Ashford and St. Peter's Hospitals
NHS Foundation Trust

TRUST BOARD
29 SEPTEMBER 2022

AGENDA ITEM	15.2	
TITLE OF PAPER	Chief Executive Report	
Confidential	No	
Suitable for public access	Yes	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
STRATEGIC OBJECTIVE(S):		
Quality of Care	Y	
People	Y	
Modern Healthcare	Y	
Digital	Y	
Collaborate	Y	
EXECUTIVE SUMMARY		
	This is the second of my CEO board reports and in response to feedback I have made some changes to the usual format. Firstly, the diary events will no longer be part of the CEO report. The board should remain assured that I remain actively engaged in trust activities with regular attendance at trust events and in hosting visitors to the organisation. My efforts will be shared through the chair's report as I am usually alongside Andy in these events. Instead, my report will focus on the core business of the organisation and how I lead on the work through my personal leadership and through the objectives and efforts of Executive Directors and their teams. The work in the report is presented as per corporate strategic objective format of Quality of care, Modern Healthcare, People, Digital and Collaboration. The purpose of the paper is to be informative and to bring together the work in a high-level summative report which demonstrates the breadth of the work, the synergies, and interdependencies and how any risks related to the work are represented within the BAF.	

	Finally, this report is iterative, and I welcome your feedback on its content and format.
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	X
Patient impact	X
Employee	X
Other stakeholder	X
Equality & diversity	X
Finance	X
Legal	X
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PRESENTED BY	Julie Smith, Chief Executive
DATE	20 September 2022
BOARD ACTION	The Board is asked to RECEIVE the report

1. Introduction

This is the second of my CEO board reports.The purpose and focus of the paper is to inform and assure the board of the key areas of work that I and the Executive Directors are leading on in delivering the core organisational business. The key areas of work are presented within the paper as per the strategic objective framework, and the work is captured within the Executive Director yearly objectives. Both the areas of work and Executive objectives have clear measures and outputs and work is ongoing to align those outputs to the corporate strategy KPIs as presented in the trust BAF.

2. Strategic Objectives

2.1 Quality of Care

Good progress has been made against the actions encompassed within the Well Led action plan to respond to the recommendations from the Deloitte external governance review. In addition however, we recognise that there is a wider programme of work to be undertaken to achieve outstanding practice in terms of governance and to this end the structure and scope of a comprehensive internal governance review has now been developed, and options for a designated resource to help drive through this important piece of work are being investigated.

Main objectives are to further develop and clarify structure, roles, and responsibilities of Board sub-committees as well as feeder committees to ensure these are effective, non-duplicative and fit for purpose. This includes the Trust Executive Committee (TEC), Executive-Divisional Reviews (EDRs) and the Team-talk forum.

Some of the proposals address:

- Inclusion and integration of both the clinical Divisional Directors and Executive Deputy triumvirate as an extension of the Executive team
- Developing the agenda for EDRs with a balanced score card for quality/ safety/ performance/ finance/ workforce
- Use of TEC – 4 times a year for deep dive/workshop sessions to facilitate face to face working sessions with organisational leaders
- Team Talk – encouraging staff in addition to executives to present items and to hear voices other than the executive.

2.2 People

Emergency Department Consultantrecruitment :

The Trust has made a significant investment in order to increase the consultant/specialist grade establishment in the Emergency Department from 10 wte to 14 whole time equivalent posts to enable extended out of hours consultant/specialist cover in the department.

Currently there are 6.8 wte substantive Consultants/Specialists in post and following a successful recruitment campaign, five new Consultants/Specialists have been appointed, two of whom will be starting at the Trust in September. Further applicants will be interviewed later this month with the aim of having all 14 wte in post by April 2023.

Engagement with Consultant workforce:

I am keen to develop a regular forum to meet with consultant colleagues. There is an initial meeting scheduled for early October, as a 'Come and meet with the CEO and the MD'. This will be an informal meeting scheduled for after work in the EDU kitchen with some refreshments, all consultants have been invited and I have received several positive responses welcoming this opportunity. The plan is to share the positive outcome of the work undertaken with the ED consultants to facilitate new job plans and recruit additional ED consultants to support service change and patient demand within our emergency services. This will also be an opportunity to hear from consultants how they see their interactions with the executive team and to hear their views on ways in which this could be strengthened.

