Good Governance Institute

NHS organisations should prioritise the interests of service users over those of the organisation: **fiduciary duty or not?**

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"The name of the game for a company in the 21st Century will be to conform while it performs."- Mervyn King (Chairman: King Report)

Is a modified concept beyond that of fiduciary duty needed that more closely represents the obligations of a publicly funded body to service users and local communities?

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Introduction

Since its inception, the National Health Service (NHS) has demanded high standards of both corporate and personal conduct in a bid to foster a common culture of putting the patient first. NHS foundation trusts (FT) in England are given a certain degree of independence from central government and have been assigned a governance structure that facilitates people from within the local community contributing to governing the trust.[1]

NHS boards have a duty to govern effectively and to instil public confidence that the health services they deliver are safe, accessible and responsive and that resources are invested so as to deliver optimal outcomes for patients.[2]

As a result of a series of high-profile failures in which organisational reputation was put ahead of patient safety, NHS bodies face intense scrutiny around the prevention of failures in clinical care and, when failures occur, acknowledging and learning from mistakes. Recent announcements indicate doctors and nurses will be able to own up to honest mistakes without fear of prosecution, and new league tables will compare trusts' levels of openness and transparency.

The NHS is, arguably, in the midst of the most serious financial crisis since its inception. The publication on February 6 2013 of the Mid Staffordshire NHS Foundation Trust Public Inquiry catalysed a shift in focus within the NHS from meeting target-driven financial and access priorities to fostering a relentless focus on clinical quality, safety and patient experience. This shift in focus is reflected in NHS trusts end-of-year financial results data, published by the Department of Health (DoH), which illustrates a marked deficit from 2013-14 onwards across trusts in England. In response to the Mid Staffordshire scandal, Jeremy Hunt emphasised that the primary directive of NHS bodies was to put the needs of patients first, stating that the NHS must "hear the patient, seeing everything from their perspective" rather than from the perspective of "the system's interests".[3] This entails that NHS boards have a duty to prioritise the interests of service users over those of their organisation.

This paper seeks to clarify the responsibilities of board members regarding the apparent conflict between protecting the success of the institution – its financial position, its meeting of national targets, and its reputation – and the prioritisation of patient safety and quality of care. The challenge around whether institutional reputation is dictated by monies and the achievement of financial targets or sits on the safety and quality side is explored later within this paper.

Whilst this paper is primarily directed towards Board members working within the English National Health Service, executive and independent directors on Boards in NHS Wales, NHS Scotland or the NHS in Northern Ireland may take away some valuable lessons.

Duties of NHS boards of directors

It is critical that each member of the board understands the extent and the limits of their respective responsibilities. An NHS board, led by a chair and comprising both executive and non-executive directors, has collective responsibility for shaping strategy, managing risk, holding the organisation to account, and for the overall governance and performance of the trust.

The temptation to fall into a formulaic mode of operation limited to strict adherence to regulations and nationally set targets should be resisted. Instead, as noted by Mervyn King in his book *The Corporate Citizen*, a board must develop *intellectual honesty*: the ability to chart its own collective path through the complexity of public accountability.

In order to ensure optimal outcomes for patients, NHS boards must be willing to engage with issues that fall outside the confines of regional and national directives and targets. In *Governance Between Organisations: Whole System Governance Across the Boundaries of Care*, John Bullivant and Andrew Corbett-Nolan explored one dimension of this theme: managing the safety of patients when delivering care in partnership with other organisations.[4] They argue that accountability must be shifted away from 'adherence to [regional and national] directives and reporting requirements', and towards the responsibility to meet the needs of their local constituents.[5] For NHS boards, this includes matters such as patient handover, joined up commissioning and mutual aid.[6] Echoing King, the authors stress the need to adopt an 'apply and explain' rather then 'comply or explain' approach to governance: 'doing the right thing and explaining why'. In general, a patient-centred approach to care requires 'a greater degree of authority and independence' than NHS managers operating within the 'comply or else regime' will be used to.[7]

Fiduciary duties

The Companies Act 2006 imposes statutory duties on company directors. Modifications incorporated into the NHS Act 2006 by the Health and Social Care Act (HSCA) 2012 mean that FT directors should adhere to statutory duties. Instead of having only a collective duty, FT directors now have personal duties, which mirror duties articulated in the Companies Act. A practice note on the key powers and duties of NHS bodies under the HSCA states that provisions to strengthen an FT's internal governance are included within the act to *"help balance the increased financial and structural freedom that trusts have as well as the reduced oversight from Monitor."* FT governors and directors are expected to adhere to provisions that bring *"the duties of FT directors in line with the fiduciary duties of directors under general company law (including a general duty to promote the success of the FT)."*[8]

Under common law, directors owe a fiduciary duty to companies that they manage. A fiduciary duty refers to a legal or ethical obligation to act solely in another party's best interests. To uphold their fiduciary duties, a fiduciary should act in the utmost good faith. This includes the duty to:

- act genuinely in the interests of the company
- exercise powers for their proper and intended purpose to benefit the company
- not exceed powers or act unlawfully
- not make personal profit
- deal fairly between different groups of shareholders
- not compete
- avoid conflicts of interest and disclose any such conflicts[9]

NHS board members have a duty not to act in a way that would compromise their duty to patients or the reputation of the organisation by pursuing personal interest. The Code of Conduct and Code of Accountability in the NHS state that chairs and board directors should declare any conflict of interest that arises when conducting NHS business. This would include, for example, personal financial interests and interests of close family members.[10]

The NHS requires high levels of probity and is subject to public scrutiny. Trust boards and individual directors have a duty to promote the success of the organisation, and to maximise the benefits for those who use its services, for its staff and for the wider public. **But what happens when the interests of current and future patients are in conflict with the survival of the business entity?**

Situations involving such conflicts can be immediate, for example following a service failure like a failed operation, or it may be a wider cultural issue. Trust boards have a duty to embed effective governance arrangements within the system that enable the board to respond swiftly to, investigate and rectify any failures to uphold fundamental standards, and to act in a way that is open, transparent and honest. Effective governance arrangements should make certain that the needs and safety of patients remain at the forefront of the agenda. It is imperative that NHS boards discuss this issue to shape and exemplify a culture that is transparent and accountable.

In order to promote a culture of openness, the Professional Standards Authority states that the dealings of an NHS body should be made public, except in justifiable and well-recorded instances.[11] In addition, an NHS body's contractual as well as commercial relationships must be honest, monitored and in line with best practice.

The statutory duty of candour

Clinical care is not without risk, and as such it is inevitable that errors will occur. When things go wrong, the primary duty of health and social care organisations is to be honest with patients, telling them what has happened, what can be done, and what measures will be taken to prevent the same thing happening again. The introduction of the statutory duty of candour was a large advance for patient safety and patient experience.

Regulation 20 of the HSCA 2008 (Regulated Activities) Regulations 2014 (HSCARAR), which lays out the statutory duty of candour, was introduced in direct response to the Francis Inquiry report.[12] It is intended to ensure that all health and social care organisations registered with the Care Quality Commission are open, honest and transparent with service users. Although the duties laid out in the regulation apply to NHS bodies rather than individuals, there is an expectation that staff abide by and uphold them.

The statutory duty of candour facilitates the creation of an open and honest culture in which mistakes are recognised, apologised for and learnt from.[13] When something goes wrong that results in a level of harm above a predetermined threshold, NHS bodies have a responsibility to inform patients truthfully and in person.[14] A notifiable patient safety incident occurs when a patient suffers (or could suffer) unintended harm that results in death, severe harm, moderate harm or prolonged psychological harm.[15] Reputation is undoubtedly a powerful driver of organisational behaviour. Instilling a culture of openness in which events that result in unanticipated harm to patients are acknowledged and reported could be viewed as a danger to reputation. The impact of disclosing such events could act as an inhibitor to instilling a culture that places patient needs above the reputation of the trust.

Leaders of NHS organisations must emphasise the importance of candour to help safeguard patient safety. This means putting an end to 'blame and shame' cultures that can result in the concealment of mistakes and thus missed opportunities to learn. For candour to succeed in catalysing improvements in patient safety, leaders should support healthcare professionals within the trust in understanding and embedding the duty throughout the organisation. In upholding this duty, organisations may well incur short-term reputational damage for the good of the service user. Further to this, upholding the duty means embracing the opportunity to learn from mistakes and to improve safety for future patients.

Risk Appetite

Risks will impact upon an organisations capability, performance and reputation. The Board should assume responsibility for the governance of risk and set levels of risk tolerance and risk appetite annually. Risk appetite provides a means by which to manage tensions between different elements of risk and can be described as *'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time*[16]*'.*

The Good Governance Institute have developed a risk appetite matrix[17] which sets out five levels of risk appetite for each of the risk vectors (money, policy, outcomes and reputation). The matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view.

For more information, see: *GGI Board Briefing: Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts* [18] *(January 2012).*

Fit and Proper Person Test (FPPT)

Alongside the statutory duty of candour, the HSCARAR requires NHS bodies to ensure that their board-level directors are fit and proper to carry out their role.[19] Regulation 5 introduced a "fit and proper persons test" for NHS bodies, effective from November 2014, which acts to prevent the appointment of unfit directors. The test is integrated into the CQC's registration requirements and falls within the scope of their regulatory approach. Trusts must demonstrate that appropriate systems are in place to ensure the suitability of their board-level personnel, including that the test is being applied correctly.

The Chair of an NHS body has a responsibility to ensure that every director:

- is of good character
- has the necessary qualifications, skills and experience
- is able, in terms of their health, to perform their role
- has not been involved (directly or indirectly) in any misconduct or mismanagement relating to the provision of a regulated activity as defined by the CQC.

The fitness of directors must be regularly reviewed, and trusts must have arrangements in place to respond to concerns regarding fitness after appointment. This requires induction, individual and whole board development as well as support in commissioning deep dives when assurance is missing.[20]

Principles of public life

The *Nolan principles of public life* set out the ethical standards expected of all public office-holders in the United Kingdom. The principles are reflected in the codes of conduct for all NHS boards and all directors of NHS bodies have a duty to abide by them. The principles are as follows:

- **Selflessness**: decisions should be taken solely in terms of the public interest.
- Integrity: no obligations to external parties should be taken on that might influence the performance of one's role.
- **Objectivity**: in carrying out public business, choices should be made solely on the basis of merit.
- **Accountability**: public office-holders are accountable to the public for their actions and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness**: decisions should be open and reasons should be given for taking them. Information should only be restricted when public interest clearly demands doing so.
- **Honesty**: private interests relating to public duties must be declared. Steps should be taken to resolve any such conflicts in a way that protects the public interest.
- **Leadership**: holders of public office should promote these principles through leadership and example.

The Scottish Executive supplemented the Nolan principles with two further principles through the Ethical Standards in Public Life etc. (Scotland) Act 2000:

- **Public Service**: Office-holders have a duty to act in accordance with the core tasks of the public body of which they are a member.
- **Respect**: Holders of public office must treat fellow office-holders with respect and courtesy at all times.[21]

Incorrect priorities: failure to put patient safety above financial performance

Directors of NHS bodies should act in the interests of service users at all times, placing quality of care and patient safety at the forefront of their priorities for investment, improvement, regular reporting and support.[22] The Professional Standards Authority emphasises the central place that expected impact on services, as well as input from patients, must take in decisions made by NHS boards and CCG governing bodies.

The NHS has a largely unwritten duty to support the communities in which it operates. As a major employer and purchaser, it therefore has a duty to carefully measure its choice between central purchasing – which may be cheapest, but fails to create jobs and well-being within the local community – or purchasing locally, which would bring these kinds of benefits.

Prioritising targets and financial health– a failure in the duty to put patients first

Guidance and regulations state that achieving national NHS targets and financial goals should never compromise the quality of care that patients receive.

The Francis inquiry into the catastrophic scandal at Stafford Hospital, in which poor care resulted in potentially hundreds of deaths, attributed the failings in large part to a management culture driven by strict adherence to targets at the expense of patient welfare and quality of care.[23] The Mid Staffordshire NHS FT public inquiry concluded that the trust *"prioritised its finances and its FT application over its quality of care, and failed to put patients at the centre of its work."*[24] This was not an isolated case within the NHS, and the target- and finance-driven culture cultivated by central NHS bodies continues to carry the threat of eroding the pre-eminence of patient safety.

With ever increasing financial and service pressures facing the NHS, it is critical to the sustainability of the health system that resources are used intelligently and inefficiencies are ironed out. Nevertheless, as highlighted in the King's Fund's report *Patient Centred Leadership*, it is crucial to avoid giving the impression that financial performance and productivity should override quality and patient safety[25]. Leaders of NHS organisations must find a balance between resource allocation and risk-minimisation. National leaders should emphasise that the needs of patients must come before financial performance and national targets. Furthermore, staff should be encouraged to raise concerns without fear of penalty wherever patient safety might be compromised by resource shortages, thereby instilling a culture of learning.[26]

Reduction in staffing to improve financial health

The NHS Constitution sets out the duty of boards to ensure appropriate staffing levels.[27] In the case of the Mid Staffordshire scandal, inadequate staffing levels (particularly in nursing) were maintained in pursuit of a healthier financial picture, resulting in fatal compromises to patient safety and severe deficiencies in quality of care. In response to the Francis report, ministers acknowledged the need to increase staffing levels in order to improve the standard of care.

The National Institute of Health Excellence (NICE) was initially charged with setting standards on safe staffing and produced guidance on safe staffing in adult acute wards and maternity. NHS England has since assumed responsibility of taking forward the issue of staffing as part of a wider programme of service improvement. In Wales, the Assembly have proposed a new law to introduce 'safe' nurse staffing levels, which would see an independent assessment for appropriate staffing levels across health boards and trusts in Wales. The proposal would see Wales become the first country in the United Kingdom to implement a legal duty on staffing levels.

Closure of services: the impact upon patients

In the private sector, administrators dealing with financially challenged organisations act in the interests of the company's creditors, rather than its customers. Closure of the company, rather than struggling on, is an option.

For the NHS, things are less straightforward. Changing or closing a service delivered by one provider will have knock-on effects on surrounding providers and the communities that they serve. Furthermore, while the provider in question may save money through such a change, the NHS as a whole will only benefit financially if surrounding providers can treat patients at a lower cost, and are able to cope with the increased levels of demand for the service.[28] Assessing the capacity of the wider system to absorb a provider's service withdrawal is essential to preventing negative impacts upon service users.

In light of this, Monitor requires all service exits to be negotiated. There are clear processes for decision-making regarding service closures that boards have a duty to adhere to. The processes seek to ensure that the reasons for closure, the risks involved and the alternative options are all properly, publicly examined. The National Audit Office, as well as the National Association for Voluntary and Community Action (NAVCA), have developed a number of tools to assist with the decommissioning of services.[29] GGI recommends that boards adopt advance protocols for disinvestment in services, so as to avoid judicial review challenges to ad-hoc processes.

Duty to ensure transparency

The handbook to the NHS Constitution states that *'patients must come first in everything the NHS does.'* This means *'always putting patient interest before institutional interest, even when that involves admitting mistakes'*[30].

NHS boards and CCG governing bodies have a duty, laid out by the Professional Standards Authority, to ensure that effective procedures are in place for whistleblowing and complaints.[31] Following the Department of Health's Learning Not Blaming report, Chief Executives of NHS trusts should *'appoint a Freedom to Speak Up Guardian, to encourage and enable staff to raise concerns over patient safety in a confidential setting'*.[32] These requirements also extend to cultural matters surrounding honesty and transparency. For example, a zero-tolerance approach to bullying, and the proper treatment of those who raise concerns, is essential to ensuring a culture of openness, respect and learning.

Whilst incidences of whistleblowing may result in short-term reputational damage, a sound whistleblowing system must be understood as reflecting a mature organisation that is better able to secure a strong and well-founded reputation in the long term.[33] As pointed out by the National Audit Office in Making a Whistleblowing Policy Work, sound whistleblowing systems indicate the willingness of trusts to listen to staff and tackle concerns early on.[34] Furthermore, addressing and learning from harmful behaviour and systemic weaknesses is a central element of a culture of improvement. Such an approach therefore supports long-term organisational success whilst at the same time prioritising patient safety.

Integrated reporting and the King III Report on Corporate Governance

The Healthy NHS Board 2013: Principles for Good Governance states that *"quality accounts should become at least as important as financial statements for boards and be seen as a key opportunity for the board to provide the public with an open and comprehensive account of the quality of care"*.[35]

In line with the King III Report on Corporate Governance, the Good Governance Institute (GGI) believes that a more integrated approach than this is required. Financial statements and quality accounts should be delivered together within a single integrated report. An Integrated Report is a concise communication about how an organisation's strategy, governance, performance and prospects have created value in the short, medium and long term.[36] Such a report requires the identification of all kinds of capital that the trust hopes to develop going forward.

Integrated reporting is better able to give confidence to stakeholders that the organisation is committed to a range of interests, rather than treating financial viability in isolation. On top of this, it facilitates an internal evaluation of ethics, values and governance.

Several NHS boards have already become pilot sites for integrated reports, and the move towards integrated reporting will be a highly positive step-change in how boards operate and work. NHS Greenwich CCG was the first NHS organisation to produce an integrated report in accordance with the Integrated Reporting framework. A copy of the report can be viewed on the CCG website.[37] The practice has since been adopted by others such as NHS Southwark CCG, North Bristol NHS Trust and East Lancashire Hospitals NHS Trust (ELHT).

Contingent capacity and social value

Engaging with patients and nurturing a person-centred culture improves service quality and assists an organisation in building social capital. In her paper *"Building Contingent Capacity: Shifting power in organisations to become more responsive to the people they serve"*, Sukhvinder Kaur-Stubbs describes 'contingent capacity' as:

"the propensity of the organisation to respond to people who use its services and to enable workers to put them first."[38]

Through building contingent capacity, organisations can bolster their **organisational value** (the quality and sustainability of their service) and their **licence to operate** (based upon public recognition and approval of this value).

The Five Case Model

With an ever-increasing demand for health and care services, it is paramount that NHS bodies make the best possible use of available resources. Accordingly, spending proposals must be robust and support evidence-based decision-making. Thorough scoping, realistic planning and an appreciation of risk are critical to the success of any project, programme or strategy.

The 'Five Case Model' is a method of business case development recommended by HM Treasury for *"all those with responsibility for deciding how public money should be spent."* The model encompasses the following elements:

1. **The Strategic Case:** The spending proposal must be a good strategic fit with national and local policies, be strongly supported by evidence, and have SMART spending objectives (specific, measurable, achievable, relevant, time-constrained).
2. **The Economic Case:** The proposal must optimise public value.
3. **The Commercial Case:** The proposal must result in a viable procurement and a well-structured deal.
4. **The Financial Case:** The proposal must be affordable.
5. **The Management Case:** The proposal must be deliverable in line with best practice.[39]

Successful use of the Five Case Model approach can result in greater efficiency in the planning and approval process. The Treasury guidance around the approach should be understood by all those within the NHS who hold responsibility for developing, assessing or approving spending proposals.

However, when a conflict arises between achieving organisational growth and delivering the best care for patients, the Five Case model presents a range of potential dangers. These arise from the method's structural bias towards financially-centred decisions. Take, for example, a pathway redesign underpinning a shift in care to the community, and involving the transfer of an asset (such as land) to a partner organisation. Such a decision is likely to deliver a lower financial return to the organisation in question than if it were to retain the asset for itself, or transfer it to a private developer. The Five Case Model would, perhaps unduly, push decision-makers toward a financial conclusion (in this case, it would create a bias against the proposed pathway redesign).

This suggests that the model needs to involve a sixth case, whereby decision-makers step back and consider the overall benefit and sustainability for the public of the proposed change. This way, the duties of the trust board and the best interest of the public would be more effectively supported.

6. **The Sustainability Case:** The proposal must support the sustainability of an existing or new service to patients.

Conclusion

Service failures are all too often the result of NHS bodies putting corporate self-interests and the achievement of national NHS targets ahead of patients and the delivery of safe, compassionate care. NHS organisations and their leaders have a corporate responsibility to deliver high quality care, and to put patients at the centre of all decisions.[40] Boards have a duty to prioritise patient safety and the quality of care, and to nurture a patient-centred culture throughout their organisations.

Risk analysis should be more forward-focused in relation to achieving objectives and the concept of 'risk appetite' is helpful when combined with delegation within clearly defined tolerances. NHS boards must find a balance between the risks to fulfilling their various duties through continuous learning and more rapid and transparent redeployment of resources.[41] We are of the belief that the majority of NHS institutions manage this well, and we have not found conflicts between the achievement of central compliance, organisational growth and the delivery of high quality care to be pervasive. Nevertheless, the task of maintaining this balance is a crucial one, and is particularly difficult for organisations sitting on the cusp of sustainability, as the ability to adjust the shape and scale of health institutions is not yet well developed.

Institutional targets and the maintenance of reputation should never compromise patient safety and wellbeing. NHS boards and individual directors have a fundamental duty to subordinate the interests of their organisation to those of its service users. This raises the question: **is a modified concept *beyond* fiduciary duties needed which more closely represents the obligations of a publicly funded body to service users and local communities?**

A test for board members

This paper seeks to raise an ethical issue of board priorities. It regards how we should behave when the viability of the trust is potentially compromised by insufficient financial or staffing resources, or pressure from outside to act in a way that board members feel would compromise patient safety.

We list below a series of challenge scenarios which could and have occurred. We suggest that boards rehearse how they would act in such scenarios, in order to be prepared for them if and when they arise.

1. The Deanery has withdrawn accreditation for a key service area. This means the service cannot be provided due to lack of junior staff (who, though under training, are essential to maintaining adequate staffing levels). The board could consider merging with a neighbouring hospital or asking their commissioners to explore this option for them.

2. The board is (a) under financial pressure with some services being unproductive, or (b) known to be providing substandard service levels. The optimum option might be to disinvest in the service but this will attract public and political pressure.

3. The governing body of the commissioning CCG have suggested a joint venture to provide community-based services currently provided by an underperforming NHS Trust. Do the benefits outweigh the complexity of this kind of arrangement?

4. A charity has approached the board for land to build, at their cost, a specialist treatment support centre. The facility would benefit patients and is complementary to our services, but the charity is only offering a nominal purchase price or 'peppercorn rent'.

References

1) Monitor, 2013, Your statutory duties: A reference guide for NHS foundation trust governors.
2) NHS Leadership Academy, 2013, The Healthy NHS Board 2013: Principles of Good Governance.
3) Department of Health, 2014, "Hard Truths: The Journey to Putting Patients First: Volume One of the Government Response to the Mid Staffordshire NHS FT Public Inquiry".
4) John Bullivant and Andrew Corbett-Nolan, 2011, Governance Between Organisations: Whole System Governance Across the Boundaries of Care. London, UK: Good Governance Institute, 7.
5) Ibid, 7.
6) Ibid., 4.
7) Ibid., 7.
8) Rosalind Ashcroft and Susan Thompson, 2012, "Health and Social Care Act 2012: key powers and duties". UK: DAC Beachcroft LLP, and PLC Public Sector.
9) John Barlow, 2011, "Directors and Officers Liability: The legal position in the United Kingdom". London, UK: Chadbourne & Parke. Available at http://www.chadbourne.com/files/upload/DandOLiability.pdf
10) NHS Appointments Commission and DoH, second revision July 2004, Code of Conduct, Code of Accountability in the NHS.
11) Professional Standards Authority, 2012, "Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England". London, UK: Professional Standards Authority.
12) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20: Duty of Candour.
13) Ibid.
14) David Dalton and Norman Williams, 2014, "Building a Culture of Candour: A review of the threshold for the duty of candour and of the incentives for care organisations to be candid". Royal College of Surgeons.
15) Available at http://www.cqc.org.uk/content/regulation-20-duty-candour#full-regulation
16) HM Treasury, 2004, The Orange Book: Management of Risk – Principles and Concepts.
17) John Bullivant and Andrew Corbett-Nolan, 2012, "Risk Appetite for NHS organisations: A matrix to support better risk sensitivity in decision taking". Good Governance Institute. Available at http://www.good-governance.org.uk/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/
18) Good Governance Institute, 2012, "GGI Board Briefing: Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts".
19) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5: Fit and Proper Persons: Directors.
20) John Bullivant, forthcoming, "What is a Deep Dive and When do I Use It? A GGI Board Assurance Prompt." Good Governance Institute.
21) Available at http://www.gov.scot/Publications/2006/07/11153800/11
22) National Advisory Group on the Safety of Patients in England, 2013, "A promise to learn – a commitment to act: Improving the Safety of Patients in England".
23) Department of Health, 2015, "Culture change in the NHS: Applying lessons of the Francis Inquiries".
24) The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.
25) The King's Fund, 2013, Patient-centred leadership: Rediscovering our purpose. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patient-centred-leadership-rediscovering-our-purpose-may13.pdf
26) Ibid.
27) The Royal College of Nursing, 2010, Guidance on safe nurse staffing levels in the UK. Available at https://www2.rcn.org.uk/__data/assets/pdf_file/0005/353237/003860.pdf
28) The King's Fund, 2014, Financial Failure in the NHS: What causes it and how best to manage it. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/financial-failure-in-the-nhs-kingsfund-oct14.pdf
29) National Audit Office, "Decommissioning: How to decommission public services delivered by third sector organisations and maintain value for money". Available at http://www.navca.org.uk/localvs/lcp/briefings/decommissioning
30) NHS, 2013, The Handbook to the NHS Constitution for England. Available at http://www.nhs.uk/choiceinthenhs/rightsandpledges/nhsconstitution/documents/2013/handbook-to-the-nhs-constitution.pdf
31) Professional Standards Authority, 2012, "Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England". London, UK: Professional Standards Authority.
32) Department of Health, 2015, "Learning not blaming: the government response to the Freedom to Speak Up, the Public Administration Select Committee report 'investigating clinical incidents in the NHS', and the Morecambe Bay Investigation". Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445640/Learning_not_blaming_acc.pdf
33) British Standards Institution, 2008, Whistleblowing Arrangements Code of Practice, PAS 1998: 2008. Available at http://wbhelpline.org.uk/wp-content/uploads/2012/07/PAS1998_Whistleblowing1.pdf
34) National Audit Office, 2014, "Making a whistleblowing policy work". Available at https://www.nao.org.uk/wp-content/uploads/2015/03/Making-a-whistleblowing-policy-work.pdf
35) NHS Leadership Academy, 2013, The Healthy NHS Board 2013: Principles of Good Governance.
36) International Integrated Reporting Council website. Available at http://integratedreporting.org/
37) NHS Greenwich CCG, 2014, Integrated Report 2013/14: Positive action for Greenwich. Available at http://www.greenwichccg.nhs.uk/News-Publications/Documents/NHG001_IAReport_2014_LINKS.pdf

38) Sukhvinder Kaur-Stubbs, 2015, Building Contingent Capacity: Shifting power in organisations to become more responsive to the people they serve. Available at http://collaboratei.com/wp-content/uploads/Building-Contingent-Capacity.pdf
39) HM Treasury, 2013, Public Sector Business Cases: Using the Five Case Model. Green Book supplementary guidance on delivering public value from spending proposals. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469317/green_book_guidance_public_sector_business_cases_2015_update.pdf
40) The King's Fund, 2013, Patient-centred leadership: Rediscovering our purpose.
41) Ibid.

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