



# GOOD GOVERNANCE HANDBOOK

From the Good Governance Institute and  
Healthcare Quality Improvement Partnership

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## 1. Introduction

This document has been designed to provide some key principles of good governance that can aid decision making at board level in healthcare providers. The guide builds on previous best practice guidance<sup>1,2</sup> whilst recognising the major impact of the current changes to the NHS architecture. It is intended to be of interest to existing NHS boards, emerging Clinical Commissioning Groups and Health and Wellbeing Boards and those responsible for managing governance systems and processes within healthcare.

## 2. Purpose of governance

Governance is based on a set of principles that has developed over time to meet new challenges in areas such as: risk, finance, quality, probity, commerce and reputation. The current 'rules' and reactions to these challenges can usually be traced back to an initiating principle. Understanding these principles helps those tasked with developing appropriate governance to apply sensible solutions.

Governance initially started to develop as the management of organisations separated from their ownership. As commerce grew more sophisticated in the late 18<sup>th</sup> century and more stakeholders became involved in organisations, governance started to develop as a means of looking after their interests. Custom and practice, advisory codes, the law and the compliance requirements of lenders and investors started to shape the governance structures and systems we know today. Governance should deliver a focus on:

- Vision – a shared understanding of what it is the organisation is trying to achieve and the difference it intends to create.
- Strategy – the planned achievement of the vision.
- Leadership – the means by which the organisation will take forward the strategy.
- Assurance – comfort and confirmation that the organisation is delivering the strategy to plan, manages risk to itself and others, works within the law, delivers safe, quality services and has a proper grip on resources of all kinds and for which it is accountable.
- Probity – that the organisation is behaving according to proper standards of conduct and acts in an open and transparent manner.
- Stewardship – that the organisation applies proper care to resources and opportunities belonging to others but for which it is responsible, or can effect.

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*1 Department of Health, Governing the NHS: A Guide for NHS Boards, June 2003*

*2 Department of Health, Integrated Governance Handbook, February 2006*

### 3. Good governance in today's NHS

#### 3.1 The context for improved governance

The Government is instituting significant system change in the NHS. Those on NHS boards, developing new organisations and overseeing service changes have all been keen to understand how this will affect the way NHS organisations will be governed in the future. The Secretary of State has said:

*“We will not fall into the trap of prescribing top-down processes or governance requirements to say how this should be achieved.”<sup>3</sup>*

This makes it clear that accountability for public funds and service provision will rest with local healthcare organisations themselves. As the Health and Social Care Bill has been developed following ‘The 2011 Pause’ and the authorisation regime for Clinical Commissioning Groups (CCGs) has emerged, it is clear that the Government requires a high degree of accountability and maturity from those leading local NHS organisations. In 2012 the Department of Health intends to publish a guide for CCGs: ‘Towards establishment: Creating responsive and accountable clinical commissioning groups’ which, in part, is aimed at helping these groups develop robust governance arrangements. The new CCGs and other healthcare providers will need to understand and apply the essential principles of good governance, and find a sensible, proportionate way of applying these locally. This challenge extends with new players entering the market in the form of Health and Wellbeing Boards (HWBs) and Clinical Senates, as well as the continuing challenge of developing accountability systems within a complex, inter-related care system where a patient’s journey is usually the joint endeavour of several organisations.

NHS organisations have been extremely agile in the past at taking prescribed models of governance and finding ways of making them work locally. The challenge is now different. While there is a degree of central ‘scripting’ of local governance models, those developing CCGs or developing NHS Foundation Trusts (FTs) need to develop their own local model which will deliver high local accountability, help fuel innovation and the achievement of business goals and at the same time sensibly manage risk and deliver quality and safety. Additionally, as health care is, increasingly, planned and delivered across pathways of care, good governance within partnerships and across organisational boundaries becomes all the more critical (governance between organisations or GBO).

Governance thinking is in part described in law, in part through academic enquiry and in part from various codes of better practice developed both within the UK and internationally. The NHS has developed its own codes and recommendations, these largely being drawn from commercial models. Those developing governance systems look to these sources, and benchmark better practice in comparable organisations.

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<sup>3</sup> *Liberating the NHS: Commissioning for Patients. A Consultation on Proposals Department of Health, 22 July 010, Gateway ref 14483, p33*

In line with the Government's approach, governance thinking has been moving on from the 'comply or explain' model to that promoted by the King Committee on Corporate Governance in South Africa in their King III report.<sup>4</sup> Professor Mervyn King has been developing the 'apply and explain' model, which encourages organisations to develop the governance system that suits them best and then explain to all stakeholders why this delivers added value. Indeed, Sir Adrian Cadbury himself has described the King III Report<sup>5</sup> as '*the future of corporate governance*'. We draw on principles advanced by Mervyn King in this document.

In healthcare, there are elements of good governance that require special emphasis. Healthcare is a high-risk industry. It is also going through significant and perpetual change. Aside from the Government's changes to the organisational architecture of the NHS, medical science is advancing at a rapid pace. At the same time, the needs of the 'customer base' (patients) are dramatically changing too. Population morbidity is moving towards one with a significant burden of treatable chronic illness, and the implications of organisational changes to meet these needs are significant. Extra resources will need to be found within the system in order to meet the known demands placed on the NHS by advances in medicine and changes in demography and morbidity. This all provides boards with a significant challenge over the next decade.

When considering safety and quality, boards need to be mindful of the enquiries and concerns around governance evidenced by Mid Staffordshire NHS Foundation Trust<sup>6</sup>, Winterbourne View<sup>7</sup> and (differently), the night nurse incidents in Airedale and the insulin incidents in Stockport. Other incidents typifying the issue around quality and safety would include the continuing fallout from the Baby Peter case<sup>8</sup>. These all imply shifts in the locus and significance of governance.

King III also commends integrated reporting. This is reinforced in a telling quote about Mid Staffordshire from former Secretary of State for Health, Andy Burnham MP:

*"The main lesson I take from the problems experienced at Mid-Staffs – that in future, we must never separate quality and financial data. They are always two sides of the same coin."*

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4 King M et al, King report on Corporate Governance – King III, King Committee on Corporate Governance, 2009

5 King M et al, *ibid*

6 <http://www.midstaffspublicinquiry.com/>

7 CQC, Review of Compliance: Castlebeck Care (Teesdale)Ltd – Winterbourne View, July 2011

8 The Lord Laming, The Protection of Children in England: A progress Report, 12 March 2009

### 3.2 The role of regulators and commissioners

Commissioners of services hold some responsibility for the quality of services they buy. However, regulators also have a key role in assessing quality alongside the provider itself. In relation to Winterbourne View, Stephen Dorrell MP, Chairman of the Commons Health Committee, pointed out:

*"Someone had to sign the cheque that the care home operator was being paid to provide a service of £3,000 per week. I presume the majority of those cases were paid for with public funds. The people who signed the cheque have a duty to make certain that standards are of an adequate nature."*

It is wrong to assume regulators with their complex systems were assuming the extended role of providing boards with assurance that all was well. Indeed, Monitor frequently espoused that a trust board must be its own first line regulator. This helps to clarify a clear principle of public sector governance. The board is not in place simply to defend the reputation of the institution but has accountability to its users and wider stakeholders. This builds on many decades of corporate governance practice in the commercial sector where directors and boards have clear, balanced responsibilities to various stakeholders and are not just there to assure the commercial success of the company concerned.

### 3.3 Addressing Risk

Boards increasingly need to take an eclectic view of risk, seeking positive assurance that services are safe, cost effective and fit for purpose. This is difficult in times of financial constraint and system upheaval. Bill Moyes, then Chief Executive of Monitor, suggested in 2009 that a number of NHS FTs still had *'An unrealistic view as to the extent of the risk and challenges they face'*. Several studies have challenged the ability of public boards to adequately handle current and potential risks, including reputational risk, from partners and suppliers. HM Treasury had defined risk appetite as *'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.'*<sup>9</sup>

Subsequent Treasury documents<sup>10</sup> indicate that if an organisation has not made a formal statement on its risk appetite, it will have a control problem. Without such a statement managers are working with insufficient guidance on the levels of risk that they are permitted to take, or not seizing important opportunities due to a perception that taking on additional risk is discouraged. This suggests the need for new joined up approaches to clarify both risk appetite and the handling of risk.

