; in this paper we are signalling our strategic intent to establish a 'Group' (refer sections 3-6 below). The report describes:

- The Case for Collaboration
- Proposed Group Leadership and Governance Developments
- Proposed Timeline, Risks and Eight Recommendations.

National Context

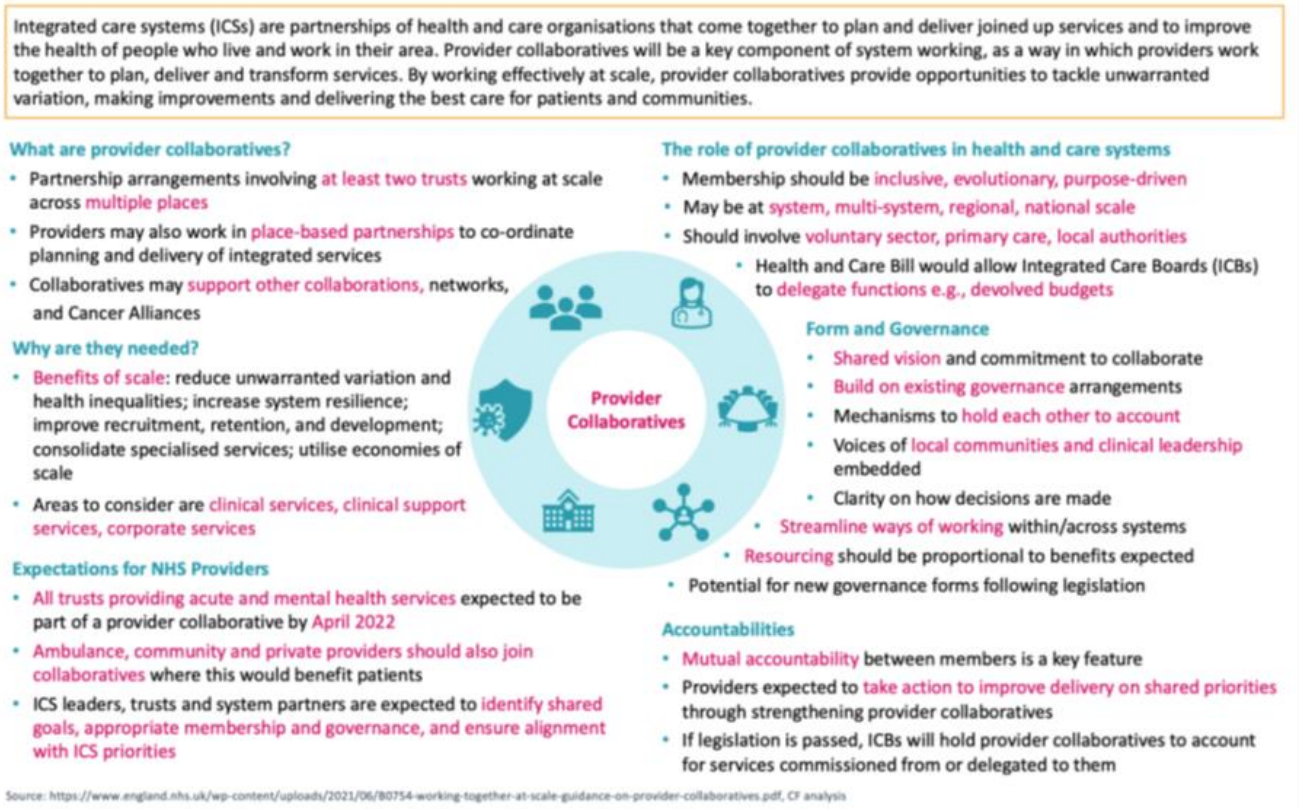
The Health and Care Act (2022)

The 2022 Health and Care Act created Integrated Care Boards (ICBs) as statutory bodies and established a new legislative framework to enable greater collaboration between health and care system partners, including NHS trusts. Provider collaboratives are core to the development of Integrated Care Systems (ICSs), particularly in terms of delivering the quadruple aim duties:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience, and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

Working Together at Scale: Guidance on Provider Collaboratives (2021)
Prior to the broader legislative framework coming into effect, guidance on provider collaboratives was published by NHS England in 2021. The guidance outlines the expectation of how providers should work together as provider collaboratives, principles to help support local decision-making, and function and form options that systems may consider in support of quadruple aim duties. NHS trusts were required to be part of at least one provider collaborative by April 2022. A high-level summary of the guidance is provided in Figure 1

Figure 1 Overview of NHS Provider Collaboratives



The developments we propose below are in the context of this increased drive for collaboration nationally.

