Integrated Governance Handbook

A handbook for executives and non-executives in healthcare organisations

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This handbook has been produced to meet the requirement of the NHS Chief Executive to ensure that the basic building blocks of Integrated Governance are in place in 2005, with roll-out and implementation planned over the following two years.

'Integrated Governance provides the umbrella for all NHS governance approaches. It combines the principles of corporate/financial accountability and it moves towards a single risk sensitivity process which covers all the trust's objectives, supported by a coordinated source of collecting information and subject to coordinated inspection'.
(Chief Executive Bulletin, 13-18 November 2004, Issue 245, Item 7, Gateway number 4161)

Integrated Governance is a co-coordinating principle. It does not seek to replace or supersede clinical, financial or any other governance domain. Rather it highlights their vital importance and their inter-dependence and inter-connectivity.

This handbook will help Boards to:

- achieve good governance in line with DH, Monitor and Healthcare Commission requirements (see self assessment matrix – appendix 1)
- challenge complex Board and committee structures
- review strategically the external environment and ensure that the work of external agencies is integrated within the committee framework
- ensure sound involvement of clinicians and patients in commissioning decisions
- interlink committee structures into an effective and non-repetitive whole
- channel information requirements and guide the more effective use of information in support of Board decisionsdevelop the quality of Board directors for the NHS by challenging their behaviour and supporting their capacity to deliver
- align as one single evidence base the Assurance Framework, compliance with Standards for Better Health, anticipated risks and regulators' requirements
- pose a set of challenges for future refinement of good governance.

'…one of the great strengths of your approach is the recognition that this change can only be achieved via a phased approach over time. That I am sure will be received well in the NHS.' (Ian Pirnie)

'it is an excellent and comprehensive guide to good/better governance, with many practical tools to help bring this about' (Peter Bareau, SHA Chair)

We welcome the opportunity to make comments on this draft of the handbook. In our view the handbook provides a clear guide towards good governance. (Healthcare Commission)

'The Section on the Committee Structure is very good, with a lot of useful and powerful guidance.' (Alasdair Cockburn, SHA NED)

'A necessary challenge, defining timescales of transition, but helpfully a calm document' (Judy Chadwick, Director of Governance, Barts & London)

'The handbook has tremendous value because for the first time it brings together the whole of the governance regimes of the health service in one place. You and the others who compiled it are owed a great deal of credit for a tremendous effort on a difficult topic.' (Kate Nealon, NED Monitor)

Foreword

The handbook seeks to provide support and best practice guidance to organisations that are keen to review their governance and assurance arrangements to ensure all the threads of quality, performance and governance are aligned and integrated. The developing pressures on NHS organisations mean that we have to consider whether our committee structures, their terms of reference and relationships and their 'supports' (the staff, advisors, systems and processes) are all fit for purpose and flexible enough to cope with changing priorities and risks.

The handbook recognises that many organisations have well developed structures and systems in place but that these may need revision to accommodate emergent governance arrangements for NHS Trusts and Foundation Trusts and the new Strategic Health Authorities, Primary Care Trusts and Ambulance Services as outlined in 'Commissioning a Patient Led NHS' and building on the 'NHS Improvement Plan' and 'Creating a Patient-Led NHS'.

The devolution of accountability to individual trusts places new demands on organisations, and highlights the need to clarify the distinction between good robust governance and the ability of non-executive and executive directors to perform corporately at board level. This means that Boards, at the same time as concentrating on strategic and important matters, also need to be certain that all risks are effectively controlled and managed and attention is focused on the core business of the organisation – to care for and treat patients – and fully understand and meet their responsibilities, both individually and collectively.

The handbook seeks to pose explicit questions rather than provide a prescriptive model or single answers. It builds on 'Governing the NHS', recognising the parallel activity in non-departmental public bodies (NDPBs) (*Building Effective Boards Public Services Productivity Panel, November 2004*) and the public sector generally (*Good Governance Standard for Public Services, CIPFA, JRF & OPM 2005*) as well as further afield in Europe (*OECD Guidelines on the Corporate Governance of State-Owned, Enterprises, Dec 2004*) and the US (*The Sarbanes-Oxley (SOX) Act passed in 2002)*.

This document has been produced in alignment with Monitors briefing on governance (The NHS Foundation Trust Code of Governance 2005) and the new NHS Audit Committee Handbook 2005 (Gateway reference 5706).

Contents

What the handbook covers

Integrated Governance is the means by which we pull together all the competing pressures on Boards and their supporting structures, to enable good governance. The move towards greater devolution in the NHS creates an opportunity for Boards to review their governance arrangements. As a key building block of good governance, Integrated Governance is a process that spans the various functional governance processes that are often unlinked and result in the handling of issues in silos. It is clear that all healthcare organisations need to demonstrate that they have strengthened and streamlined their governance arrangements within their organisations and, over time, develop a further integration between health and social care organisations in their health community. Integrated Governance offers Boards the opportunity to rethink their governance arrangements to be fit for the future direction of the NHS.

The handbook starts by reviewing the need for Integrated Governance and the developing role of effective Boards, within the context of the aims of the NHS Improvement Plan (July 2004), the increased devolution of authority to constituent NHS organisations and the need to create a truly 'Patient Led NHS' (2005).

It emphasises the critical importance of the Board defining, within the overall goals established for the NHS, its own purpose and strategic direction, with clarity of purpose, objective setting and planning of the Board's annual cycle of business. The handbook also focuses on quality as the driver of change, examining the critical role of clinical governance at the heart of the Integrated Governance agenda, and covers the legal implications for Boards and what they should to do to plan the journey towards good governance.

The second part examines three key areas of implementation to ensure fitness for purpose: the assurance arrangements, with particular reference to the Standards for Better Health; the 'intelligent' information requirements of Boards; and committee structures and supports in order to ensure they have clear terms of reference and understand the actions and behaviours expected of them.

In particular the third area suggests consideration of a 'Company Secretary' role within health organisations and development of the role of the audit committee to scrutinise and streamline committee structures and agendas, ensuring all risks (activity, quality and resources) are anticipated, aligned and integrated.

The authors recognise that different health organisations have different structures, that PCTs must ensure public and clinical involvement in the commissioning process and that Mental Health Trusts must meet the requirements of the Mental Health Act. However we have sought to keep the commentary as universal as possible.

At the end of the handbook are a number of appendices. They include a self assessment matrix which Boards may wish to use to assess their current position and progress; a set of Board etiquettes based on the Common Purpose programme and developed with NHS Boards; a Company Secretary role description; and an illustration of the role and remit of a strengthened audit committee. There is also a list of references and acknowledgements of the many contributors to the handbook.

The handbook cannot be the definitive comment on Integrated Governance. Rather it aims to be a part of the journey towards optimal governance, and concludes with a set of challenges and recommendations for future refinement of good governance. We anticipate the need for further volumes – on the strengthened role of PCTs, in relation to commissioning better services for patient's, working more closely with local government ensuring that we get the best value for money from the system, and the regulation and management of an increasing range of primary care practitioners; on inter-organisational integration, and finally in support of the development governance standard (D3) – the identification and sharing of best practice from public and private organisations in the UK and overseas.

PART 1: INTEGRATED GOVERNANCE – CONTEXT AND OVERVIEW

1.1 Introduction

'*Make no mistake; NHS Boards are facing real challenges to improve their governance abilities.'*
(Sir Nigel Crisp, Integrated Governance Development Launch, May 2004)

Integrated Governance is the means by which we pull together all the competing pressures on Boards and their supports (staff, advisors, systems and processes). It is a transitional position to good governance, but moves beyond the handling of issues in governance silos. It is clear that all healthcare organisations need to demonstrate that they have strengthened and streamlined their own governance arrangements and, over time, develop further integration between health and social care organisations in their health community.

The organisations that make up the NHS are expected to contribute to the delivery of high quality healthcare. They must do this in a way that makes best use of financial resources and delivers the services people need, to nationally consistent standards of quality and safety. NHS organisations must follow good business practices to ensure they are stable enough to respond to the unexpected without jeopardising services, and confident enough to introduce changes where services need to be improved. It is the responsibility of the Board to ensure that the organisation can deliver these expectations.

To guide NHS organisations, a whole portfolio of systems, procedures, reporting frameworks, standards and inspection requirements have been developed and introduced in a piecemeal fashion over the past decade. They have had a range of objectives – to provide reassurance to the taxpaying public that their money has been well spent; to reassure the patient community that their well-being and safety are not put at unnecessary risk; and to drive up service quality across the country. It is a great challenge for Boards to make sense of this complexity.

Boards also face enhanced scrutiny from their local population and other stakeholders. This produces significant challenges as Boards seek to respond to national policy and local context at the same time. This handbook identifies the critical challenges in order to help Boards rethink and realign their structures and committee activities and so move the healthcare agenda forward in this developing environment.

The Board of every NHS organisation carries the final overall corporate accountability for its strategies, its policies and its actions as set out in the Codes of Conduct and Accountability issued by the Secretary of State. These Directions clearly specify the duties of the Boards.

However the NHS is not made up of simple homogenous organisations. There are different service sectors, an increasing independent sector and important local variations. Each organisation must demonstrate its ability to respond to challenging needs and agendas, and ensure its strategies, staff and structures are fit for purpose especially in the context of the changing roles and emergent governance arrangements for NHS and Foundation Trusts and the new authorities and trusts outlined in 'Commissioning a Patient led NHS'

Integrated Governance

Integrated Governance is defined as: 'Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'

The definition includes 'behaviours' as there is significant evidence to support the fact that they are critical to NHS boards achieving and sustaining high quality care and sound financial management (see Bevington, Saunders, Bird, Dixon & Buggins, 2005; Stanton and Bevington, 2005). As Dame Janet Smith explained in the sixth Shipman Report:

> '…sound structures and systems are not, on their own, enough to secure good governance. A complaints system is of no value unless those who are intended to use it (customers, clients, patients, etc) know of its existence and unless staff within the organisation are trained to operate it effectively. A whistleblowing policy will not be used unless staff are made aware of it and are confident that, if they voice their concerns, those concerns will be taken seriously and the organisation will deal with them fairly. **'**

The Integrated Governance Handbook and support programme

This handbook is a reference work to support Boards implement Integrated Governance through a local strategy and monitored activity. Such a strategy, if implemented accurately, will support the Board in being satisfied that the core and development governance requirements in Standards for Better Health (C6 and D3, C7b and C7d) are met and that robust governance arrangements are in place to meet the development standard D3 (see below).

Governance Standard D3

'Integrated Governance arrangements representing best practice are in place in all healthcare organisations and across all healthcare communities and clinical networks.'

The handbook also provides clear linkages between the requirements of the Department of Health, Strategic Health Authorities, the Healthcare Commission and Monitor. As a reference tool it will help the Board to ensure it manages the difficult balancing act between quality, activity and resources,

and does this in a way that takes account both of the legal implications of being a Board member and the need to be proactive and link decisions to action.

For example, the review of financial management and governance at the Royal Wolverhampton Hospitals NHS Trust led by Professor Robert Tinston found that 'the Trust's risk assessment and assurance machinery appeared to have operated without clear and immediate linkages into the sphere of management action. The machinery appears to have worked at its own pace – *it was well behind events*'.

'We did not find evidence of a robust and timely connection between the formal process of assessing documenting review and reporting on risks to the Board and the planning approval and implementation of actions to address the risk.'

This handbook should be considered as a living document, and as the good practice described in Standard D3 develops, Boards will be expected continually to learn and adapt. Accordingly, this is not a prescriptive model for Board behaviour and development, but is designed to be a helpful and explicit set of 10 key points for chairs, non-executive and executive directors and their support teams as they critically appraise and reframe local governance arrangements – a 'what to do' governance resource. It should not be regarded a singular model to achieve Integrated Governance in all organisations. Each organisation should consider its individual governance arrangements, and own them as unique to itself.

Developing Integrated Governance

This handbook has developed from the document 'Governing the NHS' and the subsequent NHS Confederation debate paper on Integrated Governance. Governance concepts have been further developed through extensive consultation, discussion and debate with chairs, chief executives, executive and non-executive directors and associated agencies to ensure that Integrated Governance can meet all requirements and obligations.

These discussions have confirmed that moving from governing in silos (eg, clinical governance, information governance) to an integrated agenda is both an essential and practical way for Boards to meet their responsibilities. However, to achieve this a development programme also needs to be in place, to provide a support package tailored to local needs. During 2005 a first wave Board development programme has been run in a series of NHS Trusts to field test the ideas in the handbook. The handbook and the new Board Development Programme (further details fom the authors) reflect the contribution of these Trusts in a period of intense change for the NHS, for which the team developing this approach is extremely grateful.

The handbook also makes reference to a suite of supports, including the frequently asked questions that directors have posed while the approach to Integrated Governance has been developed. A set of challenges, or board assurance prompts (BAPs) has been published, see http://www.cgsupport.nhs.uk/Resources/Board_Assurance_prompts.asp, and appendix I provides a ready reckoner self-assessment tool for Boards to gauge their progress in greater integration of governance activities. In addition The NHS Clinical Governance Support Team and the NHS Institute of Innovation and Improvement, has developed an online tool to help Chairs review their own performance and the performance of their boards as a whole. For further information about this fundamental area of good governance please contact Jay.Bevington@ncgst.nhs.uk.

Supporting Boards to develop good governance

Integrated Governance is a means to create greater focus, capacity and capability for Boards. It allows directors to work more corporately as a team, to challenge Board agendas, deliver objectives in a coherent way and review the Board support structures that enable them to govern effectively. This facilitates a real focus, more directly engaged on the patient and safety agenda.

1.2 What is required now

Within the NHS, the Integrated Governance process needs to be set against an annual cycle of business (see Section 1.3). However, as in all decision-making the component parts need to be understood as dynamic and should be regularly revisited. This is fundamental to ensuring compliance and aligning to the delivery of the organisation's overall strategy.

NHS organisations are expected to consider four key elements as part of their ongoing development:

- organisational purpose
- intended outcomes of care
- core objectives
- strategic direction

The core agenda is the annual cycle of business, which must be underpinned by the financial planning cycle and capital programme.

Inputs will include:

- national targets
- compliance with Standards for Better Health
- National Service Frameworks
- the NHS Plan and its implementation

The key output is the local delivery plan (LDP).

The Standards for Better Health are also relevant to a wider picture. They underpin:

- what the Healthcare Commission will need to report to Parliament as part of the annual report on the NHS
- what information the Healthcare Commission requires to demonstrate that the various elements of the standards have been achieved
- what Boards need for their own internal controls and assurance.

The planning process (The LDP – Local Delivery Plans)

All NHS organisations will produce 'business' plans. The Local Delivery Plan (LDP) is the main vehicle for NHS planning and commissioning and, as such, it forms the basis on which Strategic Health Authorities (SHAs) hold Primary Care Trusts (PCTs) to account. Each PCT's LDP is developed across a local healthcare economy and agreed with the SHA in order to determine the core delivery schedule for the coming year. It includes contributions to both national targets and local targets, the former being also signed off by the Department of Health. The LDP is performance managed by the SHA.

Standards for Better Health

All healthcare organisations are required to ensure that quality care is delivered that meets standards laid out in statute – Standards for Better Health. The standards are pitched at two levels:

- *Core* standards describe minimum service levels, which all healthcare organisations must meet.
- *Developmental* standards describe an agenda for continuing improvement, which all healthcare organisations need to be addressing. Boards need to be satisfied that, when signing off the Statement of Internal Control (SIC) and making their annual declaration against the standards, the core standards have been met and progress is being made towards the developmental standards. This process would be informed by aligning the assurance objectives in the Assurance Framework (see below) with the Department of Health's Standards for Better Health.

National targets

These are established from national policy and must be delivered to meet local policy needs and national requirements. From April 2005 they include performance targets assessed independently by the Healthcare Commission, which will award each organisation a single, annual performance rating.

