Integrated Governance II: Governance Between Organisations

A debate paper written and edited by:
Dr John Bullivant,
Prof. Michael Deighan,
Prof. Bryan Stoten
and Andrew Corbett-Nolan

Governance
Between
Organisations

"It is clear that, in relation to service failure, problems often occur at the borders between one organisation or team and another."

LEARNING FROM INVESTIGATIONS, HEALTHCARE COMMISSION, FEB 2008

" Our current complex and pluralistic world of health and social care requires better partnership arrangements than ever before. Boundary management and boundary bridging can now only work if it takes into account local history, culture and immediate imperatives. This requires, in David Nicholson's phrase, "looking outward not upward". Local health economies will develop partnership skills unique to their own circumstances but drawing upon the successful lessons learned from the attempts of colleagues elsewhere to ensure "the crooked shall be made straight and the rough places plain". The requirement – even duty – to partner with good management and good governance between organisations may be enunciated centrally, but it will only work through local engagement and determination."

PROFESSOR BRYAN STOTEN, CHAIRMAN, NHS CONFEDERATION

Institute of
Healthcare
Management

Bradford and Airedale **NHS**
Teaching Primary Care Trust

Contents

1 Summary

1. It is just as important to have good governance between organisations as within organisations. A service that stops at the doors of the hospital or when a partner fails to deliver is not really a service, it's a broken link in the chain of care.

2. In an increasingly complex and interconnected world organisations can no longer operate in isolation. Boards must seek assurances from partners that they have identified the risks to overall strategic objectives and put adequate controls in place.

3. Integrated governance was the first part of establishing a more accountable system. Governance between Organisations (GBO) is the second part. Effective GBO is now more critical than ever given the propensity for more transfers between organisations, targets that don't stop when the patient is handed over and the increasingly complex patterns of commissioning.

4. At the moment commissioners are held to account but they have few levers to make things happen.

5. There are three key areas of governance, safety and security where relationships between organisations are critical:

   - Continuity of Care

   - Partnerships and Supplier relationships

   - Business continuity and mutual aid

   At the supra regional level, planning is fundamentally undeveloped and many directors fail to understand how to implement longer term business continuity planning as a way of reducing risk or avoiding disaster.

6. The key to effective GBO In England will be PCTs building authority in transactions with suppliers. The authors have drawn up a list of etiquettes and shared values, which can be evaluated through a series of key questions about governance between organisations. The aim is to identify good practice and turn these into a set of simple rules that can be field-tested and applied.

7. Useful first steps for boards would include seeking assurances from within and beyond the organisation that controls are in place; taking responsibility for service delivery beyond narrow organisation limits; joined up planning and consulting with service users.

8. There are risks as well as opportunities in partnerships. But failing to engage with partners also carries big risks.

WHO, in its 8th Futures Forum on Governance of Patient Safety, observed that patient safety is *'at risk when a client is transferred from one structure to another such as from primary to secondary care or after discharge from a hospital' (1).*

Most organisations recognise the critical importance of good governance. It's how an organisation can make sure it's doing the right things, at the right time, in the right way. Unfortunately the complexity of the NHS means this often applies to only one department at a time. The Department of Health's focus on Integrated Governance *(2)* sought to redress this, by enabling different components of an organisation not only to live up to their own standards, but to work effectively with the rest of the organisation to achieve the desired overall outcome.

But is that enough? NHS Director-General, David Flory, speaking to Finance Directors in December 2007, made it clear there is a *'whole field of decisions being made completely out of the context of what patients really need and how we best need to work together across organisational boundaries to support the best deal for patients.*

'We have a collective responsibility to ensure that… organisational boundaries… are not allowed to get in the way of joining up services for patients.

