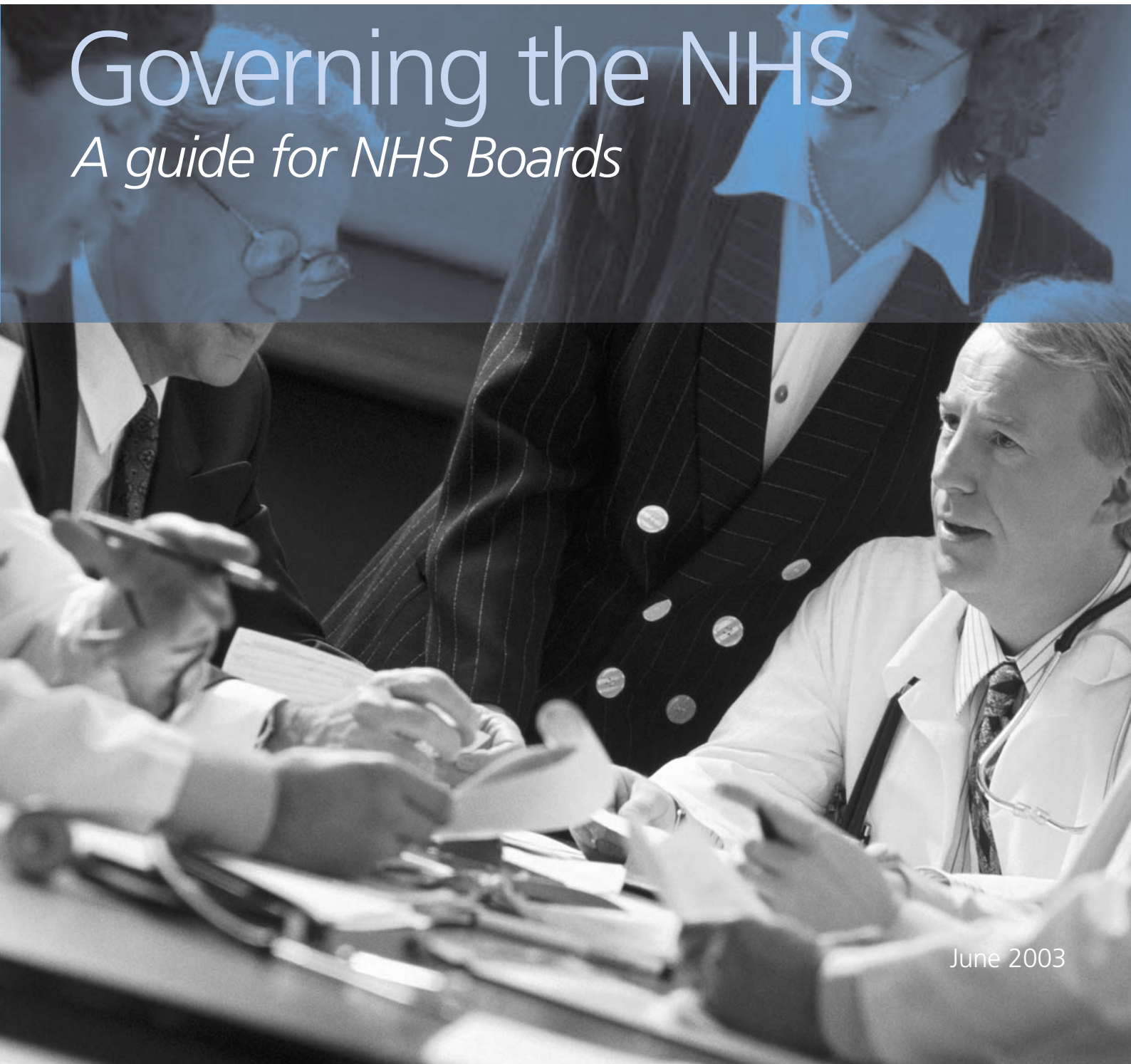
Department of Health

NHS Appointments Commission

Governing the NHS

A guide for NHS Boards



June 2003

Acknowledgement
This Guidance was produced by the NHS Appointments Commission with the assistance of a Steering Group comprising the Department of Health; Michael Deighan – Clinical Governance Support Team; Ellie Scrivens – Controls Assurance Support Unit; Gary Fereday – NHS Confederation; and Roger Moore – NHS Appointments Commission.

We are particularly grateful for those chairs and non-executives who helped by commenting on earlier drafts and assisted us by identifying omissions and correcting errors.

We would also like to acknowledge the help of Michael Dixon and the PCT readers identified by the NHS Alliance who ensured that the Guidance embraced the full breadth of the PCT role.

Notwithstanding the above, any errors are, of course, the responsibility of the authors.

RM June 2003

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Introduction

Governance in the NHS – the foundation for successful modernisation

The NHS Plan sets out a challenging agenda for modernising the NHS and improving and extending the services it provides – a scale of change unprecedented in this country in any area of public service. This calls for exceptional leadership. Hence in *Managing for Excellence in the NHS*[1] managers and Boards are encouraged to rethink what they themselves do as leaders to create the right context, incentives and operational environment for their staff and front line teams to transform patient services.

NHS organisations are part of a more decentralised and fast-changing health and social care system. Their Boards are being called upon to manage a programme of fundamental improvement and modernisation. They are being encouraged to challenge established practice and embrace change.

This guide specifically focuses on governance because it is an essential prerequisite for all modernisation effort. It argues that each Board's prime duty is to ensure good governance. Achieving high standards of patient care depends on it. The protection of patients, staff and the wider public depends on it. Accountability for the proper use of unprecedented amounts of public money depends on it. And, critically, good governance arrangements ensure that front line teams have appropriate protection and space within agreed rules to learn from failures as well as successes.

This guide sets out how the governance of the NHS rests on NHS Boards and the systems which they oversee. We have drawn from the recently published Higgs report which examined governance in the private sector, itself under scrutiny following corporate scandals in the USA.

We have detailed the critical role of the Chair and non-executive and the framework of accountability that links PCTs, NHS Trusts and Strategic Health Authorities together. We have also sketched out the developing Health and Social Care inspectorate and regulatory systems that support and impact upon NHS organisations so that Boards can see how they fit into this new landscape.

A Board that is confident in its governance and control arrangements will be confident to embrace the risks associated with change, but to focus on governance Boards will need to use their time wisely and non-executive directors, particularly, will need to resist the pull of operational matters and "fire fighting".

We have aimed to help boards by drawing together the multiple strands of NHS governance to show how clinical governance, risk management, controls assurance, financial and corporate governance provide the essential foundation for good governance. Most of the material is not new but we hope that drawing it together in this way will help to refocus boards on their prime responsibilities.

A word of warning. This guide is not a complete 'how-to-do-it' manual but rather a guide to principles. It follows that it is not intended to replace the Corporate Governance Framework Manual or other detailed financial, operational or clinical governance guidance. It is intended to reinforce the essential role of good governance by bringing the main strands together in a single high level guide. To enable it to be used as a template for further training and development, we have included references for the reader to get further details of the topics covered.

To make it easier for readers to access a particular topic, each section is largely self-contained so a certain amount of repetition is inevitable in the interests of clarity.

This guide is part of the *Managing for Excellence* programme supported by a coalition of national bodies with the shared aim of strengthening strategic leadership across the NHS. It will be supported by a comprehensive Board development programme covering the personal development of Board members, team building, organisational development and service improvement.

[1] *Managing for Excellence in the NHS* was published in October 2002. Details can be found on www.doh.gov.uk/managingforexcellence/index.htm

1

Setting the scene

The message that runs through the entire guide is that, whatever the type of Board, the interests of patients are best served by a strong system of governance.

The modern NHS Board, relatively small in size, with a non-executive Chair and equal numbers of executive and non-executive members was established with the first NHS trust in 1991. The model introduced the concept of corporate responsibility whereby executive and non-executive directors shared responsibility for the Board's decisions.

Like the private sector Boards upon which it was modelled, the non-executives were expected to provide independent expertise; represent patient, carer and public interests (shareholders interests in private sector Boards); and provide reassurance that proper standards of governance and probity were being observed.

Since 1992, private sector Boards themselves have been subject to a number of scrutinies which have also impacted upon NHS Boards.

The Cadbury Report in 1992 set new standards for corporate governance and accountability in the wake of several corporate scandals in the UK. The Cadbury recommendations were accepted for the NHS in the Codes of Conduct and Accountability, to which all non-executives subscribe, and which form the foundation on which the probity of NHS Boards has rested since 1994.

The Turnbull Report in 1999 concentrated on the controls which Boards should maintain over their organisations. It set out schemes for formalising these controls and establishing proper systems to assess and manage risk. These recommendations saw the introduction to NHS Boards of more robust Controls Assurance requirements and the Statements on Internal Control.

Within the NHS following the Bristol Inquiry, the Alder Hey Inquiry and others, serious questions were being asked about the quality of clinical care. It was realised that responsibility for quality extended beyond the clinicians concerned and was in reality a multi-facetted responsibility that could only be shouldered in its entirety by the Board. This quality management responsibility was encapsulated for the NHS in a system of Clinical Governance.

More recently private sector Boards have again been under scrutiny following the Enron and Transworld scandals in the USA. The Higgs Report published in 2003 addressed itself to the Governance responsibilities of Boards and the role of the Chair and non-executives in governing the organisation. Like its predecessor reports, Cadbury and Turnbull, there are important lessons to be learned for NHS Boards that are particularly relevant given the new freedom and responsibilities being devolved to them.

"Leadership is the art of getting things done by enabling others to do more than they could or would do otherwise".

What follows in this guide is a detailed examination and redefinition of the Board's role to fit with the demands of a more decentralised system in which new pathways for the provision of healthcare develop with new private and public sector partners.

The inter-relationships between the work of Strategic Health Authorities, Primary Care Trusts (PCTs) and NHS Trusts are now becoming much clearer with governance requirements, both internal to each organisation and across the health system. Constructive working links between NHS organisations as well as within them, often informed by a few guiding principles or simple rules, are essential to good quality care.

The message that runs through the entire guide is that, whatever the type of Board, the interests of patients are best served by a strong system of governance. Through good governance, the Board can enhance the care and wellbeing of patients and those staff who look after them. Conversely, in an organisation which is not properly governed and which is out of control, staff time is wasted in fire-fighting with inadequate plans and resources, with the effect that the care given to patients and their families inevitably suffers.

The guide sets out the role of the Chair, Non-executives, Chief Executive and Professional Executive Committee (PEC) Chair of PCTs. In practice a successful Board is one that works as a team and, although non-executives and executive directors have different roles, as Board members they share the same corporate responsibilities. Within the team they make different contributions to the work of the Board. Executives bring detailed knowledge of the institution's management systems and processes and of the health and social care sector, as well as specialist clinical and managerial expertise, whilst non-executives are strategic, challenging and more detached.

The best Boards are those where all directors, whether executive or non-executive, contribute to the work of the Board and do not restrict their input to their particular speciality/interest; where directors operate in an atmosphere of mutual trust and support that allows open and challenging debate; where challenge is seen as constructive by all directors; and where executives and non-executives understand each other's roles so that non-executives do not cross the line into management responsibilities and executives share information openly in a non-defensive manner.

Equally, good Boards are clear how the links are made between strategic leadership and operational management. Reviews by the Commission for Health Improvement (CHI) have found that too often they needed to highlight the risk of too big a gap

"The systems and processes, by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and the wider community."

between the Board and the operational heart of the organisation. Boards should not get into the detail, but they need to know that their decisions have been translated successfully into actions by those who are close to patients. In this sense, Boards are there to lead, direct and monitor but also to serve and support those who are in daily contact with the patients. Otherwise the Board's efforts have no real value.

Throughout this guide the word 'leadership' appears frequently. In different contexts, its meaning can change but it is neatly encapsulated by the NHS Leadership Centre's definition.

"Leadership is the art of getting things done by enabling others to do more than they could or would do otherwise".

That sums up the real added value of the Board as the leader of an organisation and the roles of the individuals within it as leaders in their own right.

Enabling at Board level is achieved through good governance that is supportive of staff and reassuring to patients, carers, the public and other stakeholders.

Governance itself is a word with a wide range of usage. In its narrowest sense it is often used only in relation to controls but the Audit Commission definition is much broader.

