Appendix 1

COMPOSITION OF NCL BOARDS

North Central London NHS
Barnet - Camden - Enfield
Haringey - Islington

North Central London Boards - February 2011

Statutory PCT Boards	Joint Board					Joint Board
Chair	← Chair →					Chair
Vice Chair LOCAL NED 1	Vice Chair NED Barnet	Vice Chair NED Camden	Vice Chair NED Enfield	Vice Chair NED Haringey	Vice Chair NED Islington	Vice Chair x 5
Audit Chair	← Audit Chair →					Audit Chair
LOCAL NED 2	NED B	NED C	NED E	NED H	NED I	NED x 5
NED 3 (Shared)	NED C	NED E	NED H	NED I	NED B	
NED 4 (Shared)	NED VC E	NED VC H	NED VC I	NED VC B	NED VC C	
6						12
CEO	← Chief Executive →					CEO
DOF	← Director of Finance →					DOF
DPH (See Note)	← Director of Public Health →					DPH (See Note)
Nurse (See Note)	← Nurse →					Nurse (See Note)
PEC Chair	PEC Chair B	PEC Chair C	PEC Chair E	PEC Chair H	PEC Chair I	PEC Chairs x5
5						9
11	**PCT 1**	**PCT 2**	**PCT 3**	**PCT 4**	**PCT 5**	**21**
Up to 2 Associate NED (s)	**5 x GP Consortia Representatives**					5
	5 x Local Authority Representatives					5
	5 x LiNK Representatives					5

NOTES

DPH - The DPH on each PCT Board will be the current local DPH. At joint Board meetings, the Cluster designated DPH will normally be the only DPH present. In her absence one of the other DPH's will deputise. In the event there is specific business relating to one PCT the local DPH will attend for that business.

Nurse – (Under PEC Membership Regulations, each PEC must have a nurse member, and each PCT Board must include 2 members nominated by the PEC, one of whom must be a nurse). The Nurse on each PCT Board will be the Nurse nominated by the PEC. At joint Board meetings, the Cluster Director of Quality (Nurse) will normally be the only nurse present. In the absence of that person, one of the other PCT Board Nurse members will deputise. In the event there is specific business relating to one PCT the local Board Nurse member will attend for that business.

Sharing of NEDs – the distribution of NEDs shown above is for illustration only. Allocation of NEDS to Boards will be made at the time of appointment of NEDS

Appendix 2

NHS NORTH CENTRAL LONDON
PARTNERSHIP AGREEMENT FOR JOINT WORKING OF FIVE STATUTORY PCT BOARDS

1. BACKGROUND

This Partnership Agreement sets out the working arrangements for the five statutory Boards of NHS Barnet, Camden, Enfield, Haringey, and Islington in north central London working together.

Since July 2009 the five statutory Boards for NHS Barnet, Camden, Enfield, Haringey, and Islington have been working together sharing acute commissioning and strategic planning functions governed by the Joint Committee of PCTs. Collective working was enhanced in June 2010 with a revised establishment agreement and the setting up of a Sector Board.

In response to the challenge of reducing management costs by 54% in NCL and in light of the White Paper: Equity and Excellence: Liberating the NHS, the five PCTs of NHS Barnet, Camden, Enfield, Haringey, and Islington are coming together to share executive and non-executive capacity and governance.

This Partnership Agreement is designed to describe the way the five statutory Boards will work together. It provides a framework, and allows for more details to be added or reflected in other supporting documents such as the scheme of delegation. It sets out how the Non Executive and Executive Directors will work across all 5 PCTs and how they will relate to each individual PCT.

2. PRINCIPLES

The shared governance and integrated working arrangements are designed to maximise capacity and capability, simplify tiers of management and enable flexible pace of development of the emerging GP consortia. The principles are as follows:

2.1 Design Principles

i. The collective governance arrangements are based on each of the five PCTs continuing as statutory bodies until the legislation enacting the white paper, Equity and Excellence: Liberating the NHS is in place. The new shared governance agreement reflects the requirement set out in the Operating Framework to establish clusters so as to offer capacity to emerging GP consortia and reduce running costs.

ii. The shared governance will be achieved by the five statutory PCT Boards coming together to transact business and effectively to meet as Joint Boards. This will be the normal mode of operation. Each statutory Board may where essential meet separately to conduct local business. Through the Joint Boards, each Board continues to retain the right to delegate functions and establish formal sub-committees or joint committees for particular purposes as appropriate.

iii. Each PCT receives a financial allocation for its population and must meet the costs of NHS health care for that population. Where costs are shared, the shares will be attributed pro rata under an allocation formula agreed by the Boards (such as ration of weighted capitation). As at present PCTs can agree to risk sharing and risk pooling arrangements (as they do for example for specialised commissioning)

iv. Budgets, targets and performance management as required will apply individually to each PCT to ensure clear and transparent accountability for services and a clear audit trail.

v. Standing Orders, Standing Financial Instructions and the Scheme of Delegation and reserved matters will be adopted by all five PCTs.

vi. Principal objectives for NHS Barnet, Camden, Enfield, Haringey, and Islington will be agreed and approved by the Joint Boards, and will form the basis of a joint Board Assurance Framework.

