HFMA introductory guide to NHS finance

Chapter 13: Governance – how NHS organisations are structured and run

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Overview

This chapter's focus is governance, a subject that has received considerable attention over the years following spectacular failings across all sectors of the economy, examples include the 2008 banking crisis and the much-publicised failings at Mid Staffordshire NHS Foundation Trust. These (and many other) crises have demonstrated just how important good governance is to the wellbeing of an organisation and made clear that it encompasses everything that an organisation does, not just its administrative and support functions. In the NHS this means that effective governance is as much of a concern to a nurse or consultant as it is to an accountant or manager.

It is now widely agreed that delivering high quality health and social care requires collaboration between organisations. As set out in the *NHS long-term plan*, delivering new ways of working requires 'strong governance and accountability mechanisms in place for systems to ensure that the NHS as a whole can secure the best value from its combined resources'[164]. The critical governance issue for systems is how to make decisions that are in the best interests of the population that may however have a negative impact on individual organisations. (See chapter 5 for more on system working).

Governance is a huge subject in its own right, this chapter focuses on key aspects relating to NHS finance. If you want to find out more, the HFMA produces a separate introductory guide to governance[165] and a NHS corporate governance map[166] with links to key tools and guidance.

13.1 What is governance?

The terms 'governance' and 'corporate governance' are now interchangeable, but it was the use of corporate governance as a phrase in the 1992 Cadbury Committee Report[167] that initiated widespread debate in this area. Corporate governance was defined in that report as 'the system by which companies are directed and controlled' and its focus was on how companies were run, structured, led and held to account. This report also identified the three fundamental principles of good governance as openness, integrity, and accountability.

13.2 Governance in the NHS

The NHS has been well aware of the importance of governance for many years, with a wide range of separate regulatory frameworks and ethical codes in operation for the different professions working in NHS organisations. The challenge has been to bring together the practices and information systems of these different disciplines in such a way that they form an integrated and effective organisation-wide governance structure.

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[164] NHS England and NHS Improvement, *The NHS Long-Term Plan,* January 2019
[165] HFMA, *Introductory guide – NHS governance,* April 2017
[166] HFMA, *NHS corporate governance map,* updated February 2021
[167] ICAEW, *The financial aspects of corporate governance*, December 1992

The importance of having an integrated approach to governance (i.e., covering all aspects of governance including financial, clinical, and organisational) along with high standards and an open culture has been heightened by failures which have dented public confidence in the NHS and raised questions over how NHS organisations are run.

Examples of governance failures within the NHS

In 2013 the Francis report into Mid-Staffordshire NHS Foundation Trust[168] found the root cause of hundreds of deaths due to poor care and negligence to be the Trust's (and the Trust Board's) focus on achieving NHS foundation trust status, which took its attention away from effective oversight.

In 2015 the Kirkup review of maternity services at Morecombe Bay NHS Foundation Trust[169] included concern that deliberate attempts had been made to cover failings, and that dysfunctional relationships within and between NHS organisations were at the heart of this.

In 2020 the public inquiry into mental health services in Tayside[170] noted that 'governance and leadership lie at the heart of the independent inquiry's final report because good governance and leadership are central to the effective delivery of mental health services in Tayside'.

In 2021 the Comptroller and Auditor General's (C&AG) report[171] on the DHSC annual report and accounts 2020-21 referred to financial reporting and governance issues at University Hospitals of Leicester NHS Trust (UHL) where the local auditor had noted that adjustments appeared to have been made in the 2018-19 financial statements at the request of UHL's management to achieve a certain outcome rather than to represent accurately the economic reality of transactions into which UHL entered. The auditor's findings related to accounting judgements and manual intervention associated with the previous senior leadership regime at UHL and continued failures in the management and control of accounting records. The C&AG noted that the position at UHL was unprecedented - an NHS trust had failed to comply with the Secretary of State's direction to prepare true and fair accounts and to maintain appropriate accounting records. Moreover, the restatement of the 2018-19 financial statements reflected both financial control failures and a series of actions taken by UHL in the preparation of those accounts that did not reflect the actual substance of the financial transactions entered into by the trust.

Clear linkages were drawn between the scandals and the governance failings that allowed them to continue uncorrected. Investigations into governance lapses have also underlined the need for an open and questioning culture and governance policies, procedures and structures that are comprehensive and work in practice, not just on paper.

These (and other) incidents have driven home to governing bodies and boards just how wide ranging their responsibilities are and emphasised how important it is to see governance arrangements relating to clinical and quality spheres as an integral part of an organisation's overall approach, rather than the preserve of clinicians. The National Quality Board's report[172] made this clear when it stated that 'final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care' lie with the provider organisation's board and leaders.

