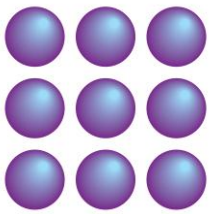
Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

Advice to the Secretary of State for Health

May 2012



council for healthcare regulatory excellence

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies[1] that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

CHRE will become the Professional Standards Authority for Health and Social Care in 2012.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values

Our values act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our partners. We are committed to being:

- Focussed on the public interest
- Independent
- Fair
- Transparent
- Proportionate.

Right-touch regulation

Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.

1 General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

Contents

Executive summary

1.1 The Council for Healthcare Regulatory Excellence was commissioned in July 2011 to advise the Secretary of State for Health on standards of personal behaviour, technical competence and business practices for members of NHS boards and Clinical Commissioning Group (CCG) governing bodies in England.

1.2 We were keen to ensure that the Standards complemented but did not conflict with existing standards. We also wanted their development to be driven by engagement with board members, other NHS staff, patients and the public, and any organisations that might be able to advise on or contribute to the work. To achieve this, we set out a comprehensive programme of work in three phases: scoping and development, consultation, and post-consultation review.

1.3 In the first phase of the project, we conducted a review of policy and standards relevant to the project, which enabled us to establish the policy drivers for this work and to position it in the context of existing standards applicable to senior NHS leaders.

1.4 We also spoke to around 30 people and organisations with an interest in this work, including NHS board members and people with a professional interest in leadership in the NHS. This gave us an idea of the challenges that board members face in their day to day work, the standards that people expect of a good board member, and the needs of the sector. We also presented our project plan and initial proposals to two Local Involvement Network public meetings.

1.5 For the second phase, we consulted on a first draft of the Standards[2], from 19 January to 11 April 2012, during which time we received just under 70 responses from a wide range of different groups, including foundation trusts, patient representative bodies, members of the public and NHS staff.

1.6 As part of the consultation process, we commissioned research to get the views on the Standards of both the general public and different groups of NHS staff – namely commissioners, staff, and managers from both primary and secondary care.

1.7 Following the consultation closure, we carried out a detailed analysis of the responses and found them to be mostly positive:

- 85% of respondents found them easy to read and understand
- 69%[3] felt they covered all the relevant areas
- 76% said they were not in conflict with other standards
- 62% thought they would help with difficult decisions
- 55% said more guidance would be useful
- 81% felt they would be useful to both Non-Executive and Executive Directors

2 The version of the Standards that was published for the consultation can be found at Annex 4.
3 This figure is an average of the 'no' responses to question 2, and the 'yes' responses to questions 10, 12 and 14.

- 62% told us separate standards would not be needed for Non-Executive Directors.

1.8 The general public and NHS staff who took part in the research all saw the need for these Standards in the remodelled NHS, and responded best to the sections on technical competence and business practices. There were suggestions for simplifying some of the language.

1.9 A number of key themes emerged from both the consultation responses and the research:

- People wanted to see a greater focus on patients and patient care, compassion and empathy, and business needs appeared, to some, to take precedence over patient needs
- We were told that whistleblowing and complaints should be more prominent in the document, more strongly worded, and include a duty to listen to and act on complaints from all parties
- Some wanted more emphasis on the importance of a board member's corporate behaviour and responsibility, and on their ability to work as part of a board team to enable it to function as a corporate body
- The importance of a non-executive director's role in constructively challenging the executive was frequently suggested as an area that needed reinforcing, and some called for more explicit acknowledgement of the differences between the executive and the non-executive roles.

1.10 In the third and final phase, we took this feedback into account to produce a more comprehensive set of Standards, written in a more accessible style and with a greater patient focus. This revised version of the Standards was considered by a review group of experts in governance and leadership in the NHS, and extremely well received.

1.11 Comments from this group resulted in a small number of further amendments, the most significant of which were the inclusion of a statement about leadership and setting the culture of the organisation from the top, and the addition of a requirement to reflect on personal and collective performance.

1.12 The version of the Standards which features in this report is the result of extensive engagement with a wide range of stakeholders. As requested by the commission, it covers personal behaviours, technical competence, and business practices, and is written in such a way as to apply equally to providers and commissioners, to executive and non-executive NHS board members, and to all members of CCG governing bodies.

1.13 We submit these Standards to the Secretary of State for Health with the recommendation that careful consideration is given to their implementation to ensure that it achieves the aims of improving accountability and driving up standards among members of NHS boards and CCG governing bodies in England, while remaining proportionate, targeted, and consistent with the principles of Right-touch regulation.

Preface

This report is our final advice to the Secretary of State for Health on the Standards for members of NHS boards and CCG governing bodies in England. We were commissioned in July 2011 to carry out this work.

The report is in two parts:

Part I: The Standards for members of boards and governing bodies in England, and supporting case studies

Part II: Background, research and development

Part I consists of the Standards that we recommend are applied to all members of NHS boards and CCG governing bodies in England.

Part II sets out what we did to develop the Standards and how we responded to the feedback we were given. It also considers the potential impact of the Standards on equality.

Some of the terminology used in this project has caused confusion, so it is important at this stage to clarify the terms used in this document.

We have used the terms 'board members', 'members', 'members of boards' and 'members of governing bodies', and 'executive directors' and 'non-executive directors' to refer to the group of NHS trust and CCG leaders for whom these Standards have been written.

We have occasionally used the term 'board' to mean both NHS trust boards and CCG governing bodies.

We have not used the term 'senior manager' as we consider that non-executives do not fall into this category.

It should be noted that although the Standards are not intended to cover foundation trust governors, the term 'governing body', as well as describing the 'board' of a CCG, is the commonly used term to describe a foundation trust's governors. Feedback from the consultation and the peer review group indicates that this dual usage could be confusing for some.

The Standards reproduced in this document have been numbered for reference purposes.

Acknowledgements

We would like to thank the following people and organisations for their contributions to and support for this project:

NHS Employers, NHS Education for Scotland, Trafford and Cleethorpes Local Involvement Networks, all our interviewees, and the peer review group.

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

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

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

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

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

Personal behaviour

1. As a Member[4] I commit to:

1.1 **The values of the NHS Constitution**

1.2 **Promoting equality**

1.3 **Promoting human rights**

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

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

2.1 **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board[5], including delegated responsibilities, and for the staff and services for which I am responsible

2.2 **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member

2.3 **Openness**: I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest

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

2.4 **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times

2.5 **Professionalism:** I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound

2.6 **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all

2.7 **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

Technical competence

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

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

3.2 To make sound decisions individually and collectively

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

4. I will do this by:

4.1 Always putting the safety of patients and service users, the quality of care and patient experience first, and enabling colleagues to do the same

4.2 Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning and continuing professional development

4.3 Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates

4.4 Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge

4.5 Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive

4.6 Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively

4.7 Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board

4.8 Thinking strategically and developmentally

4.9 Seeking and using evidence as the basis for decisions and actions

4.10 Understanding the health needs of the population I serve

4.11 Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same

4.12 Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff

4.13 Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them

4.14 Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood

4.15 Respecting patients' rights to consent, privacy and confidentiality, and access to information, as enshrined in data protection and freedom of information law and guidance.

Business practices

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

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

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

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

6. I will do this by:

6.1 Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, and removing myself from decision-making when they might be perceived to do so

6.2 Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify

6.3 Ensuring that effective complaints and whistleblowing procedures are in place and in use

6.4 Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct

6.5 Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions

6.6 Being open about the evidence, reasoning and reasons behind decisions about budget, resource, and contract allocation

6.7 Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective and properly used, and that the values in these Standards are put into action in the design and delivery of services

6.8 Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money

6.9 Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care

6.10 Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

Part II: Background, research and development

1. About the Standards

1.1 The Government made a commitment in February 2011 in *Enabling Excellence* to commission work to 'agree consistent standards of competence and behaviour for senior NHS leaders'.[6]

1.2 On 8 July 2011, Sir David Nicholson, Chief Executive of the NHS in England, announced that CHRE had been asked to develop a set of high-level ethical standards for executive and non-executive NHS board members in England.

1.3 The final version of the Standards (see Part I above) has been developed through a review of existing standards and other relevant guidelines, extensive discussion with key stakeholders across the healthcare sector, and a three-month public consultation.

1.4 They are intended to be consistent with the *Seven Principles of Public Life*[7] and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

1.5 The stages of the project were as follows:

July 2011 to January 2012: policy review and discussions with key stakeholders leading to the development of the first draft of Standards

January to April 2012: public consultation on the draft Standards

April to May 2012: development of second draft of Standards

May 2012: peer review of second draft

June 2012: development of the final version of Standards and submission to the Department of Health.

1.6 The Standards cover three distinct areas:

- Personal behaviours
- Technical competence
- Business practices.

1.7 They are intended to apply to members of boards and governing bodies in NHS organisations. This would include:

- Chief executives
- Executive directors who sit on a board, such as medical, nursing, finance, and HR
- Chairs and other non-executive directors
- Members of governing bodies of CCGs.

6 Department of Health. 2011. Enabling Excellence. The Stationery Office: London
7 Available at: http://www.public-standards.gov.uk/About/The_7_Principles.html. Accessed 31/05/12

1.8 These senior leadership roles can frequently require individuals to address dilemmas and difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers. Our Standards aim to provide a framework to guide people's judgement in these circumstances, through the consistent application of values and principles to explain how these difficult decisions are taken.

1.9 The application and implementation of these Standards was not within the scope of this project. However, in our drafting, we considered that the Standards could apply to the boards or governing bodies of the following organisations:

- All existing, remaining and/or outgoing NHS trusts
- Clinical Commissioning Groups
- NHS foundation trusts
- The NHS Commissioning Board Authority.

1.10 Therefore these Standards should be read alongside the proposals in development by the Department of Health for the governance of CCGs.[8]

1.11 We recommend that over time, as the NHS reforms take shape, consideration is given to how these Standards could be adapted for other groups, such as foundation trust governors, and extended to boards of other bodies including those not directly involved in the commissioning and provision of healthcare, such as Local Education and Training Boards.

1.12 In the following sections, we describe the activity we have undertaken in the different phases of the project, what we have learnt, and how it has informed our advice to the Secretary of State for Health.

8 Department of Health, 2011. *Towards Establishment: Creating Responsive and Accountable Clinical Commissioning Groups*.

2. Initial stakeholder engagement

2.1 We sought the views of a range of stakeholders to help with the development of the first draft of the Standards. We made use of the expertise of NHS board members themselves, and of people with specific expertise in leadership and management in the health context.

2.2 To this end, around thirty individuals contributed through either face-to-face or telephone discussions and interviews, out of a total of fifty stakeholders who were approached for their views on the work.

2.3 These contributors break down into the following categories:

- Chief executives and chairs of NHS bodies, including NHS trusts, strategic health authorities, and primary care trusts
- NHS non-executive and executive directors
- GPs
- Experts on leadership and management in health
- Experts on inclusion and equality.

2.4 The NHS Confederation, NHS Employers, the Institute of Healthcare Management, and the National Leadership Council all contributed.

2.5 Public and patient engagement took place through Local Involvement Networks (LINks): we gave presentations and sought feedback on the project at the Trafford and Cleethorpes LINks public events.

2.6 Approximately 50 individuals registered their interest in the project in response to press and other coverage.

3. Mapping existing standards

3.1 In order to put the Standards into context, we reviewed the policy background and existing standards in this area. This review is available on our website www.professionalstandards.org.uk.

3.2 In particular, we considered:

- *The Code of Conduct for NHS Managers*[9]
- *The Code of Conduct and Code of Accountability in the NHS*[10]
- *Standards of business conduct for NHS staff*[11]
- *Managing Public Money*[12]
- *Good Medical Practice*[13]
- *The Institute of Healthcare Management Code of Conduct*[14]
- *NHS Leadership Framework*.[15]

3.3 The main findings of our review were as follows:

- The need for a code of conduct for NHS board members, including those on CCG governing bodies, is likely to increase as a result of the NHS reforms
- There are many existing sets of standards that apply to some or all NHS board members, almost all of which have an ethical element to them
- There is broad consistency on the values that feature across the standards, with honesty, focus on patients, and integrity being the most prevalent
- The need for transparency of decision-making so that executive and non-executive board members can be held to account for their actions. This links to the finding that the challenges that board members face on a day to day basis call for a certain moral clarity.

---

9 Department of Health, October 2002. *Code of Conduct for NHS managers*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005410. Accessed 18/05/12

10 Department of Health, July 2004. *Code of conduct: code of accountability in the NHS - 2nd rev ed*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116281. Accessed 18/05/12

11 Department of Health, January 1993. *Standards of business conduct for NHS staff.* Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/HealthServiceGuidelines/DH_4017845. Accessed 18/05/12

12 HM Treasury, October 2007. *Managing Public Money.* Available at: http://www.hm-treasury.gov.uk/d/mpm_whole.pdf. Accessed 18/05/12

13 General Medical Council, November 2006. *Good Medical Practice.* Available at: http://www.gmc-uk.org/guidance/good_medical_practice.asp. Accessed 18/05/12

14 Institute of Healthcare Management, *Code of Conduct*. Available at: https://www.ihm.org.uk/About_Us/code_of_conduct/. Accessed 18/05/12

15 National Leadership Academy. Available at: http://www.leadershipacademy.nhs.uk/develop-your-leadership-skills/leadership-framework/the-framework-overview. Accessed 18/05/12

3.4 People told us in their interviews that there was little appetite for an entirely new set of standards, but that a document that distilled what was already available would be useful.

4. Consultation and post-consultation activity

What did we do to consult?

4.1 The consultation ran from 19 January to 10 April 2012. Consultation alerts were sent to over 120 stakeholder organisations (including third sector bodies, professional bodies, and patient representative groups), 260 public stakeholder contacts, 84 NHS middle managers and around 50 individuals who had expressed an interest.

