NHS Improvement

NHS Improvement: Rules of Procedure

Approved by NHS Improvement Board on 15 December 2020

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1. Introduction

The NHS Trust Development Authority (NHS TDA) is a statutory body that came into existence on 1 June 2012. It was established by the National Health Service Trust Development Authority (Establishment and Constitution) Order 2012 (SI 2012 no. 901). The order has been amended in particular by the National Health Service Trust Development Authority (Directions and Miscellaneous Amendments, etc) Regulations 2016 (SI 2016 no. 214).

Monitor came into being as the independent regulator of NHS Foundation Trusts under the provisions of the Health and Social Care (Community Health and Standards) Act 2003. Following consolidating legislation (the National Health Service Act 2006), the Health and Social Care Act 2012 (the 2012 Act) established Monitor as the sector regulator for health.

Since 1 April 2016 NHS Improvement is the operational name for the organisation that brings together Monitor, NHS TDA, groups from NHS England's Patient Safety teams, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

These rules of procedure set out the joint governance arrangements for NHS Improvement. They constitute both rules of procedure for Monitor under paragraph 12 of Schedule 8 to the 2012 Act and standing orders of the NHS TDA under Regulation 12(2) of the National Health Service Trust Development Authority Regulations 2012 (SI 2012 no 922, as amended). Any reference to NHS Improvement is a reference to the statutory bodies of Monitor and NHS TDA.

The Rules of Procedure have been amended to reflect the joint working arrangements between NHS Improvement and NHS England implemented from 1 April 2019, under which the organisations have a single operating model.

2. Definitions

2.1 Any expression to which a meaning is given in the NHS Act 2006, the 2012 Act or in relevant regulations, orders or directions made under them (including the regulations, orders and directions relating to NHS TDA) shall have the same meaning in these rules, unless the context otherwise requires and in addition:

- 'the 2012 Act' means the Health and Social Care Act 2012
- 'Accounting Officer' means the person appointed by the Secretary of State for Health and Social Care to assume responsibility for NHS Improvement's use of resources in carrying out its functions, as set out in the requirements of HM Treasury guidance: *Managing public money* (May 2012). NHS Improvement's chief executive acts as accounting officer
- 'Board' means the board of NHS Improvement, as constituted in accordance with paragraph 2 below

- ‘Chair’ means the person appointed by the Secretary of State for Health and Social Care as chair of NHS Improvement (and the chair of both Monitor and NHS TDA)
- ‘Chief Executive’ means the person appointed by Monitor’s non-executive directors to be the chief executive of Monitor and by the Secretary of State for Health and Social Care to be the chief executive of NHS TDA
- ‘Committee’ means a Committee of NHS Improvement (whether a Committee of Monitor or NHS TDA or both)
- ‘Committee chair’ means the member of a Committee who is the chair of that Committee
- ‘Employee’ means an interim or permanent member of staff, a member of staff who is on secondment to NHS Improvement, or a contracted external consultant or adviser
- ‘Executive Team’ means NHS Improvement’s chief executive and other executive directors
- ‘Executive Member’ means a member of the board of NHS Improvement who has responsibility for overseeing the organisation’s management, and has been appointed as both an Executive Member of Monitor and an officer member of NHS TDA
- ‘the NHS Act 2006’ is the National Health Service Act 2006
- ‘“NHS Improvement’ is a reference to both statutory bodies Monitor and NHS TDA, and is the operational name for the organisation that brings together Monitor, NHS TDA, groups from NHS England’s Patient Safety teams, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams
- ‘NHS TDA’ means the NHS Trust Development Authority
- ‘Non-executive Member’ means a member of the board of NHS Improvement who does not have any management responsibilities, and has been appointed as both a non-executive member of Monitor and a non-officer member of NHS TDA
- ‘Scheme of Delegation means the NHS England and NHS Improvement Scheme of Delegation as far as it relates to NHS Improvement functions
- Secretary’ means the member of NHS Improvement’s staff appointed as secretary to the board
- ‘Sub-committee’ means a sub-committee of NHS Improvement appointed by a Committee.

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

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

2.3 In these rules, unless the contrary intention appears, words in the singular include the plural and words in the plural include the singular.

