Bundle Trust Board Public 22 July 2024

1 OPENING BUSINESS

1.3 10:30 - Welcome and Apologies
Apologies received from Richard Holmes and David Buckle

1.4 Declaration of Interests, Fit & Proper / Good Character

2 STRATEGY AND DEVELOPMENT

2.1 10:35 - Development of Group Model

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3 CLOSING BUSINESS

3.1 10:45 - Public Questions

3.2 11:25 - Agreement of Actions and Meeting Reflection

3.3 Date next meeting 5th September 2024

Meeting of Board of Directors

Report Summary Sheet

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

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

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

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

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

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

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

1. Introduction and Context

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

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

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

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

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

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

National Context

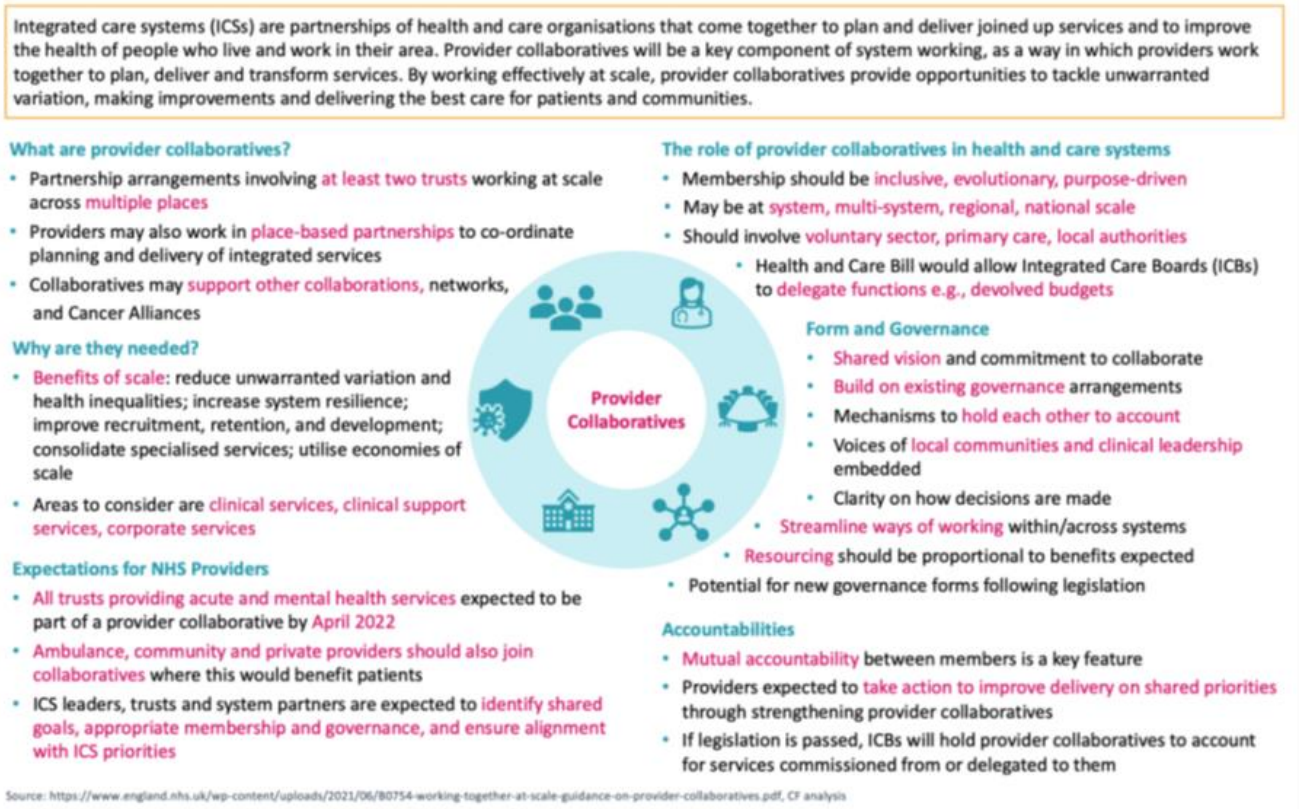
The Health and Care Act (2022)

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

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

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

Figure 1 Overview of NHS Provider Collaboratives



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

2. The Case for Collaboration and Change to Support Delivery

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

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

Figure 2. Ten Areas: Our Case for Collaboration

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

3. Proposed Provider Group Development

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

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

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

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

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

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

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

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

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

What do these proposed changes mean for our organisations?