Financial planning

Boards have a duty to achieve financial balance (Foundation Trusts must describe adequate trading surpluses) and must have annual financial plans with monthly monitoring arrangements. If Boards are not committed to strong financial management and financial controls, there cannot be sustainable improvements in patient services. The Board must also ensure that sound internal financial control systems are in place. All Board members, both executive and non-executive, need to have sufficient knowledge and skills to discharge this financial accountability effectively.

Aligning strategic direction with local assurance mechanisms

NHS organisations are required to have an Assurance Framework (AF) to underpin their Statements of Internal Control (SIC). As an approach, it is crucial for all organisations to understand and demonstrate where they are in terms of risk management and governance. This should be achieved without unnecessary duplication, meet stakeholder requirements and be achievable each year.

The Assurance Framework (AF)

The AF provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting their objectives. It also provides a structure for the evidence to support the SIC. This simplifies Board reporting and prioritisation, which in turn allows more effective performance management. The AF also facilitates reporting key information to Boards, providing it is maintained as a dynamic document.

It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance. At the same time, it provides structured assurances about where risks are being managed effectively and objectives are being delivered. The principal tool for this will be the risk register. This allows Boards to determine where to make most efficient use of their resources and address the issues identified in order to improve the quality and safety of care.

Priorities are thus identified for the Board. The organisation is able to understand its capacity to deliver within defined limits and the Board has an accurate understanding of the risks the organisation faces.

Controls and assurances, describing how the organisation will manage anticipated risks to achieving strategic objectives, need to be aligned with the organisation's long-term strategic and operational objectives:

- requirements of the LDP and local objectives
- achievement of Standards for Better Health
- national targets
- rigorous financial planning and monitoring.

In short, Boards must assess risk concurrently within the context setting of strategic objectives, and anticipate governing the organisation in relation to this.

Broader governance context

The Board also needs to operate in the context set by the Financial Services Authority's 'Combined Code on Corporate Governance' (see below) and the implications for non-executive directors and the NHS identified by the Higgs Review.

This method of operating is emphasised by Monitor (the Independent Regulator for NHS Foundation Trusts). Monitor describes the legal framework for NHS Foundation Trusts as being closer to that of a commercial company, and as such will be adopting a much more 'commercial' approach to their regulation. NHS Foundation Trusts must comply with Monitor's terms of authorisation and reporting requirements and the Audit Code used by Monitor. Each NHS Foundation Trust needs to develop individual standing orders, giving authority to each organisation's standing financial instructions, schemes of delegation and matters reserved for the Board.

Ensuring overall compliance is a complex task and the Board needs to be assured that robust and integrated mechanisms are in place to achieve this.

The Combined Code

The Combined Code is exactly what it says – a code combining the recommendations of the Cadbury, Greenbury and Hampel reports on corporate governance, revised following the Higgs Review and Sir Robert Smith's guidance for audit committees. It represents best practice for UK companies.

The Higgs Review

On 20 January 2003, Derek Higgs published his 'Review of the Role and Effectiveness of Non-executive Directors'. This was concurrent with the release of the Financial Reporting Council's 'New Guidance for Audit Committees'. The Review proposed a revised Combined Code (see above). The greatest change is a new provision that at least half of Board members should be non-executive directors. This is having a major impact on Board composition. The Review also emphasises that balance is another key requirement, to ensure that Boards are effective and neither too small nor too large and unwieldy.

The importance of the Higgs Review is that it had a significant impact on the report 'Governing the NHS'. It underpins the stated roles and responsibilities of the chair, non-executive directors and the Company Secretary.

International considerations

Whilst the UK has resisted taking a mandatory approach and relies on what is essentially a voluntary system, the United States Congress, reacting to Enron and WorldCom, took a regulatory and legally enforceable route. In 2002 the Sarbanes-Oxley (SOX) Act was passed to strengthen corporate governance and restore public confidence. The SOX Act will impact on general European Union corporate governance regulation and hence the Combined Code and consequently any 'best practice' followed by NHS Foundation Trusts. Increasingly, the SOX Act will also influence dealings between NHS Foundation Trusts and other companies, whether through contracts or joint ventures. This will most obviously be a factor where partner organisations have a US exposure.

1.3 Moving forward: Reviewing strategic purpose and the annual cycle of business

Achieving integration

'*Effective Boards are critical to the success of organisations in the public and private sectors. They set the strategic tone for an organisation, providing leadership and a clear focus on priorities. As forums of challenging debate, Boards are unified by a clear sense of collective responsibility. Effective Boards are innovative and flexible, but maintain a resolute focus on risks, accountability and performance*.'
Lynton Barker, Public Services Productivity Panel, 2004

There is a clear shift in emphasis by the Department of Health from central policy guidance to a system that delivers devolved accountability of greater ownership at local level. Many NHS organisations have retained complex systems to address their accountability requirements, but without an overall, holistic approach. Devolved accountability offers a Board the opportunity to review its purpose and strategic direction in order to realign its structures and supports and so better achieve its goals.

Integrated Governance is based on understanding that, although all elements of governance are important, there is no need to govern in such silos. To achieve more focused decision-making and deliver strategic objectives, a Board needs to consider all aspects of accountability in the round.

'It is necessary to ensure that linkages are made between finance manpower and activity reports so that the organisation can make balanced judgements regarding risk to targets'
Tinston Review

The annual cycle of business

The annual cycle of business is an ongoing process. Many of the requirements reflect levels of assurance which should be in place throughout the year but which may be externally confirmed only once or twice a year. The Board may take the view that the sequence of reviewing and informing should be planned in order to give proper opportunity for reflection of purpose, strategic direction and improvement

The text and table below describe the main activities the Board might pursue during the year. As can be seen, this creates a local jigsaw that the Board should work through to ensure there is a logical and informed agenda. New issues and priorities will arise, but sorting these will provide an orderly focus for business.

A start point might be the annual review of purpose and values (1) and objectives and priorities (2) in anticipation of producing the LDP (3) (numbers refer to the table).

Risk planning (5) should be ongoing, but will need support from the Assurance Framework processes (4) to highlight trends, critical incidents and significant new risks.

Increasingly, a whole series of activities will revolve around the new Healthcare Commission core standards assessment programme and the audit and inspection of evidenced progress in relation to the developmental standards (7). In October 2005 there will be an opportunity to test and calibrate the approach, but from 2006 a declaration affirmed by Board members will be required each April, with action plans to meet deficiencies. These reflections on the preceding 12 months will be checked against available surveillance data, with inspections where necessary through to August and an annual publication of scoring of achievements in September. This will replace the current star ratings assessment and publication (6).

The Healthcare Commission will use information from external auditors to assess compliance with C7d (finance) and from centrally held performance data to assess compliance with C7f (targets) (8). It will use findings from other regulators and other bodies to build a richer picture of performance and reduce the burden of regulation by not asking the same things more than once. Where relevant, the Commission will also use the findings of other organisations (such as the NHS Litigation Authority (9) and other accreditations such as Improving Working Lives (IWL) standard (10)) as 'trump cards' in cross checking the declaration on core standards. This means that the Commission will accept that a trust has met a particular standard (or part of it) if it has met these organisations' relevant standards.

A number of other processes will have fed into the annual review. These include reflection on national targets and accountability reviews with the SHA (11), evidence in respect of information (12) and clinical governance (13), service (14) and audit (15) reviews, contributions from SHAs, local authority overview and scrutiny committees (17) and Public and Patient Involvement (PPI) Forums (20) and, for PCTs, the quality and outcomes framework (16).

The Board will want to publish its annual report at an AGM (18), having taken into account the outcome of the annual assessment (7), auditors' opinion on accounts (15) and annual staff (19) and patient surveys (20), ensuring everything is measured by its impact on patients ('Creating a Patient-led NHS', chapter 4).

Boards should review, at least annually, the fitness for purpose of their own composition and their committee structures (21) and set aside time for setting the following year's agenda (22).

The annual cycle of requirements (as demonstrated by trusts in 2005/06 but needing rescheduling in anticipation of 2005/06)

No	ANNUAL NHS TIMELINE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	**Purpose & Values**								revisit annually in the context of LDP				
2	**Strategic & Operational Objectives & Priorities**								revisit annually in the context of LDP				
3	**Local Delivery Plans**							Stakeholders engagement Incl Trusts			Sign off by Board		Signed off by DH
4	**Assurance Framework Key Risks**	RM sub monthly- sign if issues to Board	RM sub monthly	RM sub monthly	Board update	RM sub Monthly	RM sub monthly	RM sub monthly	Draft Declaration on Standards	monthly	Board update	RM sub monthly	RM sub monthly
5	**Risk Planning**		SIC signed										
6	**Star Ratings**		SHA best guess	Published									
7	**Standards for Better Health**	Declaration	Surveillance checking				Annual scoring &						
8	**C7d (finance) and C7f (targets)**					Feed into Scoring							
9	**NHS Litigation Authority negotiated timetable**			Paper from RM sub to Board	Submission to next level	Trump card for HC scoring							
10	**HR issues – IWL dates negotiable**				Submission to next level	Trump card for HC scoring							

11	**Accountability reviews with SHA inc NSFs**	Quarterly Review	Feedback to Board		Quarterly review	Feedback to Board		Quarterly review	Feedback to Board		Quarterly review	Feedback to Board	
12	**Information & Research governance issues**												Collate for HC standards submission
13	**CG annual submission**	Submit annual work plan to SHA											
14	**Service reviews received**	Quarterly			quarterly				quarterly	set agenda		quarterly	
15	**External & internal audit**		Receive report		Audit opinion on summaries Accounts		Receive reports						Annual audit plan
16	**Quality & Outcomes Framework – GPs**	Report for May Submission											Complete Annual Reviews
17	**LA Scrutiny Panel**		quarterly			Quarterly				quarterly	set agenda		Quarterly
18	**Annual Report/AGM**						Compiled						
19	**Staff Survey**								annual staff survey			Results & action plan	
20	**PPI agenda**								annual patient survey			Results & action plan	
21	**Board & Committee Fit for purpose Review**		Review TOR										
22	**Board agenda**	Review plan			Review plan			Review plan			set forward plan for year		

Achieving alignment through Integrated Governance

Effective governance itself requires strategic thinking. Often, when Boards run their annual planning cycle, they fail to align their strategic planning and objective setting against a proactive risk assessment that is prioritised and then continually monitored by the Board. Dynamic risk assessment is critical to the Integrated Governance process.

There should be a modelling approach, once the corporate objectives and the implications of LDPs have been determined. The achievement of Standards for Better Health will now, likewise, need to be included.

The strength of governance modelling is that it allows the Board to review and challenge each strategic objective against a series of governance elements. Eight elements have been designed to ensure all NHS Board members are adequately supported in discharging their duties.

The eight elements of Integrated Governance which constitute the High Level Governance Framework

1. Resources – be financially sustainable (probity, regularity, balance at year end), sufficient human resources, estate fit for purpose, appropriate information technology
2. Efficiency and Economy, Effectiveness and Efficacy (4Es) – the organisation can be run effectively, efficiently, economically and challenged – why are we doing this activity, could someone else do it and do it better?
3. Compliance with authorisations – will be compliant at all times with its authorisation to operate (Monitor, Health & Safety, Drug and Research management)
4. Compliance with Standards for Better Health and national targets – meet and exceed core standards and demonstrate progress with the developmental standards
5. The duty of quality as reflected in clinical governance – continue to improve services for patients and be governed in accordance with current best practice
6. The duty of partnership – cooperate with local healthcare economies
7. The duty of patient and public involvement (Section 18 of the NHS Act) – have a growing and representative membership to which it is responsive and accountable, in particular in the planning of services
8. The ongoing development of the Board

The key features to achieving integration are straightforward:

- aligning the organisation's strategic plan with the Assurance Framework
- testing each strategic objective against the high level governance framework
- ensuring the Standards for Better Health are aligned to the organisational objectives, Assurance Framework and subsequent risks.

There are therefore three opportunities for the Board to challenge the organisational objectives:

1. When the objective is established against the standards
2. When the whole reporting structure is defined
3. When new risks are identified.

An example of how the strategic direction aligns to the Assurance Framework and relates to the high level governance framework is set out below. This is followed by three practical illustrations of how the organisational objectives link to the Standards for Better Health and can subsequently be challenged at key points by a series of questions linked to the high level governance framework.

In both cases, the key questions linked to the high level governance framework can be illustrated as:

No	Governance Framework	Illustrative questions
1	Resources	Are we financially sustainable to deliver on this objective?
2	4 Es	Are the systems effective, efficient and economic, and have we challenged the appropriateness of our delivery of the service?
3	Compliance with authorisations	Can we be assured we are compliant our delivery of the service at all times even with competing authorisations?
4	Compliance with Standards for Better Health	Will we be compliant with the Department of Health's Standards for Better Health?
5	The duty of quality	Are our systems supporting improvements in clinical quality?
6	The duty of partnership	Are we using the information to communicate with stakeholders in our community?
7	The duty of patient and public involvement, in particular in the planning of services	Have we involved the patient and public in decisions about their care by demonstrating the effectiveness of various clinical options?
8	The ongoing development of the Board	Does the Board understand the issue and the relevance of reliable clinical or non clinical information systems?

3) The elements of the High Level Governance Framework – "The Challenge"

- Finance – be financially sustainable
- Efficiency and Economy, Effectiveness and Efficacy – the organisation be run effectively, efficiently and economically.
- Compliance with authorisations – will be compliant at all times with its authorisation.
- Compliance with the Standards for Better Health and national targets – meet and exceed the core standards and have made progress with the developmental standards
- The duty of quality as reflected in clinical governance – continue to improve services for patients and be governed in accordance with current best practice
- The duty of partnership – cooperate with local healthcare economies
- The duty of patient and public involvement – have a growing and representative membership to which it is responsive and accountable
- Developing the Board

relate to:

2) Alignment to the Assurance Framework – "The Assurance"

- principle objectives, both strategic and directorate level objectives
- principle risks
- key controls
- assurance on controls
  - management checks
  - risk register
  - internal audit
  - clinical audit
  - Healthcare Commission reviews
  - external audit
  - CNST and RPST and other reviews
- Board reports covering:
  - positive assurances
  - gaps and control
  - gaps and assurance
- Board action plan
  - to improve control
  - ensure delivery of principle objectives
  - gain assurance

1) Strategic direction and determining risks – "The Strategy"

The organisation reviews its strategic direction by examining:

- the organisation's five year strategic plan
- a current situation analysis, including past performance
- organisational objectives and associated risks
- the organisation's strategies for each objective
- the alignment and delivery of Standards for Better Health
- requirement from the LDPs

Example 1: Assurance Framework, Financial Management (for illustration only)

Principal Objectives	**High Level Governance Framework Challenge**	**Standards for Better Health**	**Principal Risks**		**Key Controls**	**Assurances on Controls**	**Board Reports**			**High Level Governance Framework Challenge**
		Standard	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance	
What the organisation aims to deliver.		*What standard the objective relates to*	*What could prevent this objective being achieved*	*Which area within our organisation this risk primarily relates to*	*What controls/systems we have in place to assist in securing delivery of our objective*	*Where we can gain evidence that our controls/ systems, on which we are placing reliance, are effective*	*We have evidence that shows we are reasonably managing our risks and objectives are being delivered*	*Where we are failing to put controls/systems in place.* *Where we are failing in making them effective*	*Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective*	
1. To ensure sound financial management, delivering in-year/recurrent financial balance, economy, effectiveness, efficiency, probity and accountability in the use of resources as well as other financial duties.		C7d	1.1 Failure to achieve financial targets. 1.2 Inability to deliver services against PPF targets. 1.3 Inability to plan for future services across health economies. 1.4 Failure to deliver annual value for money targets. 1.5 Failures in probity and good governance. 1.6 The Board not fully engaged in financial planning.	Finance	Regular reconciliation processes. (1.1, 1.5) Sound financial systems. (1.1, 1.5) Financial performance strategy in place across health economy. (1.3) Financial strategy and associated risks formally endorsed by the Board. (1.6) Budgetary control over allocations provisions and reserves (all risks). Robust recovery plan agreed. (all risks) Financial monitoring arrangements in place at Board level. (all risks).	External Audit Annual Letter (1.1) SHA review of recovery plan (all risks) Internal audit reports relating to financial system control, reconciliation processes and budgetary control. (all risks)	Controls are deemed to be satisfactory and shown to be operating effectively in relation to risks: 1.3, 1.5 and 1.6	Regular checks are not being undertaken into the adequacy of reserves. (1.1) Insufficient monitoring of PPF targets at Board level (1.2) Risk assumptions not debated in relation to vfm targets (1.4)	Timing of Annual Letter is too late to provide in-year assurance. (1.1) No third party assurances are being received in respect of financial services being delivered by other organisations (all risks)	

