Hull University Teaching Hospitals NHS Trust

AGENDA

Extra-ordinary Meeting of the Trust Board

Monday, 14 November 2022
Via Teams

		Attached / Verbal	Time
1.	**Welcome & Introduction** Sean Lyons, Trust Chair	Verbal	5 mins
2.	**Proposal to Develop A Group Leadership Model: Final Case for Change** Sean Lyons, Trust Chair / All	Attached	40 mins
2.1.	**Appendix A: Stakeholder Engagement & Feedback**	Attached	
2.2	**Appendix B: Risks & Mitigations**	Attached	
3.	**Next Steps** Sean Lyons, Trust Chair	Verbal	5 mins
4.	**Any Other Urgent Business** Sean Lyons, Trust Chair	Verbal	
5.	**Date & Time of Next Meeting** Tuesday 14 February 2023, 9am – 12pm	Verbal	

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item	X	**Meeting**	Trust Board – Public	**Meeting Date**	Monday, 14 November 2022
Title	**Proposal to Develop A Group Leadership Model: Final Case for Change including Stakeholder Feedback (Appendix A) and Risks & Mitigations (Appendix B)**				
Lead Director	Sean Lyons, Chair				
Author	Sean Lyons, Chair				
Report previously considered by (date)	Programme Oversight Board: Thursday, 10 November 2022				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval	X	Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led	X	Partnerships and Integrated Services	X
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
To provide the final Case for Change for the move to a Group leadership model including the stakeholder feedback on the proposal and the risks & mitigations. The Trust Board is asked to approve the final Case for Change for the move to a Group leadership model.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Case for Change: Proposal to Move to a Group Leadership Model

November 2022

Executive summary

A message from our Chair: Sean Lyons

Both Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) are committed to working collaboratively to deliver more for the populations we serve with a focus on improving clinical outcomes, reducing inequalities of access and addressing the known workforce and building infrastructure challenges. Many of our patient pathways are shared and both Trusts have been supporting the Humber Acute Services Review (HASR). Fragile services are being strengthened collaboratively and several support services have been combined to improve efficiency and effectiveness.

Despite the benefits and progress seen to date, both Trust Boards agree that we need to increase our levels of collaboration if we are to respond to the challenges we face and deliver the required change at pace. It is also recognised that there is a limit to what can be achieved in the current organisational context within HUTH and NLaG with separate leadership teams, strategies, and governance mechanisms.

Over the last few months we have been considering how we can build on the work we have undertaken to date to further strengthen the collaboration between the two Trusts and importantly maximise the benefits for patients and staff. Following evaluation of a number of options, both Trust Boards have concluded that the move to a Group leadership model is the best way to deliver the benefits we have committed to. The proposal to move to a Group leadership model would see the implementation of a joint Group Chief Executive and single Executive leadership team and aligned governance and decision-making, whilst retaining the sovereignty of both organisations. We believe that, through this approach, we can deliver better, more equitable and quicker care for patients, provide greater opportunities for staff and meet more of the national targets we are set.

This paper sets out the Case for Change including the options considered, the benefits of the preferred and recommended option and the proposed timeline for implementation as well as details of stakeholder engagement and communications.

I firmly believe that we have to move forward in this way and I fully commend this proposal.

Our organisations: a summary

The combined strength of HUTH and NLaG is that of a major teaching hospital – c£1.3bn with more than 16,000 employees

Hull University Teaching Hospitals NHS Trust (HUTH)

HUTH is situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. HUTH employs c9,900 staff, has an annual turnover of £808m (2021/22) and operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area.

HUTH's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

HUTH provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services. HUTH is designated as a Cancer Centre, Cardiac Centre, Vascular Centre and a Major Trauma Centre. HUTH is a university teaching hospital and a partner in the Hull York Medical School.

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)

NLaG covers the geographic areas of North and North East Lincolnshire and parts of East Riding of Yorkshire. The Trust employs c6,600 staff and has an annual turnover of c £496m. The Trust operates from three geographic sites – Diana Princess of Wales Hospital (Grimsby), Scunthorpe General Hospital (Scunthorpe) and Goole District Hospital (Goole).

NLaG is not only a secondary care provider but also a community provider within the North Lincolnshire area. The Trust provides all District General Hospital services across its three sites serving a catchment population of c450,000

Both HUTH and NLaG work collaboratively with their local health and care partners and are "Anchor" organisations within their local communities

- **CQC (2019)**
  - HUTH: Requires Improvement
  - NLaG: Requires Improvement
- **Turnover (2021/2022)**
  - HUTH: £808m
  - NLaG: £496m
- **Employees (2021/2022)**
  - HUTH: c9,900
  - NLaG: c6,600

Our Strategic Vision and Objectives align and focus on our commitments to care, staff and collaboration

Both HUTH and NLaG have invested time in working with staff, patients and partners to develop their Vision, Values, Strategic Objectives and Priorities over the past few years

Both Trust highlight their joint commitment to:

- Delivering high quality care
- Developing the skills of their workforce
- Organisational sustainability
    - Financial performance
    - Workforce
    - Infrastructure
- Working collaboratively

Both Trusts have identified a range of strategic priorities that they have committed to deliver before 2025. These are summarised on the following page and highlight our joint commitments to:

- Service transformation and change
- Partnership working and collaboration
- Ensuring that our organisations have a long term future

A strong track record of successful collaboration

HUTH and NLaG - successful collaboration

The hospitals on either side of the Humber have been working ever more closely together for the last 25 years, ever since Cancer services at Castle Hill Hospital began to provide radiotherapy and other complex care for patients from Northern Lincolnshire and the Goole area.

This continued in the 2000s, with the establishment of Trauma Centres all over the country whose purpose was to improve dramatically the survival rates of people in major accidents and other traumatic events. Hull Royal Infirmary was designated as the Trauma Centre for a wide geography, including Northern Lincolnshire and for the last 15 years, people from Northern Lincolnshire and the Goole area have benefited from the service that they have provided, with better outcomes following major trauma.

The journey towards ever closer collaboration – for the benefit of patients - continued in 2018, with the establishment of the Humber Acute Service Review (HASR), jointly led by the Chief Executives of Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), together with the Accountable Officers at the four Humber Clinical Commissioning Groups. HASR has done much work in thinking through how, by working together, the five Humber hospitals, with health and care partners outside hospital, can improve the care and waiting times and other important issues for patients from both sides of the Humber, and also provide more attractive career opportunities for staff. The HASR is now at a very advanced stage and is preparing to go to public consultation on options after the council elections next May.

In the meantime, so as not to delay tackling urgent issues, under the umbrella of HASR, HUTH, NLaG and the local Clinical Commissioning Groups, developed an Interim Clinical Plan (ICP), covering 10 smaller specialist services such as Cardiology, Ophthalmology, Urology, Neurology and Dermatology. Work is now at a very advanced stage to have combined leadership across the Humber for these 10 specialties and already a number of the specialty teams have been amalgamated so as to make them more able to attract top quality staff and provide top quality services to patients.

Also, as part of the HASR, in September 2021, the two Trusts submitted a joint application for the Government's New Hospitals Programme for a total of £720 million investment in a new hospital in Scunthorpe and major upgrading of facilities at Grimsby hospital and Hull Royal Infirmary.

Since the pandemic, the Trusts have found a further way to collaborate clinically, with NLaG providing 'mutual aid' support to HUTH to enable them to reduce their planned surgery waiting lists.

Organisationally, in early 2020, the two Trusts decided that their increasingly close clinical collaboration would benefit from having the same Chair of their Trust Boards. Accordingly, Terry Moran was appointed as the first Joint Chair, and following his departure, Sean Lyons was appointed to the same role in February 2022. Building on the success of this Joint Chair appointment, the two Trusts have subsequently appointed two more joint roles at Board level, namely, a Joint Chief Financial Officer and a Joint Chief Information Officer. A number of other non-clinical services have also joined up in this period, including Procurement, Clinical Coding, Information Governance and Medico-legal Services, with other amalgamated non-clinical support services in the pipeline.

Taking the next step

The benefits of these successively ever closer collaborations between HUTH and NLaG, both clinically and organisationally, have now led the two Trust Boards to seek to consolidate the gains that have been made and take them a step further.

So, building on the three joint Trust Board positions that have already been appointed (Joint Chair, Joint Chief Financial Officer and Joint Chief Information Officer), the two Trusts are now recommending that a single Executive Team be established, with joint appointments covering both Trusts to all of the Executive Director roles, starting with a Group Chief Executive.

This would be in the best interests of patients from both sides of the Humber and staff in both organisations.

