North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Extra Ordinary Meeting in Common Between the Board of Directors of North Tees and South Tees NHS Foundation Trusts held in Public

Wednesday, 29 November 2023
at 12.30pm

Acklam Green Centre
Stainsby Road, Acklam, Middlesbrough, TS5 4JS

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

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AGENDA

	ITEM	LEAD	FORMAT	TIME
1.	Lunch	Chair		12.30
2.	Welcome and Introductions	Chair	Verbal	13.00
3.	Apologies for Absence	Chair	Verbal	13.05
4.	Quorum and Declarations of Interest	Chair	Enclosed	13.05
5.	Partnership Agreement	Associate Director of Group Development	Enclosed	13.10
6.	Close			13.55

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Extra Ordinary Meeting in Common Between the Board of Directors of North Tees and South Tees NHS Foundation Trusts Held in public

Title of report:	Partnership Agreement									
Date:	29 November 2023									
Prepared by:	James Bromiley, Associate Director of Group Development									
Executive sponsor:	Neil Atkinson, Managing Director, NT&HFT Rob Harrison, Managing Director, ST&HFT									
Purpose of the report	The Joint Partnership Board (JPB), which is a joint Committee of the Board of Directors for North Tees & Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, approved the draft Partnership Agreement for wider engagement on 20 September 2023, following which a report was shared with JPB on 15 November 2023 setting out the feedback to date and the final drafted agreement for approval.									
Action required:	Approve	x	Assurance		Discuss	x	Information			
Strategic Objectives supported by this paper:	Putting our Population First		Valuing People		Transforming our Services		Health and Wellbeing			
Which CQC Standards apply to this report	Safe		Caring		Effective		Responsive		Well Led	

Executive Summary and the key issues for consideration/ decision:

North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust have agreed to adopt a group model working within the wider health system of the Integrated Care System for North East and North Cumbria. A Partnership Agreement has been developed setting out how it intends to work and the benefits of the Group model for the population.

The JPB met on 15 November 2023 to consider the Partnership Agreement following a period of drafting and engagement with colleagues, stakeholders and partners and agreed to recommend its approval by the two statutory boards.

The Partnership Agreement is a formal statement of commitment on behalf of three parties: North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust; and NHS North East and North Cumbria Integrated Care Board (ICB). It builds on considerable work over a number of years to strengthen collaboration between the Trusts on a range of activities with the aim of improving care and outcomes for patients and the wider communities which the Trusts serve.

There has been appropriate levels of engagement, drafting and consideration by legal advisors.

Board Assurance Framework/Corporate Risk Register risks this paper relates to:			
Agreeing the partnership agreement will enable onward progress towards achieving the proposed timescales for the Group.			
Does the report impact on any of the following areas *(please check the box and provide detail in the body of the report)*			
Equality, diversity and or inclusion	x	Reputational	x
Workforce	x	Environmental	x
Financial/value for money	x	Estates and Facilities	x
Commercial		Compliance/Regulatory	
Quality, safety, experience and effectiveness	x	Service user, care and stakeholder involvement	x
Board Subcommittee meetings where this item has been considered (specify date)		Management Group meetings where this item has been considered (specify date)	
Joint Partnership Board: • 20 September 2023 • 15 November 2023			
Recommendation	The Board of Directors are asked to agree the Partnership Agreement		

Partnership Agreement

1. Overview and Introduction

1.1 This partnership agreement is a formal statement of commitment on behalf of three parties: North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust; and NHS North East and North Cumbria Integrated Care Board (ICB). It builds on considerable work over a number of years to strengthen collaboration between the Trusts on a range of activities with the aim of improving care and outcomes for patients and the wider communities which the Trusts serve. The Trusts have now agreed to adopt a group model working within the wider health system of the Integrated Care System for North East and North Cumbria and this Agreement is key to defining the implementation of that model. The Agreement's purpose is:

1. To set out the design of the operating model for the Group and a plan for the governance and resourcing arrangements which will enable its success;
2. To agree the priorities to be progressed during the coming months and a roadmap for the implementation and launch of the group model;
3. To signal a willingness to continue to strengthen the collaboration through further collaborative working, recognising that the development and implementation of the group model will need to be an iterative process.