"The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and the wider community."

In this guide governance is used in its broadest sense to embrace the whole function of leadership.

2

The duty of NHS Boards

A Board that is confident in its governance and control arrangements will be confident to embrace the risks and opportunities associated with change.

The duty of an NHS Board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

These criteria, set out by the Higgs Report for good governance, are directly applicable to all NHS Boards.

The role of NHS Boards

Collective responsibility for adding value to the organisation
The Board is collectively responsible for promoting the success of the organisation by directing and supervising the organisation's affairs.

Leadership and control
The Board's role is to provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.

Looking ahead
The Board should set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance.

Setting and maintaining values
The Board should set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Collective responsibility

Legally there is no distinction between the Board duties of executive and non-executive directors, they both share responsibility for the direction and control of the organisation. All directors are required to act in the best interest of the NHS. There are also statutory obligations such as health and safety that Board members need to meet. Each director has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public.

The control framework which provides the platform for successful leadership within the NHS consists of three overlapping systems:

1 Controls Assurance
2 Clinical Governance
3 Risk Management

Leadership within a framework of controls

The NHS Plan which is being taken forward through Local Delivery Plans constitutes the change programme for the improvement of the NHS. *Managing for Excellence* in the NHS sets the agenda for improved leadership and management.

The Board is expected to bring about these changes making the best use of its total resources – financial, staffing, physical infrastructure and knowledge. As leaders, the Board will work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. As leaders they will understand the opportunities for service improvement and motivate others to bring them about. They will accept risk in the interests of improvement. However, to ensure that change is developed in a way which maximises the chance of success and minimises the risks associated with failure, the Board needs to operate through a framework of control. The Board must be innovative but not reckless.

Control systems are the procedures and processes that ensure necessary actions are taken to achieve the organisation's objectives. Controls can be 'hard' such as policy, rules, standards and prescribed processes, or 'soft' which include the organisational culture, ethics, commitment and leadership of the Board, effective communication, appropriate incentives and adequate training.

The control framework which provides the platform for successful leadership within the NHS consists of three overlapping systems; Controls Assurance, Clinical Governance and Risk Management. Their interrelationship is set out in Annex 1, where Clinical Governance and Risk Management are underpinned by Controls Assurance standards.

Controls Assurance

This is a process designed to provide evidence that NHS bodies are doing their reasonable best to manage themselves so as to meet their objectives and protect patients, staff, and the public and other stakeholders against risks of all kinds. Controls Assurance provides assurance that effective controls are in place. It has two main elements.

First, are the Controls Assurance standards which bring together some of the main legislative and regulatory requirements placed upon the NHS organisation. These help Boards to set up systems and develop capability to assess risk and review controls.

Second, is the self-assessment of risks in the operating systems of the organisation. By being assured that the employees of the organisation are routinely assessing risks against the standards and in their work, the Board can be assured that the organisation is doing its reasonable best to achieve its objectives and to protect against risks of all kinds.

An outcome of the Controls Assurance process is an annual statement on the effectiveness of internal controls signed by the Chief Executive on behalf of the Board. This is known as the Statement on Internal Control (SIC). Recent Treasury guidance has made clear that the SICs should identify any significant problems associated with risk and control systems.

Further reading on Controls Assurance and Risk Management is at Annex 2.

Clinical Governance

The quality and effectiveness of the clinical services and procedures provided by an NHS body is controlled by the Board through a comprehensive system of measures known as Clinical Governance. This brings together all the activities that contribute to the clinical service provided to patients.

Clinical Governance acknowledges that it is not just the "front-end" activities of nurses, doctors and others in the clinical team which affect treatment outcome but other factors like facilities, equipment, support and ward hygiene. The Board cannot be expected to manage the detail of all these operational areas but they are expected, through Clinical Governance (and using the controls assurance standards to inform the assessment of certain aspects of clinical governance), to ensure appropriate control systems are in place. It is the duty of the Board to ensure through Clinical Governance that the quality and safety of patient care is not pushed from the agenda by immediate operational issues. Guidance for further reading on the work of the Clinical Governance Support Team is at Annex 3.

Financial management

Financial managements systems are well established and generally well understood. Nevertheless Boards need to examine regularly the robustness of their financial planning and control, not least as the new financial regime associated with Foundation Trusts status is introduced and new financial flows are developed.

Strategic planning is guided by the targets and delivery dates set out in the Priorities and Planning Framework (PPF) and the detailed objectives in the NHS Plan and National Service Frameworks.

Risk management

Risk management is a system that is used to identify and control the risks to the achievement of the organisation's objectives. It can be used to question the effectiveness of organisational structure and processes, standards of conduct and the effectiveness of the other control systems (including the Clinical Governance and Finance Management systems). The Board is expected to have in place a system for continuous risk management which extends from the front-line service through to the Board. It should be able to assess the risks to the achievement of its strategic objectives and whether the management processes and controls are in place to achieve them.

Integrated governance

Boards have noticed the overlap between clinical governance, risk management, and control assurance regimes and some have begun to pull them together into a common structure. This structure, which we have termed integrated governance, will be developed over the coming months to simplify and co-ordinate the requirements of the different systems. Furthermore, work is in hand to simplify the standards which underpin the systems to reduce the burden of multiple inspection regimes.

Looking ahead

Strategic planning and organisational objectives

NHS Boards make plans to achieve the objectives for healthcare set out by the Government. Their strategic planning is guided by the targets and delivery dates set out in the Priorities and Planning Framework (PPF) and the detailed objectives in the NHS Plan and National Service Frameworks. It is for local NHS Boards to develop strategies over the necessary time period and in the light of local needs and circumstances to deliver national priorities and targets within available resources. These requirements are not negotiable, given that they represent the Government's commitment to the public to improve health care in return for the resources allocated from public taxation.

However, in setting their objectives, Boards have scope to pace their plans to reflect local starting points. They have a very large say over the best route to delivery, and how best to integrate the various capacity building programmes in their area. They will work with partner organisations within the NHS and beyond to take account of their wider health and social care environment, local patient needs and preferences, in setting their local objectives and priorities within the national framework.

As well as being bound by the Local Delivery Plan for their area, and other planning arrangements specific to their organisations, all Boards sign off an annual business plan setting out the objectives for the year ahead within the 3 year planning framework. Alongside this, boards need to develop longer term strategic plans to map the longer term direction of travel.

More guidance on Planning is at Annex 4.

Monitoring progress

It is the function of the whole Board to ensure that progress is made against the planned objectives. In taking this collective responsibility the different Board members play different roles. It is the task of the executive team to manage the organisation for the best operational outcome. They also report to the Board regularly on progress. It is then the duty of the whole Board, executive and non-executive alike, to probe, discuss and advise so that the Board can confirm, revise or update plans as required. The monitoring process will be greatly assisted if objectives are clearly measurable or assessable and incorporate milestones for progress.

Standards, organisational values and obligations

Standards

NHS Boards work within a framework of national, legal, procedural, quality and outcome standards and with professional staff who themselves are subject to a range of professional standards and obligations. The assessment of the achievement of many of these standards is the subject of inspection regimes, e.g. The Commission of Healthcare Audit and Inspection (CHAI) which will replace the Commission for Health Improvement (CHI), Royal Colleges, Health and Safety Executive.

The Board's control systems need to incorporate self-assessment procedures which can be tested by inspectors and regulators.

The Board is ultimately responsible for the achievement of standards.

Codes of Conduct and Accountability

NHS Boards are custodians of a national asset which is directly and intimately involved in the lives of the population. They are also custodians of the resources which the population has provided through general taxation.

These two factors place an obligation on Boards to ensure that their organisations have an ethos and culture of public service which permeates everything they do and which reflects and respects public expectation.

Board members are governed by the Codes of Conduct and Accountability for non-executives and the Code of Conduct for NHS Managers for the executive team. See Annex 5.

Openness

The need for public accountability puts a special obligation on NHS Boards to conduct themselves and their business in an open and transparent way that commands public confidence. For that reason, Board meetings are open to the public and should operate in a way that makes their business understandable to the public. There are statutory obligations for public involvement, such as the new requirement on consultation and scrutiny, and requirements for Board members to register personal financial interests. This is particularly important as the NHS moves towards more public empowerment and consultation so that it can better reflect public expectations.

It is also important to ensure that all Board members are comfortable with asking questions that contribute to constructive debate without undermining the work of executive colleagues. It is possible to question openly without impugning the integrity or performance of an individual. Where there are issues of personal performance, whether of an executive or non-executive member, then these can be addressed through the individual's performance review.

It follows from this commitment to open debate that the use of the confidential part of the Board meeting should be restricted to those areas generally concerning named individuals or commercially sensitive information, where there is an over riding need for confidentiality.

3

The role of the Chair

The role of the Chair is pivotal to the success of the Board.

The key responsibilities of the Chair identified by Higgs and modified to reflect the particular role of an NHS Chair are:

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

It is clear that the overall role is one of enabling and leading so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

Leadership

As leader of the Board, the Chair has the overarching responsibility for ensuring that under his/her guidance the organisation meets its planned objectives for service delivery and clinical governance and has a clear understanding of its culture and values.

In general there is a strong correlation between the quality of the leadership by the Chair and the Chief Executive (and the PEC Chair in PCTs) and the success of the NHS organisation. Conversely, where an organisation is not delivering, then questions can legitimately be asked about the quality of the Board leadership.

Whilst the Chair leads the Board, the Chief Executive leads the executive team and takes responsibility for their achievements. A strong relationship between the Chief Executive and the Chair is therefore essential to the performance of the Board and the organisation. The Chair needs to be a source of support for the Chief Executive, both in their personal development and in the development of the organisation. At the same time, the relationship must accommodate constructive debate and challenge and should not become a 'cosy' partnership that becomes impossible for non-executives to question.

In PCTs, the Chair needs to form a similarly strong relationship with the Chair of the Professional Executive Committee (PEC) which provides the professional operational input and direction to the Board. The Chair also needs to ensure that Chair, PEC Chair and the Chief Executive work effectively together, combining their different roles and responsibilities to create strong and informed leadership for the PCT.

The Chair has a clear part to play in encouraging the step change in performance demanded by NHS modernisation. Using information about the range of performance of similar organisations against key performance measures, the Chair will be able to set the right improvement objectives for the organisation. Similarly, knowledge of improvement strategies which have proved successful elsewhere will enable the Chair to encourage the organisation to match the performance of the best.

Setting the agenda for the organisation

It is the duty of the Chair to ensure that the Board has local plans and strategies which properly reflect the Government's ambition for the NHS and which are informed by patient and public involvement. This means delivering the targets set out in the Priorities and Planning Framework as they relate to the services for which the organisation is responsible.

Keeping the Board informed

The Board can only be effective if it is well informed. The Chair needs to facilitate the proper flow of information between executives and non-executives; between the Board and other partners in the health economy; and between the Department of Health (DoH) and the Board when new policies and priorities need to be disseminated.

Chairs are in a special position because of their greater involvement with the Chief Executive and knowledge of the organisation. They should use their position to ensure that the non-executives receive all the information they need to make informed decisions on forward plans and strategies. The Board also needs to receive assurances that the control systems are in place and are working effectively and will need to agree a reporting cycle for its clinical governance, audit and risk management committees.

Non-executives will also need regular updates on the results and outcomes of their strategies to keep them abreast of the organisation's performance. It is for the Chair to ensure that this information is timely and sufficiently comprehensive, but without including unnecessary operational detail that the Board does not need and which would only serve to waste the time of directors.

The Chair needs to ensure that the Board establishes a proper communication strategy to keep all its stakeholders informed.

Within PCTs it is essential that the Board and the PEC establish formal channels for exchanging information. The Chair, together with the PEC Chair, is in the best position to ensure that these channels are in place.

Communications

The Chair needs to ensure that the Board establishes a proper communication strategy to keep all its stakeholders informed. This is more complex and important than for a private sector company because there is a wider range of stakeholders and partners and more information to exchange.

In the NHS, patients and staff, and the local communities from which they come, are also the paymasters of the NHS through general taxation. The NHS has a fundamental obligation to provide timely and accurate information about plans and performance. It also needs to ensure that patients and the community are central to planning and developing services and that legal obligations to involve staff in changes that affect their employment are properly met.