Options considered: we have looked at a number of options for strengthening our collaboration

Options for increased collaboration considered an evaluated

HUTH/NLaG

Group / Chain / Extended Group

- Shared Governance
- Shared decision making
- Work together to meet shared objectives
- Shared rewards
- Individual organisational sovereignty
- Site based management under one leadership team

Note: there are multiple group models which will be subject to option appraisal as we move forward

Other options considered were:

- **Wider Group Structures to include other acute trusts**
- **Wider Group Structure to include other health partners in the area**

See also slide 13

Merger

- Single governance
- Single management structure
- Full pooling of assets
- Full pooling of risk
- Creation of one new legal entity
- Can have site based management under one leadership team

Acquisition

- Single governance
- Single management structure
- One budget
- Can have site based management under one leadership team

NOTE:

Both the merger and acquisition options are covered by the NHSI Transaction Guidance: 2 key components – Competition & Marketing Authority (CMA) review and risk assessment by NHSI

For mergers: joint application from merging Trusts + governor approval required (FTs) / SoS support (NHS Trusts). If application granted, two trusts dissolved and a new FT established and property and liabilities transferred

For acquisitions: joint application + governor approval (FTs) / SoS support (NHS Trusts) and constitution of acquiring FT. If application granted, target Trust dissolved and assets and liabilities transferred to the acquiring FT

Transaction risk factors considered by NHSI include:

- financial and quality risk (including use of resources and CQC ratings); and
- performance (i.e. SOF rating: SOF segment 4 considered a major risk factor)

Initial hurdle criteria evaluation of options: HUTH/NLaG (unweighted)

HUTH/NLaG

Hurdle Criteria	Do Nothing	Group Chain	Merger	Acquisition
Delivery of National Policy – Collaboration	✓	✓	✓	✓
Builds on Collaboration to Date	✓	✓	✓	✓
Timescale to Deliver	✓	✓	✗	✗
Deliverability – Programme Complexity	✓	✓	✗	✗
NHSE/ ICB Support	✗	✓	✗	✗
Legal Constraints	✓	✓	✗	✗
Leverage on Improved Patient Pathways / Quality	✗	✓	✓	✓
Platform for Future Change	✗	✓	✓	✓
Risk of Challenge	Y	Y	Y	Y

Initial hurdle criteria evaluation of other options considered

Other options considered but excluded

Exclusion criteria	Group to Include another acute (includes building on CAP and recovery work)	Group to Include a different other acute	North Bank / South Bank Group (includes building on CAP and recovery work and involves external ICS)	HUTH/NLaG plus other health partners (includes mix of organisational forms and governance)
NHSE / ICB support	✗	✗	✗	✗
Legal Constraints – Org Form (incl FT/SoF)	✓	✓	✗	✗
Timescales to Deliver	✗	✗	✗	✗
Cost to Deliver	✓	✓	✗	✗
Shared Patients – to note patient flows	NLaG – limited / No sharing with this acute	NLaG – limited / No sharing with sharing with this acute	NLaG limited / No sharing with the acute	✓
Risk of Challenge	**Y**	**Y**	**Y**	**Y**

The preferred option: we have concluded that the move to a Group leadership model is the best way to deliver the benefits we have committed to

Preferred option - move to a Group Leadership Model

- Following the evaluation undertaken, **the preferred and recommended option is to proceed with implementation of a Group leadership model**.

- There are currently a number of NHS Group models in operation (i.e. there is no “off the shelf” model). An option appraisal of the different models will be undertaken as part of the project plan in order to ensure that the model is bespoke to the two Trusts involved but informed by experience from elsewhere.

- The move to a Group model will see the appointment of a joint Group Chief Executive and Executive leadership team, which would build on the programme of joint appointments which have already been made across the two Trusts.

- The move to a Group model is also intended to:

    - draw on the strengths of the two existing leadership teams;
    - seek to ensure that whilst the benefits of collaboration are delivered, there will be no loss of focus on the operational performance of the two Trusts;
    - ensure the delivery of key existing strategic priorities, and the continued development of strong relationships with external partners at both place and ICS level;
    - deliver the changes required under the HASR initiative safely, effectively and at pace.

- In respect of the option of merger, which was considered but discounted as shown earlier, evidence from other organisations which have moved to the Group model suggests it is possible to deliver substantial benefits from collaboration and scale, relatively quickly but without the costs, timescales and disruption associated with a merger.

- Under the Group model, organisational sovereignty and accountability would be retained (individual Boards retain full decision-making rights over decisions relevant to the individual Trust), but with as much decision making as practicable taking place via a committees ‘in common’ approach.

- The move to a Group model will also require a change to and streamlining of existing governance structures. External governance support has been sought to support the two Trust with the changes although the involvement of the relevant staff from both organisations will be critical to the development of options as to what these new arrangements might look like. The joint Group Chief Executive, once appointed, will then lead on shaping the Executive Team structure and new operating model including governance / decision making structures, building on the options put forward, and implementing the revised arrangements.

Intended benefits of the move to a Group leadership model

A summary of the intended benefits of the move to a Group leadership model

LEARN, SHARE AND ALIGN

Reduce unwarranted variation through more integrated leadership and better use of staff and resources
Groups provide a platform for identifying and addressing unwarranted clinical variation. The Group model enables this by providing the necessary expertise, evidence base, and analytics, which smaller organisations would struggle to replicate

Build Leadership Talent
Groups are able to leverage highly capable leaders with proven track records across an enlarged base, while nurturing and developing 'up and coming' leaders through better support mechanisms and improved career paths

Make better decisions
By aligning incentives and removing organisational barriers, Groups enable leaders to make more timely decisions that benefit both patients and reduce total system cost

Drive up quality and efficiency by operating at scale
Groups enable significant improvements in quality and cost through economies of scale, joint procurement, and investment in standardised systems and processes

Pool and share scarce resources
Groups enable the pooling and sharing of resources (both people and capital across organisations, resulting in better expertise, higher utilisation, and a greater ability to invest

Use the workforce more effectively and flexibly
Groups enable workforce to be deployed more flexibly across a wider footprint, resulting in better use of resources, improved responsiveness and an enhanced staff experience

PROVID PLATFORM AND ENABLE

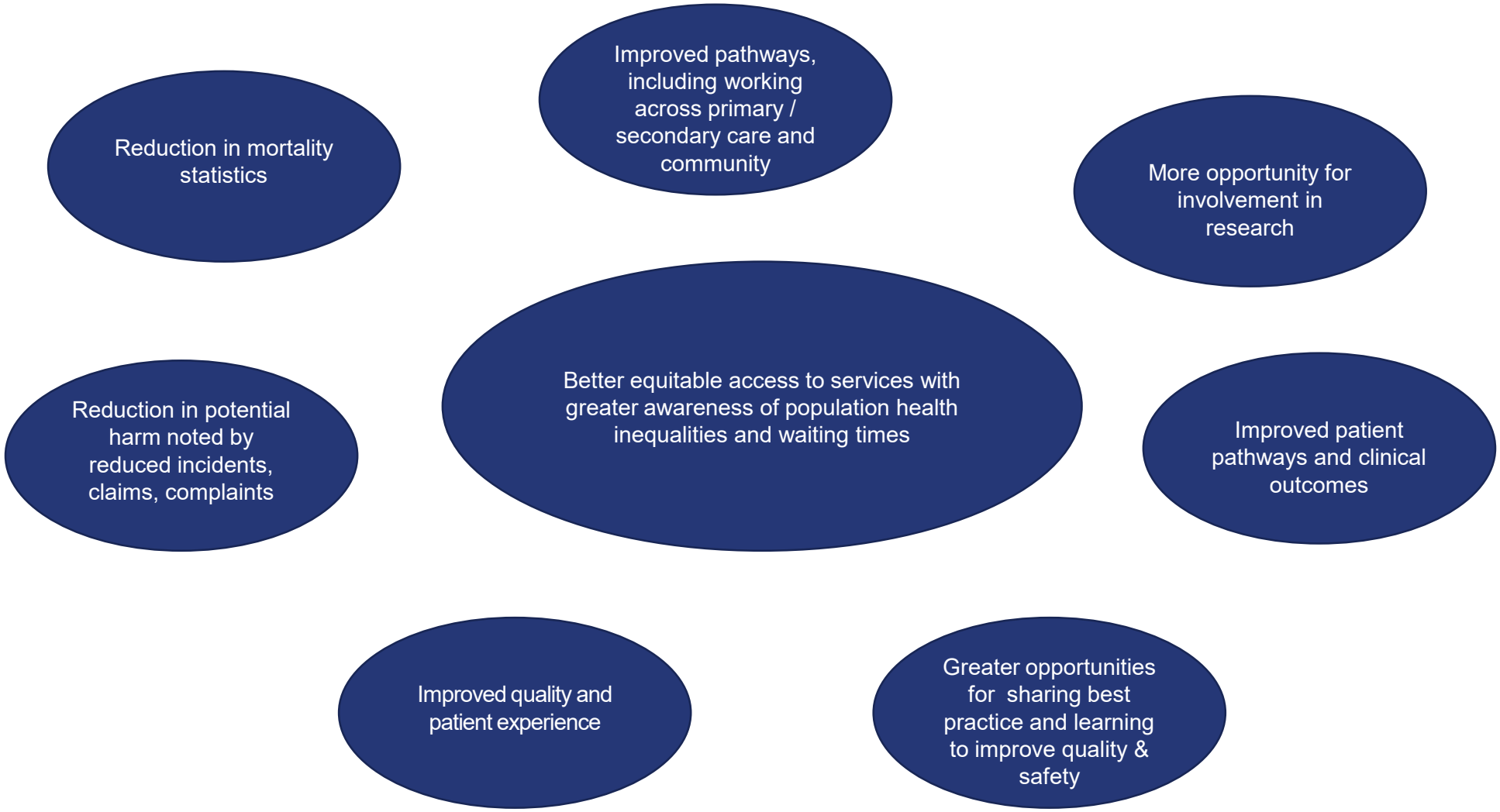
INTENDED OUTCOMES / BENEFITS:

For Patients
- Improved patient pathways and clinical outcomes
- Improved access and continuity of care
- Improved population health and reduced health inequalities
- Improved quality and patient experience and reduction in harm
- Enhanced research opportunities