1.2. All parties agree that there are major benefits from the effective implementation of greater collaboration to help to address deep-rooted health issues in the population served by the Trusts. The Tees Valley has a higher than average prevalence of chronic disease and the high demand for services to tackle these issues is likely to be exacerbated by a demographic shift over the period to 2040, through which the over 65 population of the Tees Valley increases while the under 65 population decreases in absolute terms[1].

1.3 High levels of deprivation and major social and economic variations including a scarcity of quality employment for some in the area drive health inequalities and demand for services in the Tees Valley and parts of County Durham and North Yorkshire. All Tees Valley local authorities are more deprived than the national average and there are stark differences across the Tees Valley and within individual boroughs. Given that there is a clear link between higher levels of deprivation and higher levels of poor health and preventable mortality, these overall levels of deprivation and the variation across the Tees Valley and beyond create a complex pattern of demand for hospital and community services.

1.4 By working collaboratively the parties will be better able to address these high and varied levels of demand and the Trusts' ability to meet the needs of the shared population will improve. The principle of the Trusts working together is already well established over a number of years and across many specialties.

[1] ONS quoted in the Tees Valley Economic Assessment 2022

1.5 The group model will enable the parties to develop the capability and capacity to deliver a significant strategic transformation and realise the benefits of collaboration. The benefits of deepening collaboration include, but are not limited to:

- Better tackling endemic health issues by collaborating on solutions;
- An unwavering focus on quality (by which we mean patient safety, clinical effectiveness and patient experience) supported by joining up our practices and systems;
- Delivering high quality and sustainable services, improving through learning and increasing resilience;
- Creating a stronger single and coherent voice for communities which is more influential regionally and nationally;
- Maintaining and enhancing local access to key services by making the most of the whole estate and greater integration with partners;
- Maximising the collective power of the existing and future workforce and providing enhanced career possibilities for our staff;
- Growing and developing our own health care workforce (doctors, nurses, AHPs, managers etc.) by close working with local secondary and tertiary education providers, and strengthening our research capacity;
- Addressing disparities in care by adopting joint models to ensure better outcomes; and
- More efficient and resilient corporate services.

1.6. In determining the best structure to enable enhanced collaboration, a range of potential models were considered and the Trusts agreed to adopt a group model, in which each organisation retains its statutory accountabilities, but there is a shared leadership structure, with shared clinical services, culture and practices. This reflects a new stage of maturity in the collaboration between the parties as it has evolved and the critical factor in the decision has been to adopt the structure which can best benefit patient care and the wider population. The Trusts also recognise their key role as leaders across the health care system within the Integrated Care System and believe this too can best be delivered through the adoption of a group model. The group operating model is described in more detail in 2.1 below.

1.7 This Partnership Agreement builds on several years of progressively greater collaboration between the parties which has been reflected in governance changes. A Memorandum of Understanding setting up a Joint Strategy Board, later renamed the Joint Partnership Board (JPB) was signed in May 2021; and a Joint Chair was appointed across the two Trusts. In October 2022 the JPB was established as a Single Joint Committee able to make legally binding decisions; and a revised Terms of Reference was agreed, delegating specific matters from the Trust Boards. In late 2022 the North East and North Cumbria ICB commissioned an external independent strategic review to take stock of progress on collaboration and this review made recommendations on how to deepen the collaboration. In 2023 the Joint Partnership Board agreed to adopt a group model and to push forward with a programme of work to deliver that model.

1.8 Since the agreement to move forward with a group model, work has been underway to design the specific form of that model for the Trusts. During this phase there has been engagement with clinical leaders and external partners, recognising that a joint clinical strategy lies at the heart of the success of the group model and that effective outcomes often rely on joint working with external partners. That level of engagement will intensify throughout the programme through:

- Multi-channel communications with our staff to seek input;
- Ongoing discussions with partners in other NHS Trusts, in particular County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust; primary care; local authorities; and the voluntary sector; and
- Regular two-way feedback with patients and the wider population, including via the Councils of Governors.

1.9 With the approval of this Agreement the priorities for action within the next phase of the Group's development will be initiated. Subject to progress with these key priorities in the coming months, these will enable the Group to be established during quarter 1 2024/25. It is proposed that the JPB regularly reviews progress in the delivery of the priorities during the mobilisation phase to determine the specific timeline for launch of the group model. We recognise that the programme of work will be an iterative process and we will continue to look for more opportunities to strengthen and deepen our collaboration.

