NHS Trust Development Authority

Monitor
Making the health sector work for patients

To: The Board

For meeting on: 22 March 2016

Agenda item: 7

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Report on: NHS Improvement governance framework

Introduction

1. This paper outlines NHS Improvement's proposed future governance framework, for approval by the Board. It is proposed that the governance framework should be in place and operational from 1 April 2016, although it will be necessary to make some amendments in relation to executive decision making in particular after this date once the operating model and accompanying assurance framework are finalised.

2. The Board is asked to:

   a) note the proposed governance framework set out in this paper; and
   b) approve Annex A, the proposed new Rules of Procedure, including the Matters Reserved to the Board and Terms of Reference for Board committees.

Background

3. From 1 April 2016, Monitor and the NHS Trust Development Authority (TDA) with four other teams from other bodies (the Patient Safety Domain and Advancing Change Team from NHS England, the National Reporting and Learning System and Intensive Support teams from NHS Interim Management and Support) will come together to form NHS Improvement. As there will be no legislative changes to facilitate this, the two organisations will continue to exist as separate legal entities. For this reason, each organisation will continue to have its own board, however, these two boards will have identical membership and will meet as one board (regulations being passed in October 2015 enabling joint non executive positions, meaning that non executives are appointed to both boards).

4. The process of setting NHS Improvement's objectives, and developing its operating model, is still ongoing. The governance team has used the latest information available to develop these governance proposals, but in case of significant changes to the objectives or the operating model, amendments may be required.

5. As part of developing the governance framework, the governance team has reviewed the 'Code of Good Practice for Corporate Governance in Central Government Departments', the 'UK Corporate Governance Code' and the 'NHS Foundation Trust Code of Governance', and complied where appropriate.

6. The structure of the remainder of this paper addresses the main principles of the UK Corporate Governance Code, i.e. leadership, effectiveness, accountability, remuneration and relations with stakeholders.

Leadership

7. The role of the Board is to lead the organisations, by setting its strategy and agreeing the framework within which operational decisions will be taken. In order to discharge its duties effectively, the Board must determine the scope of its activities, and the areas of the organisation to which it will assign high priority. This 'job description' for the Board is set out in the Matters Reserved to the Board, attached as Annex C to the Rules of Procedure (Annex A to this paper).

8. Whilst the Matters Reserved to the Board reflects the Board's priorities and the matters in which it intends to be actively involved, it also delineates the areas in which the Board considers it appropriate to delegate authorities to others, including Board committees, the Chief Executive and other directors. The Scheme of Delegation, which sets out these arrangements, is attached as Annex D to the Rules of Procedure. Note that delegation at executive level will be determined once the operating model and accompanying assurance framework are finalised.

Effectiveness

<u>Board composition</u>

9. The process for Board appointments should be led by a Nomination Committee, which should evaluate the level of skills, knowledge and experience of existing Board members and agreeing, for submission to Ministers, a description of the role and capabilities required for particular appointments. The Nomination Committee should also take the lead in succession planning for the Board. For the purpose of the ongoing appointments of NHS Improvement's new Board members, the Chair has been working closely with the Department of Health's Permanent Secretary, and a panel of the Chair, Permanent Secretary and a non-executive director of NHS England was constituted for the purpose of the selection process.

10. The governance team proposes to combine the Nomination Committee with the Remuneration Committee, as there is significant overlap between matters considered by these committees, and the skills, knowledge and experience required to consider them effectively.

Operation of the Board

11. There are Board meetings scheduled for April and May 2016. From May 2016, it is proposed that the Board week meet formally every other month, although it is possible that additional ad hoc meetings are required. These formal meetings will be supported by regular Board development workshops, to give the Board an opportunity to explore particular strategic issues in more detail. A forward agenda plan is attached as Annex C to this paper.

12. In addition to Board meetings and workshops, it is proposed that the Board establishes the following Board committees (Terms of Reference in Annex F of the Rules of Procedure):

    a) Audit and Risk Assurance Committee (see under Accountability below);
    b) Nomination and Remuneration Committee (see above and under Remuneration below);
    c) Appointments and Remuneration Committee (to consider external appointments and remuneration matters for NHS trusts); and
    d) Technology and Data Assurance Committee (to provide assurance on technology and data used by NHS Improvement).

13. It is also proposed that NHS Improvement sets up a small number of executive committees (not formally appointed by the Board) to make operational decisions which the Board has not reserved for itself. Key amongst these is the Executive Team Meeting, made up of the executive Board members, other direct reports to the Chief Executive, and additional attendees as required. An overview of the proposed executive team structure is at Annex B, with terms of reference to be developed once the operating model has been finalised.

14. Finally, it will be appropriate from time to time for Task and Finish Groups to be created, which will be chaired by non-executive directors where relevant. It is proposed that, from 1 April 2016, a Task and Finish Group is created to oversee the implementation of the recommendations of the Carter Review.

Accountability

15. Each financial year, Monitor and the NHS TDA publish, and will continue to publish, their separate Annual Report and Accounts. However, we will also provide an aggregation of these accounts to represent NHS Improvement, which will be the main internal and external reporting mechanism. The following information will be included:

    a) A report on performance against objectives over the past year, and key areas of focus in the coming year;

b) A Governance Statement including the role of the Board and the Executive, the key risks faced and how these have been managed, and data on performance, human resources and remuneration.
c) Annual accounts including the External Auditors' Opinion.

16. The Board requires an Audit and Risk Assurance Committee to provide it with independent assurance on risk management and internal controls, as well as governance systems. There will be a single Audit and Risk Assurance Committee for NHS Improvement, and the internal auditors for NHS Improvement will report to this Audit and Risk Assurance Committee the findings of their detailed reviews. The external auditor will audit Monitor and the TDA's annual accounts, which will remain separate for the two legal entities, but with an 'audited' aggregation for NHS Improvement.

Remuneration

17. A Remuneration Committee is required to make recommendations on the remuneration of the Chief Executive and senior executive directors (within the frameworks established by the Government). As mentioned above, it is proposed that this Board committee is combined with the Nomination Committee. In line with the UK Corporate Governance Code, it is proposed that the committee is chaired by a non-executive director, but not the chair.

Relations with stakeholders

18. The Chief Executive has a specific relationship with the Department of Health (DH) as the organisation's Accounting Officer. This follows the requirements of the relationship between sponsor departments and Accounting Officers, as set out by HM Treasury in Managing Public Money.

19. Monitor's accountability is threefold: it is accountable to Parliament, to the Secretary of State for Health, and to the DH's Permanent Secretary as the Principal Accounting Officer. The TDA is accountable to the Secretary of State for Health: it must exercise its functions subject to and in accordance with directions given by that office holder. The combined organisation, NHS Improvement, will be reviewed by the Health Select Committee, and will provide evidence on a regular basis to the Public Accounts Committee.

20. In addition to these formal accountabilities, NHS Improvement aims to be open and transparent. The Board will meet in public every other month. Information about NHS Improvement's activities will be published on an annual basis. NHS Improvement will also comply with relevant parts of the Code of Practice on Official Statistics, and of the Freedom of Information Act 2000 with regard to Publication Scheme requirements.

Making a difference for patients:

Monitor's mission is to make the health sector work better for patients. This includes ensuring that decisions are made in a timely manner with relevant information being available.

Public Sector Equality Duty:

Monitor has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. We have thought about how the issues dealt with in this paper might affect protected groups.
We believe the paper will not have any adverse impact upon these groups and that Monitor has fulfilled its duty under the Act.

Exempt information:

None of this report is exempt from publication under the Freedom of Information Act 2000.

Annexes:

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NHS IMPROVEMENT

RULES OF PROCEDURE

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RULES OF PROCEDURE

INTRODUCTION

The NHS Trust Development Authority (NHS TDA) is a statutory body, which came into existence on 1 June, 2012. It was established by the National Health Service Trust Development Authority (Establishment and Constitution) Order 2012 (Statutory Instrument SI 2012 no. 901).

Monitor, the Independent Regulator of NHS Foundation Trusts, came into being under the provisions of the Health and Social Care (Community Health and Standards) Act 2003.

Following consolidating legislation (The National Health Service Act 2006), the Health and Social Care Act 2012 (the 2012 Act) established Monitor as the sector regulator for health. From 1 April 2016 NHS Improvement will be the operational name for the organisation that brings together Monitor, NHS TDA, groups from NHS England's Patient Safety teams, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

These Rules of Procedure set out the joint governance arrangements for NHS Improvement. Any reference to NHS Improvement will be a reference to the statutory bodies of Monitor and the NHS TDA.

1. DEFINITIONS

1.1. Any expression to which a meaning is given in (i) the National Health Service Act 2006, the 2012 Act or Regulations or Orders made under them, and (ii) in the Orders and Directions relating to the NHS TDA, shall have the same meaning in these Rules, unless the context otherwise requires and in addition:

"Accounting Officer" is the person appointed by the Secretary of State to assume responsibility for NHS Improvement's use of resources in carrying out its functions, as set out in the requirements of HM Treasury guidance *Managing Public Money* (May 2012). NHS Improvement's Chief Executive acts as Accounting Officer.

"Board" means the Members of the Board, as constituted at paragraph 2 below.

"Chairman" is the person appointed by the Secretary of State as Chairman of NHS Improvement .

"Chief Executive" is the person appointed by Monitor's Non-Executive Directors and the Secretary of State for the NHS TDA Chief Executive.

"Committee" means a Committee appointed by the Board.

"Committee Chair" means the Chair of a Committee or a Sub-Committee, as the context requires, whether or not he/she is also a member of NHS Improvement.

"Committee Member" means a member of the Committee or a Sub-Committee, as the context requires, whether or not he/ she is also a member of NHS Improvement .

"Employee" means an interim or permanent member of staff, a member of staff who is on secondment to NHS Improvement , and a contracted external consultant or adviser.

"Executive Team" means NHS Improvement's Chief Executive and other senior executive directors.

"Executive Member" means a member of NHS Improvement who has responsibility for overseeing the organisation's management.

"Member of the Board" means a Member (whether Executive or Non-Executive) of NHS Improvement, as defined in paragraph 2.1 below.

"NHS Improvement" means the operational name for the organisation that brings together Monitor, NHS TDA, groups from NHS England's Patient Safety teams, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams .

"Non-Executive Member" means a member of NHS Improvement who does not have any management responsibilities.

"Secretary" means the member of NHS Improvement's staff appointed as Secretary to the Board.

"Secretary of State" means the Secretary of State for Health.

"Sub-committee" means a sub-committee appointed by the Board to report to a Committee.

"Sub-committee Chair" means the Chair of a sub-committee.

"Sub-committee Member" means a member of a sub-committee, whether or not he/she is also a member of NHS Improvement.

1.2 References to any statute or statutory provision include a reference to that statute or statutory provision as from time-to-time is modified or re-enacted.

1.3 All generalised reference to the male gender should read as equally applicable to the female gender, and vice-versa.

1.4 In these Rules, unless the contrary intention appears, words in the singular include the plural and words in the plural include the singular.

1.5 These Rules shall not be amended, revoked or replaced except by a resolution passed at a meeting at which at least three members are present.

2. GOVERNANCE FRAMEWORK

2.1. The Board of NHS Improvement consists of:

(a) A Chairman appointed by the Secretary of State;

(b) At least four other Non-Executive Members so appointed; and

(c) The Chief Executive and other Executive Members appointed by the Non-Executive Members (with the consent of the Secretary of State for Health). The number of Executive Members must be less than the number of Non-Executive Members.

2.2. The constitution and proceedings of NHS Improvement are governed by the 2012 Act and SI2012 no. 901, the National Health Service Trust Development Authority Regulations 2012 no. 922, and subsequent secondary legislation.

2.3. The functions of NHS Improvement are set out in Part 3, Chapters 1 to 6 of the 2012 Act and in the secondary legislation as referenced above.

2.4. The principal office of NHS Improvement is Wellington House, 133-155 Waterloo Road, London SE1 8UG.

3. THE BOARD OF NHS IMPROVEMENT AND ITS OPERATIONAL RESPONSIBILITIES AND EXERCISE OF STATUTORY POWERS

3.1. Paragraph 10(1) of Schedule 8 to the 2012 Act provides that Monitor may regulate its own procedure and make any arrangements it considers appropriate for the discharge of its functions.