Some of the communications which need to be established are to staff and their Trade Unions; to the local community; to reference groups established to obtain the views of patients, service users and carers; the local media; to elected representatives, including MPs and local councillors; to overview and scrutinise committees; the voluntary sector; and the wider health and social care community.

Of particular significance to PCTs and NHS Trusts will be communications with their Patients Forum. The Forum will be an important vehicle for providing patient feedback as well as for dialogue with the public on future plans.

Further guidance on developing communication strategies is at Annex 6.

Performance review

It falls to the Chair to conduct the annual performance review of the Chief Executive and the non-executive directors (and, for PCTs, to monitor the performance of the PEC Chair). This is a formal annual responsibility for which the Chair will receive training to enable these reviews to be conducted in a fair, consistent and supportive way. An effective performance review enables individuals to understand their performance, identify training and development needs, and thereby increase their contribution to the organisation. For chairs and non-executives, good performance is critical to their reappointment.

Trust will enable the executive team to appreciate the non-executives as partners in the enterprise and not, in the words of Higgs, as 'an alien policing influence'.

As part of his/her own performance review, the Chair will need to reflect on the performance of the Board in discussion with the Chief Executive, the non-executive directors and for PCTs with the Chair of the Professional Executive Committee (PEC).

The Board as a whole should develop a framework for formally reviewing the effectiveness of its business management and the work of its committees. This will, in part, be through annual reporting mechanisms, but it is often useful for the Board to step back from these mechanisms and take an overview of the added value which it brings to the organisation.

Teamwork

Different individuals have different strengths, interests and methods of working. The Chair needs to recognise these attributes in the Board team and develop techniques and strategies to maximise the input from each Board member. It is for the Chair to weld the individuals into an effective team with mutual respect and understanding.

Ensuring that non-executives and executives contribute effectively means that the Chair needs to understand their different roles and acknowledge that he or she has a unique responsibility to act as a bridge between them.

The Board meeting

It is the Chair's responsibility to ensure that the Board meeting agenda takes account of the full business of the Board and reflects the proper role of the Board and its members. It should be open to non-executive directors to put forward items for consideration by the Board.

It is particularly important that the agenda concentrates on proper issues of strategy and review and does not take up Board time on operational issues that are properly the responsibility of the executive team. Trust needs to be developed to enable the non-executives to let the executive team take forward the work programme, safe in the knowledge that proper governance procedures are in place to monitor and safeguard the interests of the Board. Trust will also enable the executive team to appreciate the non-executives as partners in the enterprise and not, in the words of Higgs, as 'an alien policing influence', which is why the assurance processes are so important. It is also important for the Board to be clear how reports from external auditors and inspectors are dealt with as part of the assurance process.

Thought should be given to the balance between reporting and analysing past performance – what happened and why – and examining the critical levers which a Board has open to it to influence the future – what do we need to do and when. If the balance is wrong, revised strategies may be too late to enable performance targets to be met in the operational year. Boards at the forefront of modernisation work recognise that they need to ask themselves a different set of performance questions to those traditionally asked.

The Chair needs to facilitate and encourage scrutiny and debate by the non-executives. To do that, he or she needs to ensure that they are fully informed, have enough time to discuss the issues, and are brought into the debate with proper consideration given to their views They should not feel that they are forced into rubber-stamping proposals from the executive team which they have neither the knowledge nor time to understand or debate. Neither should the Board become engaged in matters of operational detail properly left to the executive team or the Professional Executive Committee of PCTs.

Good chairing skills can help a Board to feel less inhibited about discussing contentious or controversial issues in public.

The Chair should be careful to ensure that his or her supportive relationship to the Chief Executive does not obstruct effective scrutiny by the non-executives.

Guidance from the Higgs report on the role of the Chair is reproduced at Annex 7.

The NHS Leadership Centre offers a range of development initiatives to support all NHS Chairs in the successful discharge of their role.[1]

[1]The Chairs' Development Portfolio, published June 2003, is available from the NHS Leadership Centre

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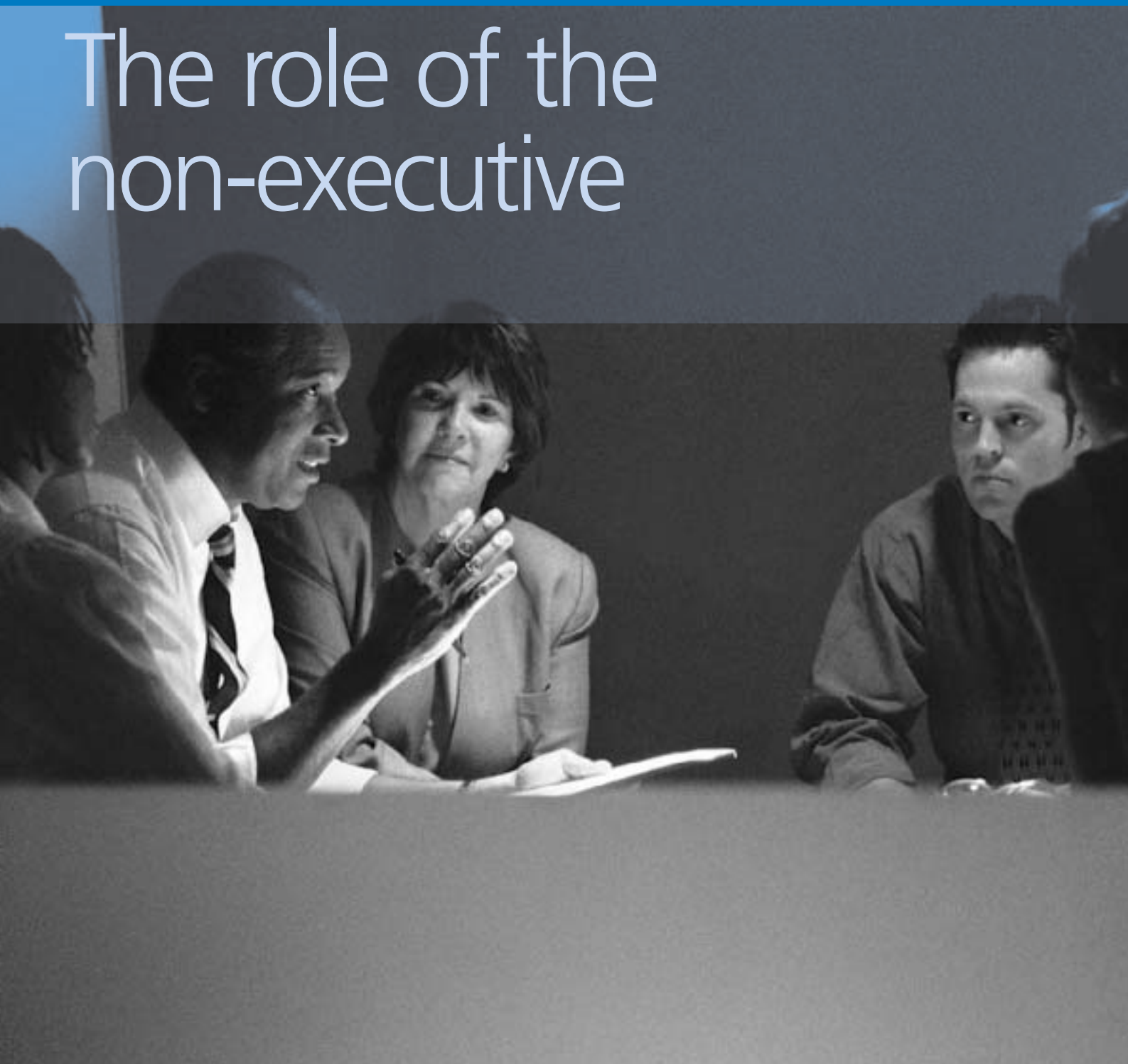
The role of the non-executive



Non-executives have a particular responsibility for encouraging the cultural change which is needed to ensure the full engagement of patients, staff and local communities.

Non-executive directors on NHS Boards share responsibility with the other directors for the success of the organisation and the duties of the Board set out above.

However, they have a special role to play within the Board team.

Higgs set out the duties of non-executives in the private sector as follows:

Strategy
Non-executive directors should constructively challenge and contribute to the development of strategy.

Performance
Non-executive directors should scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance.

Risk
Non-executive directors should satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible.

People
Non-executive directors are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary removing, senior management and in succession planning.

But non-executives on NHS Boards have an additional important responsibility, which can be summarised as:

Accountability
Non-executive directors are appointed by the NHS Appointments Commission on behalf of the local community. They therefore have a responsibility to ensure the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Some readers may be familiar with the SAGE criteria used to describe the non-executive role. These are completely consistent with the Higgs headings and a map across is provided at Annex 8.

Strategy

The Board has the collective responsibility for planning for the future and developing the strategic direction of the organisation across the span of its responsibilities. Non-executives need to be properly informed about the issues and confident to challenge the executive team as plans are developed. Sometimes there can be a narrow dividing line between strategy and operational management and non-executives need to be careful not to be drawn across this boundary. To do so risks them becoming distracted by the operational detail and thereby unable to maintain the distance and objectivity needed for their role in scrutinising performance.

Strategic planning will be guided by the targets and delivery dates in the Priorities and Planning Framework and the detailed objectives in the NHS Plan and National Service Frameworks, but each organisation will develop strategies for its own contribution to the overall goals and the way it will work with partner organisations to achieve them. It will also set local goals to reflect local circumstances and its own patient and public expectations.

Scrutiny of performance

Non-executives will be encouraged by the Chair to question and probe the executive team on its performance. To do this effectively they will need to have proper information presented in an understandable format and be given time enough to digest it.

In taking this role, the non-executive's are not acting as an external policing agency. Rather they should be constructive and guiding so that their scrutiny leads to better outcomes and improved strategies.

This level of constructive debate requires trust between executives and non-executives and a clear understanding and acceptance of each other's roles. 'Whole Board' training can be helpful in developing this level of understanding.

Risk

Non-executives need to be assured that the systems of internal control, including Clinical Governance and financial management, are properly established and that appropriate systems of risk management are in place. This is particularly important as the Board develops new strategies to modernise the way the organisation works and provides or procures services for patients. Non-executives will need to determine the level and detail of reports which they need to maintain confidence that the systems that are established provide a sufficient level of confidence in the control of the organisation.

Non-executives can ensure that the interests of patients and the community remain at the heart of the Board's discussions.

It is also a key responsibility for non-executives to be aware of their obligations around staff and patient safety and the duty of the Board regarding adverse incidents and occurrences.

The non-executives, and in particular Audit Committee members, will be able to review and endorse the Statement on Internal Control (SIC) signed by the Chief Executive. To complete the statement on internal control the Board needs to ensure it is complying with the three core standards of Governance, Financial Management and Risk Management.

People

The non-executives should be a source of support for the Chair. This does not mean uncritical support but constructive acknowledgement of the Chair's Board leadership role and authority.

The Chair, with support from one or more non-executive directors, appoints the Chief Executive and non-executives are often involved in the appointment of other executive directors.

The Chair has the power to remove the Chief Executive where necessary, but would usually only contemplate such a step with the support of the non-executives. Through the Remuneration Committee, non-executives set the remuneration for the Chief Executive and the senior executive team.

The non-executives are expected to support the executive team in raising the standards of leadership and management to meet the *Managing for Excellence* objectives. This includes paying particular attention to career development and succession planning across their organisation, spotting talent and providing the right incentives for clinicians and other professionals to contribute effectively to the management process.

Accountability

Non-executives are drawn from the local community and therefore have a particular duty to it. Clearly, the small number of non-executives on a Board cannot represent the spectrum of patient and public experience and they should not attempt to substitute for focus groups or represent single issue interests. However, non-executives can ensure that the interests of patients and the community remain at the heart of the Board's discussions.

The Patients Forum will be a particularly useful route for the exchange of information between the Board, the public and patients.

Notwithstanding this responsibility, on occasion boards will need to take a wider view in making difficult judgements between local interests and the wider population of NHS users. This could happen for example, where the establishment of a centre of excellence in a particular speciality may lead to better services in the longer term but require the closure of local provision.

Non-executives have a particular responsibility for encouraging the cultural change which is needed to ensure the full engagement with patients, staff and local communities as set out in *Managing for Excellence*. Non-executives can ensure that the organisation consults the community about significant changes to services, listens to community views and keeps the public informed about performance.

