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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S BRIEFING

BOARD OF DIRECTORS – 21 DECEMBER 2016

1. Integrated Performance Report

The Integrated Performance Report is attached at Appendix 1. Each Director will highlight the key issues for the Board of Directors to note/consider.

2. South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP)

A verbal update will be provided to Board members on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

3. Working Together: Governance Arrangements – Committees in Common

The Board of Directors of the seven organisations within the Working Together Programme have previously agreed that their Trusts could work together as part of an Acute Federation.

On Monday 7 November 2016, the Working Together Trust Chairs and Chief Executives participated in a presentation and discussion regarding a proposal for a move to a Committee in Common structure. This followed previous discussions on options for governance models at the October Trust Chairs meeting, when Trusts agreed in principle to pursue the proposal in more detail.

The attached report (Appendix 2) outlines the Committees in Common structure, which has been used in other partnerships and provides a solution to ensuring effective corporate governance across the network. More work would be required to establish the structure and define delegated authority levels.

The Board of Directors is requested to review the move to a Committees in Common structure for the Acute Federation under the terms set out in the attached paper and to discuss the implications for Sheffield Teaching Hospitals NHS Foundation Trust.

4. Awards and Events

Clinical Research Facility Status

The Trust has become one of only 23 research centres across England awarded funding, which will see its status as a designated NIHR Clinical Research Facility, renewed for a further five years. The award will enable clinicians, scientists and nurses to drive forward research into diseases which are areas of national priority such as cardiovascular disease, diabetes and respiratory diseases. All of which are important causes of premature death.

The investment is the second time in recent months that researchers from the Trust in partnership with the University of Sheffield have successfully secured a multi-million pound grant to support world-leading health research, with a £4m grant announced in September to set up an NIHR Biomedical Research Centre.

Investment in New Urology Outpatient Unit

A new outpatient service, which will provide a better experience for patients with urological emergencies, has been officially opened at the Royal Hallamshire Hospital. The Urology Assessment Unit, which provides care to patients referred with urgent needs, has been relocated to a newly refurbished outpatient department to provide an enhanced service for patients in a more appropriate setting. The concept for the new unit, which was previously based on an inpatient ward, was developed following a successful trial of relocating the service to an outpatient area. The trial highlighted a number of benefits which include an improved environment for patients, reduced length of stay, faster access to necessary tests and treatment, decreased admissions, and the prevention of further unnecessary hospital visits.

Trust Awarded Defence Employer Recognition Silver Award

The Trust has received a Defence Employer Recognition Scheme Silver Award in recognition of its support of military veterans and armed forces personnel in its training and recruitment schemes. The Trust was one of only ten organisations across the Yorkshire region, out of 500 candidates, praised for its flexible working practices and positive support for reservists, who in addition to being employees also train in the Navy, Army or RAF Reserves.

Anthony Nolan Award

Professor John Snowden, Consultant Haematologist, has been presented with a national award by the blood cancer charity Anthony Nolan. Professor Snowden has won the award for Clinical Supporter of the Year at the Anthony Nolan Supporter Awards 2016.

Sir Andrew Cash OBE
Chief Executive
14 December 2016

Appendix 2

Acute Federation Board: Committee in Common

1. Background

1.1 In July 2016 the Board of Directors, as part of the Working Together Partnership, confirmed the creation of the Acute Federation. This had been set out in the agreed vision for the Acute Vanguard in order to build a confederated approach that supported the development and implementation of a high level clinical strategy for the collective, and could drive potential different organisational models to facilitate wider scale change.

1.2 It was confirmed that further phases for changes to the governance structure would develop to enhance the delivery of the new models of care as the service change options became clearer. It was agreed that proposed changes would need to demonstrate that any prospective model confers more benefits than a single Trust authority confers, through organisational involvement with the Acute Federation. These benefits include:

- Sharing strong leadership and governance systems
- Improving sustainability of services
- Reducing unwarranted variation in clinical outcomes
- Aligning common clinical models
- Integrating corporate and support services
- Strengthening financial sustainability
- Joint working agreements and financial arrangements.

2. Committees in Common Model

2.1 The Committees in Common structure is a model that will support the governance journey to its next stage and enables a faster paced decision process for the Acute Federation to support the development and implementation of the system wide Sustainability and Transformation Plans. NHS Foundation Trusts and NHS Trusts are both able to delegate to committees in common. There are no changes required to the current regulatory framework.

- An NHS Foundation Trust constitution allows it to delegate any of its powers to a committee of directors or an executive director
- An NHS Trust may delegate any of its functions to a committee consisting wholly or partly of its directors or wholly of people who are not directors of the trust

2.2 Recent guidance on Acute Care Collaborations, from NHSI October 2016, states there is no statutory restriction on a director of an NHS Foundation or director of an NHS Trust holding more than one directorship, although in all cases fiduciary duties and the management of any potential conflicts of interest will need to be considered. NHS Foundation Trusts and NHS Trusts can therefore establish their own committees, which should meet at the same time and with the same remit and common agenda. Wherever possible, membership should be identical. Each committee can only make a decision in relation to its own provider but the decisions can be co-ordinated which will provide joint leadership without legal entity. The committees can be supported by a legally-binding contractual joint venture between the participating providers.