3.2. Paragraph 12 of SI2012 no. 922 makes provision for the conduct of NHS TDA's meetings and proceedings.

3.3. The Board shares responsibility for:

(i) ensuring that high standards of corporate governance are observed and encouraging high standards of propriety;

(ii) establishing the strategic direction and priorities of NHS Improvement within the statutory framework in the 2012 Act;

(iii) the effective and efficient delivery of NHS Improvement's plans and functions;

(iv) promoting quality in NHS Improvement's activities and services;

(v) monitoring performance against agreed objectives and targets;

(vi) ensuring effective dialogue with the Department of Health and other stakeholders to best promote the continued success and growth of NHS Trusts and NHS Foundation Trusts and other aspects of the health care sector; and

(vii) ensuring that Board Members personally, and NHS Improvement corporately, observe the seven principles of public life set out by the Committee on Standards in Public Life:

(a) Selflessness: holder of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or other friends;

(b) Integrity: holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

(c) Objectivity: in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit;

(d) Accountability: holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;

(e) Openness: holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;

(f) Honesty: holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and

(g) Leadership: holders of public office should promote and support these principles by leadership and example.

3.4. The Board will take collective responsibility for the decisions made by it. A Member of the Board must obtain the prior approval of the Chairman or in his absence, the Deputy Chairman, before making public statements to the media on behalf of NHS Improvement.

3.5. Members of the Board and Committee members shall be subject to the Code of Ethical Practice as set out at Annex B.

3.6. Any member of the Board who significantly or persistently fails to adhere to these Rules of Procedure may be judged as failing to carry out the duties of their office. Such failure might result in their removal from office.

4. MEETINGS AND PROCEEDINGS OF THE BOARD

4.1. Meetings of the Board

4.1.1. Subject to paragraph 4.1.3 below, the Board shall hold meetings at such regular intervals as may be determined by the members of the Board.

4.1.2. The Board may invite any person to attend all or part of a Board meeting.

4.1.3. The Secretary to the Board will propose each September a schedule of meetings for the following calendar year for the Board's approval.

4.1.4. Meetings will normally be held at NHS Improvement's principal office, but may take place at any other convenient location.

4.1.5. Members of the Board are expected to attend not less than four Board meetings (whether formal meetings or workshops) in any twelve month period.

4.2. Admission of the Public and the Press

4.2.1. The Board will operate in an open and transparent fashion, except where confidentiality requirements are concerned.

4.2.2. The Chairman will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and members of the press, such as to ensure that the Board's business may be conducted without interruption or disruption. Depending upon the confidential nature of the business to be transacted, the public may be required to withdraw to allow the Board to complete its business in private.

4.2.3. Members of the public and press are not admitted to meetings of Committees, except by specific invitation.

4.3. Board Meeting Agendas and Papers

4.3.1. In normal circumstances, the agenda and any papers for meetings of the Board will be circulated to members of the Board five calendar days in advance of the meeting. The non-receipt of agenda or papers for a meeting by any member of the Board shall not invalidate the meeting or any business transacted at the meeting.

4.3.2. The order of business at Board meetings shall follow the agenda issued for that meeting unless otherwise directed by the Chairman, at whose discretion, or at the request of another member of the Board, the order may be altered at any stage.

4.3.3. Papers may only be tabled at a meeting of the Board with the permission of the Chairman.

4.3.4. No business other than that on the agenda will be taken except where the Chairman considers the item should be discussed.

4.3.5. Members of the Board should treat those papers identified as private as confidential to them and not discuss them with persons other than Board Members or employees of NHS Improvement, unless this is agreed with the Chairman. If so discussed, members of the Board should ensure that those with whom they have consulted are made aware of, and respect, the need for confidentiality.

4.3.6. Members must take care not to leave Board papers identified as private unattended or where others may obtain access to them.

4.4. Special Meetings of the Board

4.4.1. Without prejudice to paragraph 4.1, where paragraph 4.5.2 applies or in the event of urgency, the Chairman may determine to hold a meeting to be known as a special meeting at such time and place as he/she may determine.

4.5. Power to Call Meetings of the Board

4.5.1. Where, in the opinion of the Chairman, an urgent matter has arisen, the Chairman may call a meeting of the Board at any time.

4.5.2. Where two or more members of the Board submit a signed request for a meeting to the Chairman, the Chairman shall call a meeting in accordance with paragraph 4.5.3.

4.5.3. Where paragraph 4.5.2 applies, the Chairman shall, as soon as practicable but no later than seven calendar days from the date the request was submitted, arrange for the meeting to be held within 28 calendar days from the date the request was submitted.

4.6. Chairing of Meetings

4.6.1. Subject to paragraphs 4.7.2 to 4.7.10, the procedure at meetings shall be determined by the Chairman presiding at the meeting.

4.6.2. The Chairman shall, if present, preside at all meetings of the Board.

4.6.3. In the absence of the Chairman, the Deputy Chairman will preside.

4.6.4. Paragraph 5.5 sets outs the provisions for the chairing of Committee meetings.

4.7. Procedure at Meetings of the Board

4.7.1. Subject to the provisions of these Rules, the Board may meet together for the despatch of business, adjourn and otherwise regulate their meetings as Board Members think fit.

4.7.2. The Chairman or person presiding over a meeting of the Board will:

(i) preserve order and ensure that all members of the Board have sufficient opportunity to express their views on all matters under discussion:

(ii) determine all matters of order, competency and relevancy;

(iii) determine in which order those present should speak;

(iv) determine whether or not a vote is required and how it is carried out in accordance with paragraphs 4.7.4 to 4.7.6 below.

4.7.3. Written comments on agenda items submitted by any member of the Board who is not present when a particular agenda item is discussed may be circulated to those members of the Board who are present at the meeting and read out at the appropriate point in the meeting.

4.7.4. Decisions of the Board will normally be made by consensus rather than by formal vote. Failing consensus, decisions will be reached by means of a vote when:

(i) the Chairman presiding at the meeting feels that there is a body of opinion among members of the Board at the meeting who disagree with a proposal or have expressed reservations about it and no clear consensus has emerged; or

(ii) when a member of the Board who is present requests a vote to be taken; or

(iii) any other circumstances in which the Chairman considers that a vote should be taken.

4.7.5. Where a decision of the Board requires a vote it shall be determined by a majority of the votes of the members of the Board present and voting on the question. The Chairman shall declare whether or not a resolution has been carried or otherwise.

4.7.6. In the case of an equality of votes, the Chairman, or in his absence the member of the Board presiding, shall have a second casting vote.

4.7.7. The minutes of the meeting will record only the numerical results of a vote, showing the numbers for and against the proposal and noting any abstentions. The minutes shall be conclusive evidence of the outcome. Votes will not normally be attributed to any individual member of the Board, but any member may require that their particular vote be recorded, provided that he/she asks the Secretary immediately after the item is concluded.

4.7.8. The Board may agree to defer a decision on an agenda item so that it can be provided with additional information or for any other reason. The decision to defer, together with the reasons for doing so, will be recorded in the minutes of the meeting together with a proposed time for returning the matter to the Board for its consideration.

4.7.9. The Board may decide to delegate decisions on agenda items to the Chairman. Any decision to do so shall be recorded in the minutes of the meeting.

4.7.10. Where in the opinion of the Chairman, and considering advice from the Chief Executive or any other of NHS Improvement's most senior executive as appropriate, significant operational or other matters require approval by the Board between formal meetings, papers will be circulated by the Secretary for approval by correspondence. Any matter capable of being passed by the Board at a meeting may instead be passed by written confirmation given by a majority of the members of the Board, with the Chairman having the power to cast a second casting vote as provided for in paragraph 4.7.6 above.

4.7.11. Only exceptionally, where the process to reach a decision would not benefit from discussion in a meeting at which members' views would inform debate or if the issue is time critical, will a Board decision be reached without a formal meeting.

4.8. Quorum of the Board

4.8.1. The quorum for a Board meeting shall be the Chairman (or Deputy Chairman) and four members of the Board. Non-Executive Board Members should be in the majority.

4.8.2. Participation will usually be in person, but in exceptional circumstances, members of the Board may participate by telephone or video-conferencing facility and be deemed to be present and constitute part of the Board for that meeting.

4.8.3. Where a Board meeting:

(i) is not quorate under paragraph 4.8.1 within half an hour from the time appointed for the meeting; or
(ii) becomes inquorate during the course of the meeting,

then the meeting shall either be adjourned to such time, place and date as may be determined by the members present or shall continue as an informal meeting at which no decisions may be taken.

4.9. Minutes of the Board

4.9.1. NHS Improvement's Head of Governance shall act as Secretary to the Board.

4.9.2. The Secretary shall record the minutes of every meeting, or nominate a deputy to do so.

4.9.3. The Secretary shall submit the draft minutes to the Board in advance of its next meeting for agreement, confirmation or otherwise.

4.9.4. The record of the minutes shall include:

(i) the names of:

(a) every member of the Board present at the meeting;

(b) any other person present; and

(c) any apologies tendered by an absent member of the Board;

(ii) the withdrawal from a meeting of any member on account of a conflict of interest; and

(iii) any declaration of interest.

4.9.5. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman decides discussion is appropriate.

4.9.6. Minutes of any meetings of the Board will record key points of discussion. They will not however attribute comments to specific members unless this is specifically requested by the Board Member concerned or required by the Chairman. Where personnel, finance or other restricted matters are discussed, the minutes will describe the substance of the discussion in general terms.

4.9.7. Once agreed, the record of the minutes shall be published on NHS Improvement's website.

4.10. Emergency Powers

4.10.1. The functions exercised by the Board may, in an emergency, be exercised by the Chairman after having consulted the Chief Executive or another Executive Member of the Board.

4.10.2. The exercise of such powers by the Chairman must be reported to the next formal meeting of the Board in public session for ratification. The reasons for why an emergency decision was required must be clearly stated.

4.11. Delegation of Powers

4.11.1. Subject to such directions as may be given by the Secretary of State to the NHS TDA, NHS Improvement may make arrangements for the exercise, on behalf of the

Board, of any of its functions by a Committee or sub-committee, a Non-Executive Member, or an employee (including the Chief Executive) of NHS Improvement, in each case subject to such restrictions and conditions as NHS Improvement thinks fit.

4.11.2. Paragraph 11(2) of Schedule 8 to the 2012 Act provides that:

"Monitor may arrange for the exercise of its functions on its behalf by -

(a) a Non-Executive Member;

(b) an employee (including the Chief Executive);

(c) a Committee or sub-committee."

4.11.3. The matters listed at Annex C are reserved to the Board. They are generally matters for which it is accountable to Parliament. The fundamental objective is to ensure that the work of NHS Improvement is managed effectively within the policies laid down by the Board.

4.11.4. The schedule at Annex D sets out those specific matters which the Board has formally agreed to delegate.

4.11.5. The Board remains accountable for all of NHS Improvement's functions, even those delegated to Committees, sub-committees, the Chairman, Chief Executive, individual senior executives or employees and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

4.11.6. The list of matters reserved for decision by the Board does not however preclude other matters being referred to the Board for decision. All powers delegated by the Board can be reassumed should the need arise and the Board reserves the right to deal with any matters previously delegated. The Board may also revoke or vary such a delegation.

4.11.7. In accordance with paragraph 5.1 of these Rules of Procedure, there is delegated from the Board to each Committee of NHS Improvement the discharge of those functions that fall within their respective Terms of Reference other than any matter reserved to the Board.

4.11.8. Any delegation made by the Board may be subject to any conditions the Board may impose and may be revoked or altered by the Board.

4.11.9. All powers of NHS Improvement which have not been:

(i) reserved by the Board under paragraph 4.10.2 of, and Annex C to, these Rules of Procedure;

(ii) delegated to a Committee or to named senior executives further to Annex D to these Rules of Procedure; or

(iii) implied by the provisions of NHS Improvement's Rules of Procedure, Standing Financial Instructions, and Scheme of Delegation

shall be exercised on behalf of NHS Improvement by the Chief Executive.

4.11.10. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to Committees, sub-committees and individual employees.

4.11.11. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

4.11.12. Powers are delegated to the Committees, sub-committees and individual employees on the understanding that they will not exercise delegated powers in a matter which in their understanding was likely to be a cause for public concern or which might have an effect on the reputation of NHS Improvement.

4.11.13. The exercise of all delegated powers is on the basis that appropriate expert advice will be sought as necessary and that any costs involved can be met within the authorised budget.