There are positive signs that NHS organisations are beginning to develop parameters for their risk appetite. For example, University Hospital South Manchester NHS FT has appointed the first Chief Risk Officer in the NHS, as suggested in the recent review of

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<sup>9</sup> HM Treasury, *Thinking About Your Risk: Setting and communicating your risk appetite*, November 2006

<sup>10</sup> HM Treasury, *Risk Assessment Framework: a tool for departments*, July 2009

corporate governance<sup>11</sup>. The Care Quality Commission (CQC) use Quality Risk Profiles which have been developed for all NHS organisations as a way of determining when and what to base their inspection programme on.

A recent Airmic publication, written by Cass Business School,<sup>12</sup> identified seven broad areas of risk that have traditionally been beyond the scope of risk management. The research identified key lessons associated with the failure to prevent significant crises and thereafter manage the consequences. The failures that gave rise to each crisis were analysed and seven key issues emerged:

- board skills and inability of Non Executive Directors (NED)members to exercise control
- blindness to inherent risks, such as risks to the business model or reputation
- inadequate leadership on ethos and culture
- defective internal communication and information flow
- organisational complexity and change
- inappropriate incentives, both implicit and explicit
- ‘Glass Ceiling’ effects that prevent risk managers from addressing risks emanating from top echelons.

### **3.4 The challenge for governance today**

All of the above adds up to a new and very different challenge to NHS and other healthcare boards in the coming years. We are moving away from a spoon-fed, prescribed model of leadership and governance to one where boards will need to craft their own arrangements, based on good governance principles and established better practice. Boards will need to ensure that they are in a state of continual preparedness for an ever-changing world, where significant demands are placed on their organisations and budgets.

Additionally, as CCG boards and HWBs develop many individuals new to board governance roles are entering the scene in critical roles, controlling complex, important organisations. And last but by no means least, organisations need to respond to the current crisis in credibility that safety and quality issues are identified and managed at board level. This amounts to a manifesto for a better understanding of what good governance is, what it can deliver and what the foundation principles are, upon which, good governance practice can be developed.

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<sup>11</sup> Financial Services Authority, *Effective Corporate Governance: Significant influence controlled functions and the Walker Review*, September 2010

<sup>12</sup> Airmic, *Roads to Ruin A Study of Major Risk Events: Their origins, impact and implications*, July 2011



## 4. Principles of Governance and why they are important

In this document the following nine foundation principles of good governance are offered. Each of these reflect Alpa's<sup>13</sup> premise that principles should be of fundamental value; understood by users as the essential characteristics of the system and reflect the system's designed purpose.

These principles will help those boards and those developing governance systems to decide what is most appropriate for the specific needs of their organisation.

### Governance principle 1: Entity

An organisation is a discrete entity and a legal personality. Thus the organisation as a corporate body owes duties of care and needs to observe responsibilities and compliances that are separate from those of the organisation's owners or those controlling the organisation. Often, the organisation will have its own limited liability.

#### *Why it is important*

Often governance issues arise when one is uncertain about what the entity is one is dealing with, such as in a network, across a service continuum or when services are delivered through a partnership or contract arrangement. It is important to understand what the entity is and who is accountable, and that the entity concerned should be legally constituted, aware of its responsibilities and easy to identify.

### Governance principle 2: Accountability - The 'controlling mind'

Organisations are run by people, and those who direct the organisation and act as the organisation's 'controlling mind' need to be readily identifiable to any who might have dealings with that organisation, in order that all can understand who is accountable for the control of the organisation and who can enter into engagements on the organisation's behalf. Where the organisation has been separated from its owners (that is, is not a sole trader or a partnership where the principals are singly and jointly liable for the control of the business entity) and is a body corporate then those who act as the controlling mind are usually termed 'directors'. Directors have responsibilities in law for looking after the interests of the organisation and of all stakeholders. The balance of how this is executed will change as the organisation encounters opportunities and challenges. Directors act collectively as a board, this being the overall accountable group that comprises the 'controlling mind'.

#### *Why it is important*

All legal entities should be controlled by identifiable individuals who can be brought to account for their actions. Within an organisation, it is important to be able to distinguish between those who are accountable for the organisation and those who

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<sup>13</sup> Alpa, Guido "General Principles of Law," *Annual Survey of International & Comparative Law: Vol. 1: Iss. 1, Article 2* 1994

are not. This is important for both internal control, and to ensure that external parties understand with whom they can make binding arrangements on behalf of the organisation. Those controlling an organisation need to be formally required to look after all stakeholder interests. They should have formal duties around their conduct and accountability.

The Corporate Manslaughter and Corporate Homicide Act 2007, which came into effect on 6 April 2008, disposed of the need to identify a single individual as the 'controlling mind' - meaning now that a trust can be prosecuted as a corporate body.

### **Governance principle 3: Stakeholders**

Governance needs to consider all stakeholders, even those who may not be immediately apparent. Stakeholders will classically include:

- owners of the enterprise
- investors (who may or may not be the owners)
- customers
- clients (who may be different from the customers)
- beneficiaries (who in healthcare organisations may be different from customers and clients)
- those whose money the organisation uses or is steward to, including creditors and bankers
- regulators, who increasingly use governance systems to help support their work
- staff
- the wider environment and community.

#### *Why it is important*

It is important to recognise that in a complex world the conduct of an organisation can have significant effects on many, and as such those controlling organisations need to pay formal consideration to those who their actions might effect. In healthcare, it is important to be able to separate out responsibilities which in other industries would be congruent, such as to customers, clients and beneficiaries.

NHS organisations are custodians, for example, of public funds, credit, private investment in the form of PFIs as well as resources belonging to individuals – pay owed to staff or patient property, for example. As in any high-risk industry, stakeholders increasingly rely on regulators to ensure that stakeholder interests are looked after and so the many regulators in healthcare have a material interest in how an organisation is governed.

## Governance principle 4: Governance and management

Directors may in addition to their governance responsibilities also have a portfolio of management responsibilities, these being the duties to manage and operate the enterprise from day-to-day. Directors need to separate themselves from their management role when they are acting as the controlling mind of the organisation and are acting as overall guardian to stakeholder interests. The origin of the word 'director' is from the word 'steer', while that of the word management is 'to hold in the hand'.

Governance concerns:

- **Vision** – being certain why the organisation exists in the first place – its purpose and what difference it intends to make.
- **Strategy** – the planned means by which the organisation delivers the vision.
- **Leadership** – how the organisation is able to deliver the strategy over time
- **Assurance** – that the organisation does what it says it will do and behaves in the manner it has agreed.
- **Probity** – that the organisation meets standards of openness and transparency, acts with integrity and in good faith. In the public sector, taking note of the Nolan principles of public life.
- **Stewardship** – that the organisation is responsible with resources, especially other people's resources (such as credit).

The purpose of governance is to ensure better decisions. We separate governance from management by the role each has in decisions. Management *makes* (or crafts) decisions. By this we mean management identifies an issue, gathers and analyses the data, identifies and weights options consults and comes up with recommendations. Directors in their governance role then *take* decisions, and move at that point from being *responsible to accountable*.

### *Why it is important*

Governance works on the separation of powers, so that those running the organisation day-to-day are internally accountable to themselves and others who have a focused governing role. This ensures that the broader interests of the organisation, investors, owner and other stakeholders are balanced and that the organisation is not run in the interests of those staffing it. Those governing an organisation are additionally charged with ensuring that they recruit in a team most able to run the organisation successfully, to meet strategic aims and in the interests of stakeholders. The board has privy knowledge of the organisation that is unique and so is the best system for ensuring that the performance of management meets the requirements of all stakeholders.

It is now generally recognised that a corporate governance structure with separate representatives in the roles of chair and chief executive "resolves inherent conflicts of interest and clarifies accountability -- the chair to the shareholders and the chief executive to the board". (Northwest & Ethical Investments commenting on RIM, Times 14 6 11))

Fred Steingraber, (AT Kearney), reflecting on the fact that it is far more common in North America than Britain for companies to combine the role of chair and chief executive has said that:

“British companies were often better placed than American groups to respond to business challenges, such as succession planning, because of the separation of the role of chairman and chief executive meant that the chairman was free to offer oversight to the board.”