By now it should be clear why an effective and integrated approach to governance is so important and equally obvious that if an NHS organisation gets it wrong it can have a disastrous impact on

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[168] UK Government, *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*, February 2013
[169] UK Government, *The report of the Morecambe Bay investigation*, March 2015
[170] Independent Inquiry into Mental Health Services in Tayside, *Final report of the independent inquiry into mental health services in Tayside,* February 2020
[171] National Audit Office, *The Department of Health and Social Care annual report and accounts 2019-2020,* January 2021
[172] Department of Health and Social Care, *Quality governance in the NHS – a guide for provider boards*, March 2011

patients and undermine public confidence in the service as a whole. But what does this mean NHS organisations need to do in practice?

Lessons from these governance lapses reinforce the importance of:

- an effective board that blends a strategic focus with a system of oversight and scrutiny, providing effective independent challenge of management
- the importance of an effective audit (and risk assurance) committee
- clarity of decision-making and accountability throughout the organisation
- competent and capable senior management
- a culture of openness, both in terms of communication from the top downwards of vision and values as well as communication upwards about areas of concern
- a focus on ensuring that business as usual is operating as it should, including core clinical services and corporate and administrative management
- values and ethics that are clearly articulated and demonstrated through leadership
- the widest possible involvement of stakeholders and understanding of their needs and interests.

NHS bodies must also recognise that governance is as much about behaviour, values and attitudes as about structures, systems, processes and controls. There is no point having a comprehensive governance framework if no-one is committed to it or understands why it exists and what it is designed to achieve.

13.3 Elements of governance

Effective governance arrangements should underpin all that an organisation does but it is helpful to break it down across three key elements – we will look at each in turn with a focus on financial aspects:

- culture and values (the people issues) – for example, an organisation's leadership style and tone, openness and adherence to relevant legislation and codes of practice
- structures and processes – for example, statutory and regulatory requirements, governing body or board and committee structures and internal policies and procedures
- control frameworks – for example, assurance, risk management, internal, external and clinical audit.

13.4 Organisational culture and values

Every organisation develops its own unique culture and values but to be effective, it is essential that there is 'a system of shared values and beliefs about what is important, what behaviours are appropriate and about feelings and relationships internally and externally'[173]. If everyone within an organisation is to 'buy in' to these shared values they must be meaningful, make sense and be realistic. There is no point having a carefully crafted statement of values if it bears no relation to how things actually feel on the front line. For example, it would be a mistake for an organisation to claim that it has a 'no blame culture' if this is not borne out in practice.

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[173] Purcell, J., Hutchinson, S., Swart, J., Kinnie, N. & Rayton, B., 2004, *Vision and Values: Organisational Culture and Values as a Source of Competitive Advantage.* Chartered Institute of Personnel and Development, London, UK

Principles of public life

Everyone involved in the public sector brings their own personality, experience, and attitudes with them. However, the public provides the resources for which they are responsible and, as a result, certain ethical standards and values are expected of them – these standards are known as the *Seven principles of public life*[174] and were set out by the Nolan Committee in 1995.

The Nolan principles of public life

Selflessness – holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

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

Objectivity – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability – holders of public office are accountable for their decisions and actions to the public and must submit to whatever scrutiny is appropriate to their office.

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

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

Leadership – holders of public office should promote and support these principles by leadership and example.

The Treasury's guidance document, Managing public money sets out the standards which it expects all public services to deliver, which overlap with the Nolan principles:

- honesty
- accountability
- integrity
- reliability
- transparency
- impartiality
- accuracy
- fairness
- objectivity
- openness

The Treasury adds that organisations should carry these standards out 'in the spirit of, as well as to the letter of, the law in the public interest, to high ethical standards, achieving value for money.'

The introduction of a statutory duty of candour is a direct response to the recommendation made in the Francis inquiry report, which stressed its importance alongside openness and transparency.

[174] Committee on Standards in Public Life, *The seven principles of public life*, May 1995

Openness, transparency and candour

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy agreed, regardless of whether a complaint has been made or a question asked about it.

Together, the Nolan principles, the Treasury standards and the recommendations set out in the Francis inquiry report provide a blueprint for the underlying culture and values of any public sector organisation.

Leadership

Effective leadership is also important. The *Good governance standard for public services*[175] recognises this when it states that 'good governance flows from a shared ethos or culture' and that it is 'the governing body that should take the lead in establishing and promoting values for the organisation and its staff.' In other words, the culture and values of an organisation are set from the top. In the context of the NHS this means that the behaviour, approach and leadership style of the governing body or board and senior management are critical in establishing an organisation's tone, 'feel' and direction.

