Belfast Health and Social Care Trust

Northern Health and Social Care Trust

Northern Ireland Ambulance Service Health and Social Care Trust

Southern Health and Social Care Trust

South Eastern Health and Social Care Trust

Western Health and Social Care Trust

TERMS OF REFERENCE

Committee in Common

Health and Social Care Trusts, Northern Ireland

Terms of Reference

1. Introduction

1.1 The six Health and Social Care Trusts (HSCT) in Northern Ireland (NI) are committed to achieving the best possible outcomes for people across NI by working collaboratively on agreed system priorities that cannot be delivered effectively by any single organisation alone. This reflects a shared commitment to a whole-system approach to optimise health and social care services, reduce variation, improve equity, and strengthen long-term sustainability.

1.2 This approach aligns with the Department of Health (DoH) Health and Social Care Reset Plan, July 2025 (the Reset Plan) and the Three-Year Strategic Plan – Stabilise, Reform, Deliver, December 2024 (the Three-Year Plan), which emphasise collective leadership, integration, prevention, and reform in response to rising demand, workforce pressures, financial constraints, and persistent health inequalities. The HSCT, in conjunction with DoH, recognise that success depends on clarity of purpose, collaboration, open and transparent dialogue and agreed ways of working.

1.3 To support this collaborative approach, each HSCT has agreed to participate in a Committee in Common (CiC) model to enable structured, strategic partnership working, subject to ongoing Trust Board approval of collective priorities. The CiC provides a formal mechanism to strengthen coordination, align strategic priorities, support provider collaboration, and enhance system-level insight, while preserving the statutory accountability and autonomy of individual Trust Boards. The governance structure and operating model for the CiC is set out in Appendix A.

1.4 The CiC will act as a system-level advisory and coordination forum for Provider Collaboratives (PCs). PCs are partnerships that bring together two or more HSC Trusts to work together at scale to benefit their populations. PCs operate as a delivery mechanism for CiC as agreed by participating Trust Boards. Trusts working together through PCs remain accountable to their respective Trust Boards.

PCs will:

- Operate as delivery vehicles for agreed collaborative priorities approved by Trust Boards
- Update on progress, risks, and outcomes through the CiC for alignment, advisory oversight, and shared learning
- Align with Trust Board approved programme priorities, informed by CiC advisory recommendations
- Support system wide standardisation, service redesign, and pathway improvement.

This ensures alignment between strategy and delivery, consistent oversight, and respect for Trust level governance and accountability.

2. Authority and Scope

2.1 The CiC provides a formal advisory forum to shape, coordinate, and support collective working across HSCT.

2.2 The CiC operates in an advisory capacity only without creating joint liability. Each Trust Board retains full statutory responsibility and accountability for decisions, service delivery, performance, quality, safety, and financial management.

2.3 The CiC's advisory role within the system governance model is illustrated in Appendix A, including its relationship to Trust Boards, PCs, and system partners.

2.4 The CiC does not replace, override, or dilute Trust Board authority. It supports Trust Boards through shared insight, strategic alignment, constructive challenge and coordination.

2.5 The CiC does not hold delegated authority to:

- Commit Trust resources
- Direct operational delivery within Trusts

- Enter binding contractual or financial agreements
- Mandate participation in PCs
- Make decisions that fetter the statutory autonomy of individual Trusts.

2.6 Any recommendations made by the CiC must be considered and, where appropriate, approved through each Trust's established governance and decision-making processes.

3. Purpose

3.1 These Terms of Reference define the role, remit, membership, authority, governance, and reporting arrangements of the CiC.

The CiC purpose is to:

- Act as a forum for collective horizon scanning, system insight and problem solving
- Promote shared learning, consistency, and standardisation whilst reducing variation
- Promote clear, consistent, and transparent communication on collaborative activity.
- Provide a strategic forum for alignment and coordination of cross Trust priorities
- Support alignment with DoH policy, Reset Plan priorities, and Strategic Planning and Performance Group (SPPG) commissioning frameworks

4. Aims and Objectives

4.1 Aims

The CiC aims to:

- Improve population health and long-term service sustainability across Northern Ireland
- Enable effective cross Trust collaboration to improve quality, productivity, and efficiency
- Strengthen scale and spread of effective practice and shared learning
- Support development of clinically safe, financially sustainable, and equitable models of care
- Promote a shared strategic vision for world class, integrated health and social care services.