Example 2: Assurance Framework, Workforce (for illustration only)

Principal Objectives	High Level Governance Framework Challenge	**Standards for Better Health**	**Principal Risks**		**Key Controls**	**Assurances on Controls**	**Board Reports**			High Level Governance Framework Challenge
		Standard	Principal Risk	Classification of Principal Risk			Positive Assurances	Gaps in Control	Gaps in Assurance	
To ensure the workforce is properly skilled		C11a, C11b	2.1 Lack of appropriate training 2.2 Inability to recruit the right staff 2.3 Failure to retain key skilled staff 2.4 Inappropriate investment in training	Workforce	Trust-wide training needs analysis (2.1) Trust-wide training strategy linked to individual staff appraisal (2.1) System for monitoring the effectiveness of training strategy (2.1) Appraisal system in place (2.1, 2.3) System for monitoring effectiveness of appraisal system (all risks) IWL Practice Plus (all risks)	Royal Colleges (2.1, 2.2) Internal audit report on effectiveness of training strategy (2.1) Internal audit report on the effectiveness of the appraisal system (2.1, 2.3) Improving Working Lives Practice Plus (all risks)	Full Assurance on nursing training (2.1) Full assurance on appraisal for all clinical staff (2.1, 2.3)	Gaps in linkage to staff appraisal for support staff (all risks)	No assurance on effectiveness of training strategy (all risks)	

Example 3: Assurance Framework, Governance (for illustration only)

To establish effective governance arrangements and ensure the organisation is run appropriately and in a way that inspires public confidence	High Level Governance Framework Challenge	C7a, C7c	3.1 Failure to identify the risks to the organisation's principal objectives 3.2 Failure to prioritise risks across the organisation in a consistent manner 3.3 Inability to deliver risk treatment/action 3.4 Lack of appropriate strategy, structure or accountability for corporate and clinical governance 3.5 Clinicians not appropriately engaged in the CG agenda	Organisation wide	Principal objectives set and agreed at board level and communicated to staff (3.1) Policy and Strategy in place regarding the identification and management of risks (3.1, 3.2, 3.3) Framework in place to gain assurance on the management of risks and the delivery of objectives – Risk Pooling Schemes for Trusts (RPST) (3.1, 3.2, 3.3) Clinical governance strategy in place (3.4) Framework in place to undertake review of Board business management (3.4) Time to learn events/ protected leaning time events held for clinicians (3.5) Appraisal system in place across all staff groups (3.5)	RPST Review (3.1, 3.2, 3.3) Internal Audit report on the working of the Board and its committees (3.4) Internal audit report on the effectiveness of the appraisal system (3.5)	Positive report from internal audit on the working of the Board and its committees (3.4) Full assurance on appraisal for all clinical staff (3.5)	Gaps in linkage to staff appraisal for support staff (3.5)	No third party assurance on quality of clinical governance strategy (3.4) No assurance on the effectiveness of the overall Assurance Framework (all risks)	High Level Governance Framework Challenge

Over the year, the Board will be expected to maintain strategic direction by ensuring progress is being made against the core objectives. This would, typically, be organised by ensuring an annual programme of progress reports to the Board, against an agreed timetable . It is also essential that the directors are satisfied that progress against objectives will demonstrate clinically competent services and financial solvency.

Do Boards manage their objectives?

There is evidence indicating that Boards do not ensure that the agendas of Board meetings cover the delivery of organisational objectives (see 'What makes Boards Effective?', NHS Confederation)

Non-executive directors often assume that executive directors keep them fully appraised of progress against objectives. Where this assumption is misguided the Board is neither managing the agenda nor its overall annual programme.

In examining the role of the non-executive directors within this process, the NHS National Clinical Governance Support Team's Board Support Team and the NHS Appointments Commission developed a tool – a board assurance prompt (BAP) – that comprehensively allows the Board to challenge progress of either an objective or an agenda item. This tool is a means of:

- identifying the proposed objective
- assigning a series of four or five key questions around the progress on that objective
- identifying the tensions in decision-making
- encouraging a balanced approach to all aspects of governance, from clinical to financial.

Compliance units

NHS Foundation Trusts and others may consider setting up a compliance unit. This needs to be complementary to and supported by the work of internal auditors. This is a new activity in corporate governance terms but can be seen to have grown, in part, out of the Turnbull Report on Internal Control. This advises that, when reviewing reports during the year, the Board should:

- consider what the significant risks are and assess how they have been identified, evaluated and managed
- assess the effectiveness of the related system of internal control in managing the significant risks having regard, in particular, to any significant failings or weaknesses that have been reported
- consider whether the necessary actions are being taken promptly to remedy any significant failings or weaknesses
- consider whether the findings indicate a need for more extensive monitoring of the system of internal control.

(Turnbull, para 31)

A compliance unit would ensure that the monitoring of internal controls is a continual process. It would provide assurance to the Board that internal controls are being implemented and followed through. The unit would not design or manage these systems, but it would become a central aspect of the controls' Assurance Framework.

Monitor states that the overriding objective is to assess and mitigate potential risks to the delivery of NHS Foundation Trusts' obligations under their terms of authorisation. Monitor intends to achieve this by obtaining information on finance and governance and assessing risk in these areas, based on similar criteria to those used in the NHS Foundation Trust assessment process. It will then require the Board to demonstrate that it has identified such risks and that they are being addressed effectively. By monitoring risk in this way Monitor will allow NHS Foundation Trusts to operate autonomously in providing health services. The compliance unit should operate with the maximum degree of that autonomy. The unit would also ensure all external compliance issues were addressed.

1.4 Re-energising quality and clinical governance[1]

(This section is based on a paper presented by Andrew Corbett-Nolan to the International Finance Corporation (IFC) Conference, hosted by the World Bank in Washington, February 2005)

Quality is at the heart of the Integrated Governance agenda. It demands the re-examination of traditional roles and boundaries, whether between doctors and patients, managers and clinicians or operations and governance activities. It is the opportunity to demonstrate to the public that the NHS is serious about quality.

Institution and development

The 1999 Health Act, placed the corporate responsibility 'the duty of quality', articulated as clinical governance, on those responsible for local healthcare systems – organisations, not individuals. Clinical governance was to be the responsibility of a corporate body, accountable for the services it organised or provided for patients. In the sixth Shipman report Dame Janet Smith indicates that clinical governance 'should consist of an integrated system of different types of activity, all aimed at improving quality of care'.
In order to discharge this accountability, a new architecture of corporate systems and processes needed to be formulated and skills embedded at every level. Six years on significant progress has been made, but few organisations have reached the state of maturity where clinical governance, the central business of a healthcare organisation, is the Board's core accountability issue. Integrated Governance aims to do just this: to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by a Board.

Today's challenges

Government has built considerably on the 1999 Act. As a spur to the local development of systems and processes to deliver clinical governance, the central mechanisms to require, foster and monitor the development of improvement have themselves been gradually re-aligned. Importantly, the 2003 Act has rationalised and integrated the monitoring arrangements for health and social care, and a common template for quality assurance and improvement has been articulated by the introduction of national standards – Standards for Better Health. More recent guidance identifies that compliance with these standards will provide the test of fitness to trade as a healthcare organisation, and identify those healthcare providers where NHS money can be spent.
A further stimulus to clinical governance has been provided by the new inspectorate, the Healthcare Commission. It has published its intended methodology for ensuring that healthcare organisations meet the

[1] This section is based on a paper presented by Andrew Corbett-Nolan to the International Finance Corporation (IFC) Conference, hosted by the World Bank in Washington, February 2005

requirements described in Standards for Better Health, which will be strongly reliant on self-assessment. Boards will need to sign an annual declaration that the standards are in place and that all services meet the new national requirements. In order to do so, healthcare organisations will have to be satisfied that the standards are embedded in working practices at all levels. Clinical governance systems need to deliver this assurance to Boards. Responsibility for ensuring that these standards are in place and that the duty of quality, as represented by clinical governance, is implemented, lies with the entire Board. Board members need to take an active role by providing strategic leadership and ensuring that the quality and safety of patient care is not pushed from the agenda by immediate operational issues. The role of non-executive directors is increasingly important in this respect. Also, the Board's programme of activity, committee structure and decision-making approach will need continually to promote the clinical agenda and use the information from clinical governance activities to ensure alignment between the development of the organisation as a corporate body and healthcare organisations' particular responsibilities.

'Business as Usual'

It is important that the clinical governance process is managed through the organisation's line management, for example via clinical directorates or their equivalent. The clinical governance programme should be drawn up from a variety of sources and agreed by the clinical governance group (or equivalent) and the executive management team and then recommended to the Board for approval. The execution of the programme will be via clinical or operational directorates using quality management processes and project management disciplines. The programme's outcomes, through the implementation of change in practice, ie 'closing the loop', should be signed off by clinical directors and monitored - perhaps by the Audit Committee but ultimately by the Board – to provide it with reassurance.

As a quality improvement process, clinical governance enables organisations to address the requirements of Standards for Better Health directly, and with patient and carer involvement in the team approach, brings to life the 'Patient Centred NHS'.

An enhanced role for non-executive directors

The introduction of clinical governance has given added importance to the role of non-executive directors. They have an opportunity to provide independent scrutiny of the work of their organisation and to hold executive directors to account for their performance. They can also help ensure that quality and safety are not pushed from the agenda by immediate operational issues. All of this demands an open, honest and constructive relationship between executive and non-executive directors, with clear lines of communication. The Bristol Enquiry (see boxes below) demonstrated this is not always easy.

'In my view, if properly developed and well resourced, clinical governance could provide the most effective means of achieving two important aims. First, it could enable PCTs to detect poorly performing or dysfunctional GPs on their lists. Second, it could have the beneficial effect of helping doctors who are performing satisfactorily or well to do even better.'
Dame Janet Smith
Sixth Shipman Report, 2005

'In our view, non-executive directors have a crucial role to play in representing the public interest in the conduct of the Trust's affairs. They must be people with a high level of ability and experience in the leadership and management of organisations … they should have a commitment to public service.'
The Bristol Royal Infirmary Enquiry, July 2001
chapter 24, paragraph 33

Lessons for non-executive directors from the Bristol Enquiry

- Non-executive directors can be prevented from exerting their authority by 'not being let in on issues' at senior executive level
- Lack of sound knowledge about Trust activity can lead to an inability to challenge chief executives' or executive directors' views
- Role objectives may not be clarified and communicated. There was:
    - variation in the roles played by non-executives on the Board
    - variation in what was expected of non-executives
    - a lack of clarity and direction for the role.

How can quality be achieved?

Several methods have evolved to achieve, sustain and improve quality. They are known as quality control, quality improvement and quality assurance – collectively known as quality management. Quality management is not the preserve of one manager but of all managers. Quality is achieved through a chain of processes, each of which has to be under control and subject to continual improvement.

The chain starts with top management expressing a firm commitment to quality, then:

- establishing customer needs and expectations
- developing and maintaining a management system that will enable achievement of customer needs and expectations – reliably, repeatedly and economically
- designing products and services with features which reflect customer needs
- building products and services so as to reproduce faithfully the design
- verifying before delivery that products and services possess the features required
- preventing the supply of products and services which possess features which dissatisfy customers
- discovering and eliminating undesirable features in products and services
- finding less expensive solutions to customer needs
- making operations more efficient and effective
- discovering what will delight customers and providing it
- most importantly, honouring commitments.

Institute for Quality Assurance, 2005

'Clinical governance provides "a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".'

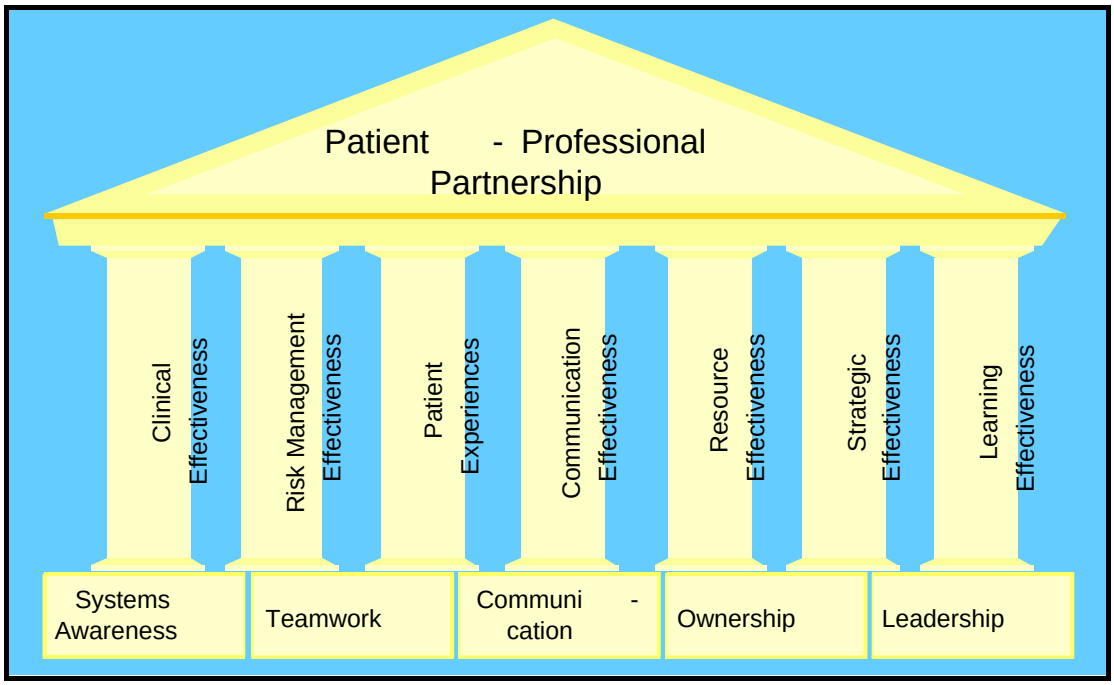
Scally G and Donaldson LJ. (1998) 'Clinical Governance is Here to Stay' *The British Medical Journal* 317: 61-65

'Clinical governance was the centrepiece of an NHS White Paper introduced soon after the Labour Government came into office in the late 1990s. The White Paper provides the framework to support local NHS organisations as they implement the statutory duty of quality which was placed on them through the 1999 NHS Act. Clinical governance provides the opportunity to understand and learn to develop the fundamental components required to facilitate the delivery of quality care – a no blame, questioning, learning culture, excellent leadership, and an ethos where staff are valued and supported as they form partnerships with patients. These elements have perhaps previously been regarded as two intangible to take seriously or attempt to improve.'

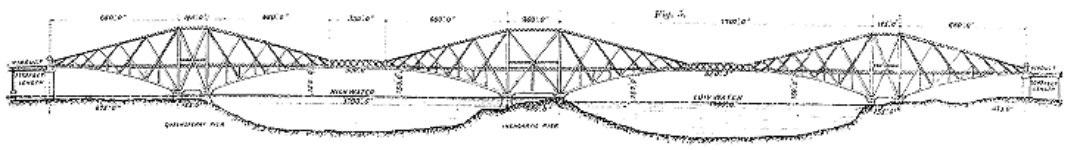
Donaldson and Halligan *Implementing clinical governance: turning vision into reality*, (BMJ 2001)

Quality in clinical governance can be summarised as:

- representing systematic joining up of initiatives to improve quality
- instituting mechanisms for establishing standards, and ensuring they are met
- fostering new approaches to leadership, strategic planning, patient involvements, and the management of staff and processes.



The Commission for Health Improvement (CHI) articulated clinical governance in a classical architectural analogy, emphasising the supportive strength of 'seven pillars'. This framework was criticised over time for appearing to place the key elements in distinct organisational silos. CHI also found in its reviews that it omitted two key themes – leadership and strategic capacity. These are now being considered by the expert panel working on the Governance Developmental Standards. An updated version of the framework would weave all these elements together more strongly, perhaps using more modern architectural analogies such as bridges and skyscrapers, where the forces which make up the structure are linked deliberately to use all the tensions (pushing and pulling) to ensure the strength of the whole (see 'Temple or Bridge: Where is the Quality Framework?', Bullivant and Corbett Nolan, HSCQC 2005)



Quality is now embedded in the Department of Health's Standards for Better Health. All health organisations, both public and independent, will be expected to meet the core standards, and be making progress towards the developmental standards.

Strategic Leadership Programme

The NHS Clinical Governance Support Team (NHS CGST) developed a Strategic Leadership of Clinical Governance programme for Boards to encourage excellence in clinical governance within a corporate framework. This involved examining executive and non-executive directors' roles and responsibilities, the effective functioning of the Board as a whole and the application of the principles of clinical governance within the organisational context.

The NHS CGST engaged with over more than 200 Boards over a four year period. In working with these Boards, it was essential to put in place a clear structure whereby the corporate Board understood the need for clinical issues to be at the heart of the boardroom agenda. Part of the development of this approach was induction days for non-executive directors on behalf of the NHS Appointments Commission. This led to the beginning of a cycle whereby clinical governance encouraged financial, research, information and all other aspects of governance to link up with the clinical agenda.

'Clinical governance is a system for improving the standard of clinical practice in the NHS and for protecting the public from unacceptable standards of care. The system comprises several different types of activity which should all fit together into a framework. This Integrated system has replaced the previously disparate and fragmented approaches to the improvement of quality of care. The different types of activity include continuing education, the introduction and maintenance of good management systems, the promotion of clinical effectiveness, clinical audit, risk management, research and development and the fostering of an ethos of openness and accountability. Some of these activities are developmental in nature, such as continuing education and the dissemination of good practice. Risk management, by which organisations seek to analyse untoward events and learn from them, is another example of a developmental activity. Other activities are of a monitoring or supervisory nature; for example, organisations are required to collect data and information about the care being provided by their clinicians. This should enable the organisation to detect poor performance so that it may be corrected, but data collection should also draw attention to good performance and therefore have a developmental effect. Yet other activities are designed to encourage clinicians to monitor themselves, with the intention that this should provide the opportunity and incentive to improve clinical performance. For example, clinicians are provided with data about their own performance and that of their team or group; they are also encouraged to audit their own activities and those of their colleagues.'

Dame Janet Smith, *Sixth Shipman Inquiry* 2005

1.5 Legal implications for Boards

(This section is based on a paper developed by David Owens of Bevan Brittan)

The best protection for individual directors is to take account of the range of issues before the Board and not merely those in which the executive has an interest. As well as challenging colleagues, it may also involve seeking advice to assist the Board in reaching its conclusions.

Liabilities of directors and Board members

The starting point for considering the liabilities of individual directors is understanding the role of the Board and the corporate nature of the Trust, PCT or Foundation Trust (in this section collectively referred to as the Trust). Any such Trust will be a corporate entity in its own right and will take decisions as such. As noted earlier, this has implications for the role of directors, who are collectively responsible for all decisions. However, the corporate nature of the organisation will mean that, in most instances, even if a decision is open to criticism, individual directors will not be legally liable. There is specific statutory protection where they are acting in good faith. (See S265 of the Public Health Act 1875). This section covers the circumstances where such personal liability can arise.

Criminal liability

An individual who, in the course of his or her activities as a director, commits a criminal offence will of course carry personal responsibility and liability. Perhaps more significantly a director can, in some circumstances, be held to have committed a criminal offence where the offence arises under statute that includes explicit provision to hold a director liable. Examples are health and safety legislation, the Environmental Protection Act and the Data Protection Act.

*'Where the organisation has committed a criminal offence and it is shown that the offence took place with the connivance or consent of, or the neglect by a director, officer or manager of the organisation then the director, officer or manager is also guilty of an offence' (*See, for example, S37 of the Health and Safety at Work Act 1974).

With regard to corporate manslaughter, the law remains that it is necessary to show that a 'controlling mind' within the organisation (usually a director) is also guilty of manslaughter, that is to say has been guilty of gross negligence that directly caused the fatality. In practice it has proved very difficult to convict either large corporations or their directors on this basis. Current proposals introduce an approach that would address the difficulty of convicting the corporation, but would not affect the test for manslaughter.

Civil liability to third parties

Civil liability, which generally relates to the payment of compensation, can arise in either contract or tort. Liability in contract will only occur if the contract is entered into in the personal name of the director rather than that of the

Trust, or where a contract entered into by the Trust is found to be ultra vires and the director has given a personal warranty or representation that the Trust has appropriate powers. Directors therefore need to be careful about what assurances they give about the powers of the organisation.

The more usual risks are for the individual to have a claim in tort made against them, most commonly in relation to either negligence or defamation. Negligence arises where an individual acts without due care towards a person to whom they owe a duty of care, and causes foreseeable loss. Usually, as with clinical negligence claims, the claim is pursued against the Trust, not the individual, and the NHS Litigation Authority will provide cover. Indeed, the Liabilities to Third Parties Scheme includes cover for directors similar to that available in the commercial market by way of directors' and officers' liability insurance.

Defamation is a potential risk, and while some degree of protection is afforded where public officers are acting honestly and in the course of their business, there are risks if they step outside the strict parameters of the role.

A potential threat is misfeasance in public office, but in practice this is very rare, and requires the establishment of deliberate malice, targeting the individual or a limited class of people who has/have suffered loss.

Claims by the Trust

A final area of risk is that of claims by the Trust. All directors owe a duty of care and skill to the Trust, and breaches could give rise to claims. In this area there is a material difference between the position of executive and non-executive directors. The latter are protected by the terms of the standard Treasury indemnity unless they have been reckless. However, executives could in theory be the subject of claims even if they have only been negligent. Although there are some high profile cases, such as Equitable Life, in practice claims against the directors for negligently carrying out their duties are rare. It does however underline the need for directors to use care and skills in carrying out their role. Where a matter is outside their competence, they may want to consider whether they need independent advice.

A further area of claim by the Trust would be for breach of fiduciary duty or for repayment of benefits improperly received. This can arise in two main ways. The first is where a director abuses his or her position to make private gain. This could occur where a director arranged for a contract with a company in which he or she had an interest, without declaring the relevant interest. In such circumstances the Trust can call for an account of the proceeds.

Secondly, and perhaps more commonly, situations arise where the auditors call into question officers' remuneration or retirement packages. Irrespective of the propriety of the individual's conduct, if the award of an enhanced pension was outside the powers of the Trust, or decided upon improperly, it can be clawed back.

Foundation Trust insolvency

One area where the risks of personal liability for Foundation Trust directors is different, is in relation to the risks on insolvency of the Trust. The Department has still not produced the final version of the rules to modify the application of the Insolvency Acts to Foundation Trusts following last year's consultation. The extent of the risk for directors under the Insolvency Act is therefore not entirely clear. However, it seems likely that the rules on wrongful trading and transactions at an under value as well as the rules on preferences will apply. Once it becomes – or should be – apparent that the Trust cannot avoid an insolvency regime, it is incumbent on the directors to run the Trust in the interests of the creditors, ie not the shareholders or other stakeholders. No new credit should be taken up and transactions at an under value can subsequently be reversed. If a liquidator considers that wrongful trading has taken place he or she can seek a contribution from the director's assets, and it seems unlikely that an indemnity would be effective (see below).

Given Foundation Trusts' commercial freedom to engage in corporate joint ventures, directors of such companies also need to be aware of their duties under the Companies Acts.

Indemnity

As indicated above, there is a degree of protection for directors. Non-executives will typically have the benefit of the Treasury approved wording (amended wording is set out in HSG 1999/104). This covers the director for acts carried out in good faith in the execution or purported execution of the functions of the Trust, short of recklessness. It does not cover criminal liability, and no indemnity could do so. There is some doubt about the position where the director is in fact acting outside the powers of the Trust, particularly where to enforce the indemnity would be to allow a collateral enforcement of an ultra vires obligation against the Trust.

Executive directors will generally be indemnified in relation to claims against them arising from third parties, but difficult issues can arise when staff make allegations of harassment, and Trusts will need to tread carefully in such cases.

Policy decisions

One area where these issues can cause concern is in relation to policy decisions, especially around the reconfiguration of services. There are often emotive claims made about the potential impact of making or failing to make the relevant service change. However, where the Board is acting collectively, and honestly considers the evidence before it and its overall duties, it will be difficult to challenge individuals, even if the decision itself is challenged on public law grounds. Acting in accordance with advice responsibly obtained is particularly helpful in defending the position of individual directors, and many of the steps the Trust will need to take to comply with its obligations in decision-making will also assist.

Summary

There are risks of legal liability for directors, but they are not as extensive as they may at first seem, and in many cases the liability will be assumed by the Trust. Protection for the director at an individual level is best assured by the proper exercise of his or her duties; taking care to act reasonably and to act as a Board member rather than an individual. This means taking account of the range of issues before the Board and not merely those in which a director has an interest. As well as challenging colleagues, this may also involve seeking advice to assist the Board in reaching its conclusions.

1.6 Action for Boards to implement Part 1

Here, and throughout the sections in Part 2, we examine the role of the Board in delivering the points addressed.

Board's Key Points for Action: 1 & 2

1. Confirm the purpose of the Trust and establish the strategic direction over the next one to five years (agreed with local community and Overview and Scrutiny Committee (OSC) of local government, or for Foundation Trusts engage with the Board of Governors) and set objectives consistent with government policy and local context.

2. Manage the agenda by establishing the annual cycle of business.

This process requires the Board to outline its approach to accountability accurately in the Assurance Framework in order to:

- ensure that all risks relating to the organisational objectives are taken into account
- test its objectives and assurance mechanisms against the high level governance framework
- clarify its understating of the duty of quality and enhance the standing of clinical governance within the organisation
- recognise the legal liabilities of executives and non-executives.

Where a specific problem has arisen this will require further scrutiny and consideration.

Part 2 of the handbook builds on the Board role. This will support the Board in measuring progress towards full integration, stage by stage. It also describes how information systems need to be aligned to the integration model. This is essential to ensuring the Board's responsibilities regarding quality and patient safety are met.

PART 2: HOW TO DO IT

2.1 Assurance and controls – Meeting Board responsibilities

All Boards need systems of reporting and monitoring that keep them informed of the progress of their objectives, the development and assessment of risks and issues that threaten the achievement of the objectives.

Implementing the Assurance Framework and the Department of Health's Standards for Better Health will enable the Board to be sure that it is in full control of its agenda.

The Assurance Framework

The following extracts from 'Building the Assurance Framework – A Practical Guide for NHS Boards' (DH, 2003) clearly indicate what the Board must do when developing an Assurance Framework.

> 'More than ever before, as the NHS embraces a culture of decentralisation, increasing local autonomy and local accountability, Boards need to be confident that their systems, policies and people are operating in a way that is effective in driving the delivery of objectives by focusing on identifying, prioritising and minimising risk. In support of that challenge, in July 2002 the Department of Health issues "Assurance: The Board Agenda" which set out the principles for an Assurance Framework to give Boards the confidence they need. This has now been further developed in "Building the Assurance Framework".
>
> 'The requirement for all NHS Chief Executive Officers to sign a Statement on Internal Control (SIC) as part of the statutory accounts and annual report, heightens the need for Boards to be able to demonstrate that they have been properly informed about the totality of their risks, both clinical and non-clinical. To do this they need to be able to provide evidence that they have systematically identified their objectives and managed the principal risks to achieving them. The Assurance Framework fulfils this purpose.
>
> 'There has been considerable interest in receiving additional direction and advice on building an Assurance Framework, and on how to bring together the existing fragmented risk management activity systematically and make sure that the process is efficient, highly focused and adds real benefits to the organisation. This section therefore describes how to construct an Assurance Framework, supported by worked examples. It also clarifies the relationship with performance management arrangements, clinical governance reporting and other sources of assurance.

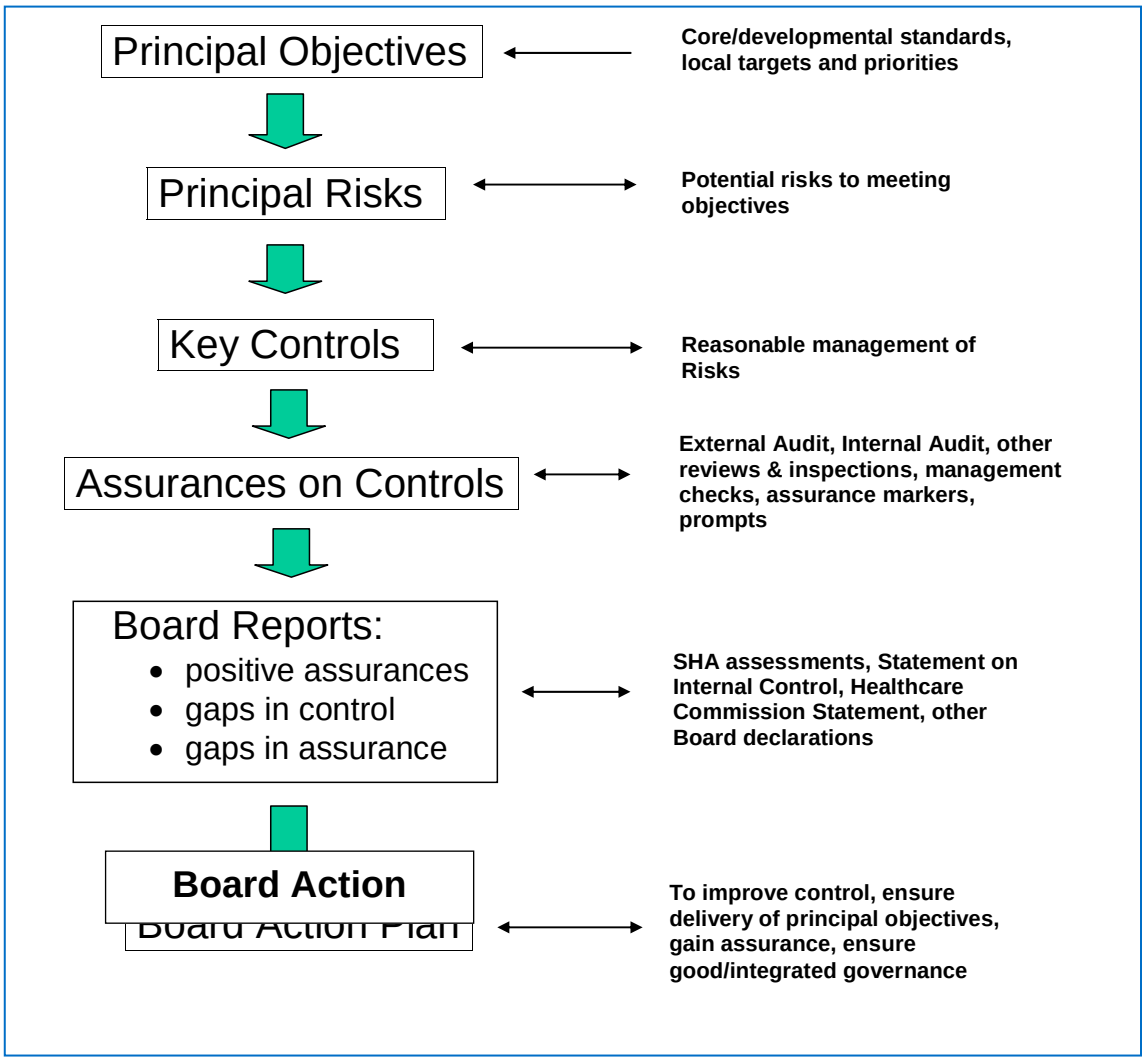
‘This does not introduce any new requirements on NHS organisations, but tries to provide practical assistance and clarity about what is currently required.’

In summary:

- Establish principal objectives (strategic and directorate).
- Identify the principal risks that may threaten the achievement of these objectives – but ensure that there is the opportunity to recognise critical risks outside key objectives.
- Identify and evaluate the design of key controls intended to manage these principal risks, underpinned by core controls assurance standards.
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk.
- Evaluate the assurance across all areas of principal risk.
- Identify positive assurances and areas where there are gaps in controls and/or assurances.
- Put in place plans to take corrective action where gaps have been identified in relation to principal risks.
- Maintain dynamic risk management arrangements including, crucially, a well founded risk register.

The Assurance Framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the SIC. This simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

The current view on the Assurance Framework, set out below, looks at how it should develop to provide a single evidence base for local priorities, standards and Integrated Governance arrangements.



We have taken the Assurance Framework and placed it in the centre of the three-phase model – 'Strategy, Assurance, Challenge' – outlined in section 1.3. This places the Assurance Framework in a carefully adjusted setting to allow it to cross check between how well the organisational objectives have been set, and then be challenged by the high level governance framework. In effect, this measures precisely what the Board needs to do in relation to its objectives and their associated risks.

Internal Audit

Internal auditors provide an opinion about the Assurance Framework to the client organisation at the year-end. This is in two distinct parts. The first is an opinion on the adequacy of the Assurance Framework itself; the second is to provide assurances on the management of those risks identified within the Assurance Framework, where the internal auditors have carried out review work during the year. This opinion is used by the Board to inform the SIC and by the Strategic Health Authority as part of its performance management role. It is also likely that Internal Audit will play a key role in supporting Trust assurances to the Healthcare Commission on compliance with standards.

External Audit

External auditors are required to review the SIC as part of their annual audit of the financial statements. The review considers whether the SIC has been prepared in accordance with the Department of Health's requirements, and whether there are any inconsistencies between the disclosures in the SIC and information the auditors are aware of from their work on the financial statements and any other work. To inform their review, auditors will consider the governance arrangements in place at NHS bodies and will place reliance on the Assurance Framework as the key piece of evidence in support of the SIC.

Department of Health's Standards for Better Health

The Department of Health's Standards for Better Health (the standards) were formally issued to the NHS in July 2004. They set out the core standards that NHS organisations must achieve in their current delivery of care and the developmental standards they must pursue in order to achieve the goals set out in the NHS Improvement Plan (DH, 2004).

The standards are described under seven 'domains' (safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environments and amenities, public health). Boards are responsible for ensuring that they exercise their governance duties in relation to all these domains, and domain 3 explicitly defines standards of governance under six core and five developmental standards.

The Healthcare Commission (HC) is developing a new approach to assess NHS performance against these standards and in May 2005 published its criteria for assessing core standards for acute services – mental health and learning disability services, primary care trusts and ambulance trusts.

As part of this approach, the standards are broken down into component parts or 'elements'. The Commission's guidance ('Criteria for Assessing Core Standards') defines the elements for each sector (acute, ambulance, mental health and primary care trusts) and provides detailed listings of the information mapped to the elements which will be used by the Commission in the checking stage of the assessment of compliance with core standards.

Taking the above into account, we need to attempt to merge the building of the Assurance Framework and the declaration against the standards and align them to the principles of integrating a governance system. Integrated Governance provides the umbrella that brings coherence to a Board's exercise of governance within its component elements. The approach – to ensure the above merging – has been informed by a critical scrutiny of the research literature on good governance (and on governance failures) in the public, private and independent sectors, both nationally and internationally, and by attention to core and developmental aspects of domain 3 (governance) in the standards.

On this basis, the approach that is being developed emphasises that:

'Integrated Governance' is a co-coordinating principle. It does not seek to replace or supersede clinical or financial governance – or any other governance domain. Rather re-energises their vital importance and the inter-dependence and inter-connection between them.

Boards must be 'fit for purpose' and work as effective corporate entities. They must draw on all the talents of their non-executive and executive members and advisors and ensure there is clarity and mutual respect between them so that they develop and sustain a culture that balances cohesion and constructive challenge. This requires the availability of robust and interpreted information to support the decisions.

Decisions taken within any one domain of governance must be informed by active scrutiny of their implications for every other domain (eg any proposed quality initiative must be balanced against the overall financial and staffing resource), including the capacity to deliver (see illustrations in section 1.3).

The supporting systems

To ensure that objectives have been accurately met and the elements of the standards have been strategically reflected, active systems, which reach from the top to the bottom of the organisation and control the elements of the organisation's activity, need to be in place.

There are several pieces of policy guidance over which the organisation's executive directors will have overall responsibility. They cover the following policy areas:

- NHS finance manual
- clinical governance guidance
- annual reporting cycle
- human resources manuals
- IT governance
- research governance.

Each appointed director is responsible for ensuring compliance with the appropriate guidance and endeavouring to ensure that all stakeholders are consulted. It is the relevant officer's responsibility to examine the organisation's objectives (for example, the Finance Director, in light of financial regulations) and ensure they align to the requirements of the standards and are accurately measured in the Assurance Framework.

In the case of any element of doubt, the director will need to:

- look at his or her specific reporting requirements
- rigorously test those requirements within the scope of the objective against the high level governance framework
- test the high level objective against the Healthcare Commission's prompts to ensure compliance
- report any suspected non compliance areas relating to his or her specialty to the Board and allow the Board to examine such implications against other specialisms and organisational objectives.

Validating the systems

A systematic approach is needed to ensure that the systems upon which the organisation relies are regularly challenged and tested. This is in order to ensure that any new information that a professional body would wish to highlight is understood and reflected in the trust's policy manuals. A number of external organisations, will, by law, regularly request information from the trust, and more specifically from the Board. Section 2.2 examines the reporting requests in greater detail and looks at the rationalisation of the request system.

Organisations need to be aware of the following policy guidance:

- Healthcare Commission Inspection Policy – this should be considered in line with the HC's regular policy updates.
- Royal College Accreditation – in line with the College's policy on accreditation for a given specialism and the assurance that the professional involved is adequately accredited for the practice that he or she regularly carries out. The trust should also be aware of the role of the GMC and other professional bodies.
- NHS Litigation Authority and its requirements that trusts accurately report, annually, all appropriate authorisations.
- Assurance Framework – to ensure that any risks relating to system validation are identified within the trust's Assurance Framework.
- Requests trusts may get from other regulators, including the Audit Commission.

Once again, in this process of validation, it is important to be aware of other sources of information that organisations and Boards can draw on. This may mean examining the types of questions outlined in the Healthcare Commission's prompts, which may be seeking a further formal validatory approach or the information from a high level reporting system.

Whole Board working

The Board should be expected to work in a fully corporate way throughout this process. The whole Board, not the designated director (such as the Medical Director for an objective relating to care), has responsibility for each objective.

The Board must accept that, by gaining integration, it is accepting a fuller corporate approach. It must also satisfy itself that it is building up to a process of signing off a statement of internal control at the end of the financial year and meeting the Healthcare Commission's requirements.

'With simplification of the system comes greater accountability' (Professor Sir Ian Kennedy).

The Role of the Board (section 2.1)

The role of the Board in this process is to ensure that integration is an active and dynamic approach.

Board's Key Points for Action: 3

Ensure an integrated assurance system is in place

This will mean that:

- it will assure itself that it is meeting, through the use of the Assurance Framework, the Standards for Better Health and statutory requests from the Healthcare Commission and other regulators
- its officers, through the appropriate professional line of accountability, have assured themselves that each element of policy has been met & adhered to
- a process of validation has been entered into and the Board can be satisfied that all requirements are fully met.

2.2 Reporting and information – Organising information and communication flows

(This section is based on a paper developed by Dr Charles Bruce, Royal Free & Hampstead NHS Trust)

This section outlines the essential reporting frameworks that provide the right information and data, in formats suitable for different users, at the appropriate time and avoid duplication of effort.

The Healthcare Commission has called this approach 'intelligent information', by which it means:

- information that allows intelligent judgement and directly informs action for improvement
- information which is of value, with clear uses defined
- intelligent information systems that collect information once (and use it repeatedly)
- information that is disseminated in a way that is appropriate to the audience and context (including locally useful data).

In order to fulfil its responsibilities, the Board will want to be given information to help formulate its strategy, benchmark existing services in terms of safety, quality, cost, effectiveness etc, and set measurable objectives and targets. It will need to be assured that the organisation is using appropriate information to performance manage its processes and outcomes and will want to receive relevant reports on the successful implementation of its strategies and policies, and those that comprise responses to regulators, the NHS, partners and the public.

Benchmarking and strategy

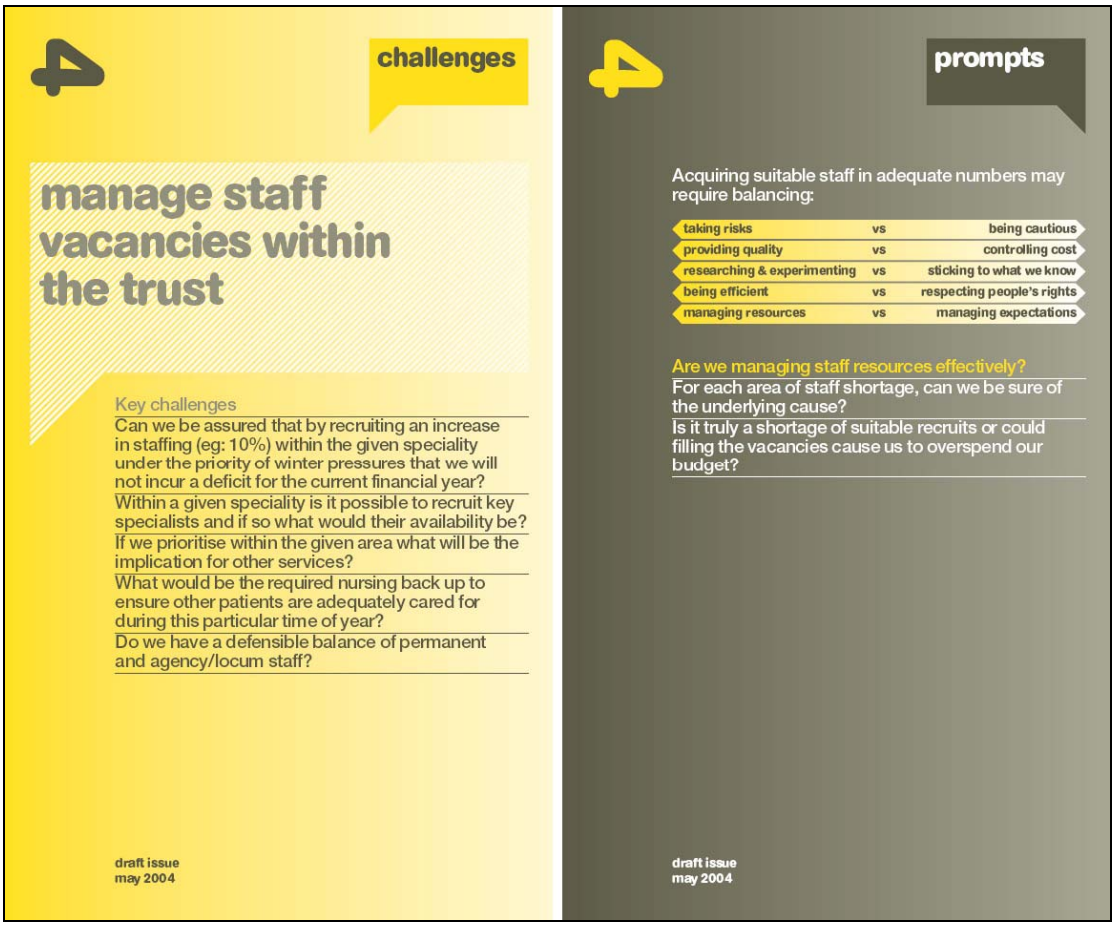
The Board is likely to set its strategy using many diverse information sources, including past performance, comparative performance, national and local public health and epidemiology data and national standards and targets. It may also wish to take a closer look at key clinical areas and receive regular progress reports on the improvement of systems and processes that ultimately affect patient care and which the Board believes are important to the population it serves.

Clinical governance information
NHS organisations have to provide an annual clinical governance report, which is sent to the SHA to corroborate clinical outcome activity, which in future will be more closely aligned to the Assurance Framework. This is not a requirement for Foundation Trusts, although their Boards may wish to review this information and compare it with others.

This information looks at the excellence of clinical team activity within the Trust but may also provide a means of critically examining the agendas of NHS Boards with regard to the scope of clinical items.

It is important to evaluate non-executives' input to this debate, and we strongly recommend that the Board should review its contribution and if necessary ascertain how non-executives will be enabled to build up their capacity to examine clinical developments within a healthcare organisation. This is a powerful quality issue, which was outlined in Part 1. The use of a suite of high level board assurance prompts (see Appendix 6, references) may be useful in helping non-executives to ask relevant questions regarding high level objectives and how they relate to clinical issues.

It is, of course, an equally important task for all executive directors, as any decision taken must be a corporate decision. The Board must also be satisfied that any decision it takes will not impact on the quality, activity or finances of other clinical specialties or, where it will, that the impact been understood and managed.



Performance management

The goal in creating performance management systems must be to provide the Board with relevant and meaningful information that can be quickly assimilated and understood.

The aim would be to develop real time performance systems through which clinicians, managers and Board members have access to the same source data, but aggregated at different levels.

The Board should be using the Assurance Framework to identify what information it needs. We reiterate below the Integrated Governance model to illustrate how the cycle functions:

We recommend that the information sought should comprise an effective balance of three distinct information channels, which could be described as the Board Core Information Schedule:

- Activity
- Quality
- Resources

Managing demand

Boards will want to make use of regular monitoring assumptions on numbers of referrals and emergency admissions: this is vital for managing demand in-year and budgeting accordingly. Assumptions will have been made when contract volumes and levels of activity were determined, and must be reviewed as part of the contract reporting process. The Board will need to agree indicators, which are likely to include information on planned and actual performance against a wide range of activity.

Boards will also wish to monitor specific indicators that affect the quality of care, some of which may have been put forward by the clinical governance sub committee. These may be presented as high level 'dashboards' of information (see below), using statistical process control charts and run charts with narrative on the work of improvement teams over the previous period.

Raw statistical data will need to be considered alongside other forms of information gathering. For example, when considering issues such as emergency readmissions, the Board may wish to look at the patient survey based on a number of patients each month in a particular clinical area, as well as activity indicators. In this way the Board is obtaining a lateral overview of the quality of care being provided across the organisation. More detailed work will be set out in the clinical governance work programme, through national and local audits.

Measurement is at the core of process improvement and performance management and is a key enabler for developing, executing and achieving organisational strategies and business goals. Performance management involves the measurement of outcomes for areas of particular pressure or problems, or to measure progress towards specific targets. Most of these areas and targets are now part of the management team's daily routine in monitoring and influencing waiting lists, waiting times, A&E targets etc. Performance management tools have been designed that provide timely and accurate information against tolerance criteria at a glance. The information is used to indicate adherence to performance targets using simple presentational techniques such as 'traffic light systems'.

Traditional 'balanced scorecards', sometimes based on criteria required by regulators and inspection regimes and external performance accountability, will have been reported to the Board in a high level traffic light style report. In their current form, balanced scorecards often do not make or include any links to measures of the outcomes of the healthcare treatment. Therefore the Board may wish to bear in mind the appropriateness of the information presented to the organisation's overarching strategy when assessing its relevance.