4.11.14. The Secretary shall keep a record of the powers, authorities and discretions delegated by the Board.

4.11.15. In the absence of an employee to whom powers have been delegated those powers shall be exercised by the relevant Executive Team member unless alternative arrangements have been approved by the Board. If the Chairman is absent, the powers delegated to him/her may be exercised by the Deputy Chairman, in relation to the Board, and the Chief Executive (or the Executive Director of Resources/Deputy Chief Executive or the Executive Director of Regulation/Deputy Chief Executive) after taking advice as appropriate from the Board and Executive Team members.

4.12. Role of Accounting Officer and Standing Financial Instructions

4.12.1. The Chief Executive acts as NHS Improvement's Accounting Officer. As Accounting Officer, he/she is responsible for ensuring that the public funds for which he/she is personally responsible are properly safeguarded and are used in line with NHS Improvement's functions and responsibilities and the requirements as set out in HM Treasury guidance Managing Public Money, including the duty to exercise functions effectively, efficiently and economically.

4.12.2. The Standing Financial Instructions, set out at Annex E to these Rules of Procedure, detail the financial responsibilities, policies and procedures to be adopted by NHS Improvement . They are designed to ensure that financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

4.12.3. All proposed expenditure of above £1m must be formally approved by the Board.

4.13. Personal Conflicts of Interest and Register of Interests

4.13.1. The NHS Code of Accountability requires members of the Board to declare interests which are relevant and material to NHS Improvement. All existing members of the Board should declare such interests. Any members of the Board appointed subsequently should do so on appointment.

4.13.2. If a member of the Board or a Committee or sub-committee member knowingly has any interest or duty which is material and relevant, or the possibility of such an interest or duty, whether direct or indirect and whether pecuniary or not, that, in the

opinion of a fair-minded and informed observer would suggest a real possibility of bias in any matter that it brought up for consideration at a meeting of the Board or any Committee or sub-committee of NHS Improvement , he/she shall disclose the nature of the interest or duty to the meeting. The declaration of interest or duty may be made at the meeting at the start of the discussion of the item to which it relates or in advance in writing to the Secretary. If an interest or duty has been declared in advance of the meeting, this will be made known by the Chair of the meeting prior to the discussion of the relevant agenda item. In the event of the person not appreciating at the beginning of the discussion that an interest or duty exists, he/she should declare such an interest as soon as he/she becomes aware of it.

4.13.3. If a member of the Board or a Committee or sub-committee member has acted in accordance with the provisions of paragraph 4.12.2 above and has fully explained the nature of their interest or duty, the members of the Board or Committee or sub-committee present will decide unanimously whether and to what extent that person should participate in the discussion and determination of the issue and this will be recorded in the minutes and the extent to which the person concerned had access to any written papers on the matter. If it is decided that he/she should leave the meeting, the Chair may first allow them to make a statement on the item under discussion.

4.13.4. Where the Chair of the meeting has a relevant interest then he/she must advise the Board or the Committee or sub-committee accordingly, and with their agreement and subject to the extent decided participate in the discussion and the determination of the issue. This will be recorded in the minutes and the extent to which he/she had access to any written papers on the matter. If it is decided that the Chair should leave the meeting because of a conflict of interest, another member or Committee or sub-committee member will be asked to Chair the discussion of the relevant agenda item in accordance with the procedure set out in paragraph 4.12.2 above.

4.13.5. NHS Improvement employees who are not members of the Board or a Committee or sub-committee, but who are in attendance at a meeting of the Board or a Committee, should declare interests in accordance with the same procedures as for those who are members of the Board or Committee or sub-committee. Where the Chair of a meeting rules that a potential conflict of interest exists, any NHS Improvement employee so concerned should take no part in the discussion of the matter and may be asked to leave the meeting by the Chair.

4.13.6. A member of the Board, Committee or sub-committee, or NHS Improvement employee shall be subject to the procedural arrangements for dealing with conflicts of interest as set out in the Code of Ethical Practice at Annex B.

4.13.7. The Secretary will ensure that a Register of Interests in established to record formally declarations of interests of:

a) Members of the Board; and

b) Members of any Committees or sub-committees of the Board.

In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive Members and Members of the Board. Members and members of any Committees or sub-committees of the Board. These details will be kept up to date by means of an annual review of the

Register in which any changes to interests declared during the preceding twelve months will be incorporated.

4.14. Allowances for Non-Executive Members of the Board

4.14.1. Non-Executive Members of the Board are entitled to seek reimbursement of reasonable expenses incurred in the exercise of the duties in accordance with the policy that was [approved by the Board in March 2016] together with any subsequent duly approved changes, a copy of which is available from the Secretary on request, and will be provided to members on joining the Board.

5. MEETINGS AND PROCEEDINGS OF COMMITTEES

Where no specific provisions are specified for Committees, these are the same as the principles and provisions for the Board, as set out above. Where there is any inconsistency between the said provisions and any provisions in the Terms of Reference for any Committee or sub-committee, then the latter shall prevail.

5.1. Appointment of Committees

5.1.1. The Board may establish a Committee for any purpose within its functions, and shall determine the powers and functions of any such Committee.

5.1.2. The Board shall appoint members of the Committees.

5.1.3. The Board shall appoint, for every Committee, a Chair who shall be a member of the Board, unless there is a specific requirement that the Chief Executive, as Accounting Officer, should be Chair.

5.1.4. The Board shall keep under review, the structure and scope of activities of each Committee.

5.1.5. The Board shall set out the Terms of Reference for each Committee.

5.1.6. The Board may at any time amend the Terms of Reference of any Committee or sub-committee.

5.2. Meetings of a Committee

5.2.1. Subject to paragraph 5.3 and such indicative schedule of meetings as may be specified by the Board, a Committee or sub-committee shall hold meetings at such regular intervals as may be determined by the members of the Committee or sub-committee.

5.2.2. The Committee shall determine the time and place of the meetings to be held under paragraph 5.2.1.

5.3. Special Meetings of a Committee

5.3.1. Without prejudice to paragraph 5.2, in the event of urgency, the Committee Chair may determine to hold a meeting to be known as a special meeting at such time and place as he/she may determine.

5.4. Attendance at Committee Meetings

5.4.1. Subject to paragraph 5.4.2, a member of the Board may attend and speak, with the permission of the Chair of the Committee, at any meeting of a Committee.

5.4.2. A member of the Board who is not a member of the Committee shall not vote on any matter before the Committee.

5.5. Chairing of Committee Meetings

5.5.1. Subject to paragraphs 5.5.2 to 5.5.3, the procedure at meetings shall be determined by the Committee Chair presiding at the meeting.

5.5.2. The Committee Chair shall, if present, preside at all meetings.

5.5.3. In the absence of the Committee Chair, a Non-Executive Board Member who is also a member of the Committee or a Board member nominated by the Committee Chair shall preside.

5.6. Quorum of Committees

5.6.1. The quorum for a Committee meeting shall generally consist of one half of the total membership of the Committee of which, at least, one Non-Executive Member of the Board is present.

5.7. Minutes of Committees

5.7.1. NHS Improvement's Head of Governance shall act as Secretary to all Committees, or nominate a deputy.

5.7.2. The Secretary shall record the minutes of every meeting of a Committee or nominate a deputy.

5.7.3. The record of the minutes shall be submitted to the Committee at its next meeting for agreement, confirmation or otherwise.

5.7.4. Minutes will be circulated to all Board Members.

5.8. Prohibition on Delegation of a Committee's Function

5.8.1. A Committee shall not delegate its functions to a sub-committee established by the Committee or to any other person unless authorised by the Board in the Committee's Terms of Reference.

ANNEX A

APPENDIX A

SCHEDULE 8, HEALTH AND SOCIAL CARE ACT 2012

MONITOR

Membership

1

(1) Monitor is to consist of—
- (a) a Chair appointed by the Secretary of State,
- (b) at least four other members so appointed, and
- (c) the Chief Executive and other members appointed in accordance with paragraph 2.

(2) The number of executive members must be less than the number of Non-Executive Members.

(3) In this Schedule—
- (a) references to Non-Executive Members of Monitor are references to the members appointed in accordance with sub-paragraph (1)(a) and (b), and
- (b) references to executive members of Monitor are references to the other members.

The Chief Executive and other executive members: appointment and status

2

(1) The Chief Executive and the other executive members of Monitor are to be appointed by the Non-Executive Members.

(2) A person may not be appointed as Chief Executive or as another executive member without the consent of the Secretary of State.

(3) The Non-Executive Members may not appoint more than five executive members without the consent of the Secretary of State.

(4) The Chief Executive and the other executive members are to be employees of Monitor.

Non-Executive members: tenure

3

(1) A person holds and vacates office as a Non-Executive Member of Monitor in accordance with that person's terms of appointment.

(2) A person may at any time resign from office as a Non-Executive Member by giving notice to the Secretary of State.

(3) The Secretary of State may at any time remove a person from office as a Non-Executive Member on any of the following grounds—
- (a) incapacity,
- (b) misbehaviour, or
- (c) failure to carry out his or her duties as a Non-Executive Member.

(4) The Secretary of State may suspend a person from office as a Non-Executive Member if it appears to the Secretary of State that there are or may be grounds to remove the person from office under sub-paragraph (3).

(5) A person may not be appointed as a Non-Executive Member for a period of more than four years.

(6) A person who ceases to be a Non-Executive Member is eligible for re-appointment.

Suspension from office

4

(1) This paragraph applies where a person is suspended under paragraph 3(4).

(2) The Secretary of State must give notice of the decision to the person; and the suspension takes effect on receipt by the person of the notice.

(3) The notice may be—

(a) delivered in person (in which case, the person is taken to receive it when it is delivered), or

(b) sent by first class post to the person's last known address (in which case, the person is taken to receive it on the third day after the day on which it is posted).

(4) The initial period of suspension must not exceed six months.

(5) The Secretary of State may at any time review the suspension.

(6) The Secretary of State—

(a) must review the suspension if requested in writing by the person to do so, but

(b) need not review the suspension less than three months after the beginning of the initial period of suspension.

(7) Following a review during a period of suspension, the Secretary of State may—

(a) revoke the suspension, or

(b) suspend the person for another period of not more than six months from the expiry of the current period.

(8) The Secretary of State must revoke the suspension if the Secretary of State—

(a) decides that there are no grounds to remove the person from office under paragraph 3(3), or

(b) decides that there are grounds to do so but does not remove the person from office under that provision.

5

(1) Where a person is suspended from office as the Chair under paragraph 3(4), the Secretary of State may appoint a Non-Executive Member as interim Chair to exercise the Chair's functions.

(2) Appointment as interim Chair is for a term not exceeding the shorter of—

(a) the period ending with either—

(i) the appointment of a new Chair, or

(ii) the revocation or expiry of the existing Chair's suspension, and

(b) the remainder of the interim Chair's term as a Non-Executive Member.

(3) A person who ceases to be the interim Chair is eligible for re-appointment.

Payment of Non-Executive Members

6

(1) Monitor must pay to its Non-Executive Members such remuneration and allowances as the Secretary of State may determine.

(2) Monitor must pay or make provision for the payment of such pensions, allowances or gratuities as it may, with the approval of the Secretary of State, determine to or in respect of any person who is or has been a Non-Executive Member.

(3) If a person ceases to be a Non-Executive Member and the Secretary of State decides that there are exceptional circumstances which mean that the person should be compensated, Monitor must pay compensation to the person of such amount as the Secretary of State may determine.

Staff

7

(1) Monitor may appoint such persons to be employees of Monitor as it considers appropriate.

(2) Employees of Monitor are to be paid such remuneration and allowances as Monitor may determine.

(3) Employees of Monitor are to be appointed on such other terms and conditions as Monitor may determine.

(4) Monitor may pay or make provision for the payment of such pensions, allowances or gratuities as it may determine to or in respect of any person who is or has been an employee of Monitor.

(5) Before making a determination as to remuneration, pensions, allowances or gratuities for the purposes of sub-paragraph (2) or (4), Monitor must obtain the approval of the Secretary of State to its policy on that matter.

Superannuation

8

(1) Sub-paragraph (2) applies where a person who is an active or deferred member of a scheme under section 1 of the Superannuation Act 1972 is appointed as Chair.

