Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

6 April 2017

[redacted]

By email: [redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **6 March 2017** in which you requested information under the FOI Act from NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor and the NHS Trust Development Authority ("NHS TDA").

Your request

You made the following request:

1. *I would like to know what is the process for NHS Improvement to appoint a chairperson of a NHS hospital trust.*

2. *Copies of correspondence between NHS Improvement, Jon Andrewes and the Royal Cornwall Hospital Trust (these can be emailed) before and regarding his appointment to the chairmanship of the Royal Cornwall Hospital Trust*

3. *Confirmation and if possible results of any background checks, such as criminal records, which were obtained before Mr Andrewes was appointed.*

4. *Details of steps taken to check the veracity of information Mr Andrewes supplied before his appointment in order to support it. This should include whether Mr Andrewes provided referees to support his appointment and whether these were contacted.*

The numbering has been added for ease of reference.

Decision

NHS Improvement holds the information that you have requested and has decided to withhold some of the information on the application of the exemptions under sections 40 of the FOI Act, as explained in detail below.

Question 1: the process for appointing Chairs

In response to the first part of your request, we have attached a policy document outlining NHS Improvement's approach to Chair and non-executive director appointments in NHS trusts, including the relevant processes NHS Improvement will follow.

Question 2: correspondence between NHS Improvement, Jon Andrewes and Royal Cornwall Hospital Trust ("the Trust") regarding Jon Andrewes' appointment

We have decided to withhold some of this information on the basis of the application of the exemptions in section 40 of the FOI Act, as explained below. The information we are able to release is attached to this letter.

Section 40 – personal data

I consider that some of the information in response to the second part of your request is exempt from disclosure under section 40(2) and 40(3)(a) of the FOI Act on the grounds that it contains personal data and that the first condition under section 40(3)(a) is satisfied, namely, that disclosure would amount to a breach of the first data protection principle (personal data should be processed fairly and lawfully). This is an absolute exemption and consideration of the public interest test is not required.

The information being withheld includes correspondence between Mr Andrewes and NHS Improvement regarding Mr Andrewe's application and interview for the role of Chair at the Trust, which Mr Andrewes would have a reasonable expectation would not be disclosed. In addition, it includes the names and contact details of junior members of staff of NHS Improvement who would have a reasonable expectation that they would not be disclosed. The documents being released include redactions in relation to the latter information.

Questions 3 and 4: confirmation and results of any background checks, such as criminal records, and details of steps taken to check the veracity of information Mr Andrewes supplied

NHS Improvement carried out the checks outlined below, all of which it found to be satisfactory, prior to deciding to invite Mr Andrewes to serve as Chair of the Trust:

- Review of application, including review of CV, application letter, monitoring form and 360 feedback relating to previous position
- Panel interview
- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- Review of two written references provided for the post
- Review of two written references from a previous post
- Review of Google and news search
- Review of appraisals provided from previous non-executive roles
- Written confirmation from Mr Andrewes that he is a "fit and proper person"

In accordance with our policy (which we have released in response to this request), NHS Improvement did not carry out a Disclosure and Barring Scheme (DBS) check. This check

and a number of other checks are left to the NHS trust to which the appointment is being made to carry out, where appropriate to the role. NHS Improvement's appointment is subject to satisfactory completion of the relevant checks. Further details about the checks to be carried out by the relevant NHS trust can be found on page 8 of the enclosed document.

Please note that NHS trusts are subject to the FOI Act and as such it is open to you to seek information directly from them. They will need to consider whether information can properly be provided by them in response to any such requests within the terms of the FOI Act.

NHS Improvement did not carry out a check of the qualifications Mr Andrewes claimed to hold in his application. The current policy approach is not to routinely request proof of qualifications unless a particular qualification is listed in the person specification (for example, if the post holder required a finance qualification, proof of relevant qualification(s) would be sought). In any case, where this check is deemed relevant, we would usually ask the Trust to which the appointment is to be made to carry it out. NHS Improvement is currently considering its approach to this issue.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

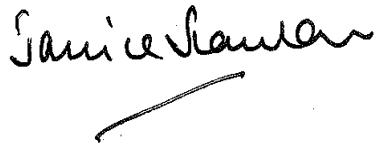
If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,



Janice Scanlan
HEAD OF NON-EXECUTIVE DEVELOPMENT

NHS Improvement

NHS trust chair and non-executive directors – How NHS Improvement will discharge it's role and responsibilities

Principles

1. Chair and NED appointments to NHS trusts are regulated by the Commissioner for Public Appointments and must comply with his "Code of Practice for Ministerial Appointments to Public Bodies". The Code sets out three basic principles that must be observed when making these appointments:
   - **Merit** – this means identifying a strong and diverse field of candidates with the skills, experience and qualities required from which the appointing authority can be provided with a choice of high quality candidates from which to make an appointment
   - **Fairness** – ensuring that all candidates are assessed against the same published criteria and that the selection processes used are objective, impartial and consistently applied
   - **Openness** – details of all posts and the selection processes used must be made public
2. The "fit and proper persons" requirement plays a major part in ensuring the accountability of directors of NHS bodies, to encourage a culture of openness and to enable providers and directors to be held to account. NHS Improvement (NHSI) has a duty to ensure that the chairs and non-executives it appoints meet the requirements of the "fit and proper persons" regulations.
3. NHSI's arrangements for these appointments have been designed to ensure that its policies and procedures comply both with the principles of the Commissioner's Code and the requirements of the "fit and proper persons" regulations.

Appointing authority

4. The board of NHSI has delegated its authority to appoint, suspend and terminate the appointment of the chairs and NEDs of NHS trusts and NHS charity trustees to its Provider Leadership Committee (PLC).
5. In turn, the PLC has delegated some of its responsibilities in relation to the appointment of NHS trust NEDs and NHS charity trustees to the relevant sub-committee.

Roles and responsibilities

6. The PLC and its sub-committees will be responsible for performing the functions defined in this document and in line with the requirements of the relevant terms of reference. The PLC will have oversight of and monitor the performance of this and related activities and agree all supporting policies and procedures. It will also report to the NHSI Board on chair, NED and trustee appointment or governance issues, the diversity of appointments, associated risks and any issues that require further action.

7. The NED Appointments Team (NAT), reporting to the ERMD of London, will be responsible for the delivery of these functions, working in collaboration with the PLC and the Executive Regional Managing Directors (ERMD), Delivery and Improvement Directors (DID's) and their teams.

Diversity

8. NHSI is committed to diversity and equality of opportunity for all.

9. When making any decision, the PLC and its sub-committees will consider the impact it will have on diversity, in particular in relation to the protected characteristics of gender, ethnicity and disability. In addition to considering these issues in relation to individual appointments and NHS trust boards, the PLC will also regularly review the overall diversity of all NHS trust chairs and NEDs.

Making new appointments

10. **Dealing with vacancies** – When the NAT is advised of a new vacancy, it will contact the relevant ERMD or DID to discuss the future requirements and the arrangements for filling the vacant post(s).

11. Where the vacancy relates to a NED post, the NAT or DID will discuss the requirements for the role with the relevant chair, or in the case of the appointment of an NHS charity trustee, with the chair or chief executive of the charitable fund.

12. Where it is agreed that a vacancy should be filled through open competition, the processes set out in paragraphs **14 - 30** will be followed.

13. Where it is agreed that an interim appointment should be made, the processes set out in paragraphs **31 - 33** will apply.

14. **Selection panels** – For each post that goes out to open competition, the NAT will establish a selection panel comprising at least three members.

15. For chair appointments, in order to comply with the requirements of his Code of Practice for Ministerial Appointments to Public Bodies, the panel will be chaired

by the appropriate ERMD or exceptionally the relevant DID. For chair appointments it will also include the relevant ERMD, or exceptionally the relevant DID. It may also include an NHSI NED. Membership of the panel will be agreed with the ERMD.

16. The panel to select a new NED will be chaired by the chair of the relevant NHS trust.

17. All panels, including for chair appointments, are also required to include a person who is independent of NHSI and the organisation to which the appointment is made.

18. Other members of selection panels will be determined as required but may include the chair of another NHS trust or NHS foundation trust or a subject expert (for example, when an audit committee chair is being recruited).

19. Panel arrangements related to the appointment of NHS charity trustees will be agreed on a case by case basis but will always include an independent person.

20. Developing person specifications – based on the discussions set out in paragraphs **8 – 9** above the NAT will develop a draft person specification for the post to be filled.

21. In developing the person specification, the NAT will be mindful of best practice and ensure that they do not unnecessarily restrict the ability to identify a strong and diverse field of candidates.

22. Where the person specification relates to the appointment of a chair, it will be agreed by the ERMD or DID. Where it relates to the appointment of a NED, it will be agreed by the ERMD or DID and the chair of the organisation concerned. For NHS charity trustee appointments, it will be agreed with the chair or chief executive of the charitable fund.

23. **Recruitment strategies** – As a minimum, all posts will be advertised on the NHSI and Cabinet Office websites. The NAT will search their "talent" database to identify potential suitable candidates and encourage them to apply. It will also ensure chairs in the wider health economy are informed about the vacancies and encouraged to identify suitable candidates.

24. The NAT will work with NHS trusts and NHS charitable trusts to develop a local communications strategy including:
    - advertising vacancies on their own websites;

- contacting local MPs and other local leaders to help identify suitable candidates; and
- using press releases, relevant local networks and contacts, and social media to promote the vacancy; and
- In addition, NHS trusts in particular will be asked to consider advertising in local, national or online media.

25. For chair posts, NHS trusts will generally be asked to either engage executive search consultants or support a search exercise to be undertaken by the NAT.

26. **Selection process** – The selection panel established under the arrangements set out in paragraphs **14 - 19** will be responsible for overseeing the selection process and making a recommendation to the PLC or the relevant sub-committee.

27. All panel members will be asked to declare any prior knowledge of candidates so that this can be appropriately managed.

28. The selection process will include the long-listing and preliminary interviews of candidates (where appropriate), generally by either the executive search company or by the NAT, shortlisting and interviewing. For chair posts, shortlisted candidates will generally be asked to participate in a stakeholder engagement event, before being interviewed by the selection panel.

29. Other tools may be used as part of the selection process, for example, psychometric testing, in advance of the final panel interview. In general they will only be used when considering candidates for chair posts and will only be conducted at the expense of the NHS trust or NHS charitable body.

30. At the end of the selection process the chair of the selection panel will prepare a panel report which will form part of the recommendation to the PLC or sub-committee.

Interim appointments

31. Where it is considered to be in the best interests of the organisation concerned to make an interim appointment, for example, where NHSI needs to act quickly to respond to concerns about governance or performance issues, or the future of the organisation is not clear, it is possible to make an appointment without the need for an open competition in the usual way.

32. Candidates for appointment in these circumstances will generally be people who already hold or have held a chair or NED role on an NHS trust board or have been through an NHS TDA, Appointments Commission or NHSI recruitment process

and deemed "appointable" by a selection panel. For appointments to NHS trusts, such individuals are deemed to have been through a selection process that was regulated by the Commissioner for Public Appointments.

33. Other candidates for interim roles can be considered, including those who hold or have held chair or non-executive director roles on NHS Foundation Trusts, but for appointments to NHS trusts approval of the Commissioner for Public Appointments is required before an appointment can be made.

Re-appointments

34. Where an appointee has served less than eight years in post, he/she can be considered for an extension or a further term of office without the need to go out to open competition. In exceptional circumstances, an appointee who has served more than eight years can be considered for re-appointment but he / she will not be able to remain in the same post for more than ten years, as set out in paragraph **40- 41**.

35. In order to be considered for re-appointment, it must be clear that the appointee:
    - has the skills and experience the organisation will need in the future;
    - has received a satisfactory appraisal in the last twelve months; and
    - meets the requirements of the "fit and proper persons" regulations as set out in paragraph **46 - 48**.

36. The relevant ERMD will be asked to recommend a chair for re-appointment before the PLC is asked to make a final decision.

37. The relevant ERMD or DID is also required to support the re-appointment of a NED recommended for re-appointment by his / her NHS trust chair or the chair or chief executive of the charitable fund before the relevant sub-committee is asked to make a final decision.

Appointment terms

38. Terms of appointment will generally be for periods of two to four years on the recommendation of the NHS trust chair for NED appointments, and in agreement with the ERMD or DID.

39. Individual appointment terms will depend on local circumstances. Longer terms can be helpful to secure "corporate memory" or to ensure that the terms of appointment of NEDs are "staggered" against those of other members of the board. Terms of less than two years may be appropriate, for example, when the appointment is intended as an interim arrangement or a change to the legal form of the organisation is anticipated.

40. Appointees can remain in the same post for up to ten years.

41. Only in the most exceptional circumstances can an individual remain in post for more than ten years, and in the case of an appointment to an NHS trust, would require the prior approval of the Commissioner for Public Appointments.

Appraisals

42. NHSI is responsible for ensuring that chairs and NEDs of NHS trusts receive regular performance appraisals. The NAT will ensure that this responsibility is met and that they are conducted in line with agreed policies and procedures.

43. **NHS trust chairs –** will be required to submit to a formal appraisal process each year which as far as possible will reflect NHSI's single oversight model. It will be informed by self-assessment, and may include 360° feedback and an assessment of the Trust's performance, as appropriate. Chairs may be invited to take part in an appraisal discussion, particularly if there are concerns about performance and / or a difference of opinion between the chair and NHSI about the standard of that performance.

44. The process itself will be reviewed regularly to ensure it continues to meet the needs of both NHSI and the chair community.

45. **NHS trust NEDs** - will be appraised by their chair who will be required to submit an annual return of the appraisals conducted, identifying the overall assessment and the development needs of each NED.

Suitability checks

46. All NHS trust chairs and NEDs must:

- be of good character;
- have the necessary qualifications, skills and experience;
- exhibit appropriate personal behaviour and business practices;
- have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments);
- supply certain information (including a full employment history); and
- have not been involved in, known of or facilitated any serious misconduct or mismanagement in carrying on a regulated activity.

47. The NAT, in conjunction with the NHS trust concerned will conduct specific checks on all those recommended for appoint more or re-appointment. Every effort will be made to minimise the impact this will have on timescales for

recruitment exercises. Inevitably, some of these checks will take some time, so it is likely that offers of appointment will be conditional on the satisfactory completion of the necessary checks. The following checks will be completed by the NAT before the PLC or the relevant sub-committee of the PLC is asked to consider a recommendation:

- CV check for gaps in history, potential issues and conflicts of interest
- Check of self-declaration form completed by the candidate, and renewed for reappointments
- Scrutiny of references
- Scrutiny of panel assessment documentation, where appropriate for new appointments
- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- Check with relevant regulators, where individuals have a history of regulated activity
- Check of corporate knowledge, where the individual has a background in the NHS
- Google and news search, including high profile roles, any regulated activity, or work with children or vulnerable adults

48. A number of additional checks will be undertaken by the NHS trust and appointments will be offered conditionally on satisfactory completion of:

- Disclosure and Barring Scheme (DBS) checks
- Occupational Health Assessment for new appointments only
- Proof of identity by producing passport or driving licence for new appointments only
- Proof of qualifications only where appropriate and for new appointments only
- Proof of right to work, where individual does not provide an EU passport as proof of identity for new appointments only

Making appointments

49. **Chairs of NHS trusts** – All chairs of NHS trusts will be formally appointed by the PLC.

50. **NEDs of NHS trusts and NHS charity trustees** –These appointments will generally be made by the relevant sub-committee of the PLC. Where the

appointment is potentially controversial, high profile or there is a conflict of interest, the PLC may be asked to consider the recommendation.

51. Appointment recommendations will generally be sent to members of the PLC and sub-committees by e-mail. They will be asked to individually confirm, generally by e-mail, that they agree the recommendation. Where all PLC or sub-committee members agree, the appointment will be made. When there is disagreement, a meeting will be convened, usually by telephone to consider the recommendation.

Suspensions

52. In order for a suspension of an NHS trust chair or non-executive to be considered, there must be an indication that there may be grounds for the termination of the appointee's term of office, as defined by the appropriate legislation and associated NHSI policies.

53. The evidence in support of suspension will be considered by the PLC. In order to do so promptly, this will generally be done by telephone conference after the recommendation has been circulated to members by e-mail.

Terminations

54. All requests to consider a termination of appointment will first be considered by the PLC.

55. In these cases where a technical case is made to terminate an appointment, for example where the individual has become disqualified or has not attended a meeting of the board for three months, the PLC will make the final decision.

56. When considering whether an appointment should be terminated on the grounds that it is no longer in the interests of the health service for an appointee to remain in post, and when members agree that there is a case to answer, a Termination of Appointment Panel (TAP) will be convened. The TAP will be chaired by a member of the PLC and will include others such as other members of the PLC as appropriate, together with at least one independent person. The TAP will consider the evidence both in support of and against the

termination recommendation. If the TAP finds against the appointee, it will make a recommendation to the board of NHSI, which will make the final decision.

Remuneration increases

57. The rates of remuneration payable to the chairs and NEDs of NHS trusts are determined by the Secretary of State for Health. Recommendations to Ministers to consider an increase in the rate of remuneration payable to an individual NHS trust chair will be made on behalf of the PLC by the NAT, in consultation with the relevant ERMD and reported retrospectively to the next PLC meeting.

Development and support

58. NHSI has been directed to ensure that chairs and NEDs of NHS trusts have access to appropriate induction, development and support opportunities. The NAT will ensure that this responsibility is met, in accordance with agreed policies and procedures.

Policies and procedures

59. The PLC will agree all policies and procedures relating to the performance of these functions.

From: [redacted] (NHS IMPROVEMENT - [redacted]
Sent: 01 May 2015 12:22
To: [redacted] (NHS IMPROVEMENT - [redacted]
Subject: Chair - Royal Cornwall Hospitals NHS Trust

Good afternoon
Thank you again for your application for the above post.

As we have received a small field of applications for this post, the decision has been taken to extend the closing date until 11 May 2015. I will be in touch again, shortly after the new closing date.

Regards

[redacted]
Appointments Officer
Governance and Non-executive Development Team
NHS Trust Development Authority
2C18
Quarry House
Leeds
LS2 7UE

Tel: [redacted] –please note this is a new number
[redacted]@nhs.net

From: [redacted] (NHS IMPROVEMENT - T1520)
Sent: 19 May 2015 15:55
To: [redacted]
Subject: Royal Cornwall Hospitals NHS Trust
Attachments: Information pack.pdf; Map.docx

Dear Dr Andrewes

Re: Chair – Royal Cornwall Hospitals NHS Trust

Further to our email correspondence, I am pleased to confirm that your interview will take place at [redacted] t NHS TDA offices, South West House, Blackbrook Park Avenue, Taunton, Somerset, TA1 2PX.

Directions to the venue location are attached. Please report to reception on arrival and ask for myself, the contact number, should you require it is as follows: 01823 361 325

We expect that the interview will take around an hour. The panel will be made up of:

- Sara Nathan, Public Appointments Assessor as Panel Chair
- Anne Eden, Director of Delivery and Development, NHS Trust Development Authority as Panel Member
- Brian Stables, Chair, Royal United Hospitals Bath NHS Foundation Trust as External Panel Member
- I will be in attendance as an observer only

The information for applicants indicated that shortlisted candidates would need to demonstrate at interview that they have both the required expertise and the leadership behaviors needed to be effective as a member of an NHS board. A copy of the information for applicants is attached for reference.