2.2 Arrangements in Common: Joint Boards

i. One Chair who is the Chair for each of the five PCTs.

ii. One Audit Chair who is Chair of Audit for each of the five PCTs.

iii. A total of 10 Non Executive Directors (NEDs) whose responsibilities will be corporate as well as PCT specific, which can be achieved via The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment Regulations 2010. NEDs will need to be clear when making decisions which role they are fulfilling.

iv. One Accountable Officer/Chief Executive who is the Accountable Officer/Chief Executive for each of the five PCTs.

v. One Finance Director who is the statutory Finance Director for each of the five PCTs.

vi. One Director of Public Health.

vii. Five PEC Chairs

viii. One Nurse Member

2.3 Arrangements distinct to each PCT Board

i. A Vice Chair will be appointed for each of the PCTs providing leadership for local business including partnerships, projects and local transition and effective interface with the Joint Boards. Each Vice-Chair will be appointed to his/her Board from the existing complement of Chair and NEDs for that PCT. Remuneration of the Vice Chair will be as determined by NHS London and the Appointments Commission.

ii. Each PCT Board will have a Chair (common to all five), and five NEDs (the minimum provided for in statutory regulations). One of those five will be the Audit Chair (an appointment common to all PCTs). The other four NEDs will be made up of two NEDs appointed to the board from the existing complement of Chair and NEDs for that PCT and two NEDs appointed from amongst the NED Members (and Vice-Chairs) of other PCTs in NCL (all appointed in accordance with those same principles). In total there will a Chair and 11 NEDs across all the PCTs in NCL (one audit chair, 5 vice chairs and 5 other NEDs).

iii. Each PCT Board will have 5 Executive Members, consisting of the Cluster CEO and DoF, the local DPH and two Members nominated by each PCTs Professional Executive Committee, one being the Chairperson and including a GP and a Nurse member.

iv. With agreement of the Joint Boards, each PCT Board may also appoint up to two of Associate (Consultant) NEDs who will have specific responsibilities in respect of aspects of the PCT Board's work at borough level (or corporately in committees).

3. MEETINGS OF THE FIVE STATUTORY BOARDS (JOINT BOARDS)

3.1 The combined membership will maintain a majority of NEDs including the chair.

3.2 Board Executive members (voting)

3.2.1 Shared members:

i. Chief Executive/Accountable Officer
ii. Director of Finance
iii. One Nurse Member.
iv. One Director of Public Health

3.2.2 Local members:

i. One PEC Chair per PCT

3.2.3 Total Executive members are four shared and five local (Total 9).

3.2.4 The Local DPH and Nurse Member for a PCT will attend if there is business specific to that PCT.

3.3 Non Executive Director members (voting)

3.3.1 Total voting NED members are 12. Associate NEDs will not be voting members and will not attend meetings of the Joint Boards unless invited.

i. Chair
ii. Audit Chair
iii. Five Vice Chairs
iv. Five Non Executive Directors

3.4 Observers (non-voting)

3.4.1 The Joint Boards will invite attendance from the following as observers with speaking rights (subject always to the discretion of the Chair):

i. GP consortia representatives, one per PCT
ii. Local authority representatives, one per PCT
iii. LINK representatives, one per PCT.

3.5 Flexibility for developing GP consortia

PCTs are required by statute to have PECs, and they have to nominate two Board members including a GP and a nurse. These are the sole requirements. This provides considerable flexibility as consortia develop to meet the statutory requirements from the proposed Consortia governance models.

i. During the development period for GP Consortia (GPC) governance arrangements will operate in accordance with NHS London guidance for consortia Development. Shadow GPC with delegated commissioning responsibilities and budgets will operate as committees of the relevant PCT as they will not be a formally established entity until April 2013. As the development of GPCs and Health and Wellbeing Boards gathers pace NEDs and Executive working arrangements will need to be reviewed. The role of the Joint Boards in relation to the GPCs when they are established will be performance management until these responsibilities transfer to the National Commissioning Board.

3.6 Board meetings

- The five PCT Boards will meet simultaneously and will support each other through the breadth of joint discussion, building on the shared expertise across NHS Barnet, Camden, Enfield, Haringey, and Islington and the single integrated executive management arrangements which support the Boards.

- Arrangements for the meetings of the Joint Boards will be set out in Standing Orders, and the Board meetings will be conducted with due compliance.

- Meetings of the Joint Boards will take place in public on alternate months; in the intervening month the boards will meet in seminar sessions. Standing Orders will provide for the calling of Extraordinary Meetings. The public meetings will be held as far as possible on a rotational basis in each borough.

- Each PCT Board must be quorate (as defined in Standing Orders) at the meeting of the Joint Boards.

- Each PCT will appoint a Vice Chair whose role is to provide a leadership with local partners and a link to the Joint Boards. One of the Vice Chairs will be identified to deputise for the Chair of the Joint Boards. .

- An annual cycle of business will be prepared which will be agreed by the Joint Boards which will ensure that agenda items are planned to meet the business of all five PCT Boards, whilst responding where appropriate to the specific needs of each PCT.

- Agenda items and associated reports will where appropriate refer to the specifics of each PCT e.g. with regard to budgets, performance, capital schemes and health needs.

- Agendas for the Joint Boards meeting will be agreed by the Chief Executive and Chair with input from all Board members in accordance with the recent guidance on board governance – 'Healthy NHS Boards: Principles of Good Governance': February 2010, National Leadership Council.

- In accordance with Standing Orders, members of the public and representatives of the press will be asked to withdraw at the end of the public session of Joint Boards meeting to enable confidential matters to be discussed.

- Confidential issues will be dealt with under a separate agenda and minuted as confidential.

- It will be a convention enshrined in Standing Orders that in discussion of matters pertaining to a specific PCT Board, members of the other Boards will acknowledge that whilst they may feel able to contribute to the discussion, the primary discussion and decision making on the matter will rest with the relevant PCT Board members.

- Where a matter requires a vote, only statutory voting Board members of each Board will vote.

- Where a matter requiring a vote pertains to all five PCTs, voting will be by PCT. If at least four of the PCT Boards vote in favour of a proposal it will be adopted equally by all five PCTs.

- Where a matter requiring a vote pertains specifically to one PCT only the voting members of that PCT will vote.

3.7 Seminar sessions

Seminar sessions in private will be planned in the corporate calendar to enable deeper discussion on individual subjects/issues, and within which Board development will be undertaken. Agenda planning will be flexible to facilitate programming of topics raised by NEDs.

3.8 Joint Committees

The Joint Boards will establish committees which will be integrated across the five PCTs which are required by regulation and which are:

i. Joint Audit Committee
ii. Joint Pay and Remuneration Committee

The Joint Boards may establish other committees, to be agreed by the cluster board when it starts up. It is envisaged that at the outset there will be the following committees each to be chaired by a NED or in the case of Quality and Safety a clinician (with NED membership). Others may be identified.

iii. Financial Stability Committee
iv. Joint Strategy and Commissioning Committee
v. Joint Quality & Safety Committee.

4. OTHER COLLECTIVE AND LOCAL ARRANGEMENTS

a. Shared business and working arrangements

The five PCTs will continue to build on collective working arrangements for strategic planning and clinical leadership, reviewing these as appropriate as GP consortia develop. All PCT Boards retain the right to establish Joint Committees with other PCTs as appropriate to conduct business in common e.g. consultation on major service changes across London.

b. Individual PCT Board meetings

4.2.1 Each PCT Board retains the right to meet individually to conduct specific local business in exceptional circumstances

4.2.2 Committees may be set up in each PCT to take forward the business of the Joint Boards, including with specific delegated responsibility. The arrangements will need to be flexible during the transition period and reflect the development of GP consortia and Health &Wellbeing Boards.

4.3 Local clinical commissioning

Each PCT will build on its clinical commissioning arrangements to support the development of the emerging GP consortia, in collaboration with the local authority and LINks. A PEC Chair will be required to fulfil the statutory role in each PCT until such time as this is no longer a statutory requirement, and/or it is superseded by legislation relating to the formal establishment of GP Consortia.

4.4 Local leadership and relationship management

The local PCT Vice-Chair, the local NED *(NEDs)*, the PEC Chair and any Associate NEDs in each PCT will play a key role in:

i. Supporting and guiding the Borough Director and local PCT staff team and overseeing local projects and programmes within the programme set by the Joint Boards.

ii. Developing and supporting productive partnerships between the emerging GP Consortia, the local Authority, LINks and 3rd Sector.

iii. Sharing an understanding of the Joint Strategic Needs Assessment (JSNA), existing partnership arrangements, local commissioning issues and local performance.

5. DISPUTE RESOLUTION

This Partnership Agreement is voluntarily entered into and will be observed and adhered to by all five PCTs, but it is not an enforceable legal agreement. It follows that there is the potential for unresolved disputes on points of interpretation or application of this Agreement. If the Chair and Vice Chairs cannot between them agree to resolve a dispute between the five PCTs and broker agreement with their Boards, then they or the Chief Executive will refer the matter to the SHA for mediation or arbitration. Arbitration will be a last resort – the Chair and Vice Chairs will take all reasonable steps to resolve any dispute, including any discussion needed to seek compromise with Board members (executive and non-executive).

6. REVIEW OF THE PARTNERSHIP AGREEMENT

The effectiveness of the working arrangements under this Agreement will be reviewed every six months and more frequently if necessary, in the light of changing circumstances and when one or more GP Consortia reach the Intermediate Stage.

7. SIGNATURES

Signed for and on behalf of NHS Barnet; NHS Camden; NHS Enfield; NHS Haringey; and NHS Islington by the five PCT Chairs:

NHS Barnet
Name

Signature

Date

NHS Camden
Name

Signature

Date

NHS Enfield
Name

Signature

Date

NHS Haringey
Name

Signature

Date

NHS Islington
Name

Signature

Date

Appendix 3

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

Draft Governance Framework (including Sources of Assurance)

This framework draws substantially on work developed in South West London. It has been amended to reflect the local circumstances and agreements in North Central London. We acknowledge South West London's contribution to our work.

The governance framework will form the basis upon which the new NHS North Central London Board will operate from 1 April 2011. It is acknowledged that there will need to be sufficient flexibility within this to enable:

- the combined NHS North Central London Board to discharge its responsibilities in a manageable way without overly restrictive specification.
- GP consortia to develop their own governance arrangements and for incremental delegation to GP Consortia to happen over time.

The proposed arrangements are set out in a draft Partnership Agreement between the five NCL PCTs. This sets out:

- how the five statutory Boards of NHS Barnet, Camden, Enfield, Haringey, and Islington will work together from 1 April 2011;
- how non-executive and executive directors will work across all five PCTs, and how they will relate to each individual PCT; and
- an overview of proposals for Board sub-committees.

The Partnership Agreement sets out a framework for joint working in North Central London. Further work will be carried out on the operating arrangements including standing orders, schemes of delegation and operation and standing financial instructions to enable the NHS North Central London Board and single management team to operate effectively from 1 April 2011. North Central London will continue to work with NHS London and other sectors to ensure that it follows guidance and benefits from exchanging good practice.

DRAFT GOVERNANCE FRAMEWORK
(including SOURCES OF ASSURANCE)

1. INTRODUCTION

The North Central London (NCL) Board was established in 2009 to support collective working across the five PCTs in NCL to strengthen commissioning arrangements. The staffing structures to support these arrangements were put in place from autumn 2009. Since the establishment of the NCL Board there have been two particular changes to the context in which we work. The first is the tightening public sector finances. The Operating Framework for the NHS in England 2010/11 highlighted the need to significantly reduce management costs across PCTs. In London the requirement is a 54% reduction in management costs. The second significant change to the context is the proposals set out in the July White Paper "Equity and Excellence – Liberating the NHS" which signals a fundamental change to the structure of the NHS, including the introduction of GP commissioning consortia.

The management cost reduction is a key driver to enable investment in the maintenance and development of services, as well as providing funding to support the new commissioning arrangements. NHS London, which has overall responsibility for the transition from current to the new NHS structures, made it clear that it expects to use the existing sectors as the transitional vehicle in London. NHS London will also monitor the management cost reduction target for the sector as a whole rather than by individual PCT. To enable this, PCT Boards agreed to establish a single management team for NCL to enable key functions to be carried out with significantly reduced management resource and to reduce duplication.

The NCL Board concluded that the reduction required in management costs meant that the current operational model is not viable, and that we need to do more things once and fewer functions five or six times across the patch. The Board also decided that it would be appropriate to reorganise management functions with a view to the future organisational form of the NHS whilst maintaining a focus on the delivery of key functions in the short term. The reorganisation of management functions has also considered the views of key stakeholders, particularly GPs and Local Authorities.

2. NCL'S PRIORITIES FOR THE TRANSITIONAL PERIOD

During this period of substantial change, NHS NCL has agreed that to retain focus on the key priorities for health in North Central London, which are:

- Improving health outcomes for the population of North Central London;
- Financial recovery through effective service commissioning;
- Service change and transformation, with a focus on primary care;
- Assuring the quality and safety of services provided to patients in our communities; and
- Managing the transition to new commissioning arrangements for the NHS in NCL including GP Commissioning Consortia and the local authority role in Public Health.

The structure and governance for the new management arrangements must support the delivery of these key objectives across all of five PCTs in NCL.

2. PURPOSE OF THIS DOCUMENT

2.1 The primary purpose of this draft Governance Framework document is to describe in more detail the revised governance arrangements reached thus enabling those arrangements to be embedded effectively and to aid better understanding of them. It includes a Partnership Agreement for the five statutory Boards, emerging thinking on Board sub-committee structures, details of accountability arrangements as well as Executive Director roles and

responsibilities. A corporate calendar and annual cycle of business for the statutory Boards will be developed in due course once the Board sub-committee structure has been agreed.

2.2 The document describes the Governance arrangements (which are the system for controlling and directing the organisation to meet its objectives). It also sets out the assurance arrangements (both internal and external) upon which the organisation relies to ensure that its governance arrangements are working effectively. Details of these are provided in Section 10.

2.3 This document will need to be read alongside NCL's Risk Management Strategy when published and its corporate risk register. Five PCT registers together with the sector risk register will be consolidated into a single risk register by 1 April 2011. This register draws together the high level risks to which the organisation are exposed together with details of the controls for managing them. This single Risk Register will be subject to regular review by the Joint Boards as statutory Boards meeting jointly as well as the proposed single NCL Audit Committee.

2.5 These governance and assurance arrangements will be reviewed after six months following agreement to their implementation in April 2011, then annually (or more frequently if required) to ensure that they reflect the needs of the organisation and current NHS guidance and best practice. It is noted that The NHS National Leadership Council is leading a project to renew *Governing the NHS: A Guide for NHS Boards,* originally published by the Appointments Commission and the Department of Health in 2003 and upon which the governance framework within this document is based. The revised guidance was published in February 2010 (The Healthy Board; Principles for Good Governance) and will be incorporated in future reviews of this document

2.6 The NCL Organisational Development and Transitional Programme has developed alongside NCL's proposed new governance framework. The new organisational structure creates the accountability and ownership to take governance forward. As team members come into new posts they will lead on relevant areas. Working with Internal Audit, NCL has used an assurance mapping process to ensure that it is clear where duties and responsibilities fall.

3. TERMINOLOGY USED IN THIS DOCUMENT

3.1 Governance

A basic definition of (corporate) governance is:

> "the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness".

Governance is concerned with the systems, controls, accountabilities and decision-making at the highest level of the organisation. It is about the way the organisation leads and manages through its values (in the public sector of accountability, probity and openness) and its systems (such as governance structures and risk management).

3.2 Governance Framework

The governance framework describes the structure and systems that are in place to "direct and control" the organisation. For NHS NCL these are the Committee structures, management arrangements, Standing Orders, Standing Financial Instructions, Scheme of Delegation and risk management strategy. These arrangements also provide the "assurance" that the organisation relies on to know that its governance arrangements are effective.

For the purpose of this document we are confining the definition of governance framework to our Committee structures and high level management arrangements, reflecting strategic and operational accountabilities.

3.3 Assurance

Assurance is the positive evidence that the controls are managing a given risk and it is likely that the objective will be achieved. There are a wide variety of sources of assurance available to the Joint Boards, both internal and external and these are described at Section 10.

The Board Assurance Framework (BAF) is a key document that sets out the organisation's principal objectives and the risks to achieving them, along with the controls in place and assurances available on their operation. It forms a key part of the annual statutory requirement for completion of the Statement on Internal Control, which provides confirmation that the governance and assurance arrangements for the organisation are operating as they should be.

3.4 Risk Management

Risk Management is a key element of the governance framework and its components are described as follows;

Risk is the chance that something will happen that will have an impact on the achievement of NHS NCL objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

Risk Assessment is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.

Risk Management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

3.5 Glossary of Terms

A detailed glossary of terms relating to Corporate Governance is attached at Appendix 1.

4. STRATEGIC AND OPERATIONAL ACCOUNTABILITY

4.1 The Role of the statutory Boards (as set out in the NHS Reform and Health Care Professions Act 2002)

The board has **collective** responsibility for

- Adding value to, and promoting the success of the organisation.
- Providing leadership to the organisation within a framework of prudent and effective controls
- Setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance.
- Safeguarding values and ensuring the organisation's obligations to its key stakeholders are met.

Non Executive Directors on the Board share responsibility with other directors for the success of the organisation and the role of the Board set out above. However they have a special role to play within the Board team providing an independent view which is removed from the day-to-day running of the organisation. In line with the duties of non-executives in the private sector set out by Higgs[1], they have the following duties:

- *Constructively challenging and contributing to the development of strategy.*
- *Scrutinising the performance of management in meeting goals and standards, and monitoring the reporting of performance and service quality.*
- *Satisfying themselves that financial information is accurate and that financial controls and system of risk management are robust and defensible.*
- *Determining appropriate levels of remuneration of executive directors, and prime role in appointment, and where necessary removal, of senior management and in succession planning*
- *Ensuring the board acts in the best interests of the public and other stakeholders and is fully accountable for the services provided and the public funds used.*

The Joint Boards will continue to fulfil this responsibility. They will maintain their statutory responsibility conducting their business in concert as Boards meeting jointly.

4.2 The Role of the PCT Chair

The Chair is responsible for

- Leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda.
- Ensuring the provision of accurate, timely and clear information to directors.
- Arranging the regular evaluation of the performance of the board, its committees and individual directors.
- Facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

Although appointed by the NHS Appointments Commission on behalf of the local community, the Non Executive Directors report to the NHS NCL Chair, who is the Chair of the five PCTs. The Chair has a duty to meet with and support the NEDs to ensure that they are able to perform their role effectively.

4.3 Chief Executive as Accountable Officer

The NHS NCL Chief Executive is accountable to each of the statutory Boards for meeting their objectives and, as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation, via the Strategic Health Authority. It is recognised that this is likely to transfer to the National Commissioning Board subject to legislation. As Accountable Officer for each of the statutory Boards the Chief Executive has responsibility for ensuring that the organisation meets all its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and information governance, health and safety and risk management. The Chief Executive is required to sign off the Statement on Internal Control for each PCT Board annually in keeping with these responsibilities.

[1] [1] *Review of the Role and Effectiveness of Non-Executive Directors. D Higgs (2003)*

Whilst this overall responsibility is maintained, responsibilities for some aspects of governance have been delegated to statutory Board executive directors as follows, including:

Clinical Governance	Medical Director for the five PCTs who will work with the Professional Executive Committee Chairs for each PCT
Corporate Governance & Strategic Risk Management	Director of Finance
Financial Governance	Director of Finance (appointed as Accounting Officer for each of the 5 PCTs)
Information Governance	Director of Finance

The Director of Infection Prevention and Control (DIPC) role will be undertaken by the Medical Director or Directors of Public Health through expert advice from the nursing and infection control to the Board.

The responsibilities of the Chief Executive, in addition to the significant leadership and managerial elements of the role are to ensure that the Boards are empowered to govern the Trusts and that the objectives they set are accomplished through effective and properly controlled executive action.

The Chief Executive's roles and responsibilities cover:

- Leadership - helping to create the vision for the board and the organisation to modernise and improve services, with the skill to communicate this vision to others and the ability to empower them to deliver the PCTs' agendas.

- Delivery planning - by ensuring that the Board has sufficient information to agree the Strategic and Quality, Innovation, Prevention and Productivity Plan (QIPP) and/or service level agreements (SLAs) that meet the NHS Operating Framework and other priorities and that are based on realistic estimates of physical, workforce, financial capacity and patient and public involvement.

- Performance management - by ensuring that the Boards' plans and objectives are implemented and that progress towards implementation is regularly reported to the Boards using accurate systems of measurement and data management, such information being regular and timely. By agreeing the objectives of the senior executive team and reviewing their performance.

- Governance - by ensuring that the systems on which the Boards rely to govern the organisation are effective. This will enable the Chief Executive to sign the annual Statement on Internal Control on behalf of the respective Boards, to state that the systems of governance, including financial governance and risk management, are properly controlled.

4.4 Role of the Professional Executive Committee Chair

The Professional Executive Committee (PEC) Chairs are required by statue. They are responsible for clinical leadership within each PCT. Arrangements will need to be agreed in each PCT as GP Commissioning Consortia emerge to make sure that the statutory requirements for PECs are met as these new governance structures develop.

5. BOARD GOVERNANCE ARRANGEMENTS

5.1 The statutory Boards' governance arrangements are set out in the NHS NCL Partnership Agreement (Appendix 2) which has been put to all PCT Boards to agree in late February 2011. These describe clear principles for integrated working, the ways in which the statutory Boards will work together and, in the unlikely event, a mechanism for resolving disputes between the PCTs.

5.2 This Governance Framework will be supplemented with a scheme of corporate governance which includes Standing Orders, a Scheme of Delegation and Schedule of Matters Reserved to the Board, and Standing Financial Instructions. The matters reserved to the Board comprise:

- Regulations and controls
- Appointments and dismissals
- Strategy, Annual Operational Plan and Budgets
- Audit
- Annual Reports and Accounts
- Monitoring

5.3 Key features of the revised governance arrangements that will be in place from 1 April 2011 include:

- The five statutory Boards will meet simultaneously and will support each other through the breadth of joint discussion, building on the shared expertise across NHS Barnet, Camden, Enfield, Haringey, and Islington and the single integrated executive management arrangements which support the Boards.

- Board meetings will be conducted with due compliance with Standing Orders.

- Each Board must be quorate at the meeting of the Joint Boards.

- Each PCT will appoint a Vice Chair whose role in addition to being a member of the Joint Boards is to provide local leadership.

- An annual cycle of business which will ensure that agenda items are planned to meet the business of all five PCT Boards, whilst responding where appropriate to the specific needs of each PCT.

- Agenda items and associated reports will, where appropriate, refer to the specifics of each PCT eg with regard to budgets, capital schemes and health needs.

- In accordance with Standing Orders, members of the public and representatives of the press will be asked to withdraw at the end of part one of the Joint Boards meeting to enable confidential matters to be discussed.

- Confidential issues will be dealt with under a separate agenda and minuted as confidential.

- It will be a convention enshrined in Standing Orders that in discussion of matters pertaining to a specific PCT Board, members of the other Boards will acknowledge that whilst they may support discussion, primary discussion and decision making on the matter will rest with the relevant PCT Board members.

- Where a matter requires a vote, only statutory Board members of each Board will vote.

- Where a matter requires a vote which pertains specifically to one PCT only the Voting members of that PCT will vote.

5.4 Non Executive Director appointments

The framework proposes 12 voting Non Executive Director posts: a Chair; Audit Chair; five Vice Chairs; five Non Executive Directors. This means that each PCT has two local Non Executive Directors and two pooled Non Executive Directors. The Vice Chairs would be in the pool of Non Executive Director posts, meaning that each Non Executive Director will be on two PCT Boards. This proposal is designed to create capacity and resilience for PCT Boards.

There is ongoing discussion about the capacity at borough level and the possibility of local associates.

6 CORE GOVERNANCE COMMITTEE STRUCTURE

6.1 In order to deliver the Principal Objectives and the strategic priorities within the NHS NCL Strategic Plan and Quality, Innovation, Prevention and Productivity (QIPP) Plan, the Boards will establish relevant sub-Committees, the remits of which are still under discussion.

6.2 Each Committee is authorised by the statutory Boards of the PCTs to pursue any activity within their Terms of Reference and within the Scheme of Reservation and Delegation. They are required to comply with:

- the PCTs' Standing Orders and Standing Financial Instructions
- the PCTs' Conflict Of Interest Policy
- the section of the PCTs' Scheme of Delegation which refers to the committee.

6 BOARD COMMITTEES

The statutory Boards will establish a single Joint Audit Committee and a Joint Remuneration and Terms of Services Committee which will be integrated across the five PCTs. All other Board sub-committees are being determined. Should functions be delegated to pathfinder GP consortia until 2013 PCT Board sub-committees will be established and will adopt the NHS London model terms of reference and scheme of delegation.

7.1 Single Audit Committee (that is meeting of each PCTs' Audit Committees jointly)

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the five statutory Boards propose to establish a Joint Audit Committee. The Committees will provide each of the five Boards with an independent and objective review of their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Committees' cycle of business will include a review of an integrated Boards Assurance Framework and corporate risk register. The Committees are non-executive committees of the Joint Boards and have no executive powers, other than those specifically delegated. Accounts will continue to be produced for each of the five PCTs. Terms of reference for the single Audit Committee are under discussion and will be in place by 1 April 2011.

Reporting arrangements: The formal minutes of Joint Audit Committee meetings shall be recorded and submitted to the Joint Boards. The Audit Chair shall draw to the attention of the Joint Boards any issues that require disclosure, or require executive action.

The Audit Committee will report to the Joint Boards annually on its work in support of the Statements on Internal Control, specifically commenting on the fitness for purpose of the governance and assurance arrangements, the extent to which it considers the application

of risk management as a discipline to be embedded within the organisation, and the appropriateness of the self-assessment against the Care Quality Commission standards. The single Audit Committee will ensure each PCT completes their annual accounts.

7.2 Joint Remuneration and Terms of Service Committee

The Committee is established to advise on and make recommendations to the Statutory Boards in respect of the remuneration and terms of service for the Chief Executive, Directors and other officer members paid through the Very Senior Manager Pay Framework. The Committee will also take decisions on appointment, remuneration and terms of service for the Clinical Executive Committee in line with Department of Health guidance.

Reporting arrangements: The membership of the Committee for each of its meetings should be recorded and recommendations should be formally reviewed by the Joint Chair of the PCTs, Non Executive Directors and the Chief Executive.

The Committee will report in writing to the Joint Boards the basis for its recommendations. The Joint Boards will use that report as the basis for their decisions but remain accountable for taking decisions on the remunerations, allowances and terms of service of other officer members. Minutes of the Statutory Boards' meetings shall record such decisions.

7.3 Local Committees

Each statutory Board may in exceptional circumstances meet individually to conduct specific local business.

7.4 Governance Support to Statutory Boards and Board Committees

Support is provided to the statutory Boards to conduct their business and to the Board Committees through governance resources falling under the Director of Transition and Corporate Affairs, as well as functional lead directors' team for the committees. The support role is to ensure that all meetings operate effectively with regard to their Terms of Reference and their reporting arrangements.

An annual cycle of business for the Statutory Boards will be prepared which will be refreshed annually.
A Board development programme will be developed annually to support Directors in fulfilling their roles and responsibilities, and will be evaluated at Board seminars.

8. PARTNERSHIP WORKING

The local PCT Vice-Chair, the local Non-Executive Director, the PEC Chair or GP Consortia leads and any Associate Non-Executive Directors (if confirmed) will play a key role in:

- supporting and guiding the Borough Director and local PCT staff team and overseeing local programmes and projects within remit set by joint boards/CEO; and
- developing and supporting productive partnerships between the emerging GP Consortia, the Local Authority, LINks and the third sector, sharing an understanding of the Joint Strategic Needs Assessments (JSNAs), partnership arrangements, local commissioning issues and local performance.

The statutory Boards retain the right to establish Joint Committees with other PCTs as appropriate to conduct business in common e.g. consultation on major service changes across NCL or London.

8.1 Local partnerships

A range of partnerships are in place in each borough to support communities to thrive, deliver improved outcomes for local people, achieve improvements in respect of 'place', make best use of resources and secure integrated services that better meet health and social care needs. The White Paper Equity and Excellence: Liberating the NHS increases the role of Local Authorities in respect of democratic accountability, strategic planning, holding the ring and health and well-being. Public Health led by the Directors of Public Health will play an increasingly important role in supporting both parties to achieve joint solutions and better health and well being outcomes as well as efficiencies in the planning and commissioning of health and social care services. The JSNAs, led by Directors of Public Health, will provide a solid foundation for this work. Each PCT will continue to play an active part in local planning and partnership arrangements with governance arrangements led by the respective Local Authorities.

8.2 Development of pathfinder GP Consortia

By April 2013 consortia will be established as freestanding NHS bodies with responsibility for commissioning a wide range of services. PCTs will be accountable for commissioning up to April 2013. NHS NCL will be:

- working within the single London-wide process for assessing pathfinder proposals;
- agreeing with pathfinders a timetable setting out when they will be assuming delegated responsibilities; and
- adopting London-wide model terms of reference and a scheme of delegation for a PCT Board committee to support delegation of responsibilities to pathfinders.