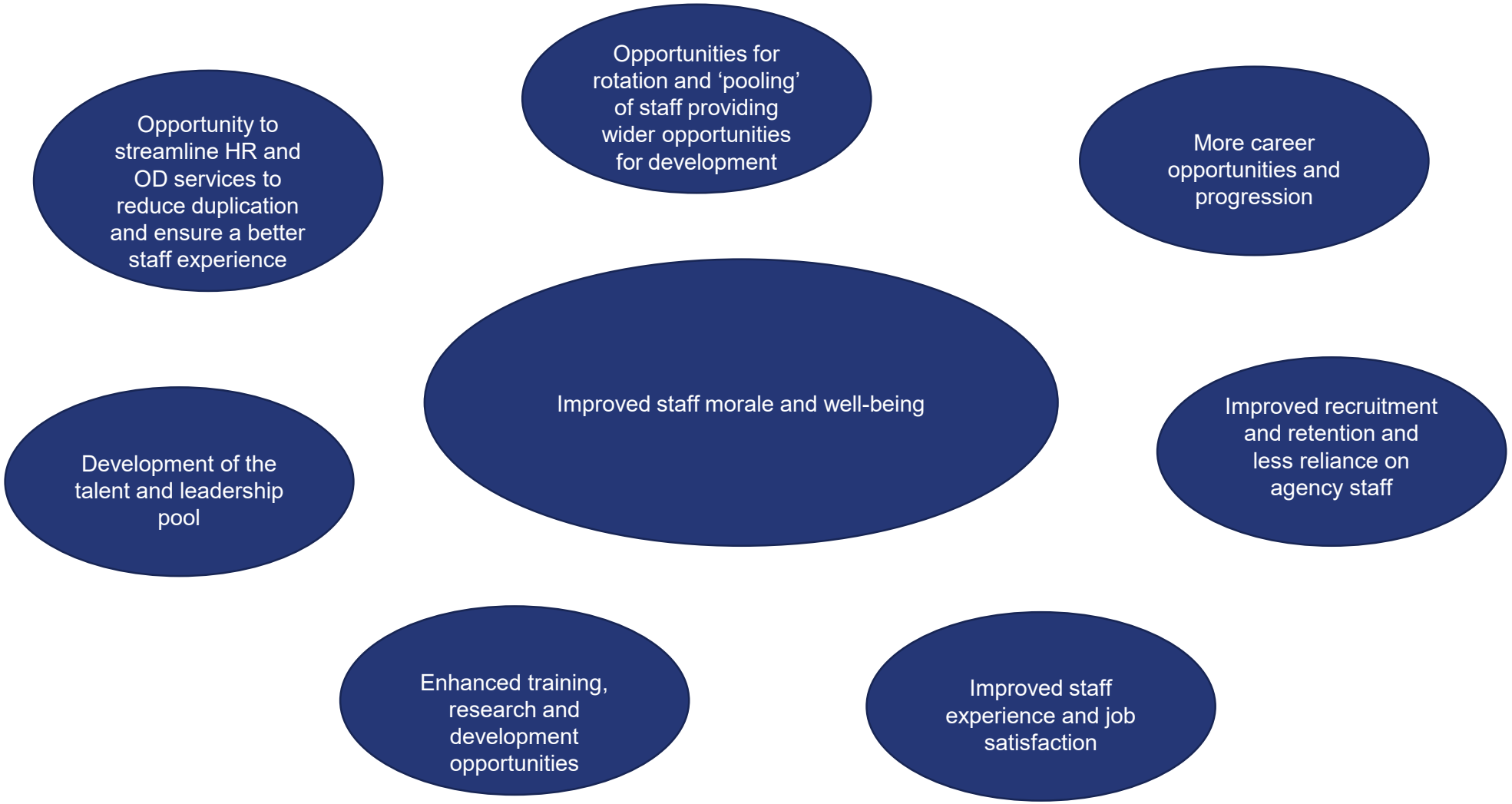
For the Organisation
- Improved financial performance through the elimination of duplication and waste
- Aligned and streamlined governance and the ability to make more timely decisions
- More cohesive and consistent management and decision making
- Increased service capacity and resilience
- Economies of scale
- Shared learning

For Staff
- Improved staff experience and development of the talent and leadership pool
- Improved recruitment and retention and less reliance on agency staff
- Enhanced training and development opportunities
- More career opportunities and progression

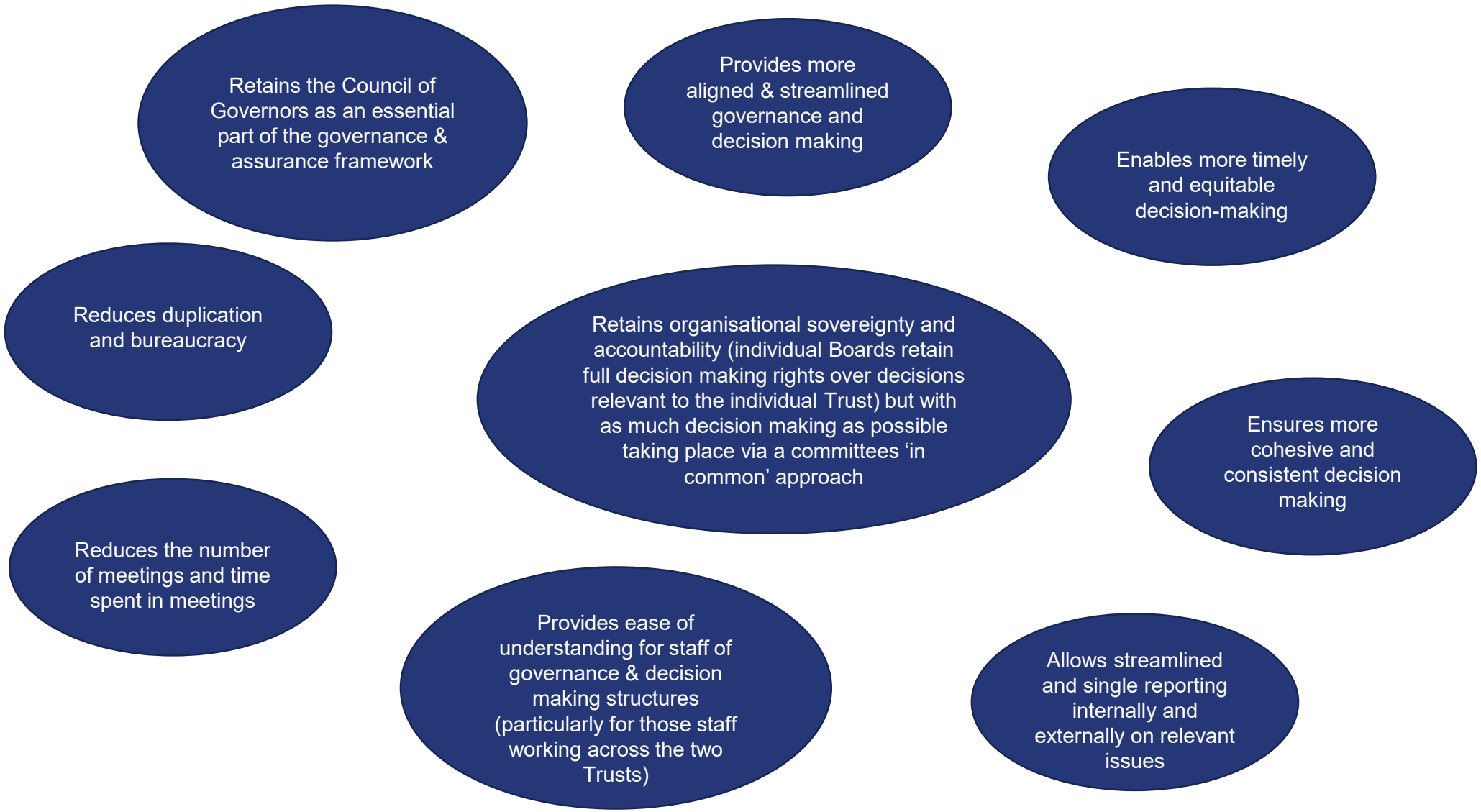
The intended benefits for patients of the move to a Group leadership model explained in more detail