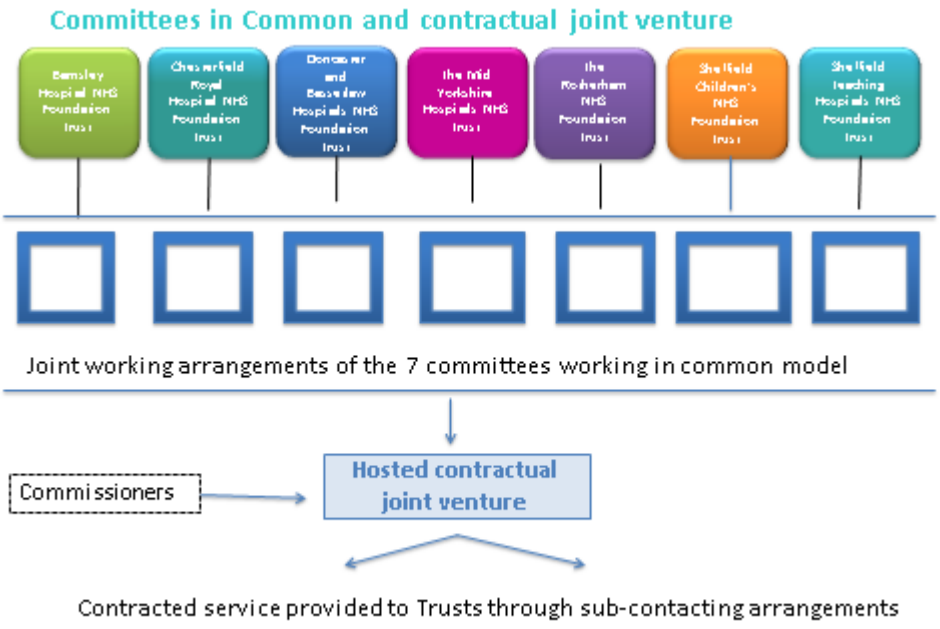
2.3 The key features of committees in common are:

- They are accountable to their own respective Boards
- Decisions made bind their own NHS Foundation Trust/.NHS Trust they do not bind any other Trust

- Although each provider appoints its own committee, they can meet at the same time and with the same remit
- Co-ordinated decision-making is improved by each committee having, wherever possible, the same membership
- The committees form a committees in common which can coordinate leadership and way of management for services
- Commissioning contracts remain with the respective providers
- Assets remain in each provider's ownership but committees in common can be given responsibility for managing them.

2.4 Addendum 1 sets out a model decision-making structure from the NHSI guidance October 2016, which is not intended to be prescriptive but illustrates how to establish effective arrangements. The model has been worked through in detail with NHSI and is operating in other health economies. The model is being explored by Foundation Groups and also other acute provider alliances.

2.5 A committees in common model has joint working arrangements setting out the principles and terms of the arrangement but is not a joint committee. The committees in common model involves each committee meeting in common with the other committees so that the seven meetings are held together at the same time. This is illustrated below.



2.6 Each Trust in the partnership will retain organisational sovereignty:

- All systems of governance remain in place at an individual site level, entailing no loss of organisational sovereignty, save that which is willingly pooled.
- Trust Board accountability and respect for the requirements for Foundation Trusts to be governed by their local communities remains.
- Nothing in the partnership agreement will require any Trusts to do anything which is in breach of legal obligations (including procurement, competition law and company law (as applicable) or which breaches any regulatory or provider licence requirements

3. The Proposal

3.1 The proposal is for the Board of Directors to formally delegate authority to a committee of Directors, i.e the Trust Chair and Chief Executive.

3.2 The extent of actual decision- making to be delegated should be determined based on usual good governance. The delegation by the Board of Directors should enable the committees in common to progress and at pace but the delegation should not be so far as to deprive the Board of its responsibility for oversight and the structure should allow the directors to discharge their statutory duties.

3.3 Delegated limits can be set as part of Standing Orders and Standing Financial Instructions and some restrictions on what can be delegated exist for example;

- appointments
- duty of candour

3.4 A NHS Foundation Trust/ NHS Trust can be in two different committees in common if the Trust is part of a different STP and is also engaged with another alliance. It could be the same committee but would probably need two separate joint working agreements. In each case the decisions that were delegated would need to be clear in respect of each remit.

3.5 The committees must be set up in the same way as any other Board committee so as to allow the directors on the Board to discharge their duties. If directors on the committee (executive or non- executives) properly act in accordance with their mandate and duties delegated to them, then they will be covered by the usual indemnities and Directors and Officers cover (through NHSLA most commonly)

3.6 There is no technical difference in the powers that are delegated to executive or non-executive directors. However it is important that the principles of good governance in relation to the executive and non- executive roles are adhered to and are compliant with the NHSI's code of governance and the Trust's own licence conditions.