As *Creating a Patient Led NHS – Delivering the NHS Improvement Plan* (DH, March 2005) makes clear:

'The NHS needs a change of culture as well as of systems to become truly patient led where everything is measured by its impact on patients. This will mean we:

- design systems to continually improve
- take a process view of patient flow across departmental and organisational boundaries
- work smarter by
  - segmenting and scheduling patients according to their specific needs
  - managing and reducing causes of variation in patient flow
- implement measurement systems for improvement that reveal the true performance of the system and the impact of any changes made in real time.'

Performance related information displays represent the final output of any performance management system. A dashboard type display is often the most valuable. Whilst measuring their organisation's performance against set targets and goals, Boards should also consider their own soft intelligence systems through detailed presentations of clinical areas/services. This will enable the Board to consider specific indicators it may require for measurement and improvement in these areas. The Board should also consider the key clinical indicators it would like to see to understand quality and cost effectiveness better, and encourage continual improvement by comparison over time between departments and with other organisations. This will enable the Board to discharge its duty of care and ensure quality of services provided.

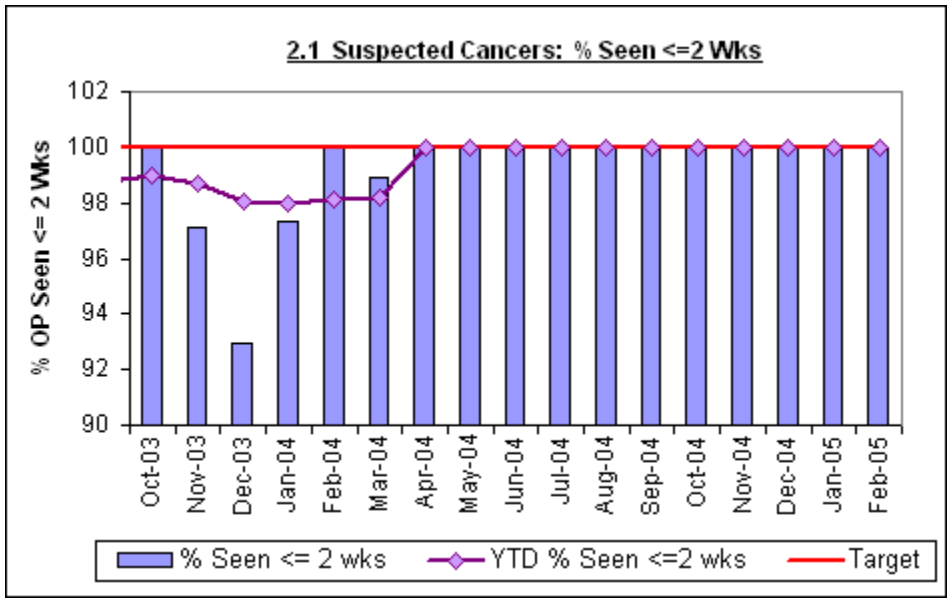
Examples of clinical indicators might be:

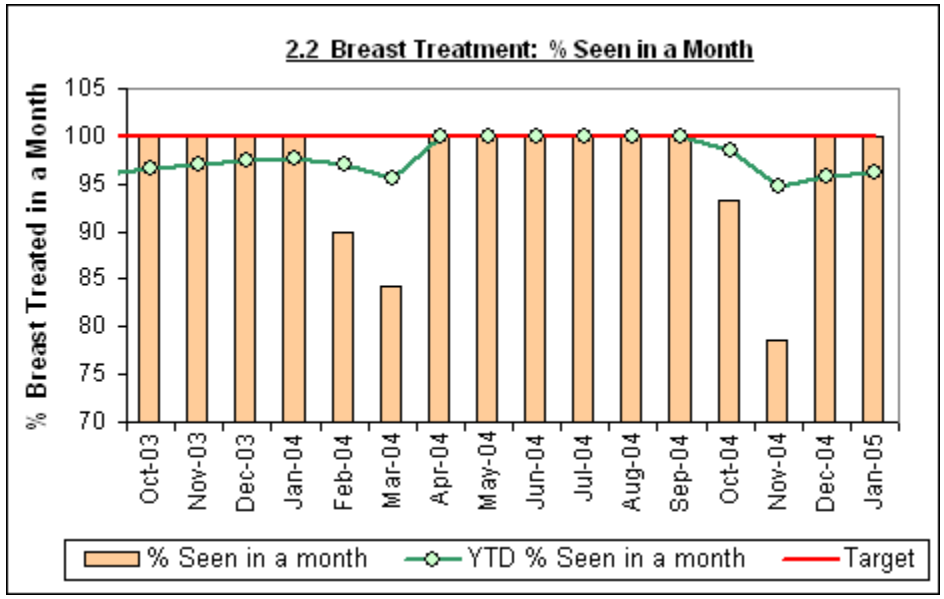
- time to theatre for fractured neck of femur patients following admission;
- percentage of re-admissions by ward and diagnosis
- mortality and morbidity rates in identified areas
- hospital acquired infection rates by ward

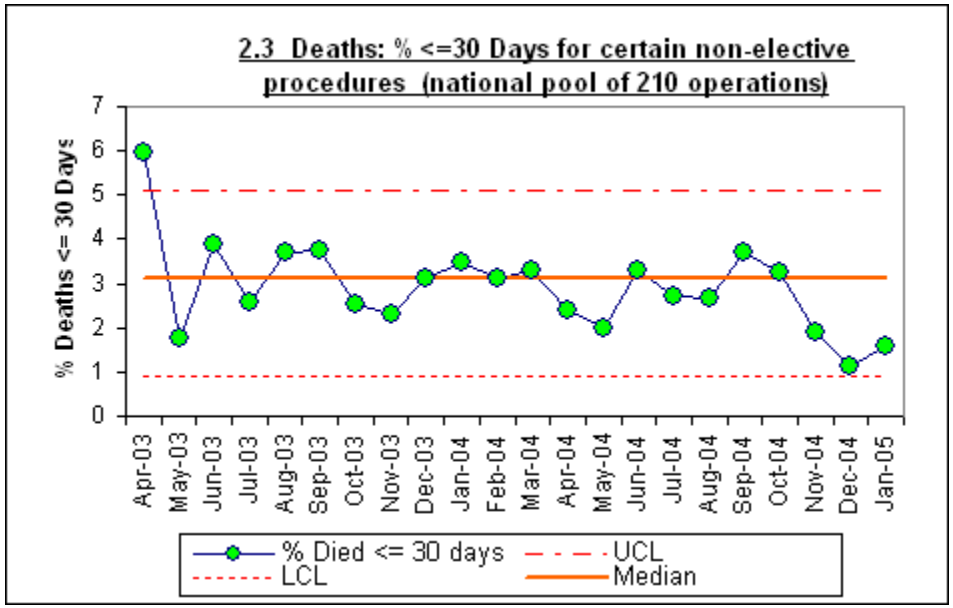
The majority of this information can be measured in the form of statistical process control charts (SPC) within pre-determined boundaries or tolerances. A short narrative would also inform the Board of a team's next stage for improvement. The following pages show typical performance reports to Boards using balanced scorecards and SPCs.

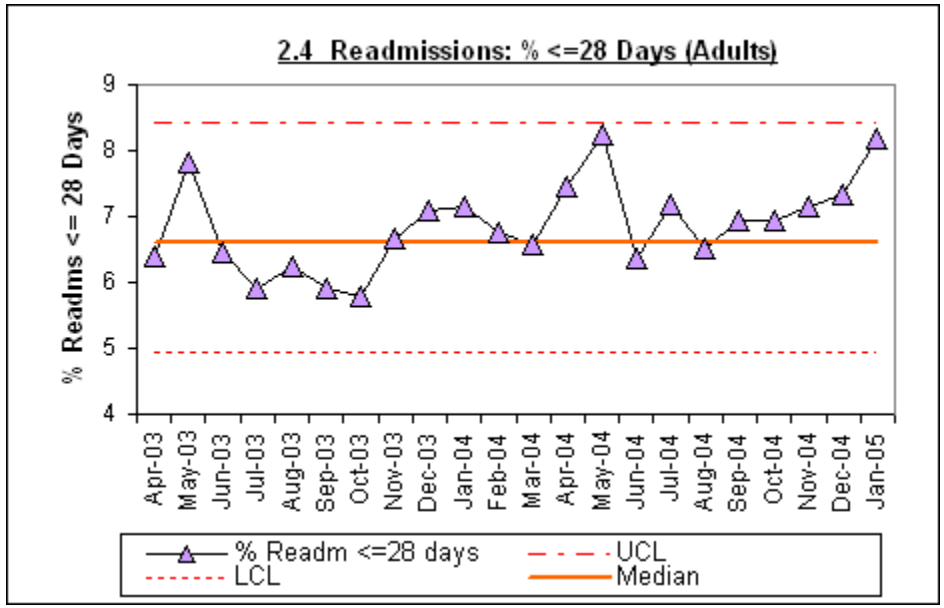
Performance Dashboard for Month x 2005,
Provided by Barts and London NHS Trust

Clinical Quality

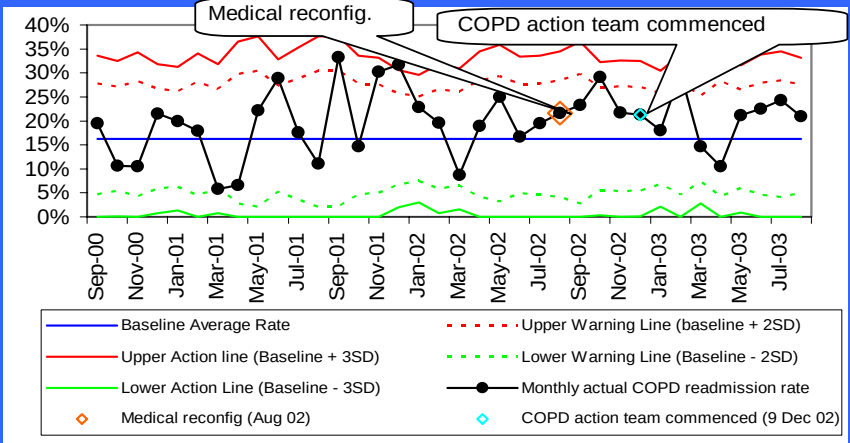








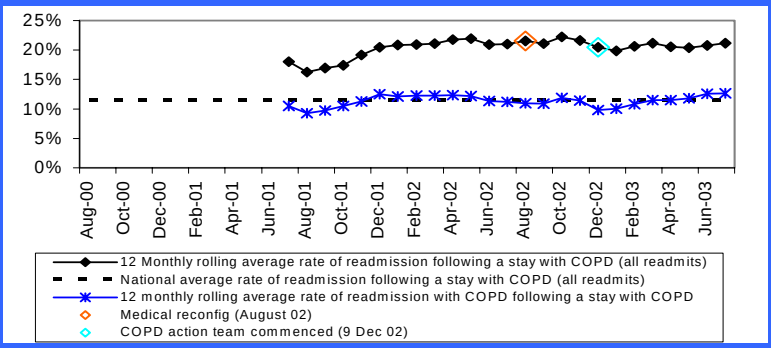
More detailed measures:



Specialty specific indicators chosen by clinicians

General Medicine Drill down – COPD

Chart 2 - Run chart comparing 12-monthy average readmission rate from COPD with national readmission rate from COPD



- Stable performance
- No clear sign of improvement yet

- **COPD Respiratory Network Group**
- **Redesigned Care Pathway**
- **Readmission Audit**
- **Education in Primary Care**

External reporting

With the advent of Foundation Trusts and the Department of Health's drive rigorously to realign reporting requirements from NHS organisations by streamlining its systems, there is a need to evaluate radically the relevance, quantity and quality of data being requested. The objective must be to simplify and focus requests, giving due regard to the impact of collection and using information already used for local clinical, management and governance decision-making.

Within the Integrated Governance cycle there needs to be a coherent alignment of requests to ensure that the organisation can respond cost effectively to those from external organisations such as the Healthcare Commission, Monitor and the NHS Litigation Authority. It is incumbent on the external bodies to ensure that, wherever possible, the data sets are the same, regardless of which body requests the information.

As the external requests become aligned, the Board should keep under review the information needed by external sources. For an FT this would include the Regulatory codes (Appendix A of Monitor's Compliance Framework); the Core National Healthcare Standards (Appendix B of Monitor's Compliance Framework and targets contained in the Health & Social Care Standards & Planning Framework) reported each month in the Trust performance report; the annual plan requirements (Appendix C), including membership analysis and reports, Board performance, management roles and structures; and capacity exception reports. Trusts would need to compile a list of issues they know about and check all reports arising from Schedule 6 of the Foundation Trust Authorisation.

Information sources a Trust might use include the following:

- H&S audits across the hospital (including fire, COSHH, DSE, manual handling, statutory training and environment)
- Non-compliance with own policies (usually indicated by an incident form)
- Internal and external audit reports
- Clinical audit reports
- CHKS reports
- National Patient Safety Agency (NPSA) compliance with seven steps
- HSE audits
- Health Protection Agency reports
- Overview and Scrutiny Committee
- LDPs from PCTs
- Confidential enquiries – self assessment against recommendations and action plans to meet best practice
- Clinical Negligence Scheme for Trusts (CNST)/Risk Pooling Scheme for Trusts (RPST) reports
- Patient Environment Action Team (PEAT)
- Improving Working Lives (IWP)
- Essence of Care
- Deanery reports
- Risk assessment (clinical and non-clinical)
- Clinical Governance Development Plans
- Infection control issues from Infection Control Committee
- Issues raised through Board of Directors, Board of Governors,
- any Trust committees'/groups' surveys and questionnaires
- PPI reports
- Incident, complaints and claims reporting Issues revealed during training sessions
- National reports – Climbie, Bristol, Shipman
- Media alert notices
- Exit interviews with staff
- Trade union communications
- Whistleblowing
- Impact of new legislation or changes in circumstances (eg contingencies for reduction in supply of red cells for transfusion)
- Backlog maintenance logs
- Coroner's reports
- Risk profiling assessments (clinical and non-clinical)
- NICE
- NSFs and other professional body guidelines

Example of a compliance information register

Requester	Information Requirement	Collator	Responsible Officer	Collection Frequency
NHSLA	RPST			Every 2 years
NHSLA	CNST			Every 2 years
DH/HPA	Surveillance of Hospital Acquired Infection			As required
DH	Regional Librarians Group (RLG) statistics now Library and Knowledge Development Network			Annual
DH	KT31 – Summary of Contraceptive Services			Annual
DH	Hospital and community health services (HCHS) (KO41) complaints			Annual
DH	KP90 – Informal Patients and Patients detained under the Mental Health Act: the number of uses of the Act			Annual
DH	Mental Health Minimum Dataset (MHMDS)			Annual
DH	Weekly Access Return			Weekly
DH	Emergency Pressures – Situation Report (SITREP) (updated version)			Weekly
DH	Local Delivery Plan return			Quarterly
DH	Annual hospital and community health services HCHS medical and dental workforce census			Annual
DH	Annual HCHS non-medical workforce census			Annual
SHA	Safety Alert Register: uptake of safety alerts by NHS			As required
DH	National Joint Registry			As required
DH	Monitoring Sickness and Absence Targets			Annual
DH	NHS Information Governance Survey			Annual
DH	Defects and failure reporting system			As required
DH	Junior Doctors' Hours			Bi-annual
DH	Fire Reporting (only report fire incidents, not false alarms from 1 April 2005)			As required
DH	Annual Certification of Fire Safety Management			Annual
DH	National Survey of Patient Experience			Annual
DH	NHS Workforce vacancy survey			Annual
DH	KH03 – Summary of Bed Availability and Bed Occupancy			Annual
DH	National cancer dataset, waiting time sub-set			Quarterly
DH	Consultant level prospective waiting time information			monthly
DH	ERIC [FT] version			Annual
DH	Mixed sex hospital accommodation			Annual
DH	QM08 – Consultant Outpatient First Attendances			Quarterly
DH	KH06 – Demand for Elective Admission: events occurring during the quarter			Quarterly
DH	KH07 – Demand for Elective Admission: position at the end of the quarter			Quarterly
DH	KH07a – Demand for Elective Admission: number of patients who have deferred admission waiting at end of the quarter			Quarterly
DH	Quarterly Monitoring Accident and Emergency (QMAE)			Quarterly
DH	Quarterly Monitoring Cancelled Operations (QMCO)			Quarterly
DH	Quarterly Monitoring of Outpatients Services (QMOP)			Quarterly
DH	Monthly Monitoring return (FT version)			Monthly
DH	KH03a – Critical Care Census			Bi-annual
DH	KH12 – Diagnostic Departments: Radiology, Nuclear Medicine & MP			Annual
DH/HPA	KC60 – Summary of Genito-urinary Medicine Services			Quarterly
DH	KC65 – Colposcopy clinics, referrals, treatments and outcomes			Annual
DH	National Database of Reference Costs			Annual
DH	KC62 – Adult Programme Breast Screening (Screening Unit)			Annual
NCWS	Admitted Patient Care CDS Type – General Episode			Monthly
NCWS	Admitted Patient Care CDS Type – Birth episode			Monthly
NCWS	Admitted Patient Care CDS Type – Delivery episode			Monthly

NCWS	Admitted Patient Care CDS Type – Detained and/or long-term psychiatric census			Monthly
NCWS	Admitted Patient Care CDS Type – Other delivery			Monthly
NCWS	Admitted Patient Care CDS Type – Other birth event			Monthly
NCWS	Outpatient Attendances CDS Type			Monthly
NCWS	A&E Attendance CDS Type – A&E Attendance			Monthly
Monitor	Annual Plan			Annual
Monitor	Annual Accounts (Unaudited)			Annual
Monitor	Audited Annual Accounts/ report			Annual
Monitor	Reconciliation between Annual Plan and audited accounts			Annual
Monitor	Quarterly financials			Depends on risk
DH	Exception reports			Annual
DH	Capital charge estimates			Annual

It is imperative that any information request emanating from an external agency is validated against the Assurance Framework and, in particular, the current mapping of the organisation's success in achieving its strategic plan and organisational objectives.