1.10 The parties have agreed a set of principles which define the work of the Group:

- The very best care for everyone
- Equity of access for services[2]
- Respect, compassion and dignity in everything we do
- Learning from all, everyone counts
- Improving lives by working together across Tees Valley and parts of North Yorkshire and areas of County Durham – Peterlee, Easington and Sedgefield
- Using all possible resources effectively and efficiently

These principles both describe the shared values which we expect all staff to demonstrate and also the objectives we hold in delivering the programme.

2. Group Operating Model

2.1 The Trusts shall implement their group operating model by exercising their powers under sections 65Z5 and 65Z6 of the National Health Service Act 2006 to extend the functions that are exercisable jointly with each other and to authorise their Joint Partnership Board (being a joint committee) to exercise such functions in accordance with updated terms of reference that they shall each approve. The group operating model will provide the organisational structures and governance necessary for the Group to operate efficiently and effectively and deliver the Group's strategic ambitions for patients and the wider population. It will also ensure that we maintain proper accountability for our performance and finances, both at a Group level, and where it remains necessary, at a Trust level.

2.2 The Trusts shall report and be accountable operationally and financially as follows:

- The Trusts shall continue to report and be accountable operationally and financially as separate corporate bodies
- Additionally the Trusts will commence reporting in shadow form on a Group basis
- Subsequently, subject to the agreement of the ICB and NHS England, the Trusts will move to a position where they report on a Group basis and are accountable operationally and financially at a Group level rather than as individual Trusts.

[2] Including compliance with the Equalities Act 2010 and associated legal framework

2.3 The Trusts have agreed the following key components of the group operating model:

- Group leadership: board arrangements and executive capacity/capability;
- Clinical teams to develop clinical strategy and transformation;
- Site leadership teams responsible for operational delivery; and
- Corporate services supporting the Group, site and clinical leadership.

2.4 In the process of developing the group operating model a range of design principles have been applied:

- A clinically-driven "Patient First" ethos whereby patients are at the heart of what we do;
- Strategic decision-making which reflects the overall benefit of the Group rather than its component parts;
- A capable distributed leadership model to enable clinical transformation;
- A need to ensure statutory and regulatory requirements continue to be met;
- Form follows function in the design of structures;
- We should start from existing organisational structures in order to retain stability and talent within the Trust structure;
- We avoid duplication and ensure efficiency through clarity of roles;
- We provide enough capacity at Group level to drive strategy;
- A matrix structure in which all senior roles have responsibility and accountability for Group strategy and performance;
- We retain a place-based focus into the communities we serve; and
- Cost effectiveness and potential for efficiencies.

Board Arrangements

2.5 The aim of the group leadership structure will be to provide effective strategic leadership, accountability and oversight of the group model. It will be headed by the Joint Chair, a role which has been in place since 2021. The Trusts have recruited a Joint Group Chief Executive to lead the executive team.

2.6 The Trusts are standardising their committee structures and as part of the move to a group model have agreed to adopt a Group Board structure with all decisions and accountability that can be delegated flowing through the Group Board and its joint committees. The Trusts intend to review and revise their constitutions as necessary to allow these changes during the mobilisation phase, subject to the approval of the Councils of Governors.

2.7 Where joint committees are not currently permitted by legislation and a separate committee is required for each Foundation Trust (for Audit, Remuneration and Charitable Funds) these committees will meet as Committees in Common.

2.8 The composition of the Group Board will ensure that it meets all statutory requirements and the principles of good governance while being as efficient as possible.

2.9 The intention wherever possible will be for Non-Executive roles to be held jointly with both organisations making simultaneous appointments. Non-Executive roles will hold responsibility for engagement with specific place-based communities.

2.10 There will be a transition plan in place to move to a revised Group Board structure during the mobilisation phase and ahead of the formal launch of the Group, subject to the agreement of NHS England and the ICB.

2.11 With their agreement the intention is that the Councils of Governors for each Trust will normally meet as Committees in Common, with separate meetings by exception, and the nominations committees will also do so. The Councils of Governors has a key role in many of the proposed changes, for example in having approved the appointment of the Group CEO and in appointing and continuing to hold Non-Executive directors to account.

