Chelsea and Westminster Hospital NHS Foundation Trust Extraordinary Board of Directors Meeting

22 July 2022 16:00 - 22 July 2022 17:00

AGENDA

#	Description	Owner	Time
1	GENERAL BUSINESS 1.0 Extraordinary Board Agenda 22 July 2022.doc 5		
1.1	Welcome & Apologies for Absence Verbal	Chair	16:00
1.2	Declarations of Interest Verbal	Chair	16:02
2	GOVERNANCE		
2.1	Establishing the North West London Acute Provider Collaborative – governance model Paper 2.1 Collaborative Governance - For approval - Trust... 7	Director of Corporate Governance (ICHT, CWFT), Director of Corporate Affairs (LNWT, THHFT) and Programme Director, NWL	16:05
2.2	Any Other Business Verbal	Chair	16:55
2.3	NHS Acronyms NHS Acronyms.docx 39		

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL
Extraordinary Board of Directors Meeting (OPEN SESSION)

Location: Teams meeting
Date: 22 July, 2022
Time: 16.00 – 17.00

Agenda

	1.0	**GENERAL BUSINESS**		
16.00	1.1	Welcome & Apologies for Absence	Verbal	Chair
16.02	1.2	Declarations of Interest	Verbal	Chair
	2.0	**GOVERNANCE**		
16.05	2.1	Establishing the North West London Acute Provider Collaborative – governance model	Paper	Director of Corporate Governance (ICHT, CWFT), Director of Corporate Affairs (LNWT, THHFT) and Programme Director, NWL
16.55	2.2	Any Other Business	Verbal	Chair
17.00		Close of meeting		

CONFIDENTIAL

TITLE AND DATE (of meeting at which the report is to be presented)	Extraordinary Board Meeting 22 July 2022

AGENDA ITEM NO.	2.1
TITLE OF REPORT	Establishing the North West London Acute Provider Collaborative – governance model
AUTHOR NAME AND ROLE	Peter Jenkinson, Director of Corporate Governance (ICHT, CWFT) David Searle, Director of Corporate Affairs (LNWT, THHFT); Dawn Clift, Programme Director;
ACCOUNTABLE EXECUTIVE DIRECTOR	Matthew Swindells, Chair in Common
THE PURPOSE OF THE REPORT Decision/Approval: x Assurance: Info Only: Advice:	The purpose of this paper is to seek approval from the four acute provider Trust Boards in North West London (Chelsea & Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust) for the establishment of the North West London acute provider collaborative ('the collaborative') within the defined governance structure detailed in the paper.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	Trust boards are asked to: • note the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common (section 7) • approve the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (section 10) • approve the proposed meeting structure for the collaborative (section 10); • approve the process for the initial NED appointments (section 12) • approve the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (section 14)

	• note next steps (section 15)
KEY RISKS ARISING FROM THIS REPORT	

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)		
Deliver high quality patient centred care		
Be the employer of Choice		
Deliver better care at lower cost		

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		Through this collaborative model we aim to reduce health inequalities across NWL
Equality And Diversity		
Quality		
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance		
Public Consultation		
Council of Governors	x	

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT)	
Commercial Confidentiality	
Patient Confidentiality	
Staff Confidentiality	
Other Exceptional Circumstances	x

1. Purpose of this report

1.1 The purpose of this paper is to seek approval from the four trust boards in north west London (Chelsea & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust) for the establishment of the north west London acute provider collaborative ('the collaborative').

1.2 The paper sets out to;

- summarise the key considerations in the operation of a collaborative governance arrangement;
- outline the high level principles and assumptions which will underpin the formation and development of the collaborative;
- propose a meeting structure for the collaborative, based on agreed principles;
- propose the principles and the process for establishing an initial non-executive director (NED) complement for the collaborative, based on agreed principles, and a process to then manage recruitment / retention of NEDs (subject to the approval of councils of governors);
- propose required amendments to the NHS foundation trust constitutions to support the implementation of the collaborative (subject to the approval of councils of governors).

1.3 The paper also sets out next steps for the implementation of the proposed arrangements, if approved.

1.4 Trust boards are asked to:

- note the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common (section 7)
- approve the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (section 10)
- approve the proposed meeting structure for the collaborative (section 10);
- approve the process for the initial NED appointments (section 12)
- approve the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (section 14)
- note next steps (section 15)

2. Executive Summary

2.1 This paper provides the background and rationale for the governance changes required in order to give effect to the north west London acute provider collaborative, whose purpose is indicated in a statement of intent agreed by all four trust boards.

2.2 These proposed arrangements are a product of an appraisal of various options, considered against the principles set out in the draft statement of intent shared with boards in December 2021:

- Collaborative decision-making
- Holding each other to account
- Ensuring compliance with statutory and regulatory requirements

2.3 The Collaborative will adopt the London Leadership Values:

- Core values
  - Courage, passion and decisiveness
  - Compassion
  - Integrity
- Aspirational values
  - Consistently hard on problems but generous with people
  - Effortlessly inclusive
- Eradicate our accidental values
  - Putting institutions and staff ahead of patients and citizens
  - Using power to obstruct or for gaming, point scoring, personal attacks and bullying
  - Using information and knowledge as a "bargaining chip"
  - Failing to be open and honest
  - Learned helplessness and "playing safe"
- Alongside honesty and integrity, we expect our leaders to
  - Work collaboratively and
  - Take accountability

2.4 The paper has been developed with input from the respective vice chairs and chief executives and chair-led discussions with trust boards and, for the two foundation trusts, councils of governors during June 2022, as well as input from key regulators, Care Quality Commission and NHS England (London).

2.5 If approved, the aim is to hold the inaugural meetings of the board in common in October 2022.

2.6 The proposed collaborative arrangements must ensure the continuation of public accountability and stakeholder involvement at trust level as well as at the level of the whole collaborative. There are also wider aspects of patient, public and staff involvement that need to be assured at all levels of the collaborative. We have sought to ensure these important issues are central to our proposed governance arrangements and ways of working and will be seeking further input from our local and sector level stakeholders to consider how we best maintain local accountability and stakeholder involvement.

2.7 We also want to support and expand other ways of building effective two-way stakeholder relationships at a local and collaborative level to help ensure openness, scrutiny and further collaboration. We will develop a shared involvement and collaboration charter, including best practice for local and collaborative transparency and wider collaboration with all stakeholders. For example, we will continue to publish trust level data on quality, finances, workforce and performance as part of the board in common meetings.

Reports from the board in common and trust level committees and the board in common cabinet meetings will also be noted at the public board in common meetings. We will also expect individual trust senior teams to have regular meetings with governors (in NHS foundation trusts), elected representatives, staff side, HealthWatch and other key stakeholders.

2.8 The proposed governance arrangements have been developed based on core principles of corporate governance in a collaborative system, including adhering to the principle of subsidiarity while ensuring collaborative decision-making and holding each other to account. The proposals have also been developed to ensure the continuation of public accountability and stakeholder involvement and engagement at trust level as well as at the level of the collaborative.

2.9 The approach is consistent with the recently published (22 May 2022) NHS England draft guidance on governance and collaboration, and supports the NHS London values – working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives; everyone counts.

2.10 The proposed governance arrangements have been developed to ensure continued trust level oversight of quality of care, and effective and efficient use of resources, and to provide collaborative decision-making on strategy in the interests of the population of north west London.

2.11 The central proposal is to create a board in common comprising four committees in common, each with delegated authority from its respective trust board. The board in common will meet in public and will be responsible for setting the strategy for the collaborative. It will be comprised of all voting members of the four trust boards and will normally meet four times per year. To ensure agility in decision making and to maintain oversight, the board in common will delegate some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the board in common is not meeting.

2.12 Five collaborative level committees which report into the board in common will be established (finance and performance, quality, people, nominations and remuneration, capital and digital), each chaired by a trust vice chair or chair and to include the lead chief executive (or nominee) and the NED who chairs their respective trust board committee. Each trust will have five standing board level committees (audit and risk management, finance and performance, quality, people, nominations and remuneration), each chaired by a vice chair or NED. This covers the statutory obligation to have committees covering audit and remuneration. Other trust and collaborative level board committees can be created by the board in common as required.

