NHS

NHS England
NHS Improvement

Meetings in Common of the Boards of NHS England and NHS Improvement

Meeting date: Thursday 27 September

Agenda item: 04.ii

Report by: Dido Harding, Chair, NHS Improvement
Malcolm Grant, Chair, NHS England

Report on: **Governance model for joint working between NHS England and NHS Improvement**

Request: The Boards are asked to consider and endorse the proposals

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Introduction

1. At the public meetings in common of the NHS England and NHS Improvement Boards on 24 May 2018, both organisations committed to delivering a new model of joint working, and specifically to proposals on joint governance and accountability; on creating integrated regional teams and new regional geographies; on aligning appropriate national functions, and on managing change well.

2. The purpose is to transform the ways of working to provide a single system view, single messaging and shared leadership to support and enable integrated care across England.

3. Although it is not possible to merge the two organisations, NHS England and NHS Improvement's affairs can be conducted in a way that maximises our ability to achieve these joint working objectives.

Executive leadership

4. In terms of executive leadership, we have proposed:

    a. the creation of a single NHS Executive Group, co-chaired by the two CEOs, and with membership from all national directors from the two organisations and the new regional directors;

b. A set of new single national director roles, reporting to the two CEOs, to include:

   i. a single NHS Medical Director;

   ii. a single NHS Nursing Director/Chief Nursing Officer for England;

   iii. a single Chief Financial Officer, whose responsibilities will include leadership of the integrated financial and operational planning and performance oversight process; and

   iv. A single National Director for Transformation and Corporate Development.

c. Other national director roles hosted within either NHS England or NHS Improvement but assuming responsibility for functions across the two organisations with shared governance and oversight;

d. Single regional teams bringing together NHS England and NHS Improvement functions in the regions, led by regional directors with a single reporting line to the two CEOs, and with responsibility for the performance of all NHS organisations in their region in relation to quality, finance and operational performance; and

e. Significant devolution of responsibility to regional directors: a different model of local leadership in the NHS, where regional directors will promote, encourage and support local systems to achieve more integrated and sustainable models of care, and where the locus of ALB decision-making will be centred more on them and their teams. National teams will provide expertise, challenge, support and intervention – all in line with strategies agreed at the NHS Executive Group comprising regional and national directors.

5. Taken together, these are significant changes which will need to be managed carefully and overseen by both Boards.

Board governance

6. The proposed changes have important implications for Board governance. The resources of the two Boards need to be brought into alignment with the shared leadership executive model, in a timely and supportive fashion, whilst at the same time respecting the legal constraints on this work and maintaining grip on the system and the individual statutory duties of their own organisation. The following principles are proposed:

   a. Strong board and non-executive oversight for the NHS without increasing the governance burden on executive colleagues;

   b. Single lines of reporting and accountability wherever possible; and

   c. Governance form should follow and facilitate as far as legally possible the new single system purpose and executive function.

7. This implies combining all the competences of the two organisations into Board structures that afford oversight of all aspects of strategy and transformation, and of plan implementation and delivery. This cannot be through joint boards or committees but can be achieved through committees in common.

8. The design, outlined in more detail in the next section, must properly respect the statutory commissioner or provider responsibilities that can be discharged only by NHS England or NHS Improvement. This can be achieved by maintaining:

    a. separate Audit and Risk Assurance Committees, working closely together on the oversight of strategic system risk;

    b. Separate Nominations and Remuneration Committees, working together where appropriate. While we believe there is a strong case for conducting much of the present business, such as the appointment and terms and conditions of the executive directors through committees in common, our current committees have significantly different remits and this area requires further work; and

    c. Separate statutory committees in both organisations, populated only by Non-Executive Directors and National Directors of those organisations as necessary. This could for example, include a statutory committee for provider oversight, and one for distinctive commissioning functions. These committees will be required to exercise their statutory functions independently but will do so within the context of the system-wide approach underpinning the new governance system. Alternatively, the respective boards may determine that some or all of these matters should for the future be reserved to the Board and not delegated. NHSE and NHSI each have different functions and different approaches, so each needs to develop a function-by-function approach that reflects the new executive leadership arrangements and the new governance proposals in this paper. NHSE proposals are in the course of being developed.

9. The above requires a new start in defining decision-making structures and the terms of reference of all committees. A process is being designed for transferring committee responsibilities in an orderly fashion and a transition period will enable the two Boards to support and challenge the Executives as the new structures are implemented.