Clinical Leadership

2.12 Clinical leadership will play a key role in the emerging Group – both to drive clinical strategy and ensure delivery of high quality clinical services. Clinical leadership will be provided by a series of clinical boards which will be responsible for leading transformational change in a range of agreed specialities. The proposed clinical boards and a Clinical Strategy Council will sit centrally in the group operating model, with the Clinical Strategy Council reporting directly to the Group Executive and clear delegated accountabilities. It is vital that there is a strong connection between senior clinicians leading clinical transformation, the Group Executive and the Group Board.

2.13 Clinical boards will be led by triumvirates (Medical, Nursing or Allied Healthcare Professional, and General/Operational Manager) and chaired by a clinician; all drawn from the two Trusts. Clinical boards may also include external clinical expertise for example drawn from primary care. Clinical boards will have dedicated support from corporate services including HR and business intelligence which is aligned across the Group to support effective decision-making and operation.

2.14 The Clinical Strategy Council (chaired by the Chief Medical Officer) will oversee and drive the development of the overarching clinical strategy and ensure coherence across clinical boards as well as wide engagement with clinical leaders. This is critical to ensure that the strategy can then be translated into local operational implementation. This Council will draw its membership from clinical leaders across both organisations, the Group Executive and site leadership teams and be accountable to the Group Executive.

2.15 To realise the benefits of working as a Group, we need to ensure a safe transition. We are therefore, initially at least, keeping the current Care Group structure at North Tees and the Collaboratives structure at South Tees.

2.16 The clinical strategy is described in more detail at 3.1.

Group and Site Leadership Teams

2.17 Group and Site Leadership teams, each with clearly defined responsibilities, will together provide the strategic, oversight and operational capabilities to drive improvement. The Group director team (led by the Group CEO) will develop a range of enabling strategies (including quality, people, estates, digital, finance and communications) to support delivery of the clinical strategy. It will hold executive accountability for the Group on behalf of both Trusts and will be responsible for driving performance across the Group. The Group director team will also be the ‘guiding mind’ to ensure that effective executive governance arrangements are in place and working well.

2.18 It is proposed that in place of executive director posts for each Trust the following executive posts will be at Group level and sit as members of the Board:

- Group CEO
- Chief Medical Officer
- Chief Nursing Officer
- Chief Finance Officer
- Managing Director North Tees and Hartlepool
- Managing Director South Tees
- Chief People Officer
- Chief Strategy Officer

2.19 The following roles will also sit at group level but will not be members of the Board:

- Director of Estates
- Chief Information and Technology Officer
- Director of Communications
- Board Secretary

There may be further roles designated as Group roles in due course.

2.20 Site leadership teams will be responsible for delivery (quality, performance, operations and finance). Site leadership teams will need to work effectively within agreed group governance arrangements and will contribute significantly to strategic development and delivery. These teams will initially reflect existing Trust arrangements in order to maintain stability, but the roles will both be responsible for their own areas and expected to make a wider contribution to the Group. Each site team will be led by a Managing Director, who will be a voting member on the Group Board and will also be personally accountable for a Group-wide strategic activity or function.

2.21 There will be site director roles reporting to the site Managing Director. These will consist of medical, nursing, allied health and operations leadership roles. Proposals for specific site director roles will be developed and will reflect the operational requirements of each site. Site leadership teams will also play a key role in working with local system partners in local place-based partnerships and in our communities.

2.22 Clinicians will be involved in due course to assess the feasibility of alignment of collaborative/ clinical directorate structures and leadership arrangements in each site. This will evolve over time to determine how best to connect Group and site clinical leadership arrangements in an effective matrix structure.

2.23 In the next phase of detailed design of the executive governance structures, roles and responsibilities, it will be critical to articulate the respective functions of the Group and site arrangements. There will need to be clarity about the value of the Group Executive structure, that there is no duplication in roles and that the aggregate value of the matrix (Group and site) is capable of addressing the significant strategic agenda ahead as well as ensuring effective operational delivery.

Corporate Services

2.24 Effective corporate services are needed to support the Group to achieve its goals, with each service being designed to provide capable leadership operating at scale and working effectively within Group and site structures.

2.25 All corporate services will move towards joint service provision with a single strategy and single responsible director. Each Group director will be responsible for the developing plans for the transformation of corporate services and we will instigate an overarching programme for the work to be taken forward.

2.26 The delivery model will vary between these enabling services, with a combination of centralised Group functions designed to benefit from economies of scale; business partnering from embedded teams using an agreed framework; and functions devolved to a trust level but with professional oversight at a group level.