In terms of working with our consultant body going forward, currently there is an LNC, Local Negotiating Committee in place and there is some desire to re-establish the MSC Medical Staffing Committee. I am also keen to consider opportunities to develop a clinical executive, whereby the executive and key clinical leaders come together on a monthly basis to discuss key issues and inform the trust strategy. This forum would be a formal part of the trust management and governance and is in line with the recent well led review and resultant recommendations.

2.3 Modern Healthcare

Estates and Facilities Strategy and alignment with the emerging clinical strategy:

Following approval of the Trust Strategy at July Board we are taking steps to develop the Trust's clinical strategy and an aligned estates strategy. The clinical strategy will focus on the Trust's Strategic Mission of providing high quality sustainable services to our community, building on the SWOT analyses carried out by clinical divisions over the summer and informed by our clinical sustainability tool. Our intent with this work is to engage clinical leaders and their teams in developing the solutions where there are challenges with service sustainability. As part of the Surrey Heartlands system we will need to ensure that our clinical strategy aligns with that of the ICS, which will bring challenges but also open up opportunities for collaboration and networking.
Our estates strategy will need a refresh to reflect our clinical objectives and ensure that we are allocating scarce capital resources to the essential developments. A strategic estates partner, Prime Developments, has been appointed by the NW Surrey Alliance and will support us with this project as part of their work in our local system.

Minor works, backlog and proactive maintenance:

Concerns about the quality of the Trust's built environment and response of estates operational services have mounted over recent months and the Modern Healthcare Committee BAF Risk 2.2 outlines the importance of maintaining the Trust's physical environment in order to provide safe and high quality care. At its September meeting the Committee received a report outlining the current known challenges and constraints and also an overview of plans that have been developed following an internal review of estates and facilities services over June to November 2021. The plans include the introduction of a new facilities management system which is the facilities equivalent to the implementation of Surrey Safe Care for clinical services; an essential enabler to increase productivity, better workflows and improved management grip and assurance. This system has already enabled us to achieve major improvements in our management of medical devices.

It was recognised that due to many factors, we have been working in a reactive way and our core vision is to transform the facilities service model into one focused on delivering our planned maintenance. This is widely acknowledged to be the optimal approach to minimising ongoing backlog maintenance and the challenges that this presents, and to maximising the productivity of the maintenance workforce. The Modern Healthcare Committee will continue to oversee progress with this important transformation project.

Main effort:

The direction of travel for the Main Effort programme of work, led by the Executive Triumvirate, is very good and we are now seeing data that shows it is working. The iterative approach is working well but does require agility, flexibility and a more 'hands on' approach. As one challenge is unlocked others are identified. This is a good way of dealing with complex, interwoven problems.

The Main Effort is also now more focused on smaller, quicker wins as well as large number activity. A lot of small things add up to a big thing so the clinical divisional triumvirate teams are being encouraged to undertake activity that improves discharge and flow around low numbers as well as large. This is proving a good way of maintaining momentum and generates small, quick wins that keeps people positively engaged.

The existing work remains the priority but after a recent 'review and refine' session a number of new areas of focus were identified for the next phase:

- Creation of Navigators (Nurse led) within ED to facilitate a more rapid way of getting patients on to the correct pathway
- A review and rationalisation of areas and resources within UEC to avoid duplication and inefficiency
- A focus on Surgery to reduce Length of Stay and improve the seven day a week service
- A review of Palliative Care both within the Trust and wider
- A review of (clinical) shift start and end times to avoid loss of activity within handover windows.

The Main Effort continues to innovate and ensure that those that will be delivering, own the 'how'. September's Trust Executive Committee has a dedicated section for the Main Effort allowing Triumvirates to showcase what they have been doing at Divisional level and what their next steps are before a TEC level workshop on patient transfer and patient 'ownership'.