At the interview you will be asked to give a 5 minute presentation on the subject: **"What are the top three challenges for the organisation and how would you address them?"** As previously stated this presentation should not include any aids such as Powerpoint, handouts etc.

Given the significant public profile and responsibility members of NHS boards hold, it is vital that those appointed can maintain the confidence of the public, patients and NHS staff at all times. New regulations now require the NHS TDA to make a number of specific background checks to ensure that those we appoint are "fit and proper" people to hold these important roles. These checks will include:

- Occupational Health Assessment
- Proof of ID
- Proof of qualifications, where appropriate
- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- Check with relevant regulators, where appropriate

You should be aware that if you are appointed the results of the checks, your references and any other relevant information may be shared with CQC which will consider whether board members meet the requirements of the 'fit and proper persons' regulations. More information about the fit and proper person requirements can be found on our http://www.ntda.nhs.uk/blog/2014/12/04/fit-proper-persons-requirements/

If there are any issues in your personal or professional history that could potentially fall within the definition of an "unfit person", jeopardise public confidence or cause embarrassment to the Trust, it is important that you bring it to the attention of the selection panel or the NHS TDA before appointment.

While every effort will be made to minimise the impact these new arrangements will have on the recruitment timescale, inevitably some of these checks will take some time. It is likely that some offers of appointment may be made conditional on the satisfactory completion of the necessary checks.

The panel operates as an advisory panel to NHS Trust Development Authority's Appointments Committees which are ultimately responsible for making these appointments. I expect the Committee will make their decision about this appointment during May/June.

I will let you know the outcome of your interview by letter as soon as possible.

Regards

[redacted]
Appointments Officer
Governance and Non-executive Development Team
NHS Trust Development Authority
2C18
Quarry House
Leeds
LS2 7UE

Tel: [redacted]
[redacted]@nhs.net

From: [redacted](NHS IMPROVEMENT - [redacted]
Sent: 25 June 2015 11:13
To: [redacted]
Subject: Appointment letter
Attachments: Dr Andrewes-appointment letter.pdf; NHSLeadership-HealthyNHSBoard-2013.pdf; PSA-standards-for-board-members.pdf; TDA appointment info_Feb15.pdf

Dear Jon
Please find attached the letter inviting you to serve as Chair of Royal Cornwall Hospitals NHS Trust. I have also attached other related documentation.

If you have any further questions, please do not hesitate to contact me.

Many thanks

[redacted]
.ppointments Officer
Governance and Non-executive Development Team
NHS Trust Development Authority
2C18
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Leeds
LS2 7UE

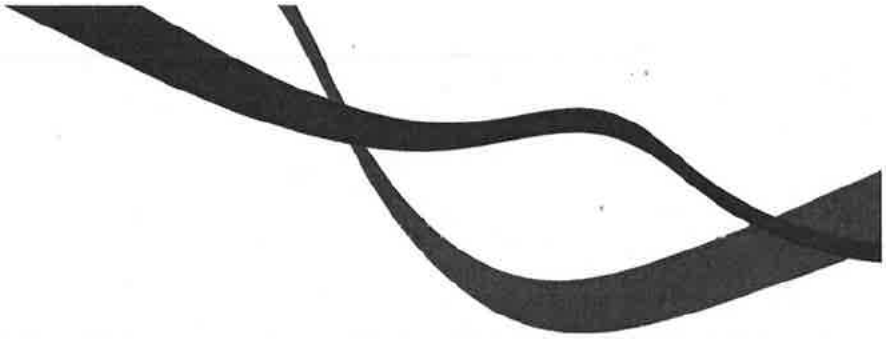
Tel: [redacted]
[redacted]@nhs.net

NHS
Leadership Academy

The Healthy NHS Board 2013

Principles for Good Governance

www.leadershipacademy.nhs.uk



This document has been prepared
for the NHS Leadership Academy by:

Foresight Partnership

www.foresight-partnership.co.uk

In partnership with:

Department of Applied Health Research
UCL

Foreword

We are delighted to introduce this refreshed edition of 'The Healthy NHS Board 2013 - Principles for Good Governance' commissioned by the NHS Leadership Academy.

In the period since its original publication in 2010, this guide has supported boards in their efforts to develop their governance and board effectiveness and thereby build public confidence that the NHS organisations on which patients rely provide safe, sustainable, compassionate, high quality care. However, the recent report of the Francis inquiry sets out the very significant challenges that remain for the health and social care system overall - and for the boards of NHS organisations in particular.

In this edition, the fundamental principles for good governance originally described in 'The Healthy NHS Board' remain but have been enriched by a review of the considerable body of new research and guidance that has been published over the past three years.

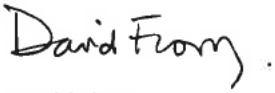
Wide-ranging health reform has produced a significantly changed organisational landscape and the guide also responds to these changes in organisational roles, relationships and accountabilities.

Boards are leading NHS organisations in an enormously demanding environment. The long-predicted impact of demographic change and the substantial growth in long term conditions is now upon us. Severe constraints on resources and the drive to improve efficiency, whilst protecting quality, are a daily challenge for health and social care providers alike. NHS leaders are increasingly aware that high quality, safe, sustainable healthcare depends on boards and organisations that are capable of building and maintaining mature, sophisticated partnerships across a complex, multi-faceted local health and social care economy. And although we know that the boards and staff of most NHS organisations demonstrate daily their deep commitment to providing effective, safe, compassionate care, instances of appalling failure have provided very painful lessons and have undermined public trust.

The refreshed guide shines an even brighter light than previously on the critical role that the board plays in shaping and exemplifying an organisational culture that is open, accountable and compassionate and puts patients first. Crucially, it identifies a key role for the board to play in prioritising the development of a people strategy that truly hears, supports and nurtures all staff and enables and rewards a culture of innovation and improvement. Finally it offers new insights to boards as they ensure that the organisation builds transparent, accountable relationships and partnerships with patients and the public as well as with key partners and stakeholders.

The value of robust, accountable, engaged and transparent governance has never been greater and we therefore warmly commend this resource to all boards as they seek to meet the challenges that lie ahead.

David Bennett



David Flory

Contents

1 Introduction

This chapter explains the purpose of the Healthy NHS Board guidance and provides a visual summary to help readers navigate through the document.

The NHS Leadership Academy recognises the crucial importance of effective, engaged, accountable board leadership and is therefore very pleased to have commissioned this refreshed edition of 'The Healthy NHS Board 2013 - Principles for Good Governance'.

This guidance supports the NHS Leadership Academy's mission to develop outstanding leadership in health in order to improve people's health and their experience of the NHS.

The strong relationship between leadership capability and performance is well demonstrated in the evidence. Good leadership leads to a good organisational climate and good organisational climates lead, via improved staff satisfaction and loyalty, to sustainable, high performing organisations.

The updated guide has been enormously enriched by the insights of experienced, thoughtful leaders of NHS, regulatory and patient advocacy organisations who have generously responded to our call to contribute their time and their wisdom.

We are also very grateful to our partners - Monitor, the NHS Trust Development Authority, the Care Quality Commission, the Foundation Trust Network and the NHS Confederation - all of whom fielded senior leaders to join us as part of a steering group to provide advice and oversight to the process.

The guide will serve as a cornerstone of the Academy's wider programme of work to support and enable board and governance development. We hope that boards of NHS organisations will find that it can also serve as a cornerstone for your board development.

Karen Lynas
Deputy Managing Director, NHS Leadership Academy

Purpose of this guidance

2 This document sets out the guiding principles that will allow NHS board members to understand the:

- Collective role of the board including effective governance in relation to the wider health and social care system
- Activities and approaches that are most likely to improve board effectiveness in governing well.
- Contribution expected of them as individual board members

3 It is hoped that NHS board members will continue to find this good practice guidance valuable and will focus effort in ways that the evidence suggests should be most productive. 'The Healthy NHS Board' (February 2010) was underpinned by a comprehensive review of governance literature and an extensive process of engagement with the NHS. In all, some 1,000 NHS staff and board members took part in this consultation, and the shape and content of the guide reflect their contributions. The first literature review, entitled 'The Healthy NHS Board: a review of guidance and research evidence[42], considered over 140 sources. This second edition has again been supported by a process of engagement with leaders across the NHS. It is informed by a further review of governance research evidence and good practice guidance[42] available since the initial publication, both the original and updated reviews are available for download together at www.leadershipacademy.nhs.uk/healthyboard

4 This guidance is primarily intended for boards of NHS Trusts and Foundation Trusts. With some interpretation it will be relevant for organisations operating at a national level. Clinical Commissioning Groups, as membership organisations, have developed very specific governance architecture and are not therefore the primary focus of this guidance, although the general principles outlined are relevant to them. It offers a framework that will help them to place reliance on the effective governance of provider organisations.

5 The guidance will also be of interest to those aspiring to be NHS board members, to governors of Foundation Trusts who have a role in ensuring that the board operates effectively and to those who support and work with NHS boards.

6 This document aims to describe the enduring principles of high quality governance, that transcend immediate policy imperatives and the more pressing features of the current health care environment. It can be used by board members as an introduction to the subject of governance in the NHS. Since it is designed to be enduring, it can be kept as a reference - a first place to turn - in the future.

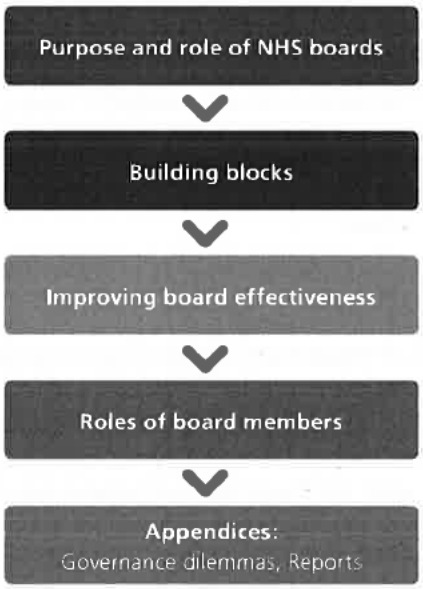


Figure 1: Structure of this guidance:

2 Purpose and role of NHS boards

The purpose and role of NHS boards is set out in this chapter, helping board members to navigate through the wide range of guidance available.

7 The purpose of NHS boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services.
- That resources are invested in a way that delivers optimal health outcomes.
- In the accessibility and responsiveness of health services.
- That patients and the public can help to shape health services to meet their needs.
- That public money is spent in a way that is fair, efficient, effective and economic.

8 This guide aims to provide board members with an overarching and durable framework that will allow them to make sense, and effective use, of the wide range of available advice and guidance both in the United Kingdom and internationally. It draws on established good practice in governance and a wide-ranging review of more recent literature, from all sectors.

9 The role of NHS boards is described below and is illustrated in Figure 2.

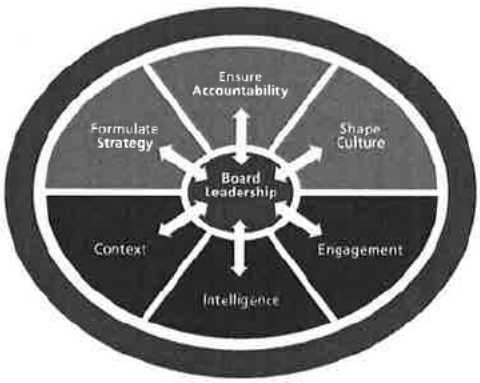


Figure 2: Roles and building blocks of NHS boards

10 Effective NHS boards demonstrate leadership by undertaking three key roles:

- **Formulating strategy** for the organisation.
- **Ensuring accountability by:** holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable.
- **Shaping a healthy culture** for the board and the organisation.

11 Underpinning these three roles are three building blocks that allow boards to exercise their role. Effective boards:

- Are informed by the **external context** within which they must operate.
- Are informed by, and shape, the **intelligence** which provides an understanding of local people's needs, trend and comparative information on how the organisation is performing together with market and stakeholder analyses.
- Give priority to **engagement** with stakeholders and opinion formers within and beyond the organisation; the emphasis here is on building a healthy dialogue with, and being accountable to, patients, the public, and staff, governors and members, commissioners and regulators.

12 The three roles of the board and the three building blocks all interconnect and influence one another. This is shown in Figure 2. They are examined in more detail in the next sections.

Roles of the board

1 Formulate Strategy

13 The first of the three roles of the board is formulating strategy. There are three main elements to consider:

- The **process** of developing strategy
- The **hallmarks** of an effective strategy
- The approach to strategic **decision-making**

Strategic Process

14 In general, an effective strategic **process**:

- Ensures that the strategy, including identification of strategic options, is demonstrably shaped and owned by the board
- Provides for the active involvement of and influence by staff
- Ensures that there have been open, transparent, accountable consultation and involvement processes with patients, the community, governors and through them members (in the case of Foundation Trusts)
- Ensures that there has been collaborative engagement with partners to shape strategy in the interests of patients
- Ensures that these consultation and involvement processes help to identify strategic choices, risks and proposed ways forward
- Is underpinned by regular strategic discourse in the board, throughout the year. Strategy needs to be dynamic in responding to changes in the external environment

Hallmarks of an effective strategy

15 Some of the **hallmarks** of an effective strategy include:

Vision and purpose: putting patients first

- A compelling organisational vision for the future that puts quality of care and the safety of its patients at its heart
- A clear statement of the organisation's purpose
- Well-developed values and behaviours, owned by the organisation and supporting the desired culture to deliver the vision
- A vision that is underpinned with clear strategic objectives that are reflected in an explicit statement of desired outcomes and key performance indicators, including a balance of locally and nationally relevant indicators
- Explicit attention paid to the ability of the organisation to implement the strategy successfully
- Demonstrable influence of the needs and preferences of users, patients and communities served
- Inclusion at its heart so that services that are delivered produce accessible, fair and equitable services and outcomes for all sections of the population served
- Commitment to treating patients, service users and staff with equity
- Inspires and enables innovation
- An integrated approach to prevention and health promotion

Takes account of external context and drivers

- An approach that takes appropriate account of the external context and related risk environment in which the organisation is operating, including the organisation's responsibility as part of the wider health economy, and provides evidence of doing so
- A perspective which balances the priority given to national and local performance indicators and targets

Based on well-informed intelligence

- Evidence that the strategy has been shaped by the intelligence made available to the board (both hard and soft data)

Takes a longer term view

- A longer term view, with at least a 3 to 5 year planning horizon
- A long-term financial model and risk analysis
- A long-term people strategy (see Building Effectiveness for more information)

Strategic Decision Making

16 Strategic **decision-making** is an integral part of the board's role in formulating strategy. Good practice here includes:

- Strategic decisions which are aligned to overall strategic direction, and are expressly identified as such
- Testing strategic decisions to ensure that they balance excellence in the safety and quality of care together with long term financial sustainability and value for money
- A formal statement that specifies the types of strategic decisions, including levels of investment and those representing significant service changes that are expressly reserved for the board, and those that are delegated to committees or the executive
- Early involvement of board members in debating and shaping strategic decisions and appropriate consultation with internal and external stakeholders
- For significant strategic decisions: consideration by the board of options and analyses of those options and the board's appetite/tolerance for the major risks involved
- Criteria and rationale for decision making that are transparent, objective and evidence based
- Clarity about which key strategic decisions also require approval of governors[12] (for Foundation Trusts), such as: mergers, acquisitions, separations or dissolutions; significant increases in private patient income and amendments to the Trust's constitution
- Clarity about which strategic decisions require approval of other external organisations or bodies

'Board members should be transparent in decision-making, providing evidence, reasoning and reasons behind decisions about budget and resource allocation.'

Francis, second Inquiry report[3]

'In our organisation there are two key tests that we apply to all the decisions that we make - Would you spend your own money this way and would you wish to use this service? In this way we ensure that we have the taxpayer on one shoulder and the patient on the other.'

NHS chief executive, Healthy NHS Board consultation

Roles of the board

2 Ensure Accountability

17 The second core role of NHS boards is **ensuring accountability**. This has three main aspects:

- Holding the organisation to account for the delivery of the strategy
- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour
- Seeking assurance that the systems of control are robust and reliable

Holding the organisation to account for its performance in the delivery of strategy

18 In unitary NHS boards, all directors are collectively and corporately accountable for organisational performance.

19 This aspect is, therefore, a fundamental part of the board's role in pursuing high performance for its organisation, ensuring that the best interests of patients are central to all it does. It is important that boards are assured rather than too readily reassured. Where issues arise they need to be addressed - swiftly, decisively, knowledgeably and with humanity - by the whole unitary board. A robust but fair approach is important, particularly where there are problems of underperformance. Effective boards recognise that 'the buck stops with the board'.

Assurance: being assured because the board has reviewed reliable sources of information and is satisfied with the course of action.

Reassurance: being told by the executive or staff that performance or actions are satisfactory.

Monitor: Quality Governance Guidance[4]

20 A key observation from a review[5] of how boards get their assurance is 'that there has been no lack of guidance... the challenge for boards is therefore not finding out what to do, but instead translating the theory into an approach that works in their Trust and then following through with appropriate rigour'.

21 The fundamentals for the board in holding the organisation to account for performance include:

- Drawing on timely board intelligence - to monitor the performance of the organisation in an effective way and satisfy itself that performance is continually improving and that appropriate action is taken to remedy problems as they arise
- Looking beyond written intelligence to develop an understanding of the daily reality for patients and staff, to make data more meaningful
- Seeking assurance that staff are clear about their responsibilities and accountabilities and how these fit with the organisation's vision and purpose
- Triangulation[4] which ensures that board members are able to 'test' the intelligence and seek assurance by looking at more than one source and type of information, including through direct engagement with the services
- Seeking assurance of sustained improvement where remedial action has been required to address performance concerns
- Offering appreciation and encouragement where performance is excellent or improving
- Taking account of, and positively encouraging, independent scrutiny of performance, including from governors (for Foundation Trusts), regulators and overview and scrutiny committees
- Rigorous but constructive challenge from all board members, executive and non-executive as corporate board members

'Often the executive team presents a united front on an issue, which does not allow non-executives to get a feel for the divergence of opinion and views behind a recommended way ahead... but open and constructive debate among all board members, equal in status, will ensure that when a decision has been taken, it will in all probability, be the right one.'

J Deffenbaugh[6], 2012

Being accountable for ensuring the organisation operates with openness, transparency and candour

22 The board has an overarching responsibility, through its leadership and oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with patients and the public.

23 The board, itself, will be held to account by a wide range of stakeholders, for the overall effectiveness and performance of the organisation that it oversees, and the extent to which the board and the organisation operates with openness, transparency and candour. The approach to engagement of key stakeholders is described in the Engagement section.

24 One key part of this accountability includes the need for the board to ensure that published figures on all aspects of the quality of care are accurate and provide an honest and fair account to commissioners, regulators, patients and the public (see section on Intelligence for more information).

25 Boards of health and care providers will also need to be assured that the organisation is complying with the contractual duty of candour,[7] which requires providers to inform people if they believe treatment or care has caused death or serious injury.

26 Boards have a role in creating the culture which supports open dialogue. This should include directors personally listening to complaints, concerns and suggestions from patients and staff, and being seen to act on them fairly.