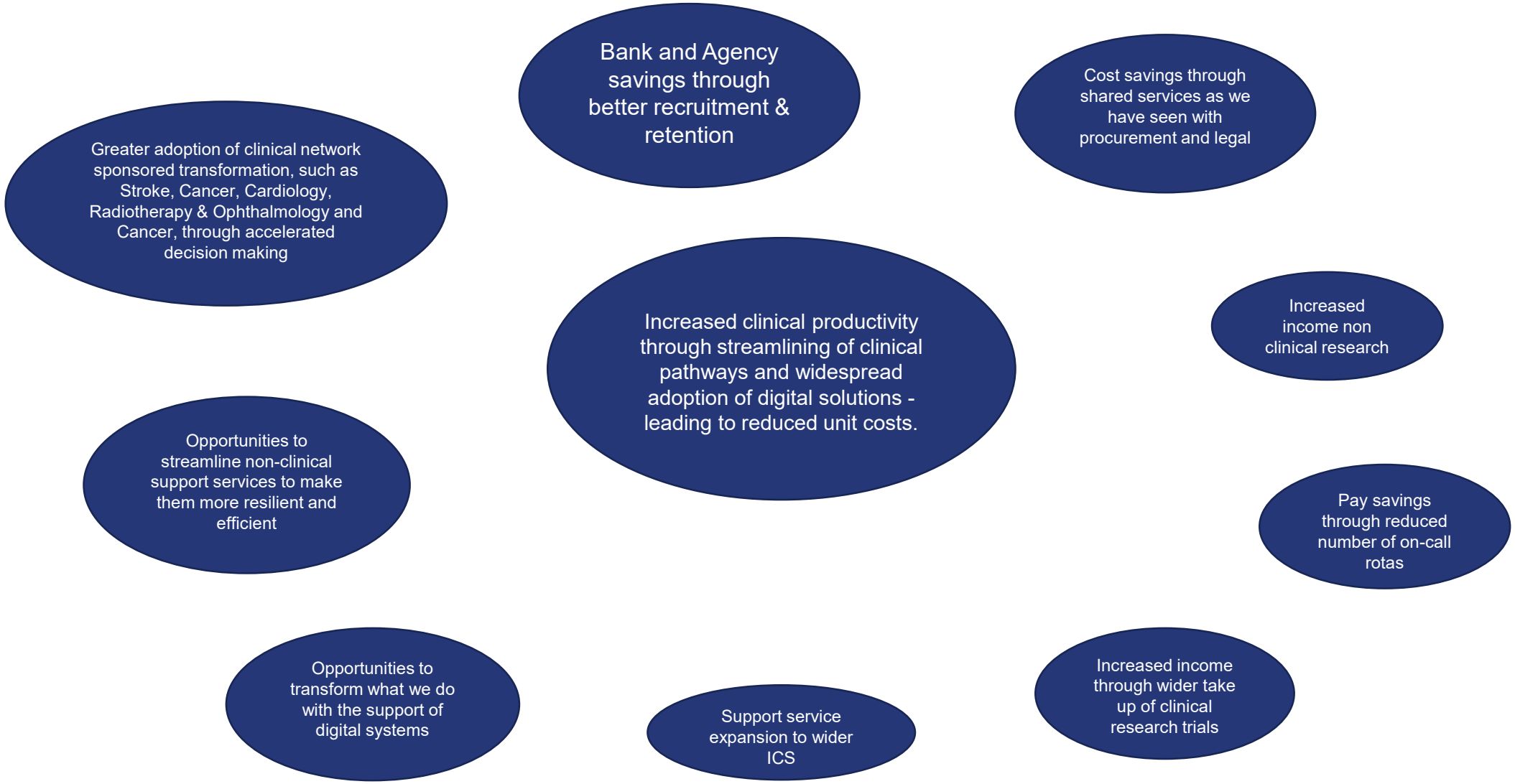
The intended benefits for staff of the move to a Group leadership model explained in more detail



The intended benefits to organisational governance and decision making of the move to a Group leadership model explained in more detail



The intended financial benefits of the move to a Group leadership model explained in more detail

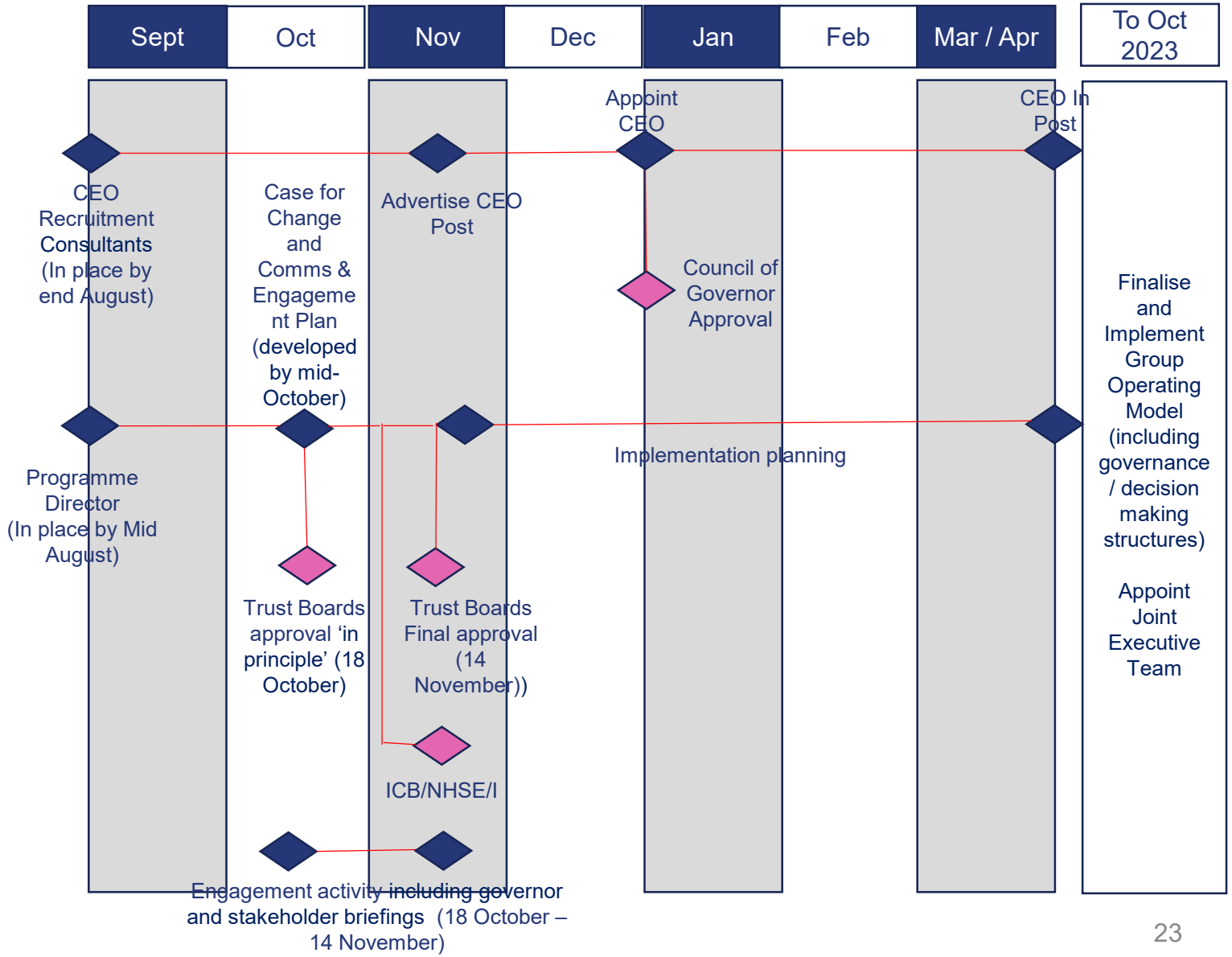


What matters to you matters to us: our proposed timeline and engagement approach

Timeline and key milestones / approvals

The critical milestones within the timeline are:

- Development and approval of the Case for Change and Communication & Engagement Plan
- Briefing / engagement of key stakeholders
- Programme Director & Chief Executives, in association with Executive Teams, to work up Case for Change and proposed operating model / implementation plan
- Recruitment of joint Group Chief Executive
- New joint Group Chief Executive, once in post, to lead on:
  - finalising and implementing the group operating model (including corporate governance / decision making structures) proposed through the project
  - appointment of Joint Executive Team
- Assurance in respect of Case for Change and implementation by NHSE/I/ICB



Communication and engagement

Following approval ‘in principle’ of the outline Case for Change by both Trust Boards on 18 October 2022, a 21-day period of consultation and engagement was initiated with key internal and external stakeholders, as detailed below:

19 & 20 October	Briefing of NLaG Council of Governors Briefing of Senior Leadership teams at both Trusts Notification to staff and trade unions at both Trusts with invite to follow-up briefings Notification to stakeholders and partners with offer of follow-up briefings
21 October – 13 November	Follow-up briefing meetings with staff and stakeholders
14 November	Trust Boards to meet in public to make a final decision on the way forward

As part of the initial communication, staff and stakeholders were advised of the plan for both Trust Boards to make a final decision on the way forward on 14 November 2022. Once a final decision is made, staff and stakeholders will be contacted to announce the decision and to confirm next steps including the timescale for the planned selection and appointment of the joint Group Chief Executive.

The full list of stakeholders, the feedback received and the Trusts’ response is attached at Appendix A.