2.13 Each trust will meet at least once per year to deal with matters reserved only for that respective trust board, including approval of the annual accounts and report. Each trust will also hold its own annual general meeting / annual members meeting.

2.14 While the board in common and collaborative committees' remit will be to develop and agree collaborative level strategy, standardised approaches and common policies, the board level committees will be responsible for oversight of local implementation of these policies and discharging the responsibilities of the statutory organisations.

2.15 While ensuring that NED voting members at both trust board and board in common levels remain in the majority, the overall number of NEDs will be reduced. The NED composition of each trust will comprise the chair, vice chair, six NEDs and a university appointed NED. NEDs will be appointed as shared roles across two trusts, chairing one board committee, serving on the trust board committees of two trusts, one collaborative committee and the board in common. Vice chairs will also be a member of one other trust and sit on one of the other trust's committees.

2.16 Subject to approval by councils of governors and NHS England, NEDs will be appointed against selection criteria to ensure the collaborative has the skills and experience required, using the following process:

- Where eligible NEDs demonstrate that they have the capacity and competency to fill positions, the NEDs will be 'slotted in';
- Where there are more eligible and interested NEDs than there are positions at a trust, there will be an internal competition;
- Once these two processes are complete, any remaining vacancies will be opened up to eligible NEDs within the collaborative;
- Any vacancies that are still unfilled at the end of this process will be advertised through external competition.

2.17 In the NHS foundation trusts, the duties of governors remain the same but the scope of their remit is enhanced. This is in terms of not being restricted to representing the interests of a narrow section of the public served by 'their' NHS foundation trust but to take account of the interests of the 'public at large', including the population of the local system of which their trust is a part.

2.18 Some additional amendments are required to other governance documents to support these proposals, including the amendment of NHS trust establishment orders and NHS foundation trust constitutions.

3. Approval process

3.1. This paper has previously been discussed by the four trust boards (including vice chairs, chief executives, audit chairs), councils of governors (NHS foundation trusts), NHS England, and Care Quality Commission.

4. Recommendation(s)

4.1 Trust boards are asked to:

- note the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common (section 3)

- approve the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (section 6)
- approve the proposed meeting structure for the collaborative (section 6);
- approve the process for the initial NED appointments (section 8)
- approve the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (section 10)
- note next steps (section 11)

1.5 It is recognised that this is an innovative model and the intention is that we will review and adjust the structure as we learn over time and that the effectiveness of this structure is reviewed 12 months after implementation.

5. Next steps

5.1. Next steps are set out in section 11 of the main paper.

6. Impact assessment

6.1 Quality / workforce / equality impact: Our aim is that through the partnership work we will:

- achieve recovery of our elective care, emergency care and diagnostic capacity, not just to pre-pandemic levels but to deliver sustainable reductions in waiting and treatment times that are significantly better than before the pandemic;
- support the ICS's mission to address the health inequalities that exist in our population and eliminate inequity in access to - and experience - of our services;
- create an excellent environment that attracts, retains and develops the best staff in the NHS, recognising and supporting the exceptional effort and dedication of our people, and provide resilience to workforce pressures across north west London;
- achieve continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation in clinical services and improving effectiveness and efficiency of corporate and clinical support services; and
- achieve a more rapid spread of innovation, research and transformation

6.2 Financial impact: While there has been financial target attached to these proposals, the proposed governance model outlined in this paper will provide overall savings across the four acute trusts in the cost of governance at board level.

6.3 Risk impact: a risk assessment and risk register for the collaborative will be developed and presented to the inaugural meeting of the board in common.

Main paper

7. Introduction – vision / ambition

7.1 On 1 April 2022, the first chair in common for the four acute trusts north west London was appointed. This was based upon an agreement between NHS England (London region), the provisional North West London Integrated Care System (ICS), the four trust boards and the governors of the two foundation trusts that the trusts needed to formalise their co-working for the benefit of the population of north west London.

7.2 The trusts' united response to Covid-19, where they demonstrated the value that was to be gained from working together as an acute collaborative, had made clear that as the NHS faces up to the post Covid-19 challenges of reducing long waits, tackling population health inequalities and preparing for future challenges to the health of the population, the best way forward is through working together, not working in competition.

7.3 This vision is being brought together into a statement of intent that describes our goal to broaden and deepen collaborative working across the trusts and their leadership, working in partnership with our dedicated and diverse workforce and engaging closely with non-executives as well as governors of the two foundation trusts.

7.4 We want to be demonstrably best in class in partnership working across health and care within the ICS with other parts of the NHS, Local Authorities, and the voluntary and private sectors; realising the benefits of mutual aid and working at scale for our populations and staff to deliver the highest quality of care efficiently, and supporting excellence in research and education.

7.5 Through this partnership work we will:

- achieve **recovery** of our elective care, emergency care and diagnostic capacity, not just to pre-pandemic levels but to deliver sustainable reductions in waiting and treatment times that are significantly better than before the pandemic;
- support the ICS's mission to address the **health inequalities** that exist in our population and eliminate inequity in access to - and experience - of our services;
- create an excellent environment that attracts, retains and develops the best **staff** in the NHS, recognising and supporting the exceptional effort and dedication of our people, and provide resilience to workforce pressures across north west London;
- achieve **continuous improvement** in quality, efficiency and outcomes including proactively addressing unwarranted variation in clinical services and improving effectiveness and efficiency of corporate and clinical support services; and
- achieve a more rapid spread of **innovation, research and transformation**.

7.6 Through partnership working we will demonstrate the NHS London values:

- **Working together for patients** – The value of 'working together for patients' is a central tenet guiding service provision in the NHS and other organisations providing health services. Patients must come first in everything the NHS does. All parts of the NHS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes. As well as working with each other, health service organisations and providers should also involve staff, patients, carers, local communities to ensure they are providing services tailored to local needs.
- **Respect and dignity** – Every individual who comes into contact with the NHS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff.
- **Commitment to quality of care –** The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care that is safe, effective and focused on patient experience.
- **Compassion –** Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness.
- **Improving lives –** The core function of the NHS is emphasised in this value – the NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care. This value also recognises that to really improve lives the NHS needs to be helping people and their communities take responsibility for living healthier lives.
- **Everyone counts –** We have a responsibility to maximise the benefits we obtain from NHS resources, ensuring they are distributed fairly to those most in need. Nobody should be discriminated or disadvantaged and everyone should be treated with equal respect and importance.

7.7 The Collaborative will adopt the London Leadership Values:

- Core values
  - Courage, passion and decisiveness
  - Compassion
  - Integrity
- Aspirational values
  - Consistently hard on problems but generous with people
  - Effortlessly inclusive
- Eradicate our accidental values
  - Putting institutions and staff ahead of patients and citizens
  - Using power to obstruct or for gaming, point scoring, personal attacks and bullying
  - Using information and knowledge as a "bargaining chip"
  - Failing to be open and honest
  - Learned helplessness and "playing safe"
- Alongside honesty and integrity, we expect our leaders to
  - Work collaboratively and

- Take accountability

7.8 We have developed a consensus amongst existing trust boards that the establishment of a board in common, the consequent collaborative committees and board level committees, and the sharing of NEDs between trusts in the collaborative is the necessary next step to make a reality of opportunities described above for the acute collaborative.

8. Background

8.1 The north west London acute provider collaborative is in the process of forming. A draft statement of intent expresses the aim to build on the existing collaborative arrangements, including the north west London acute care programme, to establish governance arrangements that enable providers efficiently to reach joint decisions, which each organisation is committed to upholding, while recognising the statutory roles of trust boards and, for foundation trusts, councils of governors. These arrangements will also provide strong mechanisms for acute provider partners to hold each other to account.

8.2 Through these arrangements, the collaborative will ensure that decisions are reached and implemented, and benefits of scale are realised at pace, so that the resources across the four acute trusts are harnessed to support improvements in the health and life outcomes of the population we serve as a key player in the North West London Integrated Care System (ICS).