4.2 We had a page on our website dedicated to the consultation, and links to it from the CHRE homepage. During the consultation period, the consultation web page was viewed 1,056 times.

4.3 A piece on the consultation was included in a CHRE newsletter that went to 295 stakeholders, including the health professional regulators and the devolved administrations.

4.4 We also had coverage in the *Health Service Journal*, in the Department of Health's *The Week*, in the Department of Health's bulletin to voluntary sector partners and on the National Association of LINks Members' website.

4.5 We held a focus group with NHS board members and experts on leadership and management in Scotland, which was facilitated by NHS Education Scotland.

4.6 Finally, we commissioned Research Works to conduct a series of focus groups and in-depth interviews to get the views of:

- NHS staff: commissioners, primary and secondary care staff, and managers
- Patients and the public

4.7 The report from the research is available at Annex 3.

Who did we hear from?

4.8 We received just under 70 responses from a wide range of respondents including Foundation Trusts and other NHS Trusts, professional bodies, LINks and other patient representative bodies, and regulatory bodies. The breakdown of respondents is as follows:

Clinical Commissioning Groups	1
Foundation trusts	15
Health professionals	4
LINks	4
NHS staff	5

NHS trusts	3
Other individuals	7
Other organisations	7
Other representative bodies	2
Patient representative bodies	2
Patients or members of the public	6
Primary care trusts	1
Professional bodies/ trade unions	8
Regulatory bodies	3
Grand Total	**68**

4.9 Among these were responses from the Patients Association, the British Medical Association, the Care Quality Commission, the Chartered Management Institute, the Royal College of Nursing, Skills for Health, the King's Fund, the Institute of Healthcare Management, NHS Employers, NHS Protect, and the Foundation Trust Network.

4.10 The research described in paragraph 4.6 above further extended our reach. It was conducted during April and May in Brighton, St Albans, Newcastle, Oxford, Oldham, Stockport and Birmingham.

4.11 To get the views of the general public, the researchers spoke to mixed sex groups of 18-25 year olds, 26-39 year-olds with younger children, 40-55 year-olds with older children, 56+ year-olds, and 65+ year-olds.

4.12 Most of the groups included some 'patients', and two of them also included people with caring responsibilities.

4.13 All general public groups included people with disabilities, and were diverse in terms of ethnicity, sexual orientation, and religion or belief.

4.14 An additional 10 individual, face-to-face in-depth interviews were conducted, with:

- Two people with disabilities (mental health problem and sensory impairment)
- Two older people (over 75 years old)
- Two teenagers
- Two people with significant literacy difficulties

- Two people for whom English was a second language.

4.15 The health professionals who were targeted in the research were:

- Commissioners from both primary and secondary care, all involved in local commissioning groups, in a mix of clinical and non-clinical roles
- Primary care staff with a mix of different clinical professions, e.g. nurses, GPs
- Secondary care staff with a mix of clinical professions, e.g. allied health professionals, doctors, nurses
- Managers from primary and secondary care settings.

4.16 More detailed information about the method and sample can be found at Annex 3.

Peer review

4.17 Following a redrafting of the Standards to take the consultation and research responses into account, we also sought the views of a number of individuals with expertise in governance and standards in health. The membership of the group was:

- Andrew Hind, CHRE Council Member
- David Prince, various NED roles
- Elisabeth Buggins, Chair, Birmingham Women's Hospital
- Ken Jarrold, Chair, North Staffordshire Combined Healthcare NHS Trust
- Laura Roberts, Head of Provider Leadership Development, Department of Health
- Margaret Woolley, Project Manager, CCG Development, NHS Commissioning Board Authority
- Richard Jeavons, Interim Director of Leadership and Development, Department of Health
- Sally Brearley, Lay Member, National Quality Board, and Chair, Nursing and Care Quality Forum
- Sally Irvine, CHRE Council Member; Chair, Colchester Hospital University Foundation Trust
- Sue Covill, Deputy Director, NHS Employers
- Sue Hodgetts, Chief Executive, Institute of Healthcare Management

4.18 The group met on 10 May to carry out a final check of the Standards. Their feedback is summarised in section 5 below, and in more detail in Annex 2.

Equality analysis

4.19 In the development of the Standards, we sought to assess their likely impact on equality.

4.20 We sought the views of experts on inclusion and leadership at an early point, whom we interviewed in the early stages of the project.

4.21 The consultation questionnaire invited comments on whether any aspects of the Standards could result in differential treatment of or impact on groups who share a protected characteristic covered by the Equality Act 2010[16].

4.22 We disseminated information about the consultation through our public and professional stakeholder networks, and through the Department of Health's own bulletin to voluntary sector partners. Through our own networks, we reached 58 national charities and 11 local charities or networks, including LINks. Among them were:

- Alzheimer's Society
- Association of Disabled Professionals
- Association of Muslims with Disabilities
- Care UK
- Council for Disabled Children
- Disability Action
- Mencap
- National Voices
- Patient Concern
- The Patients Association
- The Patient Information Forum.

4.23 Thanks to colleagues from the Department of Health, we were able to reach a further 17 national bodies, many of whom will have disseminated the information to partner organisations. These are:

- Age UK
- FaithAction
- Men's Health Forum
- National Association for Voluntary and Community Action
- National Care Forum and Voluntary Organisations Disability Group
- National Children's Bureau
- National Council for Palliative Care
- National Heart Forum
- Race Equality Foundation
- RADAR, National Centre for Independent Living and Shaping Our Lives National User Network

16 Age, gender reassignment, ethnicity, disability, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

- Regional Voices (a partnership of the nine Regional VCS Networks)
- Mental Health Providers Forum
- Carers UK, Princess Royal Trust for Carers and Crossroads
- Women's Health and Equality Consortium
- Royal British Legion/Combat Stress
- NACRO and Action for Prisoners' Families
- LGB&T Partnership

4.24 In addition, we ensured that the research that we commissioned reached a range of people with different perspectives. The sample of members of the public had a broad geographical spread (Brighton, St Albans, Newcastle, Oxford, Oldham, Stockport and Birmingham), and covered different age and socio-economic groups.

4.25 All five focus groups with members of the public included people with disabilities, and a mix of ethnic backgrounds, sexual orientation, and religion or belief.

4.26 Our researchers carried out one-to-one interviews with people with disabilities, older people, teenagers, people with significant literacy difficulties, and people for whom English is a second language.

4.27 Finally, we also carried out some desk research to ascertain what relevant evidence had been compiled that might help us to assess the impact on equality.

5. What people told us and how we responded

Consultation

5.1 The responses to the consultation were generally positive. The questionnaire responses can be summarised as follows:

- 85% of respondents found them easy to read and understand
- 69%[17] felt they covered all the relevant areas
- 76% said they were not in conflict with other standards
- 62% thought they would help with difficult decisions
- 55% said more guidance would be useful
- 81% felt they would be useful to both non-executive and executive directors
- 62% told us separate standards would not be needed for non-executive directors

5.2 A number of key themes emerged from the detail of the consultation responses – these are set out below. For a more detailed description, and for the full quantitative summary of questionnaire responses, please see Annex 1.

- **Focus on patients and patient care, compassion and empathy**: it was felt that there should be a greater focus on patient care and compassion – business needs appeared, to some, to take precedence over patient needs
- **Corporate behaviour and responsibility**: some wanted more emphasis on the importance of a board member's ability to work as part of a board team to enable it to function as a corporate body, particularly when it comes to decision-making and respecting the views of other board members. The commitment to corporate decisions once taken was mentioned by several respondents
- **Challenge**: the importance of non-executive directors' role in constructively challenging the executive was frequently suggested as an area that needed reinforcing
- **Differences between executive and non-executive roles**: while the overwhelming majority of respondents thought that the Standards would be equally useful to both groups, the differences between the roles of executive and non-executive directors was a very common theme, and several respondents called for greater acknowledgement of these differences
- **Whistleblowing and complaints**: we were told this should be more prominent in the document, more strongly worded, and include a duty to listen to and act on complaints from all parties
- ***The Seven Principles of Public Life***: it was felt that the Standards duplicated some but not all of these Principles, and that this could be both

17 This figure is an average of the 'no' responses to question 2, and the 'yes' responses to questions 10, 12 and 14.

confusing and unhelpful. The Seven Principles appeared to be very well respected. The Principles that we did not include are selflessness, objectivity, and leadership

- **Legal duties**: there were requests for more clarity about the legal and regulatory basis for the Standards, and for explicit mentions of the Data Protection Act, the Freedom of Information Act, the Health and Social Care Act 2012 on the duties of directors of foundation trusts, the NHS Act 2006 (sections 242 and 244) on public and patient involvement, the Mental Health Act 2007, the Public Interest Disclosure Act 1998, and the Bribery Act 2010
- **Case studies**: among those who thought more guidance would be useful, a few supported the use of case studies to clarify and reinforce the messages in the Standards
- **Equality impact**: only a very small minority of respondents told us that the Standards would have an impact on any of the groups protected under the Equality Act.

5.3 Other comments relate to areas beyond the scope of this commission:

- **Implementation and enforcement**: some felt that the key to the success of the Standards lay in their implementation and enforcement. Those who referred to enforcement generally wanted sanctions for breaches, including exclusion from NHS posts
- **Existing standards and guidance:** some expressed the view that there were already enough, if not too many documents of this kind
- **Scepticism about impact:** some members of the public and NHS staff were concerned that the Standards would not make a difference. This was sometimes connected to the fact that the existing standards were not seen to have been successful, and also links to points about implementation.

How we responded to the consultation feedback

→ We placed more emphasis on patients and their well-being, by putting the patient-centred commitments closer to the top of each section

→ We expanded the opening pledge to include a statement about care and compassion

→ We included requirements about the boundaries between the executive and the non-executive, and about corporate responsibility and challenge

→ We strengthened the statements about whistleblowing and complaints

→ We added leadership to the values in part 2 (Part I, Standards, 2.7), but considered that the other two 'missing' Principles of Public Life were adequately addressed

→ We sought to enshrine the spirit of the key pieces of legislation that were suggested in the consultation. We chose not to include explicit references to relevant primary legislation, because we felt this would detract from the conciseness of the Standards that people told us was important

→ **We recommend that a series of case studies is published alongside the Standards when they are implemented to support their application.**

Research

5.4 The first thing to note about this research is that it targeted a number of different audiences, all of whom have different interests in the Standards. This resulted in a few contradictory suggestions about amendments to the Standards, coinciding with each group's interests.

5.5 There was nevertheless a great deal of congruence in the views that were expressed on the Standards. Firstly, all saw need for Standards in new NHS context and expressed concerns about governance issues, although awareness of NHS reforms was generally low amongst the participants.

5.6 All thought accountability was central to the purpose of Standards, and, crucially, felt this was adequately addressed in the draft for consultation. The group of commissioners was particularly aware of the need for the Standards.

5.7 There was a lot more interest from all groups in the more tangible sections on Technical Competence and Business Practices, than there was in the Personal Behaviours section.

5.8 Finally, it was suggested that the Standards might ask a lot of one person but would cover what was needed of board as a whole.

5.9 The following amendments were suggested from the research:

- Make NHS values more prominent: it was felt that 'caring' was missing, and that patients' interests and safety should be more prominent
- Change the emphasis to show that the NHS is a public service that should be run like a business and not the other way around
- Simplify the language where possible: for instance 'probity' and 'stewardship' were not widely understood
- Move the Personal Behaviours section to the end: most interviewees (general public and health professionals) found the opening statements too obvious, and felt they said nothing new; if anything, they were seen as an obstacle to rest of document
- Explain 'integrity' (Part I, Standards, 2.7) better: the definition did not resonate with people, and it seemed for some to duplicate 'honesty' and 'openness'
- Put more emphasis on the conflicts of interest requirement in the Business Practices section.

How we responded to the research feedback

- → We placed more emphasis on patients and their welfare, by re-ordering the paragraphs to put the patient-centred commitments closer to the top of each section
- → We also expanded the opening pledge to include a statement about care and compassion
- → We used the terms 'collective' and 'best value' instead of 'corporate' and 'value for money' respectively, and specified that financial objectives must be pursued only in the interests of patients
- → We removed the terms 'probity' and 'stewardship', and simplified the language
- → We simplified the members' commitment in section 1 (Part I, Standards, 1). However, we did not move it to the end as we felt that the content of 1 and 2 was fundamental to the rest of the document, and therefore needed to be at the front
- → We redefined 'integrity' as acting 'consistently and fairly'
- → We made the requirement on conflicts of interests more prominent in the Business Practices section.

Peer review

5.10 This section summarises the comments of the peer review group – a more detailed note of the peer review group meeting can be found at Annex 2.

5.11 The Standards were very well received by the group, and everyone agreed that the content was right for what they were trying to achieve. Furthermore, the process for developing the Standards was felt to have been rigorous and comprehensive.

5.12 Having a single set of Standards that applied to everyone on the board or governing body, and the focus on both individual responsibilities and those of the board were welcomed.

5.13 It was felt that the Standards would encourage constructive challenge, not only between board members, but also by managers of board members, and by board members of their chair.

5.14 The Personal Behaviours section was felt to have moved on helpfully from *The Seven Principles of Public Life*, which are currently being reviewed against the current context. In particular, the move from 'accountability' to 'responsibility' was a welcome one.

5.15 It was also felt that the Standards were congruent with the *Seven Principles of Public Life*, the *NHS Constitution*[18], and the *Board Governance Assurance*

18 Department of Health, March 2012, *NHS Constitution*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961; accessed23/05/12

Framework for Aspirant Foundation Trusts[19] – for the latter, links could be made with the Standards at implementation.

5.16 The main concern expressed by the group was the absence of any statements about leadership. They stressed the importance of leading by example, and of the board modelling the behaviours which they expect of others, and setting the culture from the top.

5.17 The second omission highlighted by the group was 'reflection': making the effort to assess one's performance and its impact, and striving for continuous improvement of one's own performance as well as that of the organisation.