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

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

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

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

4. Proposed Timeline

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

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

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

Figure 3. Proposed Collaborative Development Timeline

5. Risks

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

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

Risk/s associated with pursuing this proposal:

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

6. Summary of Recommendations

Our recommendations are summarised in figure 4 below.

Figure 4. Our Eight Recommendations

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

Close

Draft 1.0.

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

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

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

Appendix 1: Draft Joint Committee Terms of Reference

DRAFT [BSW AHA Group [Name TBC]]

Joint Committee - Terms of Reference

1. **Status of the Committee**

1.1 Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust (the "**Trusts**") are parties to a long standing strategic collaboration known as the "**BSW AHA Group [NAME TBC]**", referred to hereinafter as "**the Group**".

1.2 To facilitate joint working across the Group's priorities and programmes, the Trusts have agreed to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 with these terms of reference (the "**Terms of Reference**"), to be known as the "**BSW AHA Group Joint Committee**" (the "**Committee**").

1.3 These Terms of Reference set out the membership, remit and delegation, responsibilities and reporting arrangements of the Committee.

1.4 The Committee is a committee of the boards of each of the Trusts and therefore its decisions are binding on each Trust. The Committee is authorised by the Trust boards to carry out the functions set out in these Terms of Reference to ensure the Committee can fulfil its purpose.

1.5 The Committee replaces the former Acute Hospitals Alliance/AHA committees-in-common arrangement.

1.6 Capitalised terms have the meanings given to them in these Terms of Reference or in the memorandum of understanding for the Group which the Trusts entered into on [insert x] ("**Group MoU**"). The Annex means the annex to these Terms of Reference.

2. **Purpose**

2.1 The purpose of the Committee is to ensure appropriate governance arrangements are in place to enable joint decision making in relation to the functions described in these Terms of Refence and the Annex which the Trusts have agreed to exercise jointly.

2.2 The Committee will be responsible for:

2.2.1 Oversight of the development and delivery of the Group Programme and the workstreams in accordance with the Principles of Collaboration; and

2.2.2 setting the overall strategic direction in order to deliver the Group Programme.

2.3 The Group Programme agreed by the Trusts for the years [insert financial years 2024-2028] includes:

2.3.1 the design and implementation of a group model for the Trusts (the **"Group Operating Model**");

2.3.2 the 10 agreed areas for collaboration ("**10 Areas for Collaboration"**), including annually agreed priorities for collaboration;

2.3.3 the response to the BSW integrated community health care services procurement exercise; and

2.3.4 oversight of governance over the joint EPR Programme,

all described in more detail in the Annex.

3. **General Responsibilities**

3.1 The general responsibilities of the Committee are to:

3.1.1 provide overall strategic oversight of and direction to the development of the Group Programme;

3.1.2 ensure the agreement of each of the Trusts to the vision and strategy underpinning the Group Programme;

3.1.3 formally recommend the final form of the Group Programme, including determining roles and responsibilities within the workstreams;

3.1.4 review and scrutinise the Group Programme key deliverables and ensure adherence to the required timescales;

3.1.5 obtain assurance that Group Programme workstreams have been subject to robust equality impact assessments;

3.1.6 review the risks associated with the performance of any of the Trusts in terms of the impact to the Group Programme and recommend remedial and mitigating actions across the system;

3.1.7 obtain assurance that risks associated with the Group Programme are being identified, managed and mitigated;

3.1.8 promote and encourage commitment to the Principles of Collaboration;

3.1.9 formulate, agree and implement strategies for delivery of the Group Programme;

3.1.10 determine or resolve any matter referred to it by the Group Programme Executive or any individual Trust and any dispute in accordance with the Group MoU;

3.1.11 approve the appointment, removal or replacement of Group Programme personnel;

3.1.12 review and approve the terms of reference of the Group Executive; and

3.1.13 agree the overall Group Programme budget, financial contribution and use of resources.

3.2 The Committee has the specific responsibilities set out in the Annex to these Terms of Reference.

4. **Membership**

4.1 The Committee will initially comprise the chair (representing the non-executive membership) of each of the Trusts, the Group Chief Executive and Deputy Chief Executive (representing the executive membership) of each of the Trusts. Once a chair is jointly appointed across all 3 Trusts, each of the Trusts shall nominate a non-executive director ("**NED**") to serve on the Committee. There will initially be 7

members on the Committee, 3 of whom are NEDs, and once a chair is jointly appointed there will be 8 individuals on the Committee, 4 of whom are NEDs. Each individual is hereinafter referred to as a **"Member"**.