8.3 The governance mechanism used to deliver the envisaged arrangements will be the establishment of a board in common. This model is familiar to the NHS and is already in operation in some systems.

8.4 The proposed arrangements have also been based on recently published NHS England / Improvement guidance on good governance and collaboration. The documents reflect the passing of the Health and Care Act 2022 and include provisions related to system working.

9. Key principles / assumptions

9.1 For the collaborative to form as envisaged, each trust will need to establish a committee in common (CiC). Each trust board will delegate an agreed scope of decision making, via the scheme of delegated authority, to a (new) committee of its board. In the case of our collaborative, the CiC for each trust will comprise all voting members of the board. These four committees meeting in common form the collaborative board in common.

9.2 Formal voting tends to be rare for NHS boards but is a governance concept applicable to all boards. ‘Voting’ in this paper therefore refers to the decision-making process employed by the north west London acute provider collaborative. Where the collaborative board in common votes on resolutions, under current regulations there is no delegation of powers

between the statutory trust boards and therefore no trust could be bound by a decision taken by another trust in the board in common.

9.3 For those members of the board in common who hold a shared role across one or more trust boards, that individual must consider the respective trust's best interests in relation to each matter and vote separately on each relevant CiC of which he/she is a member. That means when voting for resolutions for the board in common, each trust board will form as its own CiC to vote as a statutory body and so board members with shared roles will need to vote at each of the trust boards they serve.

9.4 The board in common will meet in public but will reserve the right to meet in private session to discuss confidential items, reflecting the current practice for trust boards.

9.5 In developing these proposals, governance mechanisms required under regulations or statute have been adhered to (eg the maintenance of audit and nomination and remuneration committee at trust level) and latest best practice in corporate governance applied.

10. Governance / meeting structure

10.1 This section of the paper sets out the proposed outline terms of reference for these meetings, including purpose, frequency and membership. The proposed governance structure is based on some core principles:

- The north west London acute provider collaborative will establish a board in common
- The board in common will be comprised of four committees in common, with delegated authority from the trust boards of Chelsea & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust.
- The board in common will have membership from all four trusts.
- The board in common will meet in public.
- Collaborative committees will be established for functional areas of governance in common to all four trusts (eg quality, finance and operations, people), and nominations and remuneration.
- Each trust will maintain at least one trust board meeting to deal with matters reserved only for that respective board, including approval of the annual accounts and report. Each trust will also hold its own annual general meeting / annual members meeting.
- Each trust will need a sub-committee structure, to include statutory duties (ie audit, remuneration) and other committees to ensure local oversight of performance (eg quality, finance, performance, people).

10.2 The collaborative will establish a board in common, by each trust delegating authority to a committee in common (CiC) and the board in common having a membership made up of the four CiCs.

10.3 The board in common will be responsible for setting the strategy for the collaborative and will provide oversight of performance in areas such as quality, finance, workforce at collaborative level, receiving assurance from the collaborative committees.

10.4 Each trust will delegate an agreed scope of decision making to a committee of its board, and maintain a trust board meeting to deal with matters reserved only for that respective board, including:

- Approval of scheme of delegated authority (annual)
- Approval of standing orders (annual)
- Approval of annual accounts and report (annual)
- Charitable funds – annual accounts and report (annual) (where applicable)
- Receive annual management letter from external auditor (annual)
- Receive the annual Head of internal audit opinion (annual)
- Approval of annual financial and operational plan (annual)

10.5 As now, each trust will establish a board level committee structure, to include statutory duties (i.e audit, remuneration) and the trust board will delegate some powers to these committees to give time to detailed scrutiny and oversight, and to make decisions within agreed levels of authority.

10.6 The key component parts of the governance structure are:

(i) Board level committees
(ii) Collaborative committees
(iii) Board-in-common

(i) Board level committees

10.7 ***Subsidiarity*** is an important principle in the governance of a collaborative - that holds that issues should be dealt with at the most immediate (or local) level that is consistent with their resolution. Local trust-level oversight and decision-making is an important feature of the proposed governance arrangements.

10.8 We propose to establish five standing board level committees at each Trust, each of which will be chaired by a NED or the vice chair.

- Audit and risk
- Finance and performance
- Quality
- Workforce
- Nominations & remuneration

10.9 There are two statutory committees that trusts must have – audit and nominations and Remuneration committee (both have NED only

membership). Trusts may also establish specific committees to meet local need, such as charity funds committee, estate redevelopment.

10.10 The normal frequency of these meetings will be:

- Audit and risk (quarterly)
- Finance and performance (bi-monthly)
- Quality (bi-monthly)
- Workforce (bi-monthly)
- Nominations and remuneration (quarterly)

10.11 This frequency can be amended at local level to accommodate local (e.g. regulatory) needs. Committees may at times need to convene extra-ordinary meetings to manage specific needs.

10.12 The purpose of these meetings will be:

- Oversight of trust level performance (assurance)
- Trust level decision-making (within the authorities set out in the scheme of delegated authority)
- Overseeing development and implementation of trust level strategy, within the strategic framework agreed at collaborative level (eg local quality priorities within the overall quality strategy for the collaborative).

10.13 With the exception of audit and the nominations and remuneration committees (NED only membership), membership will include:

- Vice chair / NED chair
- Two NED members
- Executive lead(s)
- Chief executive / nominated representative (as standing attendees)

10.14 The draft terms of reference for these committees will be considered by the respective committees and recommended to the board in common for approval.

10.15 With the exception of the audit and risk committees, the board level committees will report into the collaborative committees, to provide a trust level view of delivery against collaborative priorities; all board committees will also provide a summary of assurance to the trust board via the board in common.

(ii) <u>Collaborative level committees</u>

10.16 We propose to establish five collaborative committees, each chaired by one of the vice chairs or the chair, and including the relevant 'lead' chief executive (each chief executive has been assigned to lead a specific workstream, aligned with the collaborative committees) and the NED chairs of respective trust board committees in the membership.

- Finance and performance (Vice chair, F&P board committee chairs, lead chief executive, plus chief financial officers (CFOs)
- Quality (Vice chair, quality board committee chairs, lead chief executive)
- People (Vice chair, workforce board committee chairs, lead chief executive)
- Estates and digital (vice chair, relevant NEDs, chief executive nominations, lead chief executive)
- Nominations and Remuneration (Chair, Vice chairs)

In addition to the voting membership above, the individual terms of reference for each committee will define any regular attendees, to provide subject matter expertise.

10.17 These collaborative committees will meet quarterly.

10.18 The purpose of these meetings will be to:

- Consider a collaborative view of performance (assurance)
- Develop relevant strategy and policy at collaborative level (strategy)
- Oversee alignment / standardisation of approach (including reporting etc) (alignment)

10.19 Membership will include:

- Vice chair
- NED chairs of respective board level committees
- Lead chief executive
- Chief executive or their nominees appropriate for each committee

10.20 Additional attendees will be agreed by the appropriate Vice chair and the lead chief executive.

10.21 The relevant chief executives (or in the case of the finance committee the chief financial officers) will coordinate and provide secretariat support for these meetings.

10.22 Collaborative committees will report into the board in common to provide assurance at collaborative level.

(iii) <u>'Board in common'</u>

10.23 The core concept of the collaborative is the four statutory boards working together in the interests of their patients and the population of north west London. Therefore, a key component of the collaborative governance framework is how the four statutory boards of the trusts work together to make collective decisions and hold each other to account.

10.24 The governance model for the collaborative is focused around the role of the board in common as the primary decision-making body for the collaborative, being fully representative of the four trusts.

Key principles / statutory guidance

10.25 This is achieved by creating a board in common' which is made up of four committees in common (CiC), with delegated authority from each of the four trusts. Each trust therefore remains a statutory organisation but delegates an agreed scope of decision making to a committee of its board. These four CiCs meet at the same time and at the same place and discuss a common agenda, but decisions are taken by each individual CiC on behalf of their trust board. Each CiC has duties to the organisation from which it is constituted. The general structure is indicated in figure 1.