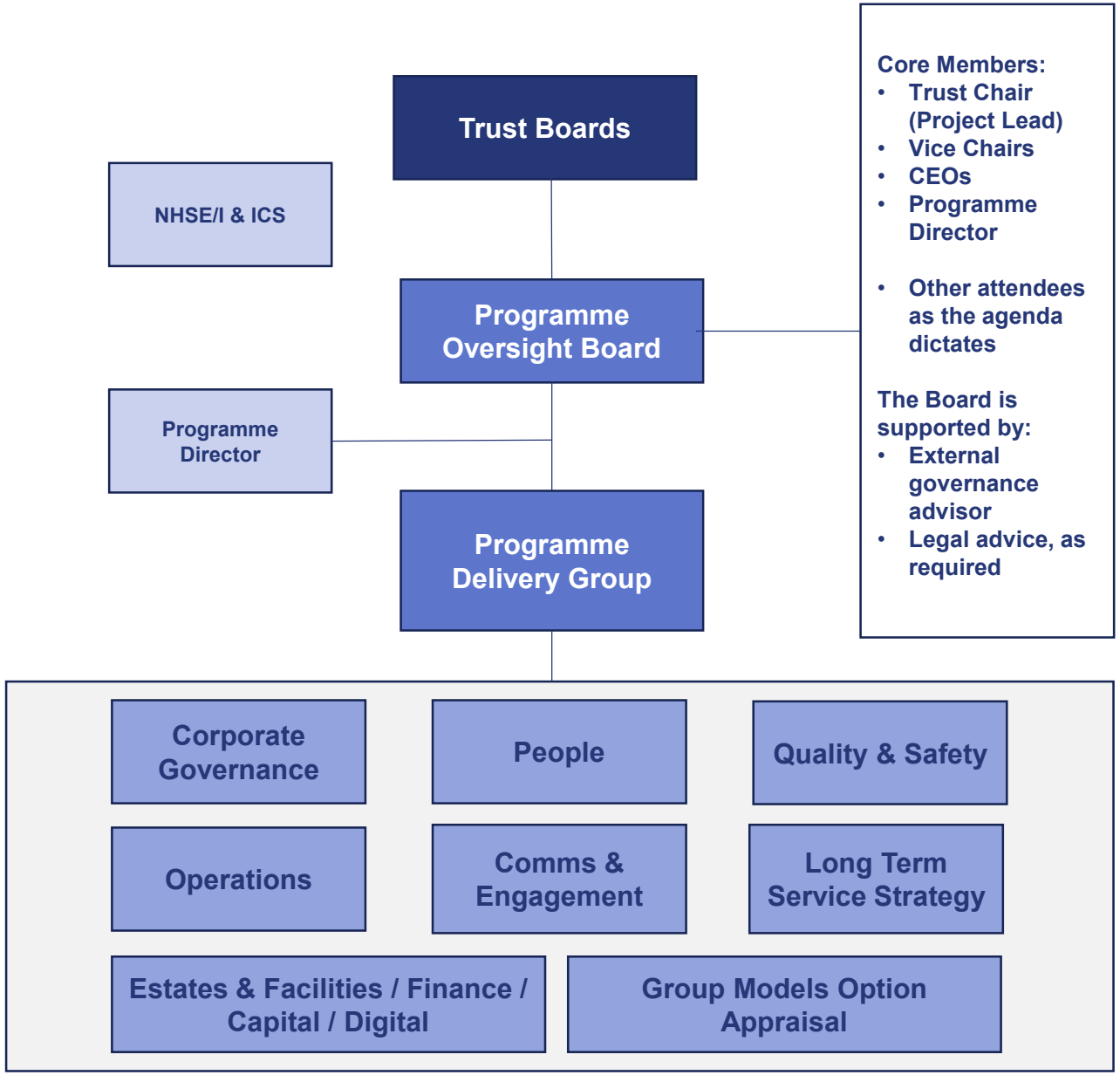
Proposed governance and oversight of the move to a Group leadership model

Programme Governance Structure

The programme will be overseen from a delivery perspective by:

- Programme Oversight Board*:*
  - *project oversight including benefits realisation, timetable and parameters of change*
  - *membership to remain under review as the project progresses;*
  - *role & remit to eventually transfer to a Transformation 'Committee in Common' as part of the move to 'business as usual' (TBC)*
- Programme Director
- Programme Delivery Group
  - Workstreams *(initial focus on identifying benefits of a move to a Group model)*

External programme assurance will be undertaken by NHSE/I & the ICB



Risks and mitigations

The risks to the successful delivery of this programme of work which have been considered and the mitigations are set out in **Appendix B**.

APPENDIX A

Proposal to Move to a Group Leadership Model: Stakeholder Communication & Engagement

1. Background & Introduction

1.1 In developing proposals for the move to a Group leadership model, the Boards of both Trusts were keen to engage with key internal and external stakeholders as well as build on learning from other group models.

1.2 Following approval 'in principle' of the outline Case for Change by both Trust Boards on 18 October 2022, a 21-day period of consultation and engagement was initiated with key internal & external stakeholders and partners to seek views on and, where appropriate, inform the proposals:

- 19 & 20 October 2022: Initial communication & briefings
- 21 October – 13 November 2022: Follow-up meetings / briefings

1.3 As part of the initial communication, stakeholders were advised of the plan for both Trust Boards to make a final decision on the way forward on 14 November 2022.

1.4 Once a final decision is made, stakeholders including staff at both Trusts will be contacted to announce the decision and to confirm next steps including the timescale for the planned recruitment and appointment of the joint Group Chief Executive. There will be ongoing communication as the project progresses.

1.5 In respect of the staff in both organisations, in addition to the issue of the initial communication and Q&As, staff were invited to attend one of a series of briefing sessions. A bespoke area was also set up on the Intranets of both Trusts to allow staff to leave feedback and ask additional questions.

1.6 This paper provides details of all stakeholders contacted including any follow-up meetings / briefings undertaken, the questions or feedback received and, where appropriate, the Trusts' response.

1.7 In summary, whilst questions were asked and additional assurance requested in respect of some aspects of the proposed arrangements, from the feedback received, staff and stakeholders are broadly supportive of the proposed way forward. If the proposal to move to a Group leadership model is approved, the feedback received will be used to help shape and inform the future arrangements and implementation plan. The top five themes from the feedback received are as follows:

- Equity of access and care for patients across both Trusts
- Perceptions of a HUTH takeover
- Whether the proposal is a merger or will lead to merger eventually
- Retention of organisational sovereignty and identity
- Whether the proposed move to a Group leadership model lead to job losses / redundancies?

2.0 Stakeholders Contacted and Feedback Received

Internal Stakeholders

Staff

Stakeholder	**Follow-up meeting / briefing(s)**
HUTH Staff	24, 26 & 28 October 2022
Questions / Feedback Received	**Response**
Will our agenda for change bandings be affected?	Agenda for change bandings will not be affected by the move to a Group leadership model.
Will anyone be made redundant?	Whilst there is likely to be some reshaping of the Executive Team, we would expect to retain our talent within both Trusts or the wider NHS. This is not a headcount reduction exercise.
Will we continue to have separate CQC reports?	As the two Trusts will remain separate legal entities under the Group model proposals, each Trust will continue to hold separate CQC registration with separate inspections, reports & ratings.
What do you expect will happen when two departments become managed by a single manager, what do you envisage will happen for the manager that is perhaps somewhat superfluous to requirements? Given you have previously said no one will be downgraded or vacating their role. How do you expect to make significant service level changes without impacting people's careers or livelihoods?	Whilst there is likely to be some reshaping of the Executive Team, we would expect to retain our talent within both Trusts or the wider NHS. This is not a headcount reduction exercise. No one needs to worry about their job, at all, there is more than enough work for everyone – that's part of the reason we want to change. Over time, as people leave for new roles or retire, we will look at what that means for their area of work and see if we want to make changes to streamline what we do and how we do it. That might happen and it might not, it depends on the circumstances at that time. Most staff will still be doing in six months, or a

	year, what they are doing now, but with enhanced connectivity with their colleagues in their partner Trust. A few specialist staff might have to travel more, and we will talk to them directly if that is the case. In the medium term we think we can look at the working environments of staff – clinical and non-clinical – by rationalising estates and having fewer buildings overall which we need to upgrade and maintain. We will also be able to pool budgets and prioritise spending on things like clinical equipment and IT. The Group arrangement means there will be more opportunities for research, training, and the development of new roles.
Are we considering having one head of service for support services?	As above.
Does streamlining HR mean we will have one HR service?	We hope teams will benefit from working together wherever possible, however there are no plans at present to merge support functions. To their great credit, lots of these services have been working collaboratively for some time now (examples: payroll, legal, clinical coding etc) and we are proud of the example they have showed in working together.
Will we be merging our digital systems?	We are already considering how we can ensure our digital systems integrate more effectively. It makes perfect sense to have single systems for our digital offering.
Do you foresee any negatives apart from the risks highlighted?	The proposal to move to a Group leadership model is not without some element of risk, however we believe the risk of doing nothing is greater than the risks we have considered as part of this proposal.
An extension of the Scunthorpe/ Grimsby minibus for staff to travel across the patch would be good.	This is a good suggestion and one which we will consider once the Executive Team is in place.
Could I ask how we are planning to review the details of clinical policies for staff working in both trusts. Where does the liability sit? Do clinical policies need reviewing? In particular I am working with the other NMP leads in HUTH and NLAG to try and ensure the governance for prescribing is robust, but this is a challenge at present. Who will be leading this sort of work?	Clinical leads will work in partnership to develop and review policies for clinical services. Again, this question supports the case for having one executive team to oversee this piece of work and avoid duplication and/or confusion.
Presumably, spending on expensive assets (imaging, therapy equipment) will be subject to creation of joint strategies? Will the joint Executive Team lead on this or the ICB?	This is correct. Many capital bids will be supported by the ICB.

This is a really positive move. However, I feel that we need to prioritise unifying HR processes across the two organisations so that staff do not have to do two lots of appraisals, mandatory training etc. It would be great to have complementary recruitment processes.	This is a key reason for progressing the proposal. We agree that unifying HR policies is the right thing to do.
The collaboration between the two Trusts is something we should all be extremely proud of.	Comments noted.
It would be great to ensure a joint approach on training / development – particularly with apprenticeships in mind.	This is another good point and once again highlights the rationale for progressing with a Group leadership mode.