NHS Constitution

The *NHS Constitution*[176] further emphasises the importance of having clear (and consistently applied) principles underpinning all that the NHS does. All providers and commissioners of NHS care in England have a statutory duty to have regard to the *NHS Constitution* in all their decisions and actions.

Of particular note in governance terms are the principles and values set out in the Constitution as these must underpin everything that an organisation does.

Principles

- the NHS provides a comprehensive service, available to all
- access to NHS services is based on clinical need, not an individual's ability to pay
- the NHS aspires to the highest standards of excellence and professionalism
- the patient will be at the heart of everything the NHS does
- the NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- the NHS is accountable to the public, communities and patients that it serves.

Values

- working together for patients

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[175] Joseph Rowntree Foundation, *Good governance standard for public services,* 2005
[176] Department of Health and Social Care, *NHS constitution for England,* updated January 2021

- respect and dignity
- commitment to quality of care
- compassion
- improving lives
- everyone counts.

The *Francis inquiry report* recognised the importance of the Constitution when it stated that:

- it 'should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.' (recommendation 3)
- its core values 'should be given priority of place and the overriding value should be that patients are put first and everything done by the NHS and everyone associated with it should be informed by this ethos'. (recommendation 4)

Legislation

There are two Acts of Parliament that are worthy of note here as they both have links to an organisation's culture:

- the *Freedom of Information Act 2000*[177] means that NHS bodies are required to answer questions from members of the public and make information available to them. In addition, the Government has introduced requirements in relation to transparency which requires the publication of items of spend over £25,000.
- the *Bribery Act 2010*[178] applies to both organisations and individuals and means that NHS bodies must ensure that they have in place adequate procedures to prevent bribery taking place. If they fail to do this, organisations can be prosecuted for the failure to prevent a bribe being paid on the organisation's behalf (for example when placing a contract for a major service or investment).

Codes of practice

Since the early 1990s, a number of codes of practice[179] have been issued to provide practical guidance on behavioural aspects of governance. For the most part, the content of these codes has been incorporated into legislation or tailored guidance but the key messages that were set out in the *Code of conduct: code of accountability in the NHS*[180] are worth repeating – namely that governing body/ board members must adhere to three crucial public sector values that are at the heart of the NHS:

- accountability – everything done by those who work in the NHS must be able to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct
- probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties
- openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients, and the public.

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[177] UK Government, *Freedom of Information Act 2000,* 2000
[178] UK Government, *Bribery Act 2010*, 2010
[179] For example, the *Code of conduct: code of accountability in the NHS* (1994), the *Code of conduct for NHS managers* (2002) and *NHS foundations trusts: code of governance* (2014)
[180] Department of Health, *Code of conduct: code of accountability in the NHS,* updated July 2004

For CCGs, NHS England's guide, *CCG governing body members: role outlines, attributes and skills*[181], is of particular relevance. This includes, amongst the 'core attributes and competencies', that each individual governing body member is expected to:

- 'embrace effective governance, accountability and stewardship of public money and demonstrate an understanding of good scrutiny
- bring a sound understanding of, and a commitment to upholding, the NHS principles and values as set out in the NHS constitution
- demonstrate a commitment to upholding the Nolan principles of public life along with his/ her leadership role and the culture of the CCG.'

NHS trust board and CCG governing body members are also expected to follow the *Standards for Members of NHS Boards and Governing Bodies in England*[182] issued by the Professional Standards Authority. These standards cover personal behaviour, technical competence, and business practices.

The Financial Reporting Council *Guidance on board effectiveness*[183] identifies the following signs of a possible culture problem:

- silo thinking
- dominant chief executive
- leadership arrogance
- pressure to meet the numbers/ overambitious targets
- lack of access to information
- low levels of meaningful engagement between leadership and employees
- lack of openness to challenge
- tolerance of regulatory or code of ethics breaches
- short-term focus
- misaligned incentives.

13.5 Structures and processes

Organisational structures

The Government (via the Secretary of State, the Department of Health and Social Care (DHSC) and its arm's length bodies (ALBs)) sets the structural arrangements that must be followed for the 'top' management and leadership structures of NHS organisations.

Although these structures vary according to the type of organisation, two basic principles apply to all – each must have its own governing body (often called the board) and a designated 'accountable' (or 'accounting') officer. In addition:

- FTs have a council of governors to represent local interests and which 'binds a trust to its patients, service users, staff, and stakeholders'[184]. The council's key role is to 'hold the non-executive directors, individually and collectively, to account for the performance of the board of directors and to represent the interests of the FT's members and of the public'.