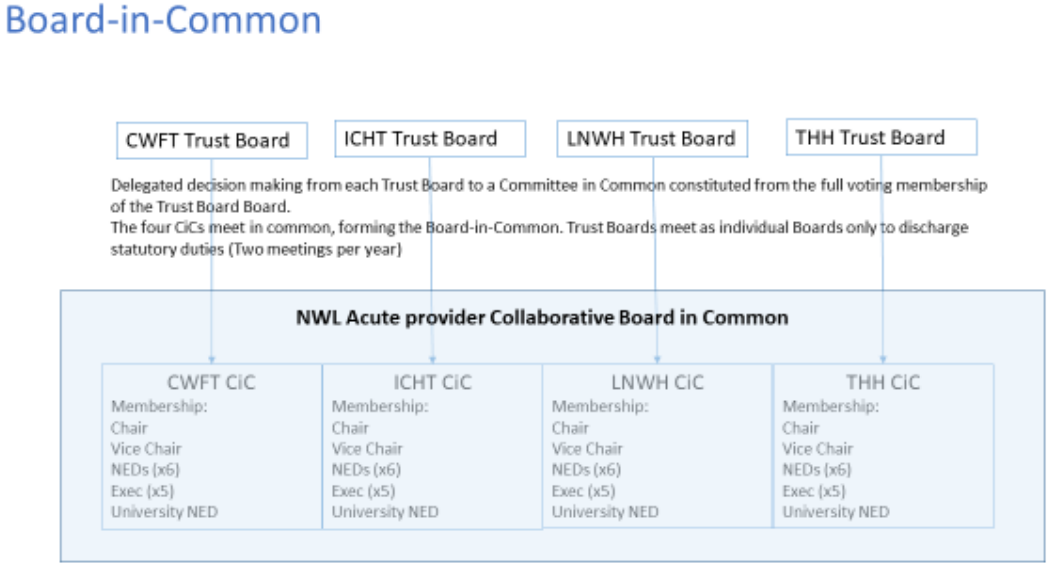

Figure 1

10.26 The members of each CiC will vote on resolutions put forward at the board in common, as a CiC – there would be no delegation of powers between trusts, therefore no trust could be bound by a decision taken by another trust's CiC.

10.27 Where an individual board member has a shared role across more than one trust, that individual must consider the respective trust's best interests in relation to each matter and vote separately on each CiC. Policies in relation to managing conflicts of interest will be included in the standing orders of the board in common.

10.28 The board in common will consist of a CiC with delegated authority from each trust board. Each CiC will be composed of the whole voting membership of each Trust board; the board in common therefore comprises the voting members of all four trust Boards.

10.29 All four Trust Boards will therefore be 'in the room' at all meetings of the board in common. The board in common will discuss common agenda items for the collaborative but would then vote on resolutions on behalf of their own trust board.

10.30 The board in common will normally meet four times per year. Each meeting will consist of three parts:

- board in common meeting in public
- board in common meeting in private – strategy / development session
- Individual trust board meetings for matters reserved for the trust board, when required.

10.31 This arrangement means that all board members are present at board in common meetings and therefore all board members get a 'vote' when it comes to decision-making. Although the actual number of NED members would be less than the number of executive directors present given the proposed model of shared NEDs, the voting rights held by the NEDs means that each CiC will have a majority of NED votes. Individual trust boards will only need to meet separately to the board in common when necessary to conduct matters reserved to individual trust boards, and may be held in public or private as the agenda dictates.

10.32 While it is important for all members of the four boards to be present at board in common, given that this will be the prime decision-making body for the collaborative, the number of members in the meeting increases the risk of ineffectiveness of the meeting by restricting individual board members' ability to contribute. To mitigate this risk, a detailed 'managing meetings' protocol has been developed, including how decisions are made and 'dispute resolution' arrangements.

10.33 There is also a risk of this arrangement being insufficiently agile should more urgent decisions be required. To mitigate this risk, the board in common will delegate authority to a board in common 'cabinet' to meet in the months when the full board in common is not meeting to make any urgent decisions required, acting within a scheme of delegated authority agreed by the full board in common. Any decisions made by the cabinet will be reported to and ratified by the full board in common.

10.34 This Board in Common Cabinet will have a membership consisting of:

- Chair
- Vice chairs of each trust
- Chief executives of each trust

10.35 Others will be invited as appropriate, as attendees.

10.36 Figure 2 below shows how this board in common will operate and the scheme of delegated authority.

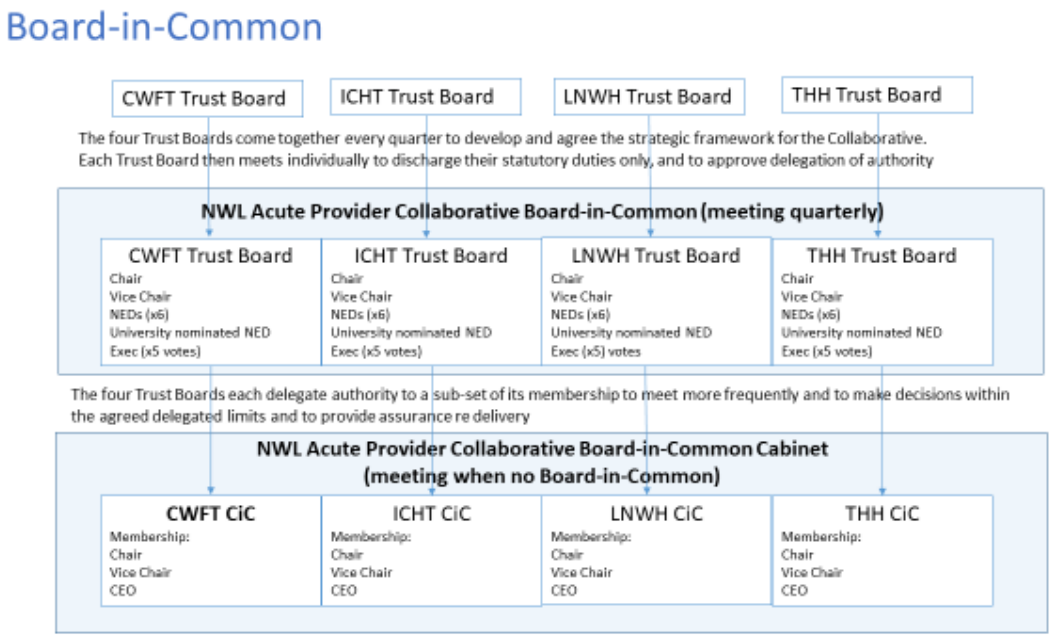

Figure 2

11. Audit and risk management

11.1 As statutorily independent organisations, each trust will establish an audit and risk management committee with delegated authority from each trust board. The role of the audit committee is to ensure, on behalf of the board, that the systems of internal control are effective and financial reporting is accurate.

11.2 The main role and responsibilities of the audit and risk committee will be set out in written terms of reference and will include:

- to monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing significant financial reporting judgements contained in them;
- to review internal financial controls and internal control and risk management systems;
- to make recommendations to the board, in relation to the appointment and terms of engagement of the external auditor;
- to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process;
- to develop and implement policy on the engagement of the external auditor to supply non-audit services, and to report to the board; and
- to report to the board on how it has discharged its responsibilities.

11.3 Other responsibilities of the audit and risk committee include:

- **Whistleblowing** – to ensure appropriate arrangements are in place by which staff can, in confidence, raise concerns about possible improprieties in matters of financial reporting, patient safety, or other matters, and to ensure that arrangements are in place for the

proportionate and independent investigation of such matters and for appropriate follow-up action.