Stakeholder	**Follow-up meeting / briefing(s)**
NLaG Staff	20 October (a pre-arranged Team Brief Live) and two specifically arranged sessions on 1 and 9 November 2022 As part of the staff briefings in November a poll was also undertaken, during which staff were asked the following questions: *Q: Having heard why we are creating the Group, do you think it is the right thing to do?* *<u>Results</u>* - *Yes: 100%* - *No: 0%* *Q: Did the announcement of working mor closely with HUTH surprise you?* *<u>Results</u>* - *Yes: 5%* - *No: 95%* Staff were also asked if they had any concerns about what it might mean for them and, if so, what those concerns are. Details of the comments

	received in response to that question and through the Trust Intranet site more generally are provided below.
Questions / Feedback Received	**Response**
The collaborative working with HUTH for the patients can only be a great thing: sharing resources, specialist skills and facilities.	Comments noted.
What is meant by 'shared governance'?	Under the Group leadership model, the corporate governance arrangements in the two Trusts will become more aligned, ensuring more timely and equitable decision-making. More aligned and streamlined governance will also help to reduce duplication and bureaucracy.
I'm a dietitian and I looked at the e-mail as it came in and was very interested in it as obviously a lot of people are and I was interested that you thought group leadership was going to help our recruitment and retention. Unless you're going to suggest that we are going to be the equivalent of one trust and even then I'm not sure how that would help, so I'm really interested how you actually think that will help us.	The closer collaboration between the two Trusts will provide greater opportunities for cross site-working, career development and progression and, in turn, support retention. It is also hoped that the Group will be more attractive to potential candidates and, in turn, support recruitment.
I'm concerned that one of the justifications is to eliminate duplication and waste, we can't do that effectively running three hospitals in one trust, I think our problems will be amplified trying to streamline anything over such a large geographic area with very different demographics across the sites. I am extremely apprehensive about this having been through a similar process of sharing services within Humberside Police and South Yorkshire Police which led to their performance dropping, this ultimately led to me leaving HP and coming to the NHS. I'll be honest and say this consultation has led me to consider my position in the trust and whether it would be safer somewhere else. I'm sure I'm not the only one considering this.	It is hoped that streamlining of systems and processes and aligned corporate governance and decision-making (i.e. doing things once where possible) will help to avoid duplication and waste. This will inevitably take time to embed.
Communication is crucial, so all staff are fully aware of what changes are being proposed to services.	Comment agreed with and commitment made to continue to do this.
I don't have any concerns. Only praise. I understand that some may worry, however, evolution will be the thing that keeps the NHS alive. It is important it is developed in the future and for future generations.	Comments noted.
Communication needs to be kept up to staff.	Comment agreed with and commitment made to continue to do this.

Yes & No ... My role is directly affected by what happens in any joint Digital collaborations and joint systems. Depending on the direction of travel this could be concerning ... will have to wait to see what transpires .... happy to have off-line chat.	Digital Services are already led by one executive and her focus is making sure new systems which will implemented are the best for patients and not because one trust uses them already.
To ensure joint working across the different sites, if digital systems need to be combined and provided by one supplier - will that be a joint discussion/agreement across both groups and not HUTH decision?	As above.
Not for me personally but I have heard concerns raised about non clinical services and staff feeling that economies of scale may mean cuts in the long term.	There is no intention for this to happen, staff do not need to worry.
My concerns are for the people working directly for the current Executive Team, if we move to a joint Executive team does that all support staff will be kept in place?	Yes, it does, there is no need for staff to worry. We want to keep all the staff we have and, where we can, improve the jobs they do. The Group will be an opportunity for many staff.
Only concern is about how safe my job is. There are staff doing the same job as me at HUTH and I wonder how my role with fit.	As above.
Changes to place of work or an expectation to work across the area and also possible reductions in staff I acknowledge that they've said no staff cuts and hope this is true.	There is no expectation to change workplace for most staff.
Not 100% sure at the moment; there will always be changes.	Comments noted.
I am worried that joint governance arrangements would put existing governance team jobs at risk.	The comment made in the presentation was about corporate governance where we could see some changes, like a joint Quality Committee for example. There is no intention to change current clinical governance arrangements.
Hull have contracted out FM services, will this impact on NLaG?	No, there are no plans to change the model of delivery of NLaG's FM services.
After attending today, I have no concerns.	Comments noted.
Does / how does this affect the long-term collaborations and working relationships with our other neighbours in Greater Lincolnshire - Eg current Pathlinks arrangements and Shared Digital Arrangements ?	It will not affect these, staff should continue to work with – and build relationships with – neighbours they are working with already.

Senior Leaders

Stakeholder	**Follow-up meeting / briefing(s)**
Senior Leadership Community (SLC) – NLAG	20 October & 3 November 2022 As part of the briefing on 3 November 2022, a poll was also undertaken, during which leaders were asked the following questions: *Q: Did the announcement of working more closely with HUTH come as a surprise to your teams?* *<u>Results</u>* - *Yes: 7%* - *No: 93%* *Q: On balance, do you think your team feels it is the right thing to do?* *<u>Results</u>* - *Yes: 89%* - *No: 11%* Details of feedback and questions asked during the briefing are provided below.
Questions / Feedback Received	**Response**
Is this going to be the start of merging further all teams /groups, with main leadership coming from HUTH?	No, there is no plan for this.
There is a feeling amongst NLAG consultants that new senior clinical appointments, both to clinical and to leadership roles, are majority owned and directed by HUTH. Will new senior appointments be paused to ensure joint participation? Will there be a framework for new senior appointments?	See later comments.
I work cross site within NLaG and what I have done in my role is taken the best practice at both sites and used this to create an	This is exactly what we are trying to replicate more widely by creating the Group.

equal pathway for patients using the best, most efficient practices I have witnessed. Also, I have been working closely with HUTH as cardiology are quite involved with HASR and I am not feeling a competition, but actually that investment in NLaG's cardiology staff and equipment will be available as we need to provide uniform services across the patch and move away from postcode lottery care.	
Is there an example of such a structure being successfully implemented in NHS previously?	There are several successful Group leadership models operating in the NHS. As part of the development of local proposals, the two Trusts are in contact with some of the Trusts with a view to learning from them although it is important that local arrangements are bespoke and work for both Trusts.
Will this exercise be Equality Impact Assessed?	An Equality Impact Assessment will be undertaken.
Does this mean we will lose jobs ?	No, this is not a job cutting or cost saving exercise.
Will the jobs be based at HUTH (admin)?	No, there are no plans to move staff around from their current workplace.
Will our line managers be at HUTH?	This depends on the service. Some leadership changes are happening because of the work HUTH and NLaG are doing together as part of the Interim Clinical Plan. There could be some line management changes in those specialities. However, generally speaking, there are no plans for wholesale changes in line management responsibilities.
Is this a merger?	This is not a merger. The option of merger was considered but discounted; not least as evidence from other organisations which have moved to the Group model suggests it is possible to deliver substantial benefits from collaboration and scale, relatively quickly but without the costs, timescales and disruption associated with a merger.
Will it means ironing out differences in patient pathways and support for staff?	Yes, for pathways we hope, over time, to develop single patient pathways in many areas of work – this is one of the key ways we will reap the maximum benefits for our patients and for our staff. Over time we would hope to develop a single offer for staff in terms of health and wellbeing, training and development opportunities and career development.
Does this mean Peter and Shaun are leaving?	There will be an open recruitment process for the Group Chief Executive. We have already said the Group Chief Executive will lead the shaping of the Group Executive Team and which roles will be a part of that. We will

	make sure everyone on both Executive Teams is treated fairly through that process.
If we are still to retain our individual organisations identity how do we decline changes which have already been agreed by a joint board?	If decisions are taken by both Boards that is what will need to happen. As is the case now decisions taken at this level are not up for debate.
Will all new Consultant roles will be joint appointments across both Trusts?	There is already a Memorandum of Understanding between the trusts to allow this to happen and it is happening in some cases. This would make sense to do at some point.
Will this result in a complete change of Directors?	This not something we expect to happen, we want to retain as much of the talent as we can.
Will we be working differently?	Yes, that is a key reason for making this change. We want to share learning and best practice between both trusts and make sure we do the best we can for each and every patient.
Will NLaG staff be asked to go and work at HUTH to assist with their staffing? Will staff be expected to work cross Trust?	Some senior staff will be expected to work across both trusts. However, we're not expecting this to be the case for all grades of staff. Both trusts face filling challenging rotas so moving between the two trusts may help one but will worsen the position of the other so it is not something we are expecting to happen.
How will the intended benefits for recruitment and retention be realised for AHP staff groups?	This is detail we need to work through. As this question suggests we expect a Group to open up more attractive roles and make recruitment easier, for AHPs as well as other groups of staff.
Are there any thoughts about NLaG using HUTH's policies and procedures or vice versa?	As things progress and teams work more closely together it is likely this will happen. It is too soon to provide any detail on what they might be or when this might happen.
What it will mean for a team if one manager leaves at HUTH or NLAG, will those teams merge under one manager?	It depends on the circumstances. This could happen but it is not the case it definitely would.
Is it really collaboration?	Yes – it is collaboration between the Trust Boards to make quicker decision in the interests of all patients across the Humber.
What are the real drivers and what are the benefits – where are the results of the cardiology review following the development of the single leadership (if a review has been done?), and if a review hasn't been done then why not as this is the best way to learn and reflect?	The drivers are to benefit all patients across the Humber and staff in both trusts. This will happen over time, it's not something we expect to see take place overnight. If the Group gets agreed we intend to learn from what has been happening in the clinical services covered by the Interim Clinical Plan, including cardiology – both the good points and, perhaps more importantly, where things haven't gone so well. Our view is on executive team will be able to better implement decisions when they are

	responsible for delivery in both trusts and this isn't the case at the moment.
What's the ultimate vision?	Whilst a vision statement hasn't been formulated so we can't answer that directly we can say we want to make sure everyone across the Humber has access to the best secondary care we have available, irrespective of where they live. We also want to create the best employment offer we can for our current and future staff – with access to good, interesting jobs, with training and development opportunities and in environments which staff can be proud to work in.
What are the risks of moving to a group structure?	These are set out in the case for change document. The proposal to move to a Group leadership model is not without some element of risk, however we believe the risk of doing nothing is greater than the risks we have considered as part of this proposal.
What will happen to the rest of the exec team once there is a single CEO? And how will this impact on the clinical divisions?	There will be an open recruitment process for the Group Chief Executive. We have already said the Group Chief Executive will lead the shaping of the Group Executive Team and which roles will be a part of that. We will make sure everyone on both Executive T eams now is treated fairly through that process and that we want to retain as much of the talent as we can.
Will care for our patients really be equitable if services are led by HUTH?	Services will not be led by HUTH – they will be led, ultimately, by a single executive team responsible for making decisions in the best interests of all patients across the Humber.