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[181] NHS England, *Clinical commissioning group governing body members: role outlines, attributes and skills*, October 2012
[182] Professional Standards Authority, *Standards for members of NHS boards and clinical commissioning group governing bodies in England*, November 2013
[183] Financial Reporting Council, *Guidance on board effectiveness*, July 2018
[184] Monitor, *Your statutory duties: a reference guide for NHS foundation trust governors*, August 2013

Governors are also expected to act in the best interests of the FT and are responsible for sharing information about key decisions with their membership community.

- CCGs have a council of members on which all the CCG's constituent GP practices are represented, and it is this Council that is responsible for determining governance arrangements and setting them out in a written constitution. The CCG is required to observe at all times 'such generally accepted principles of good governance as are relevant to it[185]' in the way it conducts its business. The council of members (i.e., the CCG as a body) has the authority to delegate functions to a governing body or to its members, employees, committees, or sub-committees. The extent of delegation depends on the CCG's scheme of reservation and delegation (as set out in its constitution) and committees' terms of reference. The council of members remains accountable for all of its functions, including those that it has delegated.

The *Health and Care Act 2022*[186] sets out the establishment of integrated care boards (ICBs) and the abolition of CCGs. Each ICB will be governed by a constitution. The constitution of each new ICB will be proposed by the CCGs covered by the initial area. Chapter 5 includes further details on the role of the ICS.

The governing body or board – purpose

The governing body or board is responsible for the strategies and actions of the organisation and is accountable to its members (in the case of FTs and CCGs), the public and, ultimately, to Parliament. The governing body also monitors the achievement of the organisation's objectives (and looks for potential problems and risks that might prevent them from being achieved) and receives assurances that things are working as they should.

Given its status and role, there is a range of responsibilities and decisions that the governing body/ board cannot delegate. These are referred to as being 'reserved to the board'.

Examples of activities 'reserved to the board'

- financial stewardship responsibilities (for example, adopting the annual report and accounts that all NHS bodies are required to produce)
- determining the organisation's strategy and policies and setting its strategic direction
- appointing senior executives
- overseeing the delivery of services
- standards of governance and behaviour.

In addition, an NHS organisation's governing body is free to agree other issues that only it will deal with and must also decide which responsibilities it will delegate by drawing up a scheme of delegation.

As noted above, the situation for CCGs is different as the council of members sits above the CCG's governing body and delegates functions to it. At the same time, the legislation (and NHS England's guidance on CCG model constitutions) requires the CCG governing body (not the council of members) to appoint the audit and remuneration committees.

This means that for CCGs, the pre-eminent body is formally the council of members. However, in practice the council delegates functions to its governing body which then operates in much the same way and with the same objectives as other NHS organisations' governing bodies.

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[185] Section 14L of the *NHS Act 2006*
[186] UK Parliament, *Health and Care Bill*, July 2021 – the Act was not available to reference at time of publication

The governing body or board – composition

The governing body or board brings together in a decision-making forum the executive directors and the non-executive directors (NEDs or lay members) of the organisation and is separate from the day-to-day management structure. Each governing body is led by an independent, non-executive chairperson.

NEDs and lay members play a particularly important role on the governing body as they provide independent, constructive challenge and a breadth of experience. By balancing the views of executive directors, they also ensure that power is not concentrated in a few hands so preventing any individual or small group from dominating the governing body's decision making.

The exact structure of each governing body/ board is different for each type of NHS body and is set out in legislation and associated regulations[187].

The boards of both non-foundation trusts and FTs comprise a chairperson, executive members (who are employees of the NHS organisation) and independent NEDs, who must be in the majority. The executive directors must include a medical director and nursing director as well as the chief executive and chief finance officer (CFO).

CCG governing bodies must include at least two independent lay members (equivalent to NEDs), at least one registered nurse and a doctor who is a secondary care specialist. The CCG's chief executive and CFO must also be members of the governing body. The two lay members have specific responsibilities: one has a lead role in patient and public involvement, while the other oversees key elements of the governance arrangements, including audit. In addition, one of the lay members undertakes the role of the governing body's chairperson or the deputy chairperson.

The governing body or board – appointments

In FTs the council of governors appoints the NEDs in line with Monitor's code of governance (Monitor now operates within NHS Improvement); this recommends that there 'should be a formal, rigorous and transparent procedure for the appointment or election of new members to the boards of directors' and that appointments should be made 'on merit and based on objective criteria.' To ensure that this is the case in practice, the code recommends a nomination committee to ensure that independence is enshrined in the process and appointments are made on the basis of need (in terms of the board's needs) and competency (in relation to the individual's ability). The code also states that it is 'desirable' for there to be a majority of governor votes on nominations committees. Final decisions about the appointment of NEDs must be taken at a meeting of the council of governors.