- **Internal controls and risk management systems** – the committee will be responsible for oversight of the trust's risk management systems and to provide assurance to the trust board that such systems are effective (management is responsible for the identification, assessment, management and monitoring of risk, for developing, operating and monitoring the system of internal control and for providing assurance to the board that it has done so). The committee will therefore act on behalf of the trust board to ensure that risks are identified and managed appropriately, and that other board level committees have appropriate oversight mechanisms for relevant risks. The committee will also review specific risks within its own remit, as specified in the terms of reference.
- **Internal audit –** the committee will ensure that there is an effective internal audit function and a plan of activities being performed by the internal audit function appropriate to the trust's risk universe.
- **Counter fraud** – The committee will receive regular updates on counter fraud activities at the trust, including initiatives to raise aware and ongoing cases under investigation.

11.4 Within the north west London acute provider collaborative, each trust remains a statutory organisation, subject to its own regulatory requirements. However, while under the subsidiarity principles the audit function will operate at individual trust level and will provide assurance to each trust board, there is a need for common issues and risks to be reported at collaborative level so that the benefits of the joint resources of the collaborative can be brought to bear to manage common issues / risks.

11.5 The board in common will ensure that there is adequate cooperation within the collaborative (and with internal and external auditors of individual trusts within the collaborative) to enable common risks to the achievement of the strategic objectives of the collaborative to be identified and managed appropriately.

11.6 Initially, there will not be a collaborative level audit and risk management committee and each audit and risk committee will report to the board in common, but this will be reviewed over time. As the collaborative develops and more common areas of risk are identified through the individual trusts' audit and risk management committees and internal / external audit functions, the opportunities of a more collaborative approach to audit and risk will be considered. While there is no case for a standing audit and risk management committee at collaborative level in the first instance, a regular audit chairs' coordination meeting will be established to allow cross-organisational learning and alignment of audit planning.

Risk and assurance management – processes and structures

11.7 Each trust must have a systematic framework for internal control, ensuring effective reporting and escalation mechanisms from 'ward to board'. This includes divisional and directorate level management and quality groups, as

well as specialist committees (for example health and safety and infection prevention and control), where quality, safety and performance reports are reviewed and issues or risks escalated, as appropriate.

11.8 Each trust's framework will consist of:

- risk appetite statement which sets the amount of risk that the Trust is prepared to accept or tolerate for each area of risk
- risk management policy which describe the approach that the Trust takes to identifying, assessing and managing risk, including: the different levels of risk registers (e.g. directorate / divisional level risk registers); how to assess and evaluate risks using a standardised matrix; and how risks are escalated through the risk management structure, ultimately to the corporate risk register if they have a significant impact on the whole organisation or on the achievement of corporate objectives
- risk registers which document risks at each level of the Trust, including actions to control, mitigate or resolve
- board assurance framework, identifying the key strategic risks to achievement of the Trust's aims and objectives, and assurance processes to ensure that these strategic risks are being managed.

11.9 The effectiveness of the risk management framework, and the management of risks, will be monitored by the trust's executive management team. The audit and risk management committee oversees the effectiveness of the risk management process, on behalf of the trust board. The corporate risk register is also reviewed regularly, together with themes from key divisional risk registers and the key divisional risks profile. These give the committee visibility of the overall trust risk exposure and how effectively risks are managed at the trust.

11.10 At collaborative level, there will be a collaborative level board assurance framework and risk register, including key strategic risks to achievement of the vision and objectives of the collaborative. This will be reviewed by the board in common and appropriate actions delegated to mitigate any risks.

11.11 Prior to the first meeting of the board in common, the collaborative level board assurance framework will be populated with strategic risks to the achievement of the collaborative aims and objectives.

12. Board composition

Non-executive directors (NEDs)

12.1 Currently, in accordance with trust constitutions and establishment orders, the four acute trusts have, in total, a voting board membership of 51 people consisting of 29 voting NEDs and 22 voting executives. In addition to this, trust boards also employ non-voting associate NEDs to provide some resilience in succession planning.

12.2 The proposal is to amend the composition of each trust board, creating shared NED posts across trusts. The creation of shared NED roles will ensure cross-organisational learning and collaborative working.

12.3 The NED complement for each Trust Board, consisting of:

- Chair
- Vice chair
- Vice chair from one other trust
- Six NEDs (shared across trusts)
- University appointed NED

12.4 In the case of the two NHS Trusts (Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust), this will mean increasing the maximum number of NEDs in the trusts' establishment order. The proposal is to appoint NEDs to shared roles on a 'designate' basis, pending the successful outcome of a process required to amend the establishment order as a statutory instrument.

12.5 In considering the NED composition across the four trust boards, and proposing an initial establishment, some key principles have been applied:

- The NED relationship with the foundation trust council of governors, and the duties of councils of governors in respect of NEDs, is unchanged.
- Each of the four trusts will have a composition of six NEDs, each NED role being a shared post across two trusts within the collaborative;
- In addition, each trust will have a chair (the chair in common), plus a vice chair.
- The two NHS trusts are required to have a university appointed NED as part of their NED establishment in addition to the six indicated above; we will seek the nomination from Imperial College London of two university appointed NEDs across the four trusts.
- There will be standardisation across the four trusts in the terms of office for NEDs. Applying the foundation trust constitution rules, and therefore compliance with the foundation trust code of governance, NEDs will be able to serve two terms of three years, plus additional years with annual approval (to a maximum of 9 years).
- NEDs will be appointed as a shared post across two of the four trusts, with shared posts across the NHS trusts and the NHS foundation trusts.
- Vice chairs will also be appointed as member of one other trust, in order to sit on one of the other trust's committees.
- No employee of the four acute trusts can be appointed as a NED due to potential conflict of interest in view of the new collaborative arrangements.
- NEDs' time commitment across both of their Trusts should not be significantly greater than currently but it is acknowledged that these roles will be more complex and require more time during the transition period.

- The NED voting composition of each trust board, including the Chair, must be in majority over the executive composition – each trust will have up to five voting executive directors.
- There will be a provision for vice chairs to appoint associate NEDs to local trust board committees, where appropriate. These will be remunerated roles, at a rate agreed by the collaborative.

12.6 In developing the governance arrangements a guiding principle has been that NEDs' time commitment should not be significantly greater than the current commitment.

12.7 It is recognised that there are several elements of a NED role that add to the time commitments, including conducting board member visits to parts of the Trust, engaging with the Governors and stakeholder groups, and participating in consultant appointment panels when appropriate.

12.8 In terms of meetings, the normally expected commitment from NEDs will include:

- chair one board-level committee (bi-monthly) and be a member of two additional board-level committees (bi-monthly);
- attend one collaborative committee in their capacity as chair of one of the Board committees feeding into the collaborative committee (quarterly);
- attend the Board-in-Common (quarterly);
- attend the Trusts' Annual General Meeting / Annual Members' Meeting (annually x2)
- take on Board Champion roles as requested
- support local committees set up by agreement with the Chair and the appropriate Vice Chairs to meet local needs when requested, such as the Charity Committee in some Trusts and the Redevelopment Committee in others

12.9 Vice chairs will chair one board committee, attend one other board committee, and chair one collaborative committee. They will also chair the trust level nominations and remuneration committee as well as the trust board meeting when convened to discharge matters reserved for their trust board.

12.10 We propose that NED champion roles will be appointed as shared roles across two trusts, with a standardised approach each champion role, unless there is a need for increased commitment at any given time (for example current requirements for maternity champions.)

12.11 It is acknowledged that these roles will be more complex and require more time during the transition period, as NEDs getting to know a second hospital and the collaborative as a whole will place additional demands. As the new structure comes into place we will undertake a thorough review of how NED time is used to ensure that it is used efficiently and effectively and that the roles are doable.

12.12 We also recognise that the new roles will be more complex and therefore, subject to approval by NHSI/E and councils of governors, we propose to recognise that by adding a 'complexity supplement' to NEDs' remuneration.

12.13 Applying these principles to consideration of an initial establishment means the following rules will be applied:

- NEDs in post with a term of office that ends in the next six months which is equivalent to, or more than six years, will not be able to continue in their current roles. They will, however, be able to apply for roles in different trusts within the collaborative, should vacancies arise.
- NEDs with a term of office below six years will have the opportunity to be appointed for a minimum period of one year; in cases where this results in a total term of office exceeding six years, any further extension will require additional approval.