2.27 The delivery strategies setting out initial plans for the transformation of each corporate service are described in more detail in 4.1.

Further development

2.28 These outline proposals for the group operating model will inform the development of the detailed governance arrangements and operating structures during the mobilisation phase. We envisage that these detailed proposals will be developed by January 2024 subject to the feasibility of the Group CEO engaging in this prior to starting in role. Their input will be crucial in finalising these proposals. This will then be followed by a formal consultation period and agreement to a firm implementation plan and timescales.

3. Clinical Strategy

3.1 The joint clinical strategy is at the heart of this Partnership Agreement. Its clear aim is to improve patient care and the health outcomes for the wider population through the transformation of clinical practice by both Trusts working together in a single integrated model. It will be developed by our experienced clinical teams of doctors, nurses, Allied Health Professionals and scientists in conjunction with our patients and colleagues in primary care, local authorities and the voluntary sector.

3.2 Key transformation priorities will be to ensure we deliver high quality and accessible services; to reduce unwarranted variation in outcomes; to make our Group a great place to work and address workforce challenges; and to achieve financial efficiency.

3.3 In delivering this transformation we will adhere to the following principles:

- The primacy of quality in all we do;
- Care will be provided as close to home as possible, whilst ensuring it is clinically effective and appropriate to local population needs;
- Prevention and early intervention must be supported across health and social care;
- We will support partners to ensure every child has the best possible start in life;
- The maintenance of strong community services focussed on prevention, admission avoidance and early discharge; and the specific needs of frail elderly;
- Mental health and well-being must be considered equal to physical health needs;
- There should be strong collaboration across health and social care, including sharing information;
- Evidence-based and best practice healthcare provision, avoiding unnecessary duplication, to promote a consistent standard of access across the Tees Valley;
- Single, unified referral, treatment and discharge planning;
- Equity of access and outcomes across the Tees Valley; and

- Provision of high quality specialist and tertiary services for the local and regional population which we serve.

3.4 Our joint clinical strategy will be strongly aligned to the ICB clinical strategy as it is developed and we will play a full role in helping to develop the strategy for the wider system. The clinical strategy sees the system as whole and looks widely across the Tees Valley and beyond and to partners as well as the Trusts. There are three key supply-side drivers:

- The need to establish clinical sustainability, given the increased demand and increased complexity;
- Improving recruitment, retention and career routes for our staff, and tackling shortage areas, by making our Group an employer of choice; and
- Ensuring long-term financial sustainability by making our Group's practices efficient while demonstrating the impact we can have with a fair share of funding allocation.

3.5 The strategy will be a live document which will evolve and develop over time so that more specialties are brought within a truly collaborative model.

3.6 While the ultimate aim of the clinical strategy is that it will cover all specialties, our initial proposal is that we will focus on the following strategic priority areas where we can drive rapid service transformation:

- Medicine – with a focus on optimising operation pathways and Urgent and Emergency Care flow;
- Urgent and Emergency Care – given the key drivers of the national focus on the new 4 hour target and ambulance handover delays, and the local development of a revised UTC model in our Group;
- Community Services and virtual ward – as a key plank of our winter plan and support for acute hospital decompression as well as an enabler of further acute service design;
- Surgery and elective recovery – as a key national target with a major clinical need along with the potential financial benefits of bringing work back from the independent sector;
- Women and children's services – with the major national focus on maternity services and the clinical benefits of paediatric service redesign; and
- Diagnostics, including the development of the joint Community Diagnostic Centres.

3.7 For each of these strategic priorities (and in due course extending to all clinical areas), a clinical board will be formed and appointments made via an open and transparent process to the triumvirate leadership roles (Medical, Nursing or Allied Healthcare Professional, and General/Operational Manager) with a chair appointed from among that triumvirate. The clinical board will have responsibility for developing strategy in each clinical area and identifying the clinical pathways for initial review, with subsequent proposals for service transformation. Where appropriate boards will involve external partners (e.g. the Community Services board could include representatives from primary care, social care and the voluntary sector). The intention is for the six priority clinical boards to be operational by Q4 2023/24.

3.8 The Clinical Strategy Council will be responsible for the development of the clinical strategy and will oversee the work of the clinical boards. It will also ensure that there is a strong connection between senior clinicians leading clinical transformation, the

Group executive and the Group Board. This distributed leadership model will ensure that the clinical transformation is successful.