27 To complement this, boards need to be assured that there is a clear 'Assurance and Escalation Framework'[4] which lays out how to escalate issues and risks. Are staff clear about what they can escalate and how they should raise their concerns? Is this included in induction and training for staff? A good framework will provide clarity about how staff can raise concerns about:

- The impact of cost improvement plans on the quality of care
- Exception reporting of incidents to the board
- Identification of data quality concerns
- Early warning triggers in relation to workforce, finance and clinical services

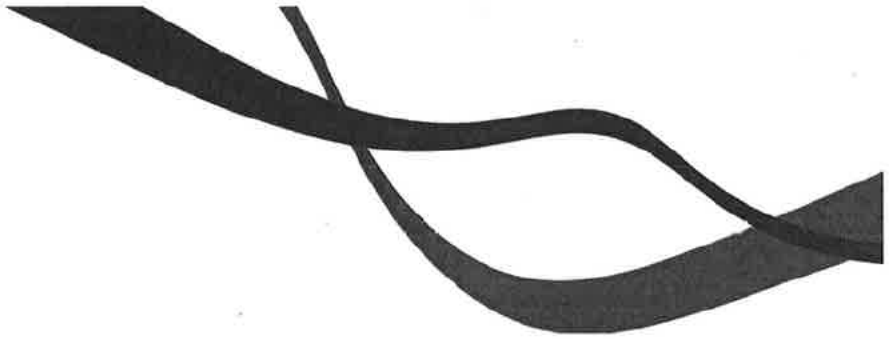
28 A key element is ensuring that there is a clear whistle blowing policy, with support and protection for bona fide whistle blowers. The right to raise concerns should be reflected in staff contracts. Boards, through their remuneration committees, must be assured that any compromise agreements do not stop staff speaking out on matters of public interest.[8]

29 These responsibilities permeate all aspects of the leadership role of the board, including the approach taken to ensuring accountability and to shaping culture (see Culture section).

Seeking assurance that the systems of control are robust and reliable

30 This third aspect of accountability has eight elements:

- Quality governance
- Financial stewardship
- Risk management
- Legality
- Decision-making
- Probity
- Information governance
- Corporate Trustee



Quality governance

A US and equivalent English study found boards of directors of English hospitals to be far more expert and engaged in quality issues than their US counterparts, but that both US and English board chairs tend to greatly overestimate the quality performance of the hospitals they oversee.[3,10]

31 NHS organisations (providers and commissioners) have a statutory duty to secure continuous improvement of quality[11] and in practice this will be the responsibility of the board. If the board is effectively to deliver its ultimate accountability for safeguarding the quality of care received by patients it needs to give robust, systematic and consistent attention to the three key facets of quality: effectiveness and outcomes; patient safety and patient experience.

32 The board needs to become both a nurturing and driving force for continuous quality improvement across the full range of services both within the organisation and in an effective partnership with commissioners and providers along the whole patient journey.

33 It is the responsibility of the board to set and monitor fundamental standards of care. Boards are accountable to external inspectors and regulators for the quality and safety of the care provided, and are required to endorse and sign off declarations to regulators. However the board's own assurance needs to be drawn from robust internal monitoring rather than relying on reports to or from external regulators and inspectors.

34 There needs to be a clear chain of delegation that cascades accountability for delivering quality performance from the board to the point of care, ensuring that robust quality intelligence then flows back to the board.

35 Quality should be a core part of main board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions. The board needs to consider quality, finance and performance decisions in the round, including a full understanding of the quality impacts of initiatives or significant service changes.

36 Boards should regularly review a quality report, including a dashboard which provides both quantitative and qualitative data at the right level of detail. The quality report should provide information in all three facets of quality. Information provided in quality reports should be clear, comparative, accurate and recent enough to be relevant. The research finding cited in the box to the left, emphasises the importance of boards being realistic about the quality performance of their organisation.

37 Boards will wish to ensure that clinical leaders are properly empowered to lead on issues relating to clinical quality. Boards benefit from regular opportunities both to take advice from clinical leaders and to reflect on ways they encourage innovative practice in relation to quality improvement. This includes encouraging managers within the organisation to respond positively to suggestions for improvement from those in clinical roles.

38 Quality performance (including monitoring of actions to maintain and improve performance) and current risks to quality of care (including controls and mitigations) should be systematically identified in the first instance by frontline clinical leaders. These are then escalated for regular, more detailed review by a quality-focused board committee with a stable, regularly attending membership that includes key clinical leaders (see section on board committees).

39 Boards should hold the organisation to account for timely, effective and compassionate complaints handling. Complaints are considered an important source of quality information. Boards also need to ensure that they understand trends and patterns in the substance of complaints.

40 Critically however, boards need to recognise that ensuring accountability in relation to quality is facilitated by more than regular board and committee scrutiny of information on quality - however exemplary. Research[42] suggests that effective quality governance demands that board members actively seek opportunities directly to hear the voice and experience of staff, patients and the public. This means that board members need regularly to step outside of the boardroom to engage directly with the reality on the ground to gain first-hand knowledge of the staff and patient experience in giving and receiving care. For Foundation Trusts, Governors can also offer boards a useful perspective and this should be actively and regularly sought. (See section on engagement).

Financial stewardship

41 The exercise of effective financial stewardship requires that the board assures itself that the organisation is operating effectively, efficiently, economically and with probity in the use of resources. It is also required to ensure that financial reporting and internal control principles are applied, and appropriate relationships with the Trust's internal and external auditors are maintained.

42 In exercising this role, it is important that financial stewardship is seen as underpinning and facilitating the delivery of quality care. This includes a careful assessment and understanding of the quality and patient care consequences of financial decisions.

43 The challenge of balancing effective financial stewardship and effective quality governance is a significant one for boards operating in a financially constrained context. Boards are encouraged to work with staff, patients and commissioners to identify opportunities for reshaping services and improving quality of care which also delivers value for money.

Risk management

44 The role of the board in risk management is twofold.

- Firstly, within the board itself an informed consideration of risk and risk tolerance should underpin organisational strategy, decision-making and the allocation of resources
- Secondly, the board is responsible for ensuring that the organisation has appropriate risk identification and risk management processes in place to deliver the annual business plan and comply with the registration and licensing requirements of key regulators. This includes systematically assessing and managing its risks. These include clinical, financial and corporate risks. For Foundation Trusts, this also includes risks to compliance with the terms of its licence

45 Oversight of effective risk management by the board is underpinned by four interlocking systems of control:

- **The Board Assurance Framework:** This is a document that sets out strategic objectives, identifies risks in relation to each strategic objective along with controls in place and assurances available on their operation. The most effective boards use this as a dynamic tool to drive the board agenda. Formats vary but the framework generally includes:
  - Objective
  - Principal risk and risk owner
  - Key controls
  - Sources of assurance
  - Gaps in control/assurance
  - Action plans for addressing gaps
- **Organisational Risk Management:** Strategic risks are reflected in the Board Assurance Framework. A more detailed operational risk register will be in use within the organisation. The board needs to be assured that an effective risk management approach is working within the organisation, and that the operational and strategic registers do join up. This involves both the design of appropriate processes and ensuring that they are properly embedded into the operations and culture of the organisation

- **Audit:** External and internal auditors play an important independent role in board assurance on internal controls, and form part of the board's second and third lines of defence, providing assurance that Executive systems of control are sufficiently comprehensive and operating effectively. There needs to be a clear line of sight from the Board Assurance Framework and the operational risk register to the programme of internal audit and a demonstrable link to the overall programme of clinical audit. Clinical audit serves as a significant source of assurance of clinical quality
- **The annual governance statement:** This is signed by the chief executive as Accountable Officer and comprehensively sets out the overall organisational approach to internal control. It should be scrutinised by the board to ensure that the assertions within it are supported by a robust body of evidence

46 The approach to risk management and related processes within the organisation need to be systematic and rigorous with risks understood and owned at the right levels. The board's risk oversight work needs to combine assurance over executive risk management processes particularly through the Audit Committee, with attention to hard and soft evidence stemming from other areas of the board's work, and identifying leading indicators that may point to escalating problems. It is crucial that boards stay alert to the reality of what is happening within the organisation. What matters substantively is recognition of, and reaction to, real risks - not unthinking pursuance of bureaucratic processes.

An international consultation in the wake of the financial crisis that began in 2007 suggests widespread failure of risk management was due to disconnection of the risk management system from strategy and other management systems.

'The topic of risk is coming to the fore. Boards of directors are seen as a crucial mechanism through which risks are identified and managed. These include the organisation's risk appetite, risk to the strategy, risk from externalities (for example the Euro crisis), and risk caused by insufficient internal capability.'

Chambers et al.[31]

Legality

47 The board seeks assurance that the organisation is operating within the law and in accordance with its statutory duties. This will include seeking assurance that the organisation's contractual and commercial relationships are honest, legal and regularly monitored.

Decision making

48 The board seeks assurance that processes for operational decision making are robust and are in accordance with agreed schemes of delegation.

Probity

49 The board and its members adheres to the seven principles of public life[13] and to the Standards for NHS Board members.[14] This includes implementing a transparent and explicit approach to the declaration and handling of conflicts of interest. Good practice here includes the maintenance and publication of a register of interest for all board members. Board meeting agendas include an opportunity to declare any conflict at the beginning.

Seven Principles of Public Life	Standards for NHS Board Members
Selflessness	Responsibility
Integrity	Integrity
Objectivity	Respect
Accountability	Professionalism
Openness	Openness
Honesty	Honesty
Leadership	Leadership

50 Another key area in relation to probity relates to the effective oversight of top level remuneration. Boards are expected to adhere to HM Treasury guidance and to document and explain all decisions made.

Information Governance

51 Practising information governance means applying principles of good management and appropriate use to information. It covers all information in the organisation, including personal information (relating to patients/service users, employees and others) and corporate information (e.g. financial and accounting records).

52 Boards have a responsibility to assure themselves that the organisation has implemented adequate policies and procedures, and is addressing the responsibilities and key actions required for effective information governance. Each organisation must have a Senior Information Risk Owner (SIRO) who is effectively supported, and who updates the board regularly on information risk issues.

Corporate trustee

53 If the organisation holds NHS charitable funds as sole corporate trustee, it is jointly responsible for the management and control of those charitable funds and is accountable to the Charity Commission.

54 Some NHS organisations have a separate trustee body which manages the charitable funds linked to the work of the NHS body. Where this applies the NHS organisation does not have responsibility for charitable funds.

Committees of the board that support accountability

55 In order to enable accountability, boards are required to establish committees responsible for **audit** and **remuneration**[15]. Current good practice also recommends a quality-focused committee of the board. Over time NHS organisations have configured board committees in a variety of ways to discharge these functions. For ease of reference, these are described as three core committees which are:

1. **Audit Committee:** This committee's focus is to seek assurance that financial reporting and internal control principles are applied, and to maintain an appropriate relationship with the organisation's auditors, both internal and external. The Audit Committee offers advice to the board about the reliability and robustness of the processes of internal control. This includes the power to review any other committees' work, including in relation to quality, and to provide assurance to the board with regard to internal controls. The Audit Committee may also have responsibility for the oversight of risk management, although some Trusts have established a separate Risk Committee. The committee should be positioned as an independent source of assurance to the board and guard its independence. Ultimately however the responsibility for effective stewardship of the organisation belongs to the board as a whole.
2. **Remuneration Committee:** The duties of this committee are to determine the remuneration and terms of service for the chief executive and other executive directors, as delegated to the committee by the board; to monitor and evaluate the performance of the executive directors and to oversee contractual arrangements, including proper calculation and scrutiny of termination payments and terms. The remuneration committee should take into account relevant nationally determined parameters on pay, pensions and compensation payments. No director should be involved in deciding his/her own remuneration. The committee may additionally have a role in succession planning for executive level roles.

Quality Committee: The ultimate accountability for quality rests with the board. However recent good practice recommends the establishment of a quality-focused board committee as a means of enhancing board oversight of quality performance and risk by ensuring input from people with particular quality expertise and responsibility for frontline clinical leadership.

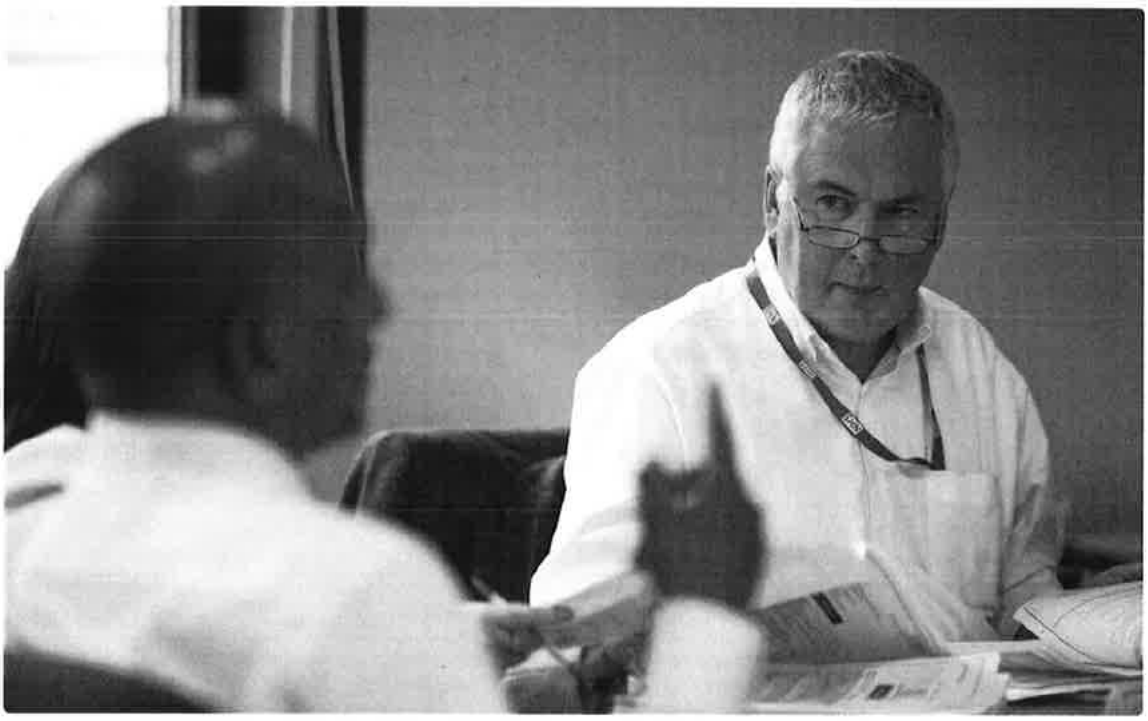
This committee offers scrutiny to ensure that required standards are achieved and that action is taken where sub-standard performance is identified. It seeks assurance that the organisational systems and processes in relation to quality are robust and well-embedded so that priority is given, at the appropriate level within the organisation, to identifying and managing risks to the quality of care.

56 All board committees normally have a non-executive chair. Audit Committee members are all non-executive directors with executives in attendance as appropriate for the work being done. At least one member of the Audit Committee must have a recent and relevant financial background. Checks and balances need to be maintained in committee membership. So, for example, the board chair cannot be a member of the Audit Committee (and should not regularly attend it), nor can the Audit Committee chair be the senior independent director. Good practice suggests that the vice chair of the organisation should not chair the Audit Committee in order to avoid potential conflicts of interest.

57 Effective boards minimise the number of standing board committees. However, boards may establish other committees. Examples include finance and investment committees, risk committees[16], people strategy committees and charitable funds committees. Some FTs have also extended the remit of remuneration committees to become nomination and remuneration committees.

'Committees (are established) only to help the board do its job.'

John Carver



Roles of the board

3 Shape culture

58 The third core role of the board is shaping a healthy culture for the board and the organisation. This recognises that good governance flows from a shared ethos or culture, as well as from systems and structures. The board also takes the lead in establishing, modelling and promoting values and standards of conduct for the organisation and its staff.

59 There is now widespread recognition that the board does indeed have a key role in shaping the culture of a healthcare organisation.

60 It is important for boards to develop a good understanding of the current values, behaviours and attitudes operating within the organisation, and to work with the staff to shape the desired values, behaviours and attitudes. The challenge then is how to achieve change.

61 What we do know is that the 'how' is less about exhorting the adoption of a culture, and more about leaders of organisations being mindful of the cultural messages that they send, intentionally or passively. For example: by the board's agenda; by the nature of the debate in the board; by the relative emphasis given to different performance criteria; by how visible board members are in the organisation; by where leaders choose to invest time and resource. All of these things are culture-shaping activities.

62 We also know that how to achieve change includes an active process of dialogue and engagement with staff and service users. These ideas are developed further below.

63 The extent to which common aspects of 'culture' can be defined, identified and then deliberately changed is hotly contested within the literature on organisational culture. There is however some consensus about the value of encouraging explicit and open exploration of 'culture' at every level and in every corner of organisations. Boards have a key role in prioritising, valuing and supporting this work within the organisation.

> *'We would do well... to be cautious about the idea of cultural uniformity and be sceptical that top down prescriptions will bring about the desired changes. Instead the emphasis needs to be on careful nurturing, reaching for gardening metaphors in place of those rooted in ideas of engineering. Local contexts provide for organic, home-grown approaches that are sensitive to local histories and pre-occupations and real change requires detailed and sustained work on the ground.'*
>
> **Davies and Manion, BMJ[17]**

Shaping organisational culture

64 Effective boards shape a culture for the organisation which is caring, ambitious, self-directed, nimble, responsive, inclusive and encourages innovation. A commitment to openness, transparency and candour means that boards are more likely to give priority to the organisation's relationship and reputation with patients, the public and partners as the primary means by which it meets policy and/or regulatory requirements. As such it holds the interest of patients and communities at its heart.

- **Openness:** enabling concerns to be raised and disclosed freely without fear and for questions to be answered
- **Transparency:** allowing true information about performance and outcomes to be shared with staff, patients and the public
- **Candour:** ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it

Source: Second Francis Inquiry Report[3]

65 Boards need to recognise the importance of ensuring that the culture of their organisation reflects the NHS values, as defined in the NHS Constitution. These are:

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

66 If shaping the culture of the organisation is a vital role for boards, then embedding the culture, so that it becomes a lived reality, is equally important and arguably the most challenging part of the role.

'The cultural challenge faced by the NHS has been talked about in many ways. The key is that boards and leaders need to create environments where staff feel supported to cope with the day to day risks and challenges of health and care work. This also enables openness: mistakes will sometimes happen - staff need to know it is safe to admit them. It also enables compassion: under stress, anyone can find it hard to be caring - staff need to know it is safe to ask for support they need to really be there for patients.'

Patients First and Foremost, Department of Health[18]

'Individuals suffering from burnout may find it more difficult to feel compassion. And yet staff with higher levels of empathy are less likely to suffer from burnout. The problem that lack of compassion creates for patients is obvious, but there is also a cost for staff, who cut themselves off from feelings from which empathy and compassion could flow - especially important as, with support, higher empathy is related to lower stress.'

Schwartz Centre Rounds, Evaluation of the UK Pilot, Kings Fund[19]

67 Embedding a healthy culture across an organisation requires sustained effort and consistency of approach, often over a number of years. International research provides some helpful points on how boards can play a role in achieving desired culture change in a health context.

Culture and Innovation:

Research in the UK, in the NHS and in industry[12], has demonstrated that boards have a responsibility to embed innovation in the organisation's culture. Innovation friendly organisations have decentralised but clearly defined structures, which encourage frontline and managerial staff to innovate by allowing them freedom to make their own decision and take risks (but not at the expense of safety). Their boards avoid a top-down, rule driven approach, but do monitor, evaluate and learn. These boards actively support innovation and innovators.