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

3. Governance framework

3.1 The Board of NHS Improvement consists of:

3.1.1 a chair appointed by the Secretary of State for Health and Social Care
3.1.2 at least four other non-executive members so appointed
3.1.3 the chief executive appointed by the non-executive members and the Secretary of State for Health and Social Care
3.1.4 other Executive Members appointed by the non-executive members and the chief executive. The number of Executive Members (including the chief executive) must be fewer than the number of Non-executive Members.

Each Member of the Board is a member of both Monitor and NHS TDA.

3.2 The constitution and proceedings of NHS Improvement are governed by Schedule 8 to the 2012 Act, SI 2012 no 901, and the National Health Service Trust Development Authority Regulations 2012 (SI 2012 no 922), as amended.

3.3 The functions of NHS Improvement are set out in Part 3 of the 2012 Act, in Chapters 5 and 5A of Part 2 of the NHS Act 2006, in SI 2012 no 922 (as amended), and in directions made by the Secretary of State for Health and Social Care under section 7 of the NHS Act 2006.

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

4. The Board of NHS Improvement and its operational responsibilities and exercise of statutory powers

4.1 Paragraphs 10(1) and 11(2) of Schedule 8 to the 2012 Act provide that Monitor may regulate its own procedure and make arrangements for the exercise of its functions.

4.2 Regulations 11 and 12 of SI 2012 no 922 make provision for the conduct of NHS TDA's meetings and proceedings, including a requirement to make standing orders for the regulation of its business, and for NHS TDA to make arrangements for the exercise of its functions.

4.3 The Board shares responsibility for:

a) ensuring that high standards of corporate governance are observed and encouraging high standards of propriety;
b) establishing the strategic direction and priorities of NHS Improvement within the statutory frameworks in the NHS Act 2006 and the 2012 Act;
c) the effective and efficient delivery of NHS Improvement's plans and functions;
d) promoting quality in NHS Improvement's activities and services;
e) monitoring performance against agreed objectives and targets;
f) ensuring effective dialogue with the Department of Health and Social Care and other stakeholders to best promote the continued success and growth of NHS Trusts and NHS Foundation Trusts and other aspects of the healthcare sector; and
g) ensuring that board members personally and NHS Improvement corporately observe the seven principles of public life set out by the Committee on Standards in Public Life:
h) selflessness: holder of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends;
i) integrity: holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties;
j) objectivity: in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit;
k) accountability: holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
l) openness: holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
m) honesty: holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
n) leadership: holders of public office should promote and support these principles by leadership and example.

4.4 The Board is also responsible for the oversight of the joint working arrangements with NHS England, including in particular the governance arrangements which involve board and committee meetings in common with NHS England's board and committees.

4.5 The Board will take collective responsibility for the decisions made by it. An Executive or Non-executive Member must obtain the prior approval of the chair or in his/her absence, the Deputy Chair, before making public statements to the media on behalf of NHS Improvement.

4.6 Members of the Board and Members of Committees and Sub-committees shall be subject to the Code of Ethical Practice as set out at Annex A.

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

5. Meetings and proceedings of the Board

5.1 Meetings of the board

5.1.1 Subject to paragraph 5.1.3 below, the Board shall hold meetings at such regular intervals as may be determined by the members of the Board. The board may decide to hold Board meetings in common with the board of NHS England.

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

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

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

5.1.5 Members of the Board are expected to attend not fewer than four Board meetings (whether formal meetings or workshops) in any 12-month period.

5.2 Admission of the public and the press

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

5.1.7 The Chair will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and members of the press, subject to the provisions of the Public Bodies (Admission to Meetings) Act 1960, such as to ensure that the board's business may be conducted without interruption or disruption. The Board may resolve to exclude the public and conduct its business in private, whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business being transacted or for other special reasons stated in the resolution.

5.1.8 Members of the public and press are not admitted to meetings of Committees or Sub-committees except by specific invitation.

5.3 Board meeting agendas and papers

5.3.1 In normal circumstances, the agenda and any papers for meetings of the Board will be circulated to members of the board five calendar days in

advance of the meeting. The non-receipt of the agenda or papers for a meeting by any Member of the Board shall not invalidate the meeting or any business transacted at the meeting.