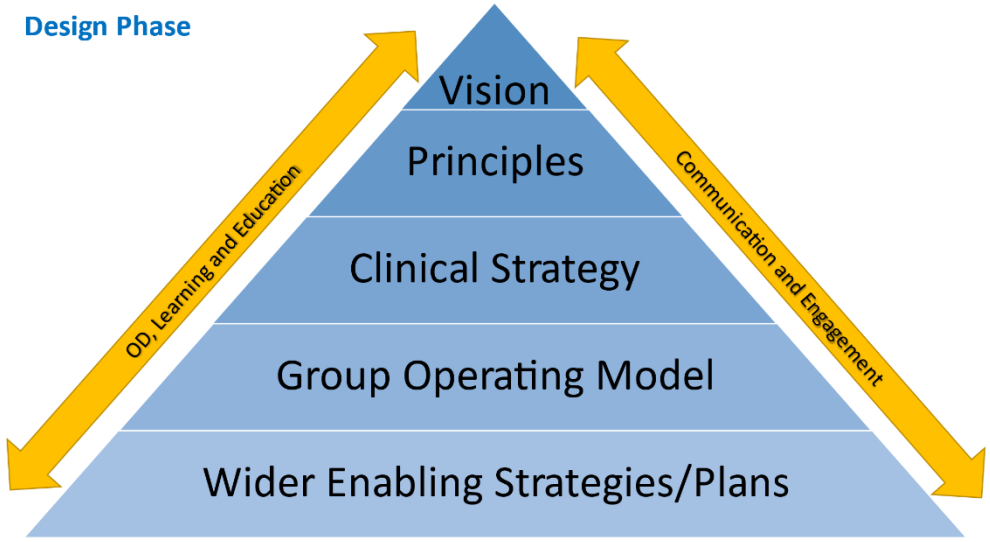
3.9 The clinical boards will delegate operational responsibility for subsequent delivery of any agreed pathway changes to relevant clinical teams (Collaborative Boards and Care Groups) and site teams, but have a continued oversight and assurance role for programme.

3.10 There is a high level of interdependence between the clinical strategy and corporate services which will support clinical transformation. In principle the requirements of the clinical strategy drive the transformation of corporate services, although a review of corporate services may create additional opportunities which had not been envisaged. For example, the availability of spare clinical estate may mean that the transformation of certain clinical services are prioritised. We will continue to map and work through these interdependencies throughout the delivery of the programme.

4. Delivery Strategies

4.1 The Group will need to develop a suite of strategies to enable delivery of the clinical strategy, to secure greater coherence for the Group and to maximise the use of all available resources so that they drive efficient and effective services. These strategies will include quality, people, estates, digital, finance and communications.

A visual representation of this approach is set out below.



4.2 These enabling strategies will set out the ambition to be delivered in the coming 3-5 year period and will identify priority programmes of work required to progress the strategic goals. They will be informed by the emerging priorities of the clinical strategy and by an appraisal of strategic challenges and opportunities facing the Group.

4.3 Group directors (when appointed) will be responsible for the development of these strategies.

4.4 As they take forward these strategic priorities, Group directors will also lead the work to develop plans for the integration of corporate services across the Group and will ensure that these arrangements provide the capacity and capability required to develop and deliver these enabling strategies in the future.

4.5 Set out below is an initial description of the purpose of the specific delivery strategies. These strategic goals will continue to iterate in the coming months, together with greater clarity on priority programmes of work that will be needed and also opportunities for more immediate 'just do it' actions to be agreed.

Quality Strategy
To ensure that our patients, across the Tees Valley and beyond, receive the same standard of high quality and safe care, no matter which care setting they attend. We will achieve this through the development of a collective quality strategy, delivered through joint governance arrangements. The emphasis will be on ensuring that the care and treatment we provide is founded on best practice and evidence with a focus on excellence in patient safety and experience, leading to optimal outcomes for our patients.

People Strategy
To develop the future workforce necessary to deliver the clinical strategy and enable the Group to be an employer of choice (through innovative and inclusive HR practice). It will focus on substantive recruitment (reducing reliance on temporary staffing and addressing key shortfalls); developing the Group training and education 'offer' and creating the conditions for an inclusive culture to thrive through a unified approach to organisational and leadership development. Policies will be aligned and will reflect best practice.