### **Governance principle 5: The board and constructive challenge**

Directors come together as a board to shape policy and take decisions. They need to consider the interests of the organisation and of all stakeholders. In order to take the best decisions the board will need to be informed, and have to hand all relevant information and advice pertinent to a decision. The board will need to consider options and consequences. In order to do this efficiently and effectively the board will go through a process of constructive challenge, where ideas, beliefs, facts and recommendations will be tested in order to verify, confirm or overturn as appropriate.

Larger organisations with more complex accountabilities to multiple stakeholders will do this by having some directors who do not hold management positions as part of the board. These are termed ‘non-executive’ or ‘independent’ directors. Independent directors may be drawn from significant investors or recruited as holding particular skills and experience in order that they can usefully challenge and help the board arrive at sound decisions. Drawing independent directors into holding a portfolio of responsibilities confounds their ability to apply constructive challenge.

In trustee boards all members of the board are usually without benefit or pay, and so will usually be non-executive.

In smaller commercial organisations all directors will usually hold a paid position within the organisation and have a portfolio of responsibilities. In larger commercial and most public corporations the board is comprised of both executive and non-executive directors and this is termed a unitary board. Whether executive or non-executive, the responsibility of all directors for the organisation’s and stakeholder interests remain the same. The need to participate in constructive challenge likewise remains the same.

#### *Why it is important*

A successful enterprise needs to continually make informed decisions about direction, markets, resource allocation and capacity. Decisions need a form of internal testing to provide a transparent explanation as to why one course of action was agreed over others. Testing such decisions is best done through a form of constructive challenge whereby assumptions are not allowed to stand without being tested, and partial views are tempered by considering alternatives

## Governance principle 6: Delegation and reservation

Boards will set out how they govern through a system of delegation and reservation. The board will overtly decide what decisions it reserves (or holds) to itself as a governance responsibility, and those it will delegate elsewhere. The most significant delegation is usually to management, but boards may also delegate to sub-groups of the board itself, to advisors, to partners or through other controlled means. Boards will describe the limits and substance of all delegations and reservations.

Typical forms of delegation within an organisation, aside that to management, will include formally agreed delegation to board sub committees. These should be few in number and not confused with management groups often misleadingly called 'committees'.

The only required committees are audit and remuneration & appointments, although many organisations will have a charitable trust committee and mental health service providers (the 'Managing Authority') and commissioners (the Supervisory Body) will require appropriate structures and assurance for their application of Deprivation of Liberty Safeguards (DOLS) and review.

Advice over the years has also variously recommended clinical governance/quality, investment and risk committees.

- **Audit committee** – a sub-committee of the board comprising non-executive directors, but not the Chair or Vice Chair, who will assure the board that ALL the governance systems and processes including clinical are working. The audit committee will have a special relationship with the internal auditors, and may invite executive colleagues to attend and participate in meetings. Better practice (Audit Committee Handbook, HFMA 2011) indicates that the audit committee should have at least one closed meeting each year without management present in order to provide feedback and discuss candidly the auditor's relationships with management and the adequacy of resources available.
- **Remuneration and appointments committee** – which will oversee appointments to the board and all matters relating to remuneration and pay for board members. It is very important that the remuneration and appointments committee is able to show proper process to explain why appointments have been made to the board, and why particular rewards packages have been agreed.
- **Risk/investment committee** – which will look at the prospective risk environment and help the board gauge its appetite for and approach to risk. This committee is rehearsed in the approach taken to governance by Sir David Walker's review of the banks, and the investment committee recommendations by Monitor. This committee will have a key role in developing the organisation's risk appetite.

- **Quality committee** – usually established to help the board develop and understand service quality issues. On occasions the committee may test the quality approach by ‘deep-dive’ type interest in areas of service quality. The aim of this committee is to ensure that the board mainstreams consideration of service and clinical issues over time. ‘Quality governance’ has been coined by Monitor to refer to the Board’s leadership on quality and their ability to understand the relative quality of services their Trust provides; identify and manage risks to quality; act against poor performance; and implement plans to drive continuous improvement. In an environment of tighter public finances and the need to make significant efficiency savings, it is crucial that all Boards of NHS organisations are able to identify and manage risks to the quality of their services in the same way they would their financial position.
- **Task and finish groups** – these ad hoc groups will be set up by the board to take on a delegated, specific and time-limited responsibility, usually around a particular task or to provide the board with specific advice. This might include financial or performance turnaround, adoption of a new status or regulatory regime or consideration of mergers and acquisitions.

#### *Why it is important*

Governing boards need to formally agree in a transparent way what role they will take in the detailed direction of an organisation. This will be different for each organisation and dependent on the level of risk, market forces, the detailed knowledge required to undertake particular tasks and the maturity of management.

The controlling mind of the organisation needs to plan and be explicit about the level of direction it will need to exert itself, and that which it is comfortable to discharge to others, both within and outside the organisation. This will help other stakeholders assess risk and control for themselves.

The board must be clear in the role and delegated authority of committees, and indeed the use of the term ‘committee’ which we suggest is overused in the NHS. It is unnecessary to include non-governance committees in the Trust organogram of governance structures and a clear distinction must be made between board committees and management groups.

#### **Governance principle 7: Openness and transparency**

Organisations should have the confidence that their business and decision-making processes would stand exposure to the public eye. This ensures that organisations meet important legal and compliance requirements, as well as fosters good business practice through building reputational and brand value. Decisions and conduct should be auditable and explainable. A new duty of candour is to be imposed on all NHS organisations, which will include a requirement for boards to meet in public and for any service failings to be dealt with in an open and transparent manner.

Nolan<sup>14</sup> says on Openness:

“Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.”

#### *Why it is important*

Boards and directors should work as if at any time their conduct, decisions and working arrangements could be made open to public scrutiny. Boards of public organisations and the work of their directors concerns public money and services.

The behaviour of boards and individual directors should be of a standard to never compromise the work of the organisation over which they preside through creating reputational damage. Lord Nolan created standards for conduct in public life that apply to all NHS board members, and Baroness Fritchie has developed guidance to help individual board members manage conflict of interest issues

It is a critical part of being an effective healthcare organisation that the public and service users should trust the organisation concerned, believe advice when it is given and feel confident to seek care for themselves and their families. Openness and transparency are essential components of building this trust

#### **Governance principle 8: Board supports**

To enable the board to work well, the board will need to work through the various roles and support systems it needs in place. These include:

- **Directors** – both executive and non-executive, who jointly comprise the unitary board and who are ultimately responsible for the enterprise.
- **Executive directors** – who in addition to their director responsibilities hold an executive portfolio.
- **Non-executives** – who are directors kept separate from the management process and can therefore support the success of the organisation by applying constructive challenge and scrutiny to matters brought before them.
- **Chief executive** – the executive accountable officer.
- **Chair** – responsible for ensuring that the board has proper information with which to carry out its responsibilities, chairs meetings in a way that allows proper debate and scrutiny of all matters brought before it. The Chair may also have an external ambassadorial role. The chair will appraise all directors – in their role as directors - on an annual basis, and provide feedback on their contribution to the work of the board. The Chair should also initiate regular reviews of the collective performance of the Board and address any developmental issues.

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14 *The Nolan Committee, First Report on standards in public life, 1995*



- **Board Secretary** – who will ensure that the proper company processes for the board are followed, and will work with the Chair and the chief executive to plan the annual cycle of business and the agenda and papers for individual board meetings. The board secretary should be available to advise the board that decisions have been properly made.
- **Senior Independent Director (SID)** – who will be available to all board members wishing to informally discuss their role and contribution to the board and who will conduct the annual appraisal and feedback session for the Chair. In Industry the SID provides the shareholder facing role and with increasing application of a membership model in the NHS this may develop as an appropriate SID role.

### *Why it is important*

A board model of governance requires different individuals to take different roles in order to deliver on the preceding principles of governance. Different actors need to be charged with different parts of the accountability continuum, and there need to be managed systems to ensure that information, advice and challenge are brought together to arrive at the best decisions for all stakeholders. It is important that the different individuals concerned understand their individual roles in making sure the board governance system works and can respond to future needs.