'The reputational damage of getting these things wrong spreads far and wide – It affects us all. It really focuses on the organisation concerned but it damages the service.' (3)

Consider the case of British Airways. When they outsourced their catering to a contractor, Gate Gourmet, they found out the hard way that joined-up governance needed to stretch beyond their own walls. Gate Gourmet subsequently sacked 670 staff based at London's Heathrow Airport. In sympathy with the sacked workers BA staff at the airport walked out and planes were grounded for two days. By the time the dispute was resolved BA had lost millions of pounds as well as untold good will.

BA may have had a very strong case for farming out their catering to a contractor, but when things went wrong, the problems of the contractor were widely perceived as the failings of BA itself.

The lesson is simple: You can outsource just about anything, but you can't outsource the risk to your reputation!

Reputational risk is the one risk for which Chief Executives have direct and individual responsibility, though this is normally shared with the board of directors. According to the *Economist Intelligence Unit (EIU) review of strategic risks,* reputational risk has been rated the highest priority *(4).* But nearly two thirds of companies also said it was the most difficult to manage.

Just as boundaries affect integrated governance *within* an organisation, they are going to affect governance *between* organisations.

Board directors need to ask if they have failed at the boundary when…

- The patient is abandoned between care settings
- The patient arrives with community-acquired MRSA
- The supplier of medicines or food poisons our patient
- The contract data analysts lose our patient data
- A lack of foresight to create mutual aid means there is no out of regional support in a pandemic
- The model contract only delivers part of the service.

Boards need to be assured that controls are in place, and that any gaps in controls or assurance are being filled in a timely fashion. We would argue that these assurances should be sought for all risks that could compromise a board's strategic direction and obligations. A service that stops at the doors of the hospital or when a partner or supplier fails to deliver is not really a service, it's just a broken link in the chain of care. If boards neglect these boundary conditions they fail as much as if they fail to deliver connected services within their institution. The public expect joined-up services and the media are quick to report failures.

Within the NHS there is a long-established culture of 'refer and relax'. Once a referral is made, there's a sense that responsibility has moved on too. But if you ask Mrs Smith about her referral to social services, you might well find that nothing has happened at all and that she's still waiting. Compared with other high risk activities like climbing, diving or the military which insist on feedback signals this might be considered an unusual way to mitigate risk.

So this is the GBO premise:

In our complex world we cannot operate without the support of others but partnerships and other relationships bring risks as well as opportunities to both service delivery and our reputation. We must manage these but our board must also seek assurance that our partners have identified risks to our strategic objectives and adequate controls have been put in place.

Integrated Governance was the first part of the joined-up governance journey. Of necessity, it focused on good governance within single healthcare organisations, ensuring that the right joined-up processes and assurances were in place. This second part, Governance Between Organisations (GBO), is a progression to a governance structure which provides assurances to organisations where activity crosses organisational boundaries. This can be at the simple level of individual patient pathways, through planning, commissioning and delivering services with others to the more complex levels of large scale incident planning.

Governance is the means by which we hold ourselves to account, but Governance Between Organisations (GBO) can be further defined as:

The means by which organisations, whether in the public or private sector, can mutually assure themselves and their wider stakeholders that they have in place the mechanisms to align their Governance arrangements where their activities inter-relate. GBO requires a greater accountability, transparency and mutual aid awareness when dealing with any form of development or incident at the boundary of services which enables, challenges or threatens individuals, the wider public wellbeing or the reputation of the organisation.(5)

What is changing that brings these issues to the forefront?

- *Patient & Media expectations for joined up services and simple accountability*
- *Targets that don't stop when you handover the patient*
- *Complex patterns of commissioning & provision including model national contracts*
- *Tighter budgets in the public sector (Health, Social Services, Criminal Justice)*
- *Commissioning of services and outcomes rather than institutions and episodes.*
- *Complex & new forces of service opportunity & development (Darzi, PCT Delivery, Local Service Boards (Wales), GPs, FTs, New Independents, Overseas & private equity)*
- *Propensity for more transfers between organisations*

All governance seeks to provide public accountability but this is tricky when we extend this to private and voluntary sectors with their different accountabilities – to members, shareholders and to other regulators. We must confront these difficulties – in a publicly-funded service the public expectation is for the parts of the service to work as an integrated whole, regardless of organisational and cultural differences.