12.14 For the initial NED establishment, where possible while maintaining accordance with the rules above, existing NEDs will be considered first for the new roles. Thereafter, when vacancies then arise, they will be filled by normal recruitment process as per NHS England / FT constitution requirements.

12.15 When appointing NEDs, we need to ensure everyone has the basic skillset of a NED, including competency and capability to:

- be a member of the board in common
- be a member of two trust boards for their statutory meeting
- chair a board level committee and sit on the related committee in common
- sit on two other committees in a second Trust
- sit on or chair other committees as required
- take on lead NED champion roles as allocated by vice chair, such as FTSU and Maternity Champion
- Maintain an engagement with the trust beyond board and committee meetings

NEDs will also need to demonstrate that they provide specific skills that Boards require, including, for example: financial experience, quality, workforce, strategy.

12.16 We will be seeking:

- The right skills for the roles
- Diversity that reflects the populations we serve
- A relationship with the north west London area or the hospitals within the collaborative

12.17 The proposed process for appointing NEDs will be:

- Where NEDs demonstrate that they have the capacity and capability as outlined above, and we have the right number of eligible NEDs for the

vacant positions, those existing NEDs will be 'slotted in' to the vacant NED positions by agreement with the individuals.

- Where there are more eligible and interested NEDs than there are positions at a trust, there will be an internal competition for the roles.
- Once these two processes are complete, any remaining vacancies will be opened up to NEDs who are still looking for a role in the new structure and to current associate NEDs
- Any vacancies that are still unfilled at the end of this process will be opened up to external applicants.

12.18 Through this process, we will establish an initial NED establishment of 12 NEDs, with the appropriate mix of skillset and characteristics. In addition, Imperial College London will be invited to nominate two university appointed NEDs, who would hold shared roles across two trusts each and would perform a specific NED portfolio in quality / education. **Appendix 1** shows how these NEDs may be allocated to trust board committees.

12.19 This approach helps to preserve corporate memory amongst NEDs within the trusts and collaborative, and avoids immediate disruption to the entirety of NED members. It, however, allows for an appropriate assessment of NEDs' skills against the required skillset, and ensures we select the best candidates while also ensuring diversity of characteristics.

12.20 Once we have an initial NED complement established, we will subsequently use the normal process of recruitment to vacant NED roles, using the same principles / rules as above, but with a particular focus on the skills and characteristics we want to achieve to ensure balanced and diverse trust boards and therefore board in common.

Next steps

12.21 Those individuals directly affected have been involved in the development of this process and will now be asked to confirm their intention to be appointed in to these revised roles and, therefore, to take part in an assessment process to be undertaken by the chair and vice chairs.

12.22 This process and the appointment of individuals is subject to approval by NHS England and NHS London in the case of appointments to NHS trusts, and the councils of governors in the case of appointments to the NHS foundation trusts.

12.23 The NHS trusts will follow the process to seek parliamentary assent to vary their respective establishment orders.

Executive directors

12.24 The proposal is for the executive director complement of each trust board to remain as is.

12.25 There is some variation in the number of voting executive directors across the four trusts. However, all trusts (FT and NHS trusts) must have:

- Chief executive
- Finance director
- Medical director
- Nurse director

12.26 In the event of the board in common electing to go to a vote on a specific resolution, each trust board will vote separately and therefore the majority between NEDs and executive director votes will apply for each trust. In normal practice at the board in common in decision making, each trust will have five executive director 'votes'.

13. Maintaining public accountability and stakeholder involvement

13.1 The proposed collaborative arrangements must ensure the continuation of public accountability and stakeholder involvement at trust level as well as at the level of the whole collaborative. There are also wider aspects of patient, public and staff involvement that need to be assured at all levels of the collaborative. We have sought to ensure these important issues are central to our proposed governance arrangements and ways of working and will be seeking further input from our local and sector level stakeholders to consider how we best maintain local accountability and stakeholder involvement.

13.2 Within the collaborative, we have NHS trusts (Imperial College Healthcare and London North West) and NHS foundation trusts (Chelsea and Westminster and Hillingdon) which have differing statutory and regulatory requirements. We will build on both existing statutory stakeholder representation via the FT councils of governors and non-statutory lay partnership input across all trusts.

13.3 The purpose of this section is to set out the role of FT councils of governors in the proposed governance arrangements for the north west London acute provider collaborative, and to outline how we will continue to ensure public accountability and effective patient and public involvement at local and collaborative levels.

Role and responsibilities of governors

13.4 For foundation trusts, governors play an integral part in the trust governance. Much of the role of governors won't change from the original statutory duties as set out in the 2006 Act. However, recent guidance published by NHS England ('System working and collaboration: The role of foundation trust councils of governors' May 2022) explains how the duties of NHS foundation trust councils of governors are enhanced in collaborative systems:

"Within those duties, councils of governors are legally responsible for representing the interests of the members of the NHS foundation trust and the public. While the meaning of 'the public' is not specified in legislation, councils of governors are not restricted to representing the interests of a narrow section of the public served by the NHS foundation trust – that is, patients and

the public within the vicinity of the trust or those who form governors' own electorates.

To support collaboration between organisations and the delivery of better, joined up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part. No organisation can operate in isolation, and each is dependent on the efforts of others."
['System working and collaboration: The role of foundation trust councils of governors' May 2022]

13.5 While staff governors and patient, carer and service user governors represent specific constituencies, they are also expected to represent the interests of the members of the trust as a whole and the public. Therefore, they are required to seek and form a view of the interests of the 'public at large'.

13.6 The proposed governance arrangements for the collaborative will not change the role that councils of governors have within their individual trusts but they will affect what governors need to consider when performing their statutory duties.

13.7 The governors hold various statutory duties. Those that will be most affected by the proposed transition to system-working within the collaborative:

- Holding the non-executive directors individually and collectively to account for the performance of the board of directors.
- Representing the interests of the members of the NHS foundation trust and the public.
- Approving 'significant transactions', mergers, acquisitions, separations or dissolutions.
- Approval of the appointment and remuneration of chair and non-executive directors.

Holding the non-executive directors individually and collectively to account for the performance of the board of directors.

13.8 To hold the non-executive directors to account, the governors already have a number of approaches in place, including:

- observing the contributions of the non-executive directors at board meetings and during meetings with governors;
- gathering information on the performance of the board against its strategy and plans;
- receiving the trust's quality report and accounts and questioning the non-executive directors on their content.

13.9 There are also local arrangements, as agreed between board and council of governors, that will remain as is.

13.10 These allow the council of governors to determine its key areas of concern and provide appropriate challenge at local trust level. These will remain under the proposed arrangement, with governors invited to attend the board-in-

common meetings (quarterly) and the individual trust board meetings (twice per year).

13.11 However, governors will also now need to form a view about their trust's contribution to system performance and development, shared planning and contribution towards the achievement of ICS strategy, and receiving assurance that the board's decisions have regard to the 'triple aim' duty – better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Observing the board-in-common meetings will help governors to gain this assurance. We will work with the two Councils of Governors to explore new ways in which they can work together to have wider visibility of the health improvement opportunities across north west London and engagement with the Board in Common.

Representing the interests of the members of the NHS foundation trust and the public.

13.12 Councils of governors have a duty to represent the interests of the members of 'their' NHS foundation trust and the public.

13.13 However, councils of governors are not restricted to representing the interests of a narrow section of the public served by the NHS foundation trust – that is, patients and the public within the vicinity of the trust or those who form governors' own electorates. To discharge this statutory duty, councils of governors are required to take account of the interests of the 'public at large'. This includes the population of the local system of which the trust is part.

13.14 The governors already have existing mechanisms to represent the interests of the members of the foundation trust, including:

- governor drop-in events where members and the public can meet governors
- a dedicated page on the foundation trust's website to share information and surveys to gather members' and the public's views
- Council of governor sub-committees, including quality, planning and membership

13.15 Governors will be invited to attend and observe the board in common meetings and will be able to input into the development of the collaborative strategy and to seek assurance that the strategy is in the interests of the public and patients of north west London (including helping to ensure equality of access, experience and outcomes to acute care and to tackle health inequalities across the population of north west London).