The National Inquiry into Fit for Purpose Governance (CIHM 2009) found that non-executive board directors were unwilling to openly challenge their executive counterparts; that there is an excessive focus on the relationship between the chief executive and chair to the detriment of other board members; and that there is too much emphasis on the structure of the board, rather than on its processes and dynamics.

### **Governance principle 9: Knowing the organisation and the market**

Those acting as the controlling mind of an organisation have a duty to know and understand the organisation they are responsible for, and the market in which the organisation operates. Within the organisation the board needs to understand and be assured that relevant compliances are being met, and that the organisation remains fit for purpose. Externally boards need to understand opportunities and risks.

In order to do this, boards should have in place systematic processes so that they remain informed and assured at all times. The most significant of these will be the organised delegation to management, described above, and the setting of tolerances around when and how management should bring matters to the attention of the board. Other systems boards will have in place to remain aware of internal and external issues will be specific governance and information systems, such as performance reports, the board assurance framework, the risk register, decision tracker, audit plans and professional advice.



To ensure that these systems are robust and are functioning properly larger organisations will have an audit committee, which is a committee of non-executives (without the Chair) who will have an on-going assurance role to the board that all relevant governance systems are working and delivering added value.

Boards need to check continually that their knowledge of their own organisation and of the market is sufficient for purpose, but do so without delving into the management of the organisation itself.

Finally, Boards and their members have a responsibility to anticipate and respond to their external environment. This is always dynamic and a good board will spend time future proofing the organisation by paying attention to new (or newly appreciated) risks and opportunities. This can be done by directors rehearsing locally what has gone wrong (and right) elsewhere, boundary issues and evaluating their own instincts.

#### *Why it is important*

Skills alone are not enough to discharge accountabilities to stakeholders. Those running an organisation must have an intimate knowledge of the organisation for themselves before they can assure and act on behalf of other stakeholders. Additionally, those governing an organisation need to understand the external environment in order that they know the consequences of their decisions can manage risk and are able to anticipate the outcome of different options.

To provide constructive challenge directors need to understand more than generic business practice. In healthcare, when strategic decisions need to be taken the various options themselves will require a degree of professional insight and confidence in order to challenge and add to informed debate. Directors who do not familiarise themselves with the market they operate in are being derelict in regard to their overall responsibilities to stakeholders.

## 5. Types of Governance

### 5.1 Mechanics of Governance

The general approach for unitary boards is to adopt the UK Corporate Governance code (previously known as the Combined Code)<sup>15</sup> on the basis of the Cadbury, Greenbury and Higgs reports.<sup>16,17,18</sup>

The main principle of the code is that every institution should be headed by an effective board, which is collectively responsible for the success of the organisation. The board's role is to provide leadership of the organisation within a framework of prudent and effective controls which enables risk to be assessed and managed.

The board should operate in the round focusing on the business of the organisation by:

- constructive challenge and shaping proposals on strategy
- scrutinising the performance of management in meeting agreed goals and objectives
- monitoring the reporting of performance
- satisfying themselves that services are safe and cost effective; on the integrity of financial information and that controls and systems of risk management are robust and defensible.

There should be just one governance; the use of qualifying adjectives is unhelpful and perpetuates or encourages silos of governance however it is important for boards to understand what is meant by regulators and others introducing terms such as Quality, Clinical, Information and Research Governance especially where compliance is expected or required. It is for the board to seek to align and integrate these components and demonstrate grip over them all.

### 5.2 Quality and Clinical Governance

Everyone who uses the NHS expects to receive care of the highest standard. "Quality Governance: The duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body" is a legal requirement.<sup>19</sup>

From 1997 and in part in response to the Bristol Heart Inquiry<sup>20</sup> this ambition has been supported by the concept of Clinical Governance:

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*15 Financial Reporting Council, The UK Corporate Governance Code, June 2010*

*16 Cadbury report, Financial Aspects of Corporate Governance, 1992*

*17 Greenbury report, Directors' Remuneration, 1995*

*18 Higgs Report, Review of the role and effectiveness of non-executive directors, 2003*

*19 Health and Social Care (Community Health and Standards) Act 2003*

*20 The Bristol Royal Infirmary Inquiry, July 2001*

“a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” – Professor Liam Donaldson, Chief Medical Officer (1997)

And a general responsibility for all to contribute:

"Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality"<sup>21</sup>

The Scottish definition of clinical governance continues to be:

“Corporate accountability for clinical performance”<sup>22</sup>

### **Quality Governance (National Quality Board)**

In 2011 the National Quality Board developed the publication: Quality Governance in the NHS - A guide for provider boards.<sup>23</sup>

“The primary purpose of the NHS, and everyone working within it, is to provide a high quality service....however ultimately, it must be the board and leaders of provider organisations that take final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care.”

The report recognises that not all NHS organisations have a formally constituted board (e.g. General Practice) and therefore, expects any reference to ‘board’ to be understood as the collective clinical leadership.

### **Quality Governance (Monitor)**

Monitor has published a framework<sup>24</sup> which sought to assess the combination of structures and processes in place, both at, and below, board level which enable a trust board to assure itself on the quality of care it provides.

Monitor expects each and every foundation trust board member to understand their ultimate accountability for quality.

There should be in place ‘a clear organisation structure’ that cascades responsibility for delivering quality performance from ‘board to ward to board.’

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<sup>21</sup> Department of Health, *A First Class Service - Quality in the new NHS*, April 1998

<sup>22</sup> The Scottish Office, *Designed to Care*, 1997

<sup>23</sup> Department of Health, *Quality Governance in the NHS – A guide for provider boards*, March 2011

<sup>24</sup> Monitor, *Quality Governance Framework*, July 2010

The Framework is underpinned by 10 questions:

1. Does quality drive the Trust's strategy?
2. Is the Board sufficiently aware of potential risks to quality?
3. Does the Board have the necessary leadership and skills?
4. Does the Board promote a quality focussed culture throughout the Trust?
5. Are there clear roles and accountabilities in relation to quality governance?
6. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
7. Does the Board actively engage patients, staff and other key stakeholders on quality?
8. Is appropriate quality information being analysed and challenged?
9. Is the Board assured of the robustness of the quality information?
10. Is quality information being used effectively?

The Good Governance Institute has produced a maturity matrix reflecting the 10 Quality Governance challenges but has added an eleventh:

11. Is quality governance aligned with other forms of governance?

### 5.3 Integrated Governance

Integrated governance was introduced as a response to a number of issues including the devolution of accountability to local services and commissioners and the view that boards are important but must be focused and add value. Also, although clinical governance encompasses clinical audit; clinical effectiveness and research; risk management; education and training; patient and public involvement. The separation of corporate and clinical governance led to a silo approach in many organisations, where clinical issues were separated from finance, staffing and estates. Integrated governance was described not as a form of governance but rather a movement from uninterrupted to integrated.

*“Integrated Governance provides the umbrella for all NHS governance approaches. It combines the principles of corporate/financial accountability and it moves towards a single risk sensitivity process which covers all the trust's objectives, supported by a coordinated source of collecting information and subject to coordinated inspection”.<sup>25</sup>*

The NHS Confederation's integrated governance debate paper<sup>26</sup> was followed by the Integrated Governance Handbook published by NHS CGST and Department of Health2

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<sup>25</sup> Chief Executive Bulletin, 13-18 November 2004, Issue 245, Item 7

<sup>26</sup> NHS Confederation, The Development of Integrated Governance, May 2004

which set out a process for integration and alignment. It set out ten key elements which were developed as maturity matrices and gave support to the use of such tools as the board assurance framework, annual cycle of business, effective use of dashboard information, annual board review and an overhaul of sub-committees of the board. The original handbook is still available on the DH website been updated in two HFMA volumes.<sup>27,28</sup>

#### **5.4 Information Governance**

Information Governance is the way by which the NHS handles all organisational information - in particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

It provides a framework to bringing together the requirements, standards and best practice that apply to the handling of information. It has four fundamental aims:

- To support the provision of high quality care by promoting the effective and appropriate use of information.
- To encourage responsible staff to work closely together, preventing duplication of effort and enabling more efficient use of resources.
- To develop support arrangements and provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards.
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

The Department of Health produces and regularly updates a performance tool ‘the Information Governance Toolkit’ which draws together legal rules and central guidance from sources such as The Data Protection Act 1998 and The Freedom of Information Act 2000.