Legislative Context

Section 75 of the National Health Service Act 2006 (formerly Section 31 of the 'Health Act 1999') *(6)* establishes a legislative framework to enable health bodies and local authorities providing health related services to pool money, and integrate resource and management structures. These arrangements allow for the joining up of commissioning for existing or new services and similarly for the development of provider arrangements. Indeed, the White Paper 'Our Health, Our Care, Our Say', highlighted the use of Section 75 Agreements as a way of improving partnerships and improving services. *(7)*

However there are limitations on the use of S75 (S33 in Wales) around what can and cannot be included, and the provision for a monitoring committee has not proved popular in most schemes, with alternative governance structures being put in place. There are other forms of partnership, and some other powers under the Children Act. However linkages particularly with independent providers sector are weak and as the Audit Commission has identified: *'Local Partnerships bring risks as well as opportunities and governance can be problematic'(8)*

We have designed and are field-testing a set of 'etiquettes' and shared values which can be locally evaluated through ten challenges. These reflect the needs of the health and social care environment: patients, community, stakeholders and shareholders alike.

Sample GBO etiquettes

a Working partnerships require partners to be explicit about expectations and how they will handle funding pressures and adverse events

b Publicly funded organisations must consider the implications of service failure to their patients, by their partners or providers, even after referral or discharge

c Publicly funded bodies have a duty of mutual aid to similar organisations confronted by major disruption to service delivery.

d Organisations have a right to protect their reputation by seeking assurance from suppliers and partners that adequate controls are in place, and that corrective actions are timely

We do not believe that, until now, GBO has been formally considered as an achievable strategy. We believe this is an oversight, and our aim is to make it not just achievable but readily so; to provide practical Governance tools so that boards can successfully rise to the challenge, and to look for the drivers and policies to encourage organisational motivation to this end.

4 Structures, Partnerships, Networks and Supports

In 'Integrated Governance, Delivering reform on two and half days a month' *(9)* we made it clear that no one structure was the right one. It is for the organisation itself to determine effective structures and supports *but they must work.* Whilst we acknowledge that PCTs in particular are seeking to commission care pathways and are developing local and strategic partnerships it is also clear that progress and impact is patchy and too often continuity of care is compromised and partnerships are weak and ineffective. A third area of concern is for plans to provide mutual aid over an extended period.

We do recognise the distinction between contracts, networks and partnerships although confusingly these terms vary between organisational and professional groups. Leeds City Council have created a useful document *(10)* to help members be clear whether the arrangement with others is a partnership or not. An arrangement is a partnership under their governance framework if there is an agreement between two or more independent bodies to work collectively to achieve an objective, excluding

- *any contractual agreement entered into by the council; or*
- *any agreement where the council provides an organisation with grant aid*

except where these arrangements create a separate decision making structure

To assess the significance of the partnership the governance framework requires us to take the following into account:

- the resources which the organisation contributes to the partnership;
- the partnership's contribution to the achievement of corporate priorities;
- the nature of the consequences if the partnership were to fail;
- the type of decisions the partnership makes;
- whether the partnership is required by law or to secure funding; and
- the extent to which the partnership helps the organisation to manage risk. *(10)*

As Jones et al (11) point out 'Networks often do not always constitute a formal partnership. They involve 'a select, persistent and structured set of autonomous firms or agencies engaged in creating products or services based on implicit and open-ended contracts to adapt to environmental contingencies and to coordinate and safeguard exchanges.'

These networks are usually socially, not legally, binding. A commonly cited example occurs in the film industry where contractors combine, disband and re-combine in varying combinations to make films. In health we are familiar with clinical networks although our evidence from cancer networks suggests varying degrees of cohesion and delivery.