Drawing from their own experience with local networks, non-executives also have an important part to play in ensuring that the Board and the organisation build networks with other organisations both within and outside the NHS to assist and inform their services. The Patients Forum will be a particularly useful route for the exchange of information between the Board, the public and patients.

Other statutory duties of the non-executive

Membership of Audit, Remuneration and Terms of Service, Clinical Governance and Risk Management Committees

The involvement of non-executives as members of these committees is detailed in Chapter 7 below.

Complaints convener

At present there is a statutory requirement for NHS Trusts and PCTs to appoint a non-executive to be a complaints convener, although the legislation allows for others in addition, who are not non-executives, to be appointed to the role. This has proved to be a very time-consuming role for the non-executive director convener. However, this complaint system is being replaced by a new procedure which will not require the complaints convener role. Local resolution will be improved so that complaints are more likely to be resolved at an early stage in the interests of all concerned. From 1st April 2004 responsibility for the independent review of complaints will become that of the Commission for Healthcare Audit and Inspection (CHAI). Support for patients in bringing a complaint will be provided by an Independent Complaints Advocacy Service (ICAS) commissioned by PCT Patients Forums.

Mental Health Act managers

Under current legislation Trusts must appoint a committee or sub-committee of the Board to undertake the duties of manager under the Mental Health Act. The committee does not have to include non-executive directors and may be made up of other "appointed and informed outside persons". Full use of this provision should be made so that non-executives on a Mental Healthcare Trust are not overwhelmed and can give proper attention to their governance responsibilities.

Although the legislation is under review, there is no date for replacement of this system.

Responsibilities as champions

At various times non-executives have been charged to act as 'champions' for particular strands of health policy. The National Service Framework for older people, design, equal opportunities, cleanliness and volunteers provide examples. The intention of designating a champion is not to draw the non-executive into operational matters but to ensure that the strategy for developing the topic is given Board attention. The non-executive should, therefore, discharge this responsibility at a high level and in the same way as other matters considered by the Board. The Board needs to establish clarity about how it wishes to consider 'championed' topics relative to other priorities so that non-executive champions are clear about the limits of their involvement.

Other duties

Non-executive directors are frequently called upon to undertake other duties, such as disciplinary and grievance panels, where they are perceived to be independent of executive management and therefore to bring more objectivity. It is important to realise that these are rarely statutory obligations and where they are particularly time-consuming can deflect the non-executives from their governance duties. Consideration should be given to employing external independent expertise rather than using non-executives.

Where non-executives have particular expertise and the available time, they may be paid for modest additional duties provided they are clearly identified as additional to their non-executive role, contracted through proper procedures and do not give rise to any conflict of interest.

Boundaries of the non-executive role

In this chapter we have set out the prime role of the non-executive. However, such is the dedication of many non-executives in the NHS that some are drawn into other areas considerably beyond those outlined above.

Non-executives have many skills to offer but these need to be properly channelled into strategy, scrutiny and constructive challenge rather than substituting for, or supplementing, executive effort.

This may have serious implications. Far from adding to the governance of the organisation, it can detract from it. Too much involvement makes it harder to see the whole system in an objective way. Non-executives have many skills to offer but these need to be properly channelled into strategy, scrutiny and constructive challenge rather than substituting for, or supplementing, executive effort.

To add most value, the non-executive's duties should not extend into operational matters. For example they should not take total responsibility for communication with the public; they should not substitute for proper consultation with the public and patients; they should not substitute for weaknesses in the executive team; and they should not need to spend time in policy committees or shadowing executive directors simply to "find out what's going on".

It is important that non-executives understand that they are appointed with a mandate to assist the Board in governance rather than to act in the representative capacity that would be more appropriate for someone who had been elected to office.

By focussing on strategy, scrutiny of performance and the tasks associated with clinical governance, risk and financial management, the governance of the organisation will be far more secure and enriched.

Advocating this high level role is not to belittle the contribution that some non-executives have made in the past year, particularly those who have rolled up their sleeves and worked with the executive team in setting up the new PCTs. This activity has undoubtedly been particularly valuable to the new organisations. However, as organisations mature it must be right to back-off and resume the greater detachment that really effective non-executives use to advantage.

None of the above is intended to prevent the Board from using the special expertise of non-executives or capitalising on their local networks and knowledge where this is clearly appropriate, but the boundaries of this activity need to be clearly understood.

It is also recognised that, as part of their induction training and their ongoing familiarisation with the staff and business of their organisation, it is essential that non-executives should have contact with the operational activities of the Trust or Strategic Health Authority. Again, this is a matter of defining appropriate boundaries which recognise responsibilities and the paramount duty of governance.

The challenge for all Boards is to operate with focus and efficiency to make the best use of their members' available time.

Within the non-executive remit, outlined in these pages, there is ample scope for the non-executive to enjoy a term of office that is rich in personal fulfilment as well as making a focused contribution to the NHS.

Time commitment

It is difficult to be prescriptive about the time commitment required of non-executives. However, those applying for posts on NHS boards need to be given some indication of the likely call upon their time. This may be particularly important for those who have carer or family responsibilities or need to make arrangements with employers or who have a portfolio of other work.

The Higgs report has determined that private sector non-executives devote between 1¼ and 2½ days per month to their duties. This compares with the current stipulation of 5 days for NHS non-executives.

In our view a non-executive serving on a board, which is properly focused on its governance responsibilities and which is properly supported by papers and information from the executive team, should be able to fulfil the role in 2½ days. This may be regarded as the minimum acceptable commitment. Clearly some individuals will be able to give more time to the organisation and where this is helpful we are not suggesting that it should be discouraged. However, these additional duties should not be regarded as an extension or part of their board role or cross the boundaries set out above.

It follows that non-executives who are only able to meet the 2½ day commitment should not be penalised at recruitment or regarded as less effective once appointed.

The challenge for all Boards is to operate with focus and efficiency to make the best use of their members' available time.

5

The role of the Chief Executive

The Chief Executive helps create the vision for the Board and the organisation to modernise and improve services.

The Chief Executive has the responsibility for ensuring that the Board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action.

The NHS Leadership Centre's Induction Guide for Chief Executives sets out the main roles and responsibilities as:

Leadership
The Chief Executive helps create the vision for the Board and the organisation to modernise and improve services and has the skill to communicate this vision to others and the ability to empower them to deliver the organisation's agenda.

Delivery planning
The Chief Executive has the duty to ensure that the Board has sufficient information to agree a Local Delivery Plan or Service Level Agreements that meet the NHS Plan and other priorities and is based on realistic estimates of physical, workforce, financial capacity and patient and public involvement.

Performance management
The Chief Executive is responsible for ensuring that the Board's plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. The Chief Executive also agrees the objectives of the senior executive team and reviews their performance.

Governance
The Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. This will enable the Chief Executive to sign the Statement on Internal Control on behalf of the Board, to state that the systems of governance, including financial governance and risk management, are properly controlled.

Accountability
The Chief Executive is accountable to the Board for meeting their objectives and, as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation.

The relationship between the Board and the Chief Executive

This relationship is complex and many facetted but can be summarised as follows:

What the Chief Executive does for the Board

Helps create the vision

Provides information and expertise

Provides operational leadership

Provides effective control systems

Delivers against operational objectives

Delivers the modernisation and change agenda

What the Board does for the Chief Executive

Challenges and hones vision into high level strategic objectives

Supports the management of the organisation

Sets demanding but realisable operational objectives

Challenges and thereby reinforces the effectiveness of control systems

Supports the Chief Executive in making changes and taking risks by corporately agreeing plans and strategies and taking corporate responsibility for outcomes

Establishes a forward thinking, modernising and patient-focused culture for the organisation

6

The role of the Professional Executive Committee Chair

The PEC Chair is the lynchpin for effective team working between PEC, Executive Team, PCT Chair, PCT Board and local clinicians.

The role of the PEC Chair reflects their unique position of clinical leadership within the PCT, their duties as a Board member and their special responsibilities as Chair of the Board committee which is expected to provide much of the direction and new thinking for the PCT. The role is challenging, as its effectiveness rests on good working relationships with their professional colleagues (from many different disciplines) in the wider PCT community as well as with the PCT Chair and the Chief Executive. Clarity over their respective roles is essential. The PEC Chair role may be summarised as follows, using the same generic headings as those for the PCT Chair.

- Leadership
  - a) of the PEC to ensure it effectively discharges the remit set for it by the Board
  - b) clinical leadership to the professionals within the PCT and within its geographical area.
- Ensuring the provision of accurate, timely and clear information to PEC members and PCT directors
- Ensuring effective communications
  - a) internally with staff and the PCT Board
  - b) externally with primary care and secondary care sector clinical partners and with patients and the public as delegated by the Board.
- Arranging the regular evaluation of the performance of the PEC and its members.
- Facilitating the effective contribution of PEC members and ensuring constructive relations between the professional PEC members and the Chief Executive and the Senior Management Team, as well as with the Chair and non-executive directors of the PCT.

Leadership

The PEC will have been given a remit by the PCT Board and it is the duty of the PEC Chair to ensure that the Committee delivers that remit in a way that meets the requirements of the Board. Since the PEC Chair also serves on the PCT Board he or she provides a vital link between the two bodies and needs to take particular responsibility for ensuring that they work in harmony, with total confidence in each other's role and perspective.

The PEC is accountable to the PCT Board for its actions and will be expected to report formally at agreed intervals.

The PEC Chair also has a distinctive responsibility, on behalf of the PCT, to provide leadership to local clinicians and particularly to engage them in the PCT's agenda for modernisation and change. This requires an active engagement with the Public Health and commissioning functions of the PCT as well as with those services that it directly provides through its own workforce and its constituent general practices. Through involvement with local clinicians and other health and social care staff, their leadership may also work in the other direction by ensuring that these views are taken into account by the PEC and the PCT Board. In this way they have an important role in the development of managed clinical networks and in securing co-ordinated and 'seamless' care for the PCT's patient population.

Keeping PEC members, the Chair and members informed

The PEC can only work effectively if members are fully informed. The PEC Chair has the opportunity to spend more time with the Chief Executive and the Board Chair and so should be well informed, but needs to recognise the information needs of other members. The PEC Chair also has a similar obligation to ensure that the PCT Board members are fully informed about PEC business.

Working with the PCT Chair and the Chief Executive, the PEC Chair should ensure the proper flow of information to PEC members, to the PCT Board and between the PEC and PCT Board. The Board will expect regular reports from the PEC about progress on operational objectives and assurance that the risk management and clinical governance systems are working.

Communications

The PEC is accountable to the PCT Board for its actions and will be expected to report formally at agreed intervals. It usually has a delegated responsibility on behalf of the Board to act as the interface between the PCT and the primary care practitioners in the locality, as well as with secondary care sector clinicians.

These relationships are essential to the effectiveness of the PCT and can only be developed on the basis of the trust that comes with full and frank exchange of information. The PEC Chair has the responsibility for ensuring that these communications are timely and inclusive.

PCTs are committed to developing services in response to the needs of patients and the PEC may have been delegated the responsibility for developing communication links with patients through focus groups or other activities. The PEC Chair may also

be required to present clinical strategies, particularly on behalf of the Board to wider external audiences.

Performance review

The PEC should annually review how effectively it has carried out its duties. In doing this the PEC Chair should seek the views of key stakeholders such as the PCT Chair and Board, non PEC members of the executive team, and external parties such as primary and acute sector clinical partners.

The PEC Chair should also reflect on his/her own performance as a part of their annual performance review with the PCT Chair.

Formal procedures are not yet in place for an annual performance review of the PEC members, other than the members of the executive team, but it should be considered good practice for all members. An effective performance review enables individuals to understand their performance, identify their training and development needs and thereby increase their contribution to the organisation.

Teamwork

The PEC Chair is the lynchpin for effective team working between PEC, Executive Team, PCT Chair, PCT Board and local clinicians.

The PEC Chair needs to ensure that all partners understand their different roles and work constructively together.

The PEC Chair particularly needs to ensure that the PEC provides clinical direction for the executive team and sound strategic advice for the PCT Board.

It is the PEC Chair's responsibility to agree the PEC meeting agenda with the Chief Executive and ensure that it reflects the delegated functions of the PEC. It should be open to all PEC members to suggest agenda items.