(2) The Minister for the Civil Service may determine that the person's office as Chair is to be treated for the purposes of the scheme as service in the employment by reference to which the person is a member (whether or not any benefits are payable by virtue of paragraph 6(2)).

(3) Employment with Monitor is among the kinds of employment to which a scheme under section 1 of the Superannuation Act 1972 can apply; and, accordingly, in Schedule 1 to that Act (in which those kinds of employment are listed), at the end of the list of “Other Bodies” insert— “Monitor”.

(4) Monitor must pay to the Minister for the Civil Service, at such times as the Minister may direct, such sums as the Minister may determine in respect of any increase attributable to sub-paragraph (2) or (3) in the sums payable out of money provided by Parliament under the Superannuation Act 1972.

Committees

9

(1) Monitor may appoint such Committees and sub-committees as it considers appropriate.

(2) A Committee or sub-committee may consist of or include persons who are not members or employees of Monitor.

(3) Monitor may pay such remuneration and allowances as it determines to any person who—

(a) is a member of a Committee or sub-committee, but

(b) is not an employee of Monitor,

whether or not that person is a Non-Executive Member of Monitor.

Procedure

10

(1) Monitor may regulate its own procedure.

(2) The validity of any act of Monitor is not affected by any vacancy among the members or by any defect in the appointment of a member.

Exercise of functions

11

(1) Monitor must exercise its functions effectively, efficiently and economically.

(2) Monitor may arrange for the exercise of its functions on its behalf by—

(a) a Non-Executive Member;

(b) an employee (including the Chief Executive);

(c) a Committee or sub-committee.

Assistance

12

(1) Monitor may arrange for persons to assist it in the exercise of its functions in relation to—

(a) a particular case, or

(b) cases of a particular description.

(2) Such arrangements may include provision with respect to the payment of remuneration and allowances to, or amounts in respect of, such persons.

Borrowing

13

(1) Monitor may, with the consent of the Secretary of State, borrow money temporarily by way of overdraft.

(2) But subject to that, and subject to sections 145 and 146 (power to borrow for exercising functions in relation to financial assistance and power of Secretary of State to lend etc), Monitor may not borrow money.

Acquiring information

14

(1) Monitor may obtain, compile and keep under review information about matters relating to the exercise of its functions.

(2) Where Monitor exercises the power under sub-paragraph (1), it must do so with a view to (among other things) ensuring that it has sufficient information to take informed decisions and to exercise its other functions effectively.

(3) In exercising the power under sub-paragraph (1), Monitor may carry out, commission or support (financially or otherwise) research.

General power

15

Monitor may do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, the exercise of its functions.

Finance

16

(1) The Secretary of State may make payments to Monitor out of money provided by Parliament of such amounts as the Secretary of State considers appropriate.

(2) Payments made under sub-paragraph (1) may be made at such times and on such conditions (if any) as the Secretary of State considers appropriate.

Accounts of NHS foundation trusts

17

(1) Monitor must prepare in respect of each financial year a set of accounts which consolidates the annual accounts of all NHS foundation trusts.

(2) The Secretary of State may, with the approval of the Treasury, direct Monitor to prepare a set of accounts in respect of such period as may be specified in the direction which consolidates any accounts prepared by NHS foundation trusts by virtue of paragraph 25(1A) of Schedule 7 to the National Health Service Act 2006 in respect of that period.

(3) In preparing any consolidated accounts under this paragraph, Monitor must comply with directions given by the Secretary of State with the approval of the Treasury as to—

(a) the content and form of the consolidated accounts;

(b) the methods and principles according to which the consolidated accounts should be prepared.

(4) Monitor must send a copy of any consolidated accounts under this paragraph to the Secretary of State and, if the Secretary of State so directs, the Comptroller and Auditor General—

(a) accompanied by such other reports or information as the Secretary of State may direct, and

(b) within the relevant period.

(5) In sub-paragraph (4)(b), the relevant period is—

(a) in relation to consolidated accounts under sub-paragraph (1), such period after the end of the financial year concerned as the Secretary of State may direct;
(b) in relation to consolidated accounts under sub-paragraph (2), such period as the Secretary of State may direct.

(6) Before giving a direction under sub-paragraph (5), the Secretary of State must consult Monitor.

(7) The Comptroller and Auditor General must—
(a) examine, certify and report on any consolidated accounts sent under this paragraph,
(b) if the Secretary of State so directs, send a copy of the report on the accounts to the Secretary of State, and
(c) if the Secretary of State so directs, lay copies of the accounts and the report on them before Parliament.

(8) Monitor must act with a view to securing that NHS foundation trusts—
(a) comply promptly with requests from it or the Secretary of State for information relating to their accounts, and
(b) otherwise act so as to facilitate the preparation of accounts by the Secretary of State.

(9) This paragraph does not apply to the financial year specified for the purposes of section 155(7) (which provides for the order that commences section 155, which itself relates to the preparation of the accounts of NHS foundation trusts, to specify the first financial year to which that section will apply) or to the subsequent financial years.

Accounts of Monitor

18

(1) Monitor must keep proper accounts and proper records in relation to the accounts.

(2) The Secretary of State may, with the approval of the Treasury, give directions to Monitor as to—
(a) the content and form of its accounts, and
(b) the methods and principles to be applied in the preparation of its accounts.

(3) In sub-paragraph (2), the reference to accounts includes Monitor's annual accounts prepared under paragraph 19 and any interim accounts prepared by virtue of paragraph 20.

19

(1) Monitor must prepare annual accounts in respect of each financial year.

(2) Monitor must send copies of the annual accounts to the Secretary of State and the Comptroller and Auditor General within such period after the end of the financial year to which the accounts relate as the Secretary of State may direct.

(3) The Comptroller and Auditor General must—
(a) examine, certify and report on the annual accounts, and
(b) lay copies of them and the report before Parliament.

20

(1) The Secretary of State may, with the approval of the Treasury, direct Monitor to prepare accounts in respect of such period or periods as may be specified in the direction ("interim accounts").

(2) Monitor must send copies of any interim accounts to the Secretary of State and, if the Secretary of State so directs, the Comptroller and Auditor General within such period as the Secretary of State may direct.

(3) The Comptroller and Auditor General must—
  (a) examine, certify and report on any interim accounts sent by virtue of sub-paragraph (2),
  (b) if the Secretary of State so directs, send a copy of the report on the accounts to the Secretary of State, and
  (c) if the Secretary of State so directs, lay copies of the accounts and the report on them before Parliament.

Reports and other information
21

(1) As soon as practicable after the end of each financial year, Monitor must prepare an annual report on how it has exercised its functions during the year.

(2) The report must, in particular—
  (a) set out the measures that Monitor has taken to promote economy, efficiency and effectiveness in the use of resources for the exercise of its functions,
  (b) include a statement of what it did to comply with the duty under section 63(2) (duty to have regard to Secretary of State's guidance on duty under section 62(9)), and
  (c) include a statement of what it did to comply with the duty under section 66(2)(h) (duty to have regard to Secretary of State's guidance on relevant parts of document on improving quality of services).

(3) Monitor must—
  (a) lay a copy of the report before Parliament, and
  (b) once it has done so, send a copy of it to the Secretary of State.

(4) Monitor must provide the Secretary of State with—
  (a) such other reports and information relating to the exercise of Monitor's functions as the Secretary of State may require;
  (b) such information about NHS foundation trusts that Monitor has in its possession as the Secretary of State may require.

Recommendations by Committees in Parliament
22
Monitor must respond in writing to any recommendation about its exercise of its functions that a Committee of either House of Parliament or a Committee of both Houses makes.

Seal and evidence
23
(1) The application of Monitor's seal must be authenticated by the signature of the Chair or any other person who has been authorised (generally or specifically) for that purpose.

(2) A document purporting to be duly executed under Monitor's seal or to be signed on its behalf must be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

Status

24

(1) Monitor must not be regarded as the servant or agent of the Crown or as enjoying any status, immunity or privilege of the Crown.

(2) Monitor's property must not be regarded as property of, or property held on behalf of, the Crown.

APPENDIX B

SI 2012 no.901, NATIONAL HEALTH SERVICE ACT, 2006

NHS TRUST DEVELOPMENT AUTHORITY

ANNEX B

CODE OF ETHICAL PRACTICE

Introduction

1. NHS Improvement expects the highest standards of its Board Members and its staff. It recognises that the seven principles of public life apply to anyone who works as a public office holder. This includes all of those who are appointed to public office and all people appointed to work in Non Department Public Bodies. All public servants are both servants of the public and stewards of public resources. This Code provides a high level statement of the standards of practice expected of NHS Improvement's Board Members and its staff. It should be read in conjunction with the relevant organisational policies (as set out in each section), which are developed and agreed in line with the principles set out in this Code.

Statutory context and commitment to the values of the NHS as set out in the NHS Constitution

2. NHS Improvement is one of the lead government agencies overseeing the NHS in England, ensuring that providers deliver what the public needs. We are working alongside providers now to tackle the immediate challenges facing NHS trusts and foundation trusts on finance, clinical quality and patient safety, and targets such as waiting lists. In light of this and the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry, this Code must also be implemented within the framework of the "Statement of Common Purpose" (Appendix C). In particular NHS Improvement recognises the importance of the principles and values identified within the NHS Constitution and is committed to taking account of the Constitution in its decisions and actions. All of the expectations set out within this Code should be considered within this context.

General Propriety and Public Service Values

3. NHS Improvement's Board Members and staff in their activities and actions will have regard to the seven principles of public life (Appendix A) and the following principles of good regulation:

    - Transparency;
    - Accountability;
    - Proportionality;
    - Consistency; and
    - Proper targeting of regulation to achieve defines goals.

4. Everyone at NHS Improvement has duty to act in good faith and in the best interests of NHS Improvement. They should play a full and active role in the organisation and not use their position to promote their personal interests of those of any connected person or organisation.

5. No Board Member or employee should engage in activity which is, or could be perceived to be, politically controversial or inappropriate in the context of NHS Improvement's statutory functions and corporate plan.

6. The highest standards of propriety, involving integrity, impartiality and objectivity must be maintained in relation to the stewardship of public funds and the management of NHS Improvement. Any conflict between personal interests and the discharge of public duties must be avoided. No-one to whom this Code applies must seek through the performance of their duties to gain material benefit for themselves, their families or their friends.

7. Suspicion that a decision might be influenced in the hope or expectation of future employment with a particular firm or organisation must be avoided. Accordingly, during their term of office no-one to whom this Code applies must seek any consultancy contracts, directorships or other form of employment in a healthcare sector body that brings them into conflict with their role at NHS Improvement. Any potential conflicts of interests must be managed appropriately.

   See Code of Conduct for Board Members (Cabinet Office 2011)

8. NHS Improvement has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In their decision-making, Board Members and staff must give consideration to the impact that it might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

   See: Equality and Diversity Policy

9. NHS Improvement has made a clear statement of its Vision and Purpose (Appendix B). It has also adopted a behavioural competency framework which is driven by various performance management policies. All members of staff are expected to comply with these policies, which will be reviewed and updated as appropriate.

   See: Grievance Policy, Harassment Policy, Discipline Policy etc.

Use of Public Funds

10. Those to whom this Code applies are required to maximise value for money through ensuring that NHS Improvement operates in the most efficient and economical way, within available resources, and with independent validation of performance achieved where practicable.

    See: Anti Fraud Policy, Business Expenses Policy

Gifts and Hospitality

11. Those to whom this Code applies have a responsibility to ensure that they are not placed in a position that risks, or appears to risk, compromising their role or NHS Improvement's public and statutory duties. They should not, not should they be perceived to, secure valuable gifts and hospitality by virtue of their role at NHS Improvement. They should not accept or provide any gift or hospitality is this would give the impression that they have been influenced or are deemed to be influencing whilst acting in an official capacity.

    See: Gifts and Hospitality Policy

Conflicts and Declarations of Interests

12. It is important for NHS Improvement to:

    (i) ensure that no member of the Board, Committee member or employee is involved in taking a decision or participates in a discussion on any matter where that person has a conflict of interest;

    (ii) ensure that those providing information to NHS Improvement can be confident that it will be properly handled; and

    (iii) avoid any impression that any member of the Board, Committee member or employee has used his relationship with NHS Improvement to their personal advantage.

13. Every member of the Board, independent member or employee should avoid situations in which their duties and private interests may conflict or where there would be a suspicion of conflict and ensure that, before he/she becomes involved in taking a decision or participating in a discussion, there are no conflicts of interest that, in the opinion of a fair-minded and informed observer, would suggest a real possibility of bias.