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

5.3.3 Papers may only be tabled at a meeting of the Board with the permission of the Chair.

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

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

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

5.4 Special meetings of the board

5.4.1 Without prejudice to paragraph 5.1, where paragraph 5.5.2 applies or in the event of urgency, the Chair may determine to hold a meeting to be known as a special meeting at such time and place as he/she may determine.

5.5 Power to call meetings of the board

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

5.5.2 Where two or more members of the Board submit a signed request for a meeting to the Chair, the Chair shall call a meeting in accordance with paragraph 5.5.3.

5.5.3 Where paragraph 5.5.2 applies, the Chair shall, as soon as practicable but no later than seven calendar days from the date the request was submitted, arrange for the meeting to be held within 28 calendar days from the date the request was submitted.

5.6 Chairing of meetings

5.6.1 Subject to paragraphs 5.7.2 to 5.7.11, the procedure at meetings shall be determined by the person presiding at the meeting.

5.6.2 The Chair shall, if present, preside at all meetings of the Board.

5.6.3 In the absence of the Chair, the Deputy Chair will preside. In the absence of both the Chair and the Deputy Chair, a Non-executive Member chosen by the other Members will preside.

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

5.7 Procedure at meetings of the Board

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

5.7.2 The Chair or other person presiding at the meeting of the Board will:

a) preserve order and ensure that all members of the Board have sufficient opportunity to express their views on all matters under discussion:
b) determine all matters of order, competency and relevancy;
c) determine in which order those present should speak;
d) determine whether or not a vote is required and how it is carried out in accordance with paragraphs 5.7.4 to 5.7.6 below.

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

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

a) the person presiding at the meeting feels that there is a body of opinion among members of the Board at the meeting who disagree with a proposal or have expressed reservations about it and no clear consensus has emerged; or
b) when a member of the Board who is present requests a vote to be taken; or
c) any other circumstances in which the person presiding at the meeting considers that a vote should be taken.

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

5.7.6 In the case of an equality of votes, the Chair, or in the Chair's absence the Member of the board presiding, shall have a second casting vote.

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

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

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

5.7.10 Where in the opinion of the chair, and considering advice from the Chief Executive or any other of NHS Improvement's Executive Directors as appropriate, significant operational or other matters require approval by the Board between formal meetings, papers will be circulated by the secretary for approval by correspondence. Any matter capable of being passed by the Board at a meeting may instead be passed by written confirmation given by a majority of the Members of the board, with the Chair having the power to cast a second casting vote as provided for in paragraph 5.7.6 above.

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

5.8 Quorum of the board

5.8.1 The quorum for a Board meeting shall be the Chair (or deputy chair or other person presiding) and four other Members of the Board. Non-executive Members should be in the majority.

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

5.8.3 Where a Board meeting:

a) is not quorate under paragraph 5.8.1 within half an hour from the time appointed for the meeting; or
b) becomes inquorate during the course of the meeting,

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

5.9 Minutes of the Board

5.9.1 The Secretary to the Board is the member of NHS Improvement's staff appointed to act as secretary to the board.

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

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

5.9.4 The record of the minutes shall include:

a) the names of:
   i. every member of the board present at the meeting;
   ii. any other person present; and
   iii. any apologies tendered by an absent member of the board;
b) the withdrawal from a meeting of any member on account of a conflict of interest; and
c) any declaration of interest.

5.9.5 No discussion shall take place upon the minutes except upon their accuracy or where the chair or in the absence of the Chair, the person presiding, decides discussion is appropriate.

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

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

5.10 Emergency powers

5.10.1 The functions exercised by the board may, in an emergency, be exercised by the Chair after having consulted the chief executive or another executive member.

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

5.11 Delegation of powers

5.11.1 Subject to paragraph 5.11.2 and such directions as may be given by the Secretary of State for Health and Social Care to NHS TDA, NHS Improvement may make arrangements:

a) for the exercise, on behalf of Monitor, of any of Monitor's functions by a committee or sub-committee of Monitor, a non-executive member, or an employee (including the chief executive) of Monitor;[1] and

b) for the exercise, on behalf of NHS TDA, or any of NHS TDA's functions by a committee or sub-committee of the NHS TDA;[2]

in each case subject to such restrictions and conditions as NHS Improvement thinks fit.