Monitor also recommends that the board of directors appoint a 'senior independent director' from amongst the NEDs (in consultation with the council of governors) so that there is someone to deal with concerns of governors and/or members that cannot be resolved through 'normal channels' (i.e., via the chairperson, the chief executive, or finance director) if conflicted.

In NHS trusts, the NHS TDA (now operating as part of NHS England and NHS Improvement (NHSE&I)) is responsible for appointing, re-appointing (and where necessary terminating) chairs and NEDs to the boards. Appointees are chosen from lay people within the community that the organisation serves and are selected with a view to ensuring a balance of skills and experience. For example, there may be NEDs with professional qualifications in law or accountancy and others who have experience as a user of NHS services.

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[187] For non-foundation NHS trusts: regulations 2 and 4 of the 1990 Trust Membership and Procedure Regulations (SI 1990/2024). For FTs: schedule 7 to the NHS Act 2006. For CCGs: s14L of the NHS Act 2006 (inserted by s25 of the 2012 Act) and the associated regulations (SI 2012/1631).

CCGs appoint their own lay members.

The governing body or board committees

To help a governing body discharge its duties effectively, a number of committees are normally established. Although it is up to each organisation to decide what committee structure best suits its needs, there are a number of mandatory committees, discussed in turn below. For ICBs, when established, the constitution will set out how the ICS overall will discharge its functions including what committees and sub-committees the ICB will have. It is usual for a board to also have additional committees that are not mandated, such as finance and performance, or quality and governance.

Oversight is achieved by a combination of reports to the board and the more detailed scrutiny undertaken by board sub-committees. Boards should agree what information is reported to the board as a whole and what information is provided to the board's sub-committees

Audit committee

Every NHS organisation must have an audit committee that reports to the governing body or board. This committee's distinctive characteristic is that it comprises only independent non-executive members – there is usually at least three, to allow for a quorum of two. In addition, the chairperson of the organisation should not be a member, although may attend by invitation. The fact that only non-executives can be members should allow the audit committee to operate independently of executive management and to be objective when and considering the opinions from independent auditors, and scrutinising the arrangements put in place and operated by the organisation's executive.

For CCGs, schedule 2, paragraph 7 (3) of the *Health and Social Care Act 2012* says that 'Arrangements …. may include provision for the audit committee to include individuals who are not members of the governing body.'

The chief executive and all other executive directors attend whenever they are invited by the audit committee chair and, in particular, to provide assurances and explanations to the committee when it is discussing audit reports or other matters within their areas of responsibility.

Detailed guidance about the role of audit committees is set out in the HFMA's *Audit committee handbook*[188]. This makes clear that one of the audit committee's key duties is to 'review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives'.

Auditor panels

Non-foundation NHS trusts and CCGs must also have an auditor panel to advise on the selection, appointment, and removal of external auditors and on maintaining an independent relationship with them. This applies to appointments that started on or after 1 April 2017. In most cases, existing audit committees (or members of those committees) are nominated to act as the auditor panel. The HFMA has produced two briefings that provide practical guidance on how to establish auditor panels[189,190].

In FTs an auditor panel is not required as it is the responsibility of the council of governors to appoint, re-appoint and remove the external auditor and approve their remuneration and terms of engagement. Support and guidance are provided by the audit committee.

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188 HFMA, *Audit committee handbook,* March 2018
189 HFMA, *Auditor panel guidance,* September 2015
190 HFMA, *Example terms of reference for an auditor panel,* December 2015

Remuneration committee

The remuneration (and terms of service) committee is another committee that is mandatory for all NHS organisations and reports to the governing body/ board. Its role is to advise the governing body or board about the pay, other benefits and terms of employment for the chief executive and other senior staff.

In FTs, the remuneration committee should be composed of NEDs including at least three who are independent.

In NHS trusts, the committee's membership comprises at least two NEDs and the trust's chairperson.

For CCGs, the requirement for a remuneration committee is set out in section 14M(1) of the 2006 Act, as inserted by section 25 of the 2012 Act. Only members of the CCG governing body can belong to the remuneration committee.

Accountable or accounting officers

Every NHS organisation has an 'accountable' (or 'accounting') officer. This is a formal role conferred upon the organisation's 'chief officer' (usually the chief executive). In a CCG, the chief officer is either the 'lead manager' or the 'lead clinician' and is nominated by the CCG itself – he or she is then appointed formally by NHSE&I. CCGs also have an option to share an accountable officer with another CCG providing that a joint memorandum of understanding was drawn up and approved by NHS England during the authorisation process.