14. The Health and Social Care Act 2012 and the National Health Service Act 2006 requires NHS Improvement to act to ensure that there is neither an actual nor a perceived conflict between the exercise of its functions. All members of staff should bear this in mind and take appropriate action if they think that their involvement in a matter or presence at a decision-making Committee might represent such an interest.

    See: Rules of Procedure (personal conflicts), Operational or Functional Conflicts and Balancing Competing Regulatory Interests Policy (operational conflicts)

Access to Information

15. NHS Improvement Board Members and employees may receive information which is not in the public domain, relating to individuals, organisation or commercial-in-confidence matters. It is the responsibility of each individual to ensure that this information is treated appropriately.

    See: Information Security Policy, Data Protection Policy

16. NHS Improvement is committed to identifying and preventing any malpractice or wrongdoing within the organisation. As part of this commitment, NHS Improvement takes whistleblowing very seriously. It recognises and encourages those to whom this Code applies to consider whistleblowing, if necessary, an aspect of good citizenship. It provides NHS Improvement with the chance to identify and investigate concerns and put them right.

    See: Whistleblowing Policy

Media, public speaking and use of social media

17. Special care should be taken about any invitation to speak publicly, including speaking to journalists. Care must also be taken in the publication of any articles or expression of views on social media. In any such instance, the Chairman and/or the Chief Executive should be informed in good time before such an article is submitted, or, in their absence, the Executive Director of Corporate Affairs, as appropriate. The Chairman, Board Members and independent members are not however restricted from access to the media in their personal non- NHS Improvement capacity, or in pursuit of a professional interest, for example, as experts. These considerations should not prevent any member of staff or Board Member from exercising their whistleblowing rights or their duty of candour, should they be aware of poor quality care being provided to patients.

March 2016

Appendix A

THE SEVEN PRINCIPLES OF PUBLIC LIFE

Selflessness
Holders of public office should act solely in terms of the public interest.

Integrity
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness
Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty
Holders of public office should be truthful.

Leadership
Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Appendix B

NHS IMPROVEMENT'S VISION AND PURPOSE

NHS Improvement is one of the lead government agencies overseeing the NHS in England, ensuring that providers deliver what the public needs.

We are working alongside providers now to tackle the immediate challenges facing NHS trusts and foundation trusts on finance, clinical quality and patient safety, and targets such as waiting lists.

We are also helping make certain that the sector is in shape for long-term, sustainable success.

Our approach is to be supportive, taking regulatory action only where there is an immediate need.

To tackle these challenges, we:

- build up leadership and other capability in the sector
- ensure local problems are tackled at local health system level
- ensure the NHS 'learns to learn' better so that striving for improvement is in its DNA.

In partnership with DH and other ALBs, we define the strategic goals for the sector on issues such as finance and system-wide change, and offer support in meeting them. NHS Improvement will then hold providers to account for their part in achieving this improvement.

We are developing a compelling vision and shared values – these will embody the underpinning principles of how we work together and deliver positive outcomes. It is up to all of us to bring these values to life and we all have a part to play in embracing new ways of working. We should be prepared to flex our styles and the way we interact with the sector as an improvement organisation

Appendix C

STATEMENT OF COMMON PURPOSE

In the light of the findings of the report into the Mid Staffordshire NHS Foundation Trust Public Inquiry, we the undersigned make the following commitments.

1. **We renew and reaffirm our personal commitment and our organisations' commitment to the values of the NHS, set out in its Constitution:**

- **Working together for patients**[1]. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

- **Respect and dignity.** We value every person – whether patients, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

- **Commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

- **Compassion.** We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

- **Improving lives.** We strive to improve health and well-being and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

- **Everyone counts.** We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

2. **We apologise to every individual affected by this deeply disturbing and tragic failing in a service that means so much to us all.** What happened in Mid

[1] As the tragic events the Inquiry investigated occurred in a hospital, this statement refers to "patients". These principles and commitments apply equally to all people in other care settings

Staffordshire NHS Foundation Trust was, and is, unacceptable and collectively we take responsibility for putting things right. We recognise that while the depth, scale and duration of the failings at this hospital were unprecedented every day the NHS is responsible for care that is poor as well as care that is good or excellent. **Our commitment to the NHS and our pride in the good that it does each day will not blind us to its failings.** It compels us to resolve them.

3. **We will put patients first,** not the interests of our organisations or the system. **We will listen to patients**, striving to ensure the quality of care that we would want for ourselves, our own families and our friends.

4. **We will listen most carefully to those whose voices are weakest and find it hardest to speak for themselves.** We will care most carefully for the most vulnerable people – the very old and the very young, people with learning disabilities and people with severe mental illness.

5. **We will work together,** collaborating on behalf of patients, combining and coordinating our strengths on their behalf, sharing what we know and taking collective responsibility for the quality of care that people experience. **Together, we will be unfailing in rooting out poor care and unflinching in promoting what is excellent.**

6. Whilst this poor care was in a hospital, poor care can occur anywhere across the health and social care system. Whether in a care home, at the family doctor, in a community pharmacy, in mental health services, or with personal care in vulnerable people's homes, **we will ensure that the fundamental standards of care that people have a right to expect are met consistently, whatever the settings.**

7. **Every one of us commits to ensuring a direct connection to patients and to the staff who care for them.** We will ensure that our organisations and our staff look outwards to the people they serve, taking decisions with patients and local communities at the forefront of their minds. **We will shape care in equal partnership with the people who depend on it.** We will do the business of the patient, before that of our organisation or the system.

8. **We will work together to minimise bureaucracy, enabling time to care and time to lead, freeing up the expertise of NHS staff and the values and professionalism that called them to serve.** Caring is demanding as well as rewarding, and depends on the personal and professional values of everyone who works in the NHS. We know well-treated staff treat patients well, so as the NHS become busier we need to ensure time to care and time to recover from caring. We will recruit, appraise and reward staff for their care, as well as their skills and their knowledge.

9. Healthcare is complex and we are part of a complicated system. Building on a foundation of fundamental and inviolable standards, **we will build a single set of nationally agreed and locally owned measures of success, focussed on what matters most to patients.** They must be credible and independently assessed so that patients, the public, Parliament and those who work for NHS patients have a single version of the truth about local services and organisations and their staff have a single set of standards of care to which they aspire. **Blind adherence to targets or finance must never again be allowed to come before the quality of care.** We need to use public money well and we need to be efficient and productive, but these are a means to an end – safe, effective and respectful care, compassionately given.

We will be balanced in what we do and what we expect, with the patient interest at the heart of it. We must all do our best to maintain and raise quality within the resources we have.

10. We believe that patients are best served and our values nurtured by a spirit of candour and a culture of humility, openness, honesty and acceptance of challenge. Things do go wrong, but when they do we must learn from mistakes, not conceal them. **We will seek out and act on feedback, both positive and negative.** We will listen to patients who raise concerns, respond to them and learn from them. We will listen to staff who are worried about the quality of care, praising them for speaking up, even if a concern was misplaced. **We have a duty to challenge ourselves and each other on behalf of patients and we will do so.**

11. Signing up to principles in offices in national organisations is easy. **Changing ourselves, our behaviour, individually and institutionally, is difficult, but we pledge to do so.** Health and care is not like any other job. It touches the hearts of people's lives, can do immense good but also immense harm – it is a matter of life or death. This is both a privilege and a great responsibility. Together, we will make ourselves accountable and responsible for what we do, not what we say, in striving to make real, for every patient, the values to which we recommit ourselves today. Over the coming months, each of us will set out our plans for making these commitments a reality. In delivering those plans, we will be judged by the difference that they make to the people whom we serve.

12. The organisations signing this pledge have different responsibilities within our healthcare system, but whatever our role we pledge to learn the lessons from Mid Staffordshire NHS Foundation Trust, help to build better care for every patient and do everything in our power to ensure it does not happen again. We invite all organisations in the health and care system to join us in signing up to this statement of common purpose.

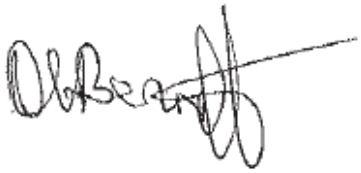
David Prior, Chair,
Care Quality Commission

Una O'Brien, Permanent Secretary,
Department of Health

Professor Sir Peter Rubin, Chair,
General Medical Council

Sir Keith Pearson, Chair,
Health Education England

Sir Merrill Cockell, Chair,
Local Government Association

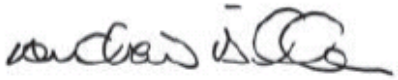


Dr David Bennett, Chair,
Monitor

Professor Malcolm Grant, Chair,
NHS Commissioning Board

Michael O'Higgins, Chair,
NHS Confederation & NHS Employers

Jan Sobieraj, Managing Director,
NHS Leadership Academy



Sir Andrew Dillon, Chief Executive,
National Institute for Health
and Clinical Excellence

Sir Peter D Carr, Chair,
NHS Trust Development Authority

Mark Addison, Chair,
Nursing and Midwifery Council

Alan Perkins, Chief Executive,
Health and Social Care Information Centre

Professor David Heymann, Chairman,
Public Health England

ANNEX C

Matters Reserved for Board Decision

Strategy and Management

- The establishment and maintenance of NHS Improvement's strategic direction – reviewing, contributing to and approving NHS Improvement's vision, mission and values.

- The approval of NHS Improvement's Corporate and Business Plans, including the distribution of NHS Improvement's financial allocation as set out in the annual business plan and any subsequent material change to this.

- The approval of NHS Improvement's risk management strategy/framework, including the determination of Monitor's risk appetite

- The approval of all of NHS Improvement's significant regulatory policies prior to consultation with stakeholders and any material amendments following responses received in response to consultation

- The review of performance in light of NHS Improvement's strategy, objectives, business plans and budgets with a view to ensuring that any necessary corrective action is taken

- The continuous appraisal of the affairs and effective management of NHS Improvement by means of the receipt of reports from Committees and officers, including the review of the top level /strategic risks facing NHS Improvement and their mitigations.

Operational decision-making

- The determination of any operational decision considered to be policy-determining (i.e. having strategic implications) and/or very high risk.

Organisation and internal controls

- The approval of NHS Improvement's high-level organisational design and control structure

- The approval of any significant change to the level and nature of insurance cover held by NHS Improvement

- The approval of significant corporate policies

- The approval of all proposed expenditure of above £1m

- The approval of the instigation, or defence of legal proceedings

- The approval of the opening or closing of any bank account*

- The approval of audit arrangements and the receipt of reports from the Audit & Risk Assurance Committee meetings with a view to taking any appropriate action*
- To consider and approve NHS Improvement's Statutory Annual Report and Accounts (paragraphs 19 and 21 of Schedule 8 to the 2012 Act)*

- The determination of the remuneration policy for executive members of the Board, subject to cross-Government controls**

Board governance, Committee membership and other appointments

- The approval of NHS Improvement's Rules of Procedure (including the schedule of matters reserved for board decisions) and Standing Financial Instructions (Paragraph 10 of Schedule 8 to the 2012 Act), including variation or amendment of these

- The handling of any instances of failure to comply with the Rules of Procedure

- The establishment of formal Committees and sub-committees, agreeing Terms of Reference and membership thereof (Paragraph 9 of Schedule 8 to the 2012 Act)

- The receipt of reports detailing the decisions and recommendations made by NHS Improvement's formal Committees and sub-committees (as appropriate)

- The approval of the delegation of the Board's powers (Paragraph 11(2) of Schedule 8 to the 2012 Act)

- The noting of urgent decisions taken by the Chair pursuant to the exercise of emergency powers

- The division of responsibilities between the Chair, the Chief Executive and other executive directors, which should be put in writing

- The evaluation of the performance of the Board at least once a year, including a review of NHS Improvement's overall governance arrangements

- The review of succession planning for the Board and senior management, with a view to ensuring its adequacy**

- (Non-Executive Board Members only) The appointment of the Chief Executive and the other executive members of the Board (with the consent of the Secretary of State) (Paragraph 2 of Schedule 8 to the 2012 Act)**

- The approval of recommendations to the Secretary of State with regard to changes to the structure, size and composition of the Board**

- The appointment of the Senior Independent Director

- The appointment of NHS Improvement's principal professional advisers

* Indicates that the matter is the responsibility of the Audit and Risk Assurance Committee, with final decision taken by the Board as a whole

** Indicates that the matter is the responsibility of the Nomination and Remuneration Committee, with final decision taken by the Board as a whole

ANNEX D

Scheme of Delegation (DS)

Delegations to Board Committees and sub-committees:

Audit and Risk Assurance Committee

- The approval of the annual set of accounts which consolidates the annual accounts of all Trusts and NHS foundation trusts
- The approval of NHS Improvement's annual and long-term internal audit programme

Delegations to the executive (subject to the caveat that the Board has reserved to itself the determination of any operational decision considered to be policy-determining (i.e. having strategic implications) and/or very high risk) are yet to be determined and are subject to the finalisation of the Operating Model

ANNEX E

Proposed NHS Improvement Standing Financial Instructions

ANNEX F (i)

APPOINTMENTS AND REMUNERATION COMMITTEE (NHS TRUSTS) TERMS OF REFERENCE

1. Purpose

1.1. The purpose of the Appointments and Remuneration Committee (NHS Trusts) is two-fold:

1.1.1. In relation to appointments, the Committee is to exercise the NHS TDA's powers, as delegated by the Secretary of State for Health, to appoint Chairs and Non-Executive directors of NHS trusts and appoint charity trustees, and suspend and terminate those appointments; and

1.1.2. In relation to remuneration of staff in NHS trusts, the Committee's purpose is to ensure consistency, equity and probity in use of the public funds, to take a system-wide view of the implications of remuneration requests, and to approve pay and other remuneration requests for designated staff in NHS trusts.