It presents them in one place as a set of information governance requirements. Organisations are required to carry out self-assessments of their compliance against the IG requirements.<sup>29</sup>

#### **5.5 Research Governance**

Research Governance can be defined as the broad range of regulations, principles and standards of good practice that exist to achieve, and continuously improve, research quality across all aspects of healthcare in the UK and worldwide.

By healthcare research it is taken to mean any health-related research which involves humans, their tissue and/or data.

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<sup>27</sup> HFMA, *Integrated Governance: delivering reform on 2 ½ days a month, 2007*

<sup>28</sup> HFMA, *Integrated Governance: A guide to risk and joining up the reforms, 2011*

<sup>29</sup> <https://www.igt.connectingforhealth.nhs.uk/>

Research Governance applies to everyone connected to healthcare research, whether as a chief investigator, care professional, researcher or their employer(s) or support staff.

The Research Governance Framework<sup>30</sup> defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards.

NB: The framework is currently under review in line with statements in the White Paper 'Equity and excellence: liberating the NHS: "The Government will cut the bureaucracy involved in medical research. We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research. In the light of this review we will consider the legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification."

## 5.6 Staff Governance

In Scotland staff governance focuses on how NHS Scotland staff are managed and feel they are managed by one of Scotland's largest employers.<sup>31</sup>

Staff governance is the third pillar of the governance framework (alongside clinical and financial governance) within which NHS Boards, must operate. The NHS Reform (Scotland) Act 2004 makes NHS employers legally accountable for staff governance, in the same way that they are already responsible under law for the quality of clinical care and for appropriate financial management.

The Staff Governance Standard<sup>32</sup> is the key policy document which defines the five elements that make up staff governance specifying that staff are entitled to be: well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and provided with an improved and safe working environment.

NHS employers must be able to show that they have systems which not only identify areas for improvement around staff governance, but also develop and monitor action plans. The Staff Governance Standard is monitored by the Partnership Forums in each NHS Board through the [national staff survey](#) and through the Self Assessment Audit Tool (SAAT). The SAAT sets out the key measures that demonstrate progress towards meeting exemplary employer status.

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<sup>30</sup> Department of Health, *Research Governance Framework for health and Social Care, August 2010*

<sup>31</sup> <http://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/overview/>

<sup>32</sup> [http://www.sehd.scot.nhs.uk/psu/documents/staff\\_governance\\_standard.pdf](http://www.sehd.scot.nhs.uk/psu/documents/staff_governance_standard.pdf)

## 6. Behaviours, Systems and Supports

The Board is not simply a group of individuals. It needs to work together if not as a team as a group which is clear about roles and relationships. It will need support from individuals and systems which provide information, analysis, assurance and identification of risk.

### 6.1 Behaviours

From outside the NHS the report on corporate governance in financial institutions prepared by Sir David Walker,<sup>33</sup> said “principal deficiencies in... boards related much more to patterns of behaviour than to organisation.”

Good board governance cannot be legislated for but can be built over time. According to Sonnenfeld,<sup>34</sup> the ‘best bets’ for success are:

- A climate of trust and candour in which important information is shared with all board members and provided early enough for them to digest and understand.
- A climate in which dissent is not seen as disloyalty and in which mavericks and dissenters are not punished.
- A fluid portfolio of roles for directors so individuals are not typecast into rigid positions on the board.
- Individual accountability with directors given tasks that require them to inform the rest of the board about issues facing the organisation.
- Regular evaluation of board performance.

The publication identified four characteristics of effective boards:

- A focus on strategic decision-making.
- Board members who trust each other and act cohesively / behave corporately.
- Constructive challenge by board members of each other.
- Effective chairs who ensure meetings have clear and effective processes.
- Attempts at Improving Board Effectiveness.

Behaviours determine the actions of the organisation and are a vital element of good governance. Some behaviours are expected and prescribed, others reflect experience, styles and etiquettes adopted or learnt.

### 6.2 Good Governance Standard for Public Services

In January 2005, an Independent Commission established by the Chartered Institute of Public Finance and Accountancy ( CIPFA) and the Office for Public Management (OPM), under the Chairmanship of Sir Alan Langlands, published its Good Governance Standard for Public Services.<sup>35</sup> The standard consists of six principles.

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33 FRC, *The Walker Review of Corporate Governance of UK Banking Industry*, 2009

34 Harvard Business Review, *What makes great boards great?* September 2002

35 [www.cipfa.org.uk/pt/download/governance\\_standard.pdf](http://www.cipfa.org.uk/pt/download/governance_standard.pdf)

### Good governance means:

- Focusing on the organisation's purpose and on outcomes for citizens and service users.
- Performing effectively in clearly defined functions and roles.
- Promoting values for the whole organisation and demonstrating the values of good governance through behaviour.
- Taking informed, transparent decisions and managing risk.
- Developing the capacity and capability of the governing body to be effective.
- Engaging stakeholders and making accountability real.

### 6.3 The Nolan Principles of Public Life

*"The only way to be sure that they do the right thing is to keep an eye on them, to challenge them, to hold them to account and, above all, to take part in them."* Nolan (1996)

The Nolan Committee<sup>14</sup> concluded that public bodies should draw up 'Codes of Conduct' incorporating the following principles, and that internal systems for maintaining standards should be supported by independent scrutiny.

#### The Seven Principles of Public Life:

1. **Selflessness:** Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
2. **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
3. **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
4. **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
6. **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
7. **Leadership:** Holders of public office should promote and support these



principles by leadership and example.

## 6.4 NHS Constitution

The NHS Constitution was first published on 21 January 2009 and applies to NHS services in England<sup>36</sup>. The NHS Constitution sets out current existing legal rights in one place. All NHS organisations have a responsibility to enforce it, and a legal duty to take note of the constitution when performing their duties. There is also a legal duty on the Secretary of State for Health to renew the constitution every 10 years. Independent and third sector providers of NHS services are 'required to take account' of the constitution in their contracting and Commissioning arrangements.

It contains 7 key principles and these are underpinned by core NHS values which have been derived from discussions with staff, patients and the public.

### 6.4.1 Principles

- The NHS provides a comprehensive service available to all, irrespective of gender, race, disability, age, sexual orientation, religion or belief.
- Access is based on clinical need, not on an individual's ability to pay.
- The NHS aspires to the highest standards of excellence and professionalism.
- NHS services must reflect the needs and preferences of patients, their families and carers.
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
- The NHS is accountable to the public, communities, and patients that it serves.

### 6.4.2 Values

**Respect and dignity.** We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

**Commitment to quality of care.** We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

**Compassion.** We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not

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<sup>36</sup> Department of Health, *The NHS Constitution for England, March 2010*

wait to be asked, because we care.

**Improving lives.** We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

**Working together for patients.** We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

**Everyone counts.** We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others' opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

#### **6.4.3 Rights, pledges and responsibilities**

The Constitution is to set out clearly what patients, the public and staff can expect from the NHS and what the NHS expects from them in return. The Constitution distinguishes between rights, pledges and responsibilities:

**Rights.** A right is a legal entitlement protected by law. The Constitution sets out a number of rights, which include rights conferred explicitly by law and rights derived from legal obligations imposed on NHS bodies and other healthcare providers. The Constitution brings together these rights in one place but it does not create or replace them.

**Pledges.** This Constitution also contains pledges which the NHS is committed to achieve, supported by its management and regulatory systems. The pledges are not legally binding and cannot be guaranteed for everyone all of the time, because they express an ambition to improve, going above and beyond legal rights.

**Responsibilities.** The Constitution sets out expectations of how patients, the public and staff can help the NHS work effectively and ensure that finite resources are used fairly. This Handbook gives further information on those responsibilities.