5.18 The third suggested addition was 'judgement', and the importance of using judgement to make sound decisions, supported by values and principles.

5.19 It was suggested that some of the operational detail may not be as relevant to non-executive directors, and could be replaced with broader statements about seeking assurance. This would address the concern that highlighted in the research about how it might not be reasonable to expect everyone to meet all the requirements in the Standards.

5.20 It was felt that the Standards would benefit from a review for accessibility before final publication. The point was made that the primary audience for the Standards is quite broad, and that they should not deter people from applying, for instance, for the lay member positions on CCGs.

How we responded to the peer review feedback

- → We added a paragraph on leadership covering culture setting and behaviour modelling
- → We added a paragraph on reflection, covering personal and collective performance and the impact of behaviour on colleagues
- → We added 'judgement' to 'skills and competencies' as something that is expected of all board members
- → We removed some of the operational detail under the Business Practices section and replaced it with an overarching statement about seeking assurance
- → We simplified the language in which the Standards are written.

Equality

5.21 This section explains how we have prepared these standards with due regard to the public sector equality duty (which in summary requires us to exercise our functions with due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations).

5.22 Our analysis has sought to answer two questions:

19 Department of Health, December 2011. Board governance assurance framework for aspirant foundation trusts. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131547. Accessed 01/06/12.

- Whether the content of the Standards could have a positive or negative impact on equality
- Whether the Standards are accessible to a range of audiences.

5.23 The primary audience for the Standards is the board members themselves, and the secondary audiences for the Standards are NHS staff and patients and the public. It was therefore important to consider the accessibility of the document.

5.24 We also wanted to understand whether the content of the Standards was likely to advantage or disadvantage any protected groups more than others – a protected group being persons who share a characteristic covered in the Act, namely: age, gender reassignment, ethnicity, disability, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

a) Content – positive impact

5.25 We drafted the Standards to have a positive impact on the behaviour of board members in relation to equality. We included an explicit commitment in the opening section to promoting 'equality in the treatment of patients and service users, their families and carers, the community, and staff in the design and delivery of services for which I am responsible' (Part I, Standards, 1.2).This first section on personal behaviours sets out the ethical basis on which the rest of the Standards sit, and the inclusion here of a commitment to promoting equality makes it integral to the behaviour and competences that are expected of a board member under these Standards.

5.26 We also placed an emphasis in the Standards on the need for effective complaints and whistleblowing procedures, and included a requirement to address, learn from and raise any concerns about 'harmful behaviour' (Part I, Standards, 6.2 and 6.3). We deliberately kept these statements at a high level to cover issues of discrimination, victimisation and harassment, alongside those issues that are more explicitly related to clinical care.

5.27 Elsewhere in the document, we also require Members to behave 'fairly' (Part I, Standards, 2.7, *Integrity*), and to 'treat patients, service users, their families and carers, staff, colleagues, and the wider community with dignity and respect at all times' (Part I, Standards, 2.4, *Respect*), all of which are fundamentally incompatible with discrimination, victimisation and harassment.

5.28 We were told in the interviews in the first phase of the project that failure to meet the Equality duty was often a result of board members not being aware of what was happening closer to the 'front line'. We sought to address this by including requirements to look 'for the impact of decisions on the services we provide, on those provided by others, on the people who use them, and on staff' and to 'listen to patients, service users, their families, carers, the community, colleagues and staff' (Part I, Standards, 4.12 and 4.13). Coupled with the complaints and whistleblowing requirements mentioned above, these paragraphs should provide a basis for improved performance in this area.

b) Content – negative impact

5.29 We also sought in this project to establish whether there were any potential discriminatory aspects in the Standards themselves. The consultation results

were very encouraging in this respect: only five people who responded to the consultation felt that there could be an impact on any of the protected groups, with two suggestions to include the term 'dignity' and one call for the Standards to be published in Braille and languages other than English. Both these points have been picked up elsewhere.

5.30 The research we commissioned with members of the public found no evidence of potentially discriminatory aspects of the Standards based on the content alone.

c) Accessibility

5.31 No issues were reported in the research about specific groups' capacity to engage with the Standards, with the exception of people with literacy difficulties. This group tended to avoid reading large amounts of text, and therefore found the bold emphasis on words in the first section extremely helpful

5.32 The research did highlight the need to simplify some of the language to make the document more accessible generally – in particular, the terms 'probity' and 'stewardship' were not widely understood, and elements of the Standards were described as jargon by some. It should be noted that these difficulties were common across the groups, and not apparently tied to any particular characteristic.

5.33 Furthermore, the consultation did not yield any responses that suggested the document was not accessible to any particular group, although a small number of responses (two) called for 'simple English' and more 'layman's language'.

d) Desk research findings about positive and negative impacts

5.34 Finally, we carried out desk research to determine what we could learn from any relevant demographic information and from equality assessments and research for comparable projects.

5.35 Although the scope of application of the Standards has yet to be confirmed, we looked for relevant data on the demographic make-up of the current NHS board workforce as whole. We found that the Appointments Commission collects data on non-executive board members, but not on executive board members. The NHS Information Centre publishes data on managers and senior managers but not on board members specifically. At the time of writing, CCGs were in development and the membership of their governing bodies was yet to be determined. Therefore we were not able to determine whether the very fact of introducing Standards would disproportionately impact on any of the protected groups.

5.36 The search for comparable projects did not yield much relevant material, as published evidence in this field rarely focuses on a code or set of standards independently of the consideration of their implementation, and where it does, the issues it brings up are specific to that code.

5.37 We were nevertheless able to draw on some of the information contained within equality analyses undertaken by two other regulatory bodies, that related to standards guidance, and could be considered in the context of our work.

5.38 These were the equality analysis[20] for the General Medical Council's (GMC) recent consultation on their code of practice for doctors, *Good Medical Practice*[21], which sets out the principles and values on which good practice is founded, and the General Osteopathic Council's (GOsC) equality impact assessment[22] for its revised Practice Standards.

5.39 Both relate to a set of standards applicable to health professionals in the NHS and within the broader healthcare context. In addition, some NHS board members and members of CCG governing bodies will also be health professionals registered with these two bodies, and will therefore be required to meet these standards.

5.40 The GMC's equality analysis draws on evidence about, for example, the barriers that women face in medicine; discrimination and barriers in the workplace; barriers for certain groups of patients in accessing healthcare; and inequalities in health outcomes. We are confident that all these areas are adequately addressed in our Standards.

5.41 The analysis also sets out a number of actions based on the evidence and analysis it had undertaken. These include engaging with diverse groups to inform the consultation process, and other actions, such as considering during the consultation process whether to strengthen the guidance by referencing specific equalities legislation. We do not believe it would be appropriate to go into detail in our Standards about equality and diversity, but suggest that supporting guidance on this topic could be of use.

5.42 The GOsC's assessment identifies issues to do with communication with certain groups with disabilities, and prejudice against some protected groups. Again, we feel our Standards address these issues.

5.43 Other research in this area tends to focus more on the combined impacts of a code of conduct or practice and its enforcement. The group that is likely to have to comply with these Standards has not previously been subject to regulation as a group, although some of its constituents will be subject to professional regulation. It is difficult to assess the equality impact that the implementation of the Standards could have without such a precedent to learn from.

5.44 We can nevertheless get an indication of the potential equality impact by looking at the evidence that the Solicitor's Regulatory Authority (SRA)[23] and the GMC[24] have compiled on regulatory frameworks. Monitoring data from the SRA has

---

20 General Medical Council, October 2011, *Equality Analysis – Good Medical Practice*. Available at https://gmc.e-consultation.net/econsult/uploaddocs/Consult222/GMP%20consultation%20equality%20analysis.pdf; accessed 17/05/12

21 General Medical Council, 2006, *Good Medical Practice*

22 General Osteopathic Council, April 2011, '*Osteopathic Practice Standards' Equality Impact Assessment*. Available at http://www.osteopathy.org.uk/uploads/ops_equality_impact_assessment_ozone.pdf; accessed 22/05/12

23 Solicitor's Regulatory Authority, April 2011, *Equality impact assessment, Conclusions on the equality impact of the SRA Handbook*. Available at: http://www.sra.org.uk/sra/equality-diversity/impact-assessments/summary-of-the-sra-handbook.page. Accessed 17/05/12

24 GMC/ ESRC, 2009, *Clarifying the factors associated with progression through GMC Fitness to Practise procedures*, Professor Charlotte Humphrey et al. Available at: http://www.gmc-uk.org/Humphrey___Clarifying_the_factors_30867967.pdf. Accessed 17/05/12

shown that black and minority ethnic solicitors are over-represented in regulatory decisions and outcomes. The GMC has found that non-UK qualified doctors are overrepresented in the fitness to practise process. We therefore recommend that the equality impact of the implementation of the Standards is closely monitored to ensure that it does not disproportionately impact on any particular groups.

How we have addressed these equality issues

- → We believe that the Standards will provide a sound basis for holding board members to account for their behaviours and attitudes in relation to equality.
- → We are satisfied that the content of the Standards does not in itself disadvantage any specific group, but **we recommend that easy-read, braille and translated versions of the Standards are published alongside the master version to increase accessibility.**
- → We have included a clear commitment to human rights and equality, and do not feel that the document in its current form would benefit from specific legislative references. **However, supporting guidance in these areas may be useful, and we recommend that this matter is given further thought in implementation.**
- → We removed the terms 'probity' and 'stewardship', and generally simplified the language.
- → The Standards clearly set out requirements that guard against discriminatory behaviour: to treat others with dignity and respect, and to act fairly.
- → Statements on CPD, appraisal and personal reflection, and on supporting others to undertake these activities, should help people returning to work after long periods of leave.
- → The Standards include explicit duties in relation to whistleblowing and complaints to support the reporting of concerns such as the failure to provide basic standards of care.
- → They also require members to strive for excellence in the accessibility of services, to provide clear and accessible information about the choices available to patients and service users, and to communicate clearly and effectively with families, carers, patients, and service users. This should improve access and communication with some of the harder to reach or alienated groups.
- → **We recommend that the full equality impact of the implementation of the Standards is assessed and monitored, in particular to determine whether their introduction has disproportionately affected any particular groups.**

6. Conclusion

6.1 The Standards that we are recommending in this document are the result of just under a year's worth of research and development. In this time, we have heard from a large number of stakeholders across the sector, as well as patients and members of the public from across England.

6.2 We used this feedback to produce a concise document that we believe will meet the needs of the sector now and in the future, while being useful and accessible not only to members of boards and governing bodies, but also to NHS staff and the general public alike.

6.3 We were wholly encouraged by the level of interest displayed in the project by different groups, and by the positive nature of the responses we received in both the consultation and the peer review. We found that there was strong support not only for the introduction of the Standards, particularly in the light of the NHS reforms, but also for the form and content of the document itself.

6.4 However, the feedback also brought to light some of the concerns that people have about this project. A minority of respondents to the consultation were more concerned about the implementation than about the content of the Standards, and reflected on the fact that previous attempts to introduce similar standards appear to have failed.

6.5 Questions were asked about how these Standards would be used to hold board members to account, what avenues will be available to people who think the Standards have been breached, and whether sanctions will be imposed if they are.

6.6 We believe that these Standards constitute a robust foundation for a new framework to improve accountability and drive up the standards of personal behaviour, technical competence, and business practices of members of NHS boards and CCG governing bodies in England. We recommend that careful consideration is given to developing a means of implementation that can achieve these aims while remaining proportionate, targeted, and consistent with the principles of Right-Touch Regulation.

7. Annex 1: Summary of consultation responses

Data summary

Q1. Are the Standards easy to read and understand?		
Answer Options	Response Percent	Response Count
Yes	85.0%	51
No	15.0%	9
Comments		13
	answered question	60
	skipped question	8
Q2. Are there any areas in addition to personal behaviours, technical competence, and business practices that you think should be covered in these Standards?		
Answer Options	Response Percent	Response Count
Yes	34.4%	21
No	65.6%	40
Comments		29
	answered question	61
	skipped question	7
Q3. Are there any aspects of the Standards that you feel could result in differential treatment of or impact on groups or individuals based on the following characteristics?		
Answer Options	Yes	Response Count
Age	2	2
Gender reassignment	1	1
Ethnicity	2	2
Disability	3	3
Pregnancy and maternity	0	0
Race	1	1
Religion or belief	0	0
Sex	1	1

Sexual orientation	0	0
Other (please specify below)	1	1
Comments		7
	answered question	5
	skipped question	63
Q4. Is any part of the Standards in conflict with existing standards frameworks that apply to all or some members of NHS boards and governing bodies?		
Answer Options	Response Percent	Response Count
Yes	23.6%	13
No	76.4%	42
Comments		21
	answered question	55
	skipped question	13
Q5. Do you think these Standards will help guide members' judgements when making difficult decisions about conflicting needs?		
Answer Options	Response Percent	Response Count
Yes	61.8%	34
No	38.2%	21
Comments		40
	answered question	55
	skipped question	13
Q6. With reference to question 5, would more detailed guidance be useful?		
Answer Options	Response Percent	Response Count
Yes	54.5%	30
No	45.5%	25
Comments		40
	answered question	55
	skipped question	13

Q7. Would these Standards be equally useful to Executive and Non-executive members of NHS Boards?		
Answer Options	Response Percent	Response Count
Yes	81.0%	47
No	19.0%	11
Comments		21
	answered question	58
	skipped question	10
Q8. Would separate standards for Non-executive Board Members be needed in certain areas?		
Answer Options	Response Percent	Response Count
Yes	38.2%	21
No	61.8%	34
Comments		31
	answered question	55
	skipped question	13
Q9. Please add any other comments you have on the draft Standards, on their development, or on the consultation process itself.		
Answer Options	Response Count	
	37	
answered question	37	
skipped question	31	
Q10. Does this section cover all aspects of personal behaviours that should be expected of members of NHS boards and governing bodies?		
Answer Options	Response Percent	Response Count
Yes	67.9%	38
No	32.1%	18
Comments		23

	answered question	56
	skipped question	12
Q11. Do you have any other comments on this section?		
Answer Options	Response Count	
	13	
answered question	13	
skipped question	55	
Q12. Does this section cover all the aspects of technical competence that should be expected of members of NHS boards and governing bodies?		
Answer Options	Response Percent	Response Count
Yes	66.7%	36
No	33.3%	18
Comments		19
	answered question	54
	skipped question	14
Q13. Do you have any other comments on this section?		
Answer Options	Response Count	
	15	
answered question	15	
skipped question	53	
Q14. Does this section cover all the aspects of business practices that should be expected of members of NHS boards and governing bodies?		
Answer Options	Response Percent	Response Count
Yes	74.1%	40
No	25.9%	14
Comments		17
	answered question	54
	skipped question	14

Q15. Do you have any other comments on this section?		
Answer Options	Response Count	
	14	
answered question	14	
skipped question	54	
Q16. Your contact details		
Answer Options	Response Percent	Response Count
Your name:	95.3%	61
Contact address:	95.3%	61
Postcode:	92.2%	59
Organisation representing (if applicable):	75.0%	48
Email:	85.9%	55
	answered question	64
	skipped question	4
Q17. Are you responding as (you may tick more than one box) -		
Answer Options	Tick as appropriate	Response Count
a. An NHS board member?	16	16
b. A member of a Clinical Commissioning Group?	3	3
c. A patient or member of the public?	15	15
d. A person with a professional interest in leadership and management in the NHS?	20	20
e. A registered health professional?	8	8
f. Other NHS employee (please specify below)?	11	11

g. Other (please specify below)?	20	20
Comments		39
	answered question	61
	skipped question	7

Summary of comments

Question 1: Are the Standards easy to read and understand?