Estates Strategy
To develop ambitious plans for improving the condition and utilisation of the estate; specifically developing plans for the North Tees hospital site (in view of the existing infrastructure challenges). It will initially review utilisation of the estates and develop future plans, aligned to the priorities of the clinical strategy.

Digital Strategy
To unify the digital infrastructure across the Group to enable the delivery of high quality patient care across all clinical services. Plans will be developed to secure interoperability across existing EPRs in the short term pending delivery of the long term single digital solution.

Finance Strategy
To create financial sustainability for the Group. There will be close alignment with the clinical strategy and the enabling strategies to assess the opportunities for best use of financial resources, reduce duplication and secure inward investment (e.g. capital resources and resources linked to structural debt).

Communications & Engagement
To ensure that an intensive and ongoing communications and engagement approach is in place with the local population, patients, staff and stakeholders that demonstrates an open and inclusive culture and places value on partnerships.

4.6 In the engagement sessions we have held with clinicians and wider staff groups two priority areas were clear. First, making progress on a Group digital strategy so that barriers to working across sites and sharing necessary clinical data were reduced; and

second the importance of considering workforce issues. As a result of this feedback, these strategies will be accelerated.

5. Roadmap to the launch of the group model

5.1 The outputs of the initial design phase of the group model have been incorporated into this partnership agreement. Progress has been made in developing the outline group operating model, plans for clinical leadership arrangements to lead the clinical strategy and transformation and proposals for the further development of key enabling strategies. This has been achieved by the Joint Partnership Board, clinical leaders and the ICB working together to shape the future of the group model and agree early priorities.

5.2 This section of the partnership agreement describes how further progress will be made during this next 'mobilisation' phase. Subject to progress in the coming months, it will be feasible for the group to be launched in the early part of 2024/25. A small core team is in place to direct the development programme, led by the Associate Director of Group Development. Joint resources are already committed to the programme and should specific priorities require further resourcing, proposals will be brought to the JPB for approval. Executive directors and their teams are also working together increasingly on agreed joint priorities.

5.3 The Group development team brings executive directors and ICB representation together to provide executive leadership and is co-chaired by the Managing Directors. The JPB provides board direction and oversight and also includes ICB representation. These arrangements will continue through the mobilisation phase and will in due course be superseded by the new group governance model.

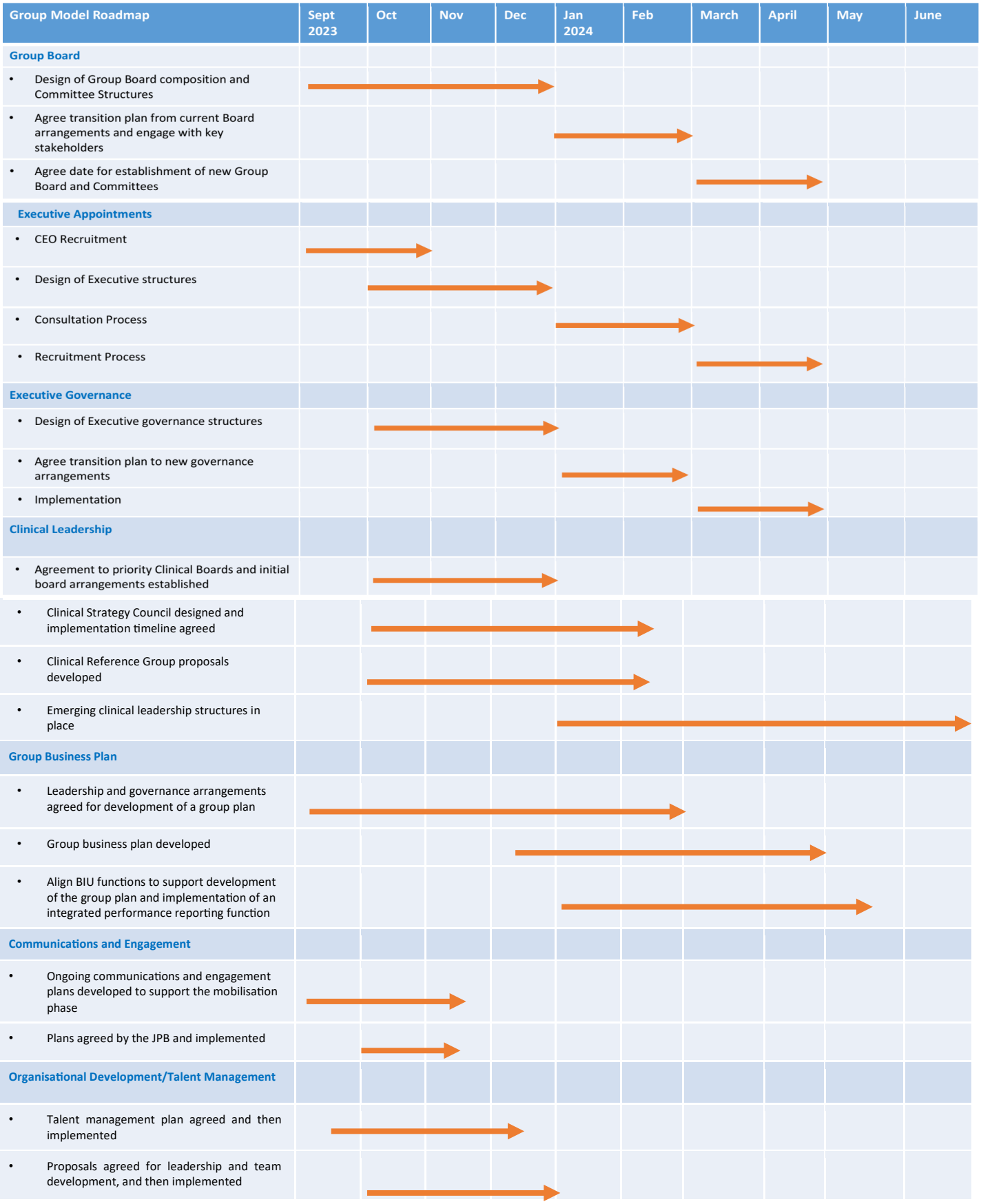
5.4 It is proposed that the following components of the operating model should, as a minimum, be in place ahead of the launch of the Group. These combine to provide a coherence to the Group and ensure that the necessary leadership and governance arrangements are established to lead strategic transformation and ensure robust operational delivery.