4.2 Objectives

The CiC will:

- Support the prioritisation, development, review, and advisory oversight of cross Trust models of care requiring collaboration between Trusts as providers
- Seek confirmation from PCs that they have undertaken appropriate engagement with clinicians, managers, staff, trade unions, partners, and service users and carers, and that such engagement has informed their proposals and delivery plans
- Support development and tracking of shared outcomes, benefits, and value
- Maintain visibility of system wide risks, interdependencies, workforce pressures, and affordability challenges
- Promote adoption at scale of best practice initiatives demonstrating improved outcomes
- Support mutual delivery review and shared challenge

- Engage with SPPG, the Public Health Agency (PHA), the Business Services Organisation (BSO), DoH, regulators, and key system partners
- Monitor CiC portfolio level risks identified by PCs and unintended impacts
- Oversee PCs and track agreed outcomes and benefits
- Provide recommendations to Trust Boards on matters with system wide impact
- Seek professional advice from clinical, finance, Human Resources (HR), and other reference groups.
- Review and advise on PCs, joint ventures, innovation or new corporate vehicles where appropriate
- Review and update the Charter and these Terms of Reference annually
- Support Trusts to deliver clinically safe, equitable, high quality, and financially sustainable services.

5. CiC Portfolio Responsibilities

5.1 The CiC will oversee a portfolio of selected collaborative work across the HSCTs. Provider Collaboratives (PCs) will deliver the individual programmes and projects within this portfolio, using a programme management framework that has been agreed by the participating Trust Boards.

5.2 The CiC does not manage, control, or direct PCs. Participation in collaborative delivery is subject to approval by individual Trust Boards.

5.3 Trusts working together through PCs remain accountable to participating Trust Boards and will provide updates to the CiC for advisory, and coordination purposes only

5.4 Monitoring CiC benefits realisation and shared outcome indicators

5.5 Identifying CiC portfolio level risks, and improvement opportunities

5.6 Supporting shared learning and scale and spread of effective practice

5.7 Reviewing portfolio priorities, interdependencies, risks, and benefits

5.8 Advising on collective opportunities where collaboration may improve outcomes or sustainability

5.9 The Trust Chief Executives Forum / System Leadership Executive Group will normally meet in advance of the Committee in Common (CiC). It will seek to

resolve issues arising from Provider Collaborative programmes where possible and consider matters that may require escalation through established Provider Collaborative reporting arrangements. The group operates in an advisory capacity and does not replace the governance responsibilities of Trust Boards or the reporting arrangements between Provider Collaboratives and the CiC.

5.10 Appendix A sets out the governance structure illustrating insight, advisory and relationships across DoH, SPPG, BSO, PHA, Partners, HSCT Boards, PCs, and the CiC.

6. Decision Pathway & Accountability

Function	**Provider Collaboratives**	**CiC Role**	**Trust Boards**
Set strategic priorities	Informs	Advises	Considers & Approves where appropriate
Approve participation in collaboration	Delivers	Recommends	Decides
Commit resources	Executes	Advise	Approves
Delivery & operations	Responsible	Advise	Accountable
Risk escalation	Mitigates	Identifies	Owns
Benefits realisation	Delivers	Reviews & advises	Accountable

7. Reporting Requirements

7.1 Following receipt of CiC meeting papers and discussion of agenda items, Members shall consider whether any matters, including risks, recommendations, performance concerns, or strategic issues, require consideration by their respective Trust Boards.

7.2 Members shall ensure matters requiring Trust Board awareness or decision are brought forward for inclusion on the agenda (normally the private or confidential section) of the next available Trust Board meeting.

7.3 Following each CiC meeting, a standardised update for Trust Boards and briefing report shall be produced summarising:

- Key discussions and system insights
- Recommendations and advisory positions
- Risks, interdependencies, and emerging concerns
- Matters requiring Trust Board consideration and decision or endorsement
- Progress against agreed priorities, outcomes, and benefits
- Updates from PCs.

This update for Trust Boards will be completed by secretariat and approved by the CiC Chair prior to being issued to the Trust Chairs by the secretariat.

7.4 Meeting notes shall be submitted to each Trust Chair and tabled at the next Trust Board meeting as soon as practicable. Meeting notes are approved by the CiC Chair and shared with CiC members by the secretariat.