4.2 Each Trust will nominate two deputy members (one from the non-executive membership of the Trust's board and one from the executive membership) (**"Nominated Deputy"**) to attend meetings of the Committee in the event that their Chair (or NED) and/or Chief Executive is unable to attend. The Nominated Deputy must be a voting board member of the respective Trust. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the Member is not personally present and do all the things which the appointing Member is entitled to do.

4.3 Each Member will have one vote.

4.4 At the first meeting of the Committee, the Committee will select a chair ("**Committee Chair**") from amongst the Members who are Trust chairs. Once a joint chair for the Trusts is appointed, he or she shall become the Committee Chair and the incumbent Committee Chair (if not the joint chair) shall immediately hand over.

4.5 In the absence of the Committee Chair at any meeting for reasons of conflict or otherwise, the Members present shall nominate one of the other NED Members to chair the meeting.

4.6 The Trusts will ensure that, except for urgent or unavoidable reasons, their respective Members (or their Nominated Deputy) attends and fully participates in the meetings of the Committee.

4.7 Meetings of the Committee will be regularly attended by the [Group Programme Director [and insert other regular attendees] on an advisory basis only. They will receive advance copies of the notice, agenda and papers for meetings. They may be invited, at the discretion of the Committee Chair, to ask questions and address the meeting but may not vote.

4.8 With the consent of the Committee Chair, other persons may be invited to attend and contribute to meetings of the Committee but not take part in making decisions.

5. Framework for Decision Making

5.1 The Committee (and each Member or Nominated Deputy) shall at all times act in accordance with these Terms of Reference and the internal governance arrangements of the individual Trusts including the Trusts' constitutions and standing orders insofar as these Terms of Reference do not provide otherwise. In the event of any inconsistency between the Trust's standing orders, the Committee Chair shall determine whose standing orders will prevail.

5.2 The following decisions may only be taken where the Members present and voting at a meeting vote unanimously in favour of it:

5.2.1 any decision relating to the design of the Group Operating Model – see the Annex;

5.2.2 [insert any other types of decisions which require unanimous approval].

5.3 Functions not delegated to the Committee in accordance with these Terms of Reference are retained by the Trust boards or other Trust committees. Matters specifically reserved to the Trusts, acting individually, include without limitation:

5.3.1 the approval of the design of the Group Operating Model;

5.3.2 a decision to enter into contracts following the Trusts' response to the BSW integrated community health care services procurement exercise;

5.3.3 [insert other matters reserved].

5.4 The Committee may not:

5.4.1 form sub-committees or delegate its functions to any individual Member;

5.4.2 pool budgets or establish any risk-gain share arrangements;

5.4.3 commit a Trust to any spend, loan or investment (including capital investment) or acquire or dispose of Trust property;

5.4.4 commit a Trust to enter into a contract, other than in relation to the Group Operating Model provided for in the Annex; or

5.4.5 carry out any function which is governed by a statutory process or reserved in law to a statutory committee of a Trust, including constitutional amendments and board appointments, or which may not be exercised jointly according to law or NHS England guidance.

5.5 In carrying out its functions, the Committee will abide by the Seven Principles of Public Life (Nolan Principles) and shall have regard to NHS England's statutory guidance for joint exercise of statutory functions and joint committees issued from time to time.

6. **Decision making**

6.1 The Committee must comply with the above framework for making decisions and have regard to the principles specified in paragraph 6.2.

6.2 When making decisions, the Members shall, recognising that some decisions may not be of obvious benefit to or impact directly upon all Trusts, nevertheless:

6.2.1 enable each Member to have an equal say in discussions;

6.2.2 work together in good faith and in an open, cooperative and collaborative manner for the benefit of one or more Trusts;

6.2.3 take collective responsibility for decisions whether impacting on one or more Trusts;

6.2.4 communicate openly about major concerns, issues or opportunities; and

6.2.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs.

6.3 The Committee will seek to make decisions on a consensus basis.

6.4 Any questions needing to be put to a vote at a meeting shall, save for the matters set out in paragraph 5.2 (matters requiring unanimous decision), be determined by a majority of the votes of the Members present and voting on the question and, in the case of the number of votes for and against a motion being equal, the chair of the meeting shall have a second or casting vote.

6.5 With the consent of the Committee Chair, urgent decisions or decisions required outside of scheduled meetings may be taken outside of a formal meeting by written resolution (including email). This is subject to the quorum of the Committee endorsing

the required decision. Any decisions taken in accordance with this section shall be reported to the next formal meeting.