The absence of effective governance elsewhere does not excuse us. As the Audit Commission explained in 'Governing Partnerships': *'Where partnerships are not corporate entities, their separate governance arrangements cannot mirror the detail found in corporate bodies. In the absence of formal governance arrangements, responsibility for supporting the governance of partnerships falls to partners' own corporate governance mechanisms. Most public bodies have clear structures and systems to support better corporate governance. However, the links between these and the governance processes involved in partnerships are often missing or unclear '* (8)

Governance in the UK, particularly within the public sector, has often been disjointed. What we are striving to attain here is a more explicit approach to the bigger picture which links across Health, Social Care, Education, Criminal Justice (Police & Prisons) and the Private/Independent Sectors.

The need for better GBO is highlighted where commissioners are held to account, but actually have had few levers to make things happen. Two examples are infection control (eg MRSA or C Difficile) and discharge of mentally ill patients back into the community. Current PCT responses might include a "fingers crossed" approach (leave it to the relevant trust!) or seeking blanket clauses in model contracts/SLAs which are unconnected to the work of individual clinicians or providers. The GBO approach would be for strategic planners/commissioners and providers to agree a common assurance framework in which the provider retains the freedom and responsibility to specify *how* the objective will be met, but does *not* have the freedom alone to specify how it will *account* for it being met.

5 Mutual Aid Strategies

We believe there are three key areas in terms of governance and security which require particular focus between organisations:

1. Longer term business continuity planning

2. Overall multi-sector organisational security and mutual aid aligned to planning for sustained events and incidents such as pandemics, weather and terrorism

3. National resilience planning

These areas are often seen as independent of the governance process and in our experience are not fully understood or addressed by boards within NHS Trusts. The evidence also indicates that broader strategies are needed to address these elements throughout the entire public and private sector; note for example the new *National Risk Register* announced by Gordon Brown in March 2008.

The Department of Health and the Cabinet Office published in 2007 '**Pandemic flu: A national framework for responding to an influenza pandemic, and supporting guidance**, *(12)* which describes the Government's strategic approach for responding to an influenza pandemic

'The Civil Contingencies Act 2004 and its accompanying non-legislative measures provide a single framework for civil protection, and resilience forums have been established to coordinate, develop and maintain links between partner agencies and coordinate planning at regional and local level. These forums provide an effective mechanism for developing integrated plans for all major threats, including pandemic influenza. A phased approach allows for a step-wise escalation of planning and responses, proportionate to the risk at any particular time.'

In practical terms this level of planning is fundamentally undeveloped and many directors fail to understand how to implement and sustain business continuity planning as a means to avert costs or mitigate longer term risk. The following trust report shows the far-reaching personal and financial implications of failing to take this into account:

"Business Continuity Management is a key component of the Civil Contingencies Act 2004 which has driven local efforts to be focused on preparing for civil emergencies such as localised flooding and major transport accidents. In my experience, what the NHS is getting right is emergency preparedness, in that tested plans are in place and well communicated in order to cope with an emergency. What we are not getting right is the alignment of business continuity plans with preparedness plans.

We instigated our major incident plan, cancelled theatres etc in readiness for a potential (worst case scenario) influx of patients, as opposed to considering the business and financial implications of so doing. When the casualties never materialised (in part because of diversion efforts of social services/PCT) it was too late… we had lost half a million pounds of activity.

The Trust failed to recognise the importance of the planning process across the locality (internally and externally) through better contacts between organisations (Police, PCT, Social Services). We could have ensured that whatever happened locally dovetailed with efforts at the hospital. It is imperative that we all share the desire to ensure any disaster or incident, natural or otherwise, has minimal effect on the economic well being of the community."