#### **6.5 Board etiquette (based on Common Purpose)**

Boards should be explicit in their values and how they intend to conduct business. The board should recognise the importance of constructive challenge and ensure there is an equal degree of openness and transparency between board members. To this end, many boards have adapted and adopted the protocol or etiquette developed in the Integrated Governance Handbook<sup>2</sup> from *Common Purpose* principles.

**Boards and their members should:**

1. Take decisions and abide by them.
2. Be explicit in the delegated authority you have to take decisions, and when you need to seek higher authority.
3. Respect one another as possessing individual and corporate skills, knowledge and responsibilities.
4. Be honest, open and constructive.
5. Show determination, tolerance and sensitivity – rigorous and challenging questioning, tempered by respect.
6. Be courteous and respect freedom to speak, disagree or remain silent.
7. Support the Chair and colleagues in maximising scope and variety of viewpoints heard.
8. Ensure individual points are relevant and short.
9. Listen carefully to all ideas and comments and be tolerant to other points of view.
10. Regard challenge as a test of the robustness of arguments.
11. Be sensitive to colleagues' needs for support when challenging or being challenged.
12. Ensure no one becomes isolated in expressing their view.
13. Treat all ideas with respect.
14. Allow differences to be forgotten.
15. Show group support and loyalty towards each other.
16. Read all papers before the meeting, clarify any points of detail before the meeting, be punctual and participate fully.
17. Focus discussion on material issues and the resolution of issues.
18. Make the most of time.

**Boards and their members should not:**

1. Refer to past systems or mistakes as being responsible for today's situation.
2. Act as 'stoppers' or 'blockers'.
3. Regard any arrangements as unchangeable or unchallengeable.
4. Adopt territorial attitudes.
5. Give offence or take offence.
6. Regard papers presented as being 'rubberstamped' without discussion or agreement.
7. Act in an attacking or dismissive manner.
8. Become obsessed by detail and lose the strategic picture.
9. Breach confidentiality.

**6.6 Board member roles & styles**

In Principle 8 (board supports) we identified the importance of clarity in roles and relationships in particular for the Chair CEO, Board Secretary, Exec and NEDs, the SID and in FTs and some commissioning organisations the role of governors or members. In addition to the formal role it is also important to consider the mix of board directors.

Board members demonstrate individual characteristics, experiences and skills. The board needs a range of competences and should be aware of its strengths and weaknesses. Boards may invite who they wish to support them and may find it useful to recognise any gaps and fill these on an ad-hoc basis by inviting non-voting colleagues to join the for specific meetings or agenda items.

Julia Unwin, Chief Executive of the Joseph Rowntree Foundation, has identified a number of different roles, and these all pose different challenges<sup>37</sup>: *“I have seen boards that are entirely entrepreneurial and they are pretty scary. I have also seen boards that are entirely compliance driven, and they are terrifying.”*

- **Peacemaker** - can't we find a common way?
- **Challenger** - can't we do better? Is it just because it has always been done this way?
- **History holder** - we need to go back to our roots, and remember what worked in the past.
- **Compliance queen** - always says, “can we do this? What will the auditors say? Is this legal?”
- **Passionate advocate** - will respond, “surely we must take a risk, we must do more”.
- **Data champion** - all the evidence shows that however often we do that, it makes no difference to the outcomes.
- **Wise counsellor** - says, “we are not the only people trying to tackle this issue, we need to think carefully, plan properly, and take this step by step”.
- **Inspiring leader** - will describe his/ her vision, will enthuse and excite.
- **Fixer** - says “I think we can get together later and sort this out”.
- **Risk taker** - says, “the crisis is simply too great. Let's just spend the money, the funds will flood in”.
- **Strategist** - says, “we need to think beyond 2012, and then our position will be much stronger and the whole environment will be different”.
- **User champion** - says, “I am worried that we are ignoring the interests of our users. We haven't mentioned their needs all through this meeting”.

The role of risk taker is often missing from public sector boards who should consider how they can achieve this valuable input.

## 6.7 Constructive challenge

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<sup>37</sup> Julia Unwin, Address to the Charity Trustee Network, November 2007

The Audit Commission<sup>38</sup> observed that some NHS boards in England appear to have become too trusting, with little constructive challenge or debate about strategic issues. A reason for this lack of challenge included the desire to present a united public face in public meetings. Challenge should not be seen as the preserve of non-executives scrutinising the executive team. Steve Bundred, Chief Executive of the Audit Commission said:

*“The NHS has, in many cases, been run on trust. But those who are charged with running our hospitals must be more challenging of the information they are given and more skeptical in their approach. Healthcare is inherently risky and complex, and assurance is not easy in the public or private sectors.”*

The Audit Commission found that:

- board assurance processes are generally in place but must be rigorously applied
- board members are not always challenging enough and
- the data received by boards is not always relevant, timely or fit for purpose.

Underlying the report was a sense that the board must create a culture where there is healthy debate. Independent members should not accept something is working just because a director says it is so.

*“No organisation can operate without a measure of trust among the key individuals. However, the larger and more complicated the organisation, the less the board can rely on such informal relationships and the more important it is for people to understand the system and what is done by others.”*

## **6.8 Legal redress & judicial review**

In the last resort, patients and staff can seek legal redress if they feel that NHS organisations have infringed the legal rights described in the NHS Constitution<sup>36</sup>. For patients and the public, this could be in the form of a judicial review of the process by which an NHS organisation has reached a decision.

Judicial review is a process by which someone can challenge a decision of the Secretary of State or an NHS body, on the basis that it is unlawful. This right is derived from administrative law. It is not a right of appeal and is concerned primarily with how decisions are made, rather than the merits of the decision itself.

To be entitled to bring a claim for judicial review, a person must have a direct, personal interest in the action or decision under challenge. There are time limits for making a claim.

A decision might be unlawful if:

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<sup>38</sup> Audit Committee, *Taking it on Trust*, 2009

- the decision-maker does not have power to make the decision, or is using their power improperly
- the decision is irrational
- the procedure followed by the decision-maker was unfair or biased
- the decision was in breach of the Human Rights Act or
- the decision breaches European Community (EC) law.

The Public Law Project Information Leaflet 2<sup>39</sup> points out that If an application for judicial review is successful, the court has available to it six possible remedies:

- **Quashing Orders:** The original decision is struck down and the public body has to take the decision again (lawfully, this time).
- **Prohibiting Orders:** The public body is forbidden from doing something unlawful in the future.
- **Mandatory Orders:** The public body is ordered to do something specific which it has a duty to do.
- **A declaration:** For example, on the way to interpret the law in future, or a declaration that a legislative provision is incompatible with the Human Rights Act.
- **An injunction:** This is usually a temporary remedy until the full application for judicial review is heard.
- **Damages:** This is rare, but may be available in some cases, particularly where there has been a breach of an individual's rights under the Human Rights Act.

All of these remedies are discretionary – the Judge does not have to order any remedy at all. More than one can be applied for in any particular case.

To avoid judicial reviews check whether the decision or action of the public body is:

- lawful
- rational
- fair and procedurally correct
- likely to withstand legal challenge; or
- supported by documentary evidence showing that it was properly taken.

## 6.9 Conflicts of Interest

The NHS, like other public bodies, requires high levels of probity and is subject to public scrutiny. It is important that board members do not act in a way that would compromise the reputation of the organisation.

Any interest that might compromise the organisation should be declared - if in doubt, declare. Board members should also check that their declarations have been recorded and adequately scrutinised.

It is good practice for the Chair of the board to ask for any new potential conflicts at

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<sup>39</sup> <http://www.publiclawproject.org.uk/downloads/WhatsIsJR.pdf>

the beginning of a meeting.

If a board member realises they have failed to declare something, they should declare as soon as possible after the relevant meeting. Baroness Rennie Fritchie, the ex-Commissioner for Public Appointments, and Malcolm Leary suggest the following as a conflicts protocol:<sup>40</sup>

1. Declare the conflict but continue to participate in the discussion.
2. Declare the conflict and abstain from discussing and deciding a particular issue.
3. Delegate your function e.g. chairing, on a temporary basis.
4. Resign – either before you become conflicted or once a conflict arises.