Culture and Compassion:

Schwartz Centre Rounds[19] provide a forum for staff across a healthcare organisation to come together once a month to explore together the challenging psychosocial and emotional aspects of caring for patients. An independent evaluation of the Rounds showed that they have benefited both individuals and teams and have influenced hospital culture.

'Hospitals that are rated highly for patient-centred care have certain characteristics in common, one of which is 'care for the caregivers through a supportive work environment that... treats them with the same dignity and respect that they are expected to show patients and families.'

Schwartz Centre Rounds, Evaluation of the UK Pilots, King's Fund[19]

An approach to shaping culture

68 Boards should consider adopting a culture shaping process that involves active but focused dialogue and engagement with staff and service users. This approach has a great deal to offer NHS boards as they seek to shape organisational culture and, in turn, use their learning from staff and user experience to set strategy and ensure accountability.

69 As boards undertake their strategy development role, this approach could involve interactive engagement with key stakeholders, staff, members and patients, at key stages in the strategy development process. It ensures that the board as a whole is listening, learning and shaping, rather than just receiving draft strategies for approval. It is more likely to achieve a viable and responsive direction, build commitment and buy in, enrich board discussion and challenge board 'group think'.

70 Similarly, when ensuring accountability, a more interactive style of governance could move beyond paper reporting. Examples could include patient safety walk rounds, hearing patient stories at the board and staff focus groups.

71 While the importance of board visibility in the organisation has long been recognised, a more interactive process allows board members, staff and users to shape organisational values and culture through direct engagement. It also ensures that board members take back to the boardroom an enriched understanding of the lived reality for staff, users and partners.

'There has been considerable support at board level. Non-executives are committed to one or two of them attending each round. They want to understand the inhibitors to staff doing what they should.'

Schwartz Centre Rounds Evaluation[19]

Board's role in exemplifying and modelling culture

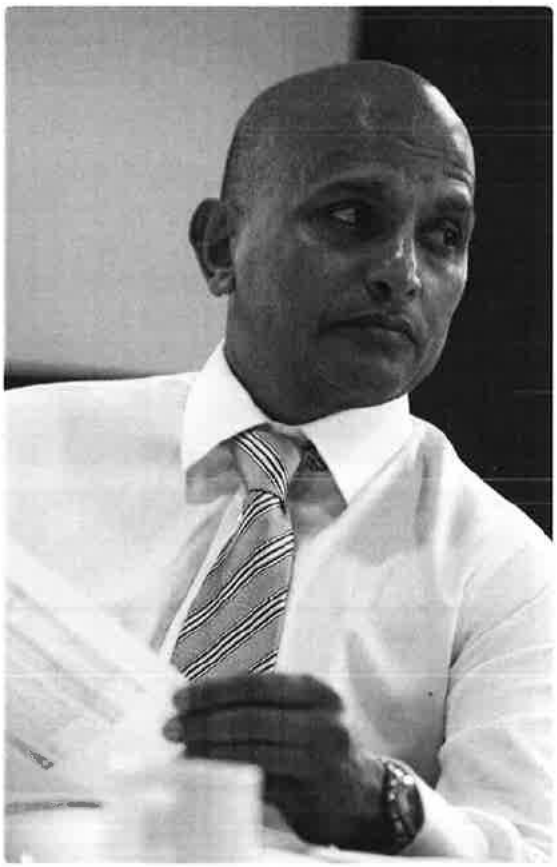
72 An outward looking board leadership culture that actively embraces change, fosters innovation, encourages learning and maintains an unswerving commitment to quality and safety of patients offers the best prospect of navigating effectively through a demanding and rapidly changing environment.

73 The board needs to be seen as champions of these values in the way the board itself operates and behaves. There are a number of facets to this. Effective boards and their members:

- Prioritise quality and patient safety
- Behave consistently in line with the seven principles of public life
- Model an open approach to learning
- Invest time to develop constructive relationships around the board table
- Reflect a drive to challenge discrimination, promote equality, diversity, equity of access and quality of services. They respect and protect human rights in the treatment of staff, patients, their families and carers, and the wider community
- Ensure that their approach to strategy, accountability and engagement are consistent with the values they seek to promote for the organisation

'The emphasis on being open to different ways of thinking encourages a learning culture, creating a system which positively seeks out new ideas and approaches with fruitful results.'

From a Canadian study of cross-sector alliances in Healthcare cited in Welbourn et al.[20]



3 Building blocks

1 Context

74 The first building block requires that boards have a comprehensive and up to date understanding of the changing external national and regional context in which they operate.

75 While many of the fundamental principles of good governance are common across a range of different types of organisations (both private and public sector), the complexity of the statutory, accountability and organisational context in which NHS boards operate is a key difference that must be fully understood by all board members. Boards operate in a demanding and changing environment. Some of these challenges are illustrated here Figure 3.

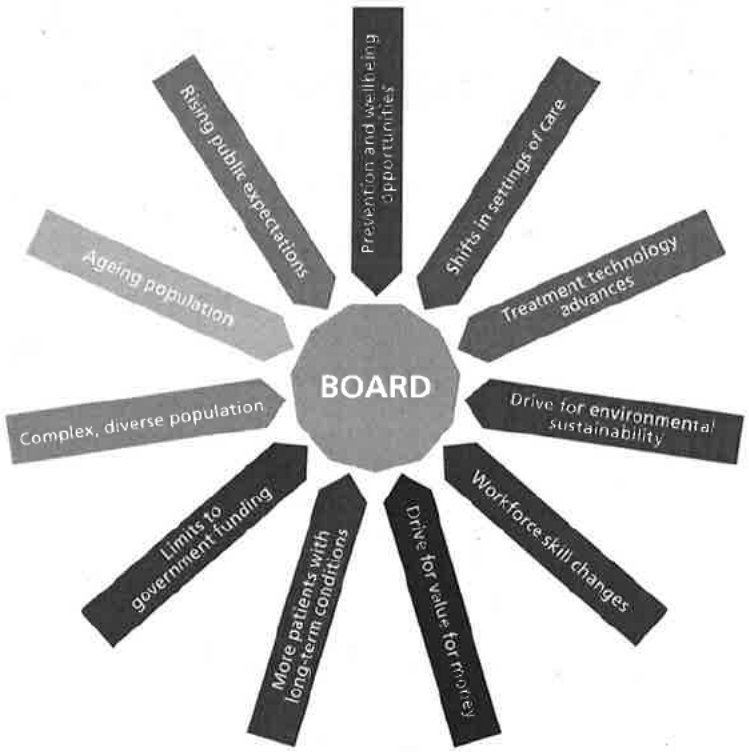


Figure 3: Challenges on NHS boards

76 The areas that boards will need to consider when developing an understanding of context are set out below:

77 **Policy:** It is important for boards to have a good understanding of the current and emerging policy direction, and the strategies for the NHS and its key partners.

78 **Economy:** Boards need to be aware of information on the economic environment for public services, and the wider economy. This assists boards in understanding the implications for future funding as well as the potential impact of economic changes on the health of the public, and the demand for health services.

79 **Legislation:** NHS bodies are subject to a wide range of legislation, from central government and from the European Union. This includes statutes, regulations and a variety of directives and Secretary of State directions.

80 **Institutional landscape:** An understanding of the structures and institutions of the NHS and those with whom the NHS does business is essential for boards to undertake their role effectively. This includes central and local government and other public and voluntary services which contribute to health and well-being.

81 **Regulation:** NHS bodies are subject to oversight from several regulators. Developing a good understanding of the most significant regulators and their requirements and expectations of NHS bodies will greatly assist boards as they steer the organisation.

82 **Public expectations:** Expectations of all public services are rising; arguably this is most pronounced in relation to the NHS. Even the most stretching national targets and standards have struggled to keep pace with mounting public expectations. The most effective NHS boards energetically develop their own understanding of trends in public and patient expectation and ensure that this actively informs their strategic choices.

83 **An understanding of the wider determinants of health status:** It is important for boards to develop an understanding of the wide range of factors that impact on health status. These include poor housing, neighbourhood deprivation, limited employment and educational opportunities, as well as the effects of affluence. This understanding helps inform the board's strategic response and shapes its whole system and partnership working.

2 Intelligence

84 Intelligence is the second key building block. It includes performance information, which can be both quantitative (such as performance metrics) and qualitative (such as staff, patient and stakeholder perspectives). It also includes information on the external local environment.

85 Boards need to be provided with information that is timely, reliable, comprehensive and suitable for board use. The Intelligent Board series[21,22,23,24,25,26] continues to offer excellent guidance to boards, and some of the key elements of this advice are summarised below. However, guidance can never be a substitute for discussion in the board aimed at evaluating the usefulness of current intelligence and shaping future intelligence requirements.

86 Intelligence that boards need to consider falls under two headings:

- Performance information including information about quality, finance and staffing
- Intelligence on the external local environment

Performance information

87 This describes how the organisation is performing both strategically and operationally. The key requirement here is that the intelligence:

- Allows the board to arrive at sound judgments about organisational performance in the delivery of strategy
- Allows the board to scrutinise operational performance 'in the round' - bringing together its appraisal of organisational performance in relation to operational activity, quality, finance and the workforce

> 'Multiple sources of data, and a capacity and willingness to explore contradictions in these, are prerequisites for openness to learning.'
>
> **Mannion et al., Open University Press[17,27]**

88 Intelligence about **strategic performance** needs to:

- Be structured around an explicit set of strategic goals
- Show trends in performance in terms of quality, including treatment outcomes and the experience and satisfaction of patients; business development; and finance
- Provide forecasts and anticipate future performance issues
- Encourage an external focus
- Enable comparison with the performance of similar organisations, including internationally, for example through benchmarking

89 Intelligence about **operational performance** needs to:

- Provide an accurate, timely and balanced picture of current and recent performance - including patient, clinical, regulatory, staffing and financial perspectives
- Focus on the most important measures of performance, and highlight exceptions
- Be appropriately standardised in order to take account of known factors that affect outcomes, such as the age and deprivation profile of patients and communities served
- Integrate informal sources of intelligence from staff and patients
- Include consideration of assessments from key regulators including comparator information
- Enable comparisons with the performance of similar organisations
- Include key indicators in relation to a People Strategy, including:
  - workforce capacity and capability to deliver future strategy
  - intelligence on values, behaviours and attitudes
  - key HR health indicators, including information in equality and diversity
  - performance appraisal, training and development
  - leadership and management development, including talent mapping

'There is a spiral of positivity in the best performing NHS trusts. The extent to which staff are committed to their organisations and to which they recommend their trust as a place to receive treatment and to work is strongly related to patient outcomes and patient satisfaction. Climates of trust and respect characterise these top performing trusts.'

West and Dawson, NHS Staff Management and Health Service Quality[30]

Focus on Quality

90 Quality is the organising principle of the NHS and needs to be at the front of the board's mind in everything the board does.

91 While significant progress has been made in shaping and sharpening the finance and activity information generally available to boards, progress has been slower in relation to information that will allow boards to scrutinise the 'quality' of services. Quality accounts should become at least as important as financial statements for boards and be seen as a key opportunity for the board to provide the public with an open and comprehensive account of the quality of care. As such they should include a balanced account both of achievements and instances where compliance with commissioned/expected standards has not been achieved and what is being done to expedite improvement.

92 Quality comprises three dimensions:

- Clinical effectiveness or patient outcomes
- Patient safety
- Quality of the patient experience

93 As with other organisational priorities, boards should receive this information in an easily digested summary. The closer the data is to 'real time' the greater its value.

Intelligence on the external local environment

94 In the previous section on context, the emphasis was on ensuring that boards have a good grasp of the national context for health and social care. Intelligence on the **local** environment is also critical and should be as important to boards as performance information. It includes:

- **Stakeholder mapping:** One of the key challenges facing NHS boards is the complex stakeholder and accountability landscape. Boards need to have a clear grasp of the entire system within which they operate. This includes an understanding of who the key local stakeholders are, their agendas, priorities and perspectives. For Foundation Trust boards, this includes developing a good understanding of governor and member perspectives
- **Market analysis:** Likewise it is important for boards to build their understanding of the local market and the place that the organisation wishes to occupy within it

In an increasingly competitive market, boards need to keep abreast of their competitors (other NHS organisations, independent providers and the voluntary sector), including an understanding of their relative strengths and weaknesses. Considering comparative benchmarks about performance, especially on quality measures, is of strategic importance.

Market analysis can also inform potential integrated care pathways.

- **Health need and demography including diversity and equality issues.** Although these aspects are generally considered to be particularly important for commissioners, this understanding is critical in informing strategic processes for providers and in ensuring that provider boards are able to forge constructive collaborative relationships in the local health and social care economy. It includes intelligence to assist boards to understand the local population, its demographic and health profile, particularly health status, healthcare needs, behaviours and aspirations; and the key equality gaps experienced by different groups within the community, both in relation to each other and compared to similar groups in other localities. This aspect of intelligence should be based on shared analysis and monitoring with local government as well as commissioners

95 Board members have a key role to play in actively shaping and designing the sort of intelligence they wish to receive.

96 The research evidence supports the view that the provision of too much or too little information can be a significant risk to a board functioning effectively, so the key is to strike a balance between providing sufficient and meaningful information in an easily digestible format without overloading board members.

97 **A final, and important, thought on intelligence:** There is an increasing recognition that paper-based (or even tablet-based) intelligence can only take the board so far. The Board needs to ensure that it operates on the basis of a sophisticated blend between soft and hard intelligence. Direct interaction between the board and key stakeholders, including staff, provides this soft intelligence and underpins the development of strategy, it gives 'texture' to ensuring accountability and shapes a culture of openness and dialogue within the organisation. This brings us to the third key building block: engagement

3 Engagement

98 The effective board gives priority to engaging with key stakeholders and opinion formers within and beyond the organisation. Engaging effectively is vital for the board and the organisation to demonstrate its openness, transparency and accountability. There are also some circumstances where involving the public is underpinned by a legal obligation.[28]

99 Engagement informs and supports the board in creatively formulating strategy, shaping culture, and in key aspects of ensuring accountability. The range of internal and external stakeholders with which boards engage includes:

- Patients and the public.
- Members and governors (for Foundation Trusts).
- Staff from all disciplines across the organisation.
- Key partners in the wider health and social care system.

100 Engagement with staff, patients, the public and stakeholders is not new, and has long been a priority of senior leaders in NHS organisations. Boards as a whole generally receive and consider the results of these processes in the form of reports and papers.

101 Research has identified the role that direct interaction between the board and staff, patients, the public and key partners plays in effective governance.

Patient and public engagement

102 A wide range of guidance is available for boards on patient and public engagement. There are three main aspects for boards to consider:

- **Empowering people:** Patients and the public want to be able to influence the priorities of the organisations that provide healthcare. They also have the right to play a full and active part in decisions regarding their own care. Boards play an important role in setting an organisational expectation that clinical staff will actively engage patients in shared decision-making
- **Putting patient experience centre stage:** Organisations need to ensure the routine, systematic collection and analysis of feedback from people who use services, including real-time patient feedback and an understanding of the perspectives of minority and hard to reach groups. Crucially, boards need to demonstrate that this feedback, alongside intelligence on effectiveness and patient safety, actively informs board priority setting, resource allocation and decision-making. Boards benefit most from an approach that blends direct engagement with patients and their carers, the views reflected by HealthWatch and consideration of reports and papers
- **Accountability to local communities:** The organisation, and therefore the board, has a statutory 'duty to involve'.[28] In addition, the organisation exercises its local accountability through overview and scrutiny arrangements led by local government

Members and governors (for Foundation Trusts)

103 Boards of Foundation Trusts need to recognise that the autonomy and freedoms granted to them in this model rest, in large part, on effective accountability to patients and the public. This is delivered by maintaining an open and accountable relationship with governors who, in turn, engage effectively with an active membership reflective of the patients and public served by the organisation and the staff who serve them.

104 If governors are to exercise this aspect of their role effectively, they require regular and meaningful engagement with the board. Governors need to be trained and supported to work effectively with directors and to engage with the members and the wider public so that they can contribute these wider perspectives and expectations in their discussions with the board. Indeed, the provision of sufficient training to Governors is now a statutory duty.

105 This demands effort and commitment from directors, who need to demonstrate that they value the governors' contribution to the Trust. The chair is integral to developing this professional, engaged and constructive mind-set, and ensuring that directors also receive development to work effectively with governors.

'We have done a lot of work in trying to improve relationships between non-executive directors and governors. This has included setting clear expectations in job descriptions and the recruitment process that NEDs are expected to work positively with the FT governance model, and are prepared to give enough time for this.'

Foundation Trust Chair, Healthy NHS Board Consultation

Staff

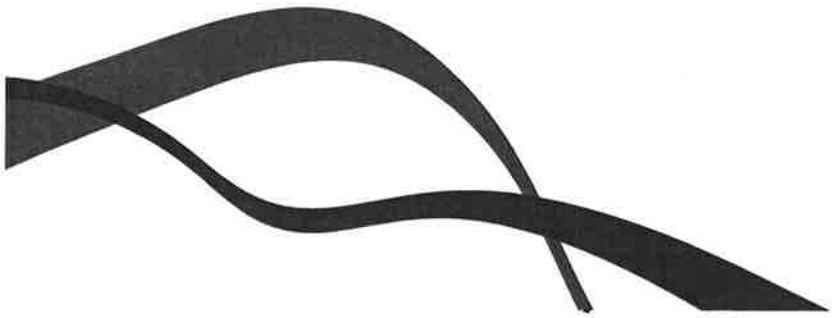
106 Engagement with staff, is a vital means by which the organisation's leaders shape organisational culture. It can help boards drive culture change, for example in encouraging staff to feed into the risk management system and actively engage in quality improvement. Boards should be alert to possible differences in culture between shifts, wards and departments and what that might indicate.

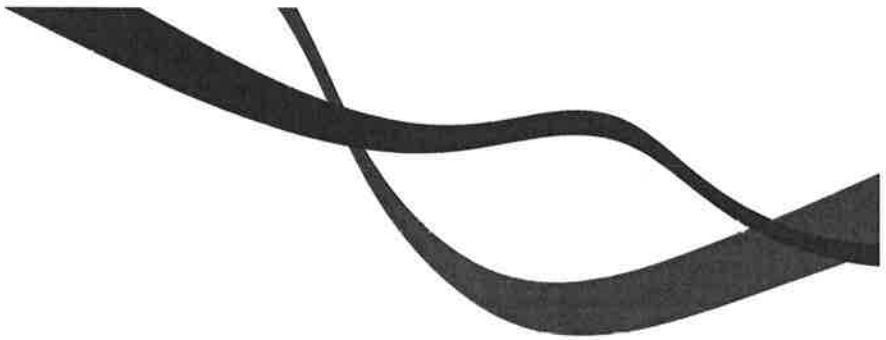
107 A review[29] of how best to engage staff suggests that use of established approaches, such as surveys seeking staff opinion, are an important but not sufficient approach as they can leave engagement as an 'add-on'. Ideally, boards should aim to achieve 'transformational engagement', staff are given space to reflect and discuss improvements and see themselves as integral to developing and delivering departmental and organisational strategy. Boards can project a 'human face of leadership', fostering trust and respect, through direct engagement including holding 'Question Time' style events and participating in web-chats. For Foundation Trusts, staff governors are an important conduit for staff engagement.