1. Of the 68 responses we received to the consultation, the overwhelming majority (85%) told us that the Standards were easy to read and understand.

2. Among the few negative comments made on this question, there was no clear consensus about how the standards could be improved, although several respondents found some repetition, and some found the format of the document unhelpful, for example breaking it down into personal behaviours, technical competence, and business practices, which was felt to result in some repetition, and one respondent felt there were too many sub-clauses. A small number of respondents said they found the language unclear.

3. It was suggested that personal and collective board standards might be a more meaningful distinction, and that it might be preferable to frame the Standards in terms of a set of basic principles by which it is suggested boards should operate. A few suggested that the Standards did nothing more than state the obvious. Other comments relate to specific drafting points which have been picked up elsewhere in this summary or in the re-drafted version of the Standards.

Question 2: Are there any areas in addition to personal behaviours, technical competence, and business practices that you think should be covered in these Standards?

4. Sixty six percent of respondents reported that they were happy with the three areas already covered in the draft Standards (personal behaviours, technical competence, and business practices).

5. A number of respondents highlighted areas that they thought needed adding. These can be summarised as follows:

   - **Corporate behaviour and responsibility**: some respondents highlighted the importance of a board member's ability to work as part of a board 'team' to enable it to function as a corporate body, particularly when it comes to decision-making and respecting the views of other board members. The commitment to corporate decisions once taken was a key theme in the responses generally
   - **Challenge:** the importance of non-executive directors' role in constructively challenging the executive was frequently mentioned as an area that needed reinforcing

- **Legal duties**: there were a number of requests for more clarity about the legal and regulatory basis for the Standards, with requests for explicit mentions of the Data Protection Act, the Freedom of Information Act, the Health and Social Care Act 2012, the NHS Act 2006 (sections 242, 244) on public and patient involvement, the Mental Health Act 2007, the Public Interest Disclosure Act 1998, and the Bribery Act 2010.
- **Professional standards**: several people felt that the Standards should include a requirement to adhere to any relevant professional standards; others asked how the draft Standards would deal with conflicts with other professional codes, and one person called for a requirement to make public the list of professional registrations and memberships on the board
- **Patients, carers, families and communities**: a few responses suggested there should be a greater focus on patients and their safety, and local communities
- **Role of the board**: some responses called for further definition of the role of the board as a whole, mostly in relation to strategy, development, and transformation, or perhaps through a statement of shared vision or purpose
- **The functioning of the board:** there was some suggestion that the Standards should set out the way in which a board should function in practice, such as the mechanisms that are in place to provide stewardship of resources and high quality care; how each member should contribute to its functioning, and how the board should relate to its 'complex web of partners'
- **Communication:** further comments relate to ensuring that the content of communications is understood, and that there is a dialogue (as opposed to one-way communication) with colleagues, staff, and patients and the public
- **Responsibility for delegating:** some responses picked up on the board's important role in delegating, while retaining responsibility, and one respondent asked for the application of the Standards to delegated committees to be made explicit
- **Other individual comments** suggest placing greater emphasis on whistleblowing, the addition of statement of shared vision or objective, encouraging board members to keep in touch with frontline practice, mentioning the unitary nature of the board, and the political nature of the role of a board member.

Question 3: Are there any aspects of the Standards that you feel could result in differential treatment of or impact on groups or individuals based on the following characteristics: age, gender reassignment, ethnicity, disability, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and/or other

6. Only five people felt that the Standards could result in the differential treatment of any of the groups defined in the Equality Act 2010.

7. Of these, three respondents thought they would have an impact on people with disabilities, and a further two on people for their age and ethnicity. Only one person thought that the Standards would result on the differential treatment of people based on each of the following: gender reassignment, race, sex, and 'other' (unqualified). All other categories remained blank.

8. There were a small number of free text responses to this question, calling for the treatment of patients with dignity as well as respect, for the Standards to be made available in other languages and braille, and for the inclusion of a Standard about board diversity.

Question 4: Is any part of the Standards in conflict with existing standards frameworks that apply to all or some members of NHS boards and governing bodies?

9. Three quarters of respondents (76%) felt that the Standards were not in conflict with any existing Standards.

10. Among the comments on this question, a number referred to the fact that the Standards duplicated some but not all of the *Seven Principles of Public Life*[25] and stressed that this could be both confusing and unhelpful. These Principles appeared to be very well respected.

11. Some noted the absence of specific references to what they considered key documents including the *NHS Foundation Trust Code of Governance*[26], the *Healthy NHS Board*[27], the *UK Corporate Governance Code*[28], the Good Governance Institute (GGI)/ Healthcare Quality Improvement Partnership (HQIP) *Good Governance Handbook*[29], and the *Seven Principles of Public Life*. Some called for more links to the *NHS Constitution*.

12. Others noted that they could clash with an organisation's own values, as well as the CCG model constitution[30] – the latter specifically with respect to conflicts of interest. The Foundation Trust Network stressed that according to the NHS Foundation Trust Code of Governance, it is the responsibility of the board of directors to set the Trust's standards of conduct, and perceived this to be in conflict with the proposed Standards.

13. The British Medical Association noted that Good Medical Practice explicitly required doctors to put the interests of their patients first, and suggested that the emphasis in the draft Standards on financial sustainability should be amended to show that quality of care should be the primary concern.

---

25 Committee on Standards in Public Life. *The Seven Principles of Public Life*. Available at http://www.public-standards.gov.uk/. Accessed 22/05/12
26 Monitor, March 2010, *NHS Foundation Trust Code of Governance*. Available at http://www.monitor-nhsft.gov.uk/sites/default/files/Code%20of%20Governance_WEB%20%282%29.pdf. Accessed 22/05/12
27 National Leadership Council, February 2010, *The Healthy NHS Board, Principles for Good Governance*
28 Financial Reporting Council, June 2010, *The UK Corporate Governance Code*
29 GGI/HQIP, January 2012, *Good Governance Handbook*. Available at: http://www.hqip.org.uk/assets/Guidance/GGI-HQIP-Good-Governance-Handbook-Jan-2012.pdf; accessed 23/05/12
30 NHS Commissioning Board Authority, April 2012. *Model constitution framework for clinical commissioning groups*. Available at: http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/ccg-mod-cons-framework/. Accessed 31/0512

14. A few respondents also expressed their concern about the number of existing standards, and questioned the purpose of introducing new ones.

Question 5: Do you think these Standards will help guide members' judgements when making difficult decisions about conflicting needs?

15. A little over 60% of respondents responded positively to this question, including some positive comments from:

- The Patients Association:

'We believe that having such a well-defined set of Standards will impress upon Members the importance of all three elements – personal behaviours, technical competence and business practices. […] The emphasis upon the personal behaviours is vital in terms of understanding and meeting patient needs while in a business or financial setting.'

- The Chief Executive of one NHS trust:

'They would encourage CEOs and directors to refer back to these to provide evidence that they were acting in good faith and balancing the sometimes conflicting demands placed on NHS executives by patients, staff and politicians.'

- Portsmouth LINk:

'They should help those concerned to make balanced judgements, especially in difficult circumstances.'

16. On the other hand, some of those who said that they did not think the Standards would help guide members' judgements thought they were too aspirational, generic and not sufficiently pragmatic. It was felt by some that they added nothing to the existing standards and guidance (which some people thought was useful, and others did not), and that they would do nothing to support individuals to '*challenge the norms of corporate behaviour*'. One respondent suggested they were too high-level to address the complexity of board decision-making.

17. Some were sceptical about whether the Standards would be adhered to, or could change management styles when other factors have stronger influences. It was suggested by the Nursing and Midwifery Council that they could be used as a reference point in investigatory processes.

18. A few respondents felt that it was asking too much of standards of this sort to hope they might be able to guide judgements in making difficult decisions, while others felt that their effectiveness in this area depended on how they were enforced. One respondent felt the Standards should address the issue of what to do when one disagrees with policy but still has to enforce it.

Question 6: With reference to question 5, would more detailed guidance be useful?

19. Just over half the people who responded to this question said they felt more detailed guidance would be useful, with half of those who responded

negatively to question 5 falling into this category. The following themes emerged from these responses:

- There was broad support for the use of case studies, examples and guidance on the practical application of the Standards. One respondent requested examples of how one might demonstrate they had been used in decision-making
- Some guidance on specific issues would be helpful, including dealing with the political pressure of the role of a board member, prioritising clinical and other legitimate needs, ethical behaviour, applying and giving weight to evidence, what to do when you disagree with a policy but still have to implement it, and working as part of a board team. There was some suggestion that guidance specific to both non-executive and executive directors could be of use – for example, guidance on challenging professional colleagues and scrutinising patient care data for non-executives. One respondent recommended supplementing the Standards with a competency framework for performance management and guidance on recruitment
- Guidance may be needed on how the Standards will be implemented, how to escalate concerns, and how they relate to other relevant standards and guidance. There was one suggestion that they should link to relevant toolkits and other reference materials, as well as signposting development opportunities
- Additional guidance and signposting would be preferable to expanding the Standards document itself, which is better brief.

20. Those who did not support the idea of additional guidance generally thought there was already sufficient, if not a surplus of guidance available. It was also suggested that board members should have sufficient knowledge, skills and judgement not to need additional guidance, and that reality was too complex to capture in examples.

Q7: Would these Standards be equally useful to executive and non-executive Board Members?

21. Eighty-one percent of respondents told us that the Standards would be equally useful to executive and non-executive board members. Comments from these respondents suggest that it is appropriate to have a common set of Standards in light of the unitary nature of NHS boards. The Patients Association told us that '*there needs to be a set of unified standards that apply to all Board members (executive or non-executive) and are universally adhered to, particularly relating to ensuring high quality patient care which must be a priority for all Board members.'*

22. While those who disagreed generally felt that the Standards focused on the appropriate areas of commonality, some felt that there were some areas that were less relevant to both groups:

- A number of responses suggested the Standards should be amended to emphasise and support the non-executives' 'responsibility to both challenge and support the executive directors' decisions, actions and

behaviour', while highlighting that this is less relevant to executive directors.

- The technical competence and the business practices sections were seen by some respondents to be less relevant to non-executive directors, for example those who may be recruited for their 'life experience'
- Some requested a clearer acknowledgement of the differences between the roles of the executive and non-executive directors
- One respondent felt that the Standards would be more useful to non-executive board members, given the context of the NHS reforms and the creation of numerous new statutory NHS organisations
- Some also made reference to existing documents that could supplement the Standards with specific standards and guidance for executive and non-executive board members (such as the *Seven Principles of Public Life* and the *NHS Constitution*).

Question 8: Would separate standards for non-executive board members be needed in certain areas?

23. Just over 60% of respondents felt that separate standards for non-executive board members would not be needed. Comments here again focus on the unitary nature of NHS boards.

24. Among the affirmative responses to this question, there was some reiteration of the issues highlighted in question 7, but the key theme emerging was again around the role of non-executives in challenging and scrutinising the work and decisions of the executive – it was felt that this was not sufficiently clear in the Standards. One respondent suggested that guidance might be needed to support non-executive board members to challenge their professional colleagues and scrutinise patient care data.

25. Other respondents emphasised in a general way the difference in the roles, competencies, and behaviours required of executive and non-executive board members and the need for the Standards to reflect these differences. One respondent expressed concern about leaving individual boards to develop their own interpretation of the different roles.

26. Further responses identified:

- The differences in the roles that individual board members might play, for instance the nursing director will have a different role on the board from that of the chief executive
- The public accountability aspect of the non-executive roles, for example in relation to the *Seven Principles of Public Life* – although one respondent noted that all members of CCG governing bodies will be appointed by the CCG and therefore would not be public appointments
- The importance of finding the correct boundary between executive and non-executive, and between operational detail and strategic overview
- The role of non-executives in bringing broader expertise to the board
- The importance of challenging majority decisions

- The local networking aspect of non-executive's roles to enable them to support or defend decisions effectively.

Question 9: Please add any other comments you have on the draft Standards, on their development, or on the consultation process itself.