Organisations should not only test the resilience of internal structures and processes but also those of the organisations on which they rely or deliver services through. In the event of an emergency integrated planning and effective communication across organisational boundaries is critical to service continuity and community resilience. Robust and cross-organisational continuity plans ensure compliance and corporate governance by enabling adherence to the wider framework of responsibilities and expectations.

Our commitment, however, is to governance containment. What we wish to emerge from this document is the basis for creating simple rules of GBO which can be affirmed and adopted by partnering organisations. The 'how to do this' is outlined below; ownership will be by the individual corporate boards and delivery will be the responsibility of the organisational chairs.

The methodology to make any form of governance work is well known – identify and manage the risks. It would be foolhardy not to invest in tested mechanisms, safeguarding the organisation's authority and reputation. One of the most important features for any board/organisation is their Assurance Framework (AF) and how they use it. If the organisation can align its performance to a robust AF then it will be working well.

The gold standard we would like to achieve is one of combined assurance/whole system frameworks. This is not going to work immediately, however with a realistic timeframe and with established working protocols developed by the company secretaries it should be possible.

One of the key recommendations in the 2006 'Integrated Governance Handbook' (2) was the appointment of a dedicated company secretary to both guide the Board and also to be the professional adviser to the Board and directors.

Governance Between Organisations is complex and may require new protocols for governance, and indeed, ways of working. We realised that to create and manage the required efficiencies (financial and otherwise) in a wider multi-organisational setting would require a special set of skills.

We have considered three options for consideration, recognising the potential conflicts of interest and confidentiality that can exist for an individual trying to cover this role for more than one organisation in the same sector:

- Each organisation could have their own dedicated company secretary, but working with similar colleagues in partner organisations.

- The creation of a multi-agency company secretary role with responsibility for wider community organisations. This role does exist (eg in industry by creating a 'special purpose vehicle') but can lead to compromising scenarios

- The final option is the use of an individual company secretary per organisation but with a nominated community secretary lead, supported by a company secretary network. This is similar to the network established to support the cadre of NHS company secretaries trained by the Institute of Company Secretaries and Administrators (ICSA)

Within the NHS context the authors would also review the Audit Committee Handbook(13) which quite rightly extends the remit of audit committees to scrutinize the workings of the whole organisation but now we believe this should be extended to include other public sector body audit documentation and the implications for the independent/private sector.

The most significant factor driving the GBO agenda in England is the potential the PCTs clearly have as commissioning bodies. Elsewhere health systems must devise other mechanisms for effecting change in the relative power of the service deliverers. Whilst commissioning could currently be regarded as a fledgling discipline it is likely to mature quickly as astute PCT Boards focus on their commissioning responsibilities and opportunities. The SHA Boards can facilitate this drive, and we envisage that the key to change will be through PCTs building authority in their transactions with suppliers using their Professional Executive Committees as a sounding board to help design and review joined up working. Governance between organisations should underpin good commissioning.

Foundation Trusts (FTs) and others are not outside this agenda nor should they expect to continue as sole or isolated providers. We believe that in the future, they will be viewed as one provider along with other public or private organisations. This inevitably reduces their independence and should encourage their own need to deliver services the chain of in partnership with others.

What can we do?

- Ask the questions
- Seek assurance from within and beyond the organisation that controls are in place
- Take responsibility to ensure delivery beyond our narrow organisational limits
- Join up with others our planning, clinical pathways and mutual aid policies
- Trust and believe in the professionalism of our suppliers and delivery partners but challenge, scrutinize and improve
- Ask our patients and service users to help us to join up their services

This is 'fitness for purpose' in a manner never previously envisaged, and the more independent the PCTs are, the more challenging the multi-sector debates will become. All new PCTs and aspirant FTs have been subject to external fitness for purpose reviews but we believe it may now be time for internal *due diligence* assessments to be more regular, independent and wider in scope. Boards must have the confidence to withhold self-certification as an indication of strong corrective governance, rather than belated recognition of systems failure over an extended period.

At a more detailed level we believe Boards should be asking themselves a series of questions reflecting boundary issues at different levels. Outlined below are the key challenges which will help us achieve simple rules in Governance Between Organisations (GBO). We also identify a suite of products which will be developed to ensure speedy implementation. The ten challenges of Governance Between Organisations could be drawn from the following so far identified:

Continuity of care

1. Do we commission/provide joined up pathways of care between service providers?

2. Have we moved beyond a simple referral service to one where patients and professionals can be assured that handover to the next service is provided in a timely and safe manner?

3. Have we tested our systems to ensure we can correct mistakes promptly before others suffer harm or delay?

4. Have we learnt lessons from past inter-service mistakes e.g. mental health enquiries following patient homicide?

Partnerships and Networks

5. Have we identified our strategic partners, the outcomes we seek and created working relationships for effective and sustained delivery?

6. Have we, the Board, identified in our Assurance Framework the potential risk to our strategic objectives if our partners/providers fail in their service delivery? If so have we controls and assurance in place that we can mitigate the risks and act promptly if required.

7. Do we understand, implement and share our local commissioning model and impact assessments for all organisational sectors?

8. Have we organised a way of sharing concerns in relation to temporary or permanent staff when they move onto a new organisation?

9. Have we established a GBO etiquette and shared values between our partner organisations?

10. Are inter organisational services integrated and budgeted for at the planning stage?

11. Are our extended care-pathways underpinned by agreed partnership protocols and governance?

Mutual Aid & Business Continuity Planning

12. Do we have a mutual aid and business continuity planning model in place for both short (1-3 days) and long term disruption (3 days to 3 months) and are we monitoring our preparedness?

13. Do we have resilience forums in place to coordinate, develop and maintain links between partner agencies and coordinate planning at regional and local level with a step-wise escalation of planning and responses, proportionate to the risk at any particular time?

14. Have we mechanisms in place (eg joint performance measures) to assure that mutual working does not compromise quality of care or increase costs?

15. Have we assessed our reputational risks in respect of the wider community?

7 Conclusion and next steps:
Field trials & products in development

We believe the premise is right that *'Boards must seek assurance that risks to strategic objectives have been identified by ourselves and by partners with adequate controls in place'*

What we wish to emerge from this document is the basis for creating simple rules of GBO which can be affirmed and adopted by partnering organisations. This might for example involve staff taking *one more step* to ensure the patient or data has arrived. The development of the 'how to do this' is outlined below; ownership will be by the individual corporate boards and adoption will be the responsibility of the organisation's chairs. We do not believe we are seeking an overambitious agenda; the tone we hope is supportive rather than prescriptive, but we believe there is value in demonstrating and sharing the utility of the approach through testing and sharing examples of better practice.

How are we going to approach this work?

Identify ten boundary issues e.g. patient referral, accountability for risk in outsourced services, clinical networks etc

Find locations where this is working well

Determine common characteristics of success

Reduce to three or four simple rules

Field test

Specific Products under development:

Consolidated documentation and sample contracts/memorandum of association for effective working partnerships

GBO performance indicators & Board Assurance Prompts for board directors and Local Authority scrutiny panels

GBO maturity matrices based on the ten challenges and simple rules, perhaps developed to provide a due diligence review structure and process

Presentations and national/regional seminars

8 References

1. 2005 8th futures forum on governance of patient safety, WHO

2. 2006 2006 Integrated Governance – a handbook for executives and non-executives in healthcare organisations, Dept of Health (Gateway 5947)

3. 2007 HFMA Conference opening speech by David Flory, DH Director General of NHS Finance, Performance and Operations

4. 2005 Reputation: Risk of Risks, Economic Intelligence Unit

5. Integrated Governance definition IHM seminar 21 4 08

6. 2006 Section 75, NHS Act 2006,

7. 2006. Our health our care our say, A new direction for our community services

8. 2005 Governing Partnerships, Audit Commission

9. 2007 Integrated Governance, Delivering reform on two and half days a month' HFMA

10. 2007 Governance Framework for Significant Partnerships: Guidance for Directors, Leeds City Council

11. 1997 A general theory of network governance, Jones, Hesterley and Borgatti, Academy *of Management Journal*

12. 2007 Pandemic flu:A national framework for responding to an influenza pandemic, and supporting guidance, DH (Gateway 7569)

13. 2005 Audit Committee Handbook, DH/HFMA (Gateway 5706)

The brief for the GBO work was to:

- Identify the issues faced by the NHS in giving confidence to public, patients and stakeholders that good governance is in place between NHS organisations

- Map the current statutory accountabilities within organisations, which may need formally extending between organisations.

- Map the current means by which boards are gaining assurance that current arrangements cannot do harm or waste public resources and if necessary design an appropriate health economy-wide assurance framework for managing risk between organisations.

- Determine the simple rules for handover and accountability for patient safety.

- Report on examples of good practice from around the UK and elsewhere.

- Make recommendation to DH, NHS, Regulators and organisations engaged in advising and supporting the NHS including SHAs, NICE, HCC, NPSA, III, Monitor, Litigation Authority, Audit Commission, Appointments Commission etc.

Professor Bryan Stoten is Chair of Warwickshire PCT. Prior to taking up this appointment he had served as Chairman of University Hospitals Coventry and Warwickshire NHS Trust since 2001 and was Chair of Warwickshire Health Authority from 1999–2001. From 1996–1999 Bryan served as Chair of Birmingham Health Authority and was Chair of South Birmingham Health Authority from 1993-1996 and Chair of Coventry Family Health Services Authority from 1990–1993.

He is a visiting Professor at Coventry University, a Fellow of the University of Warwick Business School and Chairman of Education of Health and Health Link Malawi. Bryan is Chairman of the NHS Confederation.

Professor Michael Deighan is jointly leading on the Governance between Organisations (GBO) agenda. He is a special advisor on governance and board development to a number of agencies and organisations including the Department of Health and Northern Ireland CSCGST. Michael was appointed Strategic Board Development Advisor between NCGST and the NHS Leadership Centre. He was formerly a Fellow of the Manchester Centre for Healthcare Management (the Health Services Management Unit and in 1994 became a Professor in Health Policy as a mutual role with Anglia Polytechnic University. In 1990 he was made a Fellow of the World Health Organization in the field of Quality Assurance – translating good practice in European Healthcare to the National Health Service. (m.deighant@ihm.org.uk)

Dr John Bullivant FIQA is joint lead on the Governance between Organisations (GBO) programme. He is an experienced board facilitator, with an excellent knowledge of policy, governance and the commissioning of quality in the four health administrations in the UK as well as overseas. He is a former board director of a health authority and is now visiting fellow at the University of Glamorgan, Fellow and Vice President of the quality council of the Royal Society of Medicine.

He is a peer reviewer for Healthcare Inspectorate Wales and an advisor to a number of firms including Bentley Jennison, Humana Europe, Dynamic Change and Bevan Brittan. John helped establish the ICSA NHS company secretary programme and is currently sitting the exams himself. (J.bullivant@ihm.org.uk)

Andrew Corbett-Nolan is the Chair of the Institute of Healthcare Management. He is Head of Governance and Caldicott Guardian at Humana Europe, and a non-executive director of an NHS Foundation Trust in London. Andrew is the Chair of the Chartered Quality Institute's Health and Social Care Group, and represents the United Kingdom on the Council of the European Society for Quality in Healthcare. He has worked in healthcare since 1987 in local, regional and national NHS roles, with not-for-profits and in the commercial sector. He has been Vice Chair of the Terrence Higgins Trust, on the Board of the overseas development charity Health Unlimited and worked for the Council for Health Services Accreditation of Southern Africa. (a.corbett-nolan@ihm.org.uk)