108 Clinicians might be engaged to lead improvement and innovation work as 'change agents'; to provide input and leadership on quality committees; and as a key source of 'wisdom' in an engaging approach to governance.

'Trusts with higher levels of staff engagement deliver services of higher quality and perform better financially, as rated by the Care Quality Commission. They have higher patient satisfaction scores and lower staff absenteeism. They have consistently lower patient mortality rates than other trusts.'

West and Dawson, NHS Staff Management and Health Service Quality[30]





Key Partners

109 NHS boards exist within a crowded organisational landscape that includes a range of public, private and community organisations all serving broadly the same citizens. To deliver their core purpose of building public and stakeholder confidence in health and healthcare, NHS boards need to see beyond the boundaries of their individual organisations. This delicate balance involves operating within a 'community of governance' while simultaneously respecting divergent interests in a vibrant market.

110 In a financially constrained environment this becomes particularly pertinent, as boards consider options for strategic partnerships, joint management arrangements, outsourcing, major service reconfigurations, and potential mergers. But whatever the economic environment, the need to develop an effective community of governance is important because:

- Patients and users travel across organisational boundaries to receive services and tend to see the NHS as one organisation
- Approaches to health improvement and prevention, as well as tackling health inequalities can only be addressed by taking a holistic health and social care economy perspective
- Health and social care organisations at the local level share responsibility for ensuring that patients and the public get the very best value for the taxpayer resources invested
- NHS organisations and other public bodies have a legal duty to co-operate on improving local health outcomes

111 The health and social care system in England relies on a complex interplay between collaboration and competition. Boards need to reach finely balanced judgments about how they engage with this complexity.

112 The public interest is best served when all the main actors in the system reach agreement about:

- Local health need
- A shared vision for health and healthcare including health outcomes
- The 'rules of the compact' - how players within the system will work together, including the development of a culture of co-operative transparency
- Mutual understanding of, and respect for, individual organisational interests and constraints

113 This shared understanding and agreement can only be reached through regular and ongoing processes of formal and informal dialogue and relationship building. Both chair and chief executive play an important role in shaping the climate for inter-organisational engagement and in keeping lines of communication open - especially at times when negotiations may have strained relationships within their organisations. A regular cycle of whole 'board to board' processes has proved valuable in many health economies. The joint production of an annual health system development plan could also be valuable.

114 Boards are therefore advised to develop a coherent strategy for engagement with key partners. These include commissioners, NHS providers, local government, universities and further education, the voluntary sector, independent sector and of course regulators.

115 Although this stakeholder engagement is most often led by the chair and chief executive, it must form part of a systematic and agreed approach that encourages other directors and a wide range of other leaders in the organisation to be empowered to engage across organisational boundaries, informed by a shared vision and clear messages.

116 A number of boards choose to hold 'board to board' meetings with key partners. Properly focused, this can be an important part of building understanding of, and relationships with, stakeholders.

117 Ultimately however, public and stakeholder perceptions can be very significantly shaped by media messaging. The Board's engagement strategy will need to include attention to effective media management, particularly in relation to the local press.

4 Improving board effectiveness

This chapter sets out the approaches to improving board effectiveness.

118 This chapter sets out five important clusters of activity that enable boards to improve their effectiveness, shown in figure 4:

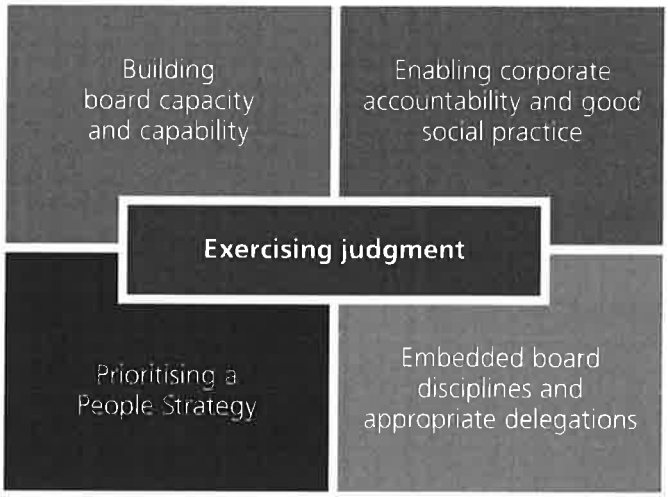


Figure 4: Building board effectiveness

1 Building board capacity and capability

119 This involves activity in the four areas shown in the table below:

Areas of board capacity and capability building
Board composition, knowledge and skills
Whole board and individual board member performance appraisal
Systematic attention to board learning and development
Appointment and remuneration of board members

Board composition, knowledge and skills

120 NHS boards should not be so large as to be unwieldy, but must be large enough to provide the balance of skills and experience that is appropriate for the organisation. The number of directors is defined in the Trust's establishment order, or in an Foundation Trust's constitution. The composition of the board should achieve a balance between continuity and renewal. Chairs and non-executive directors (NEDs) of NHS Trusts serve a maximum of 10 years in the same NHS post (or two 3 year terms for Foundation Trusts) to ensure this balance. Within this period, any second reappointment must be through open competition.

> 'The benefits accrued by larger boards, particularly in relation to increased monitoring are outweighed by higher agency costs, informational asymmetry, communication and decision-making problems.'
>
> **Chambers et al., Towards a Framework for Enhancing the Performance of NHS Boards[31]**

121 In most NHS organisations, governance is the responsibility of a unitary board, with at least half the board, excluding the chair, made up of independent NEDs.

122 The time commitment required of non-executive directors continues to be a focus of debate. Non-executive directors should be encouraged to look at their time requirements over an annual cycle. There will be a number of situations where more time is required than on average. This includes the first year after appointment, through the Foundation Trust application process and when the organisation is considering major strategic changes. All directors must be appropriately qualified to discharge their roles effectively, including setting strategy, monitoring and managing performance and nurturing continuous quality improvement. There is a growing emphasis on the importance of ensuring that prospective directors bring both the appropriate skills and a demonstrable commitment to NHS values - and the behaviours that these imply. Over time the strategic challenges facing boards give rise to the need for specific skills, and this requirement must be kept under review in a systematic way. In order to ensure an effective balance of knowledge, skills and backgrounds boards should undertake regular skills audits of current board members. Good practice suggests that this account of board member skills and experience as well as a clear annual board statement about its own balance, completeness and appropriateness to the requirements of it, should be available on the organisation's website.

'There should be a requirement that all Directors of bodies registered with the Care Quality Commission as well as Monitor for Foundation Trusts, are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.'

Second Francis Inquiry on Mid Staffordshire[3]

123 Guidance and research suggests that organisations are best served by boards drawn from a wide diversity of backgrounds and sectors. This includes the expectation that board composition reflects the diverse communities they serve.

'Recent research identified a tendency to 'opaque and subjective' board appointment processes. To counteract this the recommendations include proactively putting diversity on the agenda in the recruitment process, focussing more on underlying competencies than prior experience, creatively expanding the talent pool and offering support through the appointment process.'

Chambers et al.[29]

Whole board and individual board member performance appraisal

124 It is important that the whole board creates opportunities to reflect on its own performance and effectiveness. This should include a formal and rigorous annual evaluation of its own performance and that of its committees. Some boards choose to supplement self-assessment periodically with views obtained from a range of internal and external stakeholders who do not sit on the board but nonetheless experience its impact. This could include leading clinicians, senior managers who are not board members and external partners and stakeholders including patient groups and partner organisations both within and outside of the NHS.

125 It is important for boards to develop a framework of knowledge, skills and competencies that fit their organisational requirements and context and that can serve as the basis for whole board and board member appraisal.

126 Alongside whole board performance evaluation, board members should undergo an annual appraisal of their individual contribution and performance. This appraisal should focus on the director's contribution as a member of the corporate board; in the case of executive directors (EDs) this is distinct from their functional leadership role. The appraisal of the chief executive ('CE') by the chair is particularly important because the effective performance management of the CE is critical to the success of the organisation and sets the benchmark for other senior NHS managers. In a unitary board setting this is particularly necessary. Responsibilities for carrying out these appraisals are:

Role	Is appraised by
Chair (non Foundation Trusts)	NHS Trust Development Agency (NTDA)
Chair (in Foundation Trusts)	Senior independent director, drawing on the views and perspectives of Governors, fellow Directors, and key partners
Chief executive	Chair
NEDs	Chair
EDs	Chief executive with input from the chair on their contribution as a member of the board

127 A growing number of NHS boards are choosing to support the development of individual board members by undertaking a '360 degree review'. This offers board members feedback on their approach, performance and contribution from a wide range of colleagues with whom they have regular contact. This can be very helpful, though experience shows that it requires time and commitment from all board members. It must also be undertaken in a manner that respects and protects confidentiality and trust within the board. The whole process - especially individual feedback needs to be handled independently and professionally. 360 degree review approaches are intended to support individual development rather than to inform re-appointment.

128 All appraisal processes should culminate in a personal development plan, the delivery of which is actively supported by the organisation.

Systematic attention to board learning and development

129 Effective boards use the performance appraisal processes outlined above as the basis for focused board development action plans. The plan should include:

- **A structured process for induction of new board members.** This is an opportunity to attend to board members' understanding of local and - especially if they are new to the NHS - national context. Mentoring by more experienced board members can also be helpful and build relationships quickly
- **Individual board member opportunities to refresh and update skills and knowledge.** Conferences and similar events are likely to be very helpful. Organisations should ensure that board members are aware of relevant development opportunities and that new policy and contextual knowledge is systematically shared with board members, including through informal briefings between board meetings
- **Opportunities for the board to learn together.** Board development should not be limited to externally provided development events and conferences. These are valuable events, especially for the transmission of knowledge and information, but carving out time for the whole board to learn together is valuable. This is particularly true when exploring the applicability of new or innovative ways of working in the board, or when developing new skills and capabilities, for example new developments in quality improvement

'High performing hospitals and those with better performance in processes often have...greater expertise and formal training in quality.'

Chambers et al.[29]

'Those Boards that have made most sense of their own strategic goals and how to deliver them, and thereby achieved some distinctiveness and locally meaningful effectiveness have done so through dialogue'

Storey et al., The intended and unintended outcomes of new governance arrangements within the NHS[32]

130 **Opportunities to learn good practice from peers.** Board are encouraged to identify opportunities to network with and learn from peers within and beyond the health and social care system.

131 **Foundation Trust boards should give particular attention to supporting the development of governors.** Careful and comprehensive induction is critical. Foundation Trusts have a responsibility to ensure that governors have the skills and capability to deliver their core statutory functions[1,33]. Governors also need to be supported to build their skills and capacity to engage with their 'constituencies' in order to deliver and be accountable for their role.

132 **Support for chairs, chief executives and directors in challenging roles needs particular attention.** It should be clear to board members during the appointment process, if the posts are deemed challenging. Experienced directors should be appointed to these roles, and additional development support clearly agreed and put in place from an early stage.

Appointment and remuneration of board members

133 Formal, rigorous and transparent procedures for both the appointment and the remuneration of directors must be in place.

134 The appointments process must ensure that all appointments are made on merit and against objective criteria. Appointments panels for executives should always include an independent external assessor. Responsibilities for these appointments are summarised in the following table.

Role	In FTs is appointed by	In other organisations is appointed by
Chair	Governors, at a general meeting, informed by the nominations committee and/or governors working group, after taking account of advice of the board of directors	NHS Trust Development Authority ('NHS TDA') on behalf of the Secretary of State ('SoS')
Chief executive	Committee of the chair and NEDs, approved by the governors	Committee of the chair and NEDs with the NHS TDA and an independent external assessor, approved by the board
NEDs	Governors, at a general meeting, informed by the nominations committee and/or governors working group, after taking account of advice of the board of directors	NHS TDA on behalf of the SoS
EDs	Committee of the chair, chief executive and NEDs	Committee of the chair, chief executive and NEDs with the NHS TDA and an independent external assessor

135 Likewise, the responsibilities for setting remuneration are shown in the following table

Role	In FTs remuneration is decided by	In other organisations remuneration is decided by
Chair	Governors' at a general meeting, informed by the Nominations/ Remuneration Committee or a governors working group	SoS with advice from the NHS TDA
Chief executive	Remuneration committee of at least three independent non-executive directors	Remuneration Committee of at least three non-executive directors
NEDs	Governors' at a general meeting, informed by the Nominations / Remuneration Committee or a governors working group	SoS with advice from the NHS TDA
EDs	Remuneration Committee of at least three independent non-executive directors	Remuneration Committee of at least three non-executive directors

136 The Remuneration Committee remit will be determined by its specific terms of reference, however, in general, it has delegated responsibility for setting not only remuneration for the chief executive and all executive directors, but also including pension rights and compensation payments. This committee also recommends and monitors the level and structure of remuneration for senior management.

137 Remuneration Committees are expected to consult with external professionals to market test such remuneration levels at least every 3 years.

2 Enabling corporate accountability and good social processes

138 In unitary NHS boards, all directors are collectively and corporately accountable for organisational performance.

139 A key strength of unitary boards is the opportunity provided for the exchange of views between executives and NEDs, drawing on and pooling their experience and capabilities.

140 Boards are 'social systems'. The most effective boards invest time and energy in the development of mature relationships and ways of working.

> 'It's not rules and regulations, its the way people work together.'
>
> **Jeffrey Sonnenfeld**[34]

141 Some techniques and practices that support and hinder the effectiveness of these social systems are summarised in the following table.

Ways of working that support good social processes	Ways of working that obstruct good social processes
Building and publishing a crystal clear understanding of the roles of the board and individual board members	Board members behaving in a way that suggests a 'master-servant' relationship between non-executive and executive
Actively working to develop and protect a climate of trust and candour	Executive Directors only contributing in their functional leadership area rather than actively participating across the breadth of the board agenda
Building cohesion by taking steps to know and understand each other's backgrounds, skills and perspectives	Demonstrating an unwillingness to consider points of view that are different from individual directors' starting positions or being disinterested in others
Encouraging all board members to raise issues of concern and offer constructive challenges	Challenge primarily coming from non-executive directors, rather than all directors feeling empowered to challenge one another in board meetings
Sharing corporate responsibility and collective decision-making	Challenging in a way that is unnecessarily antagonistic and not appropriately balanced with appreciation, encouragement and support
Ensuring that neither chair nor chief executive power and dominance act to stifle appropriate participation in board debate	Working in ways that don't demonstrate overall confidence in the executive and that feed individual anxiety and insecurity about capability

3 Embedding board disciplines and appropriate delegation

3.2 Competent, systematic board disciplines form the bedrock of good board functioning. These disciplines include:

- **Giving thoughtful attention to board agenda planning and management:** The chair is central in this process, as well as seeking contributions of other board members in agenda planning. The chair needs to be vigilant in ensuring that board agendas maintain a complex range of 'balances':
  - between strategy and performance management
  - between quality, activity and finance
  - between organisational priorities and the demands of regulators
  - between information sharing (presentation) by executives and whole board discussion
  - between formal meeting time and less structured 'away' time

International research demonstrates the value of placing quality and safety as a standing item on the board agenda.

Placing quality at the top of the agenda can increase the attention given to the subject across the organisation.

Dedicating significant board time to quality (at least 20%) is associated with improved quality outcomes.[14]

- Chairs face the challenge of attending to the full breadth of the board's role while ensuring that board meetings do not descend into a gruelling test of board member endurance
- **Board and committee year planners and annual programmes of work:** The board and its committees should be supported by an annual plan that sets out a coherent overall programme for formal board meetings, board seminars and away-days and committee meetings. It needs to take account of the organisational and system-wide planning cycle including key 'watershed events' such as contract negotiations, budget setting, regulatory returns and so on. It is good practice for the work of every committee of the board to be shaped by an annual plan
- **Board papers:** The effectiveness of the board is predicated on the timely availability of board papers. Increasingly boards are receiving their papers electronically, for example on tablets. Whether they are sent electronically or on paper, the core disciplines for board papers include:
  - **Timeliness:** papers provided ideally a week ahead of meetings
  - **Cover sheets:** including, for each paper, the name of the author, a brief summary of the issue, the organisational forums where the paper has been considered, the strategic objective or regulatory requirement to which it relates, and an explicit indication of what is required of the board
  - **Executive summaries:** Succinct executive summaries that direct the readers' attention to the most important aspects
- **Action logs:** Boards and committees can be helped to keep track of actions agreed by maintaining and monitoring a log. The log should show all actions agreed by the board, and for each action the 'ownership', due dates, and status

- **Declaration and resolution of conflicts of interest:**[14] Probity requires that the board maintains an up-to-date register of board members' interests. Increasingly, board agendas include an opportunity for board members to declare conflicts of interest that may relate to specific agenda items so that these can be managed appropriately
- **Transparency and openness:** There is an important obligation on public services to ensure that they operate in an open and transparent manner. For NHS organisations this is partially achieved by holding formal board meetings in public and the publication of papers. The default position ought to be that business is conducted in the public board meeting. However, when a compelling case can be made for an item to be considered in private (for example a matter that involves individual confidentiality or commercial sensitivity), there is provision for attending to it in private. Some boards follow the principles in *The Freedom of Information Act*[35] in deciding which items are considered in private

143 Foundation Trust boards are now required to hold board meetings in public, with a caveat that members of the public may be excluded from a meeting for special reasons. Foundation Trusts remain a part of the public service and thus retain the obligation to ensure openness and transparency to the public. Foundation Trust governors are required to meet in public, and also have the right to receive the agenda and minutes of board meetings.

144 Public board meetings alone are not a guarantee of transparency, and boards need to ensure that there is a wide range of ways for the public to access information about the way in which public resources are deployed. These include clear, informative, jargon-free annual reports, regular updating of an easily navigable website, the availability of key information in a range of appropriate languages and in forms that are accessible to those with disabilities.

Delegating Appropriately:

145 The formal powers of an NHS organisation are vested in the board but the NHS Code of Accountability[36] allows the board to delegate some of its business to board committees and to the executive. The board approach to delegation should be consistently set out in:

- Standing Orders which specify how the organisation conducts its business
- Standing financial instructions which detail the financial responsibilities, policies and procedures adopted
- The scheme of reservation and delegation. This sets out which responsibilities and accountabilities remain at board level and which have been delegated to committees and to the executive, together with the appropriate reporting arrangements that ensure the board has oversight

146 Approaches and schemes of delegation must be subject to regular board review to ensure that the distribution of functions and accountabilities is accurately and appropriately described, and remains appropriate despite changes in the organisation.

147 The following table lists some tests that a board should take into account when considering its committee structure.

Boards may wish to apply the following tests before establishing a new committee:

Are the proposed functions of the committee really board functions or are they executive functions?

Is a standing committee really required - or can the task be undertaken by a short life working group?

Are there good reasons why the proposed functions cannot be carried out by the whole board?

Is the committee being established because of one major incident or issue - is it a proportionate response?

Does the creation of the committee reduce clarity of role or create lack of alignment between other committees of the board and the board itself?

4 Prioritising a People Strategy

'There is a wealth of evidence which clearly shows that the key to providing safe, effective and compassionate care to patients is supporting and valuing staff. Staff wellbeing is not just a matter of culture. It depends on tangible elements such as good management, effective job design, education, training and appropriate resources'

Patients First and Foremost, Government response to Second Francis Report[18]

148 NHS Boards are increasingly recognising that an effective board gives priority to the development of a 'people strategy' as a key enabler in meeting organisational strategic goals. Such a strategy straddles the following domains (see figure 5 below).