The role of the accountable officer is a key element in governance terms with a line of accountability for the proper stewardship of public money and assets and for the organisation's performance stretching up to Parliament. The accountable officer is also accountable to the organisation's governing body/ board for meeting the objectives it sets, for day-to-day management and for ensuring that governance arrangements are effective.

For non-foundation NHS trusts, accountable officers are accountable to the NHS TDA's accountable officer (now NHSE&I) who is in turn accountable to the DHSC's accounting officer (and on to the Secretary of State and Parliament). For FTs, accounting officers are accountable directly to Parliament (with Monitor (now part of NHSE&I) providing regulatory oversight)[191]. For CCGs, the accountable officers are accountable to NHS England's (now NHSE&I) accountable officer who is in turn accountable to the DHSC's accounting officer (and on to the Secretary of State and Parliament). The chief executive for NHSE&I is also the chief executive and accountable officer for both Monitor and the NHS TDA (the statutory bodies).

Chief finance officers

CFOs (also called finance directors or directors of finance) of health organisations are automatically executive directors with a seat on the governing body/ board. This is in line with the Treasury's guide *Managing public money* which states that the CFO should 'have board status equivalent to other board members' and that he or she should be 'a member of the senior leadership team'. Where a CFO fulfils the role for more than one organisation, he or she must be on the governing body or board of each organisation.

[191] This is the reason for the two slightly different terms – an accounting officer (for example in a foundation trust or Department of Health and Social Care) is directly accountable to Parliament (via the Public Accounts Committee) but an accountable officer (for example, in a CCG or NHS trust) is responsible to an accounting officer of a Government department who is in turn accountable to Parliament.

Executive management

Each NHS organisation must have an effective management structure designed to achieve its statutory duties and implement the strategic objectives and policies agreed by the governing body/ board. This structure will vary between organisations but should ensure that all areas of responsibility are clearly accountable to a manager and ultimately to an executive director.

Fit and proper persons

All NHS provider organisations have a duty[192] not to appoint a person to an executive level post (including associate directors) or to a non-executive position unless they are judged to be a 'fit and proper person'. In other words that they:

- are of good character
- have the necessary qualifications, skills and experience
- are able to perform the work that they are employed for
- can supply information as set out in the regulations as required by the CQC.

The 2019 review[193] of the fit and proper persons test for senior managers, led by Tom Kark QC, said new competency standards should be created for directors on NHS boards and where training is needed it should be made available. This was accepted, together with a recommendation that the government should set up a national database of directors' qualifications, previous employment, and performance.

Organisational processes

Effective internal procedures and controls are an essential part of an effective framework of governance. Collectively these are sometimes referred to as business rules. Key elements that NHS organisations need to think about in relation to finance are:

- standing orders
- procedures for dealing with any conflicts of interest
- standing financial instructions/ prime financial policies
- policies and procedures.

Standing orders (SOs)

All NHS organisations must have standing orders (SOs) which provide a comprehensive framework for carrying out activities and are therefore a critical element in the governance framework. Effectively, SOs are the link to an organisation's statutory powers and translate these powers into a series of practical rules designed to protect the interests of both the organisation and its staff. In FTs and CCGs, SOs form part of the constitution.

What standing orders contain

The majority of provisions within SOs relate to the business of running the governing body and structure of its committees – for example:

- the composition of the board and committees
- how meetings are run
- form, content, and frequency of reports

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[192] As set out in the *Health and Social Care Act 2008* (Regulated Activities) Regulations 2014
[193] Department of Health and Social Care, *Kark review of the fit and proper persons test,* March 2019

- what constitutes a quorum
- record of attendance
- voting procedures.

Other areas covered include:

- appointment of committees and sub–committees
- scheme of delegation – a detailed listing of what the governing body alone can decide on and who it empowers to take actions or make decisions on its behalf
- decisions reserved to the board – those decisions that the governing body cannot delegate
- standards of business conduct – for example, relating to how contracts should be awarded to prevent bias
- declarations of interest
- register of interests and hospitality
- duties and obligations of governing body/ board members.

Conflicts of interest

One area covered by SOs that often receives particular attention relates to standards of business conduct, and are around declarations of interest and registers of interests/ hospitality. In 2017, NHS England published *Conflicts of interest in the NHS - guidance for staff and organisations*[194], applicable to CCGs (via the statutory guidance to CCGs), NHS trusts, NHS foundation trusts and NHS England (through the standards of business conduct). It introduced common principles for managing conflicts of interest; provides advice about what to do in common situations; and supports good judgement about how interests should be approached and managed.

Governing body or board members must declare any personal or business interests or relationships that may influence (or be perceived to influence) their judgement or decisions. The fundamental principle is that no one should use their public position for private gain, either for their own benefit or for the benefit of those close to them. For example, if a governing body or board member or member of staff has any interest in a contract, that interest must be disclosed, and they must take no part in the evaluation process or decision.