2. Membership

2.1. The Committee shall be made up of:

2.1.1. Three Non-Executive Directors, one of whom will be the Committee Chair;

2.1.3 Executive Director of Corporate Affairs; and

2.1.4 Deputy CEO, Executive Director of Resources.

2.2. Appointments to the Committee shall be for a period of up to three years, which may be extended for further periods of up to three years, provided the director still meets the criteria for membership of the Committee.

2.3. In exceptional circumstances the Executive Director of Corporate Affairs or the Deputy CEO, Executive Director of Resources may appoint a deputy to attend on their behalf.

2.4. Others may be invited by the Executive Director of Corporate Affairs to attend all or part of any meeting.

2.5. It is anticipated that the following will be regular attendees at formal meetings of the Committee:

2.5.1. a member of the Board Secretariat (minutes);

2.5.2. [the Head of Human Resources]; and

2.5.3. [the Head of Appointments].

3. Secretary

3.1. A member of the Board Secretariat shall act as the Secretary of the Committee at its formal meetings.

4. Quorum

4.1. The quorum necessary for the transaction of business shall be three members including two Non-Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the Committee.

4.2. Participation will usually be in person, but, in exceptional circumstances, members of the Committee may participate by telephone or video conferencing facility and be deemed to be present and constitute part of the Committee for that meeting.

5. Frequency of Meetings

5.1. The Committee shall hold formal monthly meetings. Exceptionally, any member of the Committee can ask for a meeting to be convened in person, by video-conference or by telephone, or for a matter to be considered in correspondence.

6. Notice of Meetings

6.1. Formal meetings of the Committee, other than those regularly scheduled as above (paragraph 6.1), shall be summoned by the Secretary of the Committee at the request of the Executive Director of Corporate Affairs or the Deputy CEO, Executive Director of Resources.

6.2. Unless otherwise agreed, notice of each formal meeting confirming the venue, time and date together with an agenda of items to be discussed and any supporting papers, shall be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

7. Conduct of Meetings

7.1. Except as outlined above, formal meetings of the Committee shall be conducted in accordance with the provisions of NHS Improvement's Rules of Procedure.

8. Minutes of Meetings

8.1. The Secretary shall minute the proceedings and resolutions of all formal meetings of the Committee, including recording the names of those present and in attendance.

8.2. Minutes of formal Committee meetings shall be circulated promptly to all members of the Committee. Once approved, minutes should be circulated to all other members of the Board, unless it would be inappropriate to do so.

9. Duties

Appointments

9.1. Subject to any restrictions set out in relevant legislation, the Committee operates with the authority of the NHS TDA to determine any matter within its terms of reference. The Committee will take proper account of any directions from the Department of Health and guidance issued by the Office of the Commissioner for Public Appointments. The Committee may seek independent information as necessary to inform their decisions.

9.2. The Committee's role is to exercise the NHS Trust Development Authority (NHS TDA)'s powers, as delegated by the Secretary of State for Health, to appoint Chairs and Non-Executive Director of NHS trusts and appoint charity trustee, and suspend and terminate those appointments.

9.3. The Committee's duties in relation to NHS Trust Chairs, Non-Executive Directors and charity trustees include:

9.3.1. making appointments of Chairs, Non-Executive Directors* and trustees*;

9.3.2. considering cases for suspension and termination of appointments and establish Termination of Appointment Panels that advise the TDA, as required;

9.3.3. approving policies on the duties and roles, recruitment, appointment, development, appraisal, suspension and termination;

9.3.4. monitoring and reporting to the TDA on the diversity of appointments;

9.3.5. reviewing the performance, constitution and terms of reference of the sub-committees to ensure that they are operating at maximum effectiveness;

9.3.6. providing advice to the TDA on Non-Executive Director and trustee appointment or governance issues, managing associated risks, and ensuring that the TDA is advised of any issues that require further action; and

9.3.7. seeking legal and other advice if it considers this necessary.

[Potential for area marked with an asterisk to be delegated to a sub-committee at the Committee's request: appointments of Non-Executive Directors are currently made by regional sub-committees due to the volume of business]

NHS Trust Remuneration

9.4. In relation to remuneration in NHS trusts, the Committee will take proper account of national agreements e.g. Agenda for Change, and guidance issued by the Government, the Department of Health and the NHS in reaching its determinations. The Committee may seek independent information as necessary to inform their recommendations

9.5. The Committee's duties with regard to NHS Trust staff are to approve the following:

9.5.1. proposals from NHS trusts for implementing local Mutually Agreed Resignation (MAR) schemes and voluntary redundancy schemes*;

9.5.2. contractual payments including individual compulsory and voluntary redundancy cases and MARs cases for all CEOs and Directors and for non-VSM staff.*;

9.5.3. non-contractual payments for all staff prior to HM Treasury review*;

9.5.4. salaries for Very Senior Managers in ambulance and community trusts; and

9.5.5. salaries in excess of £142,000 in all NHS trusts.

[Potential for area marked with an asterisk to be delegated to a sub-committee at the Committee's request]

10. Reporting Responsibilities

1.1. The Executive Director of Corporate Affairs shall be responsible for ensuring that the work of the Committee is reported to the Board.

March 2016

ANNEX F (ii)

AUDIT AND RISK ASSURANCE COMMITTEE TERMS OF REFERENCE

1. Purpose

1.1. The purpose of the Committee is to support the Board and the Chief Executive (as Accounting Officer) by reviewing the comprehensiveness, reliability and integrity of the assurances provided to the Committee regarding NHS Improvement's internal controls, risk management and governance processes. On the basis of the assurance provided to it, the Committee will form an overall view on the state of risk management, governance and internal control.

2. Membership

2.1. The Committee shall comprise three members. Members of the Committee shall be appointed by the Board, in consultation with the Chair of the Board.

2.2. At least two members of the Committee shall be Non-Executive Directors. The third member of the Committee should be either an independent member who is non-voting or another Non-Executive Director. At least one of the Committee members shall have recent and relevant financial experience. The Chairman of the Board shall not be a member of the Committee.

2.3. Only members of the Committee have the right to attend Committee meetings. Other individuals, such as the Chairman of the Board, the Chief Executive, the Finance and Reporting Director, other directors, those with risk responsibilities and representatives of NHS Improvement's internal auditors may be invited to attend all or part of any meeting as and when appropriate and necessary.

2.4. Representatives of the National Audit Office (NHS Improvement's external auditor) will be invited to attend meetings of the Committee.

2.5. Appointments to the Committee shall be for a period of up to three years, which may be extended for further periods of up to three years, provided the director still meets the criteria for membership of the Committee.

2.6. The Board shall appoint the Committee Chair, who shall be a Non-Executive Director.

3. Secretary

3.1. The Head of Governance or their nominee shall act as the Secretary of the Committee.

4. Quorum

4.1. The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the Committee.

5. Frequency of Meetings

5.1. The Committee shall meet at least four times a year at appropriate times in the reporting and audit cycle and otherwise as required.

6. Notice of Meetings

6.1. Meetings of the Committee shall be called by the Secretary of the Committee at the request of any of its members or at the request of NHS Improvement's external or internal auditors, if they consider it necessary.

6.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

7. Minutes of Meetings

7.1. The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

7.2. Draft minutes of the Committee meetings shall be circulated promptly to all members of the Committee. Once approved, minutes should be circulated to all other members of the Board, unless it would be inappropriate to do so.

8. Conduct of Meetings

8.1. Except as outlined above, meetings for the Committee shall be conducted in accordance with the relevant provisions of NHS Improvement's Rules of Procedure.

9. Duties

9.1. The Committee should carry out the duties below:

9.1.1. The Committee shall monitor the integrity of Monitor and the NHS TDA's internal and external financial statements, reviewing significant reporting issues and judgements which they contain.

9.1.2. In particular the Committee shall review and constructively challenge where necessary:

9.1.2.1. Assurances about the financial systems which provide the figures for NHS Improvement's accounts and the quality of the controls over their preparation;

9.1.2.2. The consistency of, and any changes to, accounting policies on a year on year basis;

9.1.2.3. The methods used to account for significant or unusual transactions where different approaches are possible;

9.1.2.4. Whether NHS Improvement has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the NAO (as external auditor);

9.1.2.5. Whether there were any disputes arising between those responsible for preparing the accounts and the auditors;

9.1.2.6. The clarity of disclosure in NHS Improvement's financial reports and the context in which statements are made; and

9.1.2.7. All material information presented with the financial statements, such as the management commentary, the statement of Accounting Officer's responsibilities, the statement of financial impact and the annual governance statement.

9.1.3. The Committee shall carry out these same duties with regard to the production of NHS Improvement's own financial reporting and financial reporting associated with the consolidation of NHS foundation trusts' accounts.

Internal controls, risk management systems and corporate governance

9.1.4. The Committee shall:

9.1.4.1. Keep under review the adequacy and effectiveness of NHS Improvement's internal controls and risk management systems;

9.1.4.2. Consider whether appropriate internal controls and risk management systems are in place to support the Annual Governance Statement;

9.1.4.3. Keep under review the adequacy and effectiveness of NHS Improvement's core regulatory processes, with a view to determining whether these are sufficiently robust to manage the risks faced by the organisation;

9.1.4.4. Assess the corporate governance requirements of the organisation and assurances as to whether these are being met.

Whistleblowing and fraud

9.1.5. The Committee shall:

9.1.5.1. Review the adequacy and security of NHS Improvement's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall

ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action;

9.1.5.2. Review NHS Improvement's procedures for detecting fraud and receive reports of any instances;

9.1.5.3. Review NHS Improvement's systems and controls for the prevention of bribery and receive reports of any non-compliance; and

9.1.5.4. Review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

Internal audit

9.1.6. The Committee shall:

9.1.6.1. Monitor and review the effectiveness of NHS Improvement's internal auditor service in the context of the organisation's overall risk management system;

9.1.6.2. Agree the appointment of NHS Improvement's internal auditor service;

9.1.6.3. Consider and approve the remit of the internal auditor service and ensure that they have appropriate access to information to enable them to perform their function effectively and in accordance with Government Internal Audit Standards. The Committee shall also ensure that the internal audit service has an appropriate standing within NHS Improvement, and is free from management or other restrictions;

9.1.6.4. Review and assess the internal audit strategy and annual work plans to ensure that the scope is appropriate and that relevant areas of work are prioritised;

9.1.6.5. Review reports from the internal audit service;

9.1.6.6. Review and monitor management responsiveness to the findings and recommendations of the internal audit service; and

9.1.6.7. Meet with the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. In additional, the Head of Internal Audit shall be given the right of direct access to the Chairman of the Board and to the Committee.