Approving 'significant transactions', mergers, acquisitions, separations or dissolutions

13.16 Councils of governors are responsible for assuring themselves that their board of directors has been thorough and comprehensive in reaching its decision to undertake a 'significant transaction' and that it has appropriately

considered the interests of members and the public as part of the decision-making process.

13.17 This duty to consider the interests of the wider public means that there may be examples where councils of governors approve a significant transaction that may not immediately benefit 'their' individual trust but overall does benefit the population of the wider Integrated Care System (ICS).

13.18 Councils of governors will need to be assured their foundation trust board has considered the consequences of decisions on other partners within their system, and the impact on the public at large.

Appointment and deciding on the remuneration of chair and non-executive directors.

13.19 The Council of Governors duty to appoint the chair and non-executive directors of their foundation trust will not change.

13.20 More details on the proposed non-executive director composition for each trust is contained in the governance proposals. Non-executive directors of the two foundation trusts will also be appointed as non-executive directors of one other trust within the collaborative, and non-executive directors appointed by NHS trusts will also serve as non-executive directors of one of the foundation trusts. As such, there will need to be dual approval of such posts, and remuneration, by NHS England and the council of governors, with final approval for non-executives appointed by foundation trusts resting with the council of governors.

13.21 Non-executive directors will be responsible for oversight of the delivery of the regulatory requirements of their individual trusts, but will also be responsible for the delivery of the strategic objectives of the collaborative. Governors will have the appropriate mechanisms to hold those non-executive directors to account for both these areas of responsibility.

Engagement and involvement of governors

13.22 The proposed arrangements for governors will ensure that the council of governors is provided with appropriate information, and that the governors are given opportunities to meet their board to raise questions about their trust's role within the system, or systems, of which it is part.

13.23 Governors can expect to attend and observe a variety of meetings organised by the trust, which intend to help inform their decision-making, and to support governors in fulfilling their duties. Formally, this will include the existing council of governor meetings and annual members meetings. Governors will also be invited to attend and observe board in common meetings held in public, and their respective trust board meetings held in public as current.

13.24 Other existing mechanisms of engagement will continue as they are, including, for example:

- informal meetings such as Q&As with the chief executive or chair, and workshops with the non-executive directors or board
- regular briefings to members and governors from the chief executive or chair
- ad-hoc briefings or dissemination of information as an issue arises
- non-executive director committee chair reports to council of governor meetings.

Patient and public involvement strategies, including the role of lay partners

13.25 NHS Trusts do not have councils of governors and do not have the same statutory responsibilities relating to governors. However, they can and do draw on other means of helping to ensure the trust understands the needs and views of its stakeholders (including patients, local communities, carers and staff) and responds to them effectively. At Imperial College Healthcare, there is a comprehensive patient and public involvement strategy and framework that is overseen by its strategic lay forum – made up of lay partners drawn from local and patient populations. The strategic lay forum helps to ensure that the trust's strategy, priorities and major projects and programmes take into full consideration the needs and views of patients, local communities and other stakeholders.

13.26 Lay partners are also beginning to be involved in collaborative level projects and programmes, including on key project groups and programme boards, to help ensure effective patient and public involvement and user-focus. We will seek to build on and expand this approach as the collaborative develops, exploring how this can also complement the role of governors in this new environment.

Public accountability

13.27 Meetings of the board in common will be in two parts, as per current practice. While the board in common will reserve the right to deal with specific matters in private, due to confidential or commercial sensitivity, the board in common meetings will be held in public. As per current practice, members of the public, and governors, will be able to ask questions of the board as part of that meeting.

13.28 Each individual trust, as individual statutory organisations, will also hold individual trust board meetings at least once per year, to transact matters reserved for the trust board and will hold separate annual general/ annual members' meetings, where the individual trusts' annual report and accounts will be presented and members of the public/members will be invited to ask questions of the board.

Place based engagement

13.29 We are very aware that developments in the Acute Collaborative's ability to think and act strategically for the benefit of the whole population of north west London needs to be matched by an enhanced engagement at a local or "place" level with care providers, patient groups and the Local Authorities. We want to support and expand other ways of building effective two-way

stakeholder relationships at a local and collaborative level to help ensure openness, scrutiny and further collaboration.

13.30 Each of our Trusts already has strong relationship with its Local Authorities and patient groups and the dynamic of those Chief Executive and Executive level engagements will not change. In addition, we will work with stakeholder groups to discuss how they want to further improve their engagement with their local Trusts and explore how they want to engage with the Acute Collaborative. We will also work with the Local Authorities to ensure that we are national exemplars in the two-way sharing of information and data and align our plans with their aspirations, within the context of the wider ICS strategy.

13.31 We will develop a shared involvement and collaboration charter, including best practice for local and collaborative transparency and wider collaboration with all stakeholders. For example, we will continue to publish trust level data on quality, finances and performance as part of the boards in common meetings. Reports from the board in common and trust subcommittees and the board in common cabinet meetings will also be noted at the public board in common meetings. We will also expect individual trust senior teams to have a regular meetings with elected representatives, staff side, HealthWatch and other key stakeholders.

13.32 The trusts and the collaborative will also be held accountable via the ICS, quarterly system oversight meetings, local council overview and scrutiny committees and the integrated care board.

14. Amendments to constitutional documents

14.1 To enable these governance arrangements to work, and to ensure that the four trusts maintain compliance with their respective constitutions (NHS Foundation Trusts) or establishment orders (NHS Trusts), we propose some amendments to these governance instruments.

14.2 These amendments will allow provision across all four trusts for up to 10 NED posts, including the Chair, Vice Chair, and a University nominated NED.

Foundation trust constitutions

14.3 The Constitution for Chelsea and Westminster Hospitals NHS Foundation Trust states within Annex 8 clause 1.9 that:

‘The following may not become, or continue as a member of the Board of Directors: In the case of a Non-executive Director, a person who is no longer a member of the public or patients’ constituency’.

The Constitution currently determines the following as public constituencies:-

- Royal Borough of Kensington and Chelsea
- City of Westminster
- London Borough of Hammersmith and Fulham
- London Borough of Wandsworth
- London Borough of Hounslow

- London Borough of Richmond upon Thames
- London Borough of Ealing

14.4 In order to implement the proposed model of NEDs posts being shared across two Trusts, the Constitution will require an amendment to create an additional public constituency that represents 'the Rest of North West London' to ensure that any NEDs appointments are compliant with Annex 8 clause 1.9.

14.5 If approved by the CWFT Trust Board (more than half of members), approval will be sought from the Council of Governors to enact this change with immediate effect.

14.6 The proposed amendment to the CWFT constitution is therefore:

1. Annex 1 – Add an additional public constituency to represent 'The Rest of North West London' – minimum number of members to be confirmed
2. Annex 4 – Add an additional public constituency to represent 'The Rest of North West London' and create one Governor seat to represent this constituency
3. Annex 9 – Clause 3.2 – Amend to state that the Board of Directors will meet in public as part of the North West London Acute Provider Collaborative no less than four times a year and will hold an Annual Members Meeting in public once a year.

14.7 The Constitution for Hillingdon Hospitals NHS Foundation Trust states its board composition as:

- The Chair
- A maximum of 7 NEDs
- A maximum of 7 Execs

14.8 In order to enable a NED complement as proposed in this paper, we propose to amend the constitution to:

- The Chair
- A maximum of **9** NEDs
- A maximum of 7 Execs

NHS establishment orders

14.9 The Establishment Orders for both ICHT and LNWT state the NED complement of the Board to be "The Chair plus 7 NEDs, one of whom is the Imperial College nominated representative".

14.10 We are proposing the new NED complement to be

- Chair
- Vice chair
- Vice chair from one other trust
- six NEDs
- plus a university nominated NED.

14.11 We therefore propose to amend the Establishment Orders for both trust to be "The Chair, plus **9** NEDs, one of whom is the Imperial College nominated

representative". This would provide us with one spare NED post in the establishment order, in case of future need.