2. The Case for Collaboration and Change to Support Delivery

We know that 2024-2025-2026 need to be years of action, delivered well and at pace with a focus on a small number of high impact changes. We are conscious of our system's financial position and must use collective opportunities to work more efficiently.

In this context a range of stakeholders from each of the three Trusts and wider system partners joined a series of corporate services and clinical services workshops designed to identify collaborative opportunities. These sessions led to ten areas for deeper collective work being identified as the *case for collaboration*; these are outlined in Figure 2. The areas identified can be broadly grouped as clinical and non-clinical opportunities, and centre on significantly improving quality and access for the people of BSW, achieving efficiencies and effectiveness in operations, and enhancing opportunities for staff.

Figure 2. Ten Areas: Our Case for Collaboration

Our *case for collaboration* report illustrates the challenges and potential impact across these ten opportunity areas, establishing a call to action to focus on clinical and operational performance to improve outcomes for people in BSW.

3. Proposed Provider Group Development

The realisation of the significant benefits identified in the *Case for Collaboration* will require development in our leadership and governance arrangements. Our review identified these areas as a critical requirement for success. Eight proposed developments are described here.

Recommendation 1. We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Foundation Trust will retain its own sovereign board, committed to an agreed roadmap for the Group; this change would not represent a merger of the Trusts. Each Trust will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and timetable. We will ask our Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role in the first quarter 2025 [January-March].

Recommendation 2. In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.

Recommendation 3. We believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration, and improving quality. We will create a Joint Committee, from September, to help oversee our work together. There will be a clear articulation of the topics overseen by the Joint Committee and those overseen locally; refer Appendix 1 initial Joint Committee Terms of Reference.

Recommendation 4 We will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, and stabilisation of the services we deliver and our financial position,* so in September we will bring executives and non-executives together to identify collective opportunities and clear plan to work more efficiently and eliminate unnecessary duplication. The Joint Committee will hold Executives accountable for the delivery of this plan.

Recommendation 5. Also in 2024-25, we will develop a Group Operating Model that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work, ensuring access, improvement, & innovation, embracing standardisation, all in an effective and agile governance environment.

Recommendation 6. We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with *joint clinical strategy and associated workforce and digital strategies*, we will confirm our transformation programmes for clinical and corporate services.

Recommendation 7. We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*, identifying those areas where we work together most effectively locally and those where partnership working across BSW delivers added benefits to the populations we serve.

Recommendation 8. Finally, and perhaps most importantly, we recognise that the changes of the scale we are proposing will be hard to achieve and that support will be essential as our leaders, teams, non-executives, and governors help shape our future together; Organisational Development support for coming years will be secured.

What do these proposed changes mean for our organisations?

- The *changes described are designed to accelerate successful delivery* of transformed sustainable, and excellent clinical services. They are a natural next step in the interests of the BSW population, patients, and our workforce. GWH, RUH and SFT will provide the main interface with our patients and respond to the needs of our diverse population by ensuring equitable and high-quality safe care.

- We are *not recommending a merger or change in legal structure*; it is considered that such a change would be highly disruptive and would not offer value for money for our system. In establishing a

Group, we will maintain three Trusts with their own Boards and NEDs. Each of the hospitals will maintain their own identities reflecting the services they provide and the local population they serve.

- *Subsidiarity*. Our agreed operating model will describe how the subsidiarity principle will be applied. Subsidiarity will see decisions being made at the lowest practical level, embedding local decision-making, and making decisions at group level only when it is considered beneficial to do so.
- *Long-term impact*. The anticipated impact over three+ years will be related to the ten clinical and corporate services areas set-out in the *case for collaboration*.
- *In the short-term*, change will be more limited. Staff and patients should not notice significant change in day-to-day operation and management of services. A joint-chief executive, with their team including the site deputy chief executives will lead an evolutionary process, developing an operating model, identifying priority areas for transformation. After these initial steps, the Joint Chief Executive with Deputy Chief Executives will support the Trusts to accelerate sharing of best practice, reduce duplication, enhancing resilience of our services while creating career structures and opportunities for many of our services that cannot currently benefit from working at scale. Again, in the short-term significant change in delivery and strategy is not anticipated, but teams will come together to develop and deliver collaborative plans, creating excellent sustainable services for our population.
- *Cost of new model*. Costs and return on investment will be defined in detail as part of the operating model proposal – due to be developed between August and December 2024, in readiness for Board review in January 2025.