Figure 5: People strategy domains

149 In each domain, the board needs to build its understanding of:

- The current baseline position
- The position to which the board and organisation aspire to meet its strategic goals
- The focused and connected network of HR approaches and developmental interventions that will support moving the organisation and its people towards its aspiration

'NHS organisations routinely invest in workforce, leadership and culture change interventions. Across large and complex organisations there is, however, the risk that these interventions become fragmented and are delivered in isolation. It is also the case that boards too often have only a partial and fragmented picture of the 'people' dimensions of the business. What is needed is a comprehensive strategic human resource and organisational development approach, shaped and led by the board and recognised as a critical enabler for the delivery of strategy.'

Non-executive Director, Healthy NHS Board Consultation

Within each of the domains, there are key questions that a robust 'people strategy' should answer. These include:

Domain	Baseline	Future
Workforce model	What is the shape of our current workforce? How have we designed our organisation in terms of structure and roles, job design? How sophisticated is our understanding of workforce costs? How diverse is our workforce?	How do we need to shape our workforce, our roles and our organisation to meet our strategic goals? What does this mean in order to develop effective multi-disciplinary working? What approach is needed to develop a diverse, inclusive workforce?
Values, behaviours and attitudes	What do we know about current values, behaviours and attitudes? What sources of information are we drawing on: • Staff survey • Patient survey • Patient feedback • Complaints and compliments • How do we currently engage with all of our people - Board - Executive	What are the values, behaviours and attitudes to which we aspire, that will safeguard dignified and compassionate care for patients and that will underpin the delivery of our strategy? What will this mean in terms of approaches to staff engagement?
HR health indicators	What does our current performance across the range of HR indicators tell us about how effectively we are managing our staff? Which are the important leading indicators? • Turnover • Sickness • Recruitment Vacancies and time to fill Staff complaints and whistle blowing Disciplinary actions	Are these the right indicators? What level of performance would give us confidence that we are supporting our staff to perform reliably in their roles?

Table continues overleaf

Domain	Baseline	Future
Training and professional development	How effectively are we equipping our people with the right skills to undertake their roles to a high standard? What professional training and development is being offered to all staff, including through other training and education bodies - and how effectively? • What are performance appraisal rates, and what do we know about the quality of appraisals? • How are we performing in the uptake of mandatory training? • How are we approaching specific initiatives e.g. customer care or quality improvement? • Costs and value for money	What would a 'fit for purpose' approach to training and professional development look like for all staff? What approach to personal development and performance appraisal is required?
Leadership and management model	How explicit is the board about the leadership culture that it seeks to promote? How do we invest in leadership and management development? What is our approach to talent management? How do we evaluate its effectiveness? How well supported is team working?	What is the leadership model and culture that we need to promote? How do we give effect to this across all five domains? How do we describe the management model that we operate and build management competency accordingly? What is the approach to supporting team working across the organisation?

150 A good people strategy will set out the range of focused and connected organisational development interventions and HR approaches that will support moving the organisation and its people from the baseline position towards its aspiration. The key is one of 'fit', i.e. that the people strategies must fit with each other and with the overall organisational strategies for maximum impact.[37]

'Performance is seen as a function of employee ability (A), motivation (M) and opportunity to participate or contribute (O). If practices fostering these variables are enhanced, better use will be made of employee potential and discretionary judgment. In an organisational system that is truly receptive to this kind of work reform, the argument is that outcomes should be superior for both parties.'

Boxall and Purcell, 2003

5 Exercising judgment

151 This document draws the principles of effective governance from the available evidence and good practice. It is however important to recognise that at the heart of good governance is healthy debate about a spectrum of dilemmas that are not amenable to uniform guidance. Resolution of these dilemmas requires a willingness to reflect and learn good judgment and acumen on the part of the board.

152 Some of the dilemmas that present themselves to boards are set out in the appendix. They are an illustrative, not an exhaustive list. The optimal board responses to these issues cannot sensibly be mandated in guidance. Rather, boards are encouraged to set aside the necessary time to debate and explore these issues as part of their developmental journey.

5 Roles of board members

The distinct roles of members of NHS boards are outlined in this section.

153 All board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also share responsibility for ensuring that the board operates as effectively as possible.

154 The chair and chief executive have complementary roles in board leadership. These are set out in more detail at the end of this section, but it is helpful to identify the essence of these two roles, which are:

- The chair leads the board and ensures the effectiveness of the board
- For Foundation Trusts, the chair also chairs the council of governors
- The chief executive leads the executive and the organisation

155 However there are also distinct roles for different members of the board, and indeed there are distinct roles depending on the type of NHS organisation.

'It is sometimes said that the board needs to be on the bridge of the ship and not in the engine room. I think it is sometimes important to go into the engine room - because how else will you know how it works? The important thing is to remember that its not your job to play with the instruments!'

NHS Chair, Healthy NHS Board Consultation

156 These distinct roles are set out in the table overleaf, showing how they are aligned to the role of the board. The following abbreviations are used:

- **CE:** chief executive
- **NED:** non-executive director
- **ED:** executive director
- **FT:** Foundation Trust

1 Roles of board members

	Chair	Chief Executive	Non-executive Director	Executive Director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads strategy development process	Brings independence, external perspectives, skills, and challenge to strategy development	Takes lead role in developing strategic proposals - drawing on professional and clinical expertise (where relevant)
Ensure accountability	Makes sure the board understands its own accountability for governing the organisation Ensures board committees that support accountability are properly constituted Holds CE to account for delivery of strategy Leads the board in being accountable to governors and leads the council in holding the board to account.	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability Account individually and collectively to Governors for the effectiveness of the board.	Leads implementation of strategy within functional areas. Manages performance within their area and deals effectively with suboptimal outcomes
Shape culture	Provides visible leadership in developing a healthy culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision-making Board culture: Leads and supports a constructive dynamic within the board, enabling grounded debate with contributions from all directors	Provides visible leadership in developing a healthy culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision-making	Actively supports and promotes a healthy culture for the organisation and reflects this in their own behaviour Provides visible leadership in developing a healthy culture so that staff believe NEDs provide a safe point of access to the board for raising concerns	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour. Nurtures good leadership at all levels, actively addressing problems impacting staff's ability to do a good job

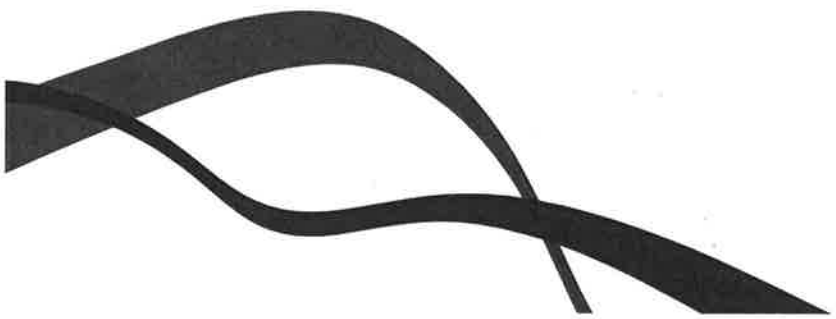
Table continues overleaf

	Chair	Chief Executive	Non-executive Director	Executive Director
Context	Ensures all board members are well briefed on external context	Ensures all board members are well briefed on external context	Mentors less experienced NEDs where relevant	
Intelligence	Ensures requirements for accurate, timely and clear information to board / directors (and governors for FTs) are clear to executive	Ensures provision of accurate, timely and clear information to board / directors (and governors for FTs)	Satisfies themselves of the integrity of financial and quality intelligence including getting out and about, observing and talking to patients and staff	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • All staff • Key partners • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • All staff • Key partners • Regulators	Ensures board acts in best interests of patients and the public Senior independent director is available to members and governors if there are unresolved concerns (FTs) Shows commitment to supporting the work of the Council of Governors (FTs)	Leads on engagement with specific internal or external stakeholder groups Shows commitment to supporting the work of the Council of Governors (FTs)

2 Board members' roles in building capacity and capability

157 The preceding table described roles of board members that are related to the role of the board as a whole. Some members have, in addition, specific responsibilities to support board effectiveness. These specific responsibilities relate in particular to building the capacity and capability of the board. They are summarised in the following table, and explained below.

Chair	Chief Executive	Non-executive Director
Ensures that the board sees itself as a team, has the right balance and diversity of skills, knowledge and perspective, both NED and ED, and the confidence to challenge on clinical as well as other intelligence and service plans	Ensures that the executive team has the right balance and diversity of skills, knowledge and perspectives	Senior independent director assists the chairman to recognise his/her own development needs via appraisal and discussion
For FTs, supports the Governors' Nomination committee to undertake its role of appointing and appraising NEDs effectively		
With NEDs, appoints and removes the CE		NEDs including the chair, appoint and remove the chief executive.
Advises the Remuneration Committee on the appropriate remuneration for EDs		For members of the Remuneration Committee: determine appropriate remuneration for EDs
Has a prime role in appointing, and where necessary removing, executive directors, and in succession planning	With the chair, has a prime role in appointing and where necessary removing executive directors, and in succession planning	As for chair, but a particular responsibility for members of the Remuneration Committee, which supports the chair
Ensures that directors (and governors) have a full induction and continually update their skills, knowledge and familiarity with the organisation	Supports the chair in, ensuring that development programmes are in place for board members (and governors for FTs)	
Arranges regular evaluation of performance of the board, and its committees and the governors (for FTs), externally run at least every 2-3 years.	Uses the (board) performance evaluations as the basis for determining individual and collective professional development programmes for executive directors relevant to their duties as board members	For FTs: senior independent director (SID) and NEDs meet annually without the chair present to review the chair's performance. The SID also takes soundings from governors
Conducts regular performance reviews of the NEDs, the CE and executive directors in relation to their board contribution. Acts on the results of these evaluations, including supporting personal development planning		



'Looking is not seeing. Listening is not hearing. It is possible to miss so much that is right in front of us if we lack the categories and skills to notice. The greatest of these skills is, perhaps, to put aside our expectations, and to stay open to the actual.'

Donald M Berwick

'The role of the chair with the governors is absolutely critical. In Trusts where the model works well, the chair typically puts in a significant amount of time into developing the relationship with his or her governors and ensuring that the information flow to and from governors is effective.'

Monitor, Director-Governor Interaction in NHS FTs[38]

3 Chair and chief executive roles and relationship

158 Clarity of role and an effective working relationship between chair and chief executive are crucial to the effectiveness of the board.

159 In essence the chair leads the board and non-executive directors, and the chief executive leads the executive and the organisation. In Foundation Trusts, the chair also chairs the council of governors.

160 The table below shows a number of helpful tips and cautionary pointers for chairs and chief executives to support the development of their relationship.[39]

Tips for maintaining a good relationship

- Being honest and open
- Communicating well
- Agreeing and reviewing clearly defined working styles and roles
- Establishing trust
- Building a personal relationship
- Developing shared values
- Promoting a 'no surprises' culture

Pointers for chairs and chief executives

Chairs should NOT...	Chief Executives should NOT...
Be too operational, interfere with details of management	Be too controlling or autocratic towards the chair
Be remote from the organisation and unknown by the majority of staff	Obstruct the Chair's access to observing services being delivered in any part of the organisation at any time
Exceed part time hours	Get too involved in NED or Chair role - e.g. no consultation on board agendas, or personally shaping them
Take specific strategic decisions alone	Break the fundamental rule of 'no surprises'
Adopt bullying, macho 'hire and fire' culture	Be too entrenched in the organisation

4 Non-executive directors' time commitment

161 This guidance does not specify the time expected of non-executive directors, but does set out some principles that may help:

- Chairs, in their board leadership role, have a key responsibility to plan and manage the time commitment required of non-executive directors in line with their role on the board in relation to strategy, accountability and culture
- Some tasks that non-executive directors are asked to do can be undertaken by other, appropriately selected and trained lay people (for example chairing appeals panels)
- Experience has shown that the higher the time commitment expected of non-executive directors, the less likely boards are to attract and retain candidates with a diverse background (such as people who are younger, of black and minority ethnic origin, women)
- There is a balance to be struck between developing a good understanding of the organisation and how it is functioning in its health economy, and getting too involved in operational matters. It is important for non-executive directors to maintain the ability for objectivity and independent scrutiny
- Newly appointed non-executive directors may find that they need and want to spend more time initially as they learn about the organisation, its people and its context
- In times of significant organisational or service change, or in the preparation for a Foundation Trust application more time is likely to be required of non-executive directors for a limited period

5 Role of the company secretary

162 The role of company secretary is well established in Foundation Trusts, and is becoming increasingly prominent in other NHS organisations.

163 The company secretary:

- Is accountable to the chair
- Ensures good information flows within the board and its committees between senior management and non-executive directors
- Facilitates induction and assists with professional development[40]
- Is responsible for advising the board through the chair on all governance matters, including ensuring that the organisation complies with the relevant legislation and regulations (and in Foundation Trusts the terms of authorisation)
- Is responsible to the board for ensuring compliance with board probity and procedures and should be accessible to all directors

164 For Foundation Trusts, the company secretary has additional responsibilities to support the council of governors.

Appendix 1

Judgment and dilemmas

165 Exercising judgment has already been identified as key to building an effective board. This appendix sets out a spectrum of dilemmas that many boards are grappling with, and yet are not amenable to uniform guidance. They are provided here to encourage boards to set aside the time to debate and explore them as part of their developmental journey.

How to ensure clarity of respective roles of governors and directors?

166 The Foundation Trust model rests to a very significant degree on robust local accountability. The council of governors plays a crucial role in ensuring that the board of directors operates in a way that is effective and accountable.

167 But the need to develop clear roles, constructive relationships and ways of working between governors and directors gives rise to a range of dilemmas including:

- How to arrive at the best balance in the governor role between the internally facing role to deliver on their formal statutory duties (including ensuring that the board of directors is performing effectively) and the externally facing role in hearing and amplifying the voice of members, patients and the public?
- How governors are supported to develop sufficient understanding of the organisation and its challenges to feel they are on a firm footing to make a constructive contribution?
- How to ensure that there is clarity in the respective roles of governors and directors?
- How governors have appropriate influence over strategic direction whilst retaining the independent voice that they need to hold the board of directors to account - how can governors avoid 'marking their own homework'?
- How much information about the board's business is shared with governors - including risk registers, and if they are what confidentiality safeguards need to be put in place?

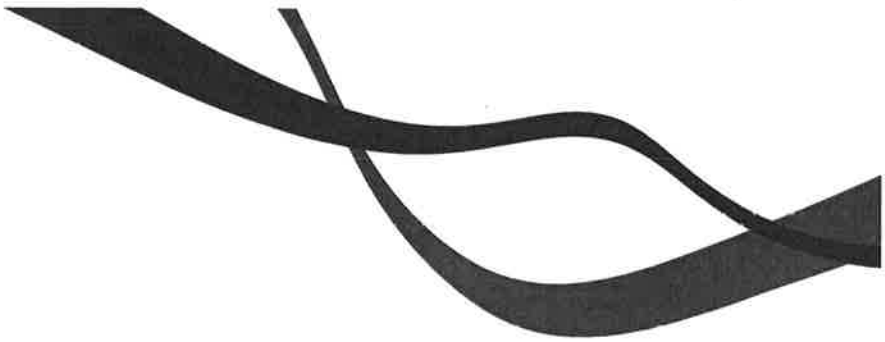
168 The experience seems to be that responding to these dilemmas lies less in seeking 'hard and fast' rules and more in the creation of well designed, thoughtful processes to:

- Give early attention to building and maintaining a clear and shared understanding between governors and directors of the core purpose and priorities of the council of governors
- Facilitation to develop an explicit 'compact' between governors and directors about how they want to work together
- Use of the shared sense of purpose, priorities and ways of working as the basis for directors and the organisation to embrace the role and contribution of governors and proactively identify opportunities for governors to make their best contribution

Paying attention to culture: beyond exhorting a person-centred culture

169 The emerging consensus about the critical importance of organisational culture in delivering compassionate, high quality care is to be welcomed; but also prompts a range of questions for boards:

- Healthcare organisations are complex and multi-faceted and rarely have a single culture. How does the board really 'know' what the culture is - especially in the light of the lively academic debate about the extent to which culture can be 'measured'?
- To what extent can the board really shape culture in a deliberate and purposeful way?
- What sorts of approaches will help the board to move beyond exhorting the culture that it aims to shape?



170 The lessons from both success and failure seem to be:

- Boards can learn a great deal about culture by hearing about the lived daily experience of staff, patients and carers. Boards need to ensure that priority is given to hearing this experience - systematically and directly
- Attending to culture starts with shining a light on it. Which specific tool or framework is used seems less important than the permission, space and priority that is given to having the conversation - whether this is in the board, the executive, within teams at the frontline or in the feedback given and received in individual appraisal
- There are examples from both inside and outside of healthcare where culture has been successfully changed over a period of time. Learning the leadership and governance lessons from these case studies may provide important pointers for boards

Building trust with local people in a financially constrained environment

171 Most boards would wish to support an approach which suggests that 'if organisations concentrate on quality - the resources will follow' but evidence of the extent to which this is the case in practice seems inconsistent.

172 Although there are some salutary examples (notably infection control), boards are often called upon to balance competing priorities where the 'high quality care can be more cost effective' mantra is more difficult to see.

173 In the financially constrained environment within which NHS boards are operating, the challenge is for organisations to work with patients, the local community, and across the health and social care divide to identify opportunities for service integration and redesign, across patient pathways to deliver better outcomes for patients in a more cost effective way in the longer term.

174 More often than not, delivering these longer term improvements will require significant service change and these can trigger anxiety, opposition and concern in the community. It is important that boards are able to work with partners, commissioners, local people and local political leaders to help to build understanding of the choices and 'trade-offs' and thereby build public trust and confidence. Difficult service decisions may never be welcome or palatable for local people but the motivation and basis for making them can be more transparent.

175 Boards may want to anticipate and explore which approaches to working with patients and local people are likely to garner their support and enable positive service change to be made. Some approaches include:

- Early and open communication with the local community on the issues and challenges facing health services - a regular process of dialogue based on the evidence
- A track record of being consistently open and transparent
- Engaging patients, the community and key staff in early stages of shaping possible solutions, and at key stages throughout the decision making process
- Potentially using socio technological approaches to decision making which combine value for money with patient involvement[41]
- Visibility of clinicians in discussions with the community about service change

Maintaining the balance between holding to account and being accountable

176 Boards and organisations devote a great deal of time and resource responding to the demands and expectations of external regulators. This brings the risk that 'accountability' comes to mean accounting for what the organisation has done rather than taking meaningful responsibility for the performance of the organisation and its adherence to standards.

177 Flowing from the findings of both Francis Reviews, there is a growing understanding that robust assurance processes begin with the intrinsic motivation of the board to set, exemplify and monitor organisational values and fundamental standards and support staff to deliver them. External regulation should be seen as a 'failsafe' rather than a primary source of assurance.

178 Few boards would now disagree with this perspective, however the capacity of the organisation to provide robust assurance is finite. The requirements of external regulators seldom seem to begin with an assessment of the information and assurance that the organisation routinely generates.