The identified officer would be responsible for ensuring that this document is regularly updated and that clear, up to date information is fed back to the Board if there is an issue around compliance. Information must be quality assured, with effective feedback loops, and data validated.

The inspection concordat established in 2004 and coordinated by the Healthcare Commission expects a close alignment of inspection organisations' requirements and establishes the linkages between the Assurance Framework and the Standards for Better Health. This is seeking to lead to a unified inspection regime with particular linkages between the requirement of FT Monitors and the Healthcare Commission. This is also a concordat that includes the following bodies:

- Audit Commission
- Academy of Medical Royal Colleges
- Commission for Social Care Inspection
- Mental Health Act Commission
- Health & Safety Executive
- National Audit Office
- NHS Estates
- NHS Litigation Authority
- Postgraduate Medical Education and Training Board

The unified approach to inspection is expected to be implemented by April 2006.

The Healthcare Commission is charged with policing an inspectors' 'gateway' control, to which the above organisations have signed up. It reflects a set of principles whose aims are:

- to reduce the amount of communication to the NHS
- to improve coordinating of information requests.

This is designed to ensure better coordination across NHS inspection, review and auditing bodies and the independent sector, including:

- the development of a better targeted, risk based approach to assessment
- the development of similar approaches to assessment irrespective of whether they are in the public or private sector
- identifying, and then using, information across inspection, review and auditing organisations
- collaborative working between agencies to integrate programmes of inspection and review in healthcare more effectively
- further development of the concordat between the main inspecting, review and auditing bodies in health.

Public reporting

The organisation will present its performance publicly in the form of an annual report and a public declaration of compliance with core standards. However, as the Board develops confidence in its internal reporting arrangements, it may wish to consider greater transparency in its public reporting through adoption of examples such as public report cards of progress against key health improvement and service delivery targets.

The IT strategy

It is important that the flow of information in the Board reporting schedule of activity, quality and finance is seen to be adopted and aligned within the organisation's IT strategy, and that activity, quality and finance reports can be made available to the Board on request. We do not in this handbook cover the specifics of the IT strategy, as this is the subject of substantial consideration elsewhere.

The Role of the Board (section 2.2)

Once again, the role of the Board must be simplified throughout this whole process, and must be seen to have a step ladder approach toward integration.

Board's Key Points for Action: 4

Move to decision-making supported by intelligent information

This would involve the Board:

- examining external organisations' information reporting requirements and seeking to align these requirements to its objectives and Assurance Framework
- assuring itself that its core reporting schedule is in place and that the three reporting lines of activity, quality and finance are established. The architecture is established and supported by the IT department
- satisfying itself that its officers have examined all relevant policy guidance in relation to reporting and information requirements and that they can assure the Board that it complies with this guidance through a dynamic Assurance Framework aligned to risk and organisational objectives.

This should now provide a seamless approach for the Board to establish how information systems will support its requirements. Research has shown that past systems have often been more responsive to the organisation and regulators than to the Board. The approach outlined in this section refines the decision-making model for Boards and allows the Board to be in the driving seat when requesting and using information. It also allows the organisation's officers, where necessary, to be able to drill down from the initial high level request and establish at what point in the organisation the problems are arising.

The strength of the approach lies in continuing to use the high level governance framework as a tool to challenge where compliance becomes a problem, rather than to obfuscate behind 'data comparison' problems. If there is an element of concern, it is an opportunity for the directors to question, through the high level framework, where the problem has appeared and to support the organisation's officers when working out where the issue of non compliance is occurring.

This safety valve provides the means of guaranteeing problems do not remain undetected until the end of the financial year or until the end of a clinical audit cycle, thereby allowing reporting to external organisations to be a much more meaningful process for the Trust as well as external inspection agencies.

2.3 Board committee structure and supports – Reforming the roles and working of committees and supports

The purpose of this section is to enable Boards:

- to review the roles and responsibilities of their committees, sub committees and advisors, and
- to ensure each committee has:
  - a clear and appropriate membership
  - a clear remit
  - defined accountability arrangements

Comments in this section are not intended to be restructuring recommendations. They present an opportunity for Boards to consider the structures that have evolved in their organisation and take the opportunity to check they are still fit for purpose. The section describes a two-year process of revision, during which time Boards should have integrated their governance arrangements to fit the organisational purpose, statutory requirements and local context of both issues and Board personality. This latter point implies that the organisational structure of governance will always be in flux as issues and members change, and should therefore be constantly under review.

Two years seems a reasonable timescale for completion of the whole programme including new appointments, but some Boards may believe they need to progress the key stages in a shorter timeframe, using the opportunity of merger of Trusts or applying for FT status to examine closely and put in place new governance arrangements.

A key task in gaining integration is to revisit the role of the audit committee and make sure it becomes the scrutineer of all sub committees reporting to the Board. Currently, many Boards have more than forty committees, some of course sub committees, reporting either through the audit committee or directly to the Board. We believe this is fundamentally unworkable. We must pay due attention to the strategic role of the non-executives; we cannot expect them to service so many committees.
The Board will be served by the following main standing committees:

- Audit
- Remuneration and Review
- Appointments

Other committees Boards may use include:

- Risk Compliance and Assurance
- Clinical Governance
- Health and Safety

For full working terms of reference, see ‘Governing the NHS – A Guide for NHS Boards’ (NHS Appointments Commission, June 2003).

We realise this is a small number of core committees and are also aware Primary Care and Mental Health Trusts have a different structure, and will therefore need some further committees and sub committees. All committees other than the standing committees should be given time limited objectives.

In writing this handbook, we are aware that, in order to gain integration, there needs to be a radical approach to committee structure and committee membership. We also note that to achieve a lean committee structure this process will require a phased integration of committees over two years. There will also need to be a different reporting structure at Board meetings to ensure that agendas are robust enough to deal adequately with the business from many of the committees that will no longer exist.

This will not mean a greater burden on Board agendas, as the strengthened audit committee will clarify much of the work prior to it being placed on the Board's agenda. This can be established,, for example in relation to Clinical Governance issues, by a Clinical Governance sub committee setting up robust systems and processed to be scrutinised by the audit committee, and the Board being able to monitor this activity through a suite of high level key clinical indicators.

What we hope to underline in this section is that the Board must want to make this happen and that adherence to good corporate company practice will help us refine our NHS Board etiquette. Below is a series of recommendations, which, if adopted, will allow the integration to happen.

The evidence

Chairs and executive directors have pointed to the fact that too much time is spent servicing committees and debating issues that are not their responsibility. For example, at working committee level, directors have been seen to spend more than two hours debating cook chill systems and parking arrangements. This is simply the tip of the iceberg – we can outline a plethora of agenda issues that are not core to a director's strategic role.

To create an evidence base of good corporate practice, there has been a series of discussions with chairs, company secretaries and non-executive directors (NEDs) from FTSE 100 city institutions to ascertain:

1. The structure of their Board
2. The committee structure underpinning the Board
3. The role of the NED
4. How the Board behaves as a corporate body.

It is apparent that most city institutions manage multi-million euro industries with three basic committees:

- Audit
- Remuneration
- Appointments.

All other committees are deemed to be sub committees, and their use is examined at the end of their terms of reference and they are disbanded where appropriate.

The following example is taken from the Combined Code of Corporate Governance.

Conducting an annual review of the Board's committee structure

The Combined Code of Corporate Governance lays down the principle that a Board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees. Areas for evaluation of a committee might usefully include the extent to which it has:

- been true to its terms of reference and followed the workplan set for it by the main Board
- worked purposefully and methodically to achieve the objectives it set for itself in order to fulfil the terms of reference and workplan
- reported regularly in a way that has furthered the work of the main Board
- been well led
- met sufficiently frequently and with good attendance
- consisted of the right number of appropriately knowledgeable, experienced, developed and supported members who have been able to contribute effectively
- received timely, accurate and helpful information

Simplifying the structure

The following recommendations, if taken up, will help simplify the committee structure and make it easier for the Board to understand how it discharges its duties. As indicated above, Boards may feel they need to progress the key stages in a shorter timeframe.

Stage	Focus	Month(s)	Products	Actions
1	Commitment to change	1-2	List of committees, roles and projected lifespan	Undertake self assessment, disband redundant committees
2	Examination & transition	2-3	Confirm core committees and set planning & strategy agenda for the year	Actively review committee business against committee's terms of reference
3	Practice & reflection: making clinical governance the business of the Board	By month 12	Development of dashboards of activity and variance	Clinical governance moves from committee to Board with appropriate assessment of risk and options for actions
4	Developing supports – establish the standing committees	12-24	Define role of audit committee	Establish and refocus as audit and scrutiny of all Trust activity
5	Developing supports – the Company Secretary	By month 24	Define role of Company Secretary	Appoint Company Secretary
6	Appointing better Boards	Ongoing	Evaluation of the existing and required skills and competencies	Appointment, induction and evaluation of non executive directors and committee chairs to meet integration agenda
7	Developing corporacy	Ongoing	Completion of Board development programme	Re-run the self assessment
8	Understanding the legal implications for NHS Boards			
9	Assurance			

Stage 1

Commitment to change (months 1-2)

The Board must be committed to change and making this a working reality. The main thrust to achieving this is a very early review of how your Trust's committees are currently constituted and, in particular, how many have a longer lifespan than they need, eg a resource committee that may have been established to support a large project is still reviewing that project two years on, when the remit of the work is no longer of relevance.

This piece of work should be examined promptly and the usefulness of current committee structures should be reviewed with the Board within one month of the review taking place.

We would also recommend that, at the beginning of the 24-month process, the Board carries out an initial self assessment in terms of where it is in gaining integration, then repeat this exercise both periodically and at the end of the 24 months, to demonstrate progress.

Product: List of committees, role and projected lifespan
Action: Undertake self assessment, disband redundant committees

Stage 2

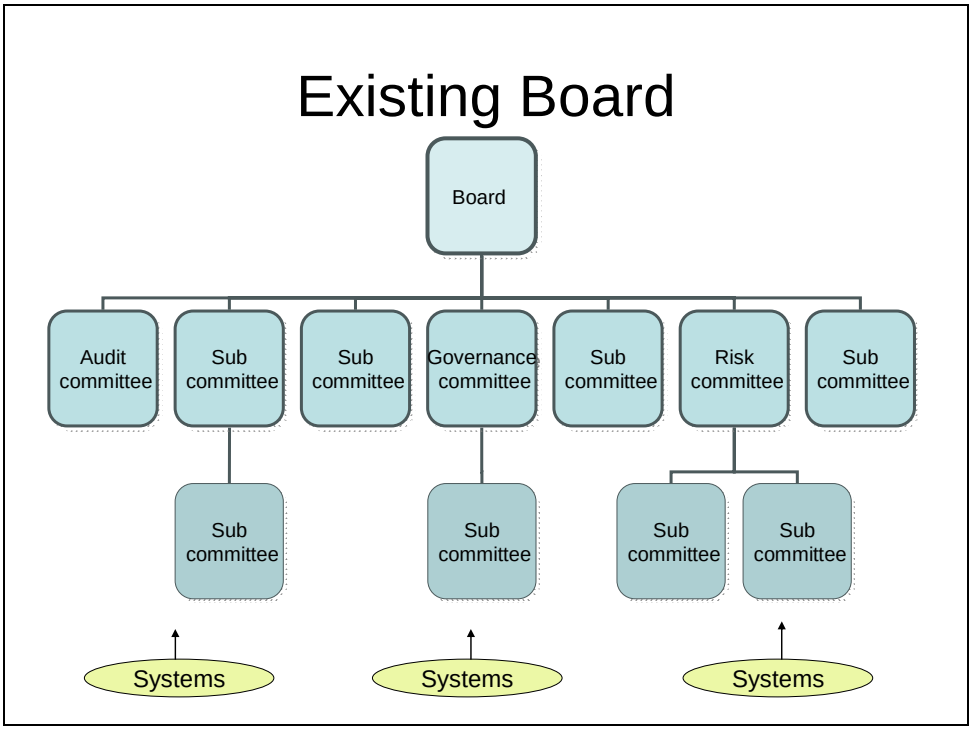
Examination and transition (months 2-3)

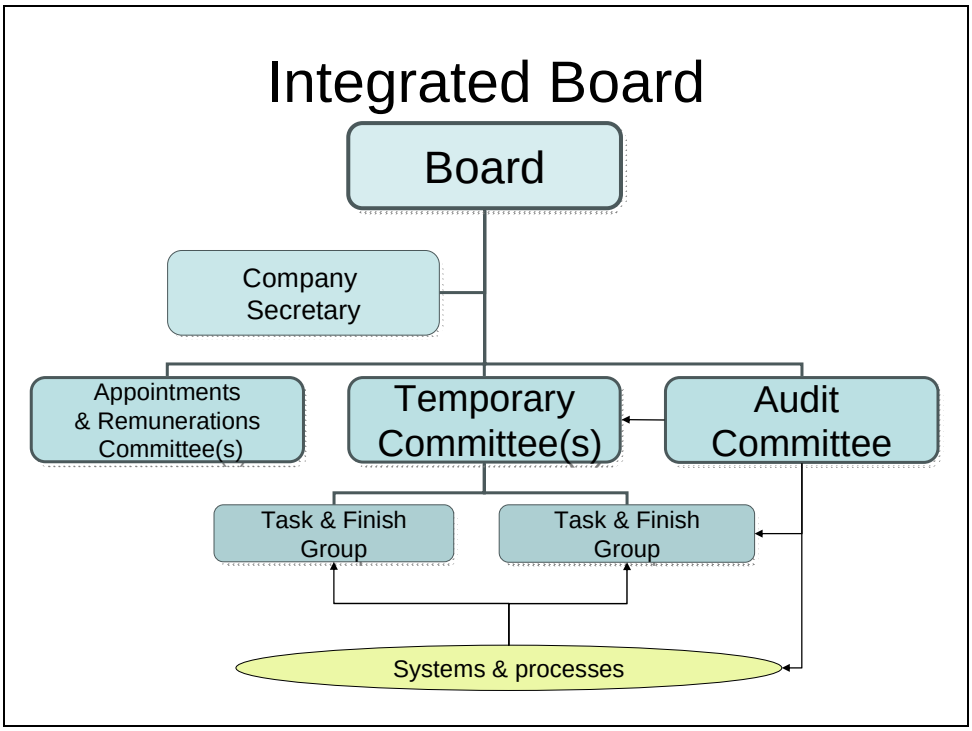
We would then recommend a full examination of the terms of reference of those committees the Board deems to be useful over the following 12 months, to ensure that it will be able to discharge its duties and legal requirements as officers with responsibility for governing an NHS organisation. We would expect the following committees would continue to be in place for the first 12 months of a two-year phased integration:

- Audit Committee
- Remuneration Committee
- Appointments Committee
- Clinical Governance Committee

We would also recommend that the Board considers having an annual planning and strategy meeting and discontinuing the finance committee (audit and financial control committee). To our knowledge none of the FTSE 100 committees had a separate finance committee. The finance function was, rightly, held by the Board.