External Audit

9.1.7. The Committee shall:

9.1.7.1. oversee the relationship between NHS Improvement and the National Audit Office, its external auditor, including:

9.1.7.1.1. Assessing annually their qualifications, expertise and resources and the effectiveness of the audit process, which shall include a report from the NAO on their own internal quality procedures; and

9.1.7.1.2. Seeking to ensure their co-ordination with the activities of the internal audit function.

9.1.7.2. Meet regularly with the NAO, including at the planning stage before the audit and after the audit, at the reporting stage. The Committee shall meet the NAO at least once a year, without management being present, to discuss the external auditor's remit and any issues arising from the audit;

9.1.7.3. Review and approve the annual external audit plan;

9.1.7.4. Review the findings of the external audit with the NAO, including:

9.1.2.4.1. A discussion of any major issues which arose during the audit;

9.1.2.4.2. Any accounting and audit judgements;

9.1.2.4.3. Levels of errors identified during the audit; and

9.1.2.4.4. The effectiveness of the audit.

9.1.7.5. Review any management representation letters requested by the NAO before they are signed;

9.1.7.6. Review the management letter and management's response to the NAO's findings and recommendations;

9.1.7.7. Review any other relevant reports by the NAO;

9.1.7.8. Where there is need to do so, develop and implement a policy on the supply of non-audit services by the NAO, taking into account any relevant ethical guidance on the matter.

10. Reporting Responsibilities

10.1.1. The Committee's Chair shall report formally in writing to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

10.1.2. The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

10.1.3. The Committee shall provide the Board with an annual report on its activities, timed to support to support the finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year.

11. Other matters

11.1. The Committee shall:

11.1.1. Have access to sufficient resources in order to carry out its duties, including access to the Head of Governance for assistance as required;

11.1.2. Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

11.1.3. Give due consideration to relevant legislation, Treasury guidance (in particular the Audit Committee Handbook) and other corporate governance best practice as appropriate;

11.1.4. Oversee any instigation of activities which are within its terms of reference;

11.1.5. Arrange for periodic reviews of its own performance and, at least annually, review its constitution and terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval;

11.1.6. Consider any other matters where requested to do so by the Board.

12. Authority

12.1. The Committee is authorised:

12.1.1. To seek any information it requires from any employee of NHS Improvement in order to perform its duties;

12.1.2. To obtain, at NHS Improvement's expense, outside legal or other professional advice on any matter within its terms of reference (subject to budgets agreed by the Board);

12.1.3. To call any of NHS Improvement's employees to be questioned at a meeting of the Committee as and when required; and

12.1.4. To have published in NHS Improvement's annual report details of any issues that cannot be resolved between the Committee and the Board.

March 2016

ANNEX F (iii)

NOMINATION & REMUNERATION COMMITTEE TERMS OF REFERENCE

1. Purpose

1.1 The purpose of the Nomination and Remuneration Committee is two-fold:

1.1.1 To ensure that NHS Improvement operates a formal and transparent procedure for developing policy on executive remuneration, for fixing the remuneration packages of individual directors and ensuring that NHS Improvement is able to recruit and retain a high performing workforce.

1.1.2 To lead the NHS Improvement process for Board appointments, by evaluating the balance of skills, knowledge and experience in existence amongst Board members.

2. Membership

2.1 The Committee shall comprise at least three members, all of whom shall be Non-Executive Directors. Members of the Committee shall be appointed by the Board. The Chairman of the Board may also serve on the Committee as an additional member if they were considered to be independent on their appointment as Chairman.

2.2 Only members of the Committee have the right to attend Committee meetings. However, other individuals, such as the Chief Executive and external advisers may be invited to attend all or part of any meeting as and when appropriate and necessary.

2.3 Appointments to the Committee are made by the Board and shall be for a period of up to three years, which may be extended for further periods of up to three years, provided the director still meets the criteria for membership of the Committee.

2.4 The Board shall appoint the Committee Chair who shall be a Non-Executive Director.

3 Secretary

3.1 The Head of Governance or their nominee shall act as the Secretary of the Committee.

4 Quorum

4.1 The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the Committee.

5 Frequency of Meetings

5.1 The Committee shall meet at least once a year and otherwise as required.

6 Notice of Meetings

6.1 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chair.

6.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

7 Minutes of Meetings

7.1 The Secretary shall minute the proceedings and resolutions of all Committee meetings, including recording the names of those present and in attendance.

7.2 Draft minutes of the Committee meetings shall be circulated promptly to all members of the Committee. Once approved, minutes should be circulated to all other members of the Board, unless it would be inappropriate to do so.

8 Conduct of Meetings

8.1 Except as outlined above, meetings of the Committee shall be conducted in accordance with the relevant provisions of NHS Improvement's Rules of Procedure.

9 Duties

9.1 The Committee shall:

9.1.1 Determine and agree with the Board the framework or broad policy for the remuneration of NHS Improvement's Chief Executive and executive directors, to be proposed for Secretary of State for Health approval. The remuneration of the Chairman and the Non-Executive members of the Board is determined by the Secretary of State for Health. No executive shall be involved in any decisions as to their own remuneration;

9.1.2 In determining such policy, take into account all factors which it deems necessary including relevant legal and regulatory requirements, Treasury guidance and other best practice as appropriate. The objective of such policy shall be to ensure that NHS Improvement's executive directors are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation;

9.1.3 Within the terms of the agreed policy and in consultation with the Chairman of the Board and the Chief Executive, as appropriate, determine the total individual remuneration package of each of NHS Improvement's executive directors including bonuses, incentive payments and other benefits. In determining such arrangements give due regard to any relevant legal requirements and Treasury guidance.

9.1.4 Ensure that contractual terms on termination, and any payments made are fair to the executive director involved, and NHS Improvement, so that failure is not rewarded and that the duty to mitigate loss is fully recognised;

9.1.5 To agree termination payments (including contractual payments such as redundancy or early retirement provisions as well as 'novel' or 'unusual payments') where payments do not exceed £100,000. These payments may then be subject to Treasury approval.

9.1.6 Obtain reliable, up-to-date information about remuneration in other organisations similar to NHS Improvement. The Committee shall have full authority to commission any reports or surveys which it deems necessary to help fulfil its obligations;

9.1.7 Consider and advise on initiatives to address specific recruitment and/or retention issues;

9.1.8 Determine and agree with the Board the design of, and the targets for, any performance related pay schemes operated by NHS Improvement, as well as the total annual payments made under such schemes;

9.1.9 Agree NHS Improvement's policy on staff remuneration and associated conditions of service, benefits and compensation commitments (including pension rights) on early termination;

9.1.10 Review and note annually the remuneration trends across NHS Improvement;

9.1.11 Agree the policy for authorising claims for expenses from the directors; and

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9.1.12 To consider applications for recognition of continuity of service for staff moving to NHS Improvement from a non-NHS body.

9.2 The Committee shall also be responsible for providing counsel to NHS Improvement's Board with respect to Board and Committee structure and membership through:

9.2.1 Keeping under review the leadership needs of NHS Improvement, both executive and Non-Executive, with a view to ensuring the continued ability of the organisation to operate effectively;

9.2.2 Taking the lead in relation to NHS Improvement's process for Board appointments. The Committee has the following roles in relation to senior appointments at NHS Improvement:

9.2.2.1 advise the Board on the appointment of executive Board members;

9.2.2.2 liaising with the Department of Health (on behalf of the Secretary of State for Health) on the recruitment of Non-Executive Board Members; and

9.2.2.3 providing input to the Chief Executive's decisions to appoint members of staff who report directly to him/her but are not Board Members.

9.2.3 Facilitating the provision of appropriate training and development opportunities for NHS Improvement's executive directors;

9.2.4 Before any appointments are made to the Board, evaluate the balance of skills, knowledge, experience and diversity on the Board and, in light of this evaluation, comment on a description of the role and capabilities required for a particular appointment; and

9.2.5 Ensure that on appointment to the Board, Non-Executive Directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, Committee service and involvement outside Board meetings.

9.2.6 Review the results of the Board performance evaluation process that relate to the composition of the Board.

9.3 The Committee shall also make recommendations to the Board concerning:

9.3.1 Formulating plans for succession for both executive and Non-executive directors and in particular for the key roles of Chairman of the Board and Chief Executive;

9.3.2 Suitable candidates for the role of senior independent director;

9.3.3 The re-appointment of any Non-Executive Director at the conclusion of their specified term of office, having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required; and

9.3.4 Any matters relating to the continuation in office of any director at any time, including the suspension or termination of service of an executive director as an employee of Monitor or NHS TDA, subject to the provisions of the law and their service contract.

10 Reporting Responsibilities

10.1 The Committee's Chair shall report formally in writing to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

10.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

10.3 The Committee shall produce a report to be included in NHS Improvement's annual report about its activities and NHS Improvement's remuneration policy and practices.

11 Other matters

11.1 The Committee shall:

11.1.1 Have access to sufficient resources in order to carry out its duties, including access to the Head of Governance for assistance as required;

11.1.2 Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

11.1.3 Give due consideration to relevant legislation, Treasury guidance and other best practice as appropriate;

11.1.4 Oversee any instigation of activities which are within its terms of reference;

11.1.5 Arrange for periodic reviews of its own performance and, at least annually, review its constitution and terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval;

11.1.6 Consider any other matters where requested to do so by the Board.

12 Authority

12.1 The Committee is authorised to obtain, at NHS Improvement's expense, outside legal or other professional advice on any matter within its terms of reference (subject to budgets agreed by the Board).

March 2016

ANNEX F (iv)

TECHNOLOGY AND DATA ASSURANCE COMMITTEE (TDAC) TERMS OF REFERENCE

1. Purpose

1.1. The purpose of the TDAC is to support the Audit and Risk Assurance Committee and the Board by providing independent assurance on information strategy and associated project proposals. On the basis of the information provided to it, the Committee will provide assurance to the Board on key decisions or recommendations which have critical strategic significance or would materially impact risk.

2. Membership

2.1. The TDAC shall comprise up to five members, all of whom shall be Non-Executive Directors unless they are independent members as specified below. Members of the TDAC shall be appointed by the Board, in consultation with the Chair.

2.2. A member of the Audit and Risk Assurance Committee shall act as the Chair of the TDAC. At least two members of the Committee shall be independent of NHS Improvement and have recent and relevant information technology experience. The TDAC should also be attended by an executive member of the NHS Improvement Board.

2.3. Only members of the TDAC have the right to attend TDAC meetings. Other individuals, such as the Chairman of the Board, the Executive Director of Resources, the Executive Director of Regulation and the Executive Director of Strategy may be invited to attend all or part of any meeting as and when appropriate and necessary.

2.4. Appointments to the TDAC shall be for a period of up to two years, which may be extended for a further period of up to two years, provided the individual still meets the criteria for membership of the TDAC.

3. Secretary

3.1. The Head of Governance or their nominee shall act as the Secretary of the Committee.

4. Quorum

4.1. The quorum necessary for the transaction of business shall be three members. A duly convened meeting of the TDAC at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable, by the TDAC.

5. Frequency of Meetings

5.1. The TDAC shall meet at least four times a year at appropriate times in the reporting and audit cycle and otherwise as required.

6. Notice of Meetings

6.1. Meetings of the TDAC shall be called by the Secretary of the TDAC at the request of any of its members, if they consider it necessary.

6.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the TDAC, any other person required to attend and all other Non-Executive Directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to TDAC members and to other attendees as appropriate, at the same time.

7. Minutes of Meetings

7.1. The Secretary shall minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

7.2. Draft minutes of the TDAC meetings shall be circulated promptly to all members of the TDAC. Once approved, minutes should be circulated the Board, unless it would be inappropriate to do so.

8. Conduct of Meetings

8.1. Except as outlined above, meetings for the TDAC shall be conducted in accordance with the relevant provisions of NHS Improvement's Rules of Procedure.

9. Duties

9.1. The TDAC should carry out the duties below:

9.1.1. Oversee the programme of work to deliver NHS Improvement's Information and IT strategy and assure the Audit and Risk Assurance Committee and Board that it is on track and meeting its objectives;

9.1.2. Deliver fresh perspectives to the Board on how to deliver a robust programme of work in relation to Information and IT strategy;

9.1.3. Identify current challenges and strengths, test specific project proposals and strategy recommendations and provide assurance on major technology decisions taken;

9.1.4. Oversee the resourcing and sourcing arrangements and provide assurance that NHS Improvement has the appropriate complement of internal skills and experience and access to the required external service partners;

9.1.5. Assure the Board that the Information and IT strategy is aligned to NHS Improvement's business strategy and annual plans; and

9.1.6. Help NHS Improvement identify risks and assure the Board that risks associated with the Information and IT strategy are appropriately managed and mitigated.