Council of Governors

Stakeholder	**Follow-up meeting / briefing(s)**
CoG – NLAG only	31 October 2022
Questions / Feedback Received	**Response**
Governors feel that it would have been preferable to delay consideration of changes to organisational form until functional changes arising from the Humber Acute Services Review have been the subject of formal consultation. We are concerned that a premature move to a single Humberwide leadership model for acute services could compromise the forthcoming consultation	Comments noted.

exercise by suggesting to patients and local politicians that changes to service delivery are a fait accompli. However, we recognise that the tensions between the leadership cultures of the two organisations that have been increasingly exposed in the management of the Interim Clinical Plan (ICP) need to be speedily addressed.	
We feel that the implementation of a Humberwide group leadership model for acute services will be widely perceived to be a Hull takeover. Communications regarding any move to a group leadership model must therefore emphasise the maintenance of NLaG's independence/sovereignty as well as the opportunities for foundation trust members to continue to influence the organisation's priorities. It would also be helpful if the case for change were to clarify the issue of the location of the base for the executive leadership team. We feel that any suggestion or apprehension that the Group Chief Executive could be based exclusively in Hull would be viewed very negatively by NLaG staff, patients, and other stakeholders.	The move to a Group leadership model is not a takeover by either Trust. Under the Group leadership model, whilst as much decision making as practicable will take place through a 'committees in common' (joint) approach, individual Boards will retain full decision making rights over decisions relevant to the individual Trust, ensuring the retention of sovereignty and accountability. The Council of Governors and trust members will remain an essential part of the NLAG governance & assurance framework. It is fully anticipated that the joint Group Chief Executive and joint executive team will work cross site and would not be based exclusively on one site.
The Joint Trust Chair indicated as part of his governor briefing that the case for change is not financially driven but that he expected over time that some unquantified economies of scale would result. We feel that the case for change and subsequent communications need to include a categoric statement that the implementation of a group leadership model will not result in increased management costs through the creation of another tier of hospital management.	It is not anticipated that the move to a Group leadership model will result in increased management costs. Analysis of the potential benefits of collaboration in other organisations that have implemented the Group model has demonstrated potential savings across the organisations involved over time. This will remain under review as the project progresses.
We recognise the need to recruit the best possible candidate available nationally to take on the vitally important leadership role as Group Chief Executive. We therefore support the need for an open recruitment process. But we are well aware of the talent and commitment of NLaG's existing cadre of executive directors which is no doubt replicated within HUTH. We would therefore welcome inclusion of a commitment within the case for change document that recruitment of all members of the group leadership	The process for appointment to the executive leadership team is currently being developed for agreement with the joint Group Chief Executive, once appointed, but it is anticipated that these posts will be ringfenced in the first instance.

team with the exception of the Group Chief Executive will initially be ringfenced.	
As a Council of Governors, it is our statutory duty to approve (or otherwise) the appointment of NLaG's Chief Executive. We recognise that governors will have no formal role in the Group Chief Executive selection process, we would welcome an assurance that governors will be given the opportunity to meet with the candidates prior to interview.	The Group Chief Executive selection and appointment process will include a range of stakeholder engagement events and will include representatives from the Council of Governors.

HUTH – staff briefing to JNCC and LNC chairs

Stakeholder	**Follow-up meeting / briefing(s)**
UNISON	Follow-up conversations / emails from HRD to JNCC and LNC Chairs.
BMA	
Questions / Feedback Received	**Response**
Request from JNCC and LNC to be kept informed as the proposal progresses.	Once a final decision is made at the Trust Board meetings scheduled for 14 November 2022, all stakeholders will be contacted to announce the decision and to confirm next steps. There will be ongoing communication as the project progresses.

NLAG – staff briefing to JNCC and LNC chairs

Stakeholder	**Follow-up meeting / briefing(s)**
JNCC: Staff Side Chair: RCN Staff Side Lead: UNITE Staff Side Secretary: UNISON	
JLNC	Extra-ordinary MAC / HCC meeting arranged for 3 November 2022
Questions / Feedback Received	**Response**
Concerns have been raised by the NLaG clinicians regarding the proposal: there is a perception that the proposal to move to a Group is a HUTH takeover and will lead to a loss of the NLaG	Specific engagement events have and are being held with clinical colleagues and due consideration is being given to the concerns raised.

voice which it is felt has the potential to adversely impact on the quality of care and services to patients on the south bank and will also have a negative affect on the working environment of NLaG staff.	The operating model and governance arrangements for the new Group will be designed to ensure an equal voice from both Trusts.

External

HUTH:

Members of Parliament (MPs): Hull and East Riding of Yorkshire

Stakeholder	**Follow-up meeting / briefing**
MP for Hull West and Hessle	No further feedback or comment.
MP for Hull North	Confirmed happy with written briefing.
MP for Hull East	No further feedback or comment.
MP for Haltemprice and Howden	No further feedback or comment.
MP for East Yorkshire	No further feedback or comment.
MP for Beverley and Holderness	No further feedback or comment.
Questions Received	**Response**
None.	N/A

Local Authorities: Hull and East Riding of Yorkshire

Stakeholder	**Follow-up meeting / briefing(s)**
Hull City Council, Chief Executive	7 November 2022
Hull City Council, Leader	
Hull City Council, Chair of Overview and Scrutiny	
Hull City Council, Adult Services and Public Health	
Hull City Council, Director of Public Health and Adult Services	
Hull City Council, Director of Adult Social Care	
East Riding of Yorkshire Council, Chief Executive	
East Riding of Yorkshire Council, Leader	
East Riding of Yorkshire Council, Chair of Health, Care and Wellbeing Overview and Scrutiny	

East Riding of Yorkshire Council, Portfolio Holder for Adult and Carer Services	
East Riding of Yorkshire Council, Portfolio holder for health and wellbeing	
East Riding of Yorkshire Council, Chair of Health and Well Being Board	
East Riding of Yorkshire Council, Director of Adult Social Services	
East Riding of Yorkshire Council, Head of Public Health	
Questions / Feedback Received	**Response**
Supportive of direction of travel. Reinforced need for continued partnership working which was agreed. Request to be involved in the joint Group Chief Executive recruitment process.	The Group Chief Executive selection and appointment process will include a range of stakeholder engagement events and will include representatives from Local Authorities.

NLAG Stakeholders:

Members of Parliament (MPs): Northern Lincolnshire

Stakeholder	**Follow-up meeting / briefing(s)**
MP for Grimsby	10 November 2022
MP for Cleethorpes	4 November 2022
MP for Scunthorpe	9 November 2022
MP for Brigg and Goole	No further feedback or comment
Questions / Feedback Received	**Response**
No concerns regarding the direction of travel but reinforced need for equitable access to services. Request to be kept informed of the process and to continue to receive the current level of communication and engagement. [Specific issue raised by one MP regarding stroke services which will be followed up separately to provide the required assurance]	The need for equitable access to services is agreed.

Local Authorities: Northern Lincolnshire

Stakeholder	Follow-up meeting / briefing(s)
North East Lincolnshire Council, Chief Executive	9 November 2022
North East Lincolnshire Council, Leader	
North East Lincolnshire Council, Chair, Health and Adult Social Care Scrutiny Panel	
North East Lincolnshire Council, Deputy Leader and Portfolio Holder for Health, Wellbeing and Adult Social Care*	
North East Lincolnshire Council, Director of ASC	
North Lincolnshire Council, Chief Executive	
North Lincolnshire Council, Leader of the Council and Chair of the HWB	
North Lincolnshire Council, Chair, Health Scrutiny Panel	
North Lincolnshire Council, Cabinet Member for Adults and Health	
North Lincolnshire Council, Director: Adults and Health	
North Lincolnshire Council, Director of Public Health	
Questions / feedback received	**Response**
No major concerns regarding the direction of travel but keen to ensure no loss of existing access and continued participation in Place arrangements. Request for regular updates. Request to be involved in the joint Group Chief Executive recruitment process.	The Group Chief Executive selection and appointment process will include a range of stakeholder engagement events and will include representatives from Local Authorities.
How will the sovereignty of each organisation be maintained?	Under the Group leadership model, whilst as much decision making as practicable will take place through a 'committees in common' (joint) approach, individual Boards will retain full decision making rights over decisions relevant to the individual Trust, ensuring the retention of sovereignty and accountability.