The Main Effort is demonstrating real success and has the potential to go a lot further. The Steering Group will continue to 'plan-do-review-refine' and work closely with those responsible for delivery to ensure that every opportunity to improve flow and discharge is identified and exploited.

Winter planning

The centre provided guidance around winter planning in mid-August, earlier than previous years. This is in recognition of the significant urgent care demand within the context of Covid recovery. Eight initiatives were set out, to be overseen within the ICB and delivered at Place level. ASPH has completed our self-assessment and we are in a good position to respond as a result of the Main Effort Programme already underway. The clinical divisional teams recently presented their on-going work to respond at the

Trust Executive Committee in mid-September, which provided good assurance with progress made.

2.4 Digital

Surrey Safe Care:

Our Surrey Safe Care electronic patient record implementation is the Trust's largest organisational transformation programme and the last few weeks have certainly not been without challenge, not just for our clinical colleagues but also our operational teams. However, I have been continually impressed by how everyone is pulling together. At our Surrey Safe Care Stabilisation Gold meeting in our Trust Executive Committee there was a real sense of optimism and togetherness. For example, we have had issues with our clinic bookings and letters, but I'm pleased to report that due to focussed efforts across multi-disciplinary teams (clinical, operational, technical) these are now largely resolved and booking to clinics is well underway with additional booking support in place to ensure the backlog of patients to be booked is cleared quickly.

Clinical care is always our priority and so we proactively seek to identify and address clinical risk. We have set up a Risk Scrutiny meeting specifically for clinical risks and issues arising from the implementation of the new system, ensuring each risk is monitored and ongoing mitigation. We have added to our Corporate Risks, raising the Board Assurance Framework (BAF) risk rating across quality, evidencing best practice and this proactive approach. Originally realising eight corporate risks, with mitigation, these have now reduced to four. This in turn enables us to prioritise our work and efforts, ensuring every team at every level is clear on where to focus their efforts.

Another area that requires attention is our external reporting figures. For example, our reported ED performance figures are not in line with our usual trends and trajectories. This is because we are still working out where to record various aspects of activity and then how to report that activity accurately. In the meantime, we continually seek assurance from our care teams that the actual performance and therefore the quality of care remains high, even if the reporting figures differ.

Overall, the Surrey Safe Care programme is starting to bed in. We have a rolling programme of changes going on behind the scenes, making sure we support best practice. Now that the new systems are set up for outpatients and beginning to become embedded, our focus is now moving to the accuracy of data we hold about patients to track and progress their pathways of care, and the operational challenges of ensuring the management teams have the reports required to book efficiently and effectively through outpatients and theatres. We continue to make good progress as evidenced by the evolving focus of our efforts from technical to operational.

Adastra system:

You may be aware that one of our suppliers, OneAdvanced, suffered a significant cyber-attack in August 2022 which resulted in them taking down several of their systems. This affected our Urgent Treatment Centre (UTC), which is run by the North West Surrey Integrated Care system (NICS)[1]. We support NICS with the clinical system (Adastra) they use to run the service. The UTC team quickly enacted their Business Continuity Plan and have been able to run a stable service. We have undertaken a risk assessment regarding reconnection to Adastra now that we have received sufficient assurance and we are liaising with our supplier and other stakeholders to ensure a smooth reconnection as well as monitoring the data catch-up required. We are fortunate that we have a

[1] NICS is made up of local GPs, who work together to provide services at scale across North West Surrey.

system that captures clinical information from scanned forms, which will facilitate this process and ensure no information is lost.

Picture archiving and communication system (PACS):

As part of a consortium of five Trusts across Surrey and Sussex, we are currently in the pre-go-live phase of our replacement programme for our radiology digital imaging system, known as PACS. The system will be provided by Sectra, one of the country's leading PACS providers and will allow us to share images seamlessly across the consortium, without having to transfer studies between Trusts.

We had hoped to go live in October, but have recently taken the decision to postpone this for a few weeks due to delays with installing the requisite leased lines. The delay is not unwelcome, allowing us to ensure the data migration work is completed and also gives colleagues a break between go-lives.