5.11.2 NHS Improvement may not make arrangements for the exercise of Monitor or NHS TDA functions by a committee or sub-committee, unless that committee or sub-committee is appointed as a committee or sub-committee of the body whose functions are to be exercised under those arrangements (whether or not it is also appointed as a committee or sub-committee of the other body).

5.11.3 The matters listed in Section 3 of Annex B to the Scheme of Delegation are reserved to the board. They are generally matters for which it is accountable to Parliament. The fundamental objective is to ensure that the work of NHS Improvement is managed effectively within the policies laid down by the board.

5.11.4 In addition to the matters reserved to the Board, the Scheme of Delegation sets out the arrangements for the delegation of functions which have been formally agreed by the Board.

5.11.5 The Board remains accountable for all of NHS Improvement's functions, including those delegated to committees, sub-committees, the chair, chief executive, individual senior executives or other employees, and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

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

[1] Paragraph 11(2) of Schedule 8 to the 2012 Act provides that: "Monitor may arrange for the exercise of its functions on its behalf by: (a) a non-executive member; (b) an employee (including the chief executive); a committee or sub-committee."

[2] Regulation 11 of SI 2012 no 922 provides that: "Subject to such directions as may be given by the Secretary of State, the [NHS TDA] may make arrangements for the exercise, on behalf of the [NHS TDA], of any of its functions by a committee or sub-committee appointed by virtue of regulation 10 or by an officer of the [NHS TDA], in each case subject to such restrictions and conditions as the [NHS TDA] thinks fit."

5.11.7 Subject to paragraphs 5.11.1 and 5.11.2, and in accordance with the Scheme of Delegation to these rules of procedure, each committee of NHS Improvement is delegated from the board the discharge of those functions that fall within their respective terms of reference other than any matter reserved to the board.

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

5.11.9 All powers of NHS Improvement which have not been:

a) reserved by the board under paragraph 5.11.3 of and the Scheme of Delegation to these rules of procedure;
b) delegated to a committee or to an employee further to paragraph 5.11.7 of and the Scheme of Delegation to these rules of procedure; or
c) implied by the provisions of NHS Improvement's rules of procedure, standing financial instructions and scheme of delegation;

shall be exercised on behalf of NHS Improvement by the chief executive.

5.11.10 The chief executive may authorise any of NHS Improvement's corporate or regional directors to act on his behalf, however the chief executive can reassume the exercise of the function in question should the need arise.

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

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

5.11.13 The secretary shall keep a record of the powers, authorities and discretions delegated by the board.

5.11.14 The Scheme of Delegation, Section 2.5, makes provision for the exercise of a function delegated to an employee, where that employee is absent etc.

5.11.15 If the chair is absent, the powers delegated to him/her may be exercised by the deputy chairman, in relation to the board, and the chief executive, after taking advice as appropriate from the board and other executive team members.

5.12 Role of the accounting officer and standing financial instructions

5.12.1 The chief executive acts as Monitor's accounting officer and in accordance with Secretary of State directions performs the role of the Chief Accountable Officer of the TDA, and is therefore the accounting officer of

both Monitor and NHS TDA. As accounting officer, he/she is responsible for ensuring that the public funds for which he/she is personally responsible are properly safeguarded and are used in line with NHS Improvement's functions and responsibilities and the requirements as set out in HM Treasury guidance, *Managing public money*, including the duty to exercise functions effectively, efficiently and economically.