8.3 Links with Pan London commissioning arrangements

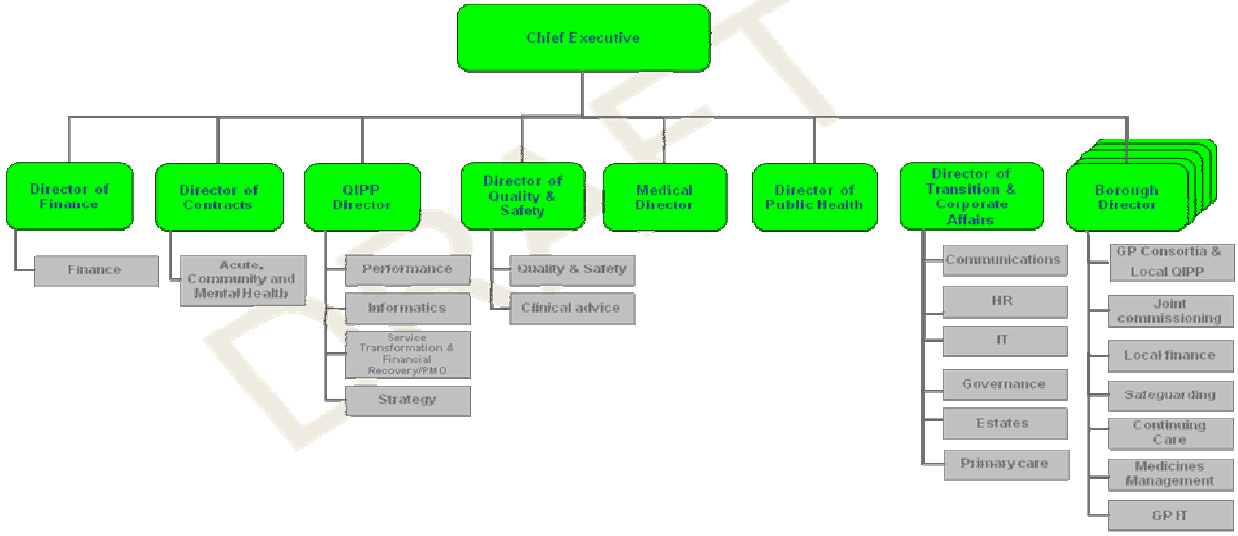
London Specialised Commissioning Group (LSCG) is hosted by NHS Croydon and is governed by the NHS NCL Governance Framework. The NHS NCL Chief Executive is accountable for the commissioning of these specialised services with NCL management responsibility lying with the Director of Contracts.

The current operating arrangements will be maintained with leadership from a Board whose non-executive directors are drawn from each of the London sectors including NCL.

9. OPERATIONAL DELIVERY - MANAGEMENT ARRANGEMENTS

9.1 In line with the Transitional arrangements approved by the PCT Boards in November 2010 for consultation the proposed senior structure is set out below.

NCL Structure



9.2 Directors have specific responsibility for the identification and management of risks as follows;

- co-ordinating operational risk in their specific area
- ensuring that all services for which they have responsibility are assessed appropriately for risks and mitigating action taken
- complying with the requirement for completion of their Directorate risk register(s)
- ensuring that risk treatment plans are produced for all extreme and high risks
- advising the Audit Committee where funding is not available to manage extreme or high risks
- monitoring progress against action plans
- ensuring that their staff are aware of their risk management responsibilities
- establishing and maintaining a team brief forum where risk management is a regular item
- incorporating risk management in the business planning process
- ensuring that policies and procedures agreed by the statutory Boards are implemented.

10. ASSURANCE ARRANGEMENTS

10.1 To complement and support the Governance arrangements, the Joint Boards will also receive assurance, both internally and externally, with the objectives of;

- providing the means of assurance as required by the Governance Framework
- using the Assurance processes as a means of ensuring that the Governance framework is complete and current

The various sources of internal and external assurance available to the Boards are set out in Appendix i.

10.2 As part of the overall assurance arrangements and in order to meet the requirement to complete an annual Statement on Internal Control, the Board is required to have in place a Board Assurance Framework (BAF). The BAF is a document that sets out the risks for each organisational objective, along with the controls in place and assurances available on their operation.

10.3 The purpose of the BAF is to provide the statutory Boards with "reasonable" assurance that systems are in place to identify and control risks that may prevent the organisation from achieving its principal organisational objectives. The term "reasonable" assurance is used in recognition of the fact that it is unlikely ever to be possible to provide absolute assurance that all risks have been identified and effectively controlled. Nevertheless, the BAF aims to provide the board with assurance that risks have been identified and are being appropriately controlled, and that there is timely and reliable assurance in place to evidence this. Importantly, there are a number of questions that this process sets out to answer as follows;

- How can the board be confident that its objectives can be achieved, what assurances exist?
- What are the risks that may prevent the achievement of strategic and corporate objectives?
- What actions are in place to manage those risks?
- How does the board know that these are effective?

In assessing risks, NHS NCL will ensure through its risk management strategy that this is done on a realistic basis and that any potential risks to achievement of its objectives and reasonably foreseeable. Full details of processes for gaining assurance through the BAF will be set out in the NCL risk management strategy.

11. MONITORING AND REPORTING

The Joint Boards will draw assurance from the following arrangements for ensuring that both the risk register and assurance framework are proactively monitored so that the processes are embedded within the organisation and link to key business, planning and investment decisions:

- Directorate Risk Registers - monitored at directorate level Directorate level and reviewed at the Operational Risk Committee
- Corporate Risk Register - monitored at Audit Committee.
- Assurance Framework - monitored at corporate level by lead Directors; for fitness of assurances/controls at Audit Committee; reviewed by statutory Boards.