Senior Leaders Group: Northern Lincolnshire

Stakeholder	Follow-up meeting / briefing
Senior Leaders Group: Northern Lincolnshire	2 November 2022
Questions Received	**Response**

North East Lincolnshire is broadly supportive but is concerned with respect to sovereignty and in particular how to maintain the best deal for the North East Lincolnshire population.	Under the Group leadership model, whilst as much decision making as practicable will take place through a 'committees in common' (joint) approach, individual Boards will retain full decision making rights over decisions relevant to the individual Trust, ensuring the retention of sovereignty and accountability.
This is a natural development for efficient and sustainable services.	Comments noted.
Glad it's Group, not merger.	Comments noted.
Is this on the road to merger? If so, that would cause alarm bells.	This is not a merger. The option of merger was considered but discounted; not least as evidence from other organisations which have moved to the Group model suggests it is possible to deliver substantial benefits from collaboration and scale, relatively quickly but without the costs, timescales and disruption associated with a merger.
What are the implications for HASR?	This detail is still to be worked through.
Senior leaders in the new Group are going to have to look in multiple directions at once across the ICS. How do you ensure they have the capacity to do this and deliver adequate local focus?	This detail is still to be worked through.
Glad it maintains a Board on the south bank. However, would a Joint Quality and Safety Committee have too big a task to do?	This question will be considered as part of the development of the Group governance arrangements.
In our local authority there is no large political voice saying No – but nor is there a large political voice saying Yes.	Comments noted.
How will the Group relate to four competing democratic voices?	This detail is still to be worked through.
Why not a merger? Would it become a merger later? Have other Groups gone into merger?	As above, there are no plans for a merger. The option of merger was considered but discounted; not least as evidence from other organisations which have moved to the Group model suggests it is possible to deliver substantial benefits from collaboration and scale, relatively quickly but without the costs, timescales and disruption associated with a merger.
The primary issue is about services and access and the quality of those services. How will the Group ensure these are protected and enhanced?	Under the Group leadership model, whilst as much decision making as practicable will take place through a 'committees in common' (joint) approach, individual Boards will retain full decision making rights over decisions relevant to the individual Trust, ensuring the retention of sovereignty and accountability and responsibilities for access and quality.

	It is anticipated that access and quality will be further enhanced through the opportunities created by strengthened collaboration.

Partner Organisations

Notification of the proposal to move to a Group leadership model was also sent to the following partner organisations.

ICB

ICB, Chair
ICB, Chief Executive
ICB, Director of Communications
ERY Place Director
NEL Place Director*
NL Place Director*
Hull Place Director

**included in Northern Lincolnshire Senior Leaders Group*

NHSE

NHSE, Regional Director NE&Y
NHSE, Associate Director of Communications

CQC

CQC: Hospital Inspection Directorate, North Region

Other Healthcare Partners

Lindsey Lodge Hospice, Chief Executive
Care Plus Group, Chief Executive
Senior GPs, North East and North Lincolnshire*

Doncaster and Bassetlaw, Chief Executive
St Andrew's Hospice, Chief Executive
RDASH, Chief Executive
Focus, Chief Executive
Navigo, Chief Executive
Navigo, Director of Mental Health
United Lincolnshire, Chief Executive
Harrogate, Chief Executive
York, Chief Executive
Humber Teaching, Chief Executive
EMAS, Chief Executive
YAS, Chief Executive
HYMS, Dean
Healthwatch
Lincolnshire Community Health Services NHS Trust, Chief Executive
Lincolnshire Partnership NHS Foundation Trust, Chief Executive
Lincs ICB, Chief Executive
St Hugh's Hospital, Chief Executive
NHS England, Chief Nurse
NHS England, Tim Savage
NHS England, Chief Medical Officer
NHS England, Director of Elective Care Transformation
NHS England, Daniel Hartley
NHS England, Patient and Information

**included in Northern Lincolnshire Senior Leaders Group*

APPENDIX B

Proposal to Move to a Group Leadership Model: Risks & Mitigations

There are a number of risks to the successful delivery of this programme of work. These are set out below with key mitigations.

Risks	Mitigations
Pre-implementation	
There is a risk of instability of leadership and loss of key resources and expertise. There is also a risk that key individuals will be less engaged in the process.	The new Group Chief Executive will lead on the appointment of the Executive Team. Implementation of the group structure will include consultation and engagement with those most directly affected by the change. This has and will include regular briefings as well as 1:1 discussion with the Chair and Vice Chairs ahead of the appointment of the joint Group Chief Executive. This will facilitate the identification of any key personnel / Trust risks prior to the finalisation of the structure and commencement of consultation. The process for appointment to the executive leadership team is currently being developed for agreement with the joint Group Chief Executive, once appointed, but it is anticipated that these posts will be ringfenced in the first instance.
There is a risk of internal and external stakeholder concern about the formation of a group model.	The move to a group model has the support of the ICB and NHSE. The outline of the direction of travel has been formally submitted to the ICB. There has been a 21-day period of engagement with key internal and external stakeholders and the feedback will help to shape the proposals. Feedback has been broadly supportive to date although questions have been asked and further assurance requested in respect of some aspects of the proposal. Key themes from the feedback include:

	• equity of access and care for patients across both Trusts; • perceptions of a HUTH takeover; • whether the proposal is a merger or will lead to a merger eventually; • whether the proposed move to a Group leadership model will lead to job losses / redundancies; • retention of organisational sovereignty and identity. As part of the above engagement, the NLaG Council of Governors has been briefed on the proposed direction of travel and in respect of the joint Group Chief Executive appointment process. (For NlaG as an FT, there is a requirement for the governors to approve the appointment at the first general meeting after the appointment.) The detailed Case for Change proposal sets out the clear clinical benefits of collaboration and the opportunities to build on the 'best of both' Trusts. These messages have been reinforced through the stakeholder communications. The Case for Change is due to be considered for approval by both Trust Board on 14 November 2022. Once a final decision has been made, the final Case for Change, response to feedback and next steps will be shared with all stakeholders. There will be ongoing communication as the project progresses.
There is a risk of lack of clinical support for the proposal. This includes the specific concerns which exist regarding perceptions of a HUTH takeover and a loss of the NLaG voice which it is felt has the potential to adversely impact on the quality of care and services to patients on the south bank.	As above. Specific engagement events have and are being held with clinical colleagues. Under the Group leadership model, whilst as much decision making as practicable will take place through a 'committees in common' (joint) approach, individual Boards will retain full decision making rights over decisions relevant to the individual Trust, ensuring the retention of sovereignty, identity and accountability. The

	operating model and governance arrangements will be designed to ensure an equal voice from both Trusts. The organisational development (OD) and change process referred to later is also key to addressing this concern.
There is a risk of not appointing to the new Group Chief Executive role or that the timescale becomes prolonged due to the need for the required approvals.	Recruitment Consultants have been recruited to support with the Chief Executive recruitment process which will be through open competition. Initial discussions have been held with NHSE and the ICB who are supportive of the proposed direction of travel. Initial discussions have also been held with NHSE regarding the recruitment process and the salary range for the joint Chief Executive post. Internal Remuneration Committee approval is also being sought. The briefing to the CoG included details of the recruitment process ensuring their engagement in the process.
There is a risk that the cultural changes required to ensure the successful move to a Group leadership model will not be made and sustained without a robust OD and change process.	The OD and change process required to ensure the successful move to a Group leadership model will be a key workstream of the project implementation plan. This will be a key focus for the Joint Group Chief Executive once appointed and will be a medium to long term piece of work. External support will be sourced, where required, to ensure that the required cultural changes are sustained.
Post-implementation	
There is a risk that the implementation of the group model is impacted by or impacts upon: - performance - operational pressures including winter - strategic priorities	The intention of leaving some flexibility in the timing of implementation commencing is to ensure that strategic and operational pressures can be taken into account. The change management approach and implementation plan will ensure there is opportunity for structured handover where leadership responsibilities change. In respect of the CQC, publication of the NLaG report is expected in December 2022 i.e. before implementation of the Group leadership

- HASR - publication of NLaG CQC inspection report - publication of the HUTH CQC report	model. No date has yet been confirmed for the publication of the HUTH CQC report. In respect of HASR, this has been delayed from November 2022 to May 2023. The development of the new operating model will need to be aligned to the developing responsibilities of the Humber and North Yorkshire Acute Collaborative.
There is a risk that the complexity of Group governance structures and arrangements impacts the delivery of the benefits of collaboration or the operational management of either Trusts' services or the delivery of major strategic initiatives.	Work will continue following Board approval of the Case for Change and as the project progresses to understand other Group models and the applicable learning. On appointment the joint Chief Executive will lead on • finalisation of the full business case for the move to a Group model; • shaping the Executive Team and new Group operating model including governance / decision-making structures, building on proposals put forward through the project; • leading the implementation of the move to a Group model. External governance support has been sought to support the two Trusts with the changes although the involvement of the relevant staff from both organisations will be critical to the development of options as to what these new arrangements might look like. As above, the joint Group Chief Executive, once appointed, will then lead on this work. Implementation of the Group operating model will require robust clinical engagement and support to ensure the clinical benefits are realised.
There is a risk that the move to a Group leadership model will lead to a loss of sovereignty and identity.	Under the Group leadership model, whilst as much decision making as practicable will take place through a 'committees in common' (joint) approach, individual Boards will retain full decision making

	rights over decisions relevant to the individual Trust, ensuring the retention of sovereignty, identity and accountability. In respect of NLaG, the Council of Governors and trust members will remain an essential part of the governance & assurance framework.
There is a risk of the two organisations being too internally focussed; the sustainability of both requires a greater understanding of population health trends in the medium-long term.	The two Trusts will continue to work in collaboration with wider system partners to ensure a greater understanding of population health trends and needs.