5.12.2 The standing financial instructions, set out in Annex B to these rules of procedure, detail the financial responsibilities, policies and procedures to be adopted by NHS Improvement. They are designed to ensure that financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

5.12.3 All proposed expenditure above £5 million must be formally approved by the board.

5.13 Personal conflicts of interest and register of interests

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

5.13.2 If a member of the board or a member of a committee or sub-committee knowingly has any interest or duty which is material and relevant, or the possibility of such an interest or duty, whether direct or indirect and whether pecuniary or not, that, in the opinion of a fair-minded and informed observer would suggest a real possibility of bias in any matter that it brought up for consideration at a meeting of the board, committee or sub-committee, he/she shall disclose the nature of the interest or duty to the meeting. The declaration of interest or duty may be made at the meeting at the start of the discussion of the item to which it relates (except that a pecuniary interest must be declared as soon as practicable after the start of the meeting) or in advance in writing to the Secretary. If an interest or duty has been declared in advance of the meeting, this will be made known by the person presiding at the meeting prior to the discussion of the relevant agenda item. In the event of the person not appreciating at the beginning of the discussion that an interest or duty exists, he/she should declare such an interest as soon as he/she becomes aware of it.

5.13.3 Subject to paragraph 5.13.4, if a member of the board or a member of a committee or sub-committee has acted in accordance with the provisions of paragraph 5.13.2 above and has fully explained the nature of their interest or duty, the members of the board or the committee or sub-committee present will decide unanimously whether and to what extent that person should participate in the discussion and determination of the issue. This will be recorded in the minutes together with the extent to which the person

concerned had access to any written papers on the matter. If it is decided that he/she should leave the meeting, the chair may first allow them to make a statement on the item under discussion.

5.13.4 In the case of a member who has declared a pecuniary interest in a matter under consideration, the member must not take part in the consideration or discussion of the matter in question.

5.13.5 Where the chair of the meeting has a relevant interest then he/she must advise the board or the committee or sub-committee accordingly, and with their agreement and subject to the extent decided participate in the discussion and the determination of the issue. This will be recorded in the minutes together with the extent to which he/she had access to any written papers on the matter. If it is decided that the chair should leave the meeting because of a conflict of interest, another member will be asked to chair the discussion of the relevant agenda item in accordance with the procedure set out in paragraph 5.13.2 above.

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

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

5.13.8 The secretary will ensure that a register of interests is established to record formally declarations of interests of:

a) members of the board; and
b) members of any committees or sub-committees.

5.13.9 In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both executive members and non-executive members, and by members of any Committees or Sub-committees. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

5.14 Allowances for non-executive members of the Board

5.14.1 Non-executive members are entitled to seek reimbursement of reasonable expenses incurred in the exercise of the duties in accordance with the policy approved by the board and in effect at the relevant time, a copy of which is available from the secretary on request and will be provided to members on joining the board.

6. Meetings and proceedings of committees

Where no specific provisions are specified for committees, these are the same as the principles and provisions for the board, as set out above. Where there is any inconsistency between the said provisions and any provisions in the terms of reference for any committee, then the latter shall prevail.

6.1 Appointment of committees

6.1.1 The board may establish a committee for any purpose within its functions and shall, subject to paragraphs 5.11.1 and 5.11.2, determine the powers and functions of any such committee.

6.1.2 Unless otherwise determined by the board, each committee shall be both a committee of Monitor and a committee of NHS TDA.

6.1.3 The board shall appoint members of the committees, including the committee chairs.

6.1.4 The board shall keep under review the structure and scope of activities of each committee. The board shall also keep under review the arrangements for committees of NHS Improvement to meet in common with their equivalent committees of NHS England, as part of NHS Improvement and NHS England's joint working arrangements.

6.1.5 The board shall set out the terms of reference for each committee.

6.1.6 The board may at any time amend the terms of reference of any committee.

6.1.7 The board may delegate its responsibility for determining the powers and functions of a committee, and its responsibilities under paragraphs 6.1.2 to 6.1.6 in relation to such a committee, to the chief executive.

6.2 Meetings of a committee

6.2.1 Subject to paragraph 6.3 and such indicative schedule of meetings as may be specified by the board, a committee shall hold meetings at such regular intervals as may be specified in the terms of reference or, in the absence of any such provision, as may be determined by the members of the committee.

6.2.2 The committee shall determine the time and place of the meetings to be held under paragraph 6.2.1.

6.3 Special meetings of a committee

6.3.1 Without prejudice to paragraph 6.2, in the event of urgency, the committee chair may determine to hold a meeting to be known as a special meeting at such time and place as he/she may determine.

6.4 Attendance at committee meetings

6.4.1 Subject to paragraph 6.4.2, a member of the board may attend and speak, with the permission of the committee chair, at any meeting of a committee.