12. CONCLUSION

12.1 The governance strategy and assurance framework are supported by the implementation of the key strategies, policies and plans. The Joint Boards need to remain confident that the systems, policies and people they have in place are operating in a way that is effective, are managing the delivery of objectives and targets and are focused on good governance practices.

12.2 In order to achieve this confidence, the PCT statutory Boards will

- review the governance arrangements after six months, and then annually to ensure they remain fit for purpose

- review and revise the organisational objectives identified with the assurance framework on an annual basis
- review the internal and independent assurances on which the assurance framework relies and make adequate arrangements to address any gaps
- require corporate documents and policies to be regularly reviewed, monitored and audited in accordance with the process identified within each document.
- implement and maintain an adequate performance review framework
- receive information/annual reports in accordance with the Boards' annual programme, and as delegated to Committees
- consider the internal auditor's opinion statement to improve the robustness of the assurance framework
- consider the outcomes of other independent assurance to improve the robustness of the assurance framework
- receive annual and other reports from core governance committees
- receive reports and communication from directors, managers and staff
- undertake evaluation of the performance of the statutory Boards as a minimum bi-annually.

12.3 Effective governance and assurance arrangements are critical in ensuring the confidence of the boards, staff, patients, the public and partner organisations and for the effective delivery and execution of its functions. Developing a culture of openness and transparency is integral to assuring all of the effectiveness of these arrangements, together with an environment that fosters and develops personal and organisational growth as a key to success.

Appendix i

"Corporate Governance" in the NHS – A Glossary of Terms

"The ideas, principles and mechanisms constituting governance in the NHS derive from an amalgam drawn from corporate governance, public governance and a variety of other sources. The resulting miscellany presents directors, managers and senior clinicians with a considerable sense-making challenge".

(Richard Solti & John Storey, Clinical and non clinical director's sense making of the new governance arrangements in the NHS. Open University Business School, May 2008).

1. Corporate Governance

A basic definition of (corporate) governance is:

"the system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness."

In effect, it is concerned with systems, processes, controls, accountabilities and decision-making at the heart of and at the highest levels of an organisation. It is about the way the organisation leads and manages through its values (in the public sector usually accountability, probity, openness) and its systems (such as governance structures and risk management).

2. Governance Framework

This describes the arrangements and systems that are in place to "direct and control" the organisation. For NHS NCL these are our Committee structures, management arrangements, Standing Orders, and risk management strategy and systems. These arrangements also provide the "**assurance"** that the organisation relies on to know that its governance arrangements are effective.

3. Assurance

3.1 **Assurance** is the positive evidence that controls are managing a given risk and it is likely that the underlying objective will be achieved. As the Audit Commission report "Taking it On Trust" suggests an informal way of looking at it was given by the chief executive of a Foundation Trust who said "assurance is about me being able to sleep at night" or put another way, "how do I know what is being done in my name?".

3.2 For a Board there are many sources of assurance (sometimes referred to as the **Assurance Framework**), some of which are as follows;

Sources of Assurance

Internal sources of assurance	External sources of assurance
• Internal audit • Performance monitoring reports • KPIs • Sub – committee reports • Compliance audit reports • Clinical audit • Local counter fraud work • Staff satisfaction surveys • Staff appraisals • Training records • Training evaluation reports • Results of internal investigations • SUI reports • Complaints records • Infection control reports • Standards for Better Health self assessment • Patient advice and liaison reports • Human resource reports • Internal benchmarking • Board Assurance Framework • Strategic Plan/Annual Operating Plan objectives (delivery of national objectives) • Risk Management Strategy • Executive Director Board reports • Executive Director reports to Committees and periodic attendance for review of risks/assurance	• External audit • Audit Commission • NHS Litigation Authority • Clinical Negligence Scheme for Trusts • Care Quality Commission • Strategic health authority reports/reviews • Royal College visits • Deanery visits • External benchmarking • Patient environment action team reports • Accreditation schemes • National and regional audits • Peer reviews • Feedback from service users • External advisers • Local networks • Investors in people • World class commissioning assessment

(Primary Source: "Taking it on Trust", Audit Commission, 2009)

3.3 The **Board Assurance Framework** (BAF) is a key document that sets out the trust's strategic objectives and the risks to achieving them, along with the controls in place and assurances available on their operation. It forms a key part of the annual statutory requirement for completion of the **Statement on Internal Control** (SIC) which the Chief Executive and Board sign off. The SIC represents confirmation that the governance and assurance arrangements for the organisation are operating as they should be.

4. Risk Management

4.1 Risk management is a key element of the governance framework and its components are described as follows;

Risk is the chance that something will happen that will have an impact on the achievement of the organisation's objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring).

Risk Management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

Risk Assessment is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.

5. Risk Registers

5.1 A **Risk Register** is

"***A log of risks of all kinds that threaten an organisation's success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how these risks should be treated."*** *(Risk Register Working Group 2002, NHS Controls Assurance).*

5.2 NHS NCL has a structured approach in place for completion of its risk registers, as follows;

- The **Directorate Risk Register** contains a local record of all potential risks identified within the Directorate.
- The **Corporate Risk Register** contains those extreme and high risks that have been identified in the Directorate risk registers to the achievement of organisational objectives.
- The **Top Risks report** sets out the most significant risks to the organisation identified from the Corporate Risk Register. The risks are mapped to the Board Assurance Framework.

6. Other Important Terms

6.1 **Integrated Governance** has become the overall term to describe the various forms of governance such as corporate, clinical and financial, and is described as follows;

"Systems, processes and behaviours by which organisations lead, direct and control their function in order to achieve organisational objectives, safety and quality of service…." *(Integrated Governance Handbook, 2006).*

6.2 **Clinical Governance** is described as;

"The means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards." *(Clinical Governance; a quality duty for health organisations 1998, Liam Donaldson)*

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