7.5 Reporting shall maintain a clear audit trail, demonstrate collective challenge, and enable Trust Boards to fulfil their governance responsibilities and exercise fully informed statutory decision making.

8. Membership

8.1 The CiC shall be constituted of Directors from each Trust as follows:

- Trust Chair
- Chief Executive
- One additional Executive Director or Non-Executive Director
- Each shall be referred to as a Member.

8.2 A Member shall nominate a Director/Non-Executive Director level Deputy (a Nominated Deputy).

8.3 In the absence of a CiC Member, a Nominated Deputy may attend meetings, count toward quorum, and participate fully. For the purposes of these Terms of Reference, Nominated Deputies shall be included within the definition of Members when attending in place of a substantive Member.

8.4 In line with the CiC Charter, Members are expected to provide senior level leadership, objective challenge, and act in the best interests of the Health and Social Care (HSC) system while remaining accountable to their respective Trust Boards.

9. Chairing Arrangements

9.1 HSC NI Trusts' Chairs will nominate a Trust Chair for the position of CiC Chair

9.2 The length of tenure will be two years with the option for a third year – subject to review

9.3 The Chair is responsible for agenda approval, meeting discipline, balanced discussion, and confirming accurate recording of actions and recommendations.

9.4 The Chair will work closely with the Programme Leads and Secretariat.

10. Attendees

10.1 The Trust Corporate Governance Secretary from the Chair's HSCT may be invited to attend CiC meetings at the Chair's discretion to support the provision of HSC Trust governance advice.

10.2 Representatives from DoH, SPPG, BSO, and PHA may attend meetings as system partners, but not as Members.

10.3 CiC Programme Leads shall attend meetings of the CiC. Programme Leads support coordination and alignment of the collaborative portfolio, programmes, and Provider Collaboratives (PCs), ensuring consistent reporting and visibility of progress, risks, and interdependencies. They support system-level coordination across participating Trusts and provide portfolio insight to inform HSCT CiC advisory oversight and Trust Board decision-making.

10.4 Programme Leads do not hold decision-making authority. Accountability for delivery remains with participating Trust Boards and their respective Provider Collaboratives.

10.5 The Chair may invite additional individuals relevant to specific agenda items to attend and contribute.

11. Meetings

11.1 Meetings will be held quarterly, or more frequently if required.

11.2 Meetings will normally be held in private.

11.3 Extraordinary meetings may be convened for urgent system matters.

12. Quorum

12.1 A meeting shall be quorate where at least two Members (or Nominated Deputies) from each Trust are present.

12.2 Where quorum is not achieved, discussions may proceed but no formal recommendations will be issued.

13. Attendance

13.1 Each Trust shall ensure Members (or Nominated Deputies) attend except in urgent or unavoidable circumstances.

13.2 Attendance may be in person or virtual. In person attendance is preferred with virtual attendance used where necessary and proportionate.

13.3 Members and attendees are expected to maintain a minimum attendance rate of 75%.

13.4 Persistent non-attendance may be escalated to Trust Chairs.

14. Administration

14.1 Secretariat support will be provided by the Northern Ireland Confederation for Health and Social Care (NICON), including:

- Development and circulation of an annual meeting schedule
- Circulation of agendas and papers at least five (5) working days before meetings
- Preparation and circulation of draft notes within five (5) working days following meetings
- The Chair will approve draft notes within five (5) working days of receipt
- Maintaining an action log, tracking progress on agreed actions, and reporting outstanding actions. At each meeting, notes will be approved unless comments are submitted within four (4) working days of circulation.