7

Board committees

Committees consume a considerable amount of time and it is essential that they add value.

NHS Boards may delegate some of their powers to formally constituted committees. These committees have a remit and decision making powers defined by the Board and are expected to report back to it at agreed intervals.

Committees may set up sub-committees and may in turn delegate powers to them.

Some committees and sub-committees will not have any executive or decision making powers but will be established to provide advice to the Board on a particular issue.

Committees consume a considerable amount of time and it is essential that they add value. Only a small number of committees need to be permanent. Consideration should be given to time-limited committees, so that when their job is done they are disbanded. Both their membership and the number of committees should be kept under review.

The small number of permanent Board committees are discussed below.

The Audit Committee

Every NHS organisation has to have an Audit Committee reporting to the Board with responsibility for ensuring effective internal control.

Traditionally Audit Committees have primarily concerned themselves with scrutiny and review of financial systems, financial information and matters of compliance with law and the Code of Conduct. However, other internal controls are equally important, particularly risk management and clinical governance. Under controls assurance the audit committee should be concerned about all controls.

The Audit Committee needs to ensure that these responsibilities are properly addressed through the organisation's committee structure.

Through its scrutiny and reports, the Audit Committee enables the Board to have confidence in its control systems and it provides an important voice when the Board considers the Statement on Internal Controls (SIC) and its implications.

The Membership of the Audit Committee normally consists of three non-executive directors. The Chair of the organisation cannot serve on the Audit Committee. The Director of Finance, Head of Internal Audit and the external auditors normally attend meetings which are held at least three times a year.

Further details on the duties of the Audit Committee are in Annex 9.

All NHS bodies concerned with the delivery of services to patients need to have a Clinical Governance Committee.

The Remuneration and Terms of Service Committee

Every NHS organisation must have a Remuneration and Terms of Service Committee reporting to the Board. Its task is to advise the Board about appropriate remunerations and terms of service for the Chief Executive and other senior staff.

In formulating their recommendations for the Board Committee, the Committee takes into account the circumstances of the organisation, the size and difficulty of the job benchmarked against other NHS organisations, the performance of the individual and national guidance as appropriate.

The Membership of the Remuneration and Terms of Service Committee consists of the Board Chair and at least two other non-executives. The Chief Executive is usually in attendance but should not be present when his or her own remuneration is to be discussed.

Further details about the work of the Remuneration and Terms of Service Committee are at Annex 10.

The Clinical Governance Committee

All NHS bodies concerned with the delivery of services to patients need to have a Clinical Governance Committee. For Strategic Health Authorities and NHS Trusts this is a committee of the Board. For PCTs it is a Committee of the PEC reporting to the Board through the PEC.

Its task is wide ranging in scrutinising and reviewing the systems in place within the organisation to ensure, monitor and improve the quality of healthcare provided for or delivered to the patient. This obligation will vary between different types of organisation. Acute Trusts, for example, will need different systems from those needed by PCTs or Strategic Health Authorities which have different responsibilities and levers for ensuring, monitoring and driving-up quality.

The reports from the Clinical Governance Committee enable the Board to meet its responsibilities for the quality of healthcare required in the Statement on Internal Control.

The Membership of the Committee does not statutorily include a non-executive director. However, in practice, because this is such an important area of activity which also impacts on the work of the Audit Committee, a non-executive usually sits on the Committee alongside the relevant members of the executive and clinical and support teams.

Risk Management Committee

All NHS organisations must have a strategy for managing the risks associated with the organisation's business. These will cover all risks that might prevent the organisation from meeting the goals set out in its Business Plans. They might be financial, staff related, associated with facilities or the quality of care. They will range from risks with low probability but enormous impact as in disaster scenarios, to those with higher probability but less impact involving individual patients or staff members.

Organisations are encouraged to have a committee which considers risks. The Risk Management Committee is expected to ensure that the organisation has a strategy which allows for:

a) the continuing identification and prioritisation of risks

b) a description of action taken to manage each key risk and

c) the identification of how risk is measured

In some smaller organisations the responsibility for risk management will be part of the remit of the Audit Committee. In other organisations it has been incorporated into a joint clinical governance and risk management committee which has much to commend it. However the Committee should report significant risks to the Board for their consideration.

In PCTs the Risk Management Committee is usually established as a sub-committee of the PEC Committee and reports to the Board through them. In other NHS bodies the Risk Management Committee is a Committee of the Board.

Membership of the Committee is not set out in statute, but like the Clinical Governance Committee, a non-executive director is often a member because of the importance of the Committee and the fact that its remit is closely related to that of the Audit Committee.

Further information on Risk Management is at Annex 2.

The Professional Executive Committee (PEC)

All PCTs have a Professional Executive Committee (PEC) as a committee of the Board. The role of the PEC reflects the composition and expertise of its membership on clinical matters but its precise role may vary between PCTs. It needs to work with the Chief Executive and the Senior Management Team to provide support and direction to the Board.

Some see PEC responsibilities as those of navigator for the PCT

Key areas for the PEC are clinical change; clinical engagement; interfacing with acute sector clinician partners; ensuring the PCT has a whole-systems approach to care; delivery of the clinical agenda; health improvement.

Some see PEC responsibilities as those of navigator for the PCT so that, when combined with the executives of the Senior Management Team, the PEC can provide operational leadership and help to shape strategy for the PCT.

The PEC brings together clinical and managerial perspectives and takes a leading role in these functions on behalf of the PCT. The PEC is also usually responsible to the Board for the Clinical Governance and Risk Management systems of the PCT.

The PCT Board and the PEC need to ensure that there is absolute clarity about the range of delegated responsibilities and that the differentiation of functions between them is explicitly agreed and understood by executive and non-executive members of the Board, as well as by all members of the PEC. Particularly important are the communications and reporting arrangements necessary for the Board to fulfil its governance and accountability obligations. It is also essential that these understandings are shared fully and openly with the wider PCT staff community and with its partner organisations.

The Membership of the PEC includes: Chief Executive; Director of Finance; Social Services representative nominated by the Local Authority; a public health professional, e.g. consultant in public health medicine, in dental public health or other specialist (it is for local determination whether Director of Public Health is a member of the PEC); and up to 14 professional members e.g. general medical practitioners, general dental practitioners, nurses, allied health professionals, pharmacists, optometrists, consultants. Membership should include as a minimum one GP and one nurse. The Chair of the PEC is drawn from the professional membership.

Further details of the work of the PEC are included in the PCT organisational competency framework (details at Annex 11).

8

Functions and accountability relationships

The more effective the working across organisational boundaries, the better the service to patients and local people.

The three NHS organisations primarily responsible for patient services at present are Strategic Health Authorities, NHS Trusts and PCTs. This section outlines their particular high-level functions and the way in which their responsibilities are linked together.

Primary Care Trusts

The Board of the PCT shares with other NHS Boards the Governance responsibilities set out in Chapter 2.

The main functions for which the PCT Board is responsible are to:

- identify the health needs of the population
- maintain an effective public health function
- work to improve the health of the community
- lead local planning
- secure the provision of a full range of services
- manage and develop primary healthcare services
- develop and improve local services
- lead the integration of health and social care
- deliver services within their remit

For Teaching PCTs to:

- develop additional clinical posts with a teaching/learning role

Key relationships:

The proper fulfilment of these functions involves a network of key stakeholders. These are:

- The local community of public and patients
- Elected representatives such as MPs and councillors
- The local authority
- Other local PCTs and the Strategic Health Authority

- The professional practitioners, through the Professional Executive Committee
- The organisations from which it commissions health services such as Acute, Ambulance, Mental Health and Community Trusts, voluntary sector and commercial providers
- The Secretary of State and Parliament

For Teaching PCTs:

- GP postgraduate deans and universities

These functions are formalised and monitored through the following arrangements:

Local Delivery Plans (LDPs)
PCTs take the lead in planning and are responsible for creating local plans which describe NHS and joint NHS and social care priorities in their area. The plans are guided by the targets and delivery dates set out in the Priorities and Planning Framework and the detailed objectives in the NHS Plan and National Service Frameworks for particular patient groups and conditions, as well as addressing the needs of the community as a whole.

The Local Delivery Plan is a three-year plan and identifies milestones for progress at monthly, quarterly or annual intervals. It needs to be supported by financial and strategic plans to show how resources will be deployed.

These plans, when agreed by the Board, specify in detail the services which the PCT intends to provide or procure for its local community in the year ahead. They are the business plans of the organisation. The LDP is agreed with the Strategic Health Authority.

Contracts for Commissioned Services/Service Level Agreements (SLAs)
Produced in negotiation with NHS Trusts, social service partners, and other service providers, these service contracts are expected to specify type, volume and cost of service together with other quality and service parameters to drive up standards and increase value for money. They will include activity profiles, details of monitoring arrangements and explain under what circumstance PCTs may withdraw funding for under-performance.

SLAs/contracts need to be in place to underpin the services to be provided in the LDP.

Performance monitoring

PCTs hold the provider organisation to account for the delivery of the services they have commissioned. Performance management is an ongoing function throughout the year. It takes the form of regular assessment against delivery targets. Good performance management requires a relationship of trust between the provider and the PCT so that the PCT can be confident that any difficulties are acknowledged and can be addressed before they become insuperable.

Annual Accountability Agreements (AAA)

The AAA is an agreement between the PCT and the Strategic Health Authority. The AAA complements the LDP and generally concentrates on a smaller number of high-level objectives which can be monitored and used to measure the in-year performance of the PCT. These may take the form of milestones or progress markers against the targets of the LDP and enable the Strategic Health Authority to assess whether the 'trajectories' within the LDP are being met. The AAA may be incorporated within the LDP.

Accountable Officer Responsibility

The Chief Executive of the PCT is accountable to the Chief Executive of the NHS for the effective use of financial resources and for obtaining value for money. The Chief Executive of the NHS is in turn accountable to Parliament for the use which the NHS has made of the resources allocated to it.

Annual Audited Accounts and Statement on Internal Control

These two documents form the basic record of the Controls Assurance of the organisation.

Relations with Overview and Scrutiny Committees

Details of how this statutory relationship between the Scrutiny Committee of the local authority and the PCT should be developed are at Annex 12. There is a duty for each local NHS body to consult the Committee on any proposals for any substantial development or variation in health service provision.

Consultation with Patients and the Public

There is a new statutory duty to consult the patients and the public on service planning and operation as well as in the development of proposals for change. Annex 12 gives details of further information.

NHS Trusts

The Board of the NHS Trust shares with other NHS Boards the Governance responsibilities set out in Chapter 2.

The main functions of an NHS Trust are to:

- Provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children).
- Ensure services are of high quality and accessible.
- Lead the development of new ways of working to fully engage patients and ensure a patient-centred service.

For teaching hospitals to:

- Provide a suitable environment for training and research.

Key relationships

- The local community of public and patients and their elected representatives
- Elected representatives such as MPs and councillors
- PCTs as Commissioning bodies
- Staff and their representative and professional organisations
- Strategic Health Authorities
- The Secretary of State and Parliament
- The University/medical school (for teaching trusts)

Business Plan/Local Delivery Plan

The NHS Trust produces a Business Plan/Local Delivery Plans setting out the services it will provide in accordance with the level of resources it has negotiated. It will detail how it intends to meet the relevant access and workforce targets within the Priorities and Planning Framework, the NHS Plan and the National Service Frameworks and in, future, to meet the standards expected by the Commission for Healthcare Audit and Inspection.

There is a new statutory duty to consult the patients and the public on service planning and operation as well as in the development of proposals for change.

The plan is agreed with the commissioning PCTs and sent to the Strategic Health Authority for agreement.

Service Level Agreements (SLAs) with PCTs

These Service Level Agreements are contracts with PCTs which will specify an agreed type, cost and volume of service together with such quality of service parameters as may have been agreed with the PCT or specified in national standards.

The Service Agreement will also specify how performance against the contract can be monitored by the PCT and under what circumstances the PCT may withdraw funding for under-performance.

Annual Accountability Agreement (AAA)

The AAA is an agreement between the NHS Trust and the Strategic Health Authority. It complements the LDP/Business Plan and provides a small number of high-level objectives which can be monitored by the Strategic Health Authority and used to monitor the 'in year' performance of the NHS Trust. These objectives will include some of the access targets such as the maximum wait for an outpatient appointment or waiting time in A&E.