179 These competing demands are extremely difficult to reconcile. However, it is important that boards model and encourage an approach that makes it clear that adherence to external standards is not enough. Rather, staff are expected to give robust and thoughtful attention to the standards of quality, service and conduct that matter most to them, to their patients and to carers - and that this thinking is reflected in the broader suite of standards that are set and monitored in the organisation.

Achieving a balance between managing risk and encouraging innovation

180 A systematic approach to the management of risk is one way that boards build public confidence. However, it is also clear that the future sustainability of the NHS and its founding values will require creative and innovative solutions. Some of the questions boards may wish to debate include:

- How do we ensure that risk and innovation aren't seen as mutually exclusive?
- How do boards ensure that individuals and teams within the organisation take full and active responsibility for the management of risk without creating a straightjacket of anxiety that stifles creativity?
- How does your board know about and act on good practice emerging from the literature on encouraging innovation?
- How does your board engage with the Academic Health Science Networks as well as tapping into other networks as sources of innovative practice?

Zero tolerance of poor care... in a learning organisation

181 The appropriate board response to flagrantly poor care is, hopefully now, beyond debate and prevarication.

182 Arguably more challenging are questions about care that is simply sub-optimal - the services that are persistently mediocre. The dilemma for boards is to identify the point at which they need to move from working collaboratively to gain improvement on an issue to the 'zero tolerance' point - and, having made that judgment, what that means the board does in practice.

183 There is a broad consensus that an open culture that encourages transparency and learning in response to adverse events is a key pre-requisite for reliably high quality, safe, compassionate care. How do boards ensure that in pursuing a policy of 'zero avoidable harm' they do not, inadvertently, drive a climate of fear and reduce the likelihood that staff will be open about mistakes so that the learning can be surfaced and disseminated?

184 If organisations are both to respond to resource constraints and encourage innovation, there will be a need for experimentation with new models of care - how do boards maintain a commitment to 'zero harm' whilst allowing space for innovation and experimentation?

185 To what extent are staff rewarded for bringing forward and/or implementing innovative ideas which improve quality?

Appendix 2

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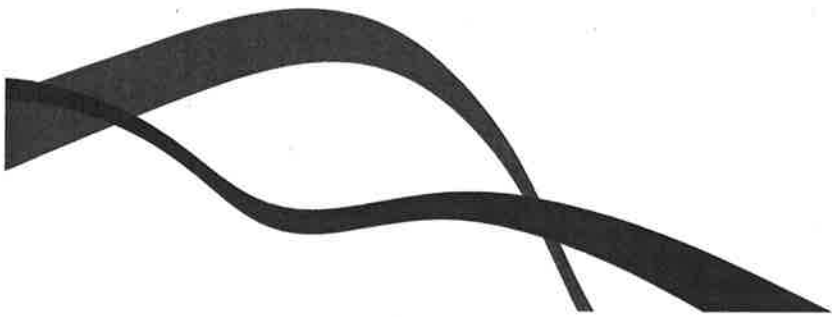

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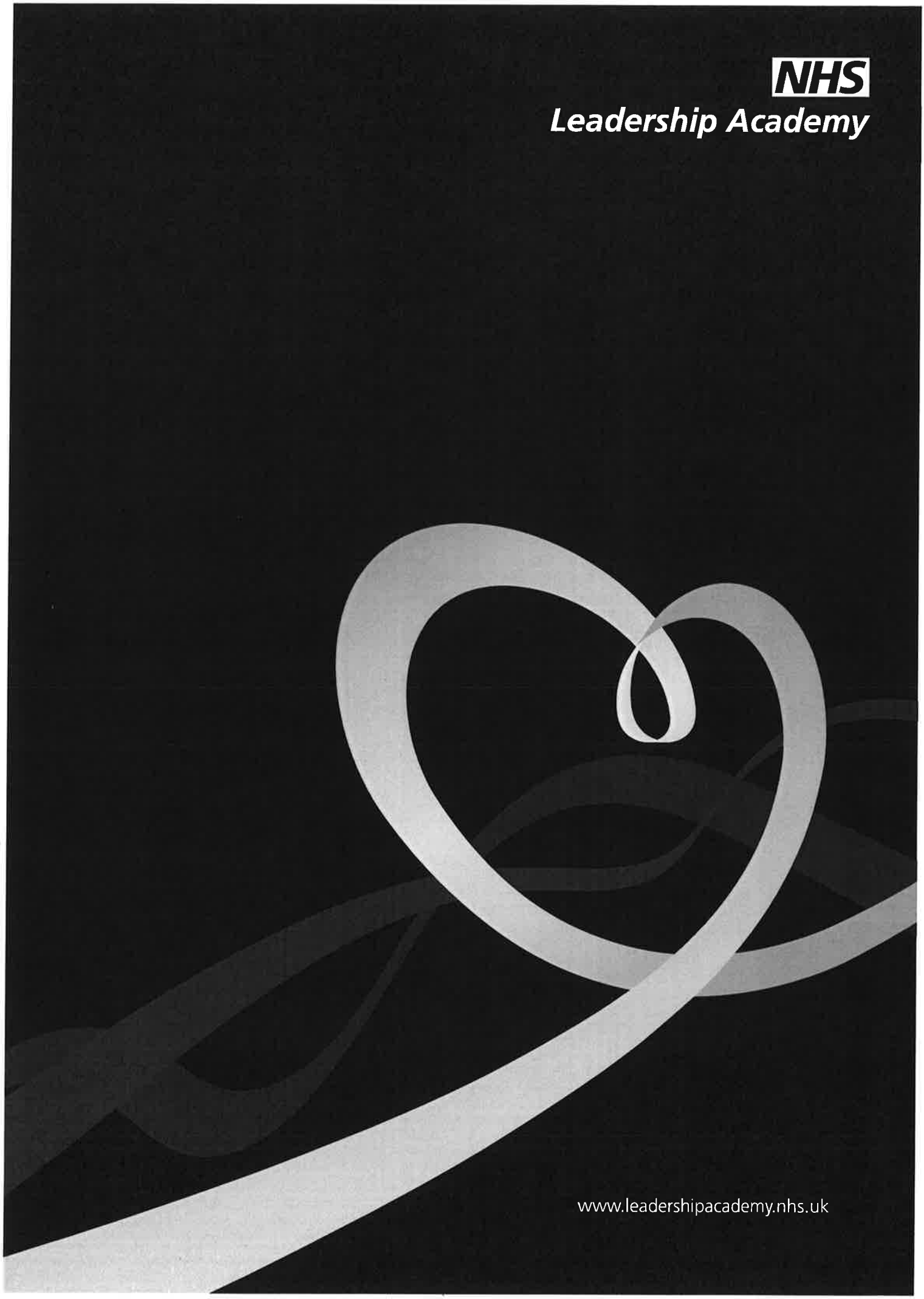
NHS
Leadership Academy



www.leadershipacademy.nhs.uk

professional standards authority

Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

All members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.

Professional Standards Authority
157-197 Buckingham Palace Road, London SW1W 9SP
Telephone: 020 7389 8030 Email: info@professionalstandards.org.uk
Web: www.professionalstandards.org.uk

The Professional Standards Authority for Health and Social Care is the new name for the Council for Healthcare Regulatory Excellence.

Personal behaviour

1. **As a Member[1] I commit to:**

   The values of the NHS Constitution

   Promoting equality

   Promoting human rights

   in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2. **I will apply the following values in my work and relationships with others:**

- **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board[2], including delegated responsibilities, and for the staff and services for which I am responsible
- **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member
- **Openness**: I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
- **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
- **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
- **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all
- **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

1 The term 'Member' is used throughout this document to refer to members of NHS boards and CCG governing bodies in England.

2 The term 'board' is used throughout this document to refer collectively to NHS boards and CCG governing bodies in England.

Technical competence

3. **As a Member, for myself, my organisation, and the NHS, I will seek:**

   Excellence in clinical care, patient safety, patient experience, and the accessibility of services

   To make sound decisions individually and collectively

   Long term financial stability and the best value for the benefit of patients, service users and the community.

4. **I will do this by:**

- Always putting the safety of patients and service users, the quality of care and patient experience first, and enabling colleagues to do the same
- Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning and continuing professional development
- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates
- Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge
- Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively
- Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board
- Thinking strategically and developmentally
- Seeking and using evidence as the basis for decisions and actions
- Understanding the health needs of the population I serve
- Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same
- Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff
- Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood
- Respecting patients' rights to consent, privacy and confidentiality, and access to information, as enshrined in data protection and freedom of information law and guidance.

Business practices

5. **As a Member, for myself and my organisation, I will seek:**

   To ensure my organisation is fit to serve its patients and service users, and the community

   To be fair, transparent, measured, and thorough in decision-making and in the management of public money

   To be ready to be held publicly to account for my organisation's decisions and for its use of public money.

6. **I will do this by**:

- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, and removing myself from decision-making when they might be perceived to do so
- Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify
- Ensuring that effective complaints and whistleblowing procedures are in place and in use
- Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource, and contract allocation
- Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective and properly used, and that the values in these Standards are put into action in the design and delivery of services
- Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care
- Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

NHS
Trust Development Authority

CHAIRS AND NON-EXECUTIVE DIRECTORS OF NHS TRUSTS
INFORMATION ABOUT YOUR APPOINTMENT

This is important information about your public appointment, please read it carefully and contact the Non-executive Appointments Team at the NHS Trust Development Authority (NHS TDA) should you have any queries. You should also notify the NHS TDA if there is any change to your situation or connections during the period of your appointment.

1. **Statutory basis for appointment** – Chairs and non-executive directors hold a statutory office under the National Health Service Act 2006. The appointment and tenure of office are governed by the NHS Trusts (Membership and Procedure) Regulations 1990. Your appointment is made by the NHS TDA using powers delegated by the Secretary of State for Health. It does not create any contract of service or contract for services between you and the Secretary of State, the NHS Trust to which you have been appointed or the NHS TDA.

   Chairs and non-executive directors have full voting rights as members of the board. You will perform statutory and other duties and exercise powers in relation to the Trust as set out in the description of your role, and as the Trust or the board may from time to time require. You will serve the Trust to the best of your ability and use your best endeavours to promote the interests and welfare of the Trust. The NHS TDA has a duty to hold the chair and non-executive directors individually and collectively to account for the performance of the board.

2. **Employment law** – This is a public appointment and not employment and therefore does not fall within the jurisdiction of Employment Tribunals.

3. **Principles of public life** - Public service values are at the heart of the NHS and Trust boards play a critical role in shaping and exemplifying an organisational culture that is open, accountable, compassionate, and puts patients first. Respect, compassion and care are at the centre of good leadership and governance in the NHS, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful with patients and the public. You are therefore expected to:
   - understand and commit to the personal behaviours, values, technical competence and business practices outlined in "The standards for members of NHS boards and clinical commissioning group governing bodies in England" produced by the Professional Standards Authority;
   - reflect the standards of selflessness, integrity, objectivity, accountability, openness, honesty and leadership set out in the Seven Principles of Public Life;
   - be honest, open and truthful in all dealings with patients and the public; and
   - uphold the policies and procedures adopted by the Trust, insofar as they are applicable to your role.

4. **Tenure of office** – Your tenure of appointment will be confirmed in your letter of appointment.

5. **Remuneration** – You are entitled to be remunerated by the NHS Trust for as long as you continue to hold office as chair or non-executive director. The level of remuneration payable is set by the Secretary of State for Health and is set out in your letter of appointment or any subsequent notification. You are entitled to receive remuneration only in relation to the period for which you

hold office. You do not have any entitlement for compensation for loss of office should your appointment come to an end before the end of the term set out in your appointment letter. Your appointment does not fall within the remit of the NHS Pension Scheme.

6. **Tax and National Insurance** – Your remuneration is taxable under "chargeable as employment income" and subject to Class 1 National Insurance contributions. Any queries on these arrangements should be taken up with HM Revenue and Customs.

7. **Allowances** – Your Trust will provide you with what you need to perform your role effectively. You are entitled to claim allowances for travel, subsistence and other expenses for legitimate costs incurred on Trust business. Any additional expenses should be paid in line with local practice and further advice is available on our website.

8. **Time commitment** – These are part time roles with considerable flexibility, and may require both day and evening work according to the requirements of the Trust. You are expected to make every reasonable effort to attend all meetings of the board and appropriate committees and to undertake any training and development required to ensure that you are able to fulfil your role and responsibilities.

9. **Public speaking** – On matters affecting the work of the NHS Trust, you should not normally make political speeches or engage in other political activities. In cases of doubt, the guidance of the Governance and Non-executive Development Team at the NHS TDA should be sought.

10. **Conflicts of interest** – You are required to declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. These must be entered into a register by the NHS Trust, which is available to the public.

11. **Indemnity** – The NHS Trust is empowered to indemnify you against any personal liability which you may incur in certain circumstances whilst appropriately carrying out your duties. HSC 1999/104, which is available locally, gives details.

12. **Additional information** - Information to support chairs and non-executive directors in their roles, including advice on induction and appraisal, is available on our website http://www.ntda.nhs.uk/blog/2013/04/26/useful-info-for-non-execs. The Governance and Non-executive Development Team is also available to provide advice and guidance on NHS trust appointments and governance issues.

13. **Extensions and reappointments** – Your initial appointment may be extended by the NHS TDA as permitted under the legislation. An extension will generally be considered when the NHS TDA considers that you continue to meet the needs of the organisation and that you have performed well during your current period in office.

    You may also be considered for reappointment at the end of your initial or extended term of office. You do not, however, have any right to an extension or reappointment. At the end of each appointment, the NHS TDA will consider afresh the question of whether you should remain in

post. Your annual performance appraisal will be an important part of the evidence to be taken into account when an extension or reappointment is being considered. In general, you will only be considered if your performance has been assessed as satisfactory or better.

The challenges faced by boards can change over time, however, and to ensure that the board is equipped for its future role, the NHS TDA will also take into account the performance of the organisation, the make-up of the board in terms of its skills and geographical representation, and the board dynamics and effectiveness of its team working when deciding whether to extend an appointment or to offer a further term of office. This might lead to an open competition even if you have previously performed well in the role.

14. **Period in office** – You will generally serve no more than eight years in one post although, depending on individual circumstances, you may remain in post for a maximum of ten years.

15. **University and Local Authority nominees** – If you have been appointed following a nomination from a university or local authority, you will need to be nominated again before being considered for an extension or reappointment. If you cease to hold a post with the nominating body you should advise the Governance and Non-executive Development Team immediately.

16. **Removal from office** - When you cease to hold your appointment, for whatever reason, you agree to immediately return all Trust property which is in your possession or under your control; and irretrievably delete or destroy any electronic or other information relating to the business of the Trust which is in your possession or under your control outside of the Trust's premises; and if requested, provide a signed statement that you have complied with this obligation.

    a. **Resignation** – You may resign at any time by giving notice in writing to the NHS TDA. Where possible, chairs should first liaise with the NHS TDA and non-executive directors with their chair to agree a leaving date.

    b. **Termination of appointment** – Regulation 9 of the NHS Trusts (Membership and Procedure) Regulations 1990 sets out the grounds on which your appointment may be terminated with immediate effect. They are:

        i. If you are, or become, disqualified for appointment.
        ii. If it is considered that it is not in the interests of the health service that you should continue to hold office.
        iii. If you do not attend a meeting of the Trust for a period of three months.
        iv. If you do not properly comply with the requirements of the regulations with regard to pecuniary interests in matters under discussion at meetings of the Trust (e.g. a failure to disclose such an interest).
        v. If you fail to disclose a non-pecuniary conflict of interest.
        vi. If you are appointed following a nomination from a university or local authority and you cease to hold a post with the nominating body.

The following list provides examples of matters which may indicate that it is no longer considered to be in the interests of the health service that you continue in office. It is not intended to be exhaustive or definitive; the NHS TDA will consider each case on its merits, taking account of all relevant factors.

vii. If you are found to be an unfit person as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
viii. If an annual appraisal or a sequence of appraisals is unsatisfactory.
ix. If you no longer enjoy the confidence of your chair, other board members, the public or local community, or the NHS TDA in a substantial way.
x. If [as Chair] you fail to ensure that the board monitors the performance of the Trust in an effective way.
xi. If you fail to meet agreed objectives.
xii. If there is a breakdown in essential relationships, e.g. between you and the Chair, you and the Chief Executive, you and the NHS TDA, or between you and other members of the board.
xiii. If you fail to apply the principles set out paragraph 3 above.
xiv. If you fail to comply with the letter and / or principle of the Trust's internal policies and procedures, as applicable.
xv. If an investigation into allegations of wrong doing results in a finding against you.
xvi. If a capability or other board effectiveness review indicates that you are not making a full contribution to the board.
xvii. If a chair has reviewed the contribution of the Trust's non-executive directors and identified performance issues and / or skills gaps.

If you are disqualified from continuing as a chair or non-executive director on any of the grounds set out above, you should immediately give notice in writing to the NHS TDA. You are also required to declare immediately if you are ever arrested, have any pending prosecutions or convictions (including driving offences) or if you have accepted any police cautions.

c. **Suspension of appointment** – Under Regulation 9A of the Membership and Procedure Regulations you can be suspended from performing your functions as chair or non-executive director while consideration is given to whether your appointment should be terminated as set out in paragraph 16b above. An initial period of suspension will not exceed 6 months, although in exceptional circumstances further periods of suspension may be considered. If you are suspended, you can request in writing a review of the decision.

Further information about how the NHS TDA will establish whether and how a chair or non-executive director of an NHS trust should be suspended or removed from office is available on our website.

From: [redacted] (NHS IMPROVEMENT - [redacted])
Sent: 19 May 2015 12:16
To: [redacted]
Subject: Royal Cornwall Hospitals NHS Trust
Attachments: Information pack.pdf; Map.docx

Dear Dr Andrewes

Re: Chair – Royal Cornwall Hospitals NHS Trust

Further to our email correspondence, I am pleased to confirm that your interview will take place at [redacted] on [redacted] at NHS TDA offices, South West House, Blackbrook Park Avenue, Taunton, Somerset, TA1 2PX. Please could you confirm your attendance and if you require any special adjustments or arrangements for your interview.

Directions to the venue location are attached. Please report to reception on arrival and ask for myself, the contact number, should you require it is as follows: 01823 361 325

We expect that the interview will take around an hour. The panel will be made up of:

- Sara Nathan, Public Appointments Assessor as Panel Chair
- Anne Eden, Director of Delivery and Development, NHS Trust Development Authority as Panel Member
- Brian Stables, Chair, Royal United Hospitals Bath NHS Foundation Trust as External Panel Member
- I will be in attendance as an observer only

The information for applicants indicated that shortlisted candidates would need to demonstrate at interview that they have both the required expertise and the leadership behaviors needed to be effective as a member of an NHS board. A copy of the information for applicants is attached for reference.

At the interview you will be asked to give a 5 minute presentation on the subject: **"What are the top three challenges for the organisation and how would you address them?"** As previously stated this presentation should not include any aids such as Powerpoint, handouts etc.