14.2 Agendas will be drafted by CiC Programme Leads and approved by the Chair.

15. Conduct & Conflicts of Interest

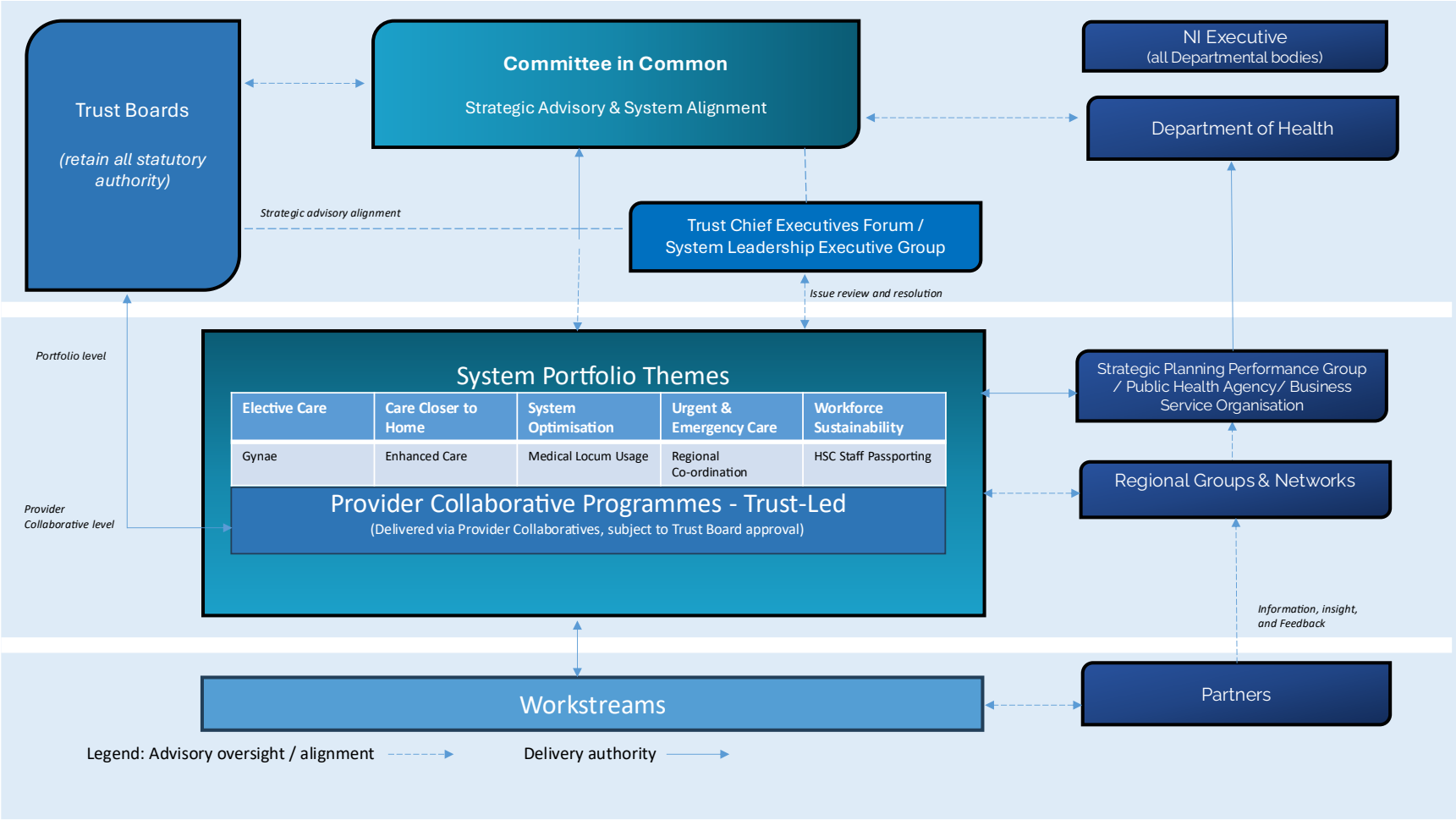
15.1 Members will:

- Declare actual or potential conflicts of interest verbally at the beginning of each meeting, and as they arise. This will be recorded in meeting notes. It will also be recorded as part of annual ToR review.
- At all relevant times act in accordance with the Nolan Principles of Public Life
- Maintain confidentiality, collective responsibility, and as far as appropriate balance Trust interests with system wide benefit.

16. Review

16.1 These Terms of Reference will be reviewed annually, or sooner if required due to legislative, policy, or system changes.

Appendix A - Governance Structure & Operating Model



The governance structure diagram illustrates insight, advisory and relationships across DoH, SPPG, BSO, PHA, Partners, HSCT Trust Boards, Provider Collaboratives, and the CiC. The CiC provides strategic Advisory oversight and system coordination. It does not hold delegated authority, does not direct Provider Collaboratives, and does not override Trust Board decision making. Statutory accountability and delivery responsibility remain with individual Trust Boards.