6.4.2 A member of the board who is not a member of the committee shall not vote on any matter before the committee.

6.5 Chairing of committee meetings

6.5.1 Subject to paragraphs 6.5.2 to 6.5.3, the procedure at meetings shall be determined by the committee chair presiding at the meeting.

6.5.2 The committee chair shall, if present, preside at all meetings.

6.5.3 In the absence of the committee chair, a member of the committee determined in accordance with the provisions of the committee's terms of reference relating to the absence of the chair or, in the absence of any such provision, nominated by the chair, shall preside at the meeting.

6.6 Quorum of committees and exercise of functions

6.6.1 Subject to paragraph 6.6.2, the quorum for a committee meeting shall be as specified in the terms of reference or, if no provision is made in the terms of reference, one half of the total membership of the committee.

6.6.2 The terms of reference of a committee may provide that, subject to any conditions specified in the terms of reference, any functions of the committee may be exercised by a member of the committee acting alone.

6.6.3 Such conditions must include provision that any novel, contentious or high-risk matter must be considered by the committee in a meeting that is quorate in accordance with paragraph 6.6.1.

6.7 Minutes of committees

6.7.1 NHS Improvement's secretary of the board shall act as the secretary of each committee, unless the committee's terms of reference provide otherwise.

6.7.2 The secretary, or their nominated deputy, shall record the minutes of every meeting of a committee.

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

6.8.4 Minutes will be circulated to all board members.

6.8 Sub-committees

6.8.1 A committee may appoint a sub-committee where authorised to do so in the committee's terms of reference.

6.8.2 A sub-committee may consist of or include persons who are not members of the committee that appointed it.

6.8.3 Subject to paragraph 5.13 (conflicts of interest) and paragraph 6.8.4, and its terms of reference, the quorum and proceedings of a sub-committee are to be such as it may determine.

6.8.4 The terms of reference of a sub-committee may provide that, subject to any conditions specified in the terms of reference, any functions of the sub-committee may be exercised by a member of the sub-committee acting alone.

6.8.5 Such conditions must include provision that any novel, contentious or high-risk matter must be considered by the sub-committee in a meeting which is quorate in accordance with the provisions for quorum in the terms of reference or adopted by the sub-committee under paragraph 6.8.3.

6.8.6 A committee shall not delegate its functions to a sub-committee established by the committee or to any other person unless authorised to do so in the committee's terms of reference.

Annex A: Code of ethical practice

Introduction

1.

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

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

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

General propriety and public service values

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

   - transparency;
   - accountability;
   - proportionality;
   - consistency; and
   - proper targeting of regulation to achieve defines goals.

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

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

7. The highest standards of propriety, involving integrity, impartiality and objectivity, must be maintained in relation to the stewardship of public funds

and the management of NHS Improvement. Any conflict between personal interests and the discharge of public duties must be avoided. No-one to whom this Code applies must seek through the performance of their duties to gain material benefit for themselves, their families or their friends.

8. Suspicion that a decision might be influenced in the hope or expectation of future employment with a particular firm or organisation must be avoided. Accordingly, during their term of office no-one to whom this Code applies must seek any consultancy contracts, directorships or other form of employment in a healthcare sector body that brings them into conflict with their role at NHS Improvement. Any potential conflicts of interests must be managed appropriately.
   See: Code of conduct for board members (Cabinet Office 2011)
9. NHS Improvement has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In their decision-making, board members and staff must give consideration to the impact that it might have on these requirements and on the nine protected groups identified by this act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).
   See: Equality and diversity policy
10. NHS Improvement has made a clear statement of its vision and purpose (Appendix B). It has also adopted a behavioural competency framework which is driven by various performance management policies. All members of staff are expected to comply with these policies, which will be reviewed and updated as appropriate.
   See: Grievance policy, Harassment policy, Discipline policy, etc

Use of public funds

11. Those to whom this Code applies are required to maximise value for money through ensuring that NHS Improvement operates in the most efficient and economical way, within available resources, and with independent validation of performance achieved where practicable.
   See: Tackling Fraud, Bribery and Corruption policy, Business expenses policy