It is important that both actual and potential conflicts of interest are declared and managed as any outside interest, hospitality or sponsorship represents a risk of a conflict arising. The procedures followed to manage conflicts of interest also help protect individuals from any subsequent allegations of bias.

In addition, the *Bribery Act 2010* makes it an offence to accept gifts or hospitality as an inducement or reward for doing something in your public role and staff are advised to refuse to accept such gifts or hospitality rather than declare them subsequently. There is usually some leeway for minor gifts (for example, pens or diaries) but the offer of higher value items should be questioned. The key point here is that governing body members and staff must be open about any gifts they have received or been offered. A good test is to think about how it would look on the front page of the local newspaper: if the action or gift could not be defended then it should not be carried out or accepted.

Standing financial instructions (SFIs) / prime financial policies (PFPs)

SFIs/ PFPs cover financial aspects in more depth and set out detailed procedures and responsibilities. They are designed to ensure that NHS organisations account fully and openly for all that they do through setting the financial control environment and scheme of delegation. SFIs are

[194] NHS England, *Conflicts of interest in the NHS - guidance for staff and organisations,* February 2017

detailed rules that must be complied with. Although FTs are not required to have SFIs/ PFPs many do, and others have written financial procedures that fulfil the same function.

Other policies and procedures

For NHS bodies to run smoothly and effectively, many more policies and procedures (both financial and non-financial) are required, all of which contribute to the achievement of the organisation's overarching objectives. These policies and procedures cover a wide variety of areas and are usually pulled together in manuals and made available to all staff via the organisation's intranet. They should include a whistleblowing policy, to ensure that concerns raised by staff and other stakeholders about possible improprieties in financial, clinical or safety matters are taken seriously, without adverse consequences for the person raising that concern.

13.6 Control frameworks

Internal control

Internal control comprises the systems and processes that an organisation has in place to assist and ensure that things are running as they should, and that the organisation is achieving its objectives and meeting its legal and other obligations. It includes the governance framework, risk management, information and communications, monitoring processes, and assurance activities.

The governing body or board is responsible for ensuring that there is an effective system of internal control and that it:

- identifies and prioritises the risks to the achievement of the organisation's objectives
- evaluates the likelihood of those risks being realised and the consequent impact
- manages the risk efficiently, effectively and economically.

In practice, this means that at the core of an effective internal control system there needs to be a structured approach to identifying objectives, risks, and mitigations. In the NHS, this structure is reported through an assurance framework underpinned by a risk management system.

The 'three lines of defence' model helps senior managers and the board get information systematically on how objectives are being met and risks are being managed. The term 'defence' is used as the model shows how directors might protect themselves from any allegations of not having due processes. The first line of defence is reporting by line management on the operation of the controls they are responsible for. The second line of defence is that of management oversight functions, for example, risk management or compliance. The third line of defence is internal audit (and similar functions) that are inside the organisation but operate to professional standards to provide 'independent' assurance to the board. Additional (or fourth line) assurance comes from external sources – for example, external auditors, inspectors, and regulators.

Assurance framework

The HFMA's *NHS audit committee handbook*[195] describes the assurance framework as 'the key source of evidence that links the organisation's 'mission critical' strategic objectives to risks, controls and assurances, and is the main tool that the governing body uses in discharging its overall responsibility for internal control'.

Each organisation designs its own 'assurance framework' (sometimes referred to as a board assurance framework or BAF) based on a sound understanding of the strategic risks that could

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[195] HFMA, *NHS audit committee handbook,* March 2018

prevent the organisation achieving its agreed objectives and the potential effect each risk could have on those objectives.

However, there are a number of essential components identified in the Department of Health's 2003 publication *Building an assurance framework: a practical guide*[196] as set out below.

How to build an assurance framework

1. Establish strategic objectives
2. Identify the principal (or strategic) risks that may threaten the achievement of these objectives
3. Identify and evaluate the design of key controls intended to manage these principal risks
4. Identify the arrangements for obtaining assurance on the effectiveness of these key controls
5. Evaluate the reliability of the assurances identified
6. Identify positive assurances and areas where there are gaps in controls and/ or assurances
7. Put in place plans to take corrective action where gaps in controls and/ or assurances have been identified in relation to principal (strategic) risks
8. Maintain dynamic risk management arrangements including, crucially, a well-founded risk register.

Risk management

In an organisation risk management is a formal process to ensure that all the main risks are identified, their importance is assessed and appropriate ways of reducing them agreed. One of the biggest mistakes that people make is thinking that filling in the risk register is the same as managing the risks. It is not. Managing risk involves management action while a register is simply a recording device.