7. **Proceedings of the Committee**

7.1 Subject to the provisions of this paragraph, the Committee may regulate its proceedings as it sees fit.

7.2 The Committee will meet [monthly], or more frequently if so required.

7.3 Meetings of the Committee are anticipated to take place in private as this is appropriate to facilitate discussion and decision making on matters deemed to be commercially sensitive or confidential.

7.4 For meetings to be quorate each of the Trusts must be represented by both its chair and chief executive, or their Nominated Deputies. No decision may be taken at any meeting unless a quorum is present.

7.5 No decision may be taken at a meeting unless a quorum is present.

7.6 Declarations and notifications of interests in relation to an item of scheduled or likely business must be made at the beginning of each meeting, and the provisions of the "Protocol for Managing Conflicts of Interest" (Schedule 4 of the Group MoU) applies.

7.7 Meetings may take place in person or remotely by telephone or video conference, or a hybrid, provided that each Member participating is able to speak to each of the others, and to be heard by each of the others simultaneously.

7.8 The Committee is authorised by the Trust boards to obtain independent legal or other professional advice and to secure the attendance of such persons with relevant experience or expertise at any meeting of the Committee.

8. **Administration of the Committee**

8.1 The administration of meetings, including the provision of governance advice, maintaining the register of interests and the preparation of minutes, will be provided by the Group Programme Office.

8.2 Agendas for meetings will be determined jointly by the Committee Chair and Group Chief Executive.

8.3 Papers for each meeting will be sent from the Group Programme Office to Members no later than five working days prior to the meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4 The draft minutes of each meeting, together with a summary report from the [Group Chief Executive], will be circulated promptly to all Members as soon as reasonably practical after the date of the meeting to ensure their inclusion in the private agenda of each of the Trust's board meetings. The Committee Chair (or chair of the meeting) will be responsible for approving the first draft set of minutes for circulation to members. The Group Programme Director will provide a summary of the meeting for sharing in the public domain.

8.5 The Committee will prepare an annual report for the Trust boards on its performance against its annual work plan.

9. **Review**

9.1 It is anticipated that these Terms of Reference will be updated to reflect strategic developments in BSW. The Committee will review these Terms of Reference at least annually. Amendments to the Terms of Reference must be approved by the Trust boards.

Approved by the boards of:
Great Western Hospitals NHS Foundation Trust
Salisbury NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust

[date] 2024

ANNEX – Specific Responsibilities

1. The Committee will:

1.1 mobilise, oversee and assure successful delivery programmes in relation to the following Group Programme initiatives:

1.1.1 the design of the future Group Operating Model;

1.1.2 the "case for collaboration" as set out in [insert document which describes the case for collaboration] which identifies the 10 Areas for Collaboration (summarised in paragraph 2 below), including formulating and implementing key strategies for delivery, with a focus on improving quality and access for the people within the BSW integrated care system, achieving efficiencies and effectiveness in operations and enhancing opportunities for staff; and

1.1.3 the Trusts' response to the BSW integrated community health care services procurement exercise;

1.2 in respect of each of the areas in paragraph 1.1 above:

1.2.1 review and scrutinise key deliverables of such programmes and ensure adherence to the required timescales;

1.2.2 review significant risks to such programmes and obtain assurance that risks are being identified, managed and mitigated;

1.2.3 hold relevant teams to account for delivery of workstreams; and

1.2.4 agree communications strategies and stakeholder management strategies.

1.3 in relation to the design and/or implementation of the Group Operating Model, have authority to award contracts for consultancy and other services with individual values of up to [£1,000,000 (one million pounds sterling)] subject to procurement law and principles. When awarding contracts, the Committee shall also decide which Trust is to hold the contract and other related matters.

1.4 ensure that effective governance arrangements are in place for successful delivery of the EPR programme (overseen by a separate EPR joint committee).

2. The 10 Areas for Collaboration are:

Area 1	Tackling the challenges from chronic illness in the ageing population in the areas of the BSW integrated care system
Area 2	Aligning around transformation in Urgent and Emergency Care to better manage acute demand
Area 3	Delivering clinically sustainable services for the future
Area 4	Improving access, effectiveness and value for money of planned care
Area 5	Tackling increasing prevalence and performance challenges in cancer
Area 6	Aligning research and innovation to accelerate delivery of shared clinical priorities
Area 7	Developing a resilient workforce for the future, drawing on talents of the local population

Area 8	Creating efficiencies in the use of data and adoption of digital innovations
Area 9	Building resilience across finance
Area 10	Supporting corporate efficiency and cost reduction