2.5 Collaborate

ASPH Clinical strategy:

Work has commenced on the development of the ASPH Clinical Strategy, which will sit alongside our recently refreshed Trust Strategy. We have had a number of very productive conversations as an executive team and with the Trust Executive Committee, carrying out a comprehensive SWOT analysis of our current clinical services, and considering the range of principles that underpin our clinical model. It is really encouraging to see that a number of our divisional teams have taken steps to develop a strategy for their services, and through enabling this more widely, supported with data and evidence, I am confident that our clinical strategy and related plans will have the full engagement of our clinical teams. At the same time the ICB is embarking on a clinical strategy development, a process we are closely involved in. My intention is to ensure that this provides a clear framework through which high quality service sustainability can be ensured through the right combination of reduced health risk at place and collaboration at scale, and that our clinical leaders are empowered to design and deliver those changes.

ICS vision and strategy:

On 1st July the ICS became a legal entity, with the Integrated Care Board and the Integrated Care Partnership being formed. The ICP is a statutory committee bringing together all system partners to produce the ICS's integrated care strategy. The ICB is the statutory body with responsibility for NHS functions and budgets, and from 1st July is fully accountable to NHSE (now formally merged with NHS Improvement) for all aspects of the health system performance. The principles underpinning ICS development include subsidiarity and a commitment to delegation to place-based partnerships, which in Surrey Heartlands are committees of the ICB. We are highly active at both Place and System level and keen to support the development of the system, with 2022/23 being seen as a year of transition.

Provider Selection Regime:

The Provider Selection Regime (PSR) is the revised procurement rules for the NHS with the aim of creating a more flexible, proportionate and less bureaucratic process for making decisions about procuring healthcare services, in a way that supports greater integration and collaboration. The policy applies to all public procurers of healthcare services (e.g. ICBs, NHSE, local authorities and trusts).

The policy envisages three different circumstances for awarding contracts, including direct award (when there is no suitable alternative provider or where choice is not reduced), most suitable provider (incumbent is undertaking a good job or meets all the criteria), and competitive procurement. The proposed policy sets out the requirement for clear decision-making criteria and detailed transparency requirements. Implementation of the PSR is dependent on the Department of Health and Social Care (DHSC) laying regulations in parliament.

The potential impact on ASPH are both at tactical and strategic levels. At the tactical level the Trust will need to review its procurement procedures. At the more important strategic level the policy provides a useful new tool to support provider collaboration as it has the potential to facilitate easier service integration across providers. Actions are being taken at both levels.

Considering options for ICS Group board structure/next steps:

The development of the ICS brings with it the opportunity to adapt the structure of the provider sector to reflect greater levels of collaboration and system working. There are a number of group models in place already across the country, which range from full integration at Board level to integration around a clinical pathway/s with individual providers taking overall provider accountability on behalf of those in the Group.

The right model for Surrey, which would need to be debated and agreed by all the individual provider Boards involved, will depend on the agreed purpose and objectives of the Group. The acute provider collaboration workstream is looking at the options and supporting the development of an ICB clinical strategy which will be key in determining the way forward. This is an important strategic area with relevance to BAF risk 5.2, and has the potential to mitigate unexpected external impacts on ASPH through establishing clear governance processes around collaborative pathways and services.

A regular meeting of provider CEOs and Claire Fuller, CEO ICB has been scheduled and facilitated by Suzanne Marcello to provide a forum to discuss and agree preferred options for potential group structures and priorities for provider collaboration. I will report back in future papers regarding progress and challenges.

I have joined a new CEOs learning set alongside other new provider CEOs and led by Stephen Dalton. This is facilitated by NHS Confed and is a great way to connect with senior NHS leaders both to gain insight and to influence discussions and planning.

Provider collaborative- Surrey heartlands elective centre:

We are very pleased that the Surrey Heartlands led bid for an expansion of Ashford Hospital to accommodate an elective surgical centre has been successful. This development will enable the creation of the only centre in Surrey providing solely elective surgery and there are opportunities for Ashford and St Peter's patients and those from other providers to benefit from this. Work on how this might be taken forward will be led by Surrey Heartlands, through the Provider Collaborative Board and the Integrated Care Board.