Staff are also required to declare interests and act appropriately. For example, any staff who are in contact with suppliers and/or contractors, in particular those authorised to sign purchase orders, are expected to adhere to professional standards of the kind set out in the Ethical Code of the Chartered Institute of Purchase and Supply.<sup>41</sup>

## 6.10 Scrutiny by Employees

The Public Interest Disclosure Act 1998 was introduced to protect employees who are worried about wrongdoing where they work and want to ‘blow the whistle’ or more formally described as ‘making a disclosure in the public interest’. The Act applies to most employees including health, local authorities; a police or fire authority; or a related body and includes those employed on a temporary basis or through an agency.

Someone making such a disclosure must do so in good faith (even if later it turns out to be untrue) and must believe that at least one of the following tests are met:

- that a criminal offence has been or is likely to be committed
- that someone is failing, or will fail, to comply with legal obligations
- that a miscarriage of justice will occur or has occurred.

The Act protects all employees, contractors, trainees or agency staff. The legal protection is that he/she can receive unlimited compensation. However, to gain the protection of the Act it is important to ensure that any whistleblowing meets the criteria of being a “qualifying disclosure” and must be to a legal adviser, employer, Minister of the Crown, or the relevant regulator, Auditor General of the NAO to whom any concerns about ‘the proper conduct of public business, value for money, fraud and corruption in relation to the provision of public services’ can be addressed.<sup>42</sup>

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*40 Baroness Rennie Fritchie, Malcolm Leary, Resolving Conflicts in organisations: A practical guide for managers, 1998*

*41 <http://www.cips.org/aboutcips/whatwedo/codeofprofessionalethics/>*

*42 [www.direct.gov.uk/en/Employment/ResolvingWorkplaceDisputes/Whistleblowingintheworkplace/DG\\_175821](http://www.direct.gov.uk/en/Employment/ResolvingWorkplaceDisputes/Whistleblowingintheworkplace/DG_175821)*

Only in more extreme circumstances are wider disclosures permitted. NHS employers have been instructed to set up “whistleblowing” procedures and ban gagging clauses. All organisations should have one and staff have a right to ask for it. An employee who is victimised or discriminated against in any way because they have ‘blown the whistle’ (known as making a ‘protected disclosure’) can take their employer to an employment tribunal.

### **6.11 When Things go wrong: Advice to patients and carers**

Any comments, whether positive or negative, can be fed back to the commissioning organisation or directly at the point of care, either to the clinician providing care or through the provider’s complaints and redress systems. The NHS has its own defined complaints procedure which is always the first step for any complaint about the NHS.

If a patient or carer is not satisfied with the way their complaint has been dealt with, they have the right to take the complaint to the Parliamentary and Health Service Ombudsman.<sup>43</sup>

The Ombudsman conducts independent investigations into complaints that government departments, a range of other public bodies in the UK, or the NHS in England have not acted properly or fairly, or have provided a poor service.

The Ombudsman can look at complaints about the actions of providers of NHS care, as well as commissioners. The Ombudsman can also look at complaints about the Department of Health; the National Commissioning Board (NCB) and its regional outposts; the Care Quality Commission and Monitor.

The Ombudsman is accountable to Parliament and independent of government and the NHS.

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43 [www.ombudsman.org.uk](http://www.ombudsman.org.uk)



## 7. Systems

### 7.1 Systems integration and alignment

The board's job is to be strategic, to look forward and up. But it must have confidence that strategies are being delivered, decisions are being acted upon and that all staff understand their roles and responsibilities.

Board members will have a number of systems and supports to build assurance that these are happening but they must be prepared to ask the right questions and support each other in securing an acceptable response. Key things to look for are:

- **Annual Cycle of Business:** A planned programme for the year ensuring board meetings cover the key annual events and anticipate critical decision taking. The cycle of business allows boards to plan their away day programme to ensure they cover emerging issues and help to shape national and local strategies.
- **Board assurance framework:** A top down listing of key objectives with risks identified together with controls and assurance. Where there are gaps in controls or assurance, action plans will be identified.
- **Decision tracking systems:** that records decisions taken by the board, its sub committees and partnership boards.
- **Internal and external audit:** Audit plans will be drawn up with the internal and external auditors to ensure systems are working in all areas of activity and that there is a strategy for alignment with clinical audit that includes an annual plan addressing national and local priorities.
- **Board Assurance Prompts:** that identify key clinical and assurance areas that boards should address and provide some guidance on the kinds of questions that should be asked and what acceptable and unacceptable responses look like.

In gaining an overall view of the organisation, boards also need to consider the different themes and streams of governance. There are ten key elements that need to be considered to ensure effective overall and connected governance:

1. Clarity of purpose aligned to objectives and intent
2. Strategic annual agenda cycle with all agendas integrated encompassing activity, resources and quality
3. Board Assurance System in place
4. Decision-taking supported by intelligent information
5. Streamlined committee structure; clear terms of reference and delegation; time limited
6. Audit Committee strengthened to cover all governance issues
7. Development & review of board members
8. Appointment of a Board Secretary
9. Board etiquette agreed
10. Annual Board review

## 7.2 Whole system: governance between organisations

*“Problems often occur at the borders between one organisation or team and another.” Learning from Investigations, Healthcare Commission, Feb 2008.*

*“In the absence of formal governance arrangements, responsibility for supporting the governance of partnerships falls to partners’ own corporate governance mechanisms.”<sup>44</sup>*

NHS Constitution Principle 5:<sup>36</sup>

***“The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being.”***

### Ten simple rules for governance between organisations:

#### Continuity of Care

1. Jointly commission outcomes and connectivity of care pathways from primary through acute, diagnostics, tertiary to community and home.
2. Patient referral or data: Take the extra step – have they arrived: what has not arrived?
3. Review and apply lessons from investigations elsewhere (NHS and other sectors). Could it happen here?

#### Partnerships and networks

4. Jointly audit critical processes across the boundary (clinical, financial, information etc) at appropriate depth & frequency respective to risk.
5. Be consistent in telling patients/carers what they are entitled to and when they are holding responsibility for their own care.
6. Check your partners/suppliers have the capacity to deliver their obligations. Mutual Aid and business continuity
7. Engage with other organisations to support you in case of long term or widespread service collapse.
8. Establish and test partner forums and networks to coordinate planning and review progress.

#### Assurance

9. Include reputational risks and potential failure of partners and suppliers in the Board Assurance Framework (BAF).
10. Apply rules for new staff (CRB checks, data handling, competence, qualifications etc) to existing and agency staff.

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<sup>44</sup> Audit Commission, *Governing Partnerships*, 2005

### 7.3 Annual cycle of business

An effective board will set out a programme for the year ensuring its board meetings cover the key annual events and anticipate critical decision taking. The programme will of course change but this allows the board to ensure that:

- committees of the board are clear by when they must conclude business and scrutiny,
- annual surveys of staff and patients inform plans,
- regulators and audit reports are prepared and presented in a timely manner,
- the board can meet to receive and sign off key documents such as the annual accounts, statement of
- internal control, compliance against standards and the annual report,
- boards and committees can revisit strategies and influence annual plans.

The cycle of business should include assigned and protected time for boards to consider emerging issues and help to shape national and local strategies.

The impact of an annual cycle of business is likely to raise more issues than can be accommodated in monthly meetings but this will drive a thoughtful approach to delegated authority to officers and sub committees and encourage more analysis to be put into routine finance, performance and risk reports.

### 7.4 Annual board review

Both the UK Corporate Governance Code<sup>15</sup> and Monitor's Code of Governance<sup>45</sup> expect the board to undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. Individual evaluation should aim to show whether each director continues to contribute effectively and to demonstrate commitment to the role (including commitment of time for board and committee meetings and any other duties).

The organisation will undertake a formal annual board review covering the whole range of the board's activities including strategy and operational performance to ensure it has mature processes in place covering:

- purpose and vision
- strategy and planning
- leadership
- finances
- risk and agility
- information, analysis and assurance
- quality, efficiency, innovation and outcomes
- probity and reputation
- decision making and decision taking
- service user, staff, stakeholder and public engagement
- board supports and main committee structures
- appraisal process of trustees, and other feedback.