27. The 33 responses we received to this question were mixed. Some were positive, including the following remarks:

- From the Patients Association:

'The Standards recognise the importance of patient safety, human rights, respect and communication, all aspects of patient care which are of vital importance but need strong leadership to be fulfilled.'

- From a registered health professional working for a community health and care trust:

'*If the Board can live and breathe these standards then this culture will quickly permeate through organisations creating a safer environment for staff to operate within.'*

- From Bolton Local Involvement Network:

'*Well put in clear language, not over embellished. Hope that standards stay as they are written and are adhered to and monitored as such.'*

28. A number of responses to this question made more critical points however. Some of the key concerns that emerged here relate to:

- **Implementation:** a number of responses talked about how they would like to see the Standards implemented. There were suggestions that the Standards should apply to all organisations providing services to NHS patients, including private and third sector organisations, and to all levels of management in the NHS. The question was raised as to whether the Standards should apply also to foundation trust governors – although not in their current form, as there are many elements that would not be relevant to them. One respondent thought that compliance with the Standards should be a precondition of providing or commissioning NHS services. The Royal College of Nursing hopes to see the Standards '*promoted throughout the new structure by the NHS Commissioning Board'.* It was also suggested that the Standards should be published alongside information on how to escalate concerns, and regularly reviewed
- **Enforcement**: a number of respondents had concerns, comments and questions about how the Standards would be enforced, who board members would be accountable to, whether the Standards would be compulsory, and if there would be sanctions for non-compliance. It was stressed that the effective enforcement was crucial to the success of the Standards. Several respondents hoped to see sanctions, such as removal from post and even disqualification from the commissioning or provision of NHS services for repeated breaches. It was also suggested that Monitor and the Care Quality Commission should both have a role in monitoring compliance. Other responses talked about the importance

of effective recruitment, performance monitoring and management as a means of enforcing the Standards, and there was some suggestion that the Standards could form a basis for more detailed competency frameworks

- **Existing standards:** a number of people felt that the existing Standards were adequate, although not always effectively enforced. Some called for more links to the *NHS Constitution*. Other documents that were quoted were the *Seven Principles of Public Life*, the *NHS Foundation Trust Code of Governance*, the *Healthy NHS Board*, the *UK Corporate Governance Code*, *Good Governance Standard for Public Services*[31], and the *GGI/HQIP Good Governance Handbook*. One respondent recommended situating the Standards in the range of other existing Standards
- **Interface with other standards, guidance, and legislation:** as mentioned above, some people questioned how these Standards would relate to the professional codes that some members of boards and governing bodies are signed up to, and others wanted more clarity on how they would fit with an organisation's own codes and values. The General Pharmaceutical Council would like to see enforcement that is compatible and complementary with the statutory professional regulation of pharmacists and owners and superintendents of pharmacy premises – a point that can no doubt be broadened to other statutorily regulated professions. It was also suggested that the Standards could conflict with CCG constitutions[32] on what to do in the event of a conflict of interests, as the model constitution gives CCGs flexibility on how to deal with such situations
- **The drivers for the Standards**: some people were unsure about the drivers for this set of Standards, and which problem they are meant to be solving
- **Impact:** some questioned the impact the Standards will have. There was some scepticism in the responses about the motivations of senior NHS officials, with the suggestion that the prevailing culture was one of self-preservation and mutual 'back-scratching'. One respondent suggested that looking more closely at how to change people's behaviour might be more effective the producing a new set of Standards
- **Timing**: the timing of this project was called in a question in particular by the Foundation Trust Network, who noted that the UK Corporate Governance Code[33] and the NHS Foundation Trust Code of Governance were due for review in 2012, and urged for the sign-off of these Standards to be delayed in order to take these developments into account.

31 Chartered Institute of Public Finance and Accountancy, 2004. *The Good Governance Standard for Public Services*. Available at: http://www.cipfa.org.uk/pt/download/governance_standard.pdf. Accessed 01/06/12

32 NHS Commissioning Board Authority, April 2012, *Model constitution framework for clinical commissioning groups*. Available at http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/ccg-mod-cons-framework/. Accessed 22/05/12

33 Financial Reporting Council, May 2010. *The UK Corporate Governance Code and associated guidance*. Available at: http://www.frc.org.uk/corporate/ukcgcode.cfm. Accessed 31/05/12

29. Other individual responses requested greater clarity on the board's role and how it should fulfil its responsibilities; more detail on competency; and the application of the Standards to social services and Health and Wellbeing Boards, and to private and third sector providers.

On personal behaviours

Question 10: Does this section cover all the aspects of personal behaviours that should be expected of Members of NHS boards and governing bodies?

Question 11: Do you have any other comments on this section?

30. Just under 70% of respondents were happy with this section as it is[34].

31. However, there were a number of suggestions for additions and amendments to this section of the Standards, most of which reinforce or finesse what was proposed. However, some also added to the values that board members should exhibit, including:

- Empathy – the Patients Association told us that *'empathy might be considered a personal behaviour which would be useful for Members of NHS board and governing bodies. When making difficult decisions about patients, it is important that patients are seen as individuals and are empathised with, rather than seen as numbers and statistics.'*
- Diligence, and a commitment to do the job properly including a time commitment – one Foundation Trust explained that '*a member of a board and committee has a duty to come to the decision-making table having studied the information given to them in the board/committee pack, having understood the decision that is being asked of them and to raise any questions they might have before making that decision in the forum they are attending*'.
- Leadership – this was seen to be a problematic omission from the *Seven Principles of Public Life* – linked to a duty to promote public confidence in the organisation
- Treating others with dignity
- Demonstrating patient and staff-centred behaviour
- Striving for excellence and showing professionalism at all times and setting an example to be followed by colleagues at all levels
- Committing to inclusiveness and board diversity, and
- Selflessness and objectivity (the remaining missing principles from the *Seven Principles of Public Life*) along with personal judgement and a duty to uphold the law.

32. One foundation trust felt that the duty to promote human rights was problematic because it was not specific enough, and could conflict with other duties and responsibilities – for example they felt the promotion of the right

34 This figure is taken directly from the questionnaire responses, however a number of respondents who responded affirmatively to this question in fact suggested amendments to it elsewhere in their responses. These may appear in the textual summary and/ or in the amended Standards in Part I.

to respect family life could cause tensions when considering some employment appeal issues. A response received from a Mental Health Trust highlighted the legal duties that Mental Health Trusts are under(under the Mental Health Act 2007) by virtue of which some decisions taken by the Trust and its staff may be against the express wishes of the patient or their family or carer. There was also a call for more clarity on what should be done if a conflict of interests arises.

On technical competence

Question 12: Does this section cover all the aspects of technical competence that should be expected of Members of NHS boards and governing bodies?

Question 13: Do you have any other comments on this section?

33. Just over 65% of respondents told us that this section covered all the necessary aspects of technical competence[35], but these questions also elicited quite a few suggestions for improvement.

34. Some of these are specific drafting points, which we picked up in the redrafting of the Standards. The following sets out the more significant proposals:

- Challenging decisions and raising concerns effectively and ensuring that I am sufficiently well prepared, and have the knowledge, skills and evidence to do so
- Striving not just for financial stability but also for the long-term maintenance and improvement of services
- Working as part of a team by both supporting and challenging fellow board members, and supporting board decisions even if I disagree with them
- Championing board decisions even if originally opposed (or resigning)
- Listening to colleagues, suspending judgement and finding the common ground in searching for a solution, or a decision
- Involving staff in decisions
- Listening to complaints made by staff, patients, carers and families, and ensuring they are acted upon
- Understanding workforce issues and how they impact on patient safety
- Understanding how good financial management and the effective use of technology contribute to the performance of my organisation
- Making the best use of my own expertise while working within the limits of my competence and knowledge

35 This figure is taken directly from the questionnaire responses, however a number of respondents who responded affirmatively to this question in fact suggested amendments to it elsewhere in their responses. These may appear in the textual summary and/ or in the amended Standards in Part I.

- Being clear about the extent of my role and powers, the boundaries between the executive and the non-executive, and the legal and regulatory frameworks within which I operate
- Working in the patients' best interests (even if this is sometimes against their express wishes or those of their family – Mental Health Act 2007)
- Understanding the principles of good governance.

On business practices

Question 14: Does this section cover all the aspects of business practices that should be expected of Members of NHS boards and governing bodies?

Question 15: Do you have any other comments on this section?

35. The responses to this question were again broadly positive, with just under three-quarters of respondents telling us this section covered all the relevant aspects of business practices[36].

36. As in the two preceding headings, the more detailed drafting points that emerged here have been picked up in the new draft, but the main suggestions for additions to this section are summarised below:

- Ensuring that effective complaints and whistleblowing procedures are in place, in use, and regularly reviewed
- Prohibiting the use of practices that could inhibit or prohibit the reporting of concerns about standards of care by board members, staff or members of the public. One respondent specifically called for the terms of David Nicholson's letter of 11th January 2012[37] on compromise agreements and the Public Interest Disclosure Act to be made compulsory through these Standards
- Thinking strategically and effectively translating strategic vision into organisational assurance frameworks
- Taking responsibility for addressing mistakes, misconduct and harmful behaviour, and ensuring that lessons are learnt – the Chartered Management Institute stated in their submission that '*given the backdrop of events and incidents which these standards are designed to address, the Standards would be made stronger by an explicit reference to leaders taking responsibility for resolving instances of misconduct and harmful behaviour, rather than just raising concerns*'
- Adhering to agreed management and finance protocols, including Standard Financial Instructions – the national organisation that tackles fraud in the NHS, NHS Protect, indicated that '*an issue […] emerging from a number of NHS Protect investigations is non-adherence to Standing Financial Instructions (SFI)*'

36 This figure is taken directly from the questionnaire responses, however a number of respondents who responded affirmatively to this question in fact suggested amendments to it elsewhere in their responses. These may appear in the textual summary and/ or in the amended Standards in Part I.
37 This letter was a reminder Foundation Trusts that 'gagging clauses' are unlawful. Available at:http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132261; accessed 23/05/12

- Working under the presumption that all my organisation's dealings should be available for public scrutiny unless there is a justifiable and documented reason to withhold them – one GP practice manager told us that '*there should be a presumption that the dealings of NHS bodies should be available for detailed public scrutiny unless there is a clear and documented need for items to be kept from the public. The criteria for withholding information should be published*'.
- Ensuring that the promotion of equality, diversity, and human rights are integral to my organisation's working practices
- Ensuring that working environments are healthy and safe and support ethical practice
- Ensuring board and staff training and development needs are met
- Setting an example by abiding by these Standards and ensuring they are adhered to by staff and contractors alike
- Committing to quality and safety and the essential standards thereof.

37. Further comments relate to the relevance of this section – one respondent from a Foundation Trust felt that the parts relating to '*contracts and commercial arrangements, effective partnership, patient and family information*' might not be relevant to all, and suggested replacing this with a high-level statement about '*ensuring an effective and comprehensive corporate governance framework* […]'.

8. Annex 2: Peer review group feedback

1. Positive feedback

1.1. **The Standards were very well received** by the group, and everyone agreed that the content was right for what they were trying to achieve. There were some suggestions for additions, amendments, and language simplification which are detailed below.

1.2. Feedback from emerging **CCGs and the NHS Commissioning Board Authority was also very positive**, although it was suggested that some of the language was more provider than commissioner focused.

1.3. The **process** for the development of the Standards was felt to have been **rigorous and comprehensive**.

1.4. Having **one set of Standards** that applied to everyone on the board or governing body, and the focus on both individual responsibilities and those of the board were welcomed. One member commented on the fact that managers need a Code to guide their behaviour and decisions.

1.5. Members liked the **conciseness** of the document, and felt that it would not necessarily benefit from supporting guidance – with the exception of **case studies**.

1.6. It was felt that the Standards would **encourage constructive challenge**, not only between board members, but also by managers of board members, and by board members of their Chair.

1.7. The **personal commitment** in the first section was particularly well received, and the suggestion from the Research Works feedback that it should be moved to the end of the document was rejected.

1.8. The Personal Behaviours section was felt to have **moved on helpfully from the *Seven Principles of Public Life***, which are in the process of being reviewed against the current context. In particular, the move from 'accountability' to '**responsibility**' was a welcome one.

1.9. It was felt that the Standards were **congruent** with the ***Seven Principles of Public Life***, the **NHS Constitution**, and the **Board Governance Assurance Framework** for Foundation Trusts (FT) – for the latter, links could be made with the Standards at implementation.

2. Suggested amendments

2.1. The main concern expressed by the group was the absence of any statements about **leadership**. They stressed the importance of leading by example, and of the board modelling the behaviours which they expect of others, and setting the culture from the top.

2.2. The second omission highlighted by the group was **reflection**: making the effort to assess your performance and its impact, and striving for continuous improvement of my own performance as well as that of my organisation.

2.3. The third suggested addition was **judgement**, and the importance of using judgement to make sound decisions, supported by values and principles.

2.4. It was felt that a statement about the **duty of board members to enable staff to deliver high quality care** to all patients would strengthen the commitment to patient care.

2.5. There were also suggestions that the Standards should make explicit reference to **whistleblowing**.

2.6. Some reservations were expressed about the **qualifiers** 'as far as I can' and 'as open as possible', as it was thought that they might be open to abuse.

2.7. It was suggested that some of the **operational detail** may not be as relevant to NEDs, and could be replaced with broader statements about **seeking assurance**. This would address the concern that the research highlighted about how it might not be reasonable to expect everyone to meet all the requirements in the Standards.

2.8. It was felt that the Standards would benefit from a review for **accessibility** before final publication. The point was made that the **primary audience** for the Standards is quite **broad**, and that they should not deter people from applying, for instance, for the lay member positions on Commissioning Groups (CCGs).

3. Other comments

3.1. There were several helpful comments about the contexts in which the Standards could be useful, including for **board member appraisal**, and for **FT governors** to hold their Board to account. There was support for the idea that one member put forward of an 'annual affirmation' that the Standards will be upheld.