15. Next steps

15.1 The aim is to enable the Board in Common to hold its inaugural meeting in early autumn. Subject to approval of the proposed governance arrangements in this paper, an implementation plan has been developed to establish the Collaborative. These include:

- Complete the appointment process for the NED complement
- Seek approval from the Councils of Governors and NHS England for the appointment of the NEDs
- Seek approval of the Councils of Governors for the amendment of respective constitutions
- Seek approval, via the DHSC, for the amendment of the NHS Trusts' establishment orders.
- Develop more detailed governance documents for approval at the inaugural Board in Common meeting, including:
    - Terms of reference for the Collaborative level committees
    - Terms of reference for the Trust Board level committees
    - Scheme of delegated authority, including scheme of delegated financial authorities
    - Standing Orders, including standard operating procedure for the Board in Common and associated meetings
- Publication of meeting dates for Board committees, Collaborative committees and Board-in-Common, and venues
- Agreement of board / committee cycles with committee chairs and executive leads, including agendas and forward planners, including essential assurance items for each committee and draft scorecards and key performance indicators.

Dawn Clift, Peter Jenkinson, David Searle

13 July 2022

Appendix 1 – NED allocation to Trust Board committees (subject to periodic change)

Imperial	Trust 1 - Chairing	Trust 2 - Attending
VC	**F&P / NomRem**	**Audit (LNW)**
NED 1	Audit	Audit / People (H)
NED 2	People	F&P / Quality (LNW)
NED 3	Quality	F&P / People (CW)
Academic NED		Quality (I / CW)
ChelWest		
VC	**Quality / NomsRems**	**F&P (H)**
NED 1	Audit	F&P / Quality (I)
NED 2	People	Audit / People (LNW)
NED 3	F&P	Audit / Quality (H)
Academic NED		Quality (I / CW)
LNW		
VC	**People / NomsRems**	**F&P (I)**
NED 1	Audit	F&P / People (H)
NED 2	Quality	Audit / People (CW)
NED 3	F&P	Audit / People (I)
Academic NED		Quality (LNW / H)
Hillingdon		
VC	**F&P / NomsRems**	**Audit (CW)**
NED 1	Quality	Audit / People (I)
NED 2	Audit	F&P / Quality (CW)
NED 3	People	F&P / People (LNW)
Academic NED		Quality (LNW / H)

Acronyms

The following document explains some acronyms and terms which Staff and Governors may come across in their role.

A			
A&E	Accident & Emergency	AHSN	Academic Health Science Network
ARC	Audit & Governance Risk Committee	ALOS	Average Length of Stay
AGM	Annual General Meeting	AMM	Annual Members Meeting
AGS	Annual Governance Statement	AO	Accountable Officer
AHP	Allied Health Professionals	ALB(s)	Arms Length Bodies
AHSC	Academic Health Science Centre		
B			
BAF	Board Assurance Framework	BAME	Black Asian Minority Ethnic
BCF	Better Care Fund	BoD	Board of Directors
BMA	British Medical Association		
C			
CAMHS	Child and Adolescent Mental Health Services	CFO	Chief Financial Officer
CapEx		CMO	Chief Medical Officer
CBA	Cost Benefit Analysis	CNO	Chief Nursing Officer
CBT	Cognitive Behavioural Therapy	CoG	Council of Governors
CCG	Clinical Commissioning Group	COO	Chief Operating Officer
CDiff	Clostridium difficile	CPD	Continuing Professional Development
CE / CEO	Chief Executive Officer	CQC	Care Quality Commission
CF	Cash Flow	CQUIN	Commissioning for Quality and Innovation
CFR	Community First Responders	CSR	Corporate Social Responsibility
CHC	Continuing Healthcare	CT	Computed Tomography
CIP	Cost Improvement Plan		

D			
DBS	Disclosure and barring service	DoF	Director of Finance
DGH	District General Hospital	DPA	Data Protection Act
DHSC	Department of Health and Social Care	DPH	Director of Public Health
DNA	Did Not Attend	DTOCs	Delayed Transfers of waiting Care
DNAR	Do Not Attempt Resuscitation	DTC	Diagnostic and Treatment Centre
E			
E&D	Equality and Diversity	EOLC	End of Life Care
ED(s)	Executive Directors or Emergency Department	EPR	Electronic Patient Record
EHR	Electronic Health Record	ESR	Electronic staff record
F			
FFT	Friends and Family Test	FT	Foundation Trust
FIC	Finance and Investment Committee	FTE	Full Time Equivalent
FOI	Freedom of Information	FTSU	Freedom to speak up
G			
GMC	General Medical Council	GDP	Gross Domestic Product
GDPR	General Data Protection Regulations		
H			
HCAI	Healthcare Associated Infection	HRA	Health Research Authority
HCA	Health Care Assistant	HSCA 2012	Health & Social Care Act 2012
HDU	High Dependency Unit	HSCIC	Health and Social Care Information Centre
HEE	Health Education England	HTA	Human Tissue Authority
HR	Human Resources	HWB / HWBB	Health & Wellbeing Board
I			
IG	Information Governance	ICU or ITU	Intensive Care Unit Intensive therapy unit
ICP	Integrated Care Pathway	IP	Inpatient
ICS	Integrated Care system	IT	Information Technology

ICT	Information Communications Technology	IV	Intravenous
K			
KLOE(s)	Key Line of Enquiries	KPIs	Key Performance Indicators
L			
LD	Learning Disability	LOS	Length of Stay
M			
M&A	Mergers & Acquisitions	MRI	Magnetic Resonance Imaging
MHPRA	Medicines and Healthcare Products Regulatory Agency	MRSA	Methicillin-Resistant Staphylococcus Aureus
MIU	Minor Injuries Unit	MSA	Mixed Sex Accommodation
MoU	Memorandum of Understanding		
N			
NAO	National Audit Office	NHSI	NHS Improvement
NED	Non Executive Director	NHSLA	NHS Leadership Academy
NHS	National Health Service	NHSP	NHS Professionals
NHS111	NHS nonemergency number	NHSX	
NHSBSA	NHS Business Services Authority	NICE	National Institute for Health and Care Excellence
NHSBT	NHS Blood and Transplant	NIHR	National Institution for Health Research
NHSE	NHS England	NMC	Nursing and Midwifery Council
O			
OD	Organisational Development or Outpatients Department	OSCs	Overview and Scrutiny Committees
OOH	Out of Hours	OT	Occupational Therapy
OP	Outpatients		
P			
PALS	Patient Advice & Liaison Service	PHSO	Parliamentary and Health Service Ombudsman
PAS	Patient	PICU	Psychiatric Intensive

	Administration System		Care Unit or Paediatric Intensive Care Unit
PbR	Payment by Results or 'tariff'	PLACE	Patient-Led Assessments of the Care Environment
PCN	Primary care network	POD	People and Organisational Development Committee
PDSA	Plan, do, study, act	PPI	Patient and Public Involvement
PFI	Private Finance Initiative	PTS	Patient Transport Services
PHE	Public Health England		
Q			
QA	Quality assurance	QIA	Quality Impact Assessment
QC	Quality Committee	QOF	Qualities and Outcomes Framework
QI	Quality improvement		
R			
R&D	Research & Development	RoI	Return on Investment
RAG	Red, Amber, Green classifications	RTT	Referral to Treatment Time
RGN	Registered General Nurse		
S			
SALT	Speech and Language Therapist	SLA	Service Level Agreement
SFI	Standing Financial Instructions	SoS	Secretary of State
SHMI	Summary Hospital Level Mortality Indicator	SRO	Senior Responsible officer
SID	Senior independent Director	STP	Sustainability and Transformation Partnership
SIRO	Senior Information Risk Officer	SUI	Series Untoward Incident / Serious Incident
SITREP	Situation Report	SWOT	Strengths, Weaknesses, Opportunities, Threats
T			
TTO	To Take Out		
V			
VTE	Venous Thromboembolism	VfM	Value for Money

W			
WLF	Well Led Framework	WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard	WTE	Whole-time equivalent
Y			
YTD	Year to Date		