Gifts and hospitality

12. Those to whom this Code applies have a responsibility to ensure that they are not placed in a position that risks, or appears to risk, compromising their role or NHS Improvement's public and statutory duties. They should not, nor should they be perceived to, secure valuable gifts and hospitality by virtue of their role at NHS Improvement. They should not accept or provide any gift or hospitality if this would give the impression that they have been influenced or are deemed to be influencing while acting in an official capacity.
   See: Standards of Business Conduct policy

Conflicts and declarations of interests

13. It is important for NHS Improvement to:
   (i) ensure that no member of the board, committee or sub-committee or employee is involved in taking a decision or participates in a discussion on any matter where that person has a conflict of interest;

(ii) ensure that those providing information to NHS Improvement can be confident that it will be properly handled; and
(iii) avoid any impression that any member of the board, committee or sub-committee or employee has used his relationship with NHS Improvement to their personal advantage.

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

15. The Health and Social Care Act 2012 and the National Health Service Act 2006 require NHS Improvement to act to ensure that there is neither an actual nor a perceived conflict between the exercise of its functions. All members of staff should bear this in mind and take appropriate action if they think that their involvement in a matter or presence on a decision-making committee might represent such an interest.
See: Rules of procedure (personal conflicts), Standards of Business Conduct policy (personal conflicts), Operational or functional conflicts and Balancing Competing Regulatory Interests Policy (operational conflicts)

Access to information

16. NHS Improvement board members and employees may receive information not in the public domain that relates to individuals, organisations or commercial-in-confidence matters. It is the responsibility of each individual to ensure that this information is treated appropriately.
See: Information security policy, Data protection policy

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

Media, public speaking and use of social media

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

Appendix A: The seven principles of public life

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

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

- **Objectivity**

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

- **Accountability**

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

- **Openness**

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

- **Honesty**

Holders of public office should be truthful.

- **Leadership**

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

Appendix B: NHS Improvement's vision and purpose

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

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

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

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

To tackle these challenges, we:

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

In partnership with the Department of Health and Social Care and other arm's-length bodies, we define the strategic goals for the sector on issues such as finance and system-wide change, and offer support in meeting them. NHS Improvement will then hold providers to account for their part in achieving this improvement.
We are developing a compelling vision and shared values – these will embody the underpinning principles of how we work together and deliver positive outcomes. It is up to all of us to bring these values to life and we all have a part to play in embracing new ways of working. We should be prepared to flex our styles and the way we interact with the sector as an improvement organisation.

Appendix C: Statement of common purpose

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

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

- **Working together for patients.**[3] Patients come first in everything we do. We fully involve patients, staff, families, carers, communities and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.
- **Respect and dignity.** We value every person – whether patients, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.
- **Commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.
- **Compassion.** We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.
- **Improving lives.** We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.
- **Everyone counts.** We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

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

2. **We apologise to every individual affected by this deeply disturbing and tragic failing in a service that means so much to us all.** What happened in Mid Staffordshire NHS Foundation Trust was, and is, unacceptable and collectively we take responsibility for putting things right. We recognise that while the depth, scale and duration of the failings at this hospital were unprecedented every day the NHS is responsible for care that is poor as well as care that is good or excellent. **Our commitment to the NHS and our pride in the good that it does each day will not blind us to its failings.** It compels us to resolve them.

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

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

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

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

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

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

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

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

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

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

David Prior, Chair,
Care Quality Commission

Una O'Brien, Permanent Secretary,
Department of Health

Professor Sir Peter Rubin, Chair,
General Medical Council

Sir Keith Pearson, Chair,
Health Education England

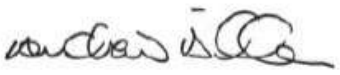
Sir Merrill Cockell, Chair,
Local Government Association

Dr David Bennett, Chair,
Monitor

Professor Malcolm Grant, Chair,
NHS Commissioning Board

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

Jan Sobieraj, Managing Director,
NHS Leadership Academy



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

Sir Peter D Carr, Chair,
NHS Trust Development Authority

Mark Addison, Chair,
Nursing and Midwifery Council

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

Professor David Heymann, Chairman,
Public Health England

Annex B: Standing Financial Instructions

[See separate document]