Given the significant public profile and responsibility members of NHS boards hold, it is vital that those appointed can maintain the confidence of the public, patients and NHS staff at all times. New regulations now require the NHS TDA to make a number of specific background checks to ensure that those we appoint are "fit and proper" people to hold these important roles. These checks will include:

- Occupational Health Assessment
- Proof of ID
- Proof of qualifications, where appropriate
- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- Check with relevant regulators, where appropriate

You should be aware that if you are appointed the results of the checks, your references and any other relevant information may be shared with CQC which will consider whether board members meet the requirements of the 'fit and proper persons' regulations. More information about the fit and proper person requirements can be found on our http://www.ntda.nhs.uk/blog/2014/12/04/fit-proper-persons-requirements/

If there are any issues in your personal or professional history that could potentially fall within the definition of an "unfit person", jeopardise public confidence or cause embarrassment to the Trust, it is important that you bring it to the attention of the selection panel or the NHS TDA before appointment.

While every effort will be made to minimise the impact these new arrangements will have on the recruitment timescale, inevitably some of these checks will take some time. It is likely that some offers of appointment may be made conditional on the satisfactory completion of the necessary checks.

The panel operates as an advisory panel to NHS Trust Development Authority's Appointments Committees which are ultimately responsible for making these appointments. I expect the Committee will make their decision about this appointment during May/June.

I will let you know the outcome of your interview by letter as soon as possible.

Regards

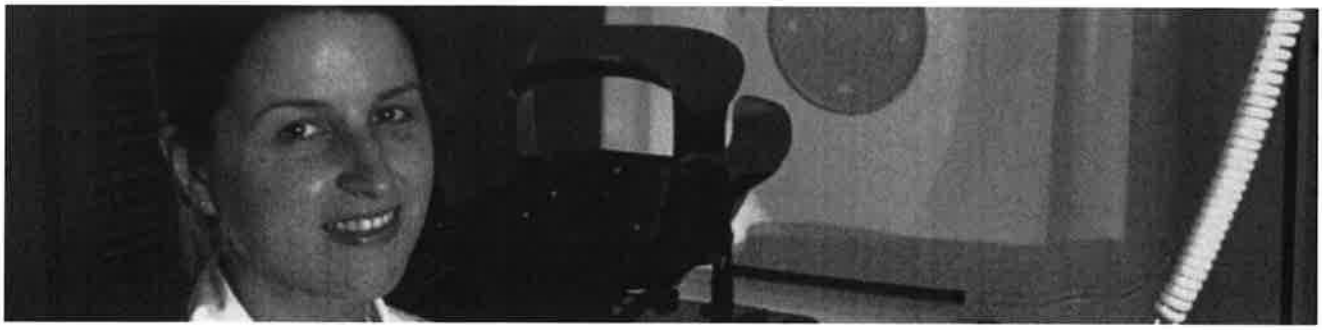
[redacted]
Appointments Officer
Governance and Non-executive Development Team
NHS Trust Development Authority
2C18
Quarry House
Leeds
LS2 7UE

Tel: [redacted]
[redacted]@nhs.net

Royal Cornwall Hospitals NHS
NHS Trust

Chair of Royal Cornwall Hospitals NHS Trust

Reference no: S730



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HUNTER

Executive talent for the healthcare sector

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tda Trust Development Authority

Quality. Delivery. Sustainability.

We value and promote diversity and are committed to equality of opportunity for all and appointments made on merit. We believe that the best boards are those that reflect the communities they serve.

We particularly welcome applications from women, people from the local black and minority ethnic communities, and disabled people who we know are under-represented in chair and non-executive roles.

Royal Cornwall Hospitals NHS Trust

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall and the Isles of Scilly. It serves a population of around 450,000 people, a figure that can be doubled by holidaymakers during the busiest times of the year. The Trust employs approximately 5,000 staff and has an annual budget of approximately £330 million.

The Trust is responsible for the provision of services at three sites (comprising approximately 750 beds):

- Royal Cornwall Hospital, Treliske, Truro
- West Cornwall Hospital, Penzance
- St Michael's Hospital, Hayle.

The Trust has teaching hospitals status as part of the Peninsula College of Medicine and Denistry (PCMD) and University of Exeter Medical School. Keeping at the forefront medical advances, the Trust is continually developing its clinical services and is committed to maximising the range of specialist care that can be offered locally. Allied to this is a growing reputation for research and innovation.

The Knowledge Spa on the Royal Cornwall Hospital site, the Cornwall base for medical students and the University of Plymouth Faculty of Health and Social Work, has further enhanced a strong reputation for training and education. This plays a vital part in attracting and retaining the Trust's highly skilled teams of doctors, nurses and other health professionals who care for well over half a million patients each year

Reflecting the high standards of care on offer, recent patient surveys have shown that over 90 per cent of patients rated their overall experience of the services as excellent, very good or good.

Challenges and opportunities

Royal Cornwall Hospitals NHS Trust is at a pivotal moment on its journey to become an 'outstanding' NHS provider and NHS Foundation Trust. In March 2014, the Chief Inspector of Hospitals, Professor Sir Mike Richards, said that the Trust "has been on a journey of improvement over recent years...But they're not there yet". These comments followed the most recent Care Quality Commission (CQC) inspection where good and outstanding care was identified but an overall rating of 'Requires improvement' was given.

One of the main reasons for that overall rating was unsatisfactory patient flow through the Trust and entire health and social care system, leading to very high bed occupancy, missed waiting time targets, cancelled operations and financial difficulties. This has also had a negative impact on staff rating the Trust as place to work and be treated. The biggest

opportunity and challenge ahead is to strengthen those internal and external relationships that will lead to an effective, sustainable and high quality healthcare system.

The Trust's vision is 'Working together to achieve outstanding care and better health outcomes' with four strategic aims:

- Quality: To provide outstanding healthcare services.
- People: To make best use of our expert skills and capabilities.
- Partnership: To collaborate and innovate with our partners.
- Resources: Make efficient use of all our resources to underpin service transformation.

The Chair will play a central role in ensuring the Trust achieves its vision and strategic aims.

Person specification

The Chair will provide the leadership needed to secure improved healthcare services for patients and the local community, both now and in the future, and be responsible for keeping the organisation on course to achieve Foundation Trust status. There will be many challenges if these goals are to be achieved, but the most challenging roles are often the most rewarding.

Essential criteria

Candidates will have a deep commitment to patients and want to use their energy and experience to drive the delivery of sustainable services that meet the standards expected by patients. They will also have experience gained from board level leadership roles in complex organisations and:

- Strategic vison and organisational development skills gained by providing clear direction in a challenged environment
- Experience of providing robust and visible leadership, with a strong focus on staff engagement and building external relationships with a range of stakeholders
- Strong people management and communication skills with a record of achievement in ambassadorial roles
- Proven governance, organisational and financial skills, including those relating to strategic planning, risk management, organisation performance management
- Experience of leading organisational and cultural change to achieve performance and quality improvement
- An understanding of the challenges facing NHS healthcare providers in delivering high quality, safe services to patients which are clinically and financially sustainable

Board level behaviours

The NHS Leadership Model describes nine behaviours which together contribute towards strong and effective NHS leaders. If you are invited to interview, you will also need to demonstrate the range of behaviours required to contribute effectively in this board level role:

- **Inspiring shared purpose** - create a shared purpose for diverse individuals doing different work, inspiring them to believe in shared values so that they deliver benefits for patients, their families and the community
- **Leading with care** - understand the underlying emotions that affect their team, and care for team members as individuals, helping them to manage unsettling feelings so they can focus their energy on delivering a great service that results in care for patients and other service users
- **Evaluating information** - are open and alert to information, investigating what is happening now so that they can think in an informed way about how to develop proposals for improvement
- **Connecting our service** - understand how things are done in different teams and organisations; they recognise the implications of different structures, goals, values and cultures so that they can make links, share risks and collaborate effectively
- **Sharing vison** - convey a vivid and attractive picture of what everyone is working towards in a clear, consistent and honest way, so that they inspire hope and help others to see how their work fits in
- **Engaging the team** - promote teamwork and a feeling of pride by valuing individuals' contributions and ideas; this creates an atmosphere of staff engagement where desirable behaviour, such as mutual respect, compassionate care and attention to detail, are reinforced by all team members
- **Holding to account** - create clarity about their expectations and what success looks like in order to focus people's energy, give them the freedom to self-manage within the demands of their job, and deliver improving standards of care and service
- **Developing capability** - champion learning and capability development so that they and others gain the skills, knowledge and experience they need to meet the future needs of the service, develop their own potential, and learn from both success and failure
- **Influencing for results** - are sensitive to the concerns and needs of different individuals, groups and organisations, and use this to build networks of influence and plan how to reach agreement about priorities, allocation of resources or approaches to service delivery
- **Championing the standards of public life** – uphold the highest standards of conduct and displaying the principles of selflessness, integrity, objectivity, accountability, openness, honesty, and leadership

For more information about the NHS Leadership Academy's Healthcare Leadership Model visit http://www.leadershipacademy.nhs.uk/discover/leadershipmodel/

Role and responsibilities

Role of the NHS board

NHS boards play a key role in shaping the strategy, vision and purpose of an organisation. They hold the organisation to account for the delivery of strategy and ensure value for money and are responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. Led by an independent chair and composed of a mixture of both executive and independent non-executive members, the board has a collective responsibility for the performance of the organisation.

The purpose of NHS boards is to govern effectively, and in so doing build patient, public and stakeholder confidence that their health and healthcare is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services
- That resources are invested in a way that delivers optimal health outcomes
- In the accessibility and responsiveness of health services
- That patients and the public can help to shape health services to meet their needs
- That public money is spent in a way that is fair, efficient, effective and economic

Role and responsibilities of chairs

NHS trust chairs are accountable to the Secretary of State, through the NHS Trust Development Authority for giving leadership to the NHS trust board, and ensuring the trust provides high quality, safe services, and value for money within NHS resources. The chairs role is to:

Formulate plans and strategy

- Ensuring that the board develops vision, strategies and clear objectives to set direction and deliver organisational purpose

Ensure accountability

- Making sure that the board understands its own accountability for governing the organisation
- Ensuring that board committees that support accountability are properly constituted
- Holding the CE to account for delivery of strategy
- Leading the board in being accountable

Shape culture and capability

- Providing visible leadership in developing a healthy culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision-making
- Leading and supporting a constructive dynamic culture within the board, enabling grounded debate with contributions from all directors
- Ensuring the board has the appropriate experience and ability, now and into the future, to positively shape the organisation's culture to deliver care in a safe and sustainable way

Context

- Ensuring all board members are well briefed on external context

Process, structures and intelligence

- Ensuring requirements for accurate, timely and clear information to board / directors are clear to executive
- Ensuring reporting lines and accountabilities are robust and support the effective oversight of the organisation

Engagement

- Playing a key role as an ambassador, and in building strong partnerships with: patients and public, all staff, key partners, regulators

In particular, the responsibilities of the chair are to:

- Provide leadership to the board, the Trust, the other non-executives, the Chief Executive and executive directors; and ensure the effectiveness of the board in all aspects of its role and agenda; including directing the organisation towards achieving the Government's objective of all trusts achieving Foundation Trust status
- Ensure the provision of accurate, timely and clear information to the board and directors to meet statutory requirements
- Ensure effective communication with the board, staff, patients & the public in a changing healthcare environment
- Arrange the regular evaluation of the performance of the board, its committees and individual non-executives, directors, and the Chief Executive
- Plan and conduct board meetings, with the Chief Executive. Facilitate the effective contribution of non-executive directors and ensure constructive relations within the organisation and between executive and non-executive directors. Share and use relevant expertise of all members of the board

- Proactively direct and manage the development of major board decisions ensuring that 'due process' has been applied at all stages of decision making and full and complete consideration has been given to all options during the process
- Hold the Chief Executive to account for the effective management and delivery of the organisation's strategic aims and objectives
- Ensure that the board develops and oversees strategies, which will result in tangible improvements to the health of the population and clinical services
- Ensure that the board establishes clear objectives to deliver agreed strategies and regularly review performance against these objectives
- Ensure that the board maintains its responsibility for the effective governance of the organisation by making the best use of resources including the development of effective risk and performance management processes
- Ensure that the board, and the organisation, observe the Secretary of State's policies and priorities, including the requirements of the Codes of Conduct and Accountability
- Be aware of relevant, regulatory and Central Government policies
- Play a key role in building strong partnerships with Local Authority, local health economy, and other stakeholders in the community and nationally, including regulators such as Monitor and the Care Quality Commission. In the future, this will include developing an effective board of Governors and promoting harmonious relations with the board
- Ensure that the interests of all stakeholders, and influence of all advisers, are fairly balanced
- Provide the leadership needed by the Board to shape the organisation; develop a culture which supports the values of the NHS, and ensure the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business
- Be an ambassador for the Trust with national, regional and local bodies; be knowledgeable and aware of local issues, and recognise the Trusts role as a major local employer
- Where necessary, assist in the appointment of executives and non-executives and ensure systems of support and appraisal

The seven principles of public life

The principles of public life apply to anyone who works as a public office-holder and therefore will apply to the successful candidate for this role:

- **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 whenever it occurs.

Given the significant public profile and responsibility members of NHS boards hold, it is vital that those appointed inspire confidence of the public, patients and NHS staff at all times. New regulations now require the NHS TDA to make a number of specific background checks to ensure that those we appoint are "fit and proper" people to hold these important roles. More information can be found on our website. http://www.ntda.nhs.uk/blog/2014/12/04/fit-proper-persons-requirements/

Terms and conditions of appointment

- Given the challenges ahead, the remuneration payable to this role is £35,000 pa.
- You will have considerable flexibility to decide how you spend your time. On average, it will require 2 to 3 days a week, including preparation time away from the trust and the occasional evening engagement
- The initial appointment will be for a period of two years, after which you may be considered for further terms of office, subject to the needs of the organisation and a good performance
- Applicants should live in or have strong connections with Cornwall

More information

For information about the Trust, such as business plans, annual reports, and services, visit their website: www.rcht.nhs.uk/

Follow the link to our website for more information about:

- The support the NHS Trust Development Authority provides to NHS trusts: http://www.ntda.nhs.uk/blog/2014/03/31/delivering-for-patients-nhs-tda-publishes-its-201415-accountability-framework-for-trust-boards/
- Term and conditions of chair and non-executive director appointments: http://www.ntda.nhs.uk/blog/2014/11/03/terms-and-conditions-of-appointment/
- Disqualification from appointment: http://www.ntda.nhs.uk/blog/2014/11/03/terms-and-conditions-of-appointment/
- How your application will be handled: http://www.ntda.nhs.uk/blog/2014/11/03/applying-for-a-post/
- Dealing with your concerns: http://www.ntda.nhs.uk/blog/2014/11/03/applying-for-a-post/
- Other sources of information: http://www.ntda.nhs.uk/blog/2014/11/03/sources-of-information/

Making an application

If you wish to be considered for this role you will be asked to provide:

- A CV that includes your address and contact details. Please also highlight and explain any gaps in your employment history.
- A covering letter that highlights your motivation for the role and how your experience matches the person specification
- The names, positions, organisations and contact details for three referees. Your referees should be individuals in a line management capacity, and cover your most recent employer, any regulated health or social care activity or where roles involved children or vulnerable adults. Your references will be taken prior to interview and may be shared with the selection panel.
- You will also be invited to complete and return a monitoring information form
- Tell us about any dates when you will not be available

Key dates

- **Closing date for receipt of applications: 11 May 2015.** Please forward your completed application to public.appointments@nhs.net
- **Preliminary interviews** – Long-listed candidates will be invited for a preliminary interview with Rhiannon Smith, Partner and Head of Executive Search, from Hunter Healthcare. To facilitate this, we will share your application form with Hunter Healthcare. Feedback from these interviews will be given to the panel.
- **Meet the team:** Short-listed candidates will be invited to meet the Chief Executive and key stakeholders ahead of the panel interview to discuss how they will approach the role and find out more about the trust, its goals and values. Feedback from these sessions will be given to the panel.
- **Interview date: 28 May 2015**

Getting in touch

- **With the Trust** - For an informal and confidential discussion about the role with the current Chair, Angela Ballatti or Bill Shields, the Chief Executive please contact [redacted] on [redacted].
- **Hunter Healthcare** - are helping us to identify potential candidates, if you would like a confidential discussion about the role contact Rhiannon Smith, Partner and Head of Executive Search on [redacted] or [redacted]
- **With the NHS TDA** – for general enquiries contact [redacted] on [redacted] or by emailing [redacted]@nhs.net

NHS Trust Development Authority
South West House
Blackbrook Park Avenue
Taunton
Somerset
TA1 2PX
Tel: 01823 361000

From Taunton Train Station

The train station is about one and a half miles from the office. There is a taxi rank right outside the station and the journey to the office takes approximately 10—15 minutes depending on traffic.

Alternatively from the station you can take bus Number 1 operated by First Bus, heading in the direction of Calder Crescent. Ask for the Blackbrook Business Park. The route goes through the centre of the town and takes between 20 and 30 minutes depending on traffic conditions.

By Car

The direct route to South West House is the M5 to Junction 25.

Depending on direction of travel, if heading north, take the first exit from the roundabout at this junction into Blackbrook Park Avenue. If heading south, go around the roundabout and under the M5 and take the first exit on the left into Blackbrook Park Avenue.

From here, go straight past the Murco garage on the right and through the first roundabout past the Express at Holiday Inn and turn right at the second roundabout, you have arrived at South West House.

If you are using the A38, take this road into Taunton. At the lights at Creech Castle, the junction with the A358, turn left towards the M5. Go straight on through the first roundabout and up to the junction with the M5. Go under and around the M5 and exit left into Blackbrook Park Avenue and follow the instructions given above.

NHS
Trust Development Authority

Phone: [redacted]
E-mail: [redacted]@nhs.net

PERSONAL
Dr Jon Andrewes
[redacted]

25 June 2015

Dear Dr Andrewes

I am pleased to invite you to serve as Chair of Royal Cornwall Hospitals NHS Trust. This is formal notification of your appointment made by the NHS Trust Development Authority (NHS TDA) using powers delegated by the Secretary of State for Health.

I have set out in the paragraphs below some important information that I hope will be helpful to you as you prepare for your new role.

Your appointment

Your term of office will start on 1 July 2015 and end on 30 June 2017. Consideration will be given to extending or renewing your appointment at the end of this term, depending on the needs of the Trust at the time.

My colleagues in the Non-executive Appointments Team will be touch with you shortly to discuss the arrangements for announcing your appointment.

In addition, you will be aware that we are required to undertake a number of checks to ensure that those appointed to board positions in the NHS are "fit and proper" people. Your appointment is therefore conditional on the satisfactory completion of these important checks, and someone from the Trust will contact you shortly to take this forward.

Your remuneration

You are entitled to receive remuneration of £35,000 per annum. This enhanced rate has been approved by the Secretary of State in recognition of the particular challenges you will face in your new role.

Additional information

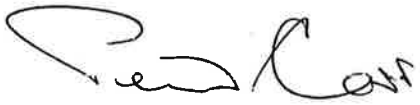
Copies of two further key documents are attached. They provide important information about your appointment, as well as the personal behaviours, values, and business practices that all public appointees are expected to demonstrate. Please ensure that you read them as soon as possible.

NHS
Trust Development Authority

Thank you for agreeing to take on this important role. Your leadership will be critical to guiding the Trust through the challenging agenda it faces. In return, I trust you will find the experience stimulating and rewarding.

Please accept my good wishes for a successful term of office.

Yours sincerely



SIR PETER D CARR CBE
CHAIR

Enclosures: Information about your appointment, PSA - standards for members of NHS boards and clinical commissioning group governing bodies in England