Risk is subjective and the extent that an organisation manages risk depends on what level of risk it can live with. This is known as risk appetite.

For an organisation's assurance framework to be effective it must be underpinned by a robust approach to risk management. This involves identifying and managing risks, particularly those that present the biggest challenge in management terms.

There are a number of ways – individually or in combination - in which managers can mitigate risk. These are often described as the 'five t's:

- terminate the action and therefore avoid the risk completely.
- transfer the risk, or the management of the risk, to another person or organisation because they are better able to manage it.
- tolerate the risk, without any further action
- take the risk because the potential gains are expected to outweigh the potential losses.
- treat the risk through a range of management or mitigation tools (usually seen as internal controls).

[196] Department of Health, *Building an assurance framework: a practical guide,* 2003

The basics of risk management are straightforward – it is about being aware of potential problems, thinking through what effect they could have and planning ahead to prevent the worst-case scenario.

Internal audit

All NHS bodies are required to have an internal audit function that plays a key role in assurance by providing an independent and objective opinion to the accountable/ accounting officer, governing body or board, and audit committee on the extent to which risk management, control and governance arrangements support the aims of the organisation. Each year the head of internal audit must produce an opinion that is used by the accountable or accounting officer to inform the governance statement. This statement forms part of each organisation's annual accounts and draws together 'position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism'. See chapter 11 for more details about this statement and the annual accounts.

Clinical audit

Another important element of the overall risk management and assurance framework is clinical audit – a process that is carried out by healthcare professionals themselves and involves:

- setting standards
- measuring current practice
- comparing results with standards
- changing the way things are done
- re-auditing to make sure practice has improved.

In its guide, *Best practice in clinical audit*[197], the National Institute for Health and Care Excellence (NICE) states that it sees clinical audit as being 'the component of clinical governance that offers the greatest potential to assess the quality of care routinely provided for NHS users' and that it (clinical audit) 'should therefore be at the very heart of clinical governance systems'.

For NHS governing bodies/boards, managing clinical risk is just as important (if not more so) as managing financial and business risk. Good clinical audit is, therefore, an enormous asset and source of assurance.

Counter fraud and corruption

The emphasis on dealing with fraud and corruption in the NHS has increased significantly over recent years. The NHS Counter Fraud Authority (NHSCFA) is a special health authority tasked to lead the fight against fraud, bribery and corruption in the NHS. – for more details, see its website.

In January 2021, the NHSCFA rolled out new counter fraud requirements, applicable to all NHS funded services, in relation to the Government Functional Standard GovS 013: counter fraud. The standard sets expectations for the management of fraud, bribery, and corruption across government and wider public services.

[197] National Institute for Health and Care Excellence, *Best practice in clinical audit,* 2002

Key learning points

- The three fundamental principles of governance are openness, integrity and accountability.
- An effective approach to governance should underpin everything that an organisation does.
- Clinical scandals have shown clear links to governance failings – if an NHS organisation gets its approach to governance wrong it can have a catastrophic impact.
- There are three key elements to governance – culture and values; policies structures and processes; control frameworks.
- Good leadership and management are crucial to sound governance as is a shared ethos or culture and a 'tone' that is set from the top.
- Everyone who works in the public sector should adhere to the seven principles of public life
- The principles and values set out in the *NHS Constitution* should underpin all that an organisation does.
- Every NHS organisation must have a governing body/board, audit and remuneration committees, an accountable/ accounting officer and a chief finance officer.
- The governing body (which includes both executive and non-executive members) is responsible for the strategies and actions of the organisation and is ultimately accountable to the public and Parliament.
- One of the audit committee's key roles is to review the system of integrated governance, risk management and internal control across the whole of the organisation's activities.
- The remuneration committee advises the governing body about pay, benefits and terms of employment of senior staff.
- The accountable / accounting officer is accountable to the organisation and (ultimately) to Parliament.
- Standing orders provide a framework for carrying out activities and translate statutory powers and duties into practical rules that all must abide by.
- Organisations need an effective and comprehensive system of internal control that is designed to ensure that things are running as they should.
- All NHS organisations must have clear objectives and an understanding of the risks that could prevent their achievement, the possible impact and how they can be avoided.
- An assurance framework links key objectives and risks with the main sources of assurance used by the board to ensure effective internal control.
- Managing clinical risk is just as important (if not more so) as financial and business risk, clinical audit is therefore a key source of assurance in this area.
- Counter fraud is overseen by the *NHS Counter Fraud Authority*.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects, including a section dedicated to risk management and governance. It also highlights e-learning courses that are available. The directory of resources can be found here.