Strategic Plan

NHS Trusts also produce a strategic plan taking the 3 year agreement of the LDP into the longer term.

Accountable Officer Responsibility

The Chief Executive of the NHS Trust is accountable to the Chief Executive of the NHS for the effective use of resources and for obtaining value for money.

Relations with Overview and Scrutiny Committees

Details of how this statutory relationship between the Scrutiny Committee of the local authority and the PCT should be developed are at Annex 12. There is a duty for each local NHS body to consult the Committee on any proposals for any substantial development or variation in health service provision.

Consultation with Patients and the Public

There is a new statutory duty to consult the patients and the public on service planning and operation as well as in the development of proposals for change. Annex 12 gives details of further information.

Foundation Trusts

These new bodies will have different planning and accountability arrangements and some of these measures are outlined in Chapter 11.

Strategic Health Authorities

The Board of the Strategic Health Authority shares with other NHS Boards the responsibilities set out in Chapter 2. The main functions for which the Strategic Health Authority is responsible are to:

- Provide strategic leadership to ensure the maintenance of provision and the delivery of improvements in local health and health services by PCTs and NHS Trusts, within the national framework of developing a patient-centred NHS and supported by effective controls and clinical governance systems.
- Lead the development and empowerment of uniformly excellent frontline NHS organisations committed to innovation and improvement.
- Consider the overall needs of the health economy across primary, community, secondary and tertiary care, and working with PCTs and NHS Trusts to deliver a programme to meet these needs.
- Performance manage and ensure accountability of local NHS Trusts and PCTs.
- Lead on the creation and development of clinical and public health networks.
- Create capacity through the preparation and delivery of strategies for capital investment, information management and workforce development.
- Ensure effective networks and joint working exists between NHS organisations for the provision of health and social care.
- Ensure the development and training of an adequate workforce of competent clinical personnel.

Key relationships

- The local community of public and patients and their elected representatives
- NHS Trusts and PCTs in the local health economy
- Local Authorities

- Regional Government offices and Regional Assemblies
- NHS Chief Executive
- The Secretary of State and Parliament
- Foundation Trusts

These functions are formalised and monitored in the following ways.

Strategic leadership

Strategic Health Authorities are the local headquarters of the NHS. Following the abolition of the Directorates of Health and Social Care in the reorganisation of the Department of Health, they have the pivotal liaison function between Departmental policy makers, National Clinical Directors, the Department's Director of Delivery, and the local NHS.

This function is two-way: to inform the Department about the aspirations and capacity of the service and to ensure the local NHS is aware of central policy development and ongoing strategic guidance and helps them to develop it operationally.

Increasingly the expertise of Strategic Health Authorities will be sought by the Department to inform the policy-making process.

Public Health

The 9 Regional Directors of Public Health have a direct reporting line to the Chief Medical Officer but are expected to work through Strategic Health Authorities in ensuring effective performance management of the local public health function. They have direct working contact with the public health team in PCTs, mediated through Strategic Health Authorities.

Planning

Strategic Health Authorities play a key role in the Planning Framework by overseeing planning within their area. They are responsible for ensuring that PCTs and NHS Trusts make adequate plans and for consolidating these into a Strategic Health Authority level, Local Delivery Plan which is agreed by the DoH.

Agreement of Local Delivery Plans and Business Plans

The Strategic Health Authority receives the LDPs from the local PCTs and Business Plans/LDPs from the local NHS Trusts. It has the duty to scrutinise and agree the final

The Strategic Health Authority monitors the performance of the NHS Trusts and PCTs against the progress outlined in the LDPs.

form of these. In doing so, it will be able to take an overview of the wider local interests of the patients and the NHS rather than the particular interest of an individual organisation. It may need to broker changes in the LDPs or Business Plans to reflect this wider interest. It needs to ensure that overall plans will meet nationally set targets, including overall financial balance within the Strategic Health Authority area.

Capital Development Planning

The Strategic Health Authority is responsible for the allocation of strategic capital and for approving business cases for major capital schemes.

Performance management

The Strategic Health Authority monitors the performance of the NHS Trusts and PCTs against the progress outlined in the LDPs. They are able to measure whether the performance trajectories are being followed and assist in addressing problems at an early stage. Customarily the Chief Executive of the Strategic Health Authority plays a role in working with Trust and PCT Chief Executives in the territory to manage performance to the overall benefit of the local health economy. However, this does not remove any responsibility from those organisations for successfully managing their programmes.

Developing leadership

Strategic Health Authorities play an important role in supporting the career development of local NHS leaders. This involves close working with Chairs and Chief Executives of PCTs and NHS Trusts, within the context of the new NHS Leaders Scheme.[1]

Performance assessment by Department of Health

Health Authorities are held to account by the Department for the way in which they fulfil their role. The assessment criteria include the performance against the LDP; the movement of star-ratings within the area; the risk management associated with the LDP; and the management capacity of the Authority.

Accountable Officer Responsibility

The Chief Executive of the Strategic Health Authority is accountable to the Chief Executive of the NHS for the effective use of the finance and resources allocated to the Authority.

[1]Details of NHS Leaders can be found at www.nhsleaders.nhs.uk

9

The role of Inspectorate and Regulatory Systems

The NHS is subject to inspection from numerous bodies, from Royal Colleges to local Fire Officers. This section does not attempt to detail all these activities but focuses on the two new regulatory bodies, the Commission for Healthcare Audit and Inspection and the Commission for Social Care Inspection.

Together the two new Commissions will:

- Strengthen the accountability of those responsible for the commissioning and delivery of health and social services
- Demonstrate to the public how the additional money being invested in these services is being spent and enable them to judge how performance is improving as a result
- Streamline inspection arrangements for health and social care

The Commission for Healthcare Audit and Inspection

Subject to legislation, from April 2004 the Commission for Healthcare Audit and Inspection (CHAI) will bring together the work of the Commission for Health Improvement, the Mental Health Act Commission; the independent healthcare work of the National Care Standards Commission, and the NHS 'Value for Money' work of the Audit Commission. Its duties will include:

- Inspection of the management and provision of healthcare against national standards and service priorities such as those set by the National Institute of Clinical Excellence, National Service Frameworks and other NHS priorities. Inspections will include not only the quantity of provision but also the 'value for money' of services.
- Publishing reports on the performance of NHS organisations, including 'star ratings' and reporting annually to Parliament on progress on healthcare delivery and the use of resources.
- Investigating serious service failures in the NHS, reporting publicly, and identifying lessons to be learnt.
- Inspection of clinical governance arrangements to ensure effective quality assurance and quality improvement, and provide advice on necessary improvements.
- Co-ordinate the second stage of the NHS complaints procedure and provide independent scrutiny.

- Replace the Mental Health Act Commission in scrutinising the operation of compulsion under the new Mental Health Bill (to be introduced when Parliamentary time allows).
- Licensing private healthcare provision.

The Commission for Social Care Inspection

The Commission for Social Care Inspection will create a single comprehensive Inspectorate for social care, bringing together the inspection functions of the Social Services Inspectorate and the National Care Standards Commission, and including the regulation of social care providers.

Its key duties will be:

- Regulation and inspection of both public and private social care providers against national standards. This will involve the registration of services that meet national minimum standards and the publication of reports following inspections.
- Performance monitoring of local social service authorities:
  - Validate all published performance assessment statistics on social care
  - Publish the star ratings for social services authorities
- Publication of an annual report to parliament on national progress on social care and analysis of where resources have been spent.
- Identification of poor performance and for local authority social services to advise the Secretary of State that action is required. For services regulated under the Care Standards Act to take appropriate enforcement action to improve performance.
- Co-operation with other public bodies, ministers and the devolved administrations of Northern Ireland and Wales on social care and social care related schemes and services.

10

The role of the NHS Appointments Commission

The NHS Appointments Commission is a Special Health Authority which has the responsibility for ensuring that NHS organisations have chairs and non-executives who are capable, trained and supported to fulfil the function of governance set out in this Guide.

The main functions of the NHS Appointments Commission are to:

- Appoint, re-appoint and, where necessary, to terminate the appointment of chairs and non-executives of Strategic Health Authorities, PCTs, NHS Trusts and Special Health Authorities.
- Ensure chairs and non-executives receive relevant and appropriate training.
- Ensure through annual performance review that chairs and non-executives are supported and developed in their role and feel valued.
- Ensure chairs and non-executives receive all necessary support through mentoring programmes.
- Ensure that overall NHS boards add value to the NHS locally and more widely.

Key relationships

- Strategic Health Authority Chairs
- All other Chairs and all non-executives
- Modernisation Agency and Department of Health
- CHAI and other regulatory bodies
- Commission for Public Appointments (OCPA)

Details of the partnership between Strategic Health Authority Chairs and Appointments Commissioners in supporting the work of NHS boards and dealing with poorly performing boards and individuals are at Annex 13.

11

Signposts for the future

Whatever Board model may be chosen by a Foundation Trust it will benefit from the good governance measures outlined in this guidance.

NHS Foundation Trusts

Subject to legislation, the first wave of NHS Foundation Trusts will be in place from April 2004. They will be established as independent public benefit organisations modelled on co-operative and mutual traditions. Within certain guidelines, the Government intends to allow the new organisations to develop innovative approaches to healthcare and implement new governance structures. Further guidance on the Governance arrangements for NHS Foundation Trusts will shortly be published.

Accountability

Foundation Trusts will not be accountable through Strategic Health Authorities to the Secretary of State. Instead they will be held to account by a local body of elected governors which will have an absolute majority of representatives elected by local people as well as representation from staff and PCTs.

The role of the Regulator

An independent Regular will be responsible for agreeing the terms of authorisation for each new Foundation Trust. The Regulator will also have the duty to monitor compliance with the terms, the power to insist that steps are taken in the case of non-compliance and, as an ultimate sanction, power to revoke authorisation.

The Board of directors

Each NHS Foundation Trust will have a Board of directors, including a Chief Executive and a Finance Director.

Beyond this guidance it is for each organisation to develop its own governance arrangements for agreement by the new Regulator.

Governance

Whatever Board model may be chosen by a Foundation Trust it will benefit from the good governance measures outlined in this guidance. Clinical excellence, quality of service, value for money, probity and risk management will be just as important for NHS Foundation Trusts in the future as they are for NHS Trusts today.

In as far as these principles are generic across the public and private sector; we would anticipate that the Regulator will expect to see good governance measures in line with this guidance as a condition of authorisation.

Patient and Public Involvement Forums (Patient Forums)

The first Patient and Public Involvement Forums (PPIF) will be established later in 2003. Attached to each NHS Trust and PCT (but not to Foundation Trusts), they will be able to provide direct input from patients into how local NHS services are run. The PPIF will be the trust's first port of call when seeking patients' views for the development of services. A strengthened patient and public voice from the Forum will obviate the need for non-executives to stand as a proxy for patients and allow them to concentrate on their governance responsibilities.

One member of the PPIF will be appointed to serve as a non-executive on the trust Board. That individual is expected to accept the full obligation of Board membership as for any other non-executive director. However they will have a special responsibility for relaying the views of the Forum to the trust Board and providing corresponding information from the Board to the Forum. This special responsibility does not relieve other Board members from their responsibility to make the care of patients central to their governance role.

More details of the Patient and Public Involvement agenda are at Annex 12.

Annexes and references

Annex 1

The Governance Framework

- Strategic planning and objective setting
- Using systems to ensure objectives are met
  - Clinical Governance
  - Risk management systems
  - Finance management systems
- Ensuring systems themselves embody satisfactory controls
  - Controls assurance

Annex 2

Controls Assurance and Risk Management

The main principle underlying controls assurance is that every NHS organisation should be assured that it is managing all risks as effectively as is reasonably possible within the resources available. This requires organisations to continuously review risk and the controls in place to mitigate risk through a process of critical self-assessment to assure itself and others that systems are in place and working effectively.

The inputs to the system include:

- Local and National objectives
- Local and National information on incidents and near misses
- Local and National audit and inspection reports
- Benchmarking information
- Controls Assurance and other applicable standards
- Laws and regulations not covered in the above standards

The process is the risk management cycle (see Controls Assurance Risk Management Standard) and the prioritisation of actions to mitigate risk.