10. Reporting Responsibilities

10.1. The TDAC's Chair shall report formally in writing to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

10.2. The TDAC shall make whatever recommendations to the Audit and Risk Committee and the Board it deems appropriate on any area within its remit where action or improvement is needed.

11. Other matters

11.1. The TDAC shall:

11.1.1. Have access to sufficient resources in order to carry out its duties, including access to the Head of Governance for assistance as required;

11.1.2. Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

11.1.3. Give due consideration to relevant legislation, Treasury guidance and other corporate governance best practice as appropriate;

11.1.4. Oversee any instigation of activities which are within its terms of reference;

11.1.5. Consider any other matters where requested to do so by the Audit and Risk Committee or the Board.

12. Authority

12.1. The TDAC is authorised:

12.1.1. To seek any information it requires from any employee of NHS Improvement in order to perform its duties;

12.1.2. To obtain, at NHS Improvement's expense, outside legal (commissioned through the Legal Directorate) or other professional advice on any matter within its terms of reference (subject to budgets agreed by the Board); and

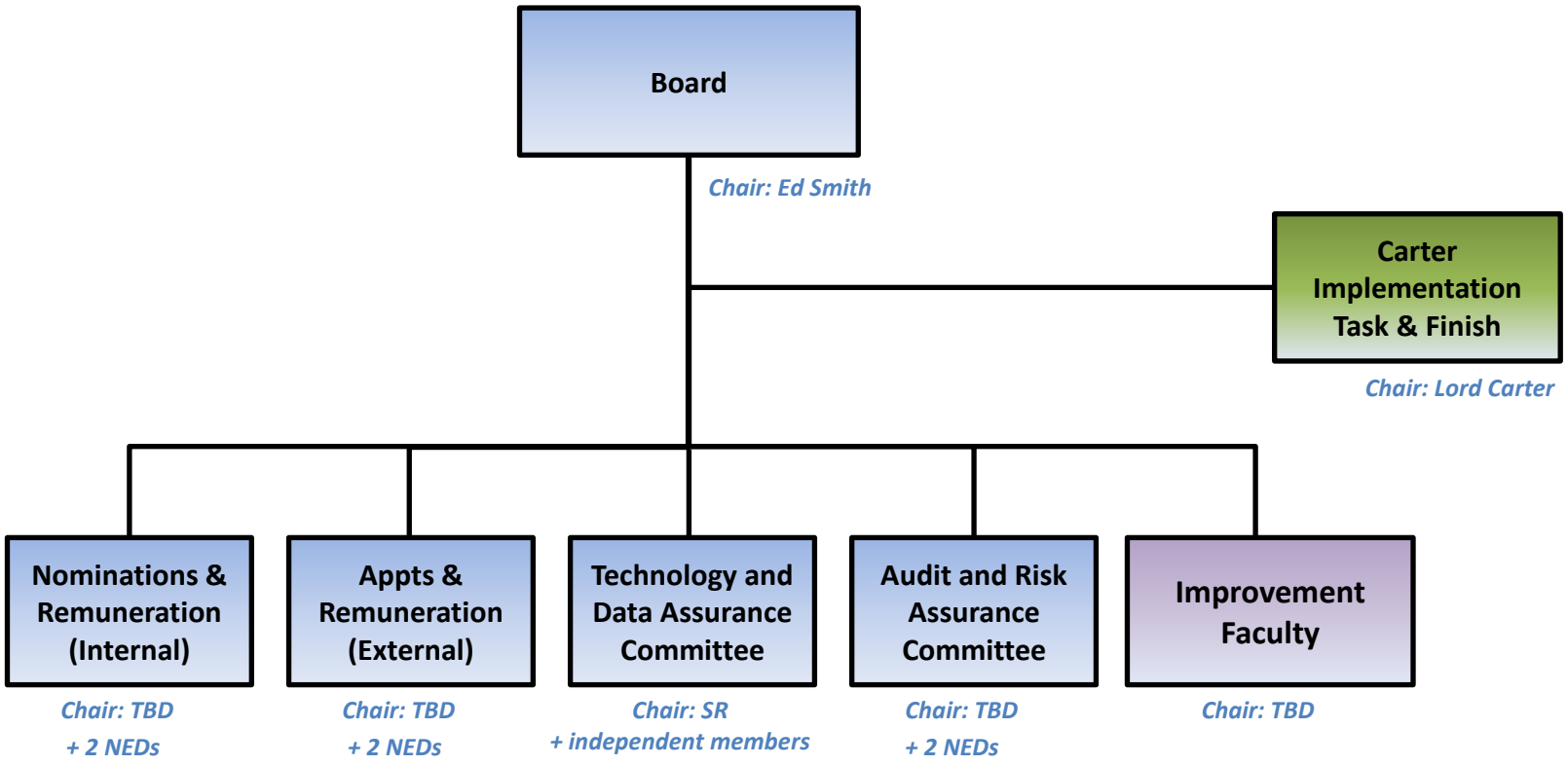
12.1.3. To call any of NHS Improvement's employees to be questioned at a meeting of the TDAC as and when required.

March 2016

ANNEX B

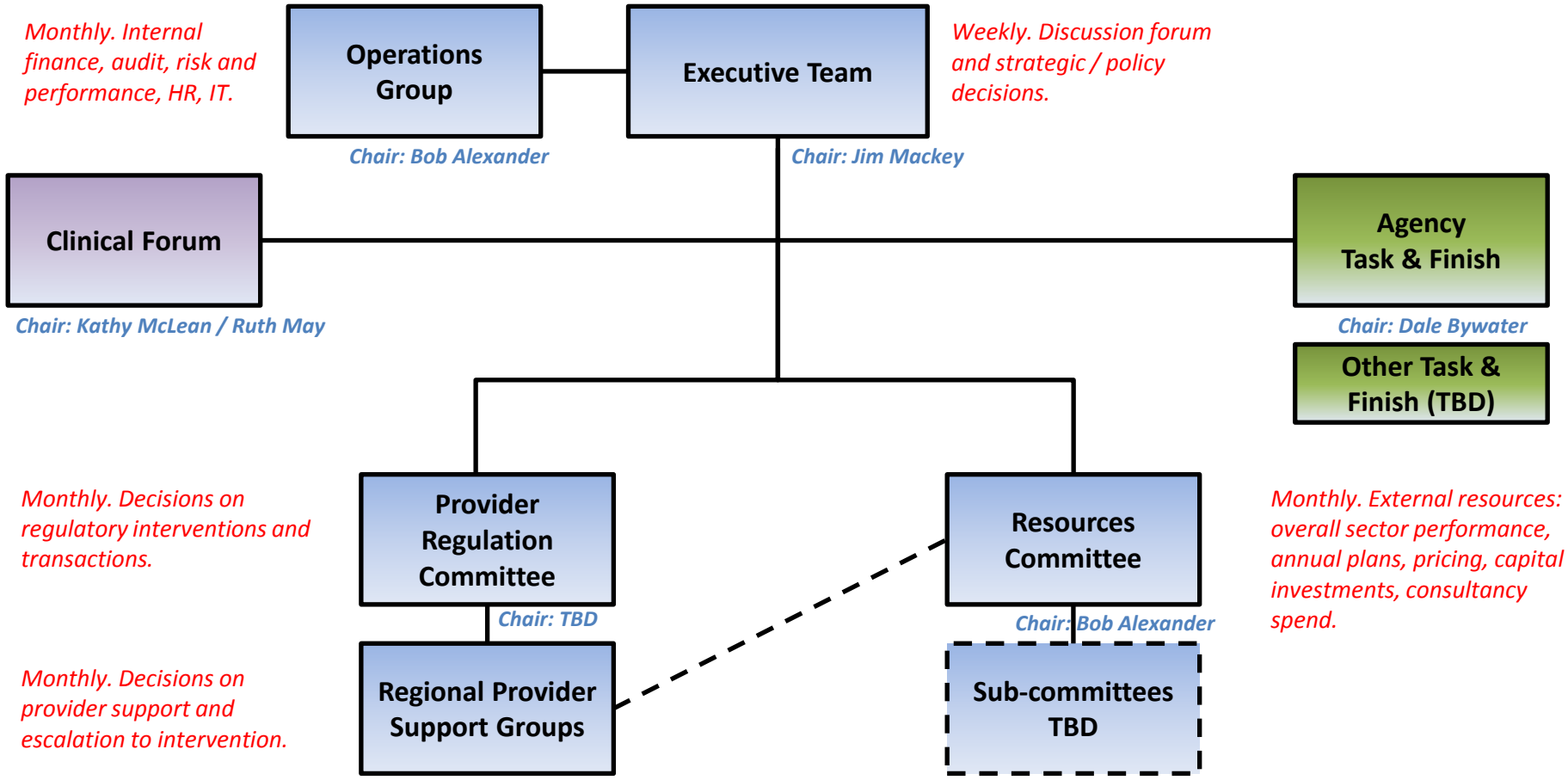
NHS Improvement Governance Arrangements

The Board and its Committees



NHS Improvement Governance Arrangements

Executive Decision Making



ANNEX C

NHS Improvement (NHSI) meeting schedule for 2016/17

1. The below table indicates the business that will be considered at the Board meetings, which are scheduled monthly from April to May 2016 and bimonthly from June 2016 to March 2017. It is anticipated that each Board meeting will be approximately 2.5 to 3 hours in length.

Board meetings	Frequency	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Corporate items													
Minutes	At every board	X	X		X		X		X		X		X
Annual report	Annual												1
Business plan and budget	Annual	X											
NHS Improvement risk and performance	Quarterly		X				X		X				X
NHS Improvement financial position	Quarterly		X				X		X				X
Report of committees of the Board	At every board	X	X		X		X		X		X		X
Chief Executive's report	At every board	X	X		X		X		X		X		X
Chairman's report	At every board	X	X		X		X		X		X		X
NHS Improvement objectives													
Sector performance: quality, finance, operational	At every board	X	X		X		X		X		X		X
Report on challenged providers	At every board	X	X		X		X		X		X		X
Carter implementation report	Quarterly		X				X				X		
Workforce report (incl. agency, pay, workforce supply)	Quarterly	X			X				X				X
Property progress report (incl disposal programme)	Bi-annual				X						X		
Technology report (esp. NHSI role in promoting adoption)	Quarterly		X				X				X		
New care models report (incl. update on vanguards)	Quarterly	X			X				X				X
Leadership and accountability	Quarterly		X				X				X		

	Frequency	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Collaboration and competition	Bi-annual		X						X				
Payment system	Quarterly		X				X				X		
Improvement report (overview of improvement activities)	Quarterly	X			X				X				X
Plus: space for adhoc items as required	At every board	X	X		X		X		X		X		X

2. The below tables indicate the anticipated meeting schedule for NHSI's board and executive committees. Please note that the numbering indicates the number of meetings that will be held for that committee in each respective month.

Board committees	Frequency	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Nominations and Remuneration Committee (int)	Bi-annually	1						1					
Appointments and Remuneration Committee (ext)	Quarterly?												
Audit and Risk Assurance Committee	Quarterly		1		1		1		1			1	
Technology and Data Assurance Committee	Quarterly	1			1			1			1		
Improvement Faculty	Quarterly		1			1			1			1	
Carter Task & Finish	Quarterly			1			1			1			1

Executive committees	Frequency	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Executive Team	Weekly	4	4	4	4	4	4	4	4	4	4	4	4
Operations Group	Monthly	1	1	1	1	1	1	1	1	1	1	1	1
Provider Regulation Committee	Monthly	1	1	1	1	1	1	1	1	1	1	1	1
Regional Provider Support Groups	Monthly	1	1	1	1	1	1	1	1	1	1	1	1
Resources Committee	Monthly	1	1	1	1	1	1	1	1	1	1	1	1
Controls Committee	Fortnightly	2	2	2	2	2	2	2	2	2	2	2	2
FT Consultancy Panel	Weekly	4	4	4	4	4	4	4	4	4	4	4	4
Clinical Forum	Quarterly		1			1			1			1	
Agency Task & Finish	Fortnightly	2	2	2	2	2	2	2	2	2	2	2	2