3.2. The group was supportive of the suggestion to create **versions of these Standards for managers** at all levels as well as for **governors** at a later stage – although it was seen to be important at this stage to focus on board members only. It was mooted that NHS Employers, IHM, and the FT governance team at the Department of Health could have a role in this.

3.3. It was noted that the **NHS Constitution** is currently under review, and that this opportunity should be taken to **reference the Standards** in the revised version.

3.4. Some members suggested that the **Care Quality Commission**, **Monitor**, the **NHS Trust Development Authority** should be involved in the enforcement of the Standards. For example, signing up to the Standards could become a condition of obtaining FT status.

3.5. It was felt that the Standards would have a greater impact if they applied to **all boards in the NHS** including those of national bodies, such as the **NHS Commissioning Board Authority**.

3.6. One member was concerned that some members of **CCGs might be sceptical** about the need for the Standards.

3.7. There was support for the suggestion that the Standards should apply to any bodies providing services on behalf of the NHS, including **private providers**.

9. Annex 3: Research with members of the public and NHS Staff

Consulting with patients, the public and health professionals on the Standards for members of NHS boards and governing bodies in England

Research Report - May 2012

Research Works Limited
Regency House
The Quadrant
219a Hatfield Road
St Albans, Herts
AL1 4TB
all@researchworks.co.uk
Tel: 01727 893 159
Fax: 01727 893 930

1. BACKGROUND

In February 2011, the government made a commitment to commission work to agree consistent standards of competence and behaviour for senior NHS leaders. As part of this commitment, **CHRE had been asked to develop a set of high-level ethical standards for executive and non-executive NHS Board members in England.**

CHRE have spent **six months developing the draft standards** through review of existing standards and other relevant guidelines, as well as extensive discussion with key stakeholders across the healthcare sector. The Standards could apply to the boards or governing bodies of the following organisations:

- All existing, remaining and/or outgoing NHS Trusts
- Clinical Commissioning Groups
- NHS Foundation Trusts
- The NHS Commissioning Board.

CHRE have now reached the conclusion of the consultation phase. Research was required **to explore the views of both NHS staff, patients and the public on the draft standards.**

2. RESEARCH OBJECTIVES

2.1 Overall objectives were to explore:

- The appropriateness and relevance of the form and content of the draft Standards
- The impact the Standards could have on any individuals or groups based on age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation

- If necessary, to provide recommendations for any changes to the wording or format of the Standards which may be required to make them more relevant to either NHS Staff or Patients and the Public.

2.2 Objectives specific to NHS staff are:

- To explore whether the Standards pick up on all the issues relevant both now and under new arrangements
- Whether the standards could be useful to them when they have serious concerns about the senior leadership of the organisation and its impact on patient and staff care

2.3 Objectives specific to patients and Public

- Whether the standards are written in a language that is accessible and relevant to them
- Whether the standards address what they feel are the problems with the senior levels of management in the NHS
- Whether and how the Standards could be useful to members of the public in their engagements with their local services.

3. METHOD AND SAMPLE

A mix of focus group discussions and individual face-to-face depth interviews were conducted with patients, the public and health professionals, as follows:
5 focus groups with patients/general public (8 respondents, 1.5 hours duration)

1. Mixed sex, 18-25 years old, single no children, BC1C2D, including 4 ‘patients’
2. Mixed sex, 26-39 Family Stagers, young children aged 0-10 years old, BC1, including those with caring responsibilities for younger/older family members, including 4 ‘patients’

3. Mixed sex, 40-55 Family stagers, older children aged 11+ years old, C2DE, including those with caring responsibilities for younger/older family members, including 4 ‘patients’
4. Mixed sex, 56+ years, Empty nesters, BC1C2D
5. Mixed sex, 65+ years, retired, BC1C2D

All groups included:

- A mix of people from a range of ethnic minority backgrounds
- A mix of sexual orientations
- A mix of religion or belief
- Inclusion of people with disabilities

Respondents with very negative experiences of the NHS services were excluded in the group sessions since – from experience – we have found that they tend to dominate and bias the discussion in an unproductive way.

10 depth interviews, 1 hour duration

To ensure that those unlikely to participate in group discussions were represented within our sample, an additional 10 individual, face-to-face depth interviews were conducted, as follows:

- 2 x people with disabilities (mental health problem and sensory impairment)
- 2 x older people (i.e. over 75 years old)
- 2 x teenagers
- 2 x people with significant literacy difficulties
- 2 x people for whom English is a second language

4 mini-focus group discussions (4-5 respondents, 1.5 hours duration) with health professionals, as follows:

1. Commissioners (both primary and secondary care), all involved in local commissioning groups, a mix of clinical and non-clinical roles

2. Primary care staff (mix of clinical e.g. nurses, GPs)
3. Secondary care staff (mix of clinical e.g. allied health professionals, doctors, nurses)
4. Managers from primary and secondary care settings

The research was conducted in the following locations during April and May 2012: Brighton, St Albans, Newcastle, Oxford, Oldham, Stockport and Birmingham.

The majority of recruitment was conducted by Research Works Limited. One group (group 3) and one pair depth interview (from group 2) were recruited by NHS Trusts on behalf of CHRE.

4. MANAGEMENT SUMMARY

4.1 General public and patients

The appropriateness and relevance of the form and content of the draft Standards was judged by the extent to which it was felt to reflect perceived NHS values. The draft version was not perceived to reflect NHS values closely or consistently enough. They therefore suggested changes designed to tailor the Standards to their vision of the NHS, for example:

- including and prioritising 'caring' at a key value in section 5.3;
- prioritising 'excellence in the safety and quality of care' in section 5.4;
- using language reflecting the NHS rather than big business e.g. 'as a team' rather than 'corporately' and 'best value' rather than 'value for money' in section 5.4;
- prioritising 'maintaining my focus on the safety of patients, the quality of care and patient experience, 'seeking the expertise and views of service users, their families, carers, the community, and staff' and 'communicating clearly, consistently and honestly with colleagues, staff, patients and the public' in section 5.5.

Overall, the general public wished to see Standards that reflected the NHS as a public service that needs to be run like a business, not a business providing public services.

The accessibility of the document – and therefore reaction to the document - varied:

- section 5.2 (the members' commitment') was poorly received. The language was perceived as a generic style of 'legalese' and therefore extremely opaque. Future development of the Standards should consider whether these high level principles could be expressed in plain English and whether there would be any merit in doing so;
- section 5.3 (values) received a positive reaction since the language was largely accessible, apart from the term 'integrity' which needs to be communicated more simply in order to be understood by the general public;

- sections 5.4 (technical competence) and 5.5 (technical skills and competencies) were extremely well received because the language successfully described specific, tangible behaviours;
- section 5.6 (business practices) received a mixed reaction. It clearly communicates two key themes in plain English – managing public money wisely and transparency in decision-making - but needs to work harder to communicate what 'probity' means;
- section 5.7 (business skills and competencies) was not particularly well received since, in places, it returns to a more opaque style of language. In future, this section should strive to reflect the plain English achieved in section 5.5 (technical skills and competencies).

The accessibility of the document – and therefore reaction to the document – also affected the extent to which members of the public felt they could use the Standards. Since section 5.5 (technical skills and competencies) described expected behaviours in a way that the general public could understand, the possibility of holding people accountable for their behaviour was perceived as credible.

It was section 5.6 (business practices) which made general public respondents feel that they would be able to hold senior managers to account. In short, this section successfully delivered the sense of governance that respondents had desired when first told about the new NHS structure. To reflect the perceived importance of accountability, consider positioning the 'personal interests' bullet at the top of the list in section 5.7.

4.2 Health professionals

The biggest challenge for the opening sections of the Standards - section 5.2 (members' commitment), 5.3 (values) and 5.4 (technical aims) - was engaging health professionals' interest. Health professionals simply failed to see the relevance of any of these sections, since it was their perception that they were not being told anything new.

The point at which health professionals became engaged with the Standards was when offered specific, tangible guidance about the behaviours required (section 5.5, technical skills and behaviours).

Similarly to the general public, health professionals felt that the document became credible when it started to identify specific behaviours that could be used to hold people to account e.g. section 5.5, technical skills and behaviours. Similarly to the general public, the business practices section (section 5.6) delivered a welcome sense of accountability, as did the specific business behaviours required (section 5.7).

There was some spontaneous support for some of the issues raised by the general public e.g. prioritising ‘a focus on the safety of patients’, explaining ‘probity’ and ‘stewardship’ and balancing references to ‘best value’ with assurances about quality not being compromised.

For most health professionals, accountability was the most important issue that the Standards needed to address, which they felt was achieved.
However, commissioners articulated more sophisticated views about what would be expected in terms of skills and behaviours (e.g. acting in the interests of ‘the greater good’, accepting majority decisions, understanding the commissioning cycle and maintaining an overview of the whole system) which they did not feel were addressed.

5. MAIN FINDINGS

5.1 General public understanding of NHS changes

Understanding of NHS changes varied within each group. Typically, one respondent had a greater understanding of the changes than the others, with their knowledge focused on the new Clinical Care Group arrangements:

"The NHS is giving the money to GPs to spend now." (Female, 56+ years old, BC1C2D)

Of the remainder in each group, some had a vague awareness that the NHS was changing in some way:

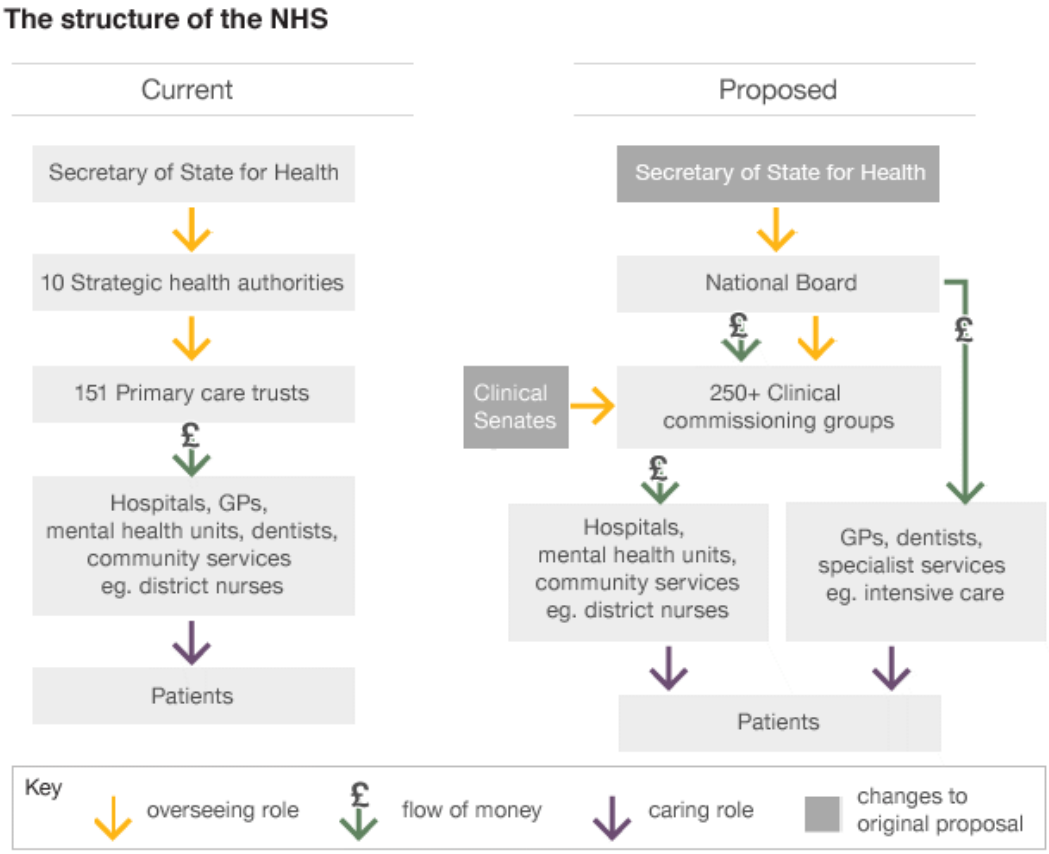
"They want to cut costs and they are doing lots of things and not everyone agrees with it." (Female, 40-55 years old, BC1, English as a second language)

Others clearly had no awareness that the NHS is changing:

"Has it been made public? Is it a big thing?" (Female, 18-25 years old, BC1)

Awareness of specific changes to the NHS structure was therefore low across all groups. The depth interviews revealed that certain groups were less likely than others to be aware of NHS changes: teenagers, people aged 75+ years old and those with literacy difficulties.

After a discussion about respondents' spontaneous awareness of NHS changes, respondents were prompted with some information about how the NHS is changing, as follows:



Reaction differed by location. Those in the Midlands and South could not see how the restructuring would make any difference to themselves as patients. The response was also passive, with respondents feeling that there was little they could do to influence what happens to the NHS:

"There's nothing you can do about it anyway. It's all been decided by the powers that be." (Male, 56+ years old, BC1C2D)

There were certain assumptions made by this group: particularly that the people on the new commissioning boards will be the same people who sat on the previous commissioning boards (typically described as 'suits'):

"The board would be playing golf all day." (Female, 56+ years old, BC1C2D)

The questions raised by this rather cynical, defeated-sounding group of respondents included:

- Will the funding be distributed fairly?
- Will there be fair representation of different professions (e.g. nurses and doctors)?
- How will people be appointed to the commissioning boards?
- Who would the CCGs and National Board be answerable to?
- How would spending be monitored?

"The only thing that makes me sceptical about this is that the GPs are going to be given the money direct. I wonder if they are going to work on the basis that they will get more money, not for my benefit. Would they choose the cheapest drugs or go with the friend's drug companies?" (Female, 18- 25 years old, BC1C2)

Reaction in the North was much more politicised. Both groups articulated their view that the changes to commissioning were a precursor to the privatisation of the NHS. The fear of privatisation was generalised: respondents were unable to articulate how this concern was linked to changes in the NHS commissioning structure.