Design of a new governance model

10. The new governance model, which has been developed and discussed at non-executive level, proposes the following main committees in common. Committees in common comprise a committee of each Board meeting at a common time, place and agenda with the same attendance.

    a. Strategy and Transformation Committee: This Committee in common would meet two to four times a year and include all Non-Executive and Executive Directors from both Boards. It would provide strategic oversight for the delivery of the long term NHS plan and so far as relates to strategic matters, would have all the powers of the existing

Boards plus the added responsibility for securing the system-wide strategic leadership that bringing the two Boards together enables. The Committee would have an interconnection with the NHS Assembly on an advisory basis – it is not proposed that the Assembly would form part of the formal governance structure.

b. Delivery and Performance Committee: It is proposed that this Committee in common will have a broad remit that captures all operational matters relating to commissioning and provision across the NHS in England. It will meet bi-monthly and consist of the two Chairs, two Deputy Chairs plus 2 x NEDs from each Board and the Executive Directors of both Boards and other National Directors as required. This Committee's remit would extend to much of what is currently:

    (i) delegated to NHS England's Commissioning Committee (but not distinct commissioning decisions and similar matters which will remain with the Board of NHS England and may be delegated to a statutory committees as mentioned above);

    (ii) within the operational oversight of the NHS Improvement Board, and

    (iii) the functions of the Joint Finance Advisory Group.

   Not all of this activity needs to flow into the Delivery and Performance Committee: its remit also needs to reflect the enhanced level of executive authority assigned to the new Regional Directors. The Committee would enable the Boards to draw together oversight of primary, community and secondary care, mental health and other services, and to review provider funding alongside commissioning. It would have delegated authority from the Boards. Any decisions flowing from their deliberations that would require exercise of specific statutory powers would remain reserved to the respective Boards.

11. In addition to these committees in common, there will be three sub-committees in common (meeting quarterly or as required) reporting into the Delivery and Performance Committee. It is proposed that these will include:

    a. People Sub-Committee: This Sub-Committee in common would oversee, for the two Boards, issues of NHS leadership and workforce. The Sub-Committee would include the current functions of the NHS Improvement Provider Leadership Committee (overseeing Chair and NED appointment, remuneration and performance across the NHS) and expand to include System appointments, senior executive talent management and other priorities set out in the workforce strategy.

    b. Quality Sub-Committee: This Sub-Committee in common would oversee quality of care across the NHS, receiving regular reports from regions and undertaking deep dives into areas of concern or interest.

    c. Digital Sub-Committee: This Sub-Committee in common would combine oversight of technology and data across the NHS, working closely with the NHS Digital Delivery Board.

12. Annex A provides an explanatory diagram of the committees in common.

13. It is proposed that the necessary changes should be brought for final approval to the meetings of the two Boards at the end of November, but that the date of their implementation should be determined by the CEOs and chairs jointly following the appointment of seven Regional Directors so as to ensure a uniform model of governance to map onto the new uniform model of executive leadership.

Board development

14. Throughout and beyond this period of change, it is important that the two Boards are supported to enable development, learning and increasingly close relationships between NEDs, National Directors and Regional Directors. As not all NEDs will be members of the Delivery and Performance Committee, it will also be important to ensure regular sharing of information between Board members. The programme of formal Board and committee meetings will therefore be underpinned by a programme of informal teach-ins, visits and networking opportunities.

15. In addition, to ensure a close link between NEDs and the regions, it is proposed that teams are formed made up of one NHS England NED and one NHS Improvement NED to support each region. The NEDs will work closely with the relevant Regional Directors and the Non Executive Chairs within the regions. The Regional Directors will be invited, on a rolling basis, to present to the Delivery and Performance Committee.

16. In order to promote the principle of shared governance, all non-executive directors will be entitled to receive the papers and to attend as observers the meetings of those Boards and committees of which they are not members, other than Nominations and Remuneration. They may on that basis participate in discussions but not in decision-making. The chairs of the respective meetings will be responsible for observing and maintaining the distinction between the statutory functions of the two organisations and may at any time invite observers to withdraw.

Conclusions and next steps

17. The Boards are asked to endorse these proposals. Subject to this endorsement, the Governance teams will continue the work already ongoing to design the new governance structure, including the development of supporting governance documentation such as Standing Orders, Rules of Procedure and committee terms of reference.