3.7 Implementation steps will include a review of constitutions and Standing Orders and Standing Financial Instructions to ensure consistency with the proposed arrangements.

3.8 Co-ordinated, consistent decision-making across multiple organisations requires careful structuring. Since accountability remains with each provider's Board, there will always be some limits on what can be achieved, particularly where there are issues of service reconfiguration and related movements of revenue.

3.9 Providers should make contact with their NHS Improvement relationship managers as part of the regular oversight arrangements; they will be able to connect providers with colleagues at NHS Improvement who can advise further on any of the technical issues that might arise.

3.10 NHSI will want to make sure the proposed arrangements:

- build in sufficient management capacity across all relevant providers
- are strategically sound and lawful
- will be properly implemented.

However, the final decision to adopt the model will normally rest with the providers concerned.

3.11 Joint appointments or the formation of committees in common will not usually trigger formal NHS Improvement regulatory process unless they are taking enforcement action to implement proposals or unless a Chair / Non-Executive director is being appointed to an NHS Trust. Neither are the arrangements usually subject to a transaction review process.

3.12 Trusts should, however, consider the competition issues which arise and consequently the potential for the Competition and Markets Authority's involvement. NHSI can assist providers in navigating the competition aspects.

4. Contractual Joint Ventures

4.1 The establishment of the committees in common framework will also act as a stepping stone and provide a governance structure for the creation and oversight of new contractual joint ventures for a single or multi-services. These arrangements may include new contractual arrangements with partners in one contract, a series of sub contracts with each other or the creation of new delivery vehicles which are jointly owned by the partners.

4.2 Both NHS Foundation Trusts and NHS Trusts can enter into contractual joint ventures that are legally binding. Such ventures do not establish new bodies but can create legally binding rights and responsibilities.

4.3 In principle, contractual joint ventures can be used to establish:

- prime contractor/sub-contractor arrangements to address changes to commissioning arrangements/proposals for service reconfiguration
- financial adjustments/risk share arrangements.

4.4 Forming a corporate or contractual joint venture may trigger an NHS Improvement transaction review if the relevant thresholds for scale, monetary value and risk are met (as set out in NHSI transactions guidance).

5. Next Steps and Implementation

Step 1	Each Board of Directors to consider and confirm proposal	December 2016
Step 2	Draft Memorandum of Understanding drawn up with Trust Corporate Secretaries and joint working arrangements	December 2016
Step 3	Review of constitutions, Standing Orders and Standing Financial Instructions of each Trust to ensure: - Consistency with set up - Delegation limits	January 2017
Step 4	Liaison with NHSI	January 2017
Step 5	Assurance process in respect of: - Competition - Directors duties and any conflicts	January 2017
Step 6	Finalise documents	February 2017
Step 7	Sign off by Board of Directors	March 2017
Step 8	Committees in Common implemented with first meeting	3rd April 2017

6. Recommendation

The Board of Directors are requested to review the move to a committees in common structure for the Acute Federation under the terms set out in this paper.

Addendum 1

**(Extract from NHSI Improvement Acute care collaborations:
Guidance on options for structuring foundation groups October 2016)**

Committees in common – example of a model decision-making structure

Board of each provider in the group

Overall, each provider's board remains accountable for all decisions but most decision-making functions can be delegated to a board committee.

The provider board's main function is to monitor the committee's activities and decisions. Each provider board retains the power to change or revoke the authority delegated to its committee at any stage.

A contractual joint venture between the participants can be used to frame the arrangements.

Committee of each board

Each provider appoints its own committee. Each committee meets at the same time with the same remit. Membership of each committee should wherever possible be identical.

The board delegates authority to the committee to make key decisions, such as those relating to the following:

Strategy

- determining the standards for clinical service and helping develop working practices that achieve them effectively
- directing the development of the standardised systems, process and procedures of operations
- directing strategy and investment plans that are normally led by corporate services, including finance, IT, informatics, workforce, estates, quality improvement, commercial development
- developing new working models for corporate functions
- determining the framework that sets out each provider's quality, financial and organisational health objectives and targets
- managing the acute care collaboration in accordance with the annual plan
- developing and monitoring achievement of operating, business, efficiency and delivery plans
- identifying, reviewing and mitigating operational risks
- proposing and implementing arrangements to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes
- proposing and implementing joint working with partner organisations where collaborative approaches will yield tangible improvements and/or efficiencies
- overseeing service transformation and pathway redesign
- providing assurance to the board about quality by monitoring and acting on performance information
- overseeing process for developing and approving contracts for external support
- approving contracts with external suppliers for goods and services
- approving leases or licences for occupation of premises Finances
- operating the group in accordance with the agreed budget
- exercising good budget management, including regular monitoring of financial performance and agreeing mitigating actions where required

- exercising good asset management and staff
- developing the model and capability for leadership and managerial development
- co-ordinating and being involved in making senior appointments across the group
- exercising discretion in relation to staff composition within the agreed budget
- recruiting staff for the group (up to an agreed grade)
- deciding training and development policies subject to statutory requirements.