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<sup>45</sup> Monitor, *The NHS Foundation Trust Code of Governance*, March 2010

## 7.5 Clinical audit

Clinical audit was originally a process by which clinicians reviewed their own practice, but is now recognised as capable of giving information and assurance about clinical quality as a whole. Ten simple questions for boards<sup>46</sup>:

1. Clinical audit can be used as a strategic tool; your organisation's clinical audit strategy should be allied to the broader interests and targets that the board needs to address.
2. There should be direction and focus on how and which clinical audit activity will be supported in the organisation.
3. There should be appropriate processes for instigating clinical audit as a direct result of adverse clinical events, critical incidents, and breaches in patient safety.
4. The clinical audit programme should be checked for relevance to board strategic interests and concerns. It is important that results are turned into action plans, followed through and re-audit completed.
5. There should be a lead clinician who manages clinical audit within the organisation, and who is clearly accountable at board level.
6. Patient involvement should be considered in all elements of clinical audit including priority setting, means of engagement, sharing of results and plans for sustainable improvement.
7. Clinical audit should be built into and inform planning, performance management and reporting.
8. Clinical audit should cross care boundaries and encompass the whole patient pathway.
9. The criteria of prioritisation of clinical audits should balance national and local interests, and the need to address specific local risks, strategic interests and concerns.
10. Check if clinical audit results and complaints are evidence based and if so, develop a system whereby complaints act as a stimulus to review and improvement.

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<sup>46</sup> HQIP, *Clinical Audit: A Simple Guide For NHS Boards and Partners*, 2010

## 8. Governance in challenging economic times

What are the lessons for leading and managing during difficult times? Boards will need to be explicit in their decision making if they are to avoid reputational risk and judicial review. In 2009 Tayside Health Board considered the following Principles for Disinvestment:

1. The organisation is committed to improving the health of the community and the quality, responsiveness and effectiveness of services.
2. The organisation has limited budgets but will work with others to lever resources from within and outside the community.
3. The organisation will always seek to do the right thing first, and then take resourcing decisions.
4. We will regularly assess our organisation's position in terms of financial management, service delivery and strategic change.
5. We will seek to speed up system reform and re-engineering.
6. We will scenario plan for the future, exploring the impact of decreasing amounts of growth.
7. We will critically review our organisation's priorities and develop plan Bs for those we cannot put off.
8. We will engage with our stakeholders and communities in decision- making and share our decisions taken.
9. We will be positive and optimistic.

On the 28 January 2011, Mr Justice Calvert-Smith gave judgment for the Claimants in judicial review proceedings brought against London Councils<sup>47</sup>. The claim was brought by Pierce Glynn, solicitors, on behalf of service-users of one of the charities affected by the cuts. The challenge related to London Councils' plans to cut £10m from the £26.4m in funding provided by London Councils to voluntary sector organizations in London.

The cuts would have affected over 200 voluntary and community sector organizations in London, and tens of thousands of Londoners. The Judge held that London Councils' consultation process was flawed and that they had failed to meet their statutory equality duties. He quashed all the funding cut decisions for the 200 plus projects and he said that London Councils must re-run the process, this time with full equality impact assessments.

“This case establishes that even in the current economic climate, it remains of paramount importance that public sector funding cut decisions are properly assessed for their gender, disability and race equality impacts. If they are not, public sector funding cut decisions will be unlawful’. Louise Whitfield, The Claimants’ solicitor

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<sup>47</sup> Neutral Citation Number: [2011] EWHC 861 (Admin)

Neil Goodwin's 10-point plan<sup>48</sup> is a straightforward method of checking whether an organisation is being proactive:

1. Assess your position in terms of financial management, service delivery and strategic change. Where are you delivering and where are you struggling? What are your strengths and weaknesses and those of your key partners?
2. Speed up system reform and re-engineering. Do not wait.
3. Review your team's capability and capacity. It needs to be match fit. If you have team weaknesses address them now.
4. Assess the strength and depth of your inter-organisational relationships. The first meaningful conversation should not be about the impact of the economic downturn.
5. Scenario plan for the future, exploring the impact of decreasing amounts of growth.
6. Critically review your organisation's priorities and develop Plan Bs for those you cannot put off. Start incorporating risk assessment in planning.
7. Communicate. Be honest and realistic with staff because above all else they will be looking for leadership. Don't withhold difficult messages. Staff will want the opportunity to contribute to solutions to wicked problems.
8. Seek external help if necessary, but be very specific about the outcomes you want.
9. Keep your nerve and maintain a balanced perspective. Do not panic. Plan ahead. Future-gazing is an activity that far too few boards spend time on.
10. Be positive and optimistic. It is OK for leaders to say they do not always have the answers, but negative emotions are infectious in organisations.

## 9. Conclusion

Good governance needs to be at the heart of the current reforms of the NHS. It is vital for the development of a vibrant healthcare market that will continue to provide high quality healthcare. Those who are working to further improve existing healthcare organisations or developing the new CCGs and HWBs need to understand and apply the principles of good governance. It is important to think through how these principles should best be applied to their own local situation. The opportunities that come with getting the right governance system in place is that a useful balance will be struck between flexibility and proper risk management, and between control and freedom to innovate. Patients and local communities will be confident in the system, and governance will become proportionate, and an asset to an organisation rather than an irksome series of tasks. These principles, allied to carefully considering how your organisation can best use the body of good governance knowledge, will ensure higher quality healthcare and proper governance.

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<sup>48</sup> <http://www.goodwinhannah.co.uk>

## 10. Further Information

A comprehensive bibliography of governance issues has been compiled by the NLC working with the Kings Fund.

The Healthy NHS Board: A review of guidance and research evidence by Angus Ramsay and Naomi Fulop, February 2010.

A select list of references and useful websites is included below:

<b>HQIP:</b>	<a href="http://www.hqip.org.uk">www.hqip.org.uk</a>
<b>GGI:</b>	<a href="http://www.good-governance.org.uk">www.good-governance.org.uk</a>
Care Quality Commission (takes over the regulation of health and social care on 1 April 2009):	<a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
Council for Healthcare Regulatory Excellence:	<a href="http://www.chre.org.uk">www.chre.org.uk</a>
Department of Health: ( <a href="http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/dh_076366">www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/dh_076366</a> )	<a href="http://www.dh.gov.uk">www.dh.gov.uk</a>
General Medical Council:	<a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
Healthcare Governance Review: <a href="http://review.wordpress.com">review.wordpress.com</a>	<a href="http://www.healthcaregovernance.org.uk">www.healthcaregovernance.org.uk</a>
IHM:	<a href="http://www.ihm.org.uk">www.ihm.org.uk</a>
Monitor:	<a href="http://www.monitor-nhsft.gov.uk">www.monitor-nhsft.gov.uk</a>
NHS Confederation:	<a href="http://www.nhsconfed.org">www.nhsconfed.org</a>
NHS Confederation Wales:	<a href="http://www.welshconfed.org">www.welshconfed.org</a>
NHS Choices:	<a href="http://www.nhs.uk">www.nhs.uk</a>
The Health Professions Council: (which regulates 13 professions, including paramedics and physiotherapists)	<a href="http://www.hpc-uk.org">www.hpc-uk.org</a>
The Nursing and Midwifery Council: (which regulates nurses, midwives and specialist community public health nurses)	<a href="http://www.nmc-uk.org">www.nmc-uk.org</a>
The General Dental Council: (which regulates dentists, dental hygienists and dental therapists)	<a href="http://www.gdc-uk.org">www.gdc-uk.org</a>
The General Chiropractic Council: (which regulates chiropractors)	<a href="http://www.gcc-uk.org">www.gcc-uk.org</a>
The General Optical Council: (which regulates dispensing opticians and optometrists)	<a href="http://www.optical.org">www.optical.org</a>
The General Osteopathic Council: (which regulates osteopaths)	<a href="http://www.osteopathy.org.uk">www.osteopathy.org.uk</a>
The Parliamentary and Health Service Ombudsman:	<a href="http://www.ombudsman.org.uk">www.ombudsman.org.uk</a>
The Royal Pharmaceutical Society of Great Britain: (which regulates pharmacists)	<a href="http://www.rpsgb.org.uk">www.rpsgb.org.uk</a>