07 July 2022

Draft Code of governance: consultation

NHS Providers response

About us

NHS Providers is the membership organisation for the NHS acute, mental health, community and ambulance services that treat patients and service users in the NHS. We help NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

About this consultation

On 27 May 2022 NHS England (NHSE) published its draft Code of governance for consultation. In our response below we have responded to each consultation question. This response provides our organisational view and reflects the feedback we have received from our members.

Aims of the code

We argued for the code to be updated, and we very much welcome this refreshed version which reflects best governance practice as described in the UK corporate code.

We understand that NHSE's aspiration is to revise the code more frequently, and specifically to update the code to reflect wider potential policy developments such as Kark's recommendations on fit and proper persons, and changes to Very Senior Manager pay. Given that the purpose of the Code is to create an overarching framework for corporate governance we believe that the Code should set out core principles rather than be frequently updated to include new policy requirements (which may be subject to regular change and might be better set out in guidance). So, there is a balance to strike between ensuring the code reflects current thinking in the field of governance and updating it too often.

Extending the Code to cover NHS trusts as well as NHS foundation trusts

The application of the Code to NHS trusts is welcome in providing a firm, transparent and consistent basis for good corporate governance across the sector and with regard to NHSE assessments about trusts' performance and leadership. This was noted by many of our members.

We also note that some members from NHS trusts are entirely unfamiliar with the code and have raised queries during the consultation period about its application in practice (particularly around how and whether enforcement action would be taken as a result of non-compliance). The framing of the Code as guidance rather than a manual of practice is welcome but should be made very explicit to NHS trusts which may be using this for the first time.

Meeting the 'comply or explain' requirement of the Code

Members welcome the retention of the requirement to "comply or explain", recognising the autonomy of boards to make arrangements to meet the principles which work in their organisations and systems.

Schedule A remains a helpful checklist for boards, and for public accountability around good governance in so far as the provisions are mentioned in trusts' annual reports.

We note that the review of the current Provider Licence includes consultation on whether to remove the requirement for boards to submit a corporate governance statement annually declaring compliance with FT4 (the governance condition of the licence). If this is removed, the annual governance statement in annual reports will be trusts' only annual declaration of compliance with good governance principles. We welcome the removal of duplication between the licence and Code reporting requirements and will keep a watching brief on how the annual report/annual governance statement works as a means for trusts to make an open commitment on compliance with the principles of good governance to NHSE and to the wider public.

Do you agree with the proposed principles and provisions in Sections A through to E?

Section A: Board leadership and purpose

References to system working in the Code are concise and not overly prescriptive which is helpful and welcome. We are pleased to see the congruence with the addendum to the guide to governors'

statutory duties in this regard and, as we will set out in our separate response on the addendum, our members welcomed this flexibility and the clarity around governors' statutory role being unchanged.

We welcome the new focus on diversity and inclusion, alignment with the Workforce Race Equality Standard and reference to disability and gender because diversity makes a positive difference in the leadership of provider trusts, supporting better decision-making, and increased diversity in trusts improves outcomes for patients[1].

We also welcome the inclusion of reference to the board's responsibilities regarding the wellbeing of the workforce, which has been under increasing pressure for many years.

We hear from members that most boards already consider these subjects within their purview in any case, so this brings the code into line with common practice.

Section B: Division of responsibilities and Appendix A The role of the trust secretary

We welcome that the significance of the role of trust secretary and its responsibilities for corporate administration and providing advice on all governance matters is retained from the previous code. It is particularly welcome that the appointment/removal of a company secretary is now a matter for the whole board instead of the chair and chief executive as this safeguards to the fullest extent the trust secretary's ability to undertake their role without fear or favour. It is crucial that trust secretaries can have robust and frank conversations about effective governance in their trust and feel protected in doing so.

Members queried with us the new provision that neither the deputy/vice chair nor senior independent director should chair the audit committee. Of course, these trusts are able to explain their positions rather than comply, however members queried the rationale for the additional exclusions.

One member also sent us the following feedback:

"It's also noteworthy that the requirement for a NEDs' third term of office to be subject to 'rigorous annual review' is removed, though there remains reference in the bullet point list of factors which may

[1] See for example: Diversity improves performance and outcomes - PubMed (nih.gov), National Library of Medicine (accessed 04.07.22)

lead a NED's independence to be called into Section 2.6 beyond six years' service. I don't understand why this restriction has been diluted and don't support the dilution."

We would agree that the principle of NED independence is best served by retaining the requirement for rigorous annual review beyond six years. The use of 'rigorous' in relation to the chair themselves beyond six years remains in place and is welcome.

Section C: Composition, succession and evaluation

Foundation trusts may need to adapt to the new expectations to involve NHSE in recruitment and selection. Equally NHSE should not seek to impose a candidate upon a trust and be aware that the statute in respect of appointments remains unchanged. Members from foundation trusts are keen to retain their autonomy in this area, and have strongly asserted the legal status of the council of governors as the appointee of NEDs.

Members describe governors' role in recruitment and selection as a means for them to fulfil their responsibility for appointments, and provide an important link to public, patient or staff representative voice in a selection process. Many noted that governors (or indeed foundation trusts) may not wish to involve an ICB member nor NHSE external assessor in interview panels. Some foundation trusts prefer to seek representation on panels from a local trust chair, for example. This would also provide the relatively independent and expert view that the Code's principle (section C: 1.1) requires and might be another option. Ensuring the diversity and inclusivity of recruitment panels should also remain a key consideration for all trusts. We suggest that the wording around it being 'best practice' to involve an external assessor from the ICB or NHSE should therefore be changed because there is scant evidence that it is best practice. It would be preferable to reiterate the principle of including an independent/expert view and then options listed as, 'for example…'. One member noted that should an NHSE assessor be requested for every NED appointment panel there may well not be the capacity at NHSE to provide such support.

Members also told us that they might struggle to insist that nominations committees use the NHSE non-executive talent and appointments team rather than an external agency to undertake talent searches. Some queried the capacity of the NHSE team to provide a diverse and geographically relevant talent pool of high enough quality. Others have specifically retained the services of specialist agencies able to help them increase the diversity of their boards. It would be a shame if the principle of building a diverse board was at odds with the provision around utilising NHSE's appointments team.

This feedback from a foundation trust chief operating officer reflects what we heard from numerous members:

> "It is important that this process remains independent and locally driven to meet the needs of the organisation and local communities. Clarification is required as to the purpose and level of involvement that is being suggested, particularly where a number of foundation trusts have undertaken this role historically and with great success. We would be keen to ensure that this appointment process is kept independent, with the governors playing an active role in the appointment process - this does not take away the ability (as is currently the case) for NHSE to nominate individuals to apply for such posts as and when they arise."

Section D: Audit, risk and internal control

We note a slight discrepancy in language between D2.1 "the vice chair or senior independent director should not chair the audit committee" and B2.5 "The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director." The use of 'ideally' in the latter dilutes the provision and it would make sense to be consistent i.e. use ideally in both or neither section. Given that the non-statutory provisions are all on a comply or explain basis the 'ideally' is implicit in all of them and seems unnecessary.

The council of governors' role in appointing the external auditor is not mentioned here but we suggest it should be because it remains their statutory duty.

Section E: Remuneration

We note that provision 2.2 for foundation trusts to 'reflect' the chair and NED remuneration structure when setting levels of remuneration can only be an aspiration as the statutory power remains with councils of governors.

Equality

We cannot envisage any direct, adverse impacts although a prescriptive approach to the composition of recruitment panels could lead trusts to prioritise involving people in particular positions over ensuring diverse panels assess candidates' suitability for a role from a range of perspectives.

As noted, we welcome the increased emphasis on the board's responsibilities in relation to inclusion and diversity within the code because we know this supports better decision-making and ultimately better outcomes for patients.

Health inequalities

We cannot envisage any adverse impacts.

Is there anything further that you want to tell us about our proposals for the draft Code?

Consistency is to be welcomed, and this must extend to the way NHSE uses the code. It was suggested by NHSE in one meeting with members that 'it would be up to the regional teams' how to respond on some issues. We would ask, on behalf of our members, that regional teams are well-versed in the 'comply or explain' principle behind the Code, and provided with clear guidance themselves around the 'lower order' status of the Code when it comes to enforcement action. Our understanding from conversations with the NHSE team revising the code is that it would be very unlikely that failure to comply with one element of the code (and presumably therefore one failure to adequately explain the reasons for diverging from the principles) would result in any enforcement action when taken as sole evidence of trust practice. This is to be welcomed but adoption of this approach across the regions is required.

Some of our members expressed concern that the wording of the Code suggests that trusts are obliged to collaborate with and provide information to ICSs but the draft Code lacked reciprocal expectations on ICSs. This echoes queries raised during our Governance Conference in May about why the good governance principles in the Code shouldn't also apply to ICBs. Our conversations with the NHSE team have suggested that national policy makers see reciprocity and consistency of approach as vital to the success of system working but that any concerns in practice would be mediated by regional teams. This messaging may need to come through more strongly in the final version of the Code and communications about it.

Members also noted that there was currently lack of clarity on when the Code would come into force. As it required reporting for the previous year in annual reports, they believed it would be challenging to introduce it mid-year (the consultation website suggests summer 2022). Members proposed that the start of the 2023-24 reporting year made more sense. This would give NHS trusts time to understand the code and make any adjustments required, and foundation trusts time to adapt to the new or changed provisions.

Finally, we would like to thank the NHSE team for working closely and iteratively with NHS Providers and our members prior to and then during the consultation period. Conversations have felt constructive, and we hope that your team also feel they have been useful.

How should the roles of trust boards and NHS foundation trust councils of governors continue to evolve within Integrated Care Systems and what further support may be required?

We have not specifically sought to discuss the future support needs and likely landscape for boards and councils with our members: our focus was on the specific documents currently being consulted on. We believe it is premature to consider the implications for boards and councils and the future of board governance and hope to continue our dialogue with NHSE, and to facilitate dialogue with our members, as the Act beds in.