This questions raised by this more actively opinionated group included:

- Will GPs have the skills to take on this role?
- How will people be appointed to the commissioning boards?

➔ **Regardless of reaction to the changes described, the general public expressed concerns about governance issues. All were conscious of the need for the appointment and behaviour of those involved in commissioning and providing NHS services to be scrutinised.**

5.1.2 Health professionals' views regarding standards of competence

There were varying levels of knowledge about the new commissioning structure across the health professional sample. The most knowledgeable respondents came from primary care settings. The least knowledgeable came from secondary care settings.

Some primary health professionals expressed concerns about the competence of those being given positions within the new NHS structure:

"A lot of people came in with little experience and have been promoted very quickly up to senior positions and many don't have a lot of NHS experience and exposure. So that comes across through some of them being over-critical of the clinical indicators without necessarily understanding the clinical agenda." (Primary Care)

"I have grave reservations about the current set up. Competencies within CCGs and the need to meet standards is all right and proper, but the issue is the individual competence of members of CCGs. Some CCGs have elected members – elected by fellow GPs. I'm not sure that necessarily means they have the competence to do the job." (Commissioner)

It was this group of respondents, and commissioners in particular, who really understood the need for the Standards, given their greater understanding of the implications of the new commissioning structure.

5.2 Views on section 5.2 of the draft Standards

5.2.1 General public/patients

The broad reaction to the members' commitment was frustration. The general public felt frustrated that personal behaviours which they regarded as 'hygiene factors' should need to be written down:

Personal behaviours

5.2 As a Member I commit to:

- The values of the NHS Constitution in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible
- Promoting equality and diversity in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible
- Promoting human rights in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible.

"I'm a bit baffled as to why they need to write this down. Surely this should be what they do without thinking about it anyway." (Female, 18-25 years old, BC1C2)

"It's something that they should be doing. Everyone should be doing." (Male, 18-25 years old, C2DE, literacy difficulties)

"This is how it should be now." (Female, 56+ years old, BC1C2)

It was only a minority who appreciated the need to formalise the expected and assumed behaviours of all those involved in commissioning and delivering NHS services:

"It's spot on. These are good points to make them pledge to." (Female, 18-25 years old, C2DE)

"My first instinct is that I would want everybody working in the NHS to make this pledge!" (Female, 40-55 years old, BC1)

The way in which the members' commitment was written was not very well received. It was considered 'wordy' and 'repetitive, and did not encourage the general public to engage with the ideas being communicated:

"It's just a big 'So what?'". (Female, 40-55 years old, C2DE)

As a result, respondents tended to re-write the members' commitment in a way that made it more accessible:

"It's to make people know that the objective is to be treating people right and like people." (Female, 40-55 years old, BC1, English as a second language)

"It's 'treat people the way you would like to be treated yourself', that's all you need to say." (Male, 65+ years old, BC1C2D)

"This sounds like they have to treat everyone fairly and the same as everyone else." (Female, 18-25 years old, C2DE)

The focus on human rights actively antagonised a small minority who felt that some people's human rights were being prioritised over others e.g. Abu Hamza and illegal immigrants.

➔ Overall, the general public's reaction to the 'members' commitment' demonstrates a desire to translate high level principles such as 'equality and diversity' and 'human rights' into accessible language that resonates and engages. The current style of generic 'legalese' proved frustrating: respondents wondered why there was a need to re-state principles regarded as 'hygiene factors'.

5.2.2 Health professionals

Health professionals' reaction mirrored that of the general public. They too felt that the 'member's commitment' was common sense:

"These are things which for us, as clinicians, we practice. That's why you do it. Every one of us would take these as principles anyway." (Secondary Care)

They too were frustrated by the generic legalese in which the 'members' commitment' was couched:

"Just typical blah, blah, blah …" (Secondary Care)

"This is just the bog standard what you'd expect." (Manager)

Overall, health professionals failed to see anything new in what they were being asked to commit to:

"I don't think they go far enough in terms of what they are asking people to commit to." (Primary Care)

At best, a minority acknowledged that the members' commitment included the principles they would expect to see, but nothing more.

➔ Health professionals also failed to engage with the opening of the document, which was perceived as a very generic 'members' commitment' and therefore lacking in impact.

5.3 Views on section 5.3 of the draft Standards

5.3.1 General public/patients

Respondents were asked to describe the type of person they would want either commissioning or providing NHS services. They described a person who is:

- caring/puts people first
- responsible
- knowledgeable
- literate/numerate
- honest/trustworthy
- understanding, with 'hands on' experience
- open to different people's needs/feelings
- good communicator and listener
- approachable/comfortable/responsive
- fair

5.3 I will apply the following values in my work and relationships with others:

- **Accountability**: I will take full responsibility for my work and for the work that I delegate, and for the performance of the staff and services for which I am responsible
- **Honesty**: I will act with honesty and probity in all my actions, transactions, communications, behaviours and decision-making, including with respect to any personal, professional or financial interests that could influence my decisions as a board member
- **Openness:** I will be as open as possible about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
- **Respect:** I will show respect to all patients, their families and carers, and to the wider community, staff and colleagues, in my actions, transactions, communications, behaviours and decision-making
- **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member, and that I am in a position to identify and fill any gaps in my knowledge and skills and will participate constructively in appraisal of myself and others
- **Integrity**: I will apply these values consistently in all my actions, transactions, communications, behaviours and decision-making, and will always raise concerns if I see harmful behaviour or misconduct by others.

Initial response to the values was considerably more positive than initial response to the 'member's commitment':

"It sounds great doesn't it? I like everything about it because it shows all the values that are necessary to make you welcome." (Female, 40-55 years old, BC1, English as a second language)

The bold emphasis on each single word value was an important short-hand for those with literacy difficulties who tended to avoid reading the explanatory sentence – or indeed any large amount of text.

When the general public reviewed the values, they consistently pointed out that 'caring' was not included. This, they felt, was an important oversight, particularly since it had been the key value all had spontaneously identified:

"That's what the NHS is about: patients." (Female, 40-55 years old, ABC1, English as a second language)

As a result, all expected to see 'caring' at the top of the list of values.

The values from the draft Standards that had already been identified by respondents were 'honesty' and 'openness'. Once they had reviewed the values in the draft Standards, respondents also supported the inclusion of 'accountability', 'respect' and 'professionalism':

"Integrity and respect surprises me. I would expect accountability – and openness and honesty goes without saying." (Female, 40-55 years old, BC1, with a disability)

"Accountability means that if they do something wrong they have to take responsibility for it." (Female, 18-25 years old, C2DE)

The one value which respondents found difficult to understand was integrity. A majority failed to understand how integrity was different to honesty and openness:

"If the rest of the board want to make a decision which they don't think is right they should speak up about it." (Female, 18-25 years old, C2DE)

➔ **The general public's reaction to the values was more positive than their reaction to the 'members' commitment'. Overall, the values were more accessible than the 'members' commitment'. The general public felt that 'caring' was the most important NHS value and therefore wanted 'caring' to be included. The meaning of 'integrity' was unclear and needs to be clarified (particularly the difference between 'integrity' and 'honesty' and 'openness').**

5.3.2 Health professionals

The values were accepted with equanimity by a majority of health professionals. Those from primary care, managers and commissioners all felt that the values identified were appropriate:

"If I was to relate these back to how I do my job I would say that all of those are absolutely appropriate." (Manager)

"It covers the Nolan principles, so I'm happy with it." (Commissioner)

This group felt that it was useful to record these values formally:

"Something like this will clearly tell you what someone's intention is and the reasons why they want to be there." (Primary Care)

"I think it's good to have these values written down. Half the time you don't know what these people actually do or what they stand for!" (Manager)

It was only those further removed from changes to the NHS commissioning structure (secondary care professionals) who failed to see the merit in recording these values:

"These are just minimum requirements aren't they? These are just things that one should just take for granted." (Secondary Care)

"These are the values of interpersonal contact that you would expect from any other human being anyway." (Secondary Care)

Suggestions for other values were captured in other parts of the Standards e.g. probity and inclusiveness. Additional suggestions included: consistency and innovation/forward-thinking.

➔ Similarly to the general public, health professionals' reaction to the values was more positive than their reaction to the 'members' commitment'. However, this section still failed to strike health professionals as offering anything new or different for either commissioners or providers.

5.4 Views on section 5.4 of the draft Standards

5.4.1 General public/patients

The next part of the standards were perceived to have a much greater focus on finance.

Technical competence

5.4 As a Member, for myself and my organisation, I will seek:

- To make sound decisions individually and corporately
- Excellence in the safety and quality of care
- Long term financial sustainability and value for money.

The focus on finance meant that the response to some of the ideas expressed tended to be negative, particularly talking about the NHS 'corporately' and the idea of seeking 'value for money':

"It sounds like a company that doesn't have anything to do with health." (Female, 40-55 years old, BC1, English as a second language)

"I don't like the word 'corporately' here. As soon as I see this word I am thinking mmmn, I'm not an individual here. I have to fit into this big organisation." (Female, 40-55 years old, BC1, with a disability)

The term 'corporately' was associated with big business, rather than values shared by all members of a group. The alternative suggestion was 'as a team'. Respondents supported the idea of teamwork i.e. that those commissioning and delivering services would need to work as teams in order to capture all the relevant skills to perform their tasks successfully.

'Value for money' was sometimes interpreted as 'cheapest':

"*As long as 'value for money' is not giving people a half-rate service." (Female, 18-25 years old, C2DE)*

'Best value' was much more positively received alternative to 'value for money'. This phrase is used in section 5.6 'business practices'.

Although there were some issues with some of the specific content, overall, this section was received more positively precisely because it was more focused. When

compared with the previous two sections, respondents felt it was saying more specific, more tangible things about how people managing NHS finances should behave:

"There's less waffle, no flowering up." (Male, 40-55 years old, C2DE)

"It's good to have these things written down and make the people sign up even if they have been working in the role before. Sometimes it's good to stir things up and make the untouchable people realise they have to change." (Male, 56+ years old, BC1C2)

Once again, respondents prioritised care. They therefore suggested that the second bullet 'Excellence in the safety and quality of care' should be placed at the top of the list, ahead of making 'sound decisions individually and corporately'.

➔ **Overall, response to the Standards document improved as the required behaviours became more specific and tangible. Once again, respondents demonstrated a desire for the Standards to reflect assumed NHS priorities i.e. leading with a commitment to 'excellence in the safety and quality of care'. Any terms felt to reflect big business more than the NHS tended to alienate: consider 'as a team' rather than 'corporately' and 'best value' rather than 'value for money'.**

5.4.2 Health professionals

Health professionals found it almost impossible to comment on the broad technical principles outlined in section 5.4. There was an appetite to define what skills and competencies people will need to demonstrate (as outlined in section 5.5) in order to fulfil these technical aims, but little interest in the broad aims themselves.

For example, primary care staff felt that the skills and competencies required would include: consultation, negotiation, excellent communication skills, the ability to challenge constructively, knowledge of NHS finances, tariffs and money allocations, budget management and people skills.

Thus, health professionals found it difficult to engage with such high level principles:

"I can't see how someone would be deemed competent just by those three statements. I could say yes to all of those but I'd be a hopeless commissioner." (Secondary Care)

In fact, commissioners became somewhat frustrated by the attempt to summarise the complexities of their role:

"This reduces the principles of what we are there for in eight words." (Commissioner)

A minority reflected the general public's discomfort with the term 'value for money'. They wanted to clarify that 'value for money' did not refer to the cheapest option and that quality was not expendable.

➔ Whilst the general public felt that the Standards were beginning to describe the required behaviours in a more specific and tangible way, health professionals remained frustrated by the generic requirements described. Although health professionals did not dispute the technical aims expressed, they still found the generic articulation of these aims frustrating and not particularly engaging.

5.5 Views on section 5.5 of the draft Standards

5.5.1 General public/patients

Respondents were asked to consider the skills and competencies required to fulfil the technical competence pledge (as outlined in section 5.4). They described a team comprising individuals with:

- clinical experience
- business experience
- management experience

- good communicators/listeners
- financial acumen

Overall, the response to the skills and competencies was positive:

"I'd like to see this up in every GP surgery. It's very comprehensive. Everything I could have wanted is written down here." (Female, 40-55 years old, BC1, with a disability)

Respondents were satisfied with the way in which this section identifies what specific skills and competencies are required. In fact, some of the skills/competencies reflected skills/competencies respondents had raised as important earlier in the group e.g. communicating clearly and listening to patients.

5.5 I will do this through:

- Demonstrating the skills and competencies necessary to fulfil my role and by engaging in training and continuing professional development
- Working collaboratively and constructively with others
- Ensuring performance is measured and risk is evaluated and managed
- Making effective use of evidence
- Maintaining my focus on the safety of patients, the quality of care and patient experience
- Understanding the health needs of the population I serve
- Looking for the impact of decisions on services we provide and those provided by others and on the people who use them
- Seeking the expertise and views of service users, their families, carers, the community, and staff
- Communicating clearly, consistently and honestly with colleagues, staff, patients and the public.

General public respondents did not take issue with any of the individual skills and competencies listed. They did, however, take issue with the order in which the skills and competencies were presented – and the language in which some were described.

Once again, the general public wanted skills and competencies closely associated with the NHS to be prioritised. The skills and competencies prioritised were:

- Firstly: ‘maintaining my focus on the safety of patients, the quality of care and patient experience’:

“They are going to learn what’s needed for the patient … sounds like they’re obviously caring a lot.” (Male, 18-35 years old, C2DE, literacy difficulties)

- And subsequently: ‘Seeking the expertise and views of service users, their families, carers, the community, and staff’;

“Asking for their opinions is making better decisions because patients have a better understanding of what needs to be changed in the NHS.” (Female, 18-25 years old, C2DE)

- And ‘communicating clearly, consistently and honestly with colleagues, staff, patients and the public’.