- New Group board and committee arrangements in place
- Key Group and site directors appointed following recruitment of Group CEO
- Executive governance arrangements in place
- Priority clinical boards and clinical strategy council established
- A Group business plan for 2024/25 in place

5.5 These key priorities inform the Group development programme in its mobilisation phase. This is set out in the roadmap below, which outlines the forward plans over the coming months and will be reviewed regularly by the JPB. A communications and engagement plan will be developed to ensure that the development programme progresses in an inclusive and transparent way, involving all key stakeholders. An effective organisational development plan will also be needed, focused on ongoing leadership and team development and talent management i.e. coaching support for staff impacted by these organisational changes.

5.6 Roadmap

Fig 1: Roadmap to the launch of the Group Model



6. Conclusion

6.1 This Partnership Agreement sets out a formal commitment by all parties to work towards the launch of a group operating model in Q1 24/25 to deliver the many benefits for our patients, staff and the wider population the Trusts serve. It has been developed through the dedication of staff, who have often been doing this work alongside other priorities; the boldness shown by the Boards of both Trusts in driving towards a new future; and the engagement of all our partners who are critical to the success of the transformation envisaged. The Trusts are grateful to the ICB for their support and direction throughout.

6.2 All parties recognise that circumstances are very likely to mean changes to the specifics of the Agreement but this does not dilute the clarity of vision and determination to deliver the benefits of the collaborative approach. Following the approval of the Agreement we will move to initiate the changes, and accelerate those changes already underway. Alongside that we will intensify our efforts to listen to our staff, patients and external partners to ensure that the clinical transformation the heart of this Agreement is successful.

6.3 As well as the initiation of change, the mobilisation phase will also include full programme planning with an increased level of detail and documentation. The Joint Partnership Board will continue to review progress on the implementation of the Agreement on a monthly basis and hold action owners to account to ensure that the programme is delivered.

6.4 While it is clear that there is much to do, we believe firmly that the future health of the people of Tees Valley and beyond will be transformed by the path this Partnership Agreement sets out.

This Agreement is signed on behalf of the three parties:

Professor Derek Bell OBE
Joint Chair
South Tees Hospitals NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust

Professor Sir Liam Donaldson
NHS North East and North Cumbria ICB[3]

[3] As host ICB for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust