EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE TRUSTS (MEMBERSHIP AND PROCEDURE) AMENDMENT REGULATIONS 2014

2014 No. 784

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 The purpose of this instrument is to amend the National Health Service Trusts (Membership and Procedure) Regulations 1990 (the "1990 Regulations") to remove the disqualification which prevents a person being appointed as chair or non-executive director of NHS trusts where they are (a) a chair, non-executive director or member of certain health service bodies, (b) providers or performers of primary health services or (c) an employee of such health service bodies or of such performers or providers.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4.1 Regulation 11 of the 1990 Regulations impose restrictions in respect of appointments of chair and non-executive directors of an NHS trust. The effect of regulation 11 is that a person may not be a chair or non-executive director of an NHS trust where they are (a) a chair, non-executive director or member of certain health service bodies, (b) providers or performers of primary health services or (c) an employee of such health service bodies or of such performers or providers.

4.2 The amendments remove some of the restrictions that relate to a person who is a chair or director of another NHS trust or Foundation trust, an employee of such trusts or is a provider or performer of primary health services.

5. Territorial Extent and Application

5.1 This instrument applies to England.

6. European Convention on Human Rights

As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

7.1. Since the 1st of October 2012 it has been the role of the NHS Trust Development Authority (TDA) to appoint chairs and non-executive directors at NHS trusts in England, on behalf of the Secretary of State for Health. The TDA was established in order to ensure that all NHS trusts successfully become Foundation Trusts, or achieve an alternative sustainable form. The TDA is required to

performance manage and provide oversight to trusts to achieve this under their Establishment Order[1].

7.2 Regulation 11 of the 1990 Regulations governs who is disqualified from being appointed as the chair or a non-executive director of an NHS trust. Currently, the Regulations do not allow a person to be the chair or non-executive of an NHS trust-

a. if the person is the chair, member, director or employee of another health service body (regulation 1(2) of the 1990 Regulations, defines a health service body – see Annex 1 attached listing the bodies) and an NHS trust or foundation trust; or
b. if the person is performing or providing primary medical, dental or ophthalmic services under the National Health Service Act 2006 or is a partner, director or employee of such a person, partner or body.

7.3 When the 1990 Regulations were being developed, the rationale for prohibiting an individual from being on more than one board was that this would prevent conflicts of interest. In 1990, NHS trusts were a new concept and were purposefully designed to create a health care provider "market" in which trusts would compete. If an individual had voting rights on more than one NHS trust board, they would have access to information from 'NHS trust A' that might allow them to make decisions which favoured 'NHS trust B', thus creating a potential conflict in their decision making.

7.4 The rationale for barring individuals who are NHS employees from being on NHS trust boards was to avoid the same potential conflicts of interests as set out above from arising.

7.5 The Department of Health view is that it is crucial that the TDA appoints talented and capable leaders at board level to ensure that standards across the sector are improved, particularly in a post-Francis Report context[2]. However, the TDA see those parts of the 1990 Regulations referred to above at paragraph 7.2 as barriers to making appointments to boards of NHS trusts, a view with which the Department concurs. The TDA and the Department consider the provisions to be no longer justified or fit-for-purpose in the context of the NHS as constituted in 2013 and beyond. This is for the following reasons:

a. Where an NHS trust has been identified as unsustainable, and either needs to be acquired by or merge with another organisation, it would aid the work to prepare for these types of transactions if there could be some shared membership between the boards of the organisations affected in advance of such a merger or acquisition.
b. Where it has been difficult to recruit non-executive directors with particular skills - be they financial, clinical or experience - it would be a pragmatic response to share these skills and experience across organisations by appointing a non-executive director of another trust with the required skill set.

[1] The National Health Service Trust Development Authority (Establishment and Constitution) Order 2012 is available at http://www.tsoshop.co.uk/parliament/bookstore.asp?Action=Book&ProductId=9780111522813
[2] The Francis Report was published in February 2013 and followed the public inquiry into the failings in care at Mid-Staffordshire NHS Foundation Trust. The inquiry was chaired by Sir Robert Francis QC and made 290 recommendations on how such failings might be prevented across the NHS in future.

c. There are no similar barriers to appointments in either the FT or independent sectors, leaving the NHS trust sector at a disadvantage in being able to appoint suitably qualified and experienced board members.

7.6 Therefore, the 1990 Regulations are being amended to allow the following:

a. An existing chair or non-executive director of an NHS trust or Foundation Trust can be appointed as a chair or non-executive director of another NHS trust.

TDA and the Department view it as crucial that where there are individuals with suitable knowledge, expertise and experience at board level of an NHST Trust or Foundation Trust, such individuals should not be prevented from being appointed to the board of another NHS trust, as this unnecessarily limits the pool of talented leaders that TDA can appoint. Therefore removing this restriction greatly increases the available pool of available qualified candidates to the TDA.

b. An employee or executive director of an NHS Trust or Foundation Trust can be appointed as a non-executive director (but not chair) of an NHS Trust.

This would allow for a further widening of the candidate pool available to the TDA to include executive directors of other NHS trusts and Foundation Trusts. However, given executive directors' responsibility to their employing Trust (Trust A), it is considered appropriate that they only be allowed to be appointed as non-executive directors at the secondary Trust (Trust B). This is because their oversight and challenge role as a non-executive of Trust B should not excessively detract from their executive responsibilities at their employing Trust (Trust A). If an executive director at Trust A were to be allowed to be appointed as chair of Trust B however, the workload involved would be too substantial (compared to that of a non-executive director), and in order not to unduly detract from their work as an executive at Trust A they shall remain disqualified from acting as chair at Trust B.

c. A partner, shareholder, director or employee of a body that provides primary care services (primary medical services, primary dental services and primary ophthalmic services) can be appointed as a non-executive director of an NHS trust.

This would further increase the pool of experienced and qualified candidates to those involved in the sphere of primary care. These individuals would be able to bring to the board a primary care perspective and unique and insightful challenges to the executive directors. It is considered beneficial for Trust boards to have consideration of the wider healthcare system in such a way, but this should not extend to allowing those involved in primary care to be appointed as a chair, as the role of chair is considered sufficiently critical and central to the strategic direction of the Trusts that potential candidates should be limited to those whose main expertise lies in the field of secondary care.

7.7 In addition, these Regulations retain the provision to allow a person to be a non-executive director of an NHS trust with a significant teaching commitment, where that person is employed by a health service body and updates this legislative provision.

7.8 However, given that one of the original intentions behind the 1990 Regulations was to prevent unmanageable conflicts of interest, an alternative safeguard against conflicts is necessary, if the restrictions contained in the regulations are removed. To this end the TDA was asked to create a formal protocol setting out how they would monitor and prevent unmanageable conflicts of interest arising. Their resultant protocol was endorsed by the chair of the TDA, and received Ministerial approval in December 2013. The protocol is attached as Annex 2 to this Explanatory Memorandum.

7.9 Furthermore, the Department consider the proposed amendments will provide greater freedom for the TDA, when acting on the Secretary of State's behalf, to adhere to a number of the Secretary of State's over-arching duties. The duties that are affected are:

a. The duty as to improvement in quality of services.
The removal of the restrictions will allow the TDA access to a larger pool of qualified and experienced candidates for chair and non-executive director positions at NHS trusts, which is likely to improve the quality of the boards across the NHS trust sector. Furthermore, where the TDA believes that the best route to high quality and sustainable services at a trust is through a merger with or acquisition by another NHS provider, the removal of these restrictions makes it possible to appoint non-executives or chairs to the boards of both bodies involved in the transaction. This dual-presence will assist in ensuring such transactions occur smoothly.

b. The duty as to promoting autonomy.
The removal of the restrictions will allow TDA greater freedoms to make appointments to NHS trust boards that they believe will provide greater quality of leadership in the NHS trust sector. This will increase the likelihood of such trusts successfully becoming Foundation Trusts. Foundation Trusts are able to exercise greater levels of autonomy than NHS trusts, such as retaining surpluses and borrowing money, and therefore these amendments will assist in the promotion of greater autonomy in the provider sector.

8. Consultation outcome

8.1 The Provider Policy Unit of the Department of Health led the consultation process. Given that the proposed amendments are a procedural change only, the following stakeholders were asked for responses:

- The NHS Commissioning Board (known as NHS England)
- The NHS Trust Development Authority
- Monitor

8.2 No objections were received as part of the consultation process.

8.3 As part of the consultation process, the Provider Policy Unit specifically raised the proposed amendments with the Assurance Directorate of the Department of Health.

8.4 The only consultation query raised was from the Department of Health Assurance Director, who raised the question of how the potential for conflicts would be managed once the restrictions to board appointments are removed, as is discussed

in section 7.8 above. This resulted in TDA producing a protocol on managing conflicts of interest.

9. Guidance

9.1 There is no intention to publish guidance but the TDA has a regulatory function in respect of NHS trusts and can if necessary issue guidance.

9.2 The TDA protocol on managing conflicts of interest is attached as an annex to this Explanatory Memorandum and will be published on:
http://www.ntda.nhs.uk/blog/2013/04/26/useful-info-for-non-execs/

10. Impact

10.1 The impact on business, charities or voluntary bodies is negligible.

10.2 The impact on the public sector is that there will be greater freedom for the TDA to appoint qualified and experienced individuals to chair and non-executive director positions at NHS trusts, which in turn will contribute to better leadership and governance of these Trusts.

10.3 An Impact Assessment is attached to this memorandum and will be published alongside the Explanatory Memorandum on the OPSI website.

11. Regulating small business

11.1 The legislation does not apply to small business.

12. Monitoring & review

12.1 The Department of Health will monitor the new measure to ensure it meets its objectives. Furthermore, the TDA is a time-limited organisation, as its function will end once the Government objective of all NHS trusts obtaining Foundation Trust status is achieved (Foundation Trusts are regulated by Monitor, not the TDA). At such point, the amendments contained in this Statutory Instrument may no longer be required and the on-going requirement shall be reviewed.

12.2 A consolidation of the 1990 Regulations was not undertaken given that the lifespans of the TDA and NHS Trusts are time-limited. However, this will be kept under review.

13. Contact

Bevan Boyle at the Department of Health, Tel: (020) 72104381 or email: bevan.boyle@dh.gsi.gov.uk can answer any queries regarding the instrument.

Annex 1 – Regulation 1(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990

"health service body" means:

a) a Strategic Health Authority;

b) a Health Authority;

c) a Special Health Authority;

d) a clinical commissioning group;

e) a Primary Care Trust;

f) an NHS trust;

g) an NHS foundation trust or a pilot scheme health service body as defined in section 16(6) of the National Health Service (Primary Care) Act 1997;

h) a PHS body as defined in section 33(6) of the Health and Social Care Act 2001;

i) a contractor which is treated as a health service body pursuant to regulation 10 of the National Health Service (Local Pharmaceutical Services etc) Regulations 2006;

j) the National Institute for Health and Care Excellence;

k) the Health and Social Care Information Centre;

l) a Health Board, a Special Health Board, the Common Services Agency for the Scottish Health Service, Healthcare Improvement Scotland, an NHS trust, an NHS foundation trust or a pilot scheme health service body as defined in section 16(6) of the National Health Service (Primary Care) Act 1997 respectively constituted under sections 2, 10, 10A and 12A of the National Health Service (Scotland) Act 1978;

m) the National Health Service Commissioning Board;

n) the Dental Practice Board constituted by Regulations having effect under section 37 of the National Health Service Act 1977;

o) the Scottish Dental Practice Board constituted by Regulations having effect under section 4 of the National Health Service (Scotland) Act 1978;

p) Monitor; and

q) the Health Protection Agency.

Annex 2 - TDA Protocol on Dealing with Conflicts of interest

1. Declarations on appointment

1.1. All candidates are required to declare other Ministerial appointments as part of the evidence they submit for consideration as part of their application to be considered for appointment. We will introduce a further question to candidates asking them to declare current NHS executive and non-executive posts.

1.2. Candidates are also asked to identify any potential conflicts of interests as part of their application. This may include interests related to a range of other activities, not just those relating to other posts in the NHS.

1.3. In addition, information about such posts will be identifiable in the candidate's CV (if not already declared in response to one of the previous headings).

2. Considering conflicts of interest

2.1. Selection panels are asked to consider any potential conflicts of interests identified as part of the assessment process. They are provided with guidance on the selection process for chair and non-executive directors; this would be amended to ensure that the sections on conflicts of interest address this issue. This would include advice on the relationships between organisations in the NHS and how they might result in a real or perceived conflict of interest.

2.2. If after considering the guidance, the panel decides to invite to interview a candidate who has declared that he holds a post in another NHS body, they will explore the issue further with the candidate during the interview. The aim of this conversation would be to be clear about the nature of the relationship between the two organisations involved, the candidate's understanding of the potential for a conflict of interest to arise and what, if anything, could be done to ensure that any conflict of interest, either real or perceived could be managed effectively. Details of this conversation are noted on the interview record.

2.3. If the panel was not convinced that there was no conflict of interest or that such conflict as might arise could be managed without having an undue impact on the ability of the candidate to undertake the full range of duties associated with the role, the panel would assess the candidate as "Not suitable for appointment" on this occasion.

2.4. If a candidate with another NHS role was assessed as "Appointable" (which would mean that the panel felt that he / she met the criteria for the role and there was no conflict of interest or that any conflict of interest was manageable if they were appointed), the NHS Trust Development Authority's Appointment Committee would consider the issue again as part of the appointment decision.

2.5. Part of the evidence that is considered by the Appointment Committee is whether there are any potential conflicts of interest. Only if the Appointment Committee also felt that there was no conflict of interest or that any conflict of interest was manageable if they were appointed, would the candidate be appointed

3. Dealing with conflicts of interest where they arise during a term of office

3.1. Once in post, chairs and non-executive directors of NHS trusts may take on roles with other NHS organisations. The next paragraphs set out how in term conflicts of interest are handled.

3.2. All NHS organisations will have a document entitled ‘Standards of Business Conduct’, signed off by their Board. This sets out in some detail the requirement for Board members, and indeed all members of staff, to declare any potential conflicts of interest.

3.3. In the case of Board members, these declarations are recorded in a "Register of Interests" which is a public document and published in the organisation's Annual Report. It would be the Board Secretary’s responsibility to discuss with the Chair if any Board member declared a conflict that could be detrimental to the organisation and the Chair would determine the appropriate course of action. If it was felt that the conflict was such that it was not manageable, the Chair would refer the case to the NHS TDA to consider whether suspension from and /or termination of the individual's appointment using existing powers.

3.4. In relation to the transaction of business at Board meetings, the process for declaring interests pertaining to particular items on the agenda is set out in an organisation’s standing orders. This makes provision for the Board member to be excluded from the meeting for that item, if appropriate.

4. Supporting action required

4.1. The NHS Trust Development Authority will make the following changes to its existing policies and procedures to ensure that any other NHS roles held by candidates for appointment are properly considered and any conflicts of interest identified as a result handled appropriately:

4.1.1. Application forms to be amended to require candidates to declare any current NHS executive and non-executive posts

4.1.2. Guidance to panels will be amended to address the consideration of potential conflicts of interests arising from other NHS roles.