The way in which this section has been written was regarded as considerably more accessible than the preceding sections. However, there were still places where respondents felt that improvements could be made by using plain English alternatives e.g.

- ‘engaging in training and continuous professional development’ could simply read ‘keeping skills updated’
- ‘working collaboratively’ could read ‘working as a team’ or ‘people working together’
- ‘ensuring performance is measured and risk evaluated and managed’ could read ‘monitor effectively’
- ‘making effective use of evidence’ was felt to need a little further explanation i.e. ‘using evidence of what works/doesn’t work’ ‘to justify decisions made’
- ‘understanding the health needs of the population I serve’ could read ‘understanding the needs of the community’

- ‘looking for the impact of decisions on services we provide and those provided by others and on the people who use them’ could read ‘reviewing’ or ‘looking at’ our decisions and ensuring they are of benefit to patients’

➔ **Overall, the skills and competencies specified were extremely well received. Once again, those closely associated with the NHS were prioritised. By being more specific about expected behaviours and communicating these expected behaviours in a way that the general public could understand, the possibility of holding people accountable for their behaviour was perceived as credible.**

5.5.2 Health professionals

It was section 5.5 which finally engaged health professionals’ attention. This section was felt to offer health professionals specific, tangible guidance about the behaviours required. It was considered useful:

“It’s getting a bit more concrete now. This is entry level. The other sections were below entry level.” (Secondary Care)

“It’s committing to more specific objectives rather than banalities.” (Secondary Care)

“I have to say that these are very, very clear. This is what you should do to manage any business. It’s all about accountability.” (Manager)

Health professionals demonstrated that they were engaging with the technical skills and competencies described in this section by making suggestions for improvements:

“It should read ‘making effective and appropriate use of evidence’ ... and ‘maintaining my focus of the safety of patients, the quality of care and patients’ and carers’ experience through understanding the needs of the population I serve.” (Primary Care)

The possibility of holding people to account for the behaviours described became much clearer for health professionals at this point in the document:

"There needs to be something about 'monitoring' in there. There's got to be a continuous programme of appropriate, on-going monitoring of board members embedded in all this." (Manager)

"It should read 'demonstrating the skills and competencies necessary to fulfil my role within a measurable framework by reflecting on your practice and continuing professional development'." (Primary Care)

A minority also reflected the general public's view that the order of the skills and competencies needed to reflect NHS values:

"Maintaining focus on the safety of patients and quality of care is a stand out one so should be first in my opinion, rather than financial priorities." (Manager)

"Patient care needs to be at the beginning because that's the business we are in. Everything else underpins that." (Commissioner)

Commissioners commented on this section at a greater level of detail than other respondents. They highlighted the need for:

- a focus on the whole population and making decisions 'for the greater good' based on a needs assessment commensurate with the local population;
- the need for 'corporate behaviour' that supports a majority decision, even if in personal disagreement with that decision;
- an understanding of the commissioning cycle including: audit processes, contracts and interviewing providers;
- an understanding of the *whole* system and the business i.e. service provision that achieves financial balance and stability:

"For a business to be successful it needs to be an organisation that delivers

high quality care, that is efficient and provides value for money with robust accountability." (Commissioner)

Commissioners reflected the general public's emphasis that particular skills and competencies would need to be delivered by the team (e.g. clinical knowledge and financial skills) whilst other behaviours and competencies (e.g. corporate behaviour) would need to be demonstrated by each individual.

➔ Specific, tangible guidance about the behaviours required was welcomed by health professionals. Similarly to the general public, health professionals felt that the document became credible when it started to identify specific behaviours that could be used to hold people to account. A minority supported the general public's view that 'maintaining focus on the safety of patients and quality of care' should be prioritised.

Commissioners articulated more detailed views about what would be expected of new commissioners: acting in the interests of 'the greater good', accepting majority decisions and maintaining an overview of the whole system.

5.6 Views on section 5.6 of the draft Standards

5.6.1 General public

Section 5.6 raised an issue that respondents had been asking about for some time: accountability.

Business practices

5.6 As a Member, for myself and my organisation I will seek:

- To demonstrate honesty, probity and integrity in our conduct, decisions and financial and commercial relationships
- To manage public money wisely and to seek best value in the interests of the people and community I serve
- To be transparent in decision-making and be ready to be held publicly to account.

From the beginning of the discussion, respondents had been asking about how the Standards would be enforced:

"This is a good pledge (section 5.2, 'members' commitment'), but only if they carry it out." (Female, 75+ years old, C2DE)

"You really have to put some kind of sanction system in because why are they going to respect the Standards?" (Female, 40-55 years old, BC1, English as a second language)

"If they do something wrong, they have to take responsibility for it." (Female, 18-25 years old, C2DE)

There was therefore a very positive response to the third bullet point: 'to be transparent in decision-making and to be ready to be held publicly to account':

"There is a big suspicion that public money is not always spent wisely, so it's very good to have this written down. Then it goes back to the accountability – it faces a worry that people have and spells it out." (Female, 40-55 years old, BC1, with a disability)

"When the public finds out what decisions they've made, if it's a bad one then they're going to be like, 'that's my money paying for it!'" (Female, 18-35 years old, C2DE)

'Managing public money wisely' was also very well received, as was the idea of seeking 'best value' and 'serving' the community:

"The NHS moves with money … big budgets have to be regulated and transparent and everyone knows where it goes." (Female, 40-55 years old, BC1, English as a second language)

The first bullet point was more difficult for the general public to understand. Firstly they questioned the meaning of 'probity' (which none understood). Secondly, respondents were unsure what 'financial and commercial relationships' were being referred to:

"I don't know what they are trying to say, I don't know what probity is. It's just waffle – big words." (Male, 40-55 years old, C2DE)

➔ **In short, the business practices section delivered the sense of governance that respondents had desired when first told about the new NHS structure. There was a strong desire for the first bullet point to match the clarity and simplicity of the second two bullet points.**

5.6.2 Health professionals

Similarly to the general public, health professionals welcomed the emphasis on accountability in this section. This part of the Standards was considered actionable:

"I prefer this to any of the previous sections. It's more concrete and I can instantly see a way by which I could challenge a decision and move something forward." (Secondary Care)

A minority felt that the phrase 'best value' needed to be qualified by the inclusion of information about quality and effectiveness to allay any fears about quality and effectiveness being compromised by cost-saving.

Similarly to the general public, a minority struggled to understand the meaning of 'probity' or the phrase 'commercial relationships' in the context of NHS services.

➔ **Overall, the business practices section delivered a welcome sense of accountability. There was some support for describing the word 'probity' and 'commercial relationships' in a more accessible way.**

5.7 Views on section 5.7 of the draft Standards

5.7.1 General public/patients

In many ways, the spirit of this section had already been successfully communicated, in summary form, by the previous section (5.6 business practices). For the general

public, the most important point raised in this section was the second bullet about 'personal interests'.

5.7 I will do this through:

- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates
- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, removing myself from decision-making when they might be perceived to do so
- Being open about the evidence, reasoning and reasons behind decisions about budget and resource allocation, and contract allocation in particular

- Careful stewardship of public money, always acting with probity, honesty and restraint
- Ensuring that the contracts and commercial relationships my organisation enters into are legal and well-founded, that they are properly monitored, that the terms of the contract are adhered to and that I fulfil my responsibilities within it
- Building and maintaining effective partnerships with relevant stakeholders, including healthcare partners, the independent sector and patient and public representative groups
- Ensuring that patients and their families have clear information about the choices available to them so that they can make decisions on their own behalf
- Taking appropriate action to raise concerns if I perceive that my organisation or my colleagues are engaging in any harmful behaviour or misconduct.

Given its perceived importance, it was suggested that the second bullet point should be placed at the top of the list:

"If they ever had to do something deeper to do with decision making they would take themselves away so there's not a bias." (Male, 18-25 years old, C2DE, literacy difficulties)

"When someone suspects you've got an interest in it, get out of it." (Female, 40-55 years old, English as a second language)

Another point which created an impact amongst general public respondents was about choice i.e. 'ensuring that patients and their families have clear information about the choices available to them so that they can make decisions on their own behalf':

"You need to know all your options, not just think that there's only one way to go … There's normally loads of different for everything but sometimes some of them aren't as clear as others." (Female, 18-25 years old, C2DE)

The first bullet point was perceived to demand too much of individuals. Once again, respondents reiterated their belief that the need to involve this range of skills would require a team-based approach:

"It's going to be very hard to form a committee with frontline people on, who would have all this business sense and management skills." (Male, 56+ years old, BC1C2D)

In places, this section saw a return to the language which general public respondents found rather frustrating. For example:

- they asked what 'being open' about evidence, reasoning and reasons actually means e.g. 'make sure any evidence for decisions is readily available':

"You have to be able to explain why you've done it so you know it wouldn't be for personal reasons." (Female, 18-25 years old, C2DE)

- 'stewardship' was not understood. 'Looking after public money' was the suggested alternative which clearly resonated with the public:

"You see the NHS as a ship full of holes that is constantly being shored up, but this is directly saying that we will be responsible for what we're looking after." (Female, 40-55 years old, BC1, with a disability)

- the fifth bullet about contracts was too long and unfocussed for the general public who did not understand what the terms 'well-founded', 'properly monitored' or 'adhered to' really meant

➔ **Overall, this section lacked the impact of the previous section which was perceived to summarise the key points about accountability. To reflect the perceived importance of accountability, consider positioning the 'personal interests' bullet at the top of the list. More generally, consider reflecting the more accessible language in which section 5.5 skills and competencies is written.**

- ***5.7.2 Health professionals***

The specific business skills and competencies described in section 5.7 were well received by health professionals. They appreciated the specific focus on business skills and competencies. Once again, by defining more specific and tangible behaviours, accountability was considered more credible:

"It's the last point – 'taking appropriate action to raise concerns' that makes everyone accountable and involved." (Secondary Care)

Similarly to the general public, health professionals focussed on the point about 'declaring any personal, professional or financial interests':

"This addresses a big fear that people have about all these changes – that people will build up businesses at the expense of the NHS." (Manager)

"The conflict of interest bit is possibly the first thing to get out of the way. It underpins everything." (Commissioner)

A minority of health professionals also struggled with the language in which this section is written:

"It all sounds like contractual speak." (Primary Care)

Similarly to the general public, this group struggled with the word ‘stewardship’ and ‘probity’ as well as ‘effective partnerships with relevant stakeholders’. Commissioners were very much in support of the points raised:

“This is a good matrix. You could sit down with a GP and ask: do you understand this? Why not? I would love a copy of these to go through.” (Commissioner)

➔ Unlike the general public, the specific business behaviours required were well received by health professionals. They appreciated the specific guidance offered, which was also felt to make individuals more accountable for the behaviour.

10. Annex 4: Consultation draft of Standards for members of NHS boards and governing bodies in England

All members of NHS boards and governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

Personal behaviours

As a Member I commit to:

- The values of the NHS Constitution in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible
- Promoting equality and diversity in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible
- Promoting human rights in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible.

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

- **Accountability**: I will take full responsibility for my work and for the work that I delegate, and for the performance of the staff and services for which I am responsible
- **Honesty**: I will act with honesty and probity in all my actions, transactions, communications, behaviours and decision-making, including with respect to any personal, professional or financial interests that could influence my decisions as a board member
- **Openness:** I will be as open as possible about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
- **Respect:** I will show respect to all patients, their families and carers, and to the wider community, staff and colleagues, in my actions, transactions, communications, behaviours and decision-making
- **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member, and that I am in a position to identify and fill any gaps in my knowledge and skills and will participate constructively in appraisal of myself and others

- **Integrity**: I will apply these values consistently in all my actions, transactions, communications, behaviours and decision-making, and will always raise concerns if I see harmful behaviour or misconduct by others.

Technical competence

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

- To make sound decisions individually and corporately
- Excellence in the safety and quality of care
- Long term financial sustainability and value for money.

I will do this through:

- Demonstrating the skills and competencies necessary to fulfil my role and by engaging in training and continuing professional development
- Working collaboratively and constructively with others
- Ensuring performance is measured and risk is evaluated and managed
- Making effective use of evidence
- Maintaining my focus on the safety of patients, the quality of care and patient experience
- Understanding the health needs of the population I serve
- Looking for the impact of decisions on services we provide and those provided by others and on the people who use them
- Seeking the expertise and views of service users, their families, carers, the community, and staff
- Communicating clearly, consistently and honestly with colleagues, staff, patients and the public.

Business practices

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

- To demonstrate honesty, probity and integrity in our conduct, decisions and financial and commercial relationships
- To manage public money wisely and to seek best value in the interests of the people and community I serve
- To be transparent in decision-making and be ready to be held publicly to account.

I will do this through:

- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates
- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications,

behaviours or decision-making, removing myself from decision-making when they might be perceived to do so

- Being open about the evidence, reasoning and reasons behind decisions about budget and resource allocation, and contract allocation in particular
- Careful stewardship of public money, always acting with probity, honesty and restraint
- Ensuring that the contracts and commercial relationships my organisation enters into are legal and well-founded, that they are properly monitored, that the terms of the contract are adhered to and that I fulfil my responsibilities within it
- Building and maintaining effective partnerships with relevant stakeholders, including healthcare partners, the independent sector and patient and public representative groups
- Ensuring that patients and their families have clear information about the choices available to them so that they can make decisions on their own behalf
- Taking appropriate action to raise concerns if I perceive that my organisation or my colleagues are engaging in any harmful behaviour or misconduct.

Council for Healthcare Regulatory Excellence
157-197 Buckingham Palace Road
London SW1W 9SP

Telephone: **020 7389 8030**
Fax: **020 7389 8040**
Email: **info@chre.org.uk**
Web: **www.chre.org.uk**

council for healthcare regulatory excellence