4. Proposed Timeline

The timeline proposed is set out *in figure 3 below*. Learning from successful collaborative transformation schemes, other groups and collaboratives, we should not seek an off-the-shelf example or model. Rather, we should develop our BSW Providers model together. A three-phased approach is proposed, whereby an *initial phase* will be followed by a central *Joint Development Phase* leading to Board decision-making gateways before a *Joint Implementation Phase*.

- Progress Initial recommendations.
    - July. Remuneration Committees to convene to confirm process and timeline for appointment of Joint-Chief Executive.
    - August-October. Establish Joint Committee to oversee Joint Development Phase. Engagement with Council of Governors regarding Joint Chair. Develop delivery plan for in-year priorities.
- Joint Development Phase
    - September – January. Trusts develop target operating model, strategic framework. Begin delivery of in-year priorities.
    - January 25. Joint Committee and Three Boards consideration of proposed Operating Model and Strategic Framework

- Joint Implementation Phase. Q4 Onwards, 2025-2026-2027. Operating Model Implementation and delivery of Case for Collaboration.

Figure 3. Proposed Collaborative Development Timeline

5. Risks

The eight recommendations in this proposal will support us to address the following risks:

- Quality of and access to the planned and urgent care we deliver for BSW and local population. There is a risk that we fail to deliver the potential benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. We will work within a clear framework that maintains responsiveness to the needs of the local populations and enables local innovation.
- Financial sustainability of our acute services. There is a risk that our Trusts fail to deliver the potential financial benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery.
- Capacity of Executives to engage in system working. The capacity of executives and senior managers in Trusts is constrained, with competing pressures from what can be irreconcilable internal and system-wide activities *Mitigation*: We have begun, and in a group model should make standard practice, modelling different ways of deploying our senior leaders. Leading on behalf of others will become common, with local hospital leaders also having group-level leadership responsibilities – working in a matrix environment.
- Timeframes for Development. A drawn-out phased approach to development may create uncertainty. Staff need to be able to focus on local operational delivery. *Mitigation*: Our decision-making timetable should be pragmatic, but with sufficient pace to reduce uncertainty.
- Oversight. There is a risk that if the case for collaboration benefits are not pursued as proposed, there will be a decrease in local control owing to deterioration in performance (financial and access to services), leading to great scrutiny, classification in SOF4 leading to mandated external support.

Risk/s associated with pursuing this proposal:

- Local ownership. There is a risk that local stakeholders perceive a loss of local ownership or influence at organisation or place level. *Mitigation:* Our communication and engagement plan will be clear that these changes offer the benefits of scale in service of local delivery.
- Uncertainty for our staff. Changes may create uncertainty for some staff. *Mitigation and Management*: A comprehensive shared and well-resourced communications and engagement strategy and organisational development programme will be required. Additionally, the programme will see development of Group operating model over coming months - allowing for senior staff to be actively involved in development through co-creation.

6. Summary of Recommendations

Our recommendations are summarised in figure 4 below.

Figure 4. Our Eight Recommendations

1. We will identify a Joint Chief Executive and Joint Chair for our Trusts. Each site will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and timetable. We will ask Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role January-March 2025.
2. In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.
3. We will create a Joint Committee, from September, to help oversee our work together. [Refer draft Terms of Reference in Appendix 1].
4. By the end of September, we will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, and stabilisation of the services we deliver and our financial position.*
5. We will develop a Group Operating Model, in 2024 that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January 2025, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work.
6. We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with joint clinical strategy and associated workforce and digital strategies, we will confirm our transformation programmes for clinical and corporate services.
7. We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*.
8. We will invest in Organisational Development support to enable the scale of required change.

Close

Draft 1.0.

Ben Irvine. 10th July 2024 with IG, LC, AR, CCB, LT, JW.

Appendix 1. Joint Committee Terms of Reference [see accompanying document]