Product: Confirm core committees and set planning and strategy agenda for the year
Action: Actively review committee business against committee's terms of reference


Existing Board
Board
Audit committee
Sub committee
Sub committee
Governance committee
Sub committee
Risk committee
Sub committee
Sub committee
Sub committee
Sub committee
Sub committee
Systems
Systems
Systems


Integrated Board
Board
Company Secretary
Appointments & Remunerations Committee(s)
Temporary Committee(s)
Audit Committee
Task & Finish Group
Task & Finish Group
Systems & processes

Stage 3

Practice and reflection: making clinical governance the business of the Board (by month 12)
The next nine months is the crucial stage of the Integrated Governance process, as at this point you will:

- have examined and reviewed the committee structure
- be establishing a series of strategic dashboards for the Board to review all issues of governance from clinical to financial
- have in place a desired strategy for refining the committees.

Initially, at the beginning of the second 12-month cycle, the Board in agreeing its objectives and local delivery plans will look closely at the committee reporting mechanisms and the manner in which information is brought to the Board.

It will look at the probability of risk around each of its objectives and only create new (time limited) sub committees where necessary and where the main audit committee cannot fulfil the recommended task.

At this stage the Board will be setting its strategy on how it will oversee clinical governance through high level assessment of clinical activity which highlights quality, activity and cost and associated risks of meeting existing and future demand.

The Clinical Governance committee may look at a process of succession planning so that its clinical decision remit will become one of an advisory capacity and it will seek to provide the Board with high level clinical dashboards on clinical activity and variance. This does not imply that clinical decisions will be hoisted onto non-executive and executive directors with no clinical experience. This is about ensuring the Board fully appreciates the implications of taking a specific approach to clinical care.

To ensure that the Board feels confident in making this decision it will, where appropriate, seek to co-opt clinicians with experience in a given specialty and take advice about how the Board should make its decision. The CG committee may remain but its role will develop as one of an advisor, with a strengthening of clinical advice by co-opting members of the CG sub committee (or other experts) onto the Board when necessary.

Examples of high level dashboards can be found in section 2.2.

Product: Development of dashboards of activity and variance
Action: Clinical governance moves from committee to Board with appropriate assessment of risk and options for actions.

Stage 4

Developing supports – establish the standing committees

(months 12 – 24)

During the second 12-month period, one of the main factors to build on will be the strengthening of the audit committee. The audit committee already has a very specific and independent scrutiny role and we recommend that the committee now refocuses itself on scrutiny of all Trust activity, by broadening its remit. It does not need to rename itself to reflect its strengthened role.

This strengthening can be outlined as follows:

- This audit committee takes on a wider focus, scrutinising established sub committees and has the necessary support to do so.
- It will not only look at financial areas but will also be expected to look at areas of compliance, clinical audit, clinical governance and associated clinical risk. It is not necessary for the committee to take on all these roles, rather to ensure they are working.
- The committee will be serviced by a Corporate Secretary (Company Secretary – see stage 5 below) to ensure that it is fully informed of activity in other sub committees and so that it may take action, where appropriate, through the Company Secretary to discharge its duties robustly. If the new committee and Company Secretary are confident that an issue can be resolved at sub committee level, it need not be brought to the Board; where there is a high level risk to the organisation, the new committee will refer to the Board for debate and decision.

Example terms of reference for the revised audit committee can be found in appendix 5. The full terms of reference can also be found in the refined audit committee handbook 2005 which will be made available to all executive and NEDs by autumn 2005.

Product: Define role of audit committee
Action: Establish and refocus as audit scrutiny of all Trust activity (still called audit committee)

Stage 5

Developing supports – the Company Secretary (by month 24)

The most significant change to gain integration might well be the appointment of a Company Secretary/Trust Board Secretary (see appendix 4). This individual should have responsibility for ensuring that all committees are fully serviced and that the Board completely understands compliance with authorisations where appropriate, and how it is meeting agreed objectives, and its achievements in meeting the requirements of the Department of Health's Standards for Better Health and those of Monitor. The Company Secretary

should also conduct a monthly appraisal of where the Board currently lies in relation to the strategic cycle.

The evidence

In an attempt to establish this new role, discussions took place with FTSE 100 companies to look at the role of the Company Secretary but, more importantly, whether these companies could exist without such an advisor. The evidence clearly points to the need for such integrated corporate support. Foundation Trusts are already appointing such individuals, as are some other NHS organisations. The significance of this role is to ensure that, for the first time in the history of NHS Boards, the Board per se can confidently assure itself that at the end of the 12-month cycle it has full evidence and is fully appraised prior to signing off the statement of internal control.

The following points should be helpful in articulating why this role is significant:

- The Company Secretary is appointed by the remuneration committee as opposed to either the chair or the CEO, in order to ensure neutrality of role.
- The Company Secretary is answerable to the Board but will be line managed by the CEO in order to ensure personal development and accountability.
- The Company Secretary will also work closely with the chair, the CEO and the non-executive directors.
- The Company Secretary will be actively involved in or be a member of the executive team to ensure a full understanding of the organisation's business.
- It is not necessary for the Company Secretary to be either an accountant or a lawyer. Appointing a lawyer may increase the Company Secretary's responsibility and may make him or her responsible for some of the legal judgements, which is fundamentally not a Company Secretary role.
- The Company Secretary will not undertake executive activity in respect of having a specific role, but will be the neutral observer and advisor to the Board or executive team.
- An NHS based Company Secretary should have sufficient knowledge of the NHS to gain the respect of the doctors in the organisation but need not necessarily be a clinician.
- The Company Secretary should be appropriately qualified to carry out his or her role and should ideally be accredited by a professional body such as the Institute of Chartered Secretaries and Administrators (ICSA).
- One avenue for recruitment might be the Company Secretaries currently employed by organisations with links to the NHS, such as large pharmaceutical companies or aspirant corporate directors within these organisations.

Each organisation should look at a job description to make sure that it suits their needs. It will also be important that membership, eg of ICSA, can be achieved and to this extent a health chapter of ICSA has been established. It will also be necessary, in terms of succession planning, to ensure that future Company Secretaries with the key skills will be developed as an NHS priority.

This role will have huge advantages for all Boards and, if appropriately supported, should bring integration and equilibrium to the boardroom.

One further essential factor is that the Company Secretary must be a high level appointment; this individual should have the skills to operate at Board director level and be deemed to be an expert in discharging his or her tasks.

Product: Define role of Company Secretary
Action: Appoint Company Secretary

Stage 6

Appointing better Boards

A full review of the appointment process can be found by logging on to the NHS Appointments Commission website. This will allow Boards to appraise themselves fully of the appointments process and what the appointment of non-executive directors entails.

To assist the integration process, it is a priority that the chair fully understands his or her role in the appointment of good non-executive directors. It is essential that the chair can influence this process and it is expected that he or she would do this in conjunction with the regional commissioners from the NHS Appointment Commission, to ensure that the right skills are brought to the right organisation. It is also important that the chair fully understands the induction and appraisal process for non-executive directors, including keeping attendance records and evaluating each director's competency in relation to the integrated agenda and their contribution at Board meetings.

The selection process entered into for Integrated Governance will require, not necessarily a new set of skills, but the ability for each appointed director to understand fully what is required of them when taking more robust decisions.

It will be critical to ensure that the non-executives appointed to the newly formed audit committee will have the right skills and ability to manage a much more varied decision-making structure than is currently expected of them.

The role of the non-executive director should be considered to be at a similar level as within a major corporate company; non-executive directors should have a strong understanding of the NHS business requirements.

Product: Evaluation of existing and required skills and competencies
Action: Appointment, induction and evaluation of non-executive directors and committee chairs to meet integration agenda

Stage 7

Developing corporacy

To date, NHS Boards have performed in a diverse manner by separating out the roles of the various directors, ie finance, medical, nursing etc, and the non-executive director/lay individual input. The result of this is that, if the Board takes a decision, it is often deemed to be the decision of, say, the finance director or HR director, rather than being a corporate decision. Board corporacy is paramount. Each decision or agreement entered into in the boardroom is a fully accepted corporate decision. If a decision around finance is taken and the information brought to the Board clarifies the debate, if there are implications say, one month after the decision, the responsibility is of the corporate whole, rather than just the finance director.

Much of the development work to achieve Integrated Governance is about:

- the corporacy of the clinically focused Board
- the strategic development of the corporate Board
- the support that will be made available over the next two years

When the Board has been through this further process of development, after the 24 months it will wish to evaluate how integrated it believes it is as a corporate entity. This can be achieved by carrying out a self assessment maturity matrix approach, as outlined in appendix 1. We would also recommend that, at the beginning of the 24-month process, the Board carries out an initial assessment in terms of where it is in gaining integration and by benchmarking both assessments together – the Company Secretary will then be able to outline the true extent of the Integrated Governance status.

Product: Completion of Board development programme
Action: Re-run the self assessment

Stage 8

Understanding the legal implications for NHS Boards

Indemnification of directors and insurance will be very important unless water-tight indemnities are transparently in place, with insurance if necessary, to make sure that those from the corporate world will participate.

See example questions

Stage 9

Assurance

It is important that each organisation examines its Assurance Framework at this stage and significantly looks at, in terms of integration, how focused its strategic objectives and LDPs are in synchronising the integration. Each organisation should examine the following in relation to the Assurance Framework:

- The complexity of Foundation Trusts in aligning to this process
- The implications for commissioning and primary care and the further implications of the payment by results agenda
- The implications for Mental Health Trusts' committee structures in light of the Mental Health Act
- The implications for Acute NHS Trusts and how they will react to integration where they are currently a failing organisation or an aspirant Foundation Trust
- The significant role of the SHA and its relationship to ensuring integration through the Assurance Framework for all Trusts reporting to it on an annual basis with regard to the statement of internal control. The importance of the SHA's role in ensuring that all organisations within its geographic area are realistically attempting to achieve Integrated Governance and meet standard C3.

The Role of the Board (section 2.3)

By following the above processes, we should be at the stage of full integration and should review progress against the matrix and the appendices.

Board's Key Points for Action: 5

Board reviews and simplifies its committee structure to reflect its corporate need and refines the structure by reducing the number of non-relevant committees/sub committees. All committees should have clarity in their terms of referfence, delegated powers and reporting requirements

Board's Key Points for Action: 6

Board establishes terms of reference for its new-role audit committee and ensures that the individuals appointed to the committee have the skills, abilities and supports to discharge their duties around the Integrated Governance agenda.

Board's Key Points for Action: 7

The preceding points on this journey will be difficult unless effective supports have benn established such as appointing a Corporate /Company Secretary at the beginning of the 24-month cycle of phased integration and ensuring a rigorous self assessment process takes place at the beginning and end of the cycle.

Board's Key Points for Action: 8

The Board has established processes to ensure Board and committee fitness for purpose though selection, induction and review of members.

Board's Key Points for Action: 9

Board etiquettes are agreed and applied.

Board's Key Points for Action: 10

The Board examines its development requirements to ensure corporacy of behaviour. It will determine the type of development programme required for executives and non-executives to ensure integration and will align where necessary with the development programme on Integrated Governance.

2.4 Future refinement of good governance – Challenges and recommendations

Recommendations

There is clearly a need to focus in the future on two specific agenda issues, which over the next 24 months will have a major impact on governance, not simply for the NHS but across whole health communities and the wider public service. These are:

1. To examine closely and put in place emergent governance arrangements for the new wave of larger health authorities and merged primary care trusts.

2. "To clarify the distinction between good robust governance and the fitness for purpose capability of non-executive and executive directors' abilities to corporately perform at Board level" (*Pearse Butler – Chief Executive, Cumbria & Lancashire SHA*)

In addition

This handbook has tried to set out comprehensively the background to Integrated Governance and assist organisations in planning their journey of integration towards good governance. However, this is not a journey that will be concluded, new destinations are in sight. There is a need to tackle some difficult issues in relation to the inter-organisational governance between statutory bodies in health and social care and between public and private bodies as well as to support Boards engaged in complex commissioning hubs and
clinical networks.

We need to continue with our research into what makes effective Boards, drawing on the best from all sectors and countries, and in doing this we need better cordination to avoid duplication of effort.

We have found that organisations lack underpinning frameworks on how to manage and steer themselves. There have been many attempts in the past but most seem to have been partial in their scope and too ephemeral, having a season but not a long lasting impact. Integrated Governance needs a business quality framework which pulls together all of the themes described above to allow organisations to have a sustainable core from which to govern and improve.

This handbook therefore makes the following recommendations for the future:

1. 1. Develop further documentation that fully embraces the strengthened role of PCTs especially in relation to commissioning better services for patient's, working more closely with local government ,ensuring that we get the best value for money from the system. And the regulation and management of an increasing range of primary care practitioners.

2. Development of a Board quality framework which fully integrates all the threads of quality, performance and governance
3. Development by auditors of a methodology for checking that adverse events, complaints, regulators' recommendations and Board members' queries are followed up and brought forward if progress falls out of agreed tolerances
4. Development and sharing of a body of knowledge of good practice from public, voluntary and private sectors to support the Department of Health's Standard D3 'Integrated Governance arrangements representing best practice are in place in all healthcare organisations and across all healthcare communities and clinical networks'
5. Analysis of governance research being undertaken in other health systems
6. Consideration of improved reporting of Board's performance

Development of inter-organisational governance, advice and support with better understanding of network and partnership governance

7. Consideration of development of alternative governance models in the UK eg from Scotland the use of staff governance committees, Board performance reviews in public and adoption of best value challenge regimes; from Wales the integration of Acute and Community services and governance and from Northern Ireland the integration of Health and Social Services.
8. Staff development to ensure that future Company Secretaries with the appropriate skills and experience will be available to the NHS and the encouragement of a health service network of Company Secretaries through ICSA.

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Sally Calverley	Bevan Brittan
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Alasdair Cockburn	Non Executive Director, Surrey & Sussex SHA
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Chris Dent	Company Secretary, Cumbria & Lancs SHA
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Heather Dunne	Unified Assurance Lead – Department of Health
Anna Ferrant	Governance Domain Lead – Healthcare Commission
Martin Green	Chief Executive, English Community Care Association
Shelley Grey	BT
Jeremy Isaacs	Chief Executive, Lehman Brothers
Rachel Johnson	Audit Commission
Professor Sir Ian Kennedy	Chair, Healthcare Commission
Dr Tracy Long	Boardroom Review
Andy McKeon	Managing Director for Health, Audit Commission
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Meg Moore	Head of Governance, Royal Surrey County Hospital NHS Trust
Dr Roger Moore	Chief Executive – NHS Appointments Commission
Kate Nealon	Non Executive Director, Monitor
Giles Peel	Institute of Company Secretaries & Administrators
Ian Pirnie	Non Executive Director – Cumbria & Lancs SHA
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