The output is safer services for staff, patients and the public. A by-product is the ability of the Chief Executive on behalf of the Board to sign an assurance statement annually on the system of internal control.Where clinical governance and controls assurance are integrated the output from the system is safer and better services for patients. Clearly the prioritisation of action to reduce risk and improve services is easier to achieve where the systems are brought together.

Many NHS organisations already have well developed specific processes to manage risk, some organisations operating within the framework of quality models may have successfully integrated their approach with risk management, others will have a stand-alone process, whilst others a joint clinical and non-clinical risk management function. What is important is that there is a robust process supporting that judgement which can be explained and understood by those with an interest in the service that the NHS provides.

The Department of Health has established the Controls Assurance Support Unit (CASU) based at Keele University with the responsibility to assist NHS organisations to improve risk management and the quality of services through the provision of standards and by acting as facilitator for identifying and sharing good practice on internal control and risk management activities.

For further information, related papers, Controls Assurance Standards, training materials and training opportunities please refer to:

www.controlsassurance.gov.uk Department of Health Controls Assurance website.

www.casu.org.uk Controls Assurance Support Unit website.

Annex 3

Clinical Governance Support Team

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."
G Scally and L J Donaldson
Clinical governance and the drive for quality improvement in the new NHS in England BMJ (4 July 1998): 61-65

"Clinical governance is the accountable delivery of a patient-centred, ever improving, safe and high quality service."
Professor Aidan Halligan
Deputy Chief Medical Officer, Director of Clinical Governance for the NHS

Clinical Governance is a framework that helps NHS organisations provide safe and high quality care. The NHS Clinical Governance Support Team (CGST) runs a series of development programmes and bespoke interventions aimed at creating change within and across NHS organisations involving patients, staff and users of the service. The programmes work at a number of levels: individual, team, operational, board and whole health community – all supporting the implementation of clinical governance.

The CGST was established in September 1999 and is part of the Modernisation Agency (www.modern.nhs.uk). The team runs a series of programmes to support the implementation of clinical governance 'on the ground', bridging the gap between health service policy and service delivery.

The main programme is the general *Clinical Governance Development Programme* (CGDP). It helps frontline staff bridge the 'knowing-doing' gap as they engage key stakeholders in service reviews through the RAID process and set up improvement projects in their local organisations. Further detail of RAID: Review, Agree, Implement and Demonstrate are on www.cgsupport.nhs.uk

There is also a specialty-specific programme for clinical teams in stroke services and maternity services. In 2003 the CGST is running programmes on Infection Prevention and Control and for children's services.

In addition, the CGST works with NHS organisations by supporting the development of boards and individuals through its *Strategic Leadership of Clinical Governance Board Development Programme.* This programme includes a period of diagnosis, identifying the roles and responsibilities of the board and its approach to leadership, policy and strategy, and the development and deployment of a prioritised strategy and bespoke programme for each trust board.

The *Team Resource Management Programme,* launched in 2002, applies learning from the airline industry and elsewhere to facilitate and improve team working – leading to improved patient and safety care – and the development of specialist 'team coaches' to work with poorly performing teams. Team coaches from the CGST also work directly with troubled teams who are experiencing difficulties working together.

The Clinical Governance – Large Groups Work team facilitates interactive events that bring together key stakeholders from a range of agencies and experiences. The stakeholders are encouraged to work together, produce an agreed action plan and commit to improved service delivery.

The CGST launched a *Clinical Governance Rapid Response Unit* in 2002. The unit supports 'nil star' and other 'challenged' NHS organisations by working jointly with trusts, health and social care communities and strategic health authorities. The team's response is customised, based on the needs of each organisation so that they can develop their own sustainable solutions to the issues raised.

The *Knowledge Management and Information Services* teams at the CGST work to capture the lessons learnt from delegates to the programmes and disseminate them across the wider NHS. It also aims to improve awareness and understanding of clinical governance among NHS organisations, health care professionals and patients. The resources section on the website details better practice case studies and lesson cards. To find out more log onto www.cgsupport.nhs.uk

Annex 4

Planning

The following section sets out the high level roles and responsibilities for organisations under the new Planning Framework. It is not intended to be exhaustive.

Department of Health

- Set priorities, targets and planning framework
- Allocate capital and revenue funding
- Provide developmental support to Strategic Health Authorities
- Sign-off Strategic Health Authority local delivery plans

Strategic Health Authorities

- Establish and oversee an effective planning process, involving all key stakeholders, local government and other agencies
- Ensure that overall plans will meet nationally set targets, including overall financial balance within the Strategic Health Authority
- Ensure coherence between and adding value to local plans
- Manage Strategic Health Authority-wide and supra-Strategic Health Authority issues
- Ensure SLAs/contracts are consistent with local delivery plans, and are signed-off by March 31st
- Ensure that planning takes account of anticipated change such as the new financial flows system or new NSFs
- Sign-off PCT local delivery plans and Trust plans for critical access targets

Primary Care Trust

- Lead production of integrated whole systems local delivery plans
- Represent the NHS in broader local planning arrangements and partnerships with key local stakeholders
- Ensure effective stakeholder involvement in planning processes – as a minimum PCTs local delivery plans should:

– be signed-off by the Professional Executive Committee and Lay Board

– demonstrate that clinicians and front-line staff have been engaged in the development of plans and support proposals

– demonstrate that provider organisations have been engaged in the development process and are supportive of planning proposals

– demonstrate the contribution of local government and other key non-NHS partners

– involve local communities and the voluntary sector in the development of plans

- Develop credible profile trajectories for delivery of targets
- Ensure flexible arrangements to handle anticipated changes such as the new financial flows system or new NSFs
- Provide NHS Trusts and social service partners with open book access to information

- Negotiate provider SLAs/contracts, ensuring that agreements are in place to underpin plans by March 31st (PCTs and Trusts will be held jointly accountable by Strategic Health Authorities for the delivery of robust plans)
- Resolve commissioner/provider disputes at a local level, and jointly with trusts alert Strategic Health Authorities at the earliest time where disputes cannot be resolved.

NHS Trusts

- Provide PCTs with open book access to information as part of the planning process
- Actively support PCTs in developing plans, so that they represent provider as well as commissioner intentions and actions
- Produce Trust plans for relevant targets (access, workforce)
- Ensure that provider SLAs/contracts are agreed and in place to underpin local delivery plans by March 31st
- Resolve commissioner/provider disputes at a local level, and with the PCT(s) alert Strategic Health Authorities at the earliest time where disputes cannot be resolved

Further information is obtainable at www.doh.gov.uk/planning2003-2006/index.htm

Annex 5

Code of conduct

Key messages

Three crucial public service values must underpin the work of the NHS:

- Accountability
- Probity
- Openness

Conflicts of interest must be detailed and registered.

Hospitality at the public expense is open to challenge.

Relations with suppliers need to follow the highest standard of business conduct.

Staff should have procedures for voicing concerns about breaches of the Code, maladministration and ethical matters.

Code of accountability

Key messages

Defines statutory duties of NHS boards and accountability regimes to the Secretary of State. Amplified and brought up-to-date by the contents of this Guide.

Code of conduct for senior managers

Key messages

The document sets out the core standards of conduct expected of NHS managers. It aims to serve two purposes: to guide NHS managers and employees in the work they do and the decisions and choices they make, and to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The core standards of conduct are to:

- make the care and safety of patients the first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for their own work and the proper performance of the people they manage;
- show commitment to working as a team member by working with all NHS colleagues and the wider community;
- taking responsibility for personal learning and development.

Codes of Conduct and Accountability obtainable from NHS Appointments Commission.

Code of Conduct for NHS Managers obtainable from DoH or www.doh.gov.uk/nhsmanagerscode/index.htm

Annex 6

Communications strategies

A clear outline of the communications needed by the modern NHS was set out in the document 'Shifting the Balance of Power in the NHS: Communications'.

The document is to be found at
www.doh.gov.uk/shiftingthebalance/communications/shiftingthebalancecomms.pdf

Summary

The most successful private sector organisations invest in communications because they recognise the value of building good relationships with their customers, clients, local organisations and the general public. They know that communications is vital for their business and are prepared to resource it.

The NHS has a far greater need for effective communications. Apart from the large numbers of staff it employs, its patients and public are far more affected by its services than anything in the private sector. In addition the NHS is accountable to the public and has a duty to provide information about its services. It must also actively involve the public through proper consultation.

The need for improved communications right across the NHS is now widely recognised and in today's society employees, patients and public will accept nothing less.

Key responsibilities for effective communications

Strategic Health Authorities	Primary Care Trusts	NHS Trusts
Scrutinise how communications is delivered in trusts and PCTs	Leading public relations (including customer services)	Leading public relations (including customer services)
Performance manage the empowerment work locally	Managing the reputation of the organisation	Managing the reputation of the organisation
Work closely with the local network of the Commission for Patient and Public Involvement in Health	Developing links with stakeholders, councils, LMCs etc.	Developing links with stakeholders, councils, other emergency services etc.
Strengthen and develop communications in the service	Taking the lead on media management: co-ordinating media training; supporting board media activity; dealing with media inquiries; planning proactive communications; and producing media releases	Taking the lead on media management: co-ordinating media training; supporting board media activity; dealing with media inquiries; planning proactive communications; and producing media releases
Ensure proactive and reactive work is handled competently	Playing key role in the issue management/planning	Playing key role in the issue management/planning
Ensure the stakeholders are well informed	Developing good links with GPs	Editorial responsibility for website
Encourage NHS staff to speak up for the organisation	Editorial responsibility for website	Establishing arrangements for dealing with serious untoward incidents
Help handle high profile media work during serious incidents	Establishing arrangements for dealing with serious untoward incidents	Managing patients/staff surveys
Establish good links with local MPs and MEPs	Managing patients/staff surveys	Managing advertising/printing budgets
Network together with the Department to ensure consistency of approach	Managing advertising/printing budgets	Support fundraising
Deal with the media including regionalising national announcements or assisting the NHS locally to do so	Support fundraising	Supporting health promotion campaigns
Co-ordinating information for patients/websites	Developing strong links with MPs and MEPs	Developing strong links with MPs and MEPs
	Producing high quality patient information	Producing high quality patient information
	Engaging the public/citizen	Engaging the public/citizen
	Contributing at trust board level	Contributing at trust board level
	Supporting the chairman and chief executive	Protecting the corporate identity of the organisation
	Protecting the corporate identity of the organisation	Ensuring effective two-way internal communications
	Ensuring effective two-way internal communications	Linking closely with PALs, Patients Forums, complaints staff
	Linking closely with PALs, Patients Forums, complaints staff	Ensuring consistent messages with PCTs
	Ensuring consistent messages with PCTs	Supporting the work of the Strategic Health Authority
	Supporting the work of the Strategic Health Authority	

Annex 7

Guidance for the Chairman

The following is an excerpt from the Higgs Report:

The Chairman is pivotal to creating the conditions for overall Board and individual director effectiveness, both inside and outside the boardroom. Specifically, it is the responsibility of the Chairman to:

- run the Board and set its agenda. The agenda should take full account of the issues and the concerns of all Board members. Agendas should be forward looking and concentrate on strategic matters rather than formulaic approvals of proposals which can be the subject of appropriate delegated powers to management;
- ensure that the members of the Board receive accurate, timely and clear information, in particular about the company's performance, to enable the board to take sound decisions, monitor effectively and provide advice to promote the success of the company;
- ensure effective communication with shareholders and ensure that the members of the Board develop an understanding of the views of major investors;
- manage the Board to ensure that sufficient time is allowed for discussion of complex or contentious issues, where appropriate arranging for informal meetings beforehand to enable thorough preparation for the Board discussion. It is particularly important that non-executive directors have sufficient time to consider critical issues and are not faced with unrealistic deadlines for decision-making;
- take the lead in providing a properly constructed induction programme for new directors that is comprehensive, formal and tailored, facilitated by the company secretary;
- take the lead in identifying and meeting the development needs of individual directors, with the company secretary having a key role in facilitating provision. It is the responsibility of the Chairman to address the development needs of the Board as a whole with a view to enhancing the overall effectiveness of the team;
- ensure that the performance of individuals and of the Board as a whole and its committees is evaluated at least once a year; and
- encourage active engagement by all the members of the Board.

The effective Chairman:

- upholds the highest standards of integrity and probity;
- sets the agenda, style and tone of board discussions to promote effective decision-making and constructive debate;
- promotes effective relationships and open communication, both inside and outside the boardroom, between non-executive directors and the executive team;
- builds an effective and complementary Board, initiating change and planning succession in Board appointments, subject to Board and shareholders' approval;
- promotes the highest standards of corporate governance and seeks compliance with the provisions of the Code wherever possible;
- ensures a clear structure for and the effective running of Board committees;
- ensures effective implementation of Board decisions;
- establishes a close relationship of trust with the Chief Executive, providing support and advice while respecting executive responsibility; and
- provides coherent leadership of the company, including representing the company and understanding the views of shareholders.

Ref: *Review of the role and effectiveness of non-executive directors,* Derek Higgs, 2003
www.dti.gov.uk/cld/non_exec_review

Annex 8

The SAGE criteria compared with Higgs

SAGE	Higgs
Steward Independent scrutiny Financial stewardship Promoting quality Appointing and remunerating senior staff	*Performance* Scrutiny of performance *Risk* Ensuring financial and clinical control systems are in place and robust *People* Appointing and remunerating senior staff
Ambassador Ensuring patients come first Developing local partnerships	*Accountability* Ensuring board acts in best interests of patient and the community
Guardian Providing leadership and strategic direction	*Strategy* Constructively challenge and develop strategy
Experience Draw from experience	Non-executives should have a balance of skills, knowledge and experience

Annex 9

Key questions for the Audit Committee to ask

On the strategic processes for risk, control and governance:

- How is the organisational culture generated and is it right?
- Is there a comprehensive process for identifying and evaluating risk?
- Is the Risk Register an appropriate reflection of the risks facing the organisation?
- Is the appropriate ownership of risk in place?
- How does management know how effective internal control is?
- Is risk management carried out in a way that really benefits the organisation or is it treated as a box ticking exercise?
- Is the organisation as a whole aware of the importance of risk management and of the organisation's risk priorities?
- Does the system of internal control provide indicators of things going wrong?
- How meaningful is the AO's annual 'Statement on Internal Control'?
- Does the SIC appropriately disclose action to deal with material problems?

On the planned activity and results of both internal and external audit:

- Is the Internal Audit strategy appropriate for delivery of a positive reasonable assurance on the whole risk, control and governance?
- Will the periodic audit plan achieve the objectives of the Internal Audit strategy?
- Does Internal Audit have appropriate resources, including skills, to deliver its objectives?
- Are Internal Audit recommendations appropriately actioned?
- What assurance is there about the quality of Internal Audit work?
- Is there appropriate co-operation between the internal and external auditors?
- Are there any issues likely to lead to qualification of the accounts?
- Are issues raised by the external auditors given appropriate attention?

On the accounting policies and the accounts of the organisation:

- Do the accounting policies in place comply with relevant requirements, particularly the Resource Accounting Manual?
- When new or novel accounting issues arise how is appropriate advice on accounting treatment gained?
- Is there an appropriate anti-fraud policy in place and are losses suitably recorded?
- Are suitable processes in place to ensure accurate financial records are kept?
- Are suitable processes in place to ensure fraud is guarded against and regularity and propriety is achieved?
- Does financial control, including the structure of delegations, enable the organisation to achieve its objectives with good value for money?

On the adequacy of management response to issues identified by audit activity:

- Are agreed procedures in place for monitoring progress with the implementation of recommendations?
- If management reject audit recommendations which the auditors stand by, are suitable resolution procedures in place?

On assurances relating to the corporate governance requirements for the organisation:

- Is the range of assurances available sufficient to facilitate the drafting of a meaningful Statement on Internal Control?
- Do those producing the assurances understand fully the scope of the assurance they are being asked to provide and the purpose to which it will be put?
- What mechanisms are in place to ensure the assurances are reliable?
- Are the assurances 'positively' stated (ie – premised or sufficient relevant evidence to support them)?
- Do the assurances draw out material weaknesses or losses which should be addressed?
- Does the Statement on Internal Control realistically reflect the assurances?

On the work of the Audit Committee itself?

- How does the Audit Committee know if it is being effective in achieving its terms of reference and adding value to corporate governance and control systems of the organisation?

The above is abstracted from the draft Audit Committee Handbook available from www.hm-treasury.gov.uk in Autumn 2003.

See also The NHS Audit Committee Handbook at www.doh.gov.uk/riskman.htm

and Delivering Excellence in Financial Governance at www.doh.gov.uk/financialgovernance

Annex 10

Remuneration and Terms of Service Committee

Remit and functions of the Committee

A Remuneration and Terms of Service Committee should be established in each NHS body to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other executive members. The Board may also decide to extend the Committee's remit to include other senior managers' terms, and should be encouraged to do so. Advice to the Board on remuneration should include all aspects of salary (including any performance-related elements/bonuses and any allowances), provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

The Board should formally agree and record in the minutes of its meetings the Committee's precise terms of reference, specifying which posts fall within its areas of responsibility, its composition and the arrangements for reporting.

The main functions of the Committee would be:

- to make such recommendations to the Board on the remuneration, allowances and terms of service of other executive members to ensure they are fairly rewarded for their individual contribution to the organisation – having proper regard to the organisation's circumstances and performance, and to the provisions of any national arrangements where appropriate;
- to monitor and evaluate the performance of other individual executive members;
- to advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance as is appropriate.

Relationship with and reporting to the Board

The Committee should report in writing to the Board the bases for its recommendations. The Board would use that report as the basis for their decisions but would remain accountable for taking decisions on the remuneration, allowances and terms of service of other officer members. Minutes of the Board's meetings should record such decisions.

Composition and conduct of the Committee

The Committee should comprise the Board Chairman and at least two non-executive members. The composition of the Committee should be given in the Annual Report. It is also recommended that in the interests of public accountability the remuneration of the Chief Executive is disclosed in the Annual Report.

The Chief Executive and other officer members should not be present for discussions about their own remuneration and terms of service, but could attend meetings of the Committee to discuss other individuals' terms.

Further information on remuneration policy and best practice is available in the Corporate Governance Frameworks at www.doh.gov.uk/riskman.htm

Annex 11

The PCT organisational competency framework

The organisational competency framework is an online self-assessment and support tool developed by the National Primary and Care Trust Development Programme (NatPaCT) to help PCTs deliver the challenging NHS Plan agenda.

The framework provides guidance on personal and organisational competencies for PCTs and their staff, the NatPaCT is developing the framework in consultation with PCT leaders, and is a response to requests for support in developing and demonstrating competencies in key areas.

The framework will evolve as PCTs become familiar with their new roles. It will provide a vehicle for sharing innovation and best practice.

The framework also highlights the many development opportunities available to PCTs nationally, regionally and locally. These are being collated in the Initiatives section of the website.

It may be accessed on www.natpact.nhs.uk/competency_framework

Annex 12

Patient and public involvement

Patient and Public Involvement Forums (PPIFs)

A PPIF will be set up for every Primary Care Trust and NHS Trust to:

- monitor and review the services arranged and or provided by the Trust from the perspective of the patient – this includes both the range and operation of services;
- seek the views of patients receiving services provided or arranged by the Trust;
- inspect premises where NHS services are delivered;
- make reports and recommendations based on the views and experiences of patients and carers to the Trust management. These may be included in the Trust's annual prospectus, along with the Trust's response;
- refer matters of concern to OSCs and the Commission for Public and Patient Involvement in Health (CPPIH), Strategic Health Authorities, CHAI and the National Patient Safety Agency etc – and to any other person or body the Forums deem appropriate, including the media;
- be represented on the Trust Boards at Non-Executive Director level (PPIFs will select one of their number to be put forward for appointment to Trust Boards by the Appointments Commission. Their appointment to be treated in exactly the same way as every other non-executive director).

The support for PPIFs will be provided by Local Network Providers. There will be around 150 of these providers across England – each supporting several PPIFs. Each provider will be a consortia of local not-for-profit organisations. These consortia will work under contract to the CPPIH and these contracts will be awarded over the summer.

PCT Patient and Public Involvement Forums

PCT PPIFs will monitor and review the services commissioned from Trusts by the PCT and, in addition:

- promote the involvement of the public in decisions and consultations on matters affecting their health, not just the NHS;
- provide training and support to empower local communities, and in particular excluded groups, to identify issues affecting their health, and take action to influence change on those issues;
- provide independent complaints advocacy and where appropriate commission from specialist providers (NB not in year 1);
- identify trends and concerns resulting from PPI activity and make reports to decision-makers;
- work with the other Trust Forums in their areas to ensure a strategic and cohesive view is taken and acted upon;
- provide a one stop shop service by providing advice and information to the public about public involvement and information and support about complaints;
- monitor and review how well the NHS is meeting its duty to involve and consult the public – section 11 of the Health and Social Care Act.

More information is available at www.doh.gov.uk/involvingpatients

Involving patients and the public

Section 11 of the Health and Social Care Act 2001 places a duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and public in service planning and operation, and in the development of proposals for changes. This is a new statutory duty, which means consulting and involving:

- not just when a major change is proposed, but in ongoing service planning;
- not just in the consideration of a proposal, but in the development of that proposal; and
- in decisions about general service delivery, not just major changes.

The duty to involve and consult was commenced on 1 January 2003 and guidance was issued in February – Strengthening Accountability – at www.doh.gov.uk/involvingpatients/invol-pat.htm

Overview and Scrutiny Committees (OSCs)

From January 2003, OSCs set up in local authorities with social services responsibilities (county councils, London Borough councils and unitary authorities) have had the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants.

OSCs will:

- take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services;
- be able to refer contested service changes to the SofS;
- be able to call NHS managers to give information about services and decisions;
- report their recommendations locally;
- have to be consulted by the NHS where there are to be major changes to health services.

More information at www.doh.gov.uk/involvingpatients

Annex 13

The Strategic Health Authority-Appointments Commissioner Partnership

- Strategic Health Authorities lead the local NHS and are accountable to the Department of Health for local NHS performance.
- Appointments Commissioners are responsible for ensuring that, in respect of chairs and non-executives, performance reviews are carried out and that proper training regimes are in place.
- Appointments Commissioners are responsible for appointments, re-appointments and terminating the appointments of chairs and non-executives.
- Strategic Health Authority Chairs and Appointments Commissioners share responsibility for identifying poor performance by individual chairs and non-executives or poorly performing boards and agreeing corrective measures.

Local NHS leadership

Strategic Health Authority Chairs and Appointments Commissioners share the common duty to ensure that NHS boards are able to plan, commission and deliver high quality health services. In making their different contributions, Strategic Health Authority Chairs and Appointments Commissioners need to work in trust and partnership supported by regular and effective communication.

Strategic Health Authorities are the local leaders of the NHS. Through effective performance management their Chairs and Chief Executives are accountable for the performance of the organisations within their territory.

Appointments and training

Appointment Commissioners have the duty to appoint, re-appoint and, where necessary, terminate the appointment of chairs and non-executives. Strategic Health Authority Chairs serve as members of the interview panel for chair appointments to NHS Trusts and PCTs, and are consulted by Appointment Commissioners with regard to chair re-appointments. They also have the duty to ensure that the individuals who they appoint are supported through proper induction and ongoing training and that they have access to other support such as mentoring.

Performance review

Appointments Commissioners also have the responsibility for ensuring that the performance of chairs and non-executives is reviewed annually against agreed annual objectives. The Commission has delegated to Strategic Health Authority Chairs the task of reviewing PCT and Trust Chairs and expects each Chair to review their non-executives. Commissioners review Strategic Health Authority Chairs. Also they act as 'grandparent' to PCT and Trust chairs and non-executives and can arbitrate where there is a dispute between reviewed and reviewer about the accuracy or fairness of the review.

Dealing with poor performance

Where a poorly functioning board is leading to an organisation performing poorly, or where the performance of an individual Chair or non-executive is weak, then the Strategic Health Authority Chair and Appointments Commissioner have a shared responsibility to take corrective action. The division of responsibility in individual situations will need to be decided between them, bearing in mind that poor performance may be due to problems with the Chief Executive or executive team. However, as a general guide, Commissioners would take the lead on issues requiring 'pastoral care', in negotiating resignations or orchestrating development opportunities. Local chairs have access directly to the Commissioners for personal mentoring and support on matters relating to the individual performance